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Mr. Jay Angoff
Director, Office of Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

File Code: OCIIO-9998-IFC

Dear Director Angoff:

On behalf of the more than 200 Care Continuum Alliance members, I ask that you consider the following comments in response to the interim final rule on implementing medical loss ratio (MLR) requirements, published Dec. 1, 2010, in the *Federal Register*.

Care Continuum Alliance members provide services across the continuum of care, from wellness and prevention to chronic care and complex case management. Care Continuum Alliance members include wellness and population health management organizations, health plans, physician groups, hospitals, labor unions, employer organizations, pharmaceutical manufacturers, pharmacy benefit managers, HIT service and device suppliers, academicians and others. These diverse organizations share the vision of aligning all stakeholders toward improving the health of populations. Our members improve health care quality and contain health care costs by providing targeted interventions and services to the well and those at-risk for or already managing one or more chronic conditions. Through advocacy, research and promotion of best practices, the Care Continuum Alliance advances evidence-based strategies to improve quality and health outcomes and create efficiency in the marketplace.

The MLR requirements of the Patient Protection and Affordable Care Act (ACA) represent a fundamental change in health plan accounting by establishing minimum MLR thresholds. The Care Continuum Alliance supports the law's goals of greater quality of care, increased efficiency and reimbursement for better health outcomes. Further, we strongly support creation of a separate category for "activities that improve health care quality," which should help remove historical barriers to recognizing the benefits of programs that promote wellness, reduce chronic disease risk, support care coordination and improve health outcomes. The new category is important, as previous applicable state laws and insurer

practices varied. Given the magnitude of these changes in health plan accounting, it will be important to monitor their implementation closely in the first year.

We remain concerned that the interim final rule's defined list of MLR expenditures is limited regarding activities that improve health care quality.[1] While §158.150(c)(14) gives the Secretary discretion to revise the list of quality activities, it creates a burdensome process with the potential for the unintended consequence of suppressing innovation. The Care Continuum Alliance urges HHS to recognize the need for the MLR list of quality activities to evolve as new approaches to improving health care quality arise. We suggest periodic review of the MLR quality improvement expense category to recognize the dynamic nature of health care delivery.

To foster new care delivery models envisioned by the ACA, the MLR requirements should facilitate collaboration and coordination across the continuum of care. The interim final rule states in §158.140 *Reimbursement for clinical services provided to enrollees*:

> The report required in §158.110 of this subpart must include direct claims paid to or received by providers, including under capitation contracts with *physicians* whose services are covered by the policy for clinical services or supplies covered by the policy.[2]

The NAIC model regulation includes reimbursement not only for physicians, but also for "other professional services," such as licensed, non-physician care providers.[3] We suggest the language be modified as follows:

> The report required in §158.110 of this subpart must include direct claims paid to or received by providers, including under capitation contracts with *physicians* <u>*and licensed non-physician providers*</u> whose services are covered by the policy for clinical services or supplies covered by the policy.

We appreciate the opportunity to provide comments and offer additional resources and expertise as needed.

Sincerely,

Tracey Moorhead
President and CEO

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[1] 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," § 158.150, Federal Register (December 1, 2010).

[2] Id. at §158.140 (a).

[3] NAIC Model Rule Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio, p. 190-39 – 190-40.