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**From:** Ned McCulloch [mailto:]  
**Sent:** Thursday, July 01, 2010 3:44 PM  
**To:** Sells, Todd  
**Cc:** Keenie McDonald; Martin J Sepulveda  
**Subject:** Letter from IBM regarding medical loss ratio

Mr. Lou Felice  
Chair, Health Care Reform Solvency Impact (E) Subgroup  
c/o National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, MO 64108-2662

Dear Mr. Felice,

IBM is a leader in providing health benefits to our employees and in creating an environment encouraging our employees to lead healthy lifestyles. Both the quality of healthcare and the cost of healthcare is critical to our employees and our company. As such we are keenly interested in the work of your committee and ask that as your committee finalizes the definition of the Medical Loss Ratio (MLR), you consider the following:

1. Investments in initiatives provided outside the traditional health care delivery system that are specific to patient outcomes and healthcare quality improvements should also be considered as spending on healthcare and not administration. These are provided by health plans, on site employer-sponsored clinics and retail clinics, for example, and drive evidence based medicine, reduction of medical errors or improvements in patient safety, health behavior change such as wellness and self-care, chronic condition management, patient support services (e.g. nurse advisors, health coaches), and care coordination. Each of these is fundamental to prevention, management of chronic conditions, and reduced reliance on in-patient care and emergency room utilization.
2. The costs associated with wellness, prevention and care management programs and the information-based systems these rely on for assessment, targeting, messaging, coaching, planning and monitoring should be considered as spending on healthcare and not administration. Allowable "medical claims" should also include such services from any provider that directly address improving patient outcomes such as adverse drug events, medication reconciliation, medical technology overuse and underuse, medical error reduction, appropriateness of care (e.g. gaps in care, medication adherence). Health information technology for clinical care support such as registries, clinical decision support, patient messaging and web visits, health risk assessments, and uses of ICD10 for improving early identification, quality measurement and the evaluation of medical processes should similarly be considered as healthcare services.

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