June 18th, 2010

Mr. Lou Felice, Chair, Health Care Reform Solvency Impact Subgroup
Steven Ostlund, Chair, Accident & Health Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Re: Calculation of Medical Loss Ratio Recommendations

Dear Mr. Felice, Mr. Ostlund, and Subgroup members:

For nearly ten years the City of Amarillo Health Department and the Caring for Children Foundation of Texas have collaborated to conduct immunization outreach and immunize thousands of Amarillo area uninsured children utilizing one of the foundation’s Care Vans. During this entire time, Blue Cross and Blue Shield of Texas, the statewide sponsor of the foundation, has provided 100% of the foundation’s administrative expenses as an in-kind donation. This is an unusually successful partnership that has literally saved children’s lives.

I am writing to urge the National Association of Insurance Commissioners (NAIC) to consider and recommend to the Department of Health and Human Services (HHS) a definition of medical loss ratio (MLR) that will encourage health plans to continue their tremendous support of community-based public health initiatives and programs. This is critical to ensure our kids receive the shots they need to attend school and stay healthy. I want to make sure that health insurers will continue their critical participation in these efforts. We cannot ignore the importance of this safety-net program.

It is my understanding that if the definitions around MLR are too narrow, health insurers will not be encouraged to support community-based health initiatives and could, in fact, be penalized for such support if their contributions are counted as administrative expenses. Penalizing support of my organization’s program and similar community-based programs across the nation would not be wise public policy.

I strongly urge the NAIC to recommend to HHS that for the purpose of calculating MLR, quality initiatives include health insurers’ involvement and investments in public health initiatives.

Thank you for consideration on this important issue. We cannot fail our children.

Sincerely,

Matt Richardson, MPH
Director
By electronic mail

June 16, 2010

Lou Felice
Chair, NAIC Health Reform Solvency Impact (E) Subgroup
National Association of Insurance Commissioners
444 N. Capitol Street, N.W., Suite 701
Washington, DC  20001-1509

Re:  Medical Loss Ratios under Public Health Service Act Section 2718

Dear Mr. Felice:

The Blue Cross Blue Shield Association (BCBSA), which is comprised of the 39 independent Blue Cross and Blue Shield Plans (“Plans”) that provide health coverage to nearly 100 million Americans, appreciates the opportunity to provide additional comments as the National Association of Insurance Commissioners (NAIC) continues its work to provide recommendations to the Department of Health and Human Services (HHS) on Section 2718 of the Public Health Service Act (PHSA), dealing with medical loss ratios (MLRs). The NAIC’s Health Reform Solvency Impact (E) Subgroup has made great progress thus far in refining the Supplemental Health Care Exhibit discussion draft, and we appreciate the subgroup taking these additional points into consideration.

Health Quality Improvements - Recommendations for Supplemental Health Care Exhibit – Part 3

Health care delivery has changed tremendously over the years, with health plans playing a more prominent role in helping drive quality and safety improvements across the health system. Blue Cross and Blue Shield (BCBS) Plans are committed to improving quality and safety – for individual patients and for specified populations – by supporting a wide range of critical quality improvement activities needed to transform the delivery system. And Plans are continually innovating and testing new quality improvement (QI) activities. We are concerned that the definition of QI expenses proposed in the current draft of Part 3 instructions would support some but not all of these activities.

To encompass the full range of health plan activities designed to improve quality – for individuals and for specified populations – and to promote future innovation, we recommend three overarching revisions to Part 3:
1. Explicitly allow health services for specified populations as QI expenses.

2. Design the QI definition to promote, not hinder, future innovation, by embedding the Institute of Medicine definition in the general definition, and by streamlining administrative complexity in other sections.

3. Incorporate references to Sections 1311 and 3011 of PPACA, to ensure that health plans’ QI activities are consistent with current and future QI reporting requirements and state exchange QI strategies.

What follows are recommended revisions to strengthen Part 3 that address each of our three “recommendation” categories. If these revisions are not made, health plans will face pressure to cutback on critical QI activities in order to live within the MLR administrative cap. Following each recommended revision is an example of a BCBS QI activity that supports the recommendation, but that might not be considered as falling within the current NAIC definition of quality activities.

We have attached to this comment letter a complete redline version of suggested language changes to Part 3.

1. **EXPLICITLY ALLOW HEALTH SERVICES FOR SPECIFIED POPULATIONS AS QI EXPENSES**

**Issue:** The Institute of Medicine (IOM) defined the quality of care as “the degree to which health services for individuals and populations [emphasis added] increase the likelihood of desired health outcomes and is consistent with current professional knowledge.” This definition identifies both individuals (e.g., improvement in individual health status) and populations (e.g., reduced aggregate burden of illness and injury in a population) as proper targets for quality assurance efforts.

However, because the General Definition does not explicitly encompass health services to improve quality and safety for populations, and because the subsequent sections (Columns 1 through 4) in general address only health services for individuals, there is a high likelihood that vital activities to promote quality and safety for all patients, including health plan members – such as programs to reduce infection rates hospital-wide – would not be counted as QI expenses.

- **We recommend revising Part 3 to ensure that health services for populations, as recommended by the IOM, are embedded in the definition of QI expenses.**

**Rationale:** IOM called on leaders of organizations such as health plans to support accountability to individual patients while also assuming responsibility for accountability to public bodies and the community at large for the populations they serve. IOM noted that the application of epidemiological knowledge to large
populations and databases – applications well-suited to health plans with their vast data resources – will enable us to understand more and more about the dynamics of wellness and disease, which will redound to the benefit of individual patients. If the QI definition does not explicitly include health services for populations, the future of such programs is threatened.

The benefits of a population approach were expanded upon in a seminal 2007 article in the Milbank Memorial Fund Quarterly, “Using Population Segmentation to Provide Better Health Care for All: The “Bridges to Health” Model.” The model offers a way to think about developing programs for specified segments of the population that meet patients’ needs for coordinated, integrated care. When these programs are aggregated, they should improve the quality and efficiency of care for the entire population.

For certain types of patients who are extremely disabled or sick – such as those with significant disabilities, or heart or lung failure, or near death from cancer, or frail with dementia – reliably improving their health requires fundamental changes in service delivery arrangements and the availability of important options. So sick and disabled are these populations that substantial re-engineering to ensure continuity of clinicians and to involve patients or their advocates in planning their care across multiple settings could prove to be among the highest priorities.1 Such QI activities focusing on specified populations will be more effective in improving health outcomes than QI activities focusing on one individual at a time.

For example, extremely sick patients hospitalized in Intensive Care Units are highly susceptible to central line bloodstream infections. Combating these infections requires the “substantial re-engineering” of hospital processes that is characteristic of a population-based approach to quality improvement. After years of research on effective steps in infection control, Peter Provonost of Johns Hopkins implemented this body of research into a multi-step checklist that translated the most effective known approaches into a series of hygienic precautions to follow when inserting, using, or removing a central line. Working with a state hospital association, a BCBS Plan was the first health plan to support testing Provonost’s ideas on a wider scale. This program benefited the Plan’s members as well as the broader hospital population.

Since then, BCBS Plans across the country have adopted the checklist approach to address another serious safety issue, surgical infection complications: the Blue Surgical Safety Checklist is the first in a series of resources created to educate and encourage providers to take proactive measures to help improve safety in the healthcare setting. The checklist, adopted from the World Health Organization Surgical Checklist, consists of 19 steps designed to improve communication and consistency of care within surgical teams. BCBS Plans have

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been sharing this Checklist with hospitals and physicians to encourage its use. This QI activity targeted on a specified population that included Plan members among a broader population has and will continue to save the lives of countless individual patients.

Explicitly including health services for populations also is necessary to achieve certain QI activities to improve health outcomes contained in PPACA and identified within the current NAIC definition, such as programs to reduce health disparities among specified populations and health plan accreditation programs. Identifying and addressing ethnic, cultural or racial disparities cannot be achieved through activities that improve care one patient at a time. Similarly, a core criterion for NCQA and URAC accreditation is to report aggregate information on outcomes for specified populations of patients, not to report outcomes for individual patients. Thus, adding “health services for specified populations” would clarify what the current General Definition already implies in certain areas.

**Recommended Language:**

**General Definition:**
Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for health services for individuals or specified populations that are designed to...

**Column 1 – Improve Health Outcomes**
Expenses for the direct interaction of the insurer, providers and the enrollee (e.g., face-to-face, telephonic, web-based interactions or other means of communication between and among patients and their providers) to improve health outcomes for the patient under the plan or coverage or to improve health outcomes for specified populations. This category can include costs for associated activities such as including:

**Column 2 – Activities to Prevent Hospital Readmission**
Expenses for implementing activities for individuals or for specified populations to prevent hospital readmissions, including:

**Column 3 – Improve Patient Safety and Reduce Medical Errors**
Expenses for implementing activities for individuals or for specified populations to improve patient safety and reduce medical errors under the patient’s plan or coverage through including:

**Column 4 – Wellness & Health Promotion Activities**
Expenses for programs for individuals or for specified populations that provide interactions with the enrollee (e.g., face-to-face, telephonic or web-based interactions or other forms of communication) that at a minimum include between and among patients and their providers) that promoting:
Impact Examples:

Blue Cross Blue Shield Plans have supported a wide range of population-based quality improvement programs that have benefited their members as well as the community at large. Below are examples of these programs:

Example 1: BCBS plans recently launched a program to reduce childhood obesity and prevent future cases of diabetes. In consultation with the American Diabetes Association and the American Academy of Pediatrics (AAP) a nationally available “toolkit” was developed and distributed – a set of materials physicians can use to help parents and children become more motivated to adopt healthier lifestyles – to pediatricians and family practitioners in more than 1,600 physician practices. The materials assist physicians, children, and families in reducing childhood obesity.

Example 2: A radiology management program established by a BCBS Plan helps enrollees receive appropriate, quality diagnostic imaging exams and avoid excessive exposure to radiation (a quality issue of increasing concern, as evidenced by the House Energy and Commerce Subcommittee on Health’s recent hearing on risks of the use of radiation in medicine). The Plan provides the ordering physician with costs and quality information – based on evidence-based guidelines – about the available imaging providers within a specified geographic area.

Example 3: A joint initiative by a BCBS Plan, a state university and the Society of Hospital Medicine (SHM) to reduce preventable hospital readmissions by working with 15 physician organizations and 14 hospitals to implement the Society of Hospital Medicine’s Project BOOST (Better Outcomes for Older Adults through Safer Transitions) model. It involves training and mentoring to help physician organizations and hospitals develop, implement, and measure programs that reduce the incidence of patients being readmitted to the hospital within 30 days of their discharge. Participating physician groups and hospitals will share best practices and key lessons learned, leading to improvements in quality and safety for all in the specified population of patients admitted to the 14 participating hospitals.

Example 4: A population-based “National Surgical Quality Improvement Program” run by a BCBS Plan to improve quality and safety for surgical procedures. Through partnerships with 34 hospitals across its state, the Plan collects and shares data and best practices to improve quality and safety for surgical procedures: in one year, overall surgical site infections were reduced by 18%; overall surgical complications, by 37%. The American College of Surgeons recently gave an award to this program.
2. **CRAFT THE QI DEFINITION TO PROMOTE, NOT HINDER, FUTURE INNOVATION**

**Issue:** Several clauses in the general definition and in the subsequent columns would have a chilling effect on future innovations by erecting unnecessary barriers and unreasonably high standards. First and foremost, it is important to recognize that medicine is not black and white, it is a blend of art and science. That is why the IOM definition of quality speaks to increasing the “likelihood of desired health outcomes.” Second, the ability to innovate, to respond nimbly in a fast-changing medical environment, would be chilled by requiring the application of yet-to-be developed standards or unreasonably high standards of care. As the Joint Commission noted in its May 25, 2010 letter to the NAIC: “Many QI strategies are reasonable for insurers to engage in because of their likelihood to result in better care and services, but cannot yet meet a rigorous requirement that they are evidence-based. Until such time as there is more empirical evidence, insurers should not be discouraged from engaging in activities with a generally accepted, strong and close causal relationship between the QI expenditures and the anticipated population or enrollee outcome.”

We recommend revising Part 3 to promote flexibility in designing new approaches to improving quality, and to avoid chilling future innovations.

**Rationale:** To promote flexibility, the definition of QI should recognize the lack of “black and white” certainty in medicine by using the IOM language that QI programs be designed to “increase the likelihood” of desired health outcomes.

We also are concerned about a requirement that QI expenses be “based on standards developed independent of any particular health insurer” since such a criterion would put the cart before the horse. Standards are rarely developed and finalized until various approaches – often based on models developed by different medical specialty societies, accreditation bodies, or other national quality organizations – have been extensively tried and refined by health insurers and others in the real world.

Similarly, in the “Other” sections of each column, requiring prior approval by HHS would be another barrier to innovation because it would add an unnecessary and administratively costly layer of regulation that would slow down the rate of innovation. Advances in medicine move so fast, and differences across markets are so vast, that health plans need the flexibility to innovate quickly and to tailor programs to the unique needs of the local community. Adding layers of review that need prospective, empirical evidence on performance would slow or end needed innovations.

Also in the “Other” sections of each column, requiring that there be a showing that costs improve the quality of healthcare is an overly strict criterion that would hinder innovation by precluding initiatives that have value but cannot yet meet a cost improvement criteria.
Recommended Language:

**General Definition**
Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), that are designed to increase the likelihood of desired health outcomes and that are grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations. They should not be designed solely to control or contain cost.

QI Standards: QI expenses should be based on standards developed independent of any particular health insurer, and be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, or government agencies. They should not be designed solely or primarily to control or contain cost.

**Column 1**
Other expenses for programs designed in ways that can be objectively measured and verified to increase the likelihood of desired health outcomes for individuals or specified populations that meet the General Definition of Quality Improvement as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs improve the quality of healthcare as set out in the first paragraph above; the burden shall be on the proponent to show that the expenses for the program conform to the definition meet these criteria.

**Column 2**
Other expenses for programs as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs are designed to prevent hospital readmissions for individuals or specified populations that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the program conform to the definition meet these criteria.

**Column 3**
Other expenses for programs designed to as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs improve patient safety or reduce medical errors for individuals or specified populations that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the program conform to the definition meet these criteria.
Column 4
Other expenses for wellness and health promotion activities for individuals or specified populations that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the programs conform to the definition.

Column 5
Other expenses for programs which support as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs support the activities described in columns 1 through 4 or otherwise support monitoring, measuring, or reporting health care Quality Improvement. The burden shall be on the proponent to show that the expenses for the programs conform to the definition, meet these criteria.

Impact Examples:

In 2008, many BCBS Plans across the country began developing targeted programs with participating physicians to determine the best ways to implement the patient-centered medical home model at the practice level. Had the current general definition been in effect, none of these programs would have been possible because standards for the patient-centered medical home did not (and still do not for a comprehensive range of models) exist. A May 2010 Health Affairs article, in noting the “novelty, complexity, and variety of medical home interventions,” underscores the chilling effect that would follow from requiring QI expenses to be based on already-developed standards.

Similarly, the medical home is a good example of a QI activity that lacks sufficient empirical evidence to show that costs improve the quality of healthcare. As noted in the May 2010 article in Health Affairs, “Evidence from the medical home pilots is currently scant…” Because medical home demonstrations began only recently, little evidence of their impact on health outcomes is currently available.

3. INCORPORATE REFERENCES TO SECTIONS 1311 AND 3011 OF PPACA

Issue: The current General Definition notes that “Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of PPACA.” Section 2717 articulates the quality improvement activities that must be reported by health insurers and group health plans. However, two other sections of PPACA are equally important in setting out quality goals: Section 1311 lays out the elements of a quality improvement strategy that must be carried out by Qualified Health Plans in the new Health Benefit Exchanges; and Section 3011 calls for a National Strategy on QI that lays out the national priorities with the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations.
We recommend revising the General Definition to incorporate Sections 1311 and 3011.

Rationale: The elements of a quality improvement strategy in 1311 are the same as the elements to be reported in 2717 (except for the addition of health disparities, which is included in the current General Definition – and is reason enough to incorporate reference to Section 1311). However, a quality improvement strategy will not be a static document.

First, the Secretary is required to develop guidelines for the quality improvement strategy, and if those guidelines call for activities that do not currently appear in Part 3, then Qualified Health Plans might not be able to define those mandated activities as QI expenses unless Section 1311 is explicitly referenced.

Second, the application of the guidelines are required to be reported periodically, which implies that the guidelines will be adjusted over time to reflect experience – again, Qualified Health Plans need the certainty that as the guidelines drive changes in their QI activities, that the Plans will be able to define these activities as QI expenses.

Section 3011 directs the Secretary, as part of developing a National Strategy for QI, to identify national priorities that have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, and to identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care. The Strategic Plan must include “Strategies to align public and private payers with regard to quality and patient safety efforts.” Therefore, to ensure consistency and alignment with the National Strategy, it is essential that the evolving priority areas be defined as QI expenses.

Recommended Language:

**General Definition**
Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses...Qualifying QI activities are primarily designed to achieve the following goals set out in Sections 2717, 1311 and 3011 of PPACA; improvement must be capable of being objectively measured and produce results and achievements that can be verified to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates; or
- Increase wellness and promote health activities; or
• Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;

Finally, we would like to reiterate the importance of maintaining a level playing field among different health plan models for the quality improvement definition in the MLR standards. If any particular activity is ultimately excluded as an expense for health care quality improvement, then uniformly it should not be counted as a medical expense, including for group and staff model HMOs that may currently report certain quality-improving activities (such as disease and case management and health risk assessments) as medical expenses. Uniform treatment will create a level playing field on which consumers will be able to make informed, apples-to-apples comparisons among their health care choices. This uniformity is important to the quality provisions as well as the non-quality section of the Exhibit as discussed below.

Comments on Parts 1 and 2

In addition to the above recommendations for the Part 3 instructions, we would like to emphasize several key issues raised in our May 24 comment letter that refer to other sections of the Exhibit and that continue to merit careful consideration.

1. We have noted the importance of consumers having meaningful comparisons among all health plans, including the ability to easily compare medical and administrative spending among different health plans, and in particular, between group and staff model HMOs and other insurance models. To accomplish this Level playing field objective, all health plans should report costs uniformly. Today, staff and capitated model HMOs report many expenses as “clinical” that other plans include in the “administrative” category. A failure to address this discrepancy would mislead consumers because certain HMOs would appear to spend a relatively higher percentage on clinical services costs. As explained for quality improvement expense reporting, consumers should be able to compare plans on an apples-to-apples basis. Also, rebate implications should be taken into account. If there is a misplacement of expenses, consumers may be denied the potential for rebate for which they otherwise might have been eligible.

2. Reporting requirements should focus first on those elements specifically required by federal law, then phase in additional reporting not specified by PPACA at a later time. This would promote timely PPACA compliance, consistency with market segment rebating requirements, and achieve accurate and meaningful results for consumers and regulators.

Systems changes are needed to ensure the accurate, consistent and comparable information that the new federal requirements are intended to produce for regulators and consumers. To produce the proposed exhibits that go beyond federal requirements, such as reporting for “uninsured” and for Part 3, significant
systems upgrades are needed. Changes include systems enhancements to gather and warehouse data, to program algorithms (e.g., to allocate items such as investment income, federal income taxes and other expenses), and to develop processes to verify the results. The changes must be made within the new internal controls environment prescribed by the NAIC version of Sarbanes-Oxley (as known as the Annual Financial Reporting Model Regulation), which is vitally important but adds time and cost. A phased approach, such as permitting those elements not required by PPACA for year-end 2010 reporting not to take effect till year-end 2011 reporting, would best allow us to accomplish those goals while helping to manage administrative costs associated with these systems upgrades.

3. Line 1.5 – PPACA allows for the inclusion of all Federal Taxes and Federal Assessments. We recommend that the exclusion be deleted from the instructions for Line 1.5.

4. Line 1.8 - Fees for examinations by state departments are in addition to annual external auditor reviews but are required under state insurance laws. They are performed by state regulators, or their subcontractors, with the fees charged directly to the insurer even though the insurer has no control over the amount of the fees. We believe that statutory examination fees meet the definition of regulatory fees, and, therefore, should be included in the definition.

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Thank you again for the opportunity to comment on the NAIC’s Supplemental Health Care Exhibit discussion draft. We look forward to continuing to work with you on this issue.

Sincerely,

Joan Gardner
Executive Director, State Services

cc: Steve Ostlund, Chair, PPACA Actuarial Subgroup
    Todd Sells, NAIC Staff
    Brian Webb, NAIC Staff

Attachment
June 21, 2010

Mr. Lou Felice, Chair  
Health Reform Solvency Impact (E) Subgroup  
c/o National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, Missouri 64108-2662

RE:  NAIC Life and Accident & Health Blank and SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3. (Post-June 17th Health Care Solvency Impact E Subgroup Call)

VIA ELECTRONIC MAIL

Dear Mr. Felice:

Your Consumer Representatives to the NAIC, representing millions of patients, consumers and workers, are writing to follow-up with you in writing after the June 17th call to offer some additional comments and observations on the benefit of segregating shared savings from incentive payments, loss adjusted expenses, accounting for agent/broker commissions, applicable provisions contained in Section 3011, definitional issues around the use of specific populations, the removal of the Secretary’s discretion to define “other expenses”, and continuing concerns regarding the broad inclusion of ICD-10 expenses. These comments are in addition to and complement the comments we offered on June 14th on the 2010 NAIC Life and Accident & Health Blank June 10, 2010 Discussion Draft (NAIC Blank) and our first comment letter dated May 20, 2010.

Medical Incentive Pools and Bonuses
We understand that the Subgroup has not accepted our position on line 3 of the blank proposal, on which incurred medical incentive pools and bonuses are reported. Our concern continues to be that, although incentive payments to promote quality improvement may be recognizable as “activities that improve health care quality,” shared savings programs under which providers are paid for not providing care should not be classified as “reimbursement for clinical services provided to enrollees.” Programs that incentivize providers to provide fewer services to enrollees should properly be classified as administrative expenses. In any event, they should be separately reported on the blank in the interests of transparency and accountability so that regulators and consumers can understand how much insurers are spending for these purposes.

Loss Adjusted Expenses
We continue to support the position that both the Health Reform Solvency Impact (E) Subgroup and the PPACA Actuarial Subgroup of the AHWG (IRD001) have adopted that loss adjustment expenses are not included in the 2718(b) rebate formula. This position is based on the plain language of the statute, which requires the disclosure of loss adjustment expenses under 2718(a), but does not include them in the rebate formula in
2718(b). This is only one of several differences between the 2718(a) disclosure formulas and the 2718(b) rebate formula. The position is also supported by correspondence the NAIC received from two of the key Senate supporters of the legislation. The fact that two law firms retained by insurers disagree with this position does not undermine the determination that the subgroups have made. To the extent that this position creates an unlevel playing field between HMOs and PPOs, the issue should be resolved by requiring HMOs to identify their loss adjustment expenses as administrative costs and not claiming them as “reimbursement for clinical services.”

**Agent/Broker Commissions**

An objection was raised last week by Cigna to agent/broker commissions being counted as part of premiums for the MLR denominator and as administrative expenses for the MLR numerator. Cigna argued that commissions should be excluded from both. This position is surprising, as the industry has consistently argued that the historically high cost of agent/broker commissions as a primary reason why a transition is needed to the statutory MLRs to avoid destabilization of the market. It is clear, however, that Congress intended agent/broker commissions to be counted as administrative costs for purposes of the MLR. On December 20, 2009, hours before the Senate passed PPACA, Senator Nelson, the former insurance commissioner of Florida, explaining how the legislation made health insurance more affordable, stated on the Senate floor:

I want to give one specific example. It is a technical term in the insurance industry called the "medical loss ratio." It is the ratio in what an insurance company actually pays out in medical claims as opposed to what it pays for administrative expenses such as marketing, insurance agent commissions, underwriting, and an insurance company's profit. . . . What this amendment, . . . says, is it causes a specific ratio so you are getting a high amount of return on the insurance premium dollar. . . . And the balance, . . . is going to things such as administrative expenses, paying for insurance agents, commissions, paying for their profit…

*155 Cong. Rec. S13558, S13626-S13627*

Section 1301(a)(1)(C)(iii) of PPACA, states that the issuer of a qualified health plan must agree “to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.” Obviously Congress understood that agent/broker commissions were part of the premium rate charged by health insurers. We support the Subgroup in maintaining this position.

**Section 3011**

The Solvency Impact Subgroup has properly focused on section 2717 as the primary provision of PPACA dealing with the responsibilities of health plans for quality of care. Section 1311(g), which addresses the payment strategies that qualified health plans are encouraged to pursue to improve quality lists similar quality of care factors and could also be seen as relevant to 2718. Section 3011, however, addresses a much broader topic, “a national strategy to improve the delivery of health care services, patient health outcomes, and population health,” and is not relevant to 2718, which only considers
“activities [of insurers] that improve health care quality.” Section 3011 focuses heavily on efficiency. While efficiency is important, it is not a factor in the 2718(b) formula. The listing of efficiency (and transparency) as a factor in the proposed revised general definition is, therefore, inconsistent with section 2718.

**Specific Populations**

We are generally supportive of the addition of specified populations and appreciate the concerns you expressed regarding offering an adequate definition of specified populations that is attributable back to the enrollees in the specific health plan. We would encourage and support a definition that would take into a consideration a targeted segment of enrollees and a broader general population where the plan has a significant market share when it is supported by the evidence-base and justified to reach their covered lives through population-level quality interventions.

You had also inquired about examples of community-level quality interventions that would be directed towards specified populations. There is a strong and growing evidence base for community-level quality initiatives and we would encourage you to hold these quality expenses to the same rigor as the Blanks Discussion Draft has established for quality initiatives directed at the individual (evidence based, focus on quality improvement and not cost containment, etc). We believe that in addition to the specific community-level interventions recommendations contained in the Community Guide (http://www.thecommunityguide.org/), you would similarly want to allow other quality initiatives that have a strong theoretical bases for intervening at the community level to achieved the desired results. As with individual quality initiatives, health plans must monitor and evaluate these interventions and periodically report on whether they are achieving their intended quality outcomes. The burden should be on the plan to demonstrate the above in a transparent manner. In addition to the examples offered on the June 17th call (infection control), we would also suggest that investments in improving underdeveloped emergency medical response systems (trauma, stroke, heart attacks and cardiac arrest, burn treatment) is another compelling example when overall care can only be achieved at the population level to benefit individual enrollees.

**Role of the Secretary of Health and Human Services**

While we appreciate and continue to vigorously support a “high bar” threshold for other expenses to be deemed quality improvement (objectively measured, verifiable, achieve desired health outcomes, burden of proof on proponent of additional expenses), we were unconvinced by the rationale offered for eliminating the discretion of the Secretary of Health and Human Services (in consultation with the NAIC) to approve any new such expenses. Our reading of this revision and the resulting language in the current discussion blank is silence on where the decision-making and authority resides to make such determinations. We are concerned that the consequences of such open-ended provision would lead to unclear roles and responsibilities of proponents, NAIC and individual commissioners; a diminished standard of what is required to demonstrate quality improvement; and a lack of public notice and transparency with regard to the process to make these determinations. We would encourage additional dialogue between the NAIC and HHS to ascertain the appropriate role for the Secretary in this regard and
until such time that further guidance and direction is received, we would strongly recommend the restoration of the Secretary’s authority in this section.

**ICD-10 Expenses**

We continue to believe that all cost directly relating to ICD-10 be considered an administrative expense. While not specifically addressed and resolved on the June 14th call, our impression is that there is some consideration being given to include ICD-10 expenses as quality initiatives. We acknowledge that ICD-10 will facilitate better tracking of important metrics such as outcomes, severity, medical complications and safety issues. And while these metrics are important to monitor and evaluate quality initiatives, the primary purpose of ICD-10-CM and ICD-10-PCS remains payment coding. So unless there is an objectives means and formula to attribute a portion of these expenses to be considered quality improvement (which we are not aware of), we would continue to recommend that all ICD-10 costs continue to be defined as administrative expenses.

We appreciate this opportunity to submit additional comments after the June 17th call and look forward to the continued opportunity to be actively engaged in the deliberations of the Health Reform Solvency Impact (E) Subgroup this week as you work to finalize the Blank instructions. If you have any questions, please contact Timothy Jost at JostT@wlu.edu or Mark Schoeberl at mark.schoebel@heart.org.

Sincerely,

Mark Schoeberl
Timothy Jost
Georgia J. Maheras
Bonnie Burns
Wendell Potter
Elizabeth Abbott
June 21, 2010

BY ELECTRONIC MAIL

Lou Felice
Chair, Health Care Reform Solvency Impact (E) Subgroup

Re: Request for Information: Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act [75 Federal Register 119,297 (April 14, 2010)] (“RFI”)

Dear Mr. Felice:

The Federation of American Hospitals (“FAH”) is the national representative of nearly 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer and psychiatric hospitals. We appreciate the opportunity to provide additional information in response to the NAIC Health Care Reform Solvency Impact (E) Subgroup with respect to the implementation of Section 2718 of the Public Health Service Act (“the Act”).

This letter responds to the Blanks document discussed on the Subgroup’s June 17, 2010 teleconference. As the NAIC’s Blanks document evolves, the FAH is concerned that each new version appears to create increasingly greater opportunity for insurers to include what we believe to be administrative expenses as medical costs and/or quality improvement expenses in the MLR formula. As stated in our previous letters to the Subgroup, we strongly believe the MLR’s quality improvement category should focus on medical costs related to improving the clinical quality of care for individual patients. We continue to strongly believe that the patient-clinician relationship is the foundation upon which meaningful quality improvement takes place and while earlier iterations of the Blanks document began to draw this boundary, the current version illustrates an erosion of this critical underpinning. It is with these overarching concerns in mind that we offer the following specific comments on the latest draft Blanks proposal.
**Supplemental Health Care Exhibit - Part 1**

The FAH recommends that an “exclude” section be added to Line 3 that clarifies that any payments based on achieving cost containment objectives or any purpose other than direct improvement of health care quality for individual patients as defined in Section 2717 of the Act be excluded from the reported cost.

**Supplemental Health Care Exhibit - Part 2**

The FAH recommends that the last sentence in the 4th paragraph in Line 2, “Direct Claims Incurred,” be rewritten to include the following caveat – “This includes capitated referrals, but only to the extent such capitation payments are for medical care provided by the physician, and shall exclude any amounts based on cost containment, utilization or other performance targets unrelated to the physician’s direct provision of medical care.” We further recommend that an “exclude” section be added to Line 2 reinforcing that any payments based on cost containment objectives or any purpose other than the direct provision of patient care and/or the direct improvement of health care quality for individual patients, as defined in Section 2717 of the Act, must be excluded from the reported cost.

**Supplemental Health Care Exhibit - Part 3**

We have a number of specific concerns with Supplemental Health Care Exhibit – Part 3, which provides the underlying data for calculating total costs related to quality improvement activities. The FAH is extremely concerned that the latest draft of the Blanks document confuses the distinct roles of insurers and providers. For example, in the introduction to Part 3, the third bullet states that qualifying quality improvement activities demonstrate results that can be verified to, among other things, “improve patient safety and reduce medical errors, lower infection and mortality rates.” We strongly believe that while these objectives are laudable, they are achieved through improvements by health care providers in the delivery of direct patient care, not by insurers. We would also like to reiterate this overarching concern as it relates to the entirety of Part 3, Column 3, “Improve Patient Safety and Reduce Medical Errors.”

Further, in Part 3, Column 1(1st bullet, 1st sub-bullet), the FAH strongly encourages the Subgroup to strike “arranging and managing transitions from one setting to another” from the list of interventions related to “effective case management, care coordination, and chronic disease management.” To the extent these activities are performed by an insurer, we believe that they are traditional case management functions that are most often undertaken as a cost containment measure. Further, this functionality is one that hospitals are already doing effectively on behalf of patients. We have effectively the same concerns related to the inclusion of “comprehensive discharge planning” costs in Column 2, “Activities to Prevent Hospital Readmissions.”

While the FAH strongly supports quality measurement and reporting as mechanisms for providing actionable information on health care quality to consumers and providers, these activities in and of themselves do not improve the clinical quality of care for individual patients. As stated above, meaningful quality improvements are achieved by clinicians in the provision of direct patient care. Simply gathering data from providers cannot directly impact the quality of health care for individual
patients. We therefore recommend that “quality reporting and documentation of care,” as stated in Column 1 (3rd bullet), be considered an administrative expense in the MLR formula.

Additionally, the FAH believes the definitions in Part 3, as currently drafted, over-allow insurers’ inclusion of health information technology (“HIT”) costs as directly improving health care quality. Expenses outlined under “activities to prevent hospital readmissions” and “improve patient safety and reduce medical errors” exemplify our assertion. Health care providers are already actively adopting (and heavily investing in) interoperable HIT systems in response to the Medicare and Medicaid EHR incentive programs passed as part of the federal stimulus package which are set to begin for hospitals on October 1, 2010. Quality improvement resulting from the implementation of interoperable HIT occurs because of how providers are using the technology in the delivery of direct patient care. Further, we believe it is inappropriate to include expenses related to “activities to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records.” Insurers are not “clinical providers” requiring access to “consistent and accurate records;” therefore investment in this area cannot improve health care quality for individual patients and should, in turn, be considered to be administrative expenses in the MLR formula.

We are also concerned that the section in Part 3, Column 5 related to 24 Hour Nurse Hotlines is confusing as currently defined. The note indicates that expenses for 24 nurse hotlines should be included in a number of activities such as Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors and Wellness & Health Promotion Activities. Immediately beneath the note there is a bullet point which indications that 24 Hour Nurse Hotlines should be broadly excluded as not meeting the criteria of this section. Because of the ambiguous nature of the descriptions as to when they do and do not qualify, and the mixed purposes of these nurse hotlines, we strongly recommend that they be excluded in their entirety and that 100% of their cost be considered administrative for MLR reporting purposes. To the extent that the primary reason for these hotlines is to redirect care and potentially avoid emergency department visits, we view them as performing cost containment activities, not improving the clinical quality of care to individual patients.

**********

The FAH appreciates the opportunity to provide comments. If you have any questions about our comments or need further information, please contact me or Jeff Micklos of my staff at (202) 624-1500.

Sincerely,

cc: Todd Sells, NAIC
June 18, 2010

Mr. Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup

Steven Ostlund
Chair, Accident & Health Working Group

National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Re: Calculation of Medical Loss Ratio Recommendations

Dear Mr. Felice, Mr. Ostlund, and Subgroup members:

I am the Benefits Manager for Hall Financial Group located in Frisco TX. Our company has expanded our wellness programs and incentives significantly over the last couple of years. Our plan has seen great results with lower claims, very important since our plan is self-funded. We have not had to raise EE or ER costs for the past 3 years.

I am writing to urge the National Association of Insurance Commissioners (NAIC) to consider and recommend to the Department of Health and Human Services (HHS) a definition of medical loss ratio (MLR) that will encourage health plans to continue their vital support of health care quality improvement activities, including our company’s employee wellness program and other member health improvement programs.

Employer-sponsored health plans often play an important role in improving the health and wellness of workers. I want to make sure that health insurers will be able to continue their critical participation in these efforts.

It is my understanding that if the definitions around MLR are too narrow, health insurers may be discouraged from supporting member health improvement activities if their contributions are counted as administrative expenses. Penalizing the support of my organization’s employee wellness program and other member health improvement activities that encourage employee wellness could have a tremendous impact on my employees’ long-term health and would not be wise public policy.

I strongly urge the NAIC to recommend to HHS that for the purpose of calculating MLR, quality initiatives should include health insurers’ involvement and investments in quality improvement activities.

Thank you for consideration on this important issue.

Sincerely,

[Signature]

Judy Martin, BCBS Advocate
PR/Benefits/HR Mgr, Hall Financial Group

6801 Gaylord Parkway • Suite 100 • Frisco, Texas 75034 • 972 377 1100 • 972 377 1170 fax
June 15, 2010

Mr. Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup

Steven Ostlund
Chair, Accident & Health Working Group

National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Re: Calculation of Medical Loss Ratio Recommendations

Dear Mr. Felice, Mr. Ostlund, and Subgroup members:

The Heart of Texas Community Health Center and the Caring for Children Foundation of Texas recently launched a preventative dental services collaboration and have already provided services to several thousand central Texas children. Blue Cross and Blue Shield of Texas, the statewide sponsor of the Foundation, has provided 100% of the Foundation’s administrative expenses as an in-kind donation.

I am writing to urge the National Association of Insurance Commissioners (NAIC) to consider and recommend to the Department of Health and Human Services (HHS) a definition of medical loss ratio (MLR) that will encourage health plans to continue their tremendous support of community-based public health initiatives and programs.

The membership of NAIC is state-based and so should understand well the important contributions that local organizations make to the overall health of communities and populations. I want to make sure that health insurers will continue their critical participation in these efforts.

It is my understanding that if the definitions around MLR are too narrow, health insurers will not be encouraged to support community-based health initiatives, and could, in fact, be penalized for such support if their contributions are counted as administrative expenses. Penalizing support of my organization’s program and similar community-based programs across the nation would not be wise public policy.

I strongly urge the NAIC to recommend to HHS that for the purpose of calculating MLR, quality initiatives include health insurers’ involvement and investments in public health initiatives.

Thank you for consideration on this important issue.

Sincerely,

Allen E. Patterson, CPA, FACMPE, MHA
Chief Financial and Operating Officer
The House of Amos

“Let Justice Surge Like Water.” Amos: 5: 24

National Association of Insurance Commissioners
% Mr. Lou Felice, Chair, Health Care Reform Solvency Impact Subgroup
Mr. Steven Ostlund, Chair, Accident & Health Working Group
2301 McGee Street Suite 800
Kansas City, Missouri 64108-2662

June 14, 2010

Dear Mr. Felice and Mr. Ostlund,

I am writing this letter regarding the calculation of Medical Loss Ratio Recommendations. Since 2004, the House of Amos and the Caring for Children Foundation of Texas have collaborated to provide immunization clinics and immunized several hundred southwest Houston area uninsured children utilizing one of the Foundation’s CARE VANS. During this entire time, Blue Cross and Blue Shield of Texas, the statewide sponsor of the Foundation, has provided 100% of the Foundation’s administrative expenses as an in-kind donation.

I am writing to urge the National Association of Insurance Commissioners (NAIC) to consider and to recommend to the Department of Health and Human Services (HHS) a definition of medical loss ratio (MLR) that will encourage health plans to continue their tremendous support of community-based public health initiatives and programs.

The membership of NAIC is state-based and so should understand well the important contributions that local organizations make to the overall health of communities and populations. I want to make sure that health insurers will continue their critical participation in these efforts. (Attached is the CARE VAN 2010 report for the Alief community of west Houston. Alief ISD has an enrollment of 45,000 students of which 80.4% qualify for the Federal Free/Reduced breakfast & lunch Program! Poverty in the Alief area is critical!)

It is my understanding that if the definitions around MLR are too narrow, health insurer will not be encouraged to support community-based health initiatives and

P.O. Box 720779 Houston, TX 77272-0779
Phone: (281) 495-9061
could, in fact, be penalized for such support if their contributions are counted as administrative expenses. Penalizing support of the House of Amos’ CARE VAN program and similar community-based programs across the nation would not be wise public policy. The House of Amos’ CARE VAN program is keeping children in school because their shots are up-to-date!

I strongly urge the NAIC to recommend to HHS that for the purpose of calculating, MLR, quality initiatives include health insurers’ involvement and investments in public health initiatives.

Thank you for consideration on this very important matter.

Sincerely yours,

Beryl Hogshead

House of Amos, Board of Directors

Cc: Harris Miller, Chair of the Aubrey & Sylvia Farb Community Service Fund
    Dr. Franklin Olsen, Chair of The Metropolitan Organization
    Rev. David Patermuehl, Minister of Grace United Church of Christ
CARE VAN 2010

Free immunizations for childhood preventable diseases are available for infant to 18 years.

- A parent/guardian must accompany the child
- Must bring the child’s shot record
  (An Alief school nurse’s letter is accepted.)

(Generous gifts from Amerigroup, Spindletop International Charities, The Methodist Hospital for medical supplies, and from Jane Fieldcamp for the summer month costs of the Alief CARE VAN at the House of Amos are received in sincere gratitude.
Thanks, Spindletop, Jane, Amerigroup and The Methodist Hospital!!)

Hours for immunizations: **4PM to 7 PM**

Where? **House of Amos  8030 Boone Road**

Marilyn Hulett, HOA coordinator

<table>
<thead>
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<th>When</th>
<th>Children seen / shots given</th>
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<tbody>
<tr>
<td>Wednesday, January 20</td>
<td>95 / 175</td>
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<td>96 / 162</td>
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<tr>
<td>Wednesday, March 17</td>
<td>134 / 286</td>
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<td>129 / 272</td>
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<td>Wednesday, September 15</td>
<td></td>
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<tr>
<td>Wednesday, October 20</td>
<td></td>
</tr>
<tr>
<td>Wednesday, November 17</td>
<td></td>
</tr>
</tbody>
</table>
CARE VAN 2010

...2nd Alief CARE VAN site:

Free immunizations for childhood preventable diseases are available for infants to 18 years.

- A parent/guardian must accompany the child
- Must bring the child’s shot record
  (An Alief school nurse’s letter is accepted.)

Where?  Grace United Church of Christ   8515 Brookwulf Drive

Jane Eixmann, coordinator / Lee Brown, assistant

When?  4 PM to 7 PM

<table>
<thead>
<tr>
<th>Date</th>
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<th>Shots given</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
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<td>74 / 125</td>
<td></td>
</tr>
<tr>
<td>Wednesday, April 7</td>
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<td></td>
</tr>
<tr>
<td>Wednesday, May 5</td>
<td>31 / 66</td>
<td></td>
</tr>
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</table>

(No CARE VAN at Grace UCC during the summer months.)

Wednesday, August 4
Wednesday, September 1
Wednesday, October 6
Wednesday, November 3
The House of Amos
Service Trends YTD December 31st 2009

Food Pantry - Individuals Served and Food Bank Costs:
2009 - 6,189 Households served - 25,272 Individuals served = $36,825
2008 - 3,655 Households served - 15,098 Individuals served = $20,733
2007 - 3,989 Households served - 14,477 Individuals served = $20,672
2006 - 2,733 Households served - 10,086 Individuals served = $10,671

HFB Food Fair:
2009 - 2,306 Households served – 10,518 Individuals fed
2008 - 1,625 Households served – 7,320 Individuals fed
2007 - 1,480 Households served – 6,583 Individuals fed

ESL/Civics Students:
2009 - 177 students
2008 - 143 students
2007 - 75 students
2006 - 17 students

Care Van Vaccines:
2009 Children – 2,530 – vaccines 6,119
2008 Children – 2,363 – vaccines 5,723
2007 Children – 2,337 – vaccines 6,303
2006 Children – 1,764 – vaccines 3,902

Summer Weekday Lunch Program:
2009 - 1,993 box lunches served to children
2008 - 2,095 box lunches served to children
2007 - 1,616 box lunches served to children
2006 - 1,438 box lunches served to children

MDUMC – Saturday Soup Mobile:
2009 - 5,000 sack lunches served to children
2008 - 5,000 sack lunches served to children
2007 - 2,550 sack lunches served to children
2006 - 2,500 sack lunches served to children

Children’s Holiday party with Santa:
2009- Total gifts needed 491 - number of children receiving gifts- 413
2008 - Total gifts needed 437 - number of children receiving gifts - 437
2007 - Total gifts needed 508 - number of children receiving gifts - 449
2006 - Total gifts needed 465 - number of children receiving gifts - 449
2005 - Total gifts needed 496 - number of children receiving gifts – 390

2009 – 685 Volunteers gave...6,509 hours of service
2008 - 569 Volunteers gave...5,813 hours of service
Industry Mark-up by:

PCMA
The Council of Insurance Agents and Brokers
AHIP
DMAA
NCQA
This exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for the Individual, Small Group and Large Group amounts.

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for health services for individuals or specified populations that are designed to increase the likelihood of desired health outcomes and that are grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed solely to control or contain cost. Qualifying QI activities are primarily designed to achieve the following goals set out in Sections 2717, 1311 and 3011 of PPACA; improvement must be capable of being objectively measured and produce results and achievements that can be verified to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates,
- Increase wellness and promote health activities, or
- Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes.

COLUMNS:

Column 1 – Improve Health Outcomes

Expenses for the direct interaction of the insurer, providers and the enrollee (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes for the patient under the plan or coverage or to improve health outcomes for specified populations. This category can include costs for associated activities including:

- Effective case management (not just general case management), Care coordination, and Chronic Disease Management, including:
  - Patient centered intervention such as:
    - Making/verifying appointments,
    - Medication and care compliance initiatives,
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center), and
    - Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;
  - Incorporating feedback from the insured to effectively monitor compliance;
  - Providing coaching to encourage compliance with evidence based medicine;
  - Activities to identify and encourage evidence based medicine;
  - Use of the medical homes model as defined for purposes of section 3602 of PPACA; and
  - Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
- Quality reporting and documentation of care;
- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above, and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; or
- Other expenses for programs designed in ways that can be objectively measured and verified to increase the likelihood of desired health outcomes for individuals or specified populations that meet the General
Column 2 – Activities to Prevent Hospital Readmission
 Expenses for implementing activities for individuals or for specified populations to prevent hospital readmissions, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Post discharge reinforcement of care instructions by an appropriate health care professional; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above, and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; or
- Other expenses for programs designed to prevent hospital readmissions for individuals or specified populations that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the program conform to the definition.

Column 3 – Improve Patient Safety and Reduce Medical Errors
 Expenses for implementing activities for individuals or for specified populations to improve patient safety and reduce medical errors, including:

- The appropriate identification and use of best clinical practices;
- Activities to identify and encourage evidence based medicine;
- Activities to lower risk of facility acquired infections;
- Health information technology expenses to support these activities (report in Column 5 – See instructions), including:
  - Data extraction, analysis and transmission in support of the activities described above, and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; or
- Other expenses for programs designed to improve patient safety or reduce medical errors for individuals or specified populations that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the programs conform to the definition.

Column 4 – Wellness & Health Promotion Activities
 Expenses for programs for individuals or for specified populations that provide interactions (e.g., face-to-face, telephonic or web-based interactions or other forms of communication) that at a minimum include promoting:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition; and
- Coaching or education programs and health promotion activities designed to change behavior (e.g., smoking, obesity);
- Health information technology expenses to support these activities (Report in Column 5 – See instructions), or
- Other expenses for wellness and health promotion activities for individuals or specified populations that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the programs conform to the definition.

Column 5 – HIT Expenses for Health Care Quality Improvements
 The PPACA also contemplates “Health Information Technology” as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or patients for the electronic creation, maintenance, access, or exchange of health information in the following ways:

1. Monitoring, measuring, or reporting clinical effectiveness including reporting analysis and compliance costs and fees related to gaining and maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC; or costs for public reporting of quality of care, including costs...
specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;

2. Advancing the ability of patients, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include Personal Health Records accessible by patients and appropriate providers to monitor and document an individual patient’s medical history;

3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes; or

4. Other expenses for programs which support the activities described in columns 1 through 4 or otherwise support monitoring, measuring, or reporting health care Quality Improvement. The burden shall be on the proponent to show that the expenses for the programs conform to the definition.

Exclude: Costs associated solely with maintaining a claims adjudication system, including cost directly related to upgrades in HIT that are designed only to improve claims payment capabilities.

Expense Allocation: A separate, non-public supplemental filing (Supplemental QI Expenses Exhibit) must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. Additionally, companies reporting QI expenses in columns 1 through 4 must include a detailed description of such expenses. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

Note: 24 Hour Medical Professional Hotlines: Expenses for 24 hour medical professional hotlines should be included in Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities. Any other expenses for 24 hour medical professional hotlines (e.g., answering member non-medically related questions) should be excluded from Improving Health Care Quality Expenses and instead included in Claims Adjustment Expenses.

Elements of the following items are excluded to the extent they do not meet the General Definition of Quality Improvement expenses set forth above and are designed solely or primarily to control or contain costs:

- 24 Hour Medical Professional Hotlines (except as noted above);
- Utilization Review;
- Fraud Prevention activities;
- Network Management; and
- Provider Contracting;

LINES:

For questions on definitions, refer to the instructions for the Annual Statement Expenses Schedule, i.e., the Underwriting and Investment Exhibit, Part 3 for P/C and Health, and Exhibit 2 for Life and Fraternal.

Lines 1.1, 2.1, 3.1 - Salaries

Lines 1.2, 2.2, 3.2 - Outsourced Services

Include: Expenses for administrative services, claim management services, new programming, membership services, and other similar services.

Exclude: Services provided by affiliates under management agreements.

Lines 1.3, 2.3, 3.3 - EDP Equipment and Software

Lines 1.4, 2.4, 3.4 - Other Equipment (excluding EDP)

Lines 1.5, 2.5, 3.5 - Accreditation and Certification

Include: Fees associated with the certification and accreditation of a health plan, including but not limited to: fees paid to Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Committee on Quality Assurance (NCQA), and American Accreditation Healthcare Commission (URAC).
Exclude: Rating agencies and other similar organizations.

Lines 1.6, 2.6, 3.6 - Other Expenses

Include: Commissions, legal fees and expenses, auditing, actuarial and other consulting services, as well as any additional expenses not included in another category.

Lines 1.8, 2.8, 3.8 - Reimbursement by uninsured plans and fiscal intermediaries

Reimbursements by Uninsured Plans:

Report as a negative amount, pharmaceutical rebates of uninsured plans that are received or change in due and uncollected by the reporting entity, to the extent that they are in excess of amounts to be remitted to the uninsured plan, administrative fees, direct reimbursement of expenses, or other similar receipts or credits attributable to uninsured health plans and the uninsured portion of partially insured accident and health plans. Deduct administrative fees and related reimbursements from general administrative expenses or claim adjustment expenses if the administrative services provided include services for claim adjustment expenses as defined in SSAP No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses.

Refer to SSAP No. 84, Certain Health Care Receivables and Receivables Under Government Insured Plans, for accounting guidance.

Reimbursements from Fiscal Intermediaries:

Report as a negative amount, administrative fees, direct reimbursement of expenses, or other similar receipts or credits attributable to Medicare, CHAMPUS and other federal and local governmental agencies.

Lines 1.9, 2.9, 3.9 - Taxes, Licenses and Fees

Include: State and local insurance taxes, state premium taxes, regulatory authority licenses and fees, payroll taxes, and any other taxes licenses or fees excluding federal income and real estate taxes.
June 16, 2010

Mr. Lou Felice  
Chair, Health Reform Solvency Impact (E) Subgroup

Mr. Steve Ostlund  
Chair, Accident & Health Working Group

National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, Missouri 64108-2662

Re: Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act

Dear Messrs Felice and Ostlund:

The Metro-Hartford Alliance, the City of Hartford’s Chamber of Commerce and the region’s economic development leader, represents nearly 600 member organizations, including over 111,000 employees. On behalf of our members, we are writing to share our comments regarding the definition of Medical Loss Ratios ("MLR") under Section 2718 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act ("PPACA").

Given our mission to support the attraction and retention of jobs, capital and talent to our region, we have strongly advocated both at the state and federal levels for increased accessibility to quality, affordable health care. To that point, we understand that your MLR recommendations cannot be too narrowly defined or too broadly defined. **We ask that any recommendation consider the impact on present and future employment.** In Connecticut, the health care and insurance industries are two of our major engines of economic growth in the past, present and future. Connecticut based companies in these fields are highly respected employers, and have been excellent community partners and corporate citizens.

In the interest of increasing employment opportunities, providing greater access to quality health care and improving consumer choice, we strongly urge you to consider a balanced approach to the establishment of the definitions of MLRs. A prudent, careful process will ensure that all stakeholders including consumers, businesses, payors and providers will benefit from this important legislation.

We applaud your efforts to develop and implement an open process and accept public comment, and we look forward to your final recommendations. Thank you for your consideration.

Sincerely,

[Signature]

Theodore S. Sergi  
Interim President & CEO

cc: Tom Sullivan, Commissioner  
CT Department of Insurance

Competing for Jobs, Capital & Talent  
www.metrohartford.com
June 18, 2010

Jacob Garn, Chair
Blanks (E) Working Group
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act (PHSA)

Dear Mr. Garn:

We are writing to respond to the draft blanks for the medical loss ratio that you exposed for comment last week. In particular, we are requesting that you remove the XXXs from the rows for accreditation and certification fees and allow these costs to be added to the other costs associated with the designated activities to improve quality for purposes of calculating the medical loss ratio.

Accreditation fees should be included as a cost associated with activities that improve quality. Our accreditation program is an excellent example of development of independent standards and measures that can be used to assess the evidence base for the activities that count towards “activities that improve quality” for purposes of the medical loss ratio calculation. It would seem short sighted to not include the accreditation costs associated with that assessment. Further, if the fees are not included as counting towards improving quality, there is a very real risk that health plans will decide not to pursue accreditation, leading to an increase in states’ burden in auditing and reviewing all of the activities and a loss of consumer protection.

NCQA’s accreditation program requires quality improvement (as opposed to quality assurance) in several ways:

1) The results of HEDIS and CAHPS make up 44 percent of the scores. We have seen upward trends in many of these measures over time. Accredited plans have higher scores than non accredited ones. We are constantly moving the bar because on many measures we score plans relative to each other.

2) We add new standards, measurements and requirements over time. Typically, we introduce new “modules” that start out voluntary but then are mandatory for all plans. For example, we are just introducing a new module called “CLAS,” which stands for “ Culturally and Linguistically Appropriate Services.” At this time, this module is voluntary, but the usual pattern would be to add this to the regular program. The module includes not only standards but measures; we routinely add new measures over time as well. We also drop standards and measures that we think all plans meet or do well on.
3) Plans that have not been accredited before actually have to invest a lot of time and money to comply with our standards and requirements. Those investments have made plans better – that is, accreditation has improved the quality of care of enrollees.

Even plans that already meet our existing standards and continue to do so have to report and be scored on new measures and standards over time. We use a rigorous and transparent process to develop the standards and measures of plan performance that involves multiple stakeholders (including public sector advisors, researchers, and consumers as well as affected entities) that draws on the best clinical and scientific evidence available.

Thank you for your consideration of these comments. Please do not hesitate to contact me or Sarah Thomas, Vice President of Public Policy and Communications at (202) 955-1705 if you have any questions or wish to discuss these comments.

Sincerely,

Margaret O’Kane
President

Attachment

cc: Todd Sells, NAIC Staff
Mary Caswell, NAIC Staff
June 16, 2010

Mr. Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup  
National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, Missouri 64108-2662

Re: Calculation of Medical Loss Ratio Recommendations

Dear Mr. Felice and Subgroup members:

My name is Jen Ohlson and I direct The PE 3 Foundation, a Texas nonprofit organization, that through funding from Blue Cross Blue Shield of Texas, (BCBSTX) has developed an innovative and revolutionary physical education elective course dedicated to students with a high Body Mass Index, working with each individual in the context of their life - physically, nutritionally, socially, psychologically and with their family for long-term health, beyond the PE classroom. The course was recently approved as an official elective course available to every school in the state by the Texas Education Agency. Also through BCBSTX funding we are also currently producing an national educational documentary film which premiers in March 2011. The film, told through the hearts of children and key stakeholders, will provide a powerful message and call to action to the public about the need for physical fitness, proper nutrition and support. If it were not for BCBSTX support, none of this would be possible. For our foundation and for the thousands of public schools and the children and families that will benefit from the PE 3 Course and be impacted by the film, BCBSTX has been our heroes.

I am writing to urge the National Association of Insurance Commissioners (NAIC) to consider and recommend to the Department of Health and Human Services (HHS) a definition of medical loss ratio (MLR) that will encourage health plans to continue their tremendous support of community-based public health initiatives and programs such as ours.

The membership of NAIC is state-based and so should understand well the important contributions that local organizations make to the overall health of communities and populations. I want to make sure that health insurers will continue their critical participation in these efforts.

It is my understanding that if the definitions around MLR are too narrow, health insurers will not be encouraged to support community-based health initiatives and could, in fact, be penalized for such support if their contributions are counted as administrative expenses. Penalizing support of my organization’s program and similar community-based programs across the nation would not be wise public policy.

At this moment, you have the opportunity to be a hero in this crucial decision and your actions will affect lives for generations to come. I strongly urge the NAIC to recommend to HHS that for the purpose of calculating MLR, quality initiatives include health insurers’ involvement and investments in public health initiatives.

Thank you for consideration on this important issue.

Sincerely,

Jen Ohlson  
Executive Director  
PE 3 Foundation  
www.pe3foundation.org  
3112 Windsor Road, Ste. A - 342  
Austin, TX 78703
Front Page News!
San Antonio Express News 6-1-10

PE class marches to different beat

By Jenny LaCoste-Caputo - Express-News
Web Posted: 06/01/2010 12:00 CDT

From left, Thairy Villasenor, 16, Ashley Hernandez, 15, Danita Harris, 15, and Ashley Castoreno, 19, exercise in PE 3: PE for the Mind, Body and Spirit at Highlands High School. Lisa Krantz/Express-News

Roger Rodriguez knew there was a childhood obesity problem in San Antonio Independent School District. As the district’s physical education and health coordinator, how could he miss it?

Rodriguez had looked at the results of Fitnessgrams, which are the yearly assessments of weight and fitness required by state law of all Texas schoolchildren in grades three through 12. He had walked the halls and visited the gym classes. But it wasn’t until he fulfilled what he thought was a simple request that he realized the magnitude of the problem.

Jen Ohlson, the Austin-based head of a company called Interactive Health Technologies who also champions physical education in schools, told Rodriguez she wanted to shoot a documentary that focused on a teen and detailed the effects of childhood obesity. She asked Rodriguez to find students with a body mass index of at least 40, which in most cases would put them in the obese range.
"We thought we'd get 20 or 30, then I'd choose from those," Ohlson said.

But when Rodriguez checked the data on sixth- through 12th-graders in San Antonio ISD, what he discovered was staggering.

"We found 440 kids," Ohlson said. "Our jaws dropped."

Rodriguez took the information to Superintendent Robert Durón.

"I told him, 'I failed these kids. We failed these kids,'" Rodriguez said. "I knew we had to do something different from what we were doing."

Durón gave Rodriguez the green light and he and Ohlson worked together to write a new program for a physical education class targeting students with a BMI of 40 or greater. It was already December, but they finished the curriculum in time to win approval from the Texas Education Agency before the end of the year and have the class offered in what they call a “pre-pilot” program for the spring semester.

The state gave its approval to the course, called PE 3: PE for the Mind, Body and Spirit, as an innovative course. That means there's not another one like it in the state, but now that it's been approved, other districts are welcome to offer it as well.

The first class was offered at Highlands High School, where Rodriguez found a large concentration of overweight kids.

Ohlson said Highlands' demographics tell the story. It's not as poor as some San Antonio ISD schools, but it's still in a neighborhood where there are few healthy food options and little emphasis on exercise.

"Parents have enough money for Xboxes, but not enough to shop at Whole Foods," she said. "We found a lack of grocery stores, a proliferation of taco stands, fast food and convenience stores. ... It's the perfect breeding ground for producing overweight kids."

In the new class, students work out while wearing heart monitors. They're also taught about nutrition and healthy lifestyles. There are future plans for field trips to grocery stores and gyms.

PE teachers have become certified in popular exercise classes such as yoga and Zumba, which is a new type of aerobics, set to Latin music.

Coach Rufus Lott Jr., who just earned his Zumba certification, thinks the class is just what his students need.

"I think it's great. San Antonio is always being tagged as one of the fattest cities in the country and Texas as one of the fattest states in the country," he said. "We need to do something about it."

Lott said the kids are motivating each other and don't seem to mind being pulled from the more traditional physical education classes.

"I had a kid come tell me just yesterday that he's already lost 15 pounds," Lott said on a recent
June 21, 2010

Mr. Lou Felice  
Chair, Health Care Reform Solvency Impact Subgroup

Steven Ostlund  
Chair, Accident & Health Working Group

National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, Missouri 64108-2662

Re: Calculation of Medical Loss Ratio Recommendations

Dear Mr. Felice, Mr. Ostlund, and Subgroup members:

For the past several years, the San Antonio Metropolitan Health District and the Caring for Children Foundation of Texas have collaborated together to provide preventive dental services to thousands of uninsured children. During this time, Blue Cross and Blue Shield of Texas, the statewide sponsor of the Foundation, has provided 100% of the Foundation’s administrative expenses as an in-kind donation. This collaboration has been extremely helpful to the Dental Division of the San Antonio Metropolitan Health District in bringing preventative care and treatment to children, who might otherwise not have the opportunity for such dental care. The Care Van provided us has allowed us to transport portable dental equipment for use in programs in elementary schools and a summer San Antonio Parks and Recreation program designed to bring preventative care to children.

I am writing to urge the National Association of Insurance Commissioners (NAIC) to consider and recommend to the Department of Health and Human Services (HHS) a definition of medical loss ratio (MLR) that will encourage health plans to continue their tremendous support of community-based public health initiatives and programs.

The membership of NAIC is state-based and so should understand well the important contributions that local organizations make to the overall health of communities and populations. I want to make sure that health insurers will continue their critical participation in these efforts.

It is my understanding that if the definitions around MLR are too narrow, health insurers will not be encouraged to support community-based health initiatives and could, in fact, be penalized for such support if their contributions are counted as administrative expenses. Penalizing support of my organization’s program and similar community-based programs across the nation would not be wise public policy.

I strongly urge the NAIC to recommend to HHS that for the purpose of calculating MLR, quality initiatives include health insurers’ involvement and investments in public health initiatives.

Thank you for consideration on this important issue.

Sincerely,

Alvin J. Elsik, Jr., DDS
Alvin J. Elsik, Jr. DDS
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(210) 206-5537