May 10, 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").

We appreciate that the NAIC Subgroup is hearing from a broad spectrum of interested parties. Hospitals and other health care providers are important stakeholders in the implementation of health insurance reform and are the entities that provide the clinical services to, and activities with the patient consumers, as well as have the primary responsibility for the quality of those services and activities. As a representative of key stakeholders, the FAH looks forward to providing meaningful input on this policy and others, as insurance reforms move forward.

**General Comments**

The FAH supports the goals of Section 2718, and its reporting requirements and medical loss ratio ("MLR") limitations as well as the corresponding need to both (a) establish uniform definitions of these reporting activities, and (b) standardize methodologies for calculating the measures of such activities.

Specifically identifying those insurer expenses that properly belong in the qualifying medical costs category, including appropriate costs to improve the quality of patient care (versus those costs that properly belong in the non-qualifying administrative expense category), is the critical element in ensuring that the intent of the Act – which is to require that a minimum percentage of premium revenue be spent on true medical costs related to patient care and not simply retained by insurers as
profit or to address excessive administrative costs – is effectively carried out. That analysis will require consideration of the myriad of insurance payment arrangements with a wide variety of provider configurations to ensure that the determinations focus on actual clinical care delivery and quality improvement, and not the administrative costs of the delivery system. Thus, the administration of benefits, establishing coverage parameters, claims adjudication, and like activities must be carefully excluded from a measurement of claims and quality improvement expenses.

Section 2718 sets mandatory levels of premium dollars for individual, small group, and large group health plans that must be spent on (1) “reimbursement for clinical services to enrollees,” and (2) “for activities that improve healthcare quality.” We comment on both categories below.

**Reimbursement for Clinical Services to Enrollees**

**Capitation Payments:** These are non-encounter/non-claim based payments to healthcare providers in exchange for providing a defined set of services to a defined set of patients (typically $X per-member-per-month for Y services) – *i.e.*, a way to reimburse providers on a risk-transference basis for population management functions (*e.g.*, primary care physicians for managing their assigned enrollees, reference laboratory for providing all lab services to a defined population of insureds, disease management vendors for managing patients’ chronic disease states, etc.). To the extent that such capitation payments compensate licensed healthcare providers for their services relative to the diagnosis and treatment of patients, these should be counted toward the mandated MLR percentage.

Capitation payments, however, typically provide for compensation of more than clinical services, and thus cannot fully qualify for inclusion in that category. Insurers are increasingly “carving out” certain services to be managed by other entities which similarly are neither licensed as healthcare providers, nor do they directly provide medical care to insureds. Often, such “carve-out” entities are actually wholly-owned subsidiaries of the insurers (*e.g.*, behavioral health plans or radiology benefit management companies), which have their own administration costs and profit retention objectives in addition to those of the upstream insurer. In addition, under capitated systems, a portion of the amounts paid often support a variety of functions which may be contractually “delegated” to the provider, and which are similarly to be excluded from the clinical services determination.

Irrespective of how capitation payments are deployed by insurers, only the portion of such capitation payments that reimburses licensed healthcare providers for direct patient care should be counted as allowable in the MLR formula. Any remaining portion must be considered as administrative expense and appropriately segregated out.

**Rebates to Insurers:** Insurers often receive rebates, and the MLR policy should be explicit in how those rebates should be accounted for in the MLR calculation. Whether in the form of retrospective payments to insurers (*e.g.*, by pharmaceutical companies) or the retention/non-distribution of “withholding” or “risk pool” fund balances, the calculation of reimbursement for clinical services to enrollees in the MLR calculation needs to be reduced by any such rebates, and other similar benefits insurers receive (such as subsequent claim, reversals, subrogation, Medicare/Medicaid recoveries, etc.) The FAH urges federal regulators to forego strict time limits as to how long a rebate must be accounted for in MLRs. We believe time limits are not appropriate as a way of excluding rebates from the MLR, but if they are instituted they should be very liberal as to recognize that rebate programs often involve a substantial lag time before they are given.
**Closed Panel HMOs:** There is a comparatively small subset of insurers who operate in a significantly different way than traditional insurers. These so-called “Closed Panel” (staff and group model HMO) programs have integrated many aspects of the healthcare provider delivery system (via the employment of a large number of their in-network physicians and, in a few cases, ownership of their own hospitals and other healthcare facilities) with a health insurance vehicle. We anticipate that these entities will seek a correspondingly different formulation and application of MLR requirements than their traditional insurer counterparts.

Without diving too deeply into this comparatively complex hybrid configuration, the FAH urges that, from an MLR perspective, the same allocation requirements should also apply to Closed Panel provider/insurer systems – but with some additional considerations to ensure uniformity and consistency in approach, including for example:

- Only “provider expenses” and “physician salaries” involved in direct clinical services should be counted for MLR calculation purposes. Costs of any office space and corresponding personnel (and their time) dedicated to health plan operations (and not to the direct delivery of patient care) need to be tracked, quantified and separated from clinical services, and must be considered as non-qualifying administrative expense.

- In order to be considered as a Closed Panel model, the insurer must have “internalized” (i.e., via ownership or employment) the vast majority of its in-network healthcare providers. An entity merely owning/operating a few physician practices (but in all other respects operating like a traditional health insurer) would not satisfy that threshold, and thus should not be considered any differently from a traditional health insurer for MLR calculation purposes.

**Activities That Improve Health Care Quality**

What qualifies as costs related to clinical services to enrollees is a concept that insurers have dealt with for many years in the MLR context under state regulatory policies. However, the inclusion of a separate category specific to activities that improve health care quality is not as common, and requires a close focus by federal regulators to avoid becoming a “catch-all” into which a wide variety of expenses not directly related to patient care and clinical service quality may arbitrarily be placed.

A key policy goal of Section 2718 is to ensure that enrollees receive direct and real value for their premiums, which is the rationale behind setting minimum mandated levels for patient care related costs. This policy was enacted in response to insurance industry data that generally shows, particularly in the individual and small group markets, a significant percentage of premium dollars goes to plan profit or administrative costs. Because this is a ratio calculation, care must be taken to evaluate the costs attributed to the numerator, i.e. clinical services and quality improvement costs, or the integrity of the ratio will be compromised and its measurement diluted, thus thwarting the goals of the legislation.

Accordingly, the FAH urges that the definitions be the product of a careful focus on the goals and, therefore, any costs associated with reimbursement for clinical services furnished to enrollees and activities that improve health care quality fall squarely within those parameters, and not be the product of a flexible or broad interpretation of activities which are not truly clinical services actually furnished directly to an enrollee or an activity which demonstrably has been shown to improve health care quality for patients. Insurers should be prevented from re-characterizing certain historically administrative costs as costs related to activities to improve health care quality in order to satisfy the mandated levels and to avoid enrollee rebates. In our view, the appropriate policy parameter to draw
is to require a direct focus on those costs related to activities specifically designed to improve health care quality for a particular patient.

There are broad categories of costs that may appear to be related to quality improvement, when in actuality the various types of costs within the broad categories need to be closely scrutinized to reach a proper classification. It is not sufficient or appropriate to allow for one type of classification for all types of costs within the broad categories. For example, most activities related to disease management and health/wellness promotion programs are not directly related to quality improvement for particular patients and should be excluded. Also, generalized programs of health education for the population at large, which are often used as much for promotion of the health plan as to be generally informative on health status, should be excluded. However, costs related to specific services furnished by health care providers to individual patients that involve disease management and certain types of patient-centered health/wellness programs should meet the costs counted for the mandate. In contrast, any costs for patient-specific services related to enrollment in a plan should be excluded.

Examples of insurer activities that clearly fall outside of the clinical care umbrella would include utilization review, quality assurance, credentialing, case management, fraud prevention, medical policy-making, referral authorization programs, health plan accreditation, and provider contracting and network management. These activities are administrative in nature and – while some of them may serve to track or report quality, or reduce the occurrence and cost of claims for healthcare provided to patients – they do not in and of themselves serve to improve healthcare quality. As such, they should not be considered as counting toward the mandated percentage of premiums in the MLR equation.

The hospital industry is currently subject to a multitude of different licensing, governance, regulation, reporting requirements and other forms of oversight. In many cases, the additional scrutiny that insurers seek to apply to providers is effectively redundant with other oversight already being done, is unnecessary, and represents administrative costs. Again, these types of costs relate to quality reporting activities and not activities that directly improve healthcare quality for individual patients.

Many healthcare insurers have adopted Pay-for-Performance (“P4P”) programs, under which healthcare providers may be paid “bonuses” for meeting certain performance criteria. To the extent that the bonus payments are determined directly based upon evidence-based quality metrics, those costs should be counted as activities that improve health care quality. However, simply denoting a program as “quality based” or a “delivery system improvement” should not be the end of analysis. While such programs may generally appear to be designed to improve quality of care, these programs often determine bonus payments based on cost-savings or other related efficiency measures that are not actually based on true patient quality improvement processes or the delivery of clinical services. In our view, only the portion of P4P program distributions, however styled, that are specifically attributed to evidence based quality improvement or clinical services delivery should be counted for MLR purposes. Payments related to cost or efficiency performance should be attributed to administrative expenses.

**Level of Aggregation**

Much discussion has focused on the level of aggregation for purposes of the MLR calculation. Allowing the MLR information to be presented and analyzed on an aggregated basis for all products and reported at the holding company level would directly contradict the statute and be inconsistent with its policies. In our view, the statute clearly requires an analysis and enforcement at least to the individual and small group markets and to the large group market, due to the different applicable
percentage floors. Further, we are mindful that the title of the section that imposes this new policy is “ensuring that consumers receive value for their premium payments,” so the implementation approach should provide consumers with the best information available. Thus, the FAH urges federal regulators to require plans to report their MLRs on an entity by entity basis at the state level, and for those entities to differentiate between plans for the individual and small group market and large group market. This approach best fits with the letter and spirit of this legislative directive.

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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,
Charles N. Kahn III
President and Chief Executive Officer