

May 11, 2010

Mr. Lou Felice  
Chair, Health Solvency Issues (E) Subgroup  
C/O New York Department of Insurance  
25 Beaver Street  
New York, New York 10004-2319

**Re: Medical Loss Ratios**

Dear Mr. Felice:

I am writing on behalf of the Kaiser Permanente Medical Care Program (“Kaiser Permanente”) to provide the Health Solvency Issues (E) Subgroup with input and comment on the Subgroup’s proposed definitions for calculating medical loss ratios pursuant to *Sections 1001 and 10101 of the Patient Protection and Affordable Care Act (PPACA)*, which added Section 2718 to the *Public Health Service Act (the PHS Act)*. Section 2718 of the PHS Act (“Section 2718”) requires health insurance issuers to annually report their medical loss ratios (“MLR”), meet specified MLR levels and provide premium rebates if they fail to do so.

The Kaiser Permanente Medical Care Program (which offers services to the public under the Program’s trade name “Kaiser Permanente”) is America’s largest private integrated healthcare delivery system, which both directly provides health care services (through 36 hospitals, 431 medical offices, 164,000 employees, most of whom are involved in the provision of health care services, and 14,600 physicians) and organizes the financing of care for its members. It comprises: Kaiser Foundation Health Plan, Inc. (and its local subsidiaries, collectively “Health Plan”), the nation’s largest not-for-profit health plan; the nonprofit Kaiser Foundation Hospitals (and its local subsidiaries, collectively “Hospital”); and the Permanente Medical Groups (“Medical Group”), eight independent physician group practices that Health Plan exclusively contracts with to meet the health needs of Kaiser Permanente’s 8.7 million members in nine states and the District of Columbia. In addition, the substantial majority of ambulatory and hospital care, most pharmacy, diagnostic, and laboratory services are performed within Kaiser Permanente by Health Plan, Hospital or Medical Group employees in Health Plan or Hospital-owned facilities.

We appreciate the opportunity to provide comment on the following proposed definitions:

**I. Incurred Claims:**

Section 2718 (a) requires health insurance issuers to calculate their MLR using, among other elements, “incurred claims.” Most services provided by Kaiser Permanente are not claims-based. What appear as “claims” to most insurance companies are usually experienced by our organization as direct health care services that we have provided. Specifically, the Medical Group and Hospital are not paid through claims. Rather, the Medical Group is paid primarily on a per member per month basis and Hospital is paid on a cost plus reimbursement basis. Claims

are submitted only by outside providers.<sup>1</sup> As such, only a small proportion of our medical expenses involve the payment of “claims”. This makes calculating a medical loss ratio more complicated than in the case of traditional health insurance companies.

Additionally, Health Plan itself is a health services provider that operates medical offices, pharmacies, and other facilities related to the delivery of health care services. Thus, unlike health insurers, Health Plan has expenses for delivering health care and for operating and maintaining its care delivery infrastructure. Health Plan pays salaries, provides security and provides human resource support for the many health care professionals it employs. It pays for the information technology infrastructure for the delivery system, including an electronic health record system that is, with the possible exception of the Veterans Administration, unparalleled in the United States. Health Plan must maintain the clinics and pharmacies it operates, including depreciation costs and equipment maintenance. Outside of an integrated delivery system, community providers build their general operating costs into the rates they charge health insurance issuers. These costs then are appropriately reflected in other insurers’ MLR as clinical services or incurred claims. Thus, in order to have fair apples-to-apples comparison, Health Plan’s comparable costs associated with operating its delivery system must be included in the definition of incurred claims, in addition to the costs of claims submitted by outside providers, given that Health Plan is directly responsible for providing care to its members and their beneficiaries.

We greatly appreciate your recognition of our integrated model and the critical need for the numerator of any MLR calculation to include the full costs of the Kaiser Permanente’s delivery system in addition to the costs of claims submitted by outside providers. The proposed instructions for incurred claims, while capturing all other medical expenses, exclude Revenue and Expense Line 14 "Aggregate write ins for other hospital and medical." For an integrated delivery system, that line captures many of the health plan's expenses for operating and maintaining its portion of the delivery systems, such as clinics and pharmacies.

### **Recommendation:**

Add Line 14 re “Aggregate write ins for other hospital and medical” from the Annual Statement, Revenue and Expense Statement to include definition of incurred claims.

### **II. Activities That Improve Care Quality:**

We are aware of the popular criticism of this category as a possible loophole for insurers to inappropriately reclassify administrative costs as health care expenses. However, we caution against being overly restrictive when defining this category. We applaud Congress for including this important category and in so doing, creating incentives for health insurance issuers to invest in quality activities, such as care and disease management, patient safety and quality assurance

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<sup>1</sup> Kaiser Permanente Regions in which Hospital owns hospitals also have large multispecialty Permanente Medical Groups, and thus claims are only a small fraction of the total medical costs in these Regions. These Regions are Northern and Southern California, Northwest and Hawaii; and they collectively serve 84 percent of Kaiser Permanente members nationwide. (Data as of December 2009). In the other Regions, which are relatively small, claims constitute a larger portion of total medical expense. Even so, claims alone are a very incomplete picture of the services we provide even in our non-hospital-based Regions.

programs, advice call centers, health education and wellness programs. If these activities are not included in the numerator of the MLR calculation, health insurance issuers will not be able to devote resources to important quality activities.

In addition to quality initiatives that benefit our enrollees, Health Plan strives to improve the health and welfare of the communities it serves through its community benefit programs. Many of these programs directly help improve care quality in the community. For example, Kaiser Permanente gives grants and provides technical assistance to community clinics, health departments and public hospitals to help these critical safety net providers train physicians and nurses and undertake quality improvement initiatives. We also fund community organizations to help them provide health education and wellness programs. To the extent these Health Plan expenditures relate to quality improvement, they should be included as “activities that improve care quality” for MLR calculations. We note that PPACA does not require quality activities to be directly related to an insurer’s enrollees. Section 2718(a) (1) requires insurers to report the percentage of their total premium revenue spent “on reimbursement for clinical services **provided to enrollees under such coverage.**” By contrast, Section (a) (2) requires insurers to report “activities that improve health care quality,” without the same limitation.

If these expenditures are not included in the MLR, it will have a disproportionate and unfair impact on nonprofit, tax-exempt health plans, like Kaiser Permanente. To maintain their tax-exempt status, health plans are required under federal tax rules to provide community benefits. In effect, community benefit revenue is analogous to paying taxes by other insurers. Under Section 2718(b) (1) (A), taxes are deducted from the premium calculation for the MLR. PPACA recognizes that taxes are not discretionary expenses and thus should not count against health insurance issuers. Likewise, community benefit expenses for tax-exempt health plans should be similarly treated. If these community benefit expenses are treated as administrative expenses under the MLR regulations, nonprofit tax-exempt health plans would be placed at a disadvantage relative to for-profit health insurers, thus creating a disincentive for health plans to be organized as nonprofits and a strong incentive to minimize community benefit expenditures, which is counter to sound public policy.

We note that quality initiatives are evolving, and thus the definition of “activities that improve care quality” should not be static. The MLR regulations should not discourage innovation. We recommend listing defining characteristics of qualifying activities, rather than a specified list.

### **Recommendation:**

“Activities the improve care quality” means activities designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care for both a health insurance issuer’s enrollees and members of the community.

### **III. Premium Revenue:**

In a typical insurance environment, patient copayments and deductibles are made directly by the patient to health care providers, who keep that revenue. Thus, other health insurance issuers’ provider costs do not reflect these revenues. Within Kaiser Permanente, however, these revenues are collected and kept by Health Plan. To accurately reflect the revenue collected from our

members and create a fair comparison with traditional health insurers, the definition of premium should include the member/patient's share of payment.

**Recommendation:**

Premium may also include other supplemental payments in lieu of dues (e.g. primarily co-payments, deductible payments and other fees) received by the health plan insurance issuer, due pursuant to a policy of insurance.

We appreciate the opportunity to provide you with our comments and welcome the opportunity to discuss these matters with you further. If you have questions or concerns, please contact me at [julie.h.stoss@kp.org](mailto:julie.h.stoss@kp.org) or (510) 271- 6430.

Very truly yours,

A handwritten signature in black ink, appearing to read "Julie Stoss". The signature is fluid and cursive, with the first name "Julie" and last name "Stoss" clearly distinguishable.

Julie Hutcherson Stoss,  
Senior Counsel  
Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals

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