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# For Insurers, Fight Is Now Over Details

By REED ABELSON

The legislative battle over the health care overhaul ended months ago, but it is hard to tell from the intense effort now under way by insurance companies to retool a critical provision.

The law requires health insurers to spend at least 80 cents out of every dollar they collect in premiums on the welfare of patients, a critical issue for the companies' bottom lines.

But state regulators are only now deciding what precisely that means, as they draft the rules to enact the law. WellPoint, which operates Blue Cross plans in more than a dozen states, wants to include the cost of verifying the credentials of doctors in its networks. Insurance companies like [Aetna](#) argue that ferreting out fraud by identifying doctors performing unnecessary operations should count the same way as programs that keep people who have [diabetes](#) out of emergency rooms.

Some insurers even insist that typical business expenses — like sales commissions for insurance agents and taxes paid on investments — should not be considered part of insurance premiums, which would make it easier for them to meet the 80-cent minimum.

The calculation of what is called the medical-loss ratio is crucial to insurance companies, because the law requires them to refund money to consumers if they spend too much on administrative costs.

But consumer advocacy groups and others see the insurers' proposals and their lobbying for a more expansive definition of what would be permitted as an effort to water down the law by including too many administrative costs under the umbrella of patient care. "A lot of what they are hoping to shift over there does not — and should not — qualify to improve an individual policyholder's quality of care," said Wendell Potter, a former insurance executive who now is critical of the industry and represents consumers in the discussions with state regulators. On Tuesday, Senator [John D. Rockefeller IV](#), Democrat of West Virginia, [sent a letter](#) to regulators expressing his concern that the insurers could have too much influence on how the regulations were being drafted. By his reckoning, insurers and their compatriots have submitted nearly 160 comment letters, totaling more than 600 pages, to the state regulators. Consumer advocates have submitted just 23, he wrote.

"The [health insurance](#) lobbyists failed to beat the [health care reform](#) bill in Congress — but with billions of dollars at stake, we cannot and we should not expect them to throw up a white flag and start looking out for the livelihoods of American families," Senator Rockefeller said in a statement. "They're working every angle of the implementation process to shirk their obligations under the new law."

At stake, according to [a report](#) issued Thursday by Health Care for America Now, a coalition that supports the new law, is hundreds of millions of dollars when the law goes into effect next year. If the six largest for-profit insurers had had to meet the new standards last year, they would have been required to refund \$1.9 billion, the coalition said.

The insurers contend that the advocates are discounting the value of an array of programs aimed at helping patients, which should be considered an aspect of quality improvement as part of the 80-cent minimum.

"This is a desperate attempt to distract attention away from the fact that these regulations could put at risk important services and benefits that improve the quality of care for millions of patients," said Robert Zirkelbach, a spokesman for America's Health Insurance Plans, a trade association in Washington. The association recently issued [an analysis](#) of what it contends should be included in the

definitions.

The debate has escalated in recent weeks as the National Association of Insurance Commissioners, which represents the state regulators, is expected to submit a final draft of its work as soon as next month to [Kathleen Sebelius](#), the secretary of health and human services, for certification. The regulators met this week in Washington to try to come closer to an agreement on the rules.

While much of the debate seems arcane, the insurers say the wording of the new regulations could exclude efforts aimed at improving the quality of medical care for patients. In its letter to regulators, [UnitedHealth Group](#), for example, says the current language requiring insurers to count only those quality efforts that can be measured and produce verifiable results is much too limited. It points to many programs — helping people to lose weight, for example — that are important but may not produce “desired results.” And while some consumer advocates argue that the efforts to root out fraud should be considered cost-saving measures, not patient care measures, Aetna defends its push to include those activities as benefiting patients because they protect patients from doctors who would give them diluted [chemotherapy](#) drugs, say, or worthless [mammograms](#).

“Notwithstanding any benefit from a financial perspective, we are fundamentally impacting the quality of care for the patient,” said Dr. Lonny Reisman, Aetna’s chief medical officer.

The insurers say they also need to be allowed to count the cost of promising experiments, even if they have not yet been able to produce hard proof that they help patients. “If it doesn’t work, we’re not going to be spending premium dollars on programs that aren’t effective,” said Alissa Fox, an executive at the Blue Cross and Blue Shield Association, the trade group that represents the nation’s Blue Cross and Blue Shield plans.

Some insurance commissioners seem sympathetic to the insurers’ arguments, including on the subject of how to treat broker commissions, which have historically been part of premiums. The insurers would exclude them from premium dollars, making it easier to meet the 80-cent minimum. The new standards “could potentially disrupt the availability of private health insurance, and do not take into

account the integral role of health insurance agents,” Kevin McCarty, the insurance commissioner for Florida, said last week in a letter sent to regulators.

Insurers also warn that the regulations could backfire. In a letter to state regulators detailing its concerns this month, WellPoint said the new rules could “paradoxically result in reduced health care quality in the system and higher costs.”

Consumer advocates counter that WellPoint wants only to derail the process. In his response, Timothy S. Jost, a law professor at Washington and Lee University in Lexington, Va., who also represents the interests of consumers, complained that the insurer was essentially asking the regulators “to tear up and discard” the work regulators had done to draft these rules.

WellPoint says its concerns are valid, contending that important functions like discharge planning when a patient leaves the hospital could be excluded.

“We’re the ones in this business and experts in the business,” said Brad Fluegel, a senior executive at WellPoint. “We have no interest in prolonging this process any more than it needs to be prolonged.”

Some consumer advocates say they hope the regulators will disregard the heated arguments on both sides.

“We do want to make sure health plans are able to experiment with efforts to improve quality,” said Ron Pollack, the executive director of Families USA, a Washington consumer group. “There needs to be careful thought and balance about what should be included.”



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