



**National
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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

September 30, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Attention: DHHS-2010-MLR
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW.
Washington, DC 20201

Re: Medical Loss Ratios—Section 2718 of the Public Health Service Act (PHSA)

Dear Secretary Sebelius:

I am writing to follow-up on our May 14, 2010 comment letter as you consider defining which activities improve quality related to the calculation of Medical Loss Ratio (MLR) under Section 2718 of the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-1489. I commend your ongoing leadership to increase the accountability and overall quality of coverage throughout our nation's health care system.

The National Business Group on Health represents approximately 298, primarily large, employers (including 64 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families.

While we are pleased that the National Association of Insurance Commissioners' (NAIC) recommendations include nearly all of our recommendations for clinically proven services that improve health care quality, we also recommend that the final classification include:

1. "Healthcare Professional Hotlines" in the expenses to improve health outcomes;
2. "Quality reporting and documentation of care in either electronic **or non-electronic format**" in the expenses to improve health outcomes; and
3. A process allowing insurers to continue to calculate MLR for the large employer market nationally in order to maintain consistency with the way they manage their health care benefits across many different products in varying markets with different costs.

We strongly disagree with the NAIC's recommendation that "Healthcare Professional Hotlines" should not be counted as expenses to improve health outcomes. Research has

proven that these services improve health care quality as well as reduce costs. One study found that 70% of patients who used a nurse advice line followed the nurses' recommendations, with 46% choosing the correct lower intensity care rather than turning to more expensive and unnecessary emergency room services.¹ Another study found that 95% of people who call a health plan nurse line reported following the nurses' recommendations.² A Denver health nurse line survey also unveiled a cost savings of \$14,568 per 266 patients or \$54.77 in avoided charges per person.³ In addition, the American Academy of Actuaries recently stated **“24-hour nurse hotlines...are more akin to benefits than administrative expenses or provisions for risk, [and] it would be appropriate to include cost containment expenses as part of the value of benefits in the loss ratio calculation. Including these expenses in the loss ratio calculation encourages insurers to effectively manage the quality, efficiency, and cost of care for policyholders.”**⁴ Accordingly, we recommend that you include “Healthcare Professional Hotlines” in the expenses to improve health outcomes in your final classification of health plan expenses related to the calculation of MLR under Section 2718.

We appreciate that the NAIC’s Blanks Form on MLR includes “health information technology expenses” to support “quality reporting and documentation of care in non-electronic format” and “ monitoring, measuring, or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law” under the category of “HIT Expenses for Health Care Quality Improvements”. We also recommend modifying the recommendation to state “quality reporting and documentation of care in either electronic **or non-electronic format**, including measurement and public reporting on the quality of performance of doctors, hospitals, and other health care providers on scientifically valid measures of clinical quality and patient experience” to clarify that that these activities are recognized contributors to quality improvement.

We also recommend ensuring that large employers who purchase insured products for their employees do not incur unnecessary, increased administrative expenses by requiring their carriers to calculate MLRs on a state-by-state basis for the large employer market. Insurance carriers should be able to continue to calculate MLR for the large employer market nationally in order to maintain consistency with the way they manage their health care benefits across many different products in varying markets with different costs.

¹ Bogdan GM, et al. Evaluating patient compliance with nurse advice line recommendations and the impact on healthcare costs. *The American Journal of Managed Care*. 2004 Aug.; 10(8): 529–530.

² Di Palo, M., et al. A Method to Determine the Effect of Nurse Call Line Advice on Subsequent Care-Seeking Behavior and Its Implications for Cost-Effectiveness Analysis. Academy for Health Services Research and Health Policy. Meeting. 2000 [cited 2008 February 12]; Available from: <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102272701.html>.

³ Bogdan, G., et al., Evaluating Patient Compliance with Nurse Advice Line Recommendations and Impact on Healthcare Costs. *The American Journal of Managed Care*, 2004. 10(8).

⁴ American Academy of Actuaries. “Critical Issues in Health Reform: Minimum Loss Ratios,” February 2010. Page 3. Available at: http://www.actuary.org/pdf/health/loss_feb10.pdf

Insurance carriers would need to make significant expenditures for systems changes to enable them to allocate expenses on a state-by-state basis if a national large group MLR is not allowed, cost that insurers would simply pass-on to the employers and employees (patients) purchasing these products with no tangible increase in value for employers and employees.

Most of our members, and most employers of any size, self-fund the health care costs for employees and dependents, and therefore, the medical loss ratio provisions do not directly apply to these plans. Nevertheless, we support the inclusion of a broad array of quality improvement activities in this calculation for the insurance market because of our own plans' positive experiences with these programs, the Federal Employee Health Benefit Plan's positive experiences with them, the fact that the Affordable Care Act expands many of them to the Medicare and Medicaid programs and because these programs will not be available to self insured employers if they are not supported in the marketplace. Broad inclusion of quality improvement activities in this calculation, including "Healthcare Professional Hotlines", will help to ensure that these programs continue to be available for the benefit of consumers in the individual and small group markets, and the exchange plans in the future.

Thank you for considering our recommendations to include the aforementioned clinically proven services in the clinical services/health care quality categories of expenses under the MLR to assure that patients continue to have access to them. We look forward to continuing to work with you and the Department as you implement the new law. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 585-1812, if you would like to discuss our comments in more detail.

Sincerely,

A handwritten signature in black ink that reads "Helen Darling". The signature is written in a cursive, flowing style.

Helen Darling
President