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Submitted via Federal eRulemaking Portal

Department of Health and Human Services
ATTN: DHHS-2010-MLR
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Sir/Madam:

Health Integrated, Inc. respectfully requests consideration of the following comments with regard to the determination of services that constitute activities that improve health care quality under the Patient Protection and Affordable Care Act (PPACA).

Section 2718(c) of the Public Health Service Act, which was added by Sections 1001 and 10101 of the PPACA directs the National Association of Insurance Commissioners (NAIC) to establish uniform definitions and standardized methodologies for determining what services constitute clinical services, activities that improve health care quality, and other non-claims costs with respect to calculating a health issuer's Medical Loss Ratio (MLR).

We support the inclusion of effective programs that intend to improve the health of or clinical outcomes for consumers for the purpose of calculating MLR.

In an April 15, 2010 press release, Senator John D. Rockefeller IV, Chairman of the U.S. Senate Committee on Commerce, Science, and Transportation commented that "It's time to give consumers the medical benefits they pay for and deserve". Consumers deserve high quality, coordinated medical services that they can understand. Programs such as Case Management, Disease Management and Population Health Management focus on solutions to make consumers healthier, ensure they get the right care at the right time and provide coaching, education and support to enable consumers to better manage their health in the context of their lives. These programs fill a gap in the disjointed structure of our care system by improving communications with patients and their providers; and educating consumers about their disease states and the services available to them. These are indeed quality focused programs that help consumers achieve the clinical outcomes necessary to reach and maintain a high quality of life. They are programs that consumers most certainly deserve and have proven to be effective at improving both their health status and reducing their overall cost of care.



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In addition to the direct benefits to consumers through communication and education, these programs also enhance the quality and consistency of care by ensuring that care plans adhere to generally accepted evidence based guidelines. The fragmented nature of care delivery in the United States presents the risk of intentional, or unintentional redundant services or prescriptions, and other disconnected episodes of care. Interventions by providers of the programs mentioned above are, in some cases, the only opportunity to reduce the risk to consumers.

Health Insurance Companies that implement proven or "experimental" programs to improve the quality of clinical outcomes and health of their members should not be penalized in the MLR. In this effort to define MLR, we should all take care in defining those programs included in the "quality" bucket to avoid discouraging or inadvertently extinguishing the successful innovation that (so frequently) arises only from a plan's ability to try new ideas.

We appreciate this opportunity to comment on this important legislation and look forward to additional guidance on its implementation.

Sincerely,

Thomas Bendoraitis
Chief Financial Officer

cc: Mr. Lou Felice, Chair, Health Reform Solvency Subgroup, c/o NAIC ✓