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Kevin McCarty, Commissioner
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399

Torre Grissom, Executive Director
Florida Health Insurance Advisory Board
200 East Gaines Street
Tallahassee, Florida 32399

Re: Federal health care reform
Medical Loss Ratio

Dear Mr. McCarty and Mr. Grissom:

Our firm represents HCA Inc.'s affiliated hospitals, ambulatory surgical centers, diagnostic imaging providers, and related outpatient services providers in Florida. On their behalf, this letter is to provide comments on the issue of the calculation and annual reporting of Medical Loss Ratio ("MLR") data by the healthcare insurance industry under Section 2718 of the Public Health Service Act (the "PHS Act"). We are responding to the invitation to comment that was contained in the April 16, 2010 Media Release issued by the Florida Office of Insurance Regulation (the "Office").

Background

The Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, was enacted on March 23, 2010. Sections 1001 and 10101 of the PPACA add Section 2718 of the PHS Act ("Section 2718"), which is entitled "Bringing Down the Cost of Health Care Coverage." In pertinent part, Section 2718 requires a "health insurance issuer" offering individual or group coverage to submit annual reports to the Secretary of the Department of Health and Human Services concerning the ratio of loss and loss adjustment expense from medical claims to earned premiums. Further, the report must include the percentage of total premium revenue (after accounting for collections or receipts for risk adjustment, risk corridors, and payments for reinsurance) for health coverage spent on the following:

- (1) reimbursement for clinical services provided to enrollees under such coverage;
- (2) activities that improve health care quality; and

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(3) all other non-claims costs, including an explanation of such costs, and excluding federal and state taxes and licensing or regulatory fees.

Section 2718 goes on to provide minimum MLR requirements which, if not met, require the Insurer to rebate premium revenue to enrollees on a pro rata basis. Specifically, Section 2718 states that beginning not later than January 1, 2011, a health insurance issuer offering group or individual coverage shall provide such rebates if the amount of premium revenue expended on categories "(1)" and "(2)" above is less than the following:

(1) 85 percent, or such higher percentage as a State may by regulation determine, of the total amount of premium revenue for coverage in the large group market (excluding federal and state taxes, licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance); and

(2) 80 percent, or such higher percentage as a State may by regulation determine, of the total amount of premium revenue for coverage in the small group market or individual market (excluding federal and state taxes, licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance). This part of Section 2718 also provides that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

Although the term "health insurance issuer" is not defined in Section 2718, the term is used elsewhere in federal health statutes to include health maintenance organizations ("HMOs") as well as indemnity health plans. See, e.g., 42 U.S.C. section 300gg-91(b)(2) (defining "health insurance issuer"). It is clear that Congress intended the term as used in Section 2718 to include HMOs. For purposes of these comments, a "health insurance issuer" will be referred to by the shorthand, "Insurer."

Section 2718 adds that "The Secretary, in consultation with the National Association of Insurance Commissions [sic], shall establish uniform definitions for the activities reported under subsection (a)." This is a reference to the National Association of Insurance Commissioners (NAIC), an association of the insurance regulators of all 50 states, and to the "activities that improve health care quality" component of the minimum MLR requirement.¹ Ultimately,

¹ For the sake of clarity, it should be noted that the term "MLR" is used as a shorthand to describe the 85% and 80% ratios required by Section 2718 to avoid the rebate requirement. The term is not used in the stricter sense commonly found in regulatory insurance law, which does not include subjective concepts such as "activities that improve health care quality."

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therefore, "activities that improve health care quality" will be determined by the Secretary in consultation with NAIC.

In the April 14, 2010 *Federal Register*, the Departments of Health and Human Services ("HHS"), Treasury, and Labor (collectively, "Departments") jointly issued a request for comments on the definitions and standards to be used in implementing the MLR provisions of Section 2718, as described above. Through the comment process, the Departments are seeking information on a variety of issues, including the following:

- How the new MLR minimums compare to health insurers' current MLRs;
- The definitions and methodologies currently in place to calculate MLRs;
- Current practices at the state level for calculating/reviewing MLRs;
- Definitions for activities that improve health care quality;
- Whether any states require MLR-related rebates similar to the new law; and
- Any terms or provisions that require further definition to facilitate compliance with the new law.

We appreciate the efforts of the Office and FHIAB to facilitate this dialogue at the State level in Florida. Our comments will give particular emphasis to Section 2718's reference to "activities that improve health care quality," as that aspect of the law has already generated, and is expected to continue to generate, considerable discussion.

Lack of Existing Criteria for "Activities That Improve Health Care Quality"

Section 2718's inclusion of "activities that improve health care quality" will necessarily be the subject of considerable debate. The phrase is not found in Florida's insurance laws, or the insurance laws of any of the fifty states. The regulatory term "medical loss ratio" is an actuarial term of art, with the general meaning of incurred losses and loss adjustment expenses due to medical claims in relation to earned premium. Several states have that definition in their insurance laws.²

Florida law requires a minimum MLR (using the traditional regulatory insurance definition) for health insurers and Medicare Supplement insurers. Sections 627.410, 627.411; Section 627.6745, Florida Statutes. Notably, Florida law does not require a minimum MLR for commercial HMOs. Pursuant to Section 641.23(6), Florida Statutes, the Office's only duty with

² See, e.g., Ct.Stat. s. 38A-478L; Pa.Stat. 40 P.S. S 981-2; Wa.Stat. 48.43.049.

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regard to MLR for commercial HMOs is to "publish at least annually the medical loss ratios of all licensed health maintenance organizations." The Office accordingly publishes MLR for HMOs in the Office's "Annual Reports," available for review online at www.flair.com/AnnualReport. Review of the Annual Reports indicates that MLR for Florida-licensed HMOs is given as a "global" number, rather than specifically for large group, small group, or individual health maintenance products. The 2009 Annual Report provides HMO MLR for calendar years 2007 and 2008. Some of the larger HMOs have a "global" MLR of less than 85% for calendar year 2008. For example, Aetna's 2008 MLR was 82%; Humana's 2008 MLR was also 82%.

Significantly, there have been recent media reports indicating that Insurers will seek to "reclassify" various administrative expenses for purposes of meeting the 85% and 80% MLR minimums required by Section 2718. That is, expenses that would be considered "administrative" under the traditional MLR definition will, for purposes of Section 2718 MLR, be reclassified as "activities that improve health care quality." This would effectively defeat the intent of Section 2718. In general, we submit that expenses for "activities that improve health care quality" should be expenses for the actual provision of health care and health services. The Office (both under its current name, and formerly as the Florida Department of Insurance) has historically had great credibility nationally and as a member of the NAIC, and we would urge you to express this position on behalf of Florida.

Insurers Are Not Providers

First and foremost, we believe it is important to understand that Insurers do not *provide* medical care to patients. Rather, they *administer* health benefit coverage plans, and their costs associated with doing so should not be confused with the actual delivery of healthcare services.

Institutional health care providers (such as hospitals) and individual health care providers (such as physicians) share a number of key commonalities: they are licensed by applicable governing bodies to provide healthcare services and are subject to government regulations regarding the healthcare services that they provide; they deliver healthcare services directly to patients via the rendition of diagnostic and treatment modalities; their services are codified via nationally-adopted healthcare provider coding standards (e.g., HCPCS, CPT-IV, ICD-9, NDC, etc.); and all generate "claims" that are billed on standard healthcare provider billing forms (e.g., UB-04, CMS-1500, DWC-66, etc.).

Conversely, none of those key characteristics are shared by Insurers. Rather, the functions that Insurers perform are administrative in nature, generating administrative expenses. These include general administration; sales (including broker fees); marketing, advertising and public relations; underwriting, finance, accounting and auditing; regulatory affairs; network

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management and provider contracting; medical policy-setting and utilization/case management (including administration of notification, prior authorization and concurrent review activities); demand management (i.e., referral hot-lines); claims adjudication; and regulatory affairs. In other words, what an Insurer does cannot be classified as “delivery of medical care,” nor does it generate “claims”.

In this regard, it is also noteworthy that Insurers have historically sought to classify as *few* of their costs/functions as possible on the “claims” side of the MLR equation. To the contrary, they have typically categorized all of these costs/functions as “administrative” in nature. Therefore, section 2718's inclusion of "activities that improve health care quality" should not be construed as enabling new “creative accounting” practices to reclassify historic administrative expenses as medical costs. Doing so would enable Insurers to circumvent the intent of Section 2718 and to retain premium dollars that should be paid out to legitimate healthcare providers for services directly provided to diagnose and treat patients.

Accordingly, and consistent with the traditionally-accepted definition of MLR (“the ratio of incurred loss and loss adjustment expenses to earned premiums”), only those claims payments made to licensed healthcare providers should qualify toward meeting the 85% and 80% thresholds (i.e., "Medical Costs") for the purposes of Insurers’ Section 2718 MLR calculations.

Addressing Likely Areas of Confusion and/or Contention

More specifically, there are several areas of administrative expenses that Insurers may seek to "reclassify" for purposes of meeting Section 2718 MLR, and which we would like to bring to your attention. These are as follows:

Capitation Payments. These are non-encounter/non-claim based payments to healthcare providers in exchange for providing a defined set of services to a defined set of patients (typically \$X per-member-per-month for Y services) – i.e., a way to reimburse providers on a risk-transference basis for population management functions (e.g., primary care physicians for managing their assigned enrollees, reference laboratory for providing all lab services to a defined population of insureds, disease management vendors for managing patients’ chronic disease states, etc.). To the extent that such Capitation Payments compensate licensed healthcare providers for their services relative to the diagnosis and treatment of patients, these should qualify as Medical Costs in the MLR calculation.

However, this is not to say that all Capitation Payments for all purposes should be so qualified. Insurers are increasingly “carving out” certain services to be managed by other entities that are neither licensed as healthcare providers nor do they directly provide medical care to insureds; and often such carve-out entities are actually wholly-owned subsidiaries of the Insurers

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(e.g., behavioral health plans), which have their own administration costs and profit retention objectives in addition to those of the upstream Insurer.

Irrespective of how Capitation Payments are deployed by Insurers, we believe that only the portion of such payments that reimburses licensed healthcare providers for direct patient care should be allowed as Medical Costs in the MLR formula – and that any remaining portion must be considered as Administrative Expense.

Rebates to Insurers. Whether in the form of retrospective payments to Insurers (e.g., by pharmaceutical companies) or the retention/non-distribution of “withholding” or “risk pool” fund balances, the calculation of Medical Costs for the purposes of inclusion in the Medical Loss component of an Insurer’s MLR needs to be reduced by any such rebates.

Activities That Improve Healthcare Quality. Although we agree that some functions performed by Insurers should qualify for inclusion in the MLR formula as “clinical services provided to enrollees” under the Act, we caution that (a) only a minute fraction of such activities should be deemed to so qualify, and (b) this is an undefined element of the Act that we suspect will create the greatest amount of contention – and potential for “gamesmanship” – as Insurers may seek to include more of their functions/costs in this category than we believe the Act was intended to allow.

Examples of such activities that *should* qualify include disease management and health/wellness promotion programs – but again, only to the extent that such activities involve direct patient contact and care delivery (and not the administration/profit components of same).

Examples of Insurer activities that *should not* be permitted to qualify include basically everything else: quality assurance, credentialing, case management, medical policy-making, referral authorization programs, healthplan accreditation, provider contracting and network management. Ultimately all of these activities are administrative in nature and – while some of them may serve to *track* or *report on* quality – they do not in and of themselves serve to *improve* healthcare quality; only healthcare providers can do that. As such, they should not be considered as Medical Costs in the MLR equation.

The hospital industry is currently subject to dozens upon dozens of different licensing, governance, regulation, reporting requirements and other forms of oversight, such that the additional healthcare provider scrutiny that Insurers seek to apply is effectively redundant – and again, these are quality *reporting* activities and not activities that *improve* quality.

Relatedly, many healthcare Insurers have adopted Pay For Performance (“P4P”) programs, under which healthcare providers may be paid “bonuses” for meeting certain performance criteria. While at first blush these programs might appear to qualify as Medical

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Costs in the MLR calculation, we caution that many of these programs' criteria are based on *cost* performance measures. We believe that only the portion of P4P program payouts that is specifically attributed to *quality* measures should be considered as Medical Costs for MLR calculation purposes; all other P4P payout portions are financially based and are thus Administrative Expense in nature.

The Closed Panel HMO Anomaly

We recognize that a comparatively small subset of Insurers operate significantly differently from traditional Insurers – those that are “Closed Panel” (staff and group model HMO) programs that have integrated many aspects of the healthcare provider delivery system (via the employment of a large number of their in-network physicians and, in a few cases, ownership of their own hospitals and other healthcare facilities) with a health insurance vehicle – and we suspect that these entities will seek a correspondingly different formulation and application of MLR requirements than their traditional Insurer counterparts.

Without going into too much detail relative to their comparatively complex hybrid configuration, from an MLR perspective we believe that the same requirements as set forth above should also apply to Closed Panel provider/Insurer systems – but with some additional considerations, including for example:

- * Not all “provider expenses” and “physician salaries” should qualify as Medical Costs for MLR calculation purposes. Costs of any office space and corresponding personnel (and their time) dedicated to healthplan operations (and not to the direct delivery of patient care) need to be tracked, quantified and separated from clinical services, and must be considered as non-qualifying Administrative Expense.
- * In order to be considered as a Closed Panel model, the Insurer must have “internalized” (i.e., via ownership or employment) the vast majority of its in-network healthcare providers; an entity merely owning/operating a few physician practices (but in all other respects operating like a traditional health Insurer) would not satisfy that threshold, and thus should not be considered any differently from a traditional health Insurer for MLR calculation purposes.

Summary

As a healthcare provider system with hospitals, diagnostic imaging centers, ambulatory surgery centers and physician practices, HCA could give many more examples of Insurers' policies, procedures and practices have served to add costs and inefficiencies to the healthcare financing/delivery equation – and to actually impede healthcare providers' efforts to operate more efficiently. Yet ironically, these have been misguidedly undertaken in the name of quality

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and efficiency. If you would like more details and examples of same, we would be more than happy to provide them.

Thank you for the opportunity to comment on this complicated issue, and for consolidating all of the other comments received from the provider community on this important matter.

Sincerely,

A handwritten signature in blue ink, appearing to read 'S.A. Ecenia', with a stylized flourish extending to the right.

Stephen A. Ecenia