American Hospital Association

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Submitted Via E-mail

October 11, 2010

The Honorable Sandy Praeger
Kansas Insurance Commissioner
Chair, NAIC Health Insurance and
Managed Care (B) Committee
NAIC Government Relations Office
444 N. Capitol Street, N.W., Suite 701
Washington, DC 20001-1509
JMatthew@naic.org

RE: ***National Association of Insurance Commissioners' Draft Medical Loss Ratio Rebate Model Regulation***

Dear Commissioner Praeger:

The American Hospital Association (AHA) is pleased to submit comments regarding the National Association of Insurance Commissioners' (NAIC) draft medical loss ratio (MLR) rebate model regulation (Model Regulation) that implements provisions of the *Patient Protection and Affordable Care Act* (ACA). With more than 5,000 member hospitals, health systems and other health care organizations, and 40,000 individual members, the AHA is the largest advocacy and membership organization representing our nation's hospitals.

We wish to commend the NAIC's openness and transparency in conducting its MLR deliberations. Defining the components of the MLR policy is a serious undertaking, and the NAIC has assumed an enormous task as it attempts to balance the interests of all stakeholders. The AHA has followed these deliberations with great interest and provided comments to the NAIC throughout the course of its work. We urge continued vigilance to ensure that the MLR policies embrace the goals of the ACA and lead insurers to pay claims appropriately while reducing the administrative burden for providers.

Our comments focus on two key issues:

- The allocation of administrative and clinical costs in capitated payments when insurers use a non-provider third-party administrator, such as a medical (management) services organization (MSO); and
- The need to include health plans' contributions toward community-wide health care quality improvement projects in the definition of quality improvement expenses when calculating their MLRs.

We also reiterate other concerns previously shared with the NAIC regarding the proper allocation of costs, in general, and establishing a meaningful level to aggregate costs for purposes of calculating MLR.

ALLOCATION COSTS FOR MSOS

The AHA recognizes that the NAIC, through its actuarial subgroup, considered the treatment of capitated payment arrangements with providers that include both administrative and clinical costs. Ultimately the NAIC subgroup decided, as outlined in issue resolution document (IRD015), that capitated payments to providers should not be allocated between administrative and clinical expenses. What AHA is concerned about is capitated arrangements with intermediate organizations (often labeled MSOs) that are not part of the provider organization(s) delivering services to the plan's enrollees. Despite a stated concern by the subgroup that particular arrangements would permit insurers and issuers of insurance to count certain administrative costs inappropriately as clinical services, the IRD simply calls for the Department of Health and Human Services and state insurance commissioners to monitor contracting trends for potential abuses. We are already hearing from our members that they are increasingly seeing insurers use intermediary MSOs as a means of circumventing the MLR requirement, suggesting that this trend is real, not just a potential issue.

The AHA believes that the current Model Regulation and IRD015 do not adequately tackle this issue by explicitly addressing the issue of intermediate MSOs. While both refer to capitated or percentage of premium "provider contracts," there is no definition of that term that would exclude MSOs that are not part of a provider organization. The AHA strongly recommends that the NAIC not allow the entire capitated payment to count in the numerator of the MLR calculation if the insurer has a MSO arrangement in which the MSO serves as the payment broker between the insurer and the provider network. In this instance, the AHA recommends that those capitated payments distinguish between administrative and clinical costs.

HEALTH CARE QUALITY IMPROVEMENT

Section 2718 of the *Public Health Service Act* imposes reporting obligations and MLR standards on health insurers aimed at ensuring that a minimum percentage of health insurance premiums is used to pay for health care services or activities that improve health care quality for enrollees. The concept of adding costs for "activities that improve health care quality" to the costs for "reimbursement for clinical services provided to enrollees" is new in the context of calculating MLRs, having just been added this year by the ACA. As such, this policy has created controversy and led to our earlier caution that specific criteria be applied to ensure that any costs added to the numerator of the ratio for health care quality improvements not permit health insurers to reclassify at will costs that were historically classified as administrative costs.

Bearing this caution in mind, the AHA would like to call the NAIC's attention to activities where hospitals, health insurers, state hospital associations and other organizations have collaborated on community-wide quality improvement initiatives that may inappropriately be classified as administrative activities. These collaborations typically go beyond the health plan's enrolled population in order to change how care is delivered to all patients and, as such, ensure that the internal provider systems necessary to implement the quality improvement activity can be

maintained and sustained throughout the entire community. We understand that there is some question as to whether health plan contributions to such quality improvement projects will be allowed to be counted in the numerator of the MLR calculation because they are not limited only to the plan's enrollees, or because the dollars may have flowed through a centralized entity, such as a state hospital association.

We would like to share some examples of collaborative projects that are significantly improving quality. Blue Cross Blue Shield of Michigan has been a major contributor to the Michigan Health & Hospital Association Keystone Center for Patient Safety and Quality. The Keystone Center has achieved international recognition for its work in developing collaborative models to improve patient care, most notably for driving central line-associated bloodstream infection rates to near zero in participating hospitals. The North Carolina Center for Hospital Quality and Patient Safety was developed by the North Carolina Hospital Association with assistance from Blue Cross Blue Shield of North Carolina. The Center has led collaborative efforts to reduce healthcare-associated infection rates, improve cardiac and surgical care, and build a culture of safety in North Carolina hospitals. In these two examples, we believe that the health plans' contributions to these quality improvement initiatives should count as quality improvement expenses in calculating their MLRs.

ALLOCATION AND AGGREGATION OF COSTS

As indicated in earlier letters, the AHA strongly believes that the MLR regulations must clearly define which activities do and do not improve health care quality, as well as restrict the ability of health insurers/issuers to make such a determination on a subjective basis. However, the regulations should not preclude the community-wide quality collaborations between health plans and providers described above. These types of quality improvement activities that are consistent with the ACA should appropriately be included in the numerator. As the AHA has recommended in prior correspondence to the NAIC and outlined below, the use of a decision tree analysis would distinguish between an activity that is primarily intended to limit services or reduce expenditures (e.g., utilization management) versus one to improve health (e.g., programs to reduce central-line infections). A decision tree analysis might incorporate a series of questions that probes whether the activity is aimed at reducing cost or utilization, or directs the patient to a lower-cost care setting, versus whether the activity measurably improves the patient's or the community's health. Rather than permitting labels to dictate the classification of expenditures, the analytic approach of a decision tree reduces the ambiguity and, therefore, the opportunity for arbitrariness, in determining which activities will improve the health quality for an enrollee, not just limit an insurer's costs.

Further, the MLR regulations should require that the "quality activity" be performed by a health professional licensed to perform the service or activity. Health insurers, by definition, are not providers of health care services, nor are they licensed to deliver care. They perform an important but largely administrative function in our health care system through the administration of health coverage plans. Insurers should not be permitted to determine without clear definition and guidance which services are defined as clinical and which activities will improve the quality of health care for an enrollee.

Additionally, the NAIC should determine a meaningful level for the aggregation of health insurance company MLRs. MLRs vary widely by insurance product type and geographic location. The intent of the ACA provision on MLR is to ensure that the majority of premium dollars are spent on health care services or activities to improve health care for enrollees. Aggregating MLRs at a company-wide level may be useful in examining solvency issues by regulators, but aggregating at too high a level might mask the variations in insurance markets and products. The AHA recommends that health insurance plans be required to aggregate MLRs at a level that is meaningful enough to ensure compliance with the letter and spirit of the law.

Again, the AHA applauds the hard work of the NAIC in developing a MLR policy for implementing the ACA. We look forward to continuing to work with the NAIC to ensure that the goals of the ACA, to achieve affordable and high quality health care coverage for all, are met. If you have questions about our comments, please contact me, Ellen Pryga, policy director, at epryga@aha.org or (202) 626-2267, or Molly Collins Offner, policy director, at mcollins@aha.org or (202) 626-2326.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President
Public Policy Analysis and Development