



Charles N. Kahn III  
President and CEO

January 31, 2011

**VIA COURIER AND ELECTRONIC MAIL**

Marilyn Tavenner  
Office of Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services  
Attention: OCIO-9998-IFC  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

RE: Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act Interim Final Rule with Request for Comments: OCIO-9998-IFC 75 Fed. Reg. 74864 (December 1, 2010)

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Dear Ms. Tavenner:

The Federation of American Hospitals (“FAH”) is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment on the Office of Consumer Information and Insurance Oversight’s interim final rule with request for comments regarding medical loss ratios (“Rule”).

Overall, we appreciate that the Rule recognizes the reasoned output of the National Association of Insurance Commissioners (“NAIC”) and supports the multi-stakeholder process through which the NAIC’s recommendations were developed. The FAH was an active participant in the NAIC process and believes the NAIC’s recommendations as adopted in the Rule generally reflect a balanced compromise of competing viewpoints that serves all the affected stakeholders.

## I. Mini-Med Plans

The FAH members are concerned about the effect that so-called “mini-med” health insurance plans have on patients and the health care market place. These products run counter to the objectives of the Patient Protection and Affordable Care Act (“ACA”) as they do not make *comprehensive* health insurance available to all, and curtail important benefits that should be available to those purchasing insurance. Accordingly, while Section 158.221(b)(3) grants “special circumstances” status to mini-med plans, we are troubled by the decision to afford such plans special status, and we believe that a limitation of that status to 2011 is in the public interest. The FAH strongly opposes extending special status in the final rule to mini-med plans for years beyond 2011.

## II. Non-Includable Costs

FAH believes amplification or clarification of the policy addressing non-includable costs in Section 158.140 is appropriate. This section addresses the costs related to clinical services provided to enrollees that are included in reportable costs for medical loss ratio purposes. Subsection 158.140(b)(3)(iii) states:

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 record copying costs, attorneys’ fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks must not be included in incurred claims.

The FAH seeks clarification regarding the insurer’s reporting responsibilities under this subsection. In our view, this subsection should be read to mean that the amounts paid which are identified in the subsection only should be excluded if they are identified separately as part of the relationship between payer and provider. The potential for confusion in interpreting this section arises with regard to payment methods that are primarily related to reimbursing for clinical services, but also have an actuarially determined portion that also pays for a provider’s administrative services. In such cases, the FAH believes that all such costs are claim costs (*i.e.* payments to the provider for the provision of services), and thus should be included in the medical loss ratio calculation.

We believe our interpretation is consistent with the statute. The ACA states:

a health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expends on: (1) reimbursement for clinical services provided to enrollees under such coverage; (2) for activities that improve health care quality; and, (3) on all other non-claim costs, including an explanation of the nature of such costs, and excluding state taxes and licensing or regulatory fees.

Under the statute, we believe “all other non-claim costs” should be interpreted to exclude any administrative expenses that may be an indiscernible component of a claims payment that relates predominantly to the costs of the clinical services rendered. To interpret this subsection

otherwise would likely result in the need for insurance plans to ask the providers for what portion of the claims payment should be excluded, which would be hard for providers to determine on a case-by-case and would create a significant burden that would take provider resources away from patient care. Absent a clarification, both providers and payers will not have clear guidance as to how to address this issue.

### III. Quality Improvement Activities

We appreciate the challenge of striking the right balance about the nature of those quality improvement costs to be included in the MLR and those costs to be excluded as more administrative in nature. We support the general premise to include in the calculation only those quality improvement costs that improve quality of care for particular patients in an evidence-based way. Along those lines, we question whether insurer credentialing costs should be included and counted toward the medical loss ratio requirement. In our view, these costs are administrative in nature as they generally are not based on evidence-based quality reviews such as those that are typical in a medical staff credentialing process, and we are not aware of any evidence that the credentialing process is designed in any way to directly result in improved quality of care for specific patients. Thus, they do not meet the test articulated for qualifying quality improvement expenses.

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The FAH appreciates the opportunity to comment on the Rule. If you have any questions about our comments or need further information, please contact me or Jeff Micklos of my staff at (202) 624-1500.

Sincerely,

