



To: Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC

Steven Ostlund
Chair, Accident & Health Working Group, NAIC

From: Robb Cohen
Chief Government Affairs Officer, XLHealth

Re: PPACA MLR Provisions

Date: 5/11/10

As the nations second largest Medicare Advantage Chronic Special Needs Plan, we think it is important that the MLR definition makes it clear that activities which are investments in an effort to reduce medical costs and/or improve quality are able to recognized in the MLR numerator.

Our company primarily offers Medicare Advantage Chronic Special Needs Plans for persons with Diabetes and Heart Failure. We were founded as a Diabetes Disease Management company (recognizing that many heart conditions are co-morbid to Diabetes), that was focused on the Medicare population, where we believe improved quality leads to decreased costs.

As background, we believe that as Medicare rates are reduced much closer to 100% of Medicare FFS costs and Risk Adjustment is improved (to reduce the overpayments to the healthy and underpayments to the chronically ill) as is required in PPACA, that Activities That Improve Health Care Quality will be the core competency that allows Medicare Advantage plans to exist and add value. Additionally, these activities are exactly the methods by which we and other Special Needs Plans must demonstrate that we are Special and add value to Medicare.

Rather than trying to enroll a more healthy population, as a Chronic Special Needs Plan for persons with Diabetes and Heart Failure, our entire business approach is to invest heavily in Activities That Improve Health Care Quality in order to improve quality and decrease costs—again, investing in these activities is the core reason for our existence. Additionally, as a Medicare Special Needs Plan, we have patient level multi-disciplinary Model Of Care requirements which are appropriately greater than for regular Medicare Advantage plans, since we care for the most vulnerable Medicare beneficiaries. The Model Of Care rules require that we invest in these activities.

Recommendation:

In creating the MLR definition of Activities That Improve Health Care Quality, to the extent items are not included as Medical Costs, the definition should include items which support the Institute Of

Medicine's (IOM) six aims for Quality Improvement—activities designed to make care more safe, effective, patient-centered, timely, efficient, and equitable.

Based on the using the IOM definition, the following activities are **examples** of items which should be able to be counted in the MLR numerator, either as Medical Costs or Activities That Improve Health Care Quality:

- Care coordination and management
- Health education and wellness
- Chronic disease management and patient monitoring
- Health risk assessments
- Transition management
- Case management
- Population health management
- Medication therapy management & compliance
- Patient safety
- Nurse hotlines / telephonic member support
- Quality assurance

Since many of these items can be provided in a variety of settings and by a variety of methods, it is important that the items can be included in the MLR whether delivered, in-home, in-person, telephonically, web enabled, or by any means that appropriately delivers valuable services.

In summary, including the full array of Care Management / Care Coordination expenses in the Medical Loss Ratio numerator is necessary so that Plans have the proper incentive and are able to invest in improving quality and decreasing costs. As a Medicare Advantage Chronic Special Needs Plan, we believe these activities are the core reason for our existence, and the foundation upon which Congress created Special Needs Plans to improve quality and decrease costs for Medicare's most high cost beneficiaries.

Please contact me at 410 967 2526 or rcohen@xlhealth.com with any questions.

Thank you for your work on health reform, and your consideration of these comments.