American Hospital Association

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June 2, 2010

Commissioner Jane L. Cline
President
National Association of Insurance Commissioners
2301 McGee Street
Suite 800
Kansas City, MO 64108-2662

RE: Section 2718 of the Public Health Service Act on Medical Loss Ratio Definitions

Dear Commissioner Cline:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to share with the National Association of Insurance Commissioners (NAIC) our comments on the medical loss ratio (MLR) provision of Section 2718 of the *Public Health Service Act* (PHSA), as established by the *Patient Protection and Affordable Care Act* (PPACA).

Section 2718 of the PHSA imposes reporting obligations and MLR standards on health insurers with the objective to ensure that a minimum percentage of health insurance premiums are used to pay for health care services or activities that improve health care quality for enrollees. The AHA supports this objective, and we recognize the need for a process for the development and adoption of standard definitions and methodology that balances the objective of the law with the realities of health care delivery and insurance operations.

Regulations implementing the new MLR provision should ensure that the allocation of costs incorporates the following three principles:

- only payments to licensed professionals and entities that deliver health care services should be classified as health care services;
- costs and expenses that are classified as activities that improve health care quality need to meet specific criteria; and
- loss adjustment activities should be counted as administrative costs because they do not provide health care services or improve quality.

MEDICAL LOSS RATIO DEFINITIONS

The PPACA directs the NAIC to develop uniform definitions and methodologies for calculating MLR, subject to certification by the Secretary of Health and Human Services. Section 2718 of the PHSA permits health insurers to add their costs for "activities that improve health care quality" to their costs for "reimbursement for clinical services provided to enrollees" for purposes of calculating their MLR under the PPACA. We would caution that the addition of the health care quality component should not be construed to permit health insurers to reclassify as health care quality costs that the insurers historically considered to be the administrative costs of doing business.

Health insurers, by definition, are not providers of health care services, nor are they licensed to deliver care. They perform an important but largely administrative function in our health care system through the administration of health coverage plans. Insurers should not be permitted to determine without clear definition and guidance what services are defined as clinical nor what activities will improve the quality of health care for an enrollee.

Recent media reports have indicated that some insurers are reclassifying expenses from administrative to clinical services to meet the terms of the new law's MLR. In addition, an April 14 MLR report issued by the U.S. Senate Commerce Committee states, "Boosting medical loss ratios through creative accounting will not fulfill the new law's goal of helping consumers realize the full value of their health insurance payments." Such behavior, if upon close examination is proven true, runs counter to the intent of the PPACA.

The AHA recommends that the test for "reimbursement for clinical services" be straightforward and include reimbursement of provider claims for clinical services or the cost of providing services, as in the case of staff-model HMOs. The test should be limited to services provided by professional individuals or entities licensed to deliver those services. In addition, the amount an insurer sets aside to pay future claims – so-called "contract reserves" – should not constitute "reimbursement for clinical services," at least not until those reserves are actually expended on such costs.

The MLR regulations must clearly define which activities do and do not improve health care quality and restrict the ability of health insurers to subjectively make such a determination. The AHA recommends that resulting regulations require that the activity be performed by a professional licensed to perform the service or activity, and employ a decision tree analysis to distinguish between an activity that is intended to limit services or reduce expenditures (e.g., utilization management) or to improve health (e.g., a diabetes management program, care coordination or shared-savings programs). A decision tree analysis might incorporate a series of questions that probes whether the activity is aimed at reducing cost, utilization, or directs the patient to a lower-cost care setting versus whether the activity measurably improves the patient's health. Some insurers have argued that nurse hotlines, care and disease management programs, and wellness programs would qualify as activities that could fall in this category of improving heath quality. Rather than permitting labels to dictate the

classification of expenditures, using the analytic approach of a decision tree should reduce the ambiguity in determining the activities that will improve the health quality for an enrollee, not just limit an insurer's costs.

The test for "activities that improve health care quality" should not include loss adjustment expenses, which generally are viewed as costs for activities associated with a specific claim such as investigation, litigation or appeals. The costs associated with loss adjustment expenses are clearly the cost of doing business, not activities that improve health care quality or constitute the reimbursement of clinical services. As stated in an April 30 letter from the NAIC consumer representatives to the NAIC task force on MLR, "Expenses related to settling claims are not payments for health services. Including them in the MLR numerator would provide a perverse incentive for insurers to spend more money on denying claims." It also would relieve the pressure on insurers to reduce their administrative costs overall – a clear objective of the PPACA.

AGGREGATION LEVEL FOR MEDICAL LOSS RATIO

Another important issue the NAIC should consider is determining a meaningful level for the aggregation of health insurance company MLRs. MLRs vary widely by insurance product type and geographic location. The intent of the PPACA provision on MLR is to make certain that the vast majority of premium dollars are spent on paying for health care services or activities to improve health care for enrollees. Aggregating MLRs at a company-wide level may be useful in examining solvency issues by regulators, but aggregating at too high a level might mask the variations in insurance markets and products. **The AHA recommends that health insurance plans should be required to aggregate MLRs at a level that is meaningful enough to ensure compliance with the letter and spirit of the law.**

The AHA looks forward to working with the NAIC on implementing the numerous health insurance reforms so that they achieve affordable health care coverage for all that is of the highest quality.

If you have any further question, please feel free to contact me, Ellen Pryga, policy director, at epryga@aha.org or (202) 626-2267, or Molly Collins Offner, policy director, at mcollins@aha.org or (202) 626-2326.

Sincerely,

Rick Pollack
Executive Vice President

cc: New York State Insurance Commissioner Lou Felice
Kansas State in Insurance Commissioner Sandy Praeger