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August 4, 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 Definition of Quality Improvement Expenses

Dear Commissioner Cline:

The American Hospital Association (AHA), on behalf of the our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, appreciates the opportunity to engage the National Association of Insurance Commissioners (NAIC) on the implementation of 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 of 2010* (PPACA). This letter expands upon our June 2 correspondence and focuses specifically on the need to include health plans' contributions toward community-wide quality improvement projects in the definition of quality improvement expenses when calculating their medical loss ratios (MLR). We wish to commend the NAIC for the open and transparent manner in which it has conducted its MLR deliberations and would encourage continued vigilance to ensure that what counts as quality improvement expenses are legitimate *improvement* expenses.

Section 2718 of the PHSA imposes reporting obligations and MLR standards on health insurers aimed at ensuring 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 concept of adding costs for "activities that improve health care quality" to the costs for "reimbursement for clinical services provided to enrollees" is new in the context of calculating MLRs, having just been added this year by the PPACA. As such, it has stimulated a great deal of controversy and led to our earlier caution that specific criteria be applied to ensure that any costs added to the numerator of the ratio for health care quality improvements not permit health insurers to reclassify at will costs that were historically classified as the administrative costs of doing business.



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Bearing this caution in mind, we would like to bring to the attention of the NAIC commissioners one area of activity where hospitals, health insurers, state hospital associations and other organizations have collaborated on community-wide quality improvement initiatives that may inappropriately be classified as administrative activities. These collaborations typically go beyond the health plan's enrolled population in order to change how care is delivered to all patients and, as such, ensure that the internal provider systems necessary to implement the quality improvement activity can be maintained and sustained throughout the entire community. We understand that there is some question about whether health plan contributions to such quality improvement projects will be allowed to be counted in the numerator of the MLR calculation because they are not limited to just the plan's enrollees, or because the dollars may have flowed through a centralized entity such as a state hospital association. We would like to share some examples of collaborative projects that are having significant impact.

In the state of Michigan, Blue Cross Blue Shield of Michigan has been a major contributor to the Michigan Hospital Association Keystone Center for Patient Safety and Quality. The Keystone Center has achieved international recognition for its work in developing collaborative models to improve patient care, most notably for driving central line-associated bloodstream infection rates to near zero in participating hospitals. The North Carolina Center for Hospital Quality and Patient Safety was developed by the North Carolina Hospital Association with assistance from Blue Cross Blue Shield of North Carolina. The Center has led collaborative efforts to reduce healthcare-associated infection rates, improve cardiac and surgical care, and build a culture of safety in North Carolina hospitals. In these two examples, we believe that the health plans' contributions to these quality improvement initiatives should count as quality improvement expenses in calculating their MLRs.

As indicated in our earlier letter, the AHA strongly believes that 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. But the regulations should not preclude the community-wide quality collaborations between health plans and providers described above. We believe that this type of quality improvement activity can be included without creating a large loophole by employing the decision tree analysis we recommended earlier to distinguish between an activity that is primarily intended to limit services or reduce expenditures (e.g., utilization management) or to improve health (e.g., programs to reduce central-line infections). A decision tree analysis might incorporate a series of questions that probes whether the activity is aimed at reducing cost or utilization, or directs the patient to a lower-cost care setting, versus whether the activity measurably improves the patient's or the community's health. 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. Further the MLR regulations should require that the "quality activity" be performed by a professional licensed to perform the service or activity.

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

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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,

A handwritten signature in black ink that reads "Rick Pollack". The signature is written in a cursive, slightly slanted style.

Rick Pollack

Executive Vice President

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