



**National
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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

May 14, 2010

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

As President of the National Business Group on Health, I am writing to offer comments to the National Association of Insurance Commissioners (NAIC) as you consider defining which activities improve quality under the classification of health plan expenses related to the calculation of Medical Loss Ratio (MLR) for your recommendations to the U.S. Secretary of Health and Human Services (HHS) under Section 2718 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-1489. As you know, most of our members, and most employers of any size, self-fund the health care costs for employees and dependents, and therefore, the medical loss ratio provisions do not directly apply to these plans. Nevertheless, we support the inclusion of a broad array of quality improvement activities in this calculation for the insurance market because of our own plans' positive experiences with these programs, the Federal Employee Health Benefit Plan's positive experiences with them, the fact that the PPACA expands many of them to the Medicare and Medicaid programs and because these programs will not be available to self insured employers if they are not supported in the marketplace. Broad inclusion of quality improvement activities in this calculation will help to ensure that these programs continue to be available for the benefit of consumers in the individual and small group markets, and the exchange plans in the future.

The National Business Group on Health represents approximately 289, primarily large, employers (including 63 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families.

Section 2178 requires health insurance issuers offering individual or group coverage to submit annual reports to the HHS Secretary on the percentages of premiums that are spent by coverage on reimbursement for clinical services and activities that improve health care quality, and to provide rebates to enrollees if this spending does not meet minimum standards for a given plan year.

The National Business Group on Health appreciates the NAIC’s important role in determining health care quality improvements for the MLR for insurance products for individual and group coverage.

Employers and insurers have vast experience with, and rely heavily upon, a range of clinically proven tools and services that promote high-quality health care focused on improving care for the patient (consumer), including: care coordination, patient decision aids, patient support services and health information technology (HIT) for clinical care and population health management. It is vital that these clinically proven services are included in the clinical services/health care quality categories of expenses under MLR to continue to improve health care outcomes for the patient and to reduce harms, disease burden, disparities, waste, and costs. The chart, below, provides additional details on these services.

Chart: National Business Group on Health Recommendations for Examples of Clinically Proven Services to Include under Activities that Improve Health Care Quality in the MLR

Patient Care Coordination ¹	Patient Decision Aids ²	Patient Support Services ³	HIT for Clinical Care and Population Health Management ⁴
Transitions: <ul style="list-style-type: none"> • Primary/specialty care • Hospital discharge Critical case support Coordination of care, such as for high risk newborns across settings Medical homes	<ul style="list-style-type: none"> • Medical expert consultations • Shared decision-making tools, 	<ul style="list-style-type: none"> • 24-7 Nurse Advice Services • Health coaches • Navigators • Care management • Complex case management and critical illness programs • Medication management, e.g., Pharm D consultations, adherence programs 	<ul style="list-style-type: none"> • Ensuring protocol-driven care and evidence-based practice • Health-risk assessments and targeted intervention • Preventive screening monitoring and outreach • Patient Registries • Reduce health disparities

¹ National Priorities Partnership, “National Priorities and Goals: Aligning our Efforts to Transform America’s Healthcare,” Washington, DC: National Quality Forum. 2008.

² O’Connor AM, et al., “Decision aids for people who are facing health treatment or screening decisions. Cochrane Database of Systematic Reviews 2009,” Issue 3, Art. No. CD001431.

³ National Priorities Partnership, “National Priorities and Goals: Aligning our Efforts to Transform America’s Healthcare,” Washington, DC: National Quality Forum. 2008.

⁴ Ibid.

		<ul style="list-style-type: none"> • Pre-conception and maternity programs • Wellness and health promotion and disease prevention 	
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It is important to note Congressional intent and the inclusion of many of these services in the PPACA. Senator Max Baucus (D-MT), Chair of the Senate Finance Committee and primary author of the PPACA, cited a number of these clinically proven services in his original White Paper⁵, which served as the basis for the new law.

- Primary/Specialty Care Transitions:
 - “Among other things, primary care practitioners...serve a critical care management and coordination role — especially for those with multiple chronic conditions who are the least healthy and most costly to our system.”⁶
- Hospital Discharge:
 - “Preliminary results from the Medicare Physician Group Practice Demonstration and reports from participants suggest that the program has achieved its goals of better coordination of care for the chronically ill, [and] careful attention to hospital discharge processes.”⁷
 - “According to some estimates, 18 percent of Medicare hospital admissions result in readmissions within 30 days post discharge. These readmissions accounted for \$15 billion in spending in 2005, and according to MedPAC, \$12 billion of this spending is potentially avoidable.”⁸
- Critical Case Support:
 - “Evidence suggests that 96 cents of every Medicare dollar and 83 cents of every Medicaid dollar are used to treat chronic diseases.”⁹
- Medical Expert Consultations
- Doctors-Shared Decision-Making Tools
- Nurse Advice Services

⁵ Baucus, Max, “Call to Action: Health Reform 2009.” U.S. Senate. November 12, 2008. Available at: http://rds.yahoo.com/_ylt=A0geu8_M4.pLojYBpU9XNyoA;_ylu=X3oDMTEzYnVsNWY5BHNIYwNzcgRwb3MDMgRjb2xvA2FjMgR2dGikA00wMDFfMTI4/SIG=1319er3ab/EXP=1273771340/**http%3a//finance.senate.gov/download/%3fid=916b0ea3-96dc-4c7a-bb35-241fa822367e

⁶ Barbara Starfield, LeiYu Shi, and James Macinko, “Contribution of Primary Care to Health Systems and Health,” *Milbank Quarterly* 83, no. 3. 2005: 457-502.

⁷ Michael Trisolini et al., “The Medicare Physician Group Practice Demonstration: Lessons Learned on Improving Quality and Efficiency in Health Care,” The Commonwealth Fund. 2008.

⁸ Medicare Payment Advisory Commission, “Report to Congress: Reforming the Delivery System.” 2008.

⁹ Paul B. Ginsburg, “Rising Costs, Low Quality in Health Care: The Necessity for Reform,” Testimony before the Senate Committee on Finance, U.S. Senate. June 2, 2008.

- “Careful consideration should be paid to the role of non-physician providers, such as nurse practitioners and home health aides, in the medical home model.”¹⁰ The PPACA provides federal funding for nurse training and incorporates nurses into a variety of medical home demonstration programs in the states.
- Health Coaches
- Navigators
- Care Management
 - “Vendor-based disease management programs, which typically involve phone-based care planning and follow-up by nurses, have found some success in the private market.”¹¹
- Complex Case Management and Critical Illness Programs
- Medication Management
- Pre-Conception and Maternity Programs
- Ensuring Protocol-Driven Care and Evidence-based Practice (HIT)
 - “Clinical IT comprises multiple applications that can support different functions in health care, such as: Providing evidence-based decision support to physicians.”¹²
- Health-Risk Assessments and Targeted Intervention (HIT)
 - “Clinical IT comprises multiple applications that can support different functions in health care, such as: Reporting to chronic disease registries.”¹³
- Preventive Screening Monitoring and Outreach (HIT)
- Reduce Health Disparities (HIT)
 - “The effort to document the extent of health disparities in the U.S. will require standard methods of collecting data. Data collection must also be more reflective of the target community from which data is gathered. Information must be reflected at the subpopulation level.”¹⁴

In addition, the NAIC needs to ensure that large employers who purchase insured products for their employees do not incur unnecessary, increased administrative expenses by calculating the MLR on a state-by-state basis for the large employer market. The NAIC should ensure that insurance carriers can continue to calculate MLR for the large employer market nationally in order to maintain consistency with the way large employers manage their health care benefits across many different products in varying markets with different costs. Insurance carriers would need to make significant expenditures in systems changes to allocate expenses on a state-by-state basis if a single large group MLR is not allowed, cost that insurers would simply pass-on to the employers and employees (patients) purchasing these products with no tangible increase in value for employers and employees.

¹⁰ Baucus, Max, “Call to Action: Health Reform 2009,” U.S. Senate. November 12, 2008. Page 39.

¹¹ RTI International, “Report to Congress: Evaluation of Phase I of Medicare Health Support (Formerly Voluntary Chronic Care Improvement) Pilot Program Under Traditional Fee-for-Service Medicare.” 2007.

¹² Baucus, Max, “Call to Action: Health Reform 2009,” U.S. Senate. November 12, 2008. Page 57.

¹³ Ibid.

¹⁴ Ibid. Page 31.

The NAIC must also ensure that it does not develop a MLR definition that is not aligned with the PPACA efforts to encourage and reward high-quality, integrated health care systems that offer these types of services, such as Billings Clinic in Montana, InterMountain in Utah, and Geisinger in Pennsylvania.

We also recommend that the NAIC adhere to the American Academy of Actuaries finding that “an NAIC regulation defines the concept of cost containment expenses, which are amounts that the insurer spends in order to manage the cost of medical claims. These expenses include case management, disease management, 24-hour nurse hotlines, wellness programs, provider network development, as well as fraud detection and prevention programs. **As these expenditures are more akin to benefits than administrative expenses or provisions for risk, it would be appropriate to include cost containment expenses as part of the value of benefits in the loss ratio calculation. Including these expenses in the loss ratio calculation encourages insurers to effectively manage the quality, efficiency, and cost of care for policyholders.**”¹⁵

Thank you for considering our recommendations to include the aforementioned clinically proven services in the clinical services/health care quality categories of expenses under the MLR to assure that patients continue to have access to them. We look forward to continuing to work with the NAIC and HHS to implement PPACA. Please contact me or Steven Wojcik, the National Business Group on Health’s Vice President of Public Policy, at (202) 585-1812, if you would like to discuss our comments in more detail.

Sincerely,



Helen Darling
President

¹⁵ American Academy of Actuaries, “Critical Issues in Health Reform: Minimum Loss Ratios,” February 2010. Page 3. Available at: http://www.actuary.org/pdf/health/loss_feb10.pdf