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January 31, 2011

The Honorable Kathleen Sebelius  
Secretary  
Department of Health and Human Services  
200 Independence Avenue, SW  
Room 445-G  
Washington, DC 20201

***Re: Interim Final Rule for Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act: OCIIO-998-IFC***

Dear Secretary Sebelius:

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 comment on the Department of Health and Human Services' (HHS) interim final rule implementing 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* (ACA).

Section 2718 of ACA seeks to establish greater transparency and accountability around the expenditures made by health insurance issuers by ensuring that health insurance premiums are used predominantly to pay for health care services or activities that improve health care quality for enrollees. The MLR standards should encourage insurers to be more efficient in their administrative operations and help ensure that policyholders receive value for their premium dollars. The AHA supports these objectives and recognizes the need for standard definitions and a methodology that balances the intent of the law with the realities of health care delivery and insurance operations.

We commend HHS for so quickly and thoroughly addressing the MLR requirements in this rule. Defining the components of MLR policy is a serious undertaking and in developing this rule, HHS has not only considered the National Association of Insurance Commissioners' (NAIC) Model MLR Regulation (Model Regulation) but also public comments. We have followed these deliberations with great interest, commenting to both NAIC and HHS, and we appreciate the enormous effort involved.



Our comments on the interim final rule focus on two key areas:

- The allocation and treatment of capitated payment amounts; and
- The proper classification of costs as activities that improve health care quality.

**Allocation and Treatment of Capitated Payments (*45 CFR §§158.140(a), 158.140(b)(3)(ii) and 158.140(b)(3)(iii)*)**

The ACA directed the NAIC to establish the uniform definitions and standardized methodologies needed to implement the MLR requirements, subject to certification by the HHS Secretary. The preamble to the rule states that HHS has certified and adopted the NAIC model regulation in full. However, the rule expands upon the NAIC model and has created some confusion and concern among our members.

The first area of concern is the provision classifying only capitated payments to physicians as medical claims, but not capitated payments to all health care providers who deliver health care services to a plan's enrollees. The second area is the apparent exclusion of at least some health care provider administrative costs from classification as medical claims. We recommend that HHS immediately clarify the rule. (For purposes of clarity, we are using the term "medical claims" in lieu of the rule's references to "incurred claims.")

The rule adopts the NAIC position that capitated payments are classified as medical claims. One of the unresolved issues that the AHA and other stakeholders raised during the NAIC's deliberations regarding the treatment of capitated payments arose from a concern that insurers would attempt to shift significant administrative costs to the medical claims portion of the MLR equation by entering into capitated payment arrangements with intermediate risk-bearing organizations, such as medical management service organizations (MSOs), that are not part of a provider organization or integrated delivery system providing services to the plans' enrollees. We commented in our October 11, 2010 correspondence to NAIC that our members were reporting that insurers were increasingly using intermediary MSOs, suggesting that this trend is real, not just a potential issue. The NAIC ultimately decided that capitated payments should be included as medical claims and that the issue of intermediate risk-bearing entities should be brought to the attention of HHS and state insurance commissioners as an area to be monitored for potential abuse.

We believe that in attempting to address this issue in the interim final rules, ambiguous language created the two problems noted above. First, in narrowing the inclusion of all capitated arrangements under medical claims, the rule references only payments made "under capitation contracts with physicians." Since capitated arrangements with other types of providers (such as hospitals) to deliver health care services to enrollees clearly should be counted as medical claims, we assume that this limitation was not intended and should be changed to read "under capitation contracts with health care providers for covered services."

Similarly, we believe the second problem resulted from an apparent attempt to limit the ability of insurers to count certain administrative costs inappropriately as clinical services through the use of capitated payment arrangements. The interim final rule specifically excludes from medical claims amounts paid for certain administrative costs by an insurer to a third-party vendor to the extent that those amounts exceed reimbursement paid to providers. We assume this language was intended to address percent-of-premium arrangements with intermediary MSOs where the MSO is accountable for network formation, network credentialing, and claims payment to providers (plan administrative functions). In such a case where the MSO is not part of a provider organization or integrated delivery system, it would be appropriate to count toward medical claims only the amounts paid to health care providers and suppliers for covered services rather than the entire percent of premium paid to the intermediary MSO. But, we believe an unfortunate choice of words has created an unintended result. The rule prohibits an insurer from including as medical claims:

Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee. For example, medical records, copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks ...

We believe that this provision could be interpreted to include provider administrative costs necessary for delivering health care services. The MLR requirement was never intended to apply to provider administrative costs integral to health care delivery, only health plan administrative costs. For example, provider janitors, medical record clerks and quality assurance analysts are not only integral to care delivery, they are required to meet Medicare conditions of participation for hospitals and other providers regarding infection control, medical records and quality improvement. A strict interpretation of this requirement also would place a serious record keeping burden on hospitals for a requirement that serves no public policy purpose.

At most, this provision should apply only to health plan administrative functions performed by the provider for the plan where a separate bill was sent to the plan. An example would be provider bills to health plans for copying medical records at the plan's request. The AHA recommends that this provision (or at least the examples) be deleted and any remaining provision be clarified to focus tightly on health plan administrative costs.

**Health Care Quality Improvement Costs (§§158.150; 158.150(b)(1)(iii); 158.150(b)(2)(i); 158.150(b)(2)(iii); and 158.150(c)(13))**

We appreciate the department's attempt to ensure that any non-claims costs added to the medical claims part of the ratio for health care quality improvement activities meet a standard that requires objective measurement and verifiable results that are grounded in evidence-based medicine so that insurers are not able to simply reclassify at will costs that were historically classified as administrative costs. We believe the criteria in the rule are sound and based on the ACA, but suffer from some continued problems in three areas regarding what is and is not

considered to be included in medical claims costs because they improve health care quality. Specifically, they:

- 1) do not clearly include health plan contributions to certain community-wide quality collaborative initiatives with providers to improve patient safety and quality;
- 2) do not limit interactions with an enrollee that are classified as improving health outcomes to those conducted by a licensed health professional; and
- 3) assume that prospective utilization review activities are related to quality when they are much more related to cost reduction.

***Community-wide Patient Safety and Quality Improvement Initiatives.*** Hospitals, insurers, state hospital associations and other organizations often collaborate on community-wide quality improvement initiatives. These initiatives frequently yield dramatic improvements to health care quality that typically benefit patients and consumers in the entire community, not just the enrolled populations of the health plans involved. The value of these initiatives is that they systemically change how care is delivered to all patients and, as such, ensure that the improvements implemented can be sustained over the long term throughout the entire community. Some of these local initiatives have been so successful that they are being replicated across the country, with support from the AHA and others.

For example, Blue Cross Blue Shield of Michigan has been a major contributor to the Michigan Health & Hospital Association's 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 financial support of the insurers should count as quality improvement expenses in calculating their MLRs and believe that might be supported by the rule depending on how it is interpreted.

The issue of recognizing the type of quality and patient safety collaboratives described above is complicated by a provision in the rule that states that quality improvement activities must be directed toward individual enrollees or provide health improvements to the population beyond those enrolled in the plan, "as long as no additional costs are incurred due to the non-enrollees." It is unclear to us what this phrase in the rule means with respect to these collaboratives. If a certain amount is being contributed by a plan to a community-wide quality improvement initiative that benefits enrollees and non-enrollees alike, such as a study of hospital infection rates and adoption of new infection control protocols, it is unclear whether that plan contribution would pass this test and be counted fully or partially, especially if there were multiple sources of funding for the initiative. Given the success of these collaboratives in improving the quality of care and patient safety, it would be extremely unfortunate if insurers felt compelled to withdraw their support because their contributions would not be recognized as quality improvement costs

under the MLR rules. We urge HHS to clarify this standard to fully recognize insurer contributions to and participation in community-wide initiatives.

***Categorical Inclusion of Communications with Enrollees.*** As we recommended in prior correspondence to NAIC and HHS, we believe an analytic approach, such as a decision tree analysis, should be used to distinguish between an activity that is primarily intended to limit services or reduce expenditures (an administrative cost management function) from one that will improve the quality and outcomes of care for an enrollee. An analytic approach is preferable to one that simply uses labels or broad categories to dictate the classification of expenditures. We recommend that the rule be revised to specifically permit states to use an analytic approach.

The AHA is concerned that some activities that are classified as improving health care quality are either not appropriate or could be used by insurers to simply reclassify administrative costs in order to meet the MLR requirement. The examples that are used to describe activities designed to improve health outcomes in the rule appear to blur the lines between utilization review (otherwise classified as administrative costs) and quality improvement. We do not believe that all communications with enrollees are directed at improving outcomes - many just carry out the business of the plan. Therefore, the AHA suggests that the rule require that in order for an interaction with an enrollee to be classified as improving health outcomes that it be conducted by a licensed health care professional.

***Categorical Inclusion of Prospective Utilization Review Activities.*** We also oppose the categorical inclusion of prospective utilization review activities among those activities that improve health care quality. While prospective utilization review may help ensure that appropriate medical treatment is given, its primary purpose and focus for insurers, in our collective experience, is cost control or containment, not quality of care.

The commentary in the rule's preamble addresses prospective utilization review, stating that it is considered a quality improving activity because "it is rendered before care is given and can help ensure that the most appropriate medical treatment is given in the most appropriate setting." The rule does not specifically include all prospective utilization review activities among those activities defined as improving health care quality; however, the rule is ambiguous and needs to be clarified.

The AHA recognizes that certain types of innovative programs adopted by insurers may truly improve health care quality and that under certain state laws, those programs could be classified as "prospective utilization review." We do not wish to quash such innovation by denying insurers the ability to include expenditures on these activities as those that improve health care quality. However, we believe that the rule should begin with the premise that traditional prospective utilization review activities do not qualify as quality activities unless specific criteria are satisfied.

### **Level of Aggregation of Data for the MLR Calculation (§158.220)**

Finally, the AHA wants to express our support for NAIC's recommendation that was adopted in the rule that MLR data and calculations be aggregated at the state - not the national - level. We

The Honorable Kathleen Sebelius

January 31, 2011

Page 6 of 6

agree with HHS' insight that state aggregation is appropriate because insurance is regulated primarily at the state level and because it is important for consumers in each state to understand whether they receive value for their insurance premiums. That would not be possible if MLRs were aggregated at the national level.

The AHA applauds the hard work of both HHS and the NAIC in developing the MLR policy. We look forward to continuing to working with HHS to ensure that the goals of the ACA to achieve affordable and high quality health care coverage are met. If you have questions about our comments, please contact Ellen Pryga, policy director, at [epryga@aha.org](mailto:epryga@aha.org) or (202) 626-2267, or Molly Collins Offner, policy director, at [mcollins@aha.org](mailto:mcollins@aha.org) or (202) 626-2326.

Sincerely,

Linda E. Fishman

Senior Vice President for Public Policy Analysis and Development