AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

August 3, 2010

Jane L. Cline
Chair, NAIC Executive Committee
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Dear Commissioner Cline,

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents over 94,700 physicians and medical students nationwide, to provide brief comments regarding the interpretation of medical loss ratio under Section 2718 of the Patient Protection and Affordable Care Act. The Academy appreciates the difficult task you are faced with and offers our support as you move forward.

The AAFP encourages you to take an approach that includes as medical expenses those that provide physician practices with actionable clinical data with the goal of improving the quality of care. Expenditures that provide incentives and rewards for meeting nationally recognized quality of care benchmarks and performance improvement should be likewise included. A more narrow calculation undermines national efforts to bolster primary care and support enhancements in the delivery of health care through performance improvement and measurement.

To date, much work has been done on the national level to bolster primary care and to encourage alternative delivery and payment systems. We would like to see that work remain intact. We feel many of the innovative ideas for changes to the delivery of primary care, such as, care coordination and disease management efforts embedded in physician practices (versus "carve out" programs), directly impact clinical outcomes and thus should be included in the medical expense portion of the medical loss ratio calculation. This is true, whether such programs and systems are on a pilot or trial basis or fully implemented.

The AAFP strongly supports enhancements in the delivery of health care through the Patient-Centered Medial Home (PCMH). By acknowledging the patient as the focal point in PCMH, with a personal physician working with a team to coordinate care, we know we can positively impact a patient's overall health while decreasing overall health spending. In PCMH pilots, both in the private sector as well as in Medicaid programs, it has been demonstrated that the PCMH model creates significant savings to the system. It has equally been shown that to foster adoption of PCMH, paying for on-going care management is essential to enable physicians to provide patient care in PCMH. In fact, such care coordination and care management fees represent payment for care received in PCMH just as much as do traditional fee-for-service claims. Thus, we feel care coordination and care management fees paid by health plans to support PCMH should also be included in medical expenses.



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We appreciate the opportunity to provide these comments and make ourselves available for any questions or clarifications you might need. Please contact Laura Schmidt, Private Sector Advocacy Specialist at 913-906-6000, extension 4134 or lschmidt@aafp.org .

Sincerely,

Ted Epperly, MD. FAAFP
Board Chair

Cc Mr. Lou Felice
Chair, Health Reform Solvency Impact Subgroup