



May 10, 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

Dear Mr. Felice:

I am writing to express the views of the Alliance of Community Health Plans (ACHP) on issues related to the calculation of Medical Loss Ratio. ACHP members are non-profit, community-based and regional health plans or subsidiaries of non-profit health systems. They deliver health care and provide coverage for approximately 18 million Americans and 15 percent of Medicare Advantage enrollees, predominantly in the individual and small and mid-sized group markets. Among our members are many of the high-performing health plans cited by the President and Congressional leaders as models of coordinated care or integrated delivery systems. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide coordinated, affordable, and high quality care.

ACHP offers the following recommendations on the discussion draft circulated on May 5:

**Definition of Quality-Related Activities:** On the May 5 conference call, Commissioner Praeger and others made the point that quality improvement models continue to evolve and that definitions will have to be modified over time. We agree, and believe that the category of quality-related activities should be broadly defined and flexible. While the draft Instructions for Line 5 entries appear to provide a relatively broad definition of expenses that are “designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care,” the expenses to be included on lines 5.1 and 5.2 are very narrowly drawn and seem to focus only on health promotion and wellness programs directed to insured members. There are many other expenses incurred by our member plans and clinical staffs that improve the quality of care. To cite just a few examples:

- activities to coordinate care across settings – e.g., transitions-in-care programs to assure that preventable rehospitalizations are avoided or minimized and that a patient receives necessary care and complies with prescriptions and other medical directions after a hospital discharge;
- support for programs that involve the patient in shared decision-making regarding treatment options;
- care management activities, including assistance to patients in navigating across the continuum of care, avoiding unnecessary care, or seeking care in an inappropriate setting;
- development of practice guidelines and other medical management activities designed to reduce variation in care and inappropriate use of services;
- expenses related to accreditation and to collection and reporting of quality measures; and
- development of patient-centered medical homes and other models to transform primary care.

**MAKING HEALTH CARE BETTER**

We would also point out that many quality-related activities have cost containment implications but that they appropriately belong in the MLR numerator as activities that improve health care quality. One example is activities designed to reduce hospital readmissions. Another example is investments in information technology upgrades that improve information sharing among providers, health plans and patients. These activities clearly have a cost containment impact, but we would argue that they are very much focused on quality of care, have a direct impact on individual enrollees, and should be included in the category of quality-related expenses.

These and other examples suggest the need for an approach that might focus on the characteristics or purposes of quality-related activities, and might set criteria for inclusion, but does not attempt to specify a list. Because this is a new component of MLR calculations, because Congress provided little guidance, and there is a paucity of research or regulatory experience to provide precedents for this new category, neither NAIC nor HHS should be overly prescriptive. We believe that these factors argue in favor of starting with a broader and more inclusive definition and encouraging HHS to establish a consultative process for the development of criteria that differentiate activities that improve quality from those that serve other purposes. We also agree with comments that were made on the conference call that NAIC should recommend that HHS will need an ongoing process to modify this category of expenses over time as new approaches are developed.

**Community Benefit Activities:** As not-for-profit plans or subsidiaries of not-for-profit systems, ACHP member organizations incur significant expenses for community benefit activities. These typically involve cancer screening, immunizations, and a wide range of health education programs for the community. Community benefit expenses are incurred in lieu of income taxes that would be paid by for-profit companies. While those taxes will be subtracted from total premium revenues in the denominator of the MLR calculation, not-for-profit plans will be put at a disadvantage if community benefit activities that they pay for in lieu of taxes are not similarly considered in the MLR. We strongly encourage NAIC to recommend that community benefit expenses be included as part of the category of activities that improve health care quality. We would point out that there is nothing in the legislation that restricts quality-related activities to those that are directed at enrollees, and we urge NAIC not to tie these expenses to enrollees only, particularly for not-for-profit organizations that have a broader mission of improving the overall health of the communities they serve.

**Three-Year Rolling Average:** As you know, MLR can fluctuate significantly from year to year. The legislation seems to recognize that variation by calling for the calculation of a three-year average MLR starting in 2014. We encourage NAIC to acknowledge both the variability of MLR and the uncertainties of adopting standard definitions and methodologies on a national basis for the first time by recommending to HHS that a three-year rolling average should also be used from the start as a mechanism for transitioning to and achieving compliance with MLR reporting and rebate requirements.

**Aggregation Level:** ACHP recommends that MLR calculations and reporting should be at the state level. That is the level that would be most meaningful to consumers, most appropriate to reflect different business and regulatory environments among the states, and most consistent with current reporting requirements. We also believe that calculations should be based on where the site of the contract is and not on where individuals reside, which is likely to introduce inaccuracies in reporting.

**Incentive and Bonus Payments:** We are pleased that NAIC proposes including medical incentive pools and bonus payments on line 3 as part of incurred claims. ACHP member health plans have implemented a variety of incentive arrangements, not all of which are shared savings agreements. We recommend adding the following underlined addition to this sentence: “Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers or rewards providers for delivering high quality services.”

**State Taxes and Assessments/Fees:** It appears that the discussion draft includes major categories of state taxes, assessments, and fees, including high-risk pools or other assessments to provide health care for individuals who do not have coverage. Some states use assessments to fund public health types of activities, and we encourage you to allow leeway for inclusion of these assessments. The more general point is similar to the one made above for quality-related activities: Given the wide range of assessments and fees across the states, we encourage you to recommend that HHS interpret this category broadly and with flexibility so that health plans can include all of the taxes, assessments, and fees that they are required by states and other authorities to pay.

Thank you for your consideration of our views. Please let me know if you have any questions about these recommendations or require additional information.

Sincerely,



Patricia P. Smith  
President and CEO

## ACHP Member Organizations

**CAPITAL DISTRICT PHYSICIANS'  
HEALTH PLAN**

Albany, New York

**CAPITAL HEALTH PLAN**

Tallahassee, Florida

**CARE OREGON**

Portland, Oregon

**EMBLEM HEALTH**

New York, New York

**FALLON COMMUNITY HEALTH PLAN**

Worcester, Massachusetts

**GEISINGER HEALTH PLAN**

Danville, Pennsylvania

**GROUP HEALTH**

Seattle, Washington

[www.ghc.org](http://www.ghc.org)

**GROUP HEALTH COOPERATIVE OF  
SOUTH CENTRAL WISCONSIN**

Madison, Wisconsin

**HEALTH PARTNERS**

Minneapolis, Minnesota

**INDEPENDENT HEALTH**

Buffalo, New York

**KAISER FOUNDATION HEALTH PLAN  
AND THE PERMANENTE FEDERATION**

Oakland, California

**MARTIN'S POINT HEALTH CARE**

Portland, Maine

**NEW WEST HEALTH SERVICES**

Helena, MT

**PRESBYTERIAN HEALTH PLAN**

Albuquerque, New Mexico

**PRIORITY HEALTH**

Grand Rapids, Michigan

**SCOTT & WHITE HEALTH PLAN**

Temple, Texas

**SECURITY HEALTH PLAN**

Marshfield, Wisconsin

**TUFTS HEALTH PLAN**

Waltham, Massachusetts

**UCARE**

Minneapolis, Minnesota

**UPMC HEALTH PLAN**

Pittsburgh, Pennsylvania