



Charles N. Kahn III
President

May 17, 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 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").

On May 10, 2010, the FAH submitted comments to the Subgroup on a variety of issues related to calculating the medical loss ratio ("MLR"). We appreciate the opportunity to participate as an interested party in the Subgroup's ongoing discussion around identifying those expenses that properly belong in the qualifying medical costs category for purposes of calculating the MLR. At the invitation of the Subgroup's leadership, we provide additional comments on the revised draft blanks proposal discussed on the May 12th conference call related to the category of activities that improve health care quality.

As stated previously, this new category requires a close focus by regulators to avoid becoming a "catch-all" into which a wide variety of expenses not directly related to patient care and clinical quality may arbitrarily be placed. Notably, the NAIC shares our view, as indicated by the comments to the Department of Health & Human Services in its May 12, 2010 letter. (*See* section 3(b).) We believe, based on the latest draft of the blanks proposal, that the Subgroup appreciates the need to draw clear and distinct boundaries around this category, but urge the Subgroup to provide greater specificity that will allow for a clear and consistent interpretation by all stakeholders.

Health plans are in the business of making coverage determinations and administering plan benefits, while their networked providers are focused on providing high quality, effective clinical care. We are concerned with the some stakeholder views shared with the Subgroup that quality improvement in the new federal MLR context is meant to include those costs that improve the *quality of the insurance product*. We disagree; we believe the MLR's quality improvement is in the context of medical services and should focus on medical costs related to improving the *clinical quality of care for individual patients*. In this light, the revised blanks document begins to establish this boundary, but we are concerned that the definitions for qualifying activities and expenses are still too broad and allow for the mischaracterization of administrative costs as medical costs. Thus, we urge the Subgroup to make further refinements to the blanks document that allows quality improvement expenses to focus solely on the costs related to improving clinical quality of care for individual patients.

Activities that Improve Healthcare Quality

The FAH believes that the patient-clinician relationship is the foundation upon which meaningful quality improvement takes place, and as such, clinicians and providers are well poised to speak directly to the definition of quality improvement. Quality improvement in the context of the MLR should mean truly better care for individual patients that can be quantified using evidence-based metrics. Quality improvement does not mean creating greater operational efficiencies that result in reduced costs. Thus, utilization management and fraud prevention costs should not qualify as acceptable quality improvement expenses because, in reality, they are just cost reduction mechanisms.

Further, the FAH believes that to be a meaningful policy, the determination of what costs should be counted and what costs should be excluded from this category needs to draw clear lines that point to specific costs that can be quantified and subject to meaningful audit and review. Setting broad parameters that define general concepts that drive plans to include as much as they can deem related to quality and for which individual expenses cannot be audited and verified by regulators does not result in a meaningful policy. Insurance examiners must be in a position to make an objective assessment of qualifying expenses based on clear definitions that are not left open to interpretation, and therefore, vulnerable to manipulation by those wishing to include activities not directly related to improving the quality of care for an individual patient.

The FAH is concerned that the parameters in the current definitions of the categories in Line 5.1 (1-3) are not drawn tightly enough to ensure that there is a direct nexus between the allowable expense and the individual patient. Any qualifying activities related to care coordination, chronic disease management and preventive care and wellness, should be conducted by a clinician, meaning a licensed health care professional, and individually tailored to a specific patient. Consistently requiring these two components for any qualifying expense will result in the least amount of ambiguity for the insurers as well as those examiners responsible for auditing the MLR calculation.

Further, the FAH does not believe the term "hands on," included in the definition of each of these categories, is specific enough to establish a required nexus between an individual patient and a clinician. Without a clear requirement to tailor these activities to an individual patient, insurers could capitalize on an opportunity to include expenses for programs that serve to market a particular insurance product rather than result in meaningful quality of care improvement for a specific patient.

- **Care Coordination.** The definition of Care Coordination should be revised to include the concept of a clinician (as defined above) coordinating an individual patient's care and

transitions. To narrow the scope appropriately, the definition should also include examples of costs that are excluded from this category.

- **Chronic Disease Management.** Similarly, the definition of Chronic Disease Management should be revised to include the concept of programs administered by a clinician (as defined above), tailored to address an individual patient's specific chronic conditions. To narrow the scope appropriately, the definition should also include examples of costs that are excluded from this category.
- **Preventive Care and Wellness Programs.** The definition of Preventive Care and Wellness Programs should likewise specifically reference programs administered by a clinician (as defined above), tailored to advise an individual patient on what is best for that patient based on his or her unique medical needs. These programs should not include providing general counsel to enrollees about general wellness issues. As a point of reference, section 2717 of the Act refers specifically to “personalized wellness and prevention services,” which we believe supports our assertion that these activities should be tailored to the individual patient. To narrow the scope appropriately, the definition should also include examples of costs that are excluded from this category.

The need for objectivity in what qualifies as quality improvement in patient care is particularly important in light of the relationship which insurers commonly draw with providers. Generally, insurers use network contracts with providers that include a clause reminding providers that insurers do not actually provide care, nor are they responsible for the same. Instead, the insurers indicate they are only responsible for making benefit coverage determinations. Therefore, it seems difficult to reconcile the idea that a health plan's only role is to make coverage determinations with the idea that plans also improve the quality of care provided to specific patients.

There are a number of other functions that insurers characterize as quality improvement, but in reality are focused on strong cost-containment initiatives. In our members' experience, plans are generally much more focused on *measuring* the quality of patient care than they are on *improving* the quality of that care, and that plan measurement tools often have material cost-savings components. There are other plan functions that may seem quality-related, but are really administrative in nature. For example, the credentialing of providers that health plans undertake is really just an exercise to collect documentation of licensure, accreditation, and/or Medicare certification that is bestowed by third parties. Insurers often need this information for their files, but they are not conducting any meaningful review of their own.

As the definitions of activities related to quality improvement are finalized, the FAH would strongly recommend that definitions included in the body of the blanks document be repeated in the exhibits related to quality improvement expenses. We believe that clear, consistent definitions (expressed in both places) are especially important given that insurers have little experience with this new, separate category of expenses for purposes of calculating the MLR.

Administering Self Insured Business

The FAH strongly supports the inclusion of new section 11, income and expenses related to administering self insured business, in the revised blanks proposal. We believe this data point will contribute to providing a fair assessment by which the MLR should be calculated by including additional appropriate costs in the denominator.

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,

A handwritten signature in black ink, appearing to read "Todd Sells". The signature is fluid and cursive, with a large initial "T" and "S".

cc: Todd Sells, NAIC