

August 6, 2010

Mike Geeslin
Commissioner of Insurance
Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104



Dear Commissioner Geeslin:

As you meet with your colleagues next week at the National Association of State Insurance Commissioners, the Texas Hospital Association wants to clarify its position on some key issues that your group will be discussing related to health care reform. Of particular interest is the NAIC's final recommendations to Health and Human Services Secretary Kathleen Sebelius regarding the medical loss ratio provisions within the Patient Protection and Affordable Care Act.

As you know, the PPACA requires health plans to provide a rebate to their enrollees if the ratio of premium revenue exceeds expenses for clinical services and activities to improve health care quality (the medical loss ratio). The law establishes the minimum medical loss ratio for the large group market at 85 percent and small group/individual market at 80 percent. 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.

Texas hospitals recommend that the MLR allocation of costs incorporate the following 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 – such as investigation, litigation or appeals – should be counted as administrative costs because they do not provide health care services or improve quality.

The criteria for defining "activities that improve health care quality" should include the following:

- the activity must be performed by a professional licensed to perform the service or activity; and
- community-wide or statewide initiatives to improve overall quality of care. An example would be the Texas Center for Quality and Patient Safety's initiative to reduce/eliminate central line-associated bloodstream infections. While such collaborative efforts benefit patients beyond those covered by a particular health plan, they do improve outcomes for health plan patients and will reduce costs over time, a primary goal of health care reform.

THA recommends that the NAIC's recommendation require the MLR regulations to define clearly which activities do and do not improve health care quality and restrict the ability of health insurers to subjectively make such a determination. Texas hospitals recommend that the final regulation require use of a decision-tree analysis to distinguish between an activity that is

intended to limit services or reduce expenditures (e.g., utilization management) and those intended to improve health (e.g., a diabetes management program, care coordination or shared-savings programs).

A decision-tree analysis should incorporate a series of questions that probes whether the activity is aimed at reducing cost or utilization, or directing 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 health 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 which activities 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.

Another important issue the NAIC should consider in its recommendation is the **determination of 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. Texas hospitals believe that the aggregation level should meet both the letter *and* spirit of the law.

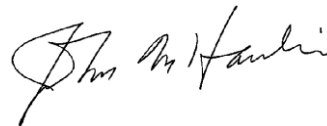
Texas hospitals request your leadership on helping establish appropriate definitions for costs included in "medical loss ratios" and "activities that improve health care quality." Clearly, consumers are purchasing health care insurance to pay for health care services, not insurance company administrative costs. In your role as Commissioner of Insurance, you can help achieve the goals of the health care reform legislation and protect consumers.

If you have any questions or would like to discuss the medical loss ratios further, please do not hesitate to contact us at 512/465-1044. Thank you for your help and support.

Sincerely,



Dan Stultz, M.D., FACP, FACHE
President/CEO



John Hawkins
Senior Vice President,
Advocacy & Government Relations