June 14, 2010

Mr. Lou Felice, Chair  
Health Reform Solvency Impact (E) Subgroup  
c/o National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, Missouri 64108-2662

RE:  NAIC Life and Accident & Health Blank and SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3. (June 10th Discussion Draft)

VIA ELECTRONIC MAIL

Dear Mr. Felice:

As Consumer Representatives to the NAIC representing millions of patients, consumers and workers, we appreciate this opportunity to submit comments on the 2010 NAIC Life and Accident & Health Blank June 10, 2010 Discussion Draft (NAIC Blank). We were very pleased to note that most of the recommendations in our May 20, 2010 letter were incorporated into the June 10, 2010 Blank and SUPPLEMENTAL HEALTH CARE EXHIBIT –Part 3. The modifications and additional detail in the PART 3 are a significant improvement. The explicit definitions, standards and exclusions provide all parties with a much clearer understanding of the items that can be included as expenses in the activities to improve health care category.

We applaud the new definition of Quality Improvement (QI) Standards which incorporates the requirement that the QI initiatives be grounded in evidence based medicine, accepted best practices or criteria issued by recognized professional associations…and based on standards developed independent of any particular health insurer. The definition also retained the sentence stating that QI initiatives “should not be designed solely or primarily to control or contain costs”. We recognized that cost containment activities play a role in assuring that health care dollars are devoted to the efficient and appropriate delivery of care, but we do not consider these activities to be quality improvement and support categorizing cost containment activities as administrative expenses.

We also noted that the provision regarding the Secretary’s authority to approve other expenses at her or his discretion was not modified and is listed as an instruction for Columns 1 through 5. We support this provision and in particular, the requirement that the burden be on the proponent to show that the expenses meet the required criteria to be an expense that improves the quality of healthcare.

We continue to appreciate the thoughtful process that the NAIC has employed to assure meaningful participation of all stakeholders in developing definitions and instructions for recording the various expenses related to activities to improve health care pursuant to the
Patient Protection and Affordable Care Act of 2009 (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA).

As requested, we are writing to provide you with our general comments and comments on specific items in the NAIC Life and Accident & Health Blank and SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3. (June 10th Discussion Draft).

**General Comments:**

Our comments focus on areas that require further clarification to ensure that all parties have the same understanding of the definitions and scope of activities to improve health care listed in the instructions in Part 3 that meet the legislative intent of the law. In general the NAIC Blank and Part 3 Instructions should:

- Clarify that all cost directly relating to ICD-10 be considered an administrative expense. The question was raised on a recent call that ICD-10 has qualities that would justify a portion of these expenses to be considered quality improvement. We acknowledge that today’s data needs are dramatically different than they were 30 years ago when ICD-9 was introduced and ICD-10 will advance healthcare in many ways including tracking outcomes, severity, medical complications and safety issues. However, the primary purpose of ICD-10-CM diagnosis coding and ICD-10-PCS inpatient hospital procedure coding is to support fairer reimbursement policies.

- Reinforce the difference between “quality assurance” and “quality improvement” activities. In particular, adding a definition of quality assurance would be useful. We have included quality definitions from The Health Care Quality Glossary (Russia-USA Joint Commission on Economic and Technical Cooperation; 1999) and the definition of a quality assurance program from the Virginia Managed Care Health Insurance Plan regulations in the specific comments section for your consideration. NCQA, The Joint Commission or URAC and Medicare may also have definitions that could be adopted for use in the definition of activities to improve health care section.

- Continue to include accreditation costs and Quality Assurance (QA) program costs as administrative costs. Section 2718(b) only allows the costs of activities that improve quality of health care, and not activities that assure the quality of health insurance, to be counted in the rebate formula. Some quality assurance costs are incurred for accreditation, but in many states, they are also incurred to meet state quality regulations which are required as a condition of licensure. Health plans also seek accreditation largely because of pressure from their employer customers and accreditation gives plans a competitive distinction and advantage. Health plans may also received “deemed status” for meeting state quality regulations and licensure requirements if they are accredited. As a result, we believe health plans will continue to pursue accreditation if these costs remain administrative costs.

- Clearly articulate the parameters for defining “community level benefits” that qualify as quality initiatives. Specifically, these initiatives should be targeted to
populations with demonstrated need (underdeveloped emergency medical services coordinated systems of care, medically underserved populations, communities with limited English proficiency, etc) and be measurable with the outcomes reported on an annual basis as part of the QI Program Evaluation or posted federal or exchange websites so that consumers can see the impact of these initiatives.

- Demonstrate that an activity is designed to ‘improve health quality” using evidence based criteria and not just a system or process that is used to ensure that the care or care delivery is reasonable and adequate. For example, the patient centered interventions listed under Effective Case Management in Column 1, Improve Health Outcomes are frequently performed by case management, discharge planning or pharmacy compliance programs for certain patients and would be classified as administrative costs or quality assurance. These activities have a plausible link to quality (aka 6 degrees of separation), but they do not meet a "reasonable person" test for being a quality improvement initiatives consistent with PPACA unless they are part of a specific evidence based program that is measured and has outcomes that are reported annually to demonstrate that the activities improves care rather than just assuring that the appropriate care is rendered.

- Provide more detailed instructions for the definition of cost or quality Research and Development activities that can be included as quality initiatives. We do not want to discourage innovation (particularly for targeted at risk populations), but plans would need to document the QI standards as defined in Part 3 that are applicable to the cost or R& D activity that is being included as an activity to improve health care quality.

We also wanted to express our support for NAIC’s stance on the exclusion of cost containment expenses such as utilization review, fraud prevention, handling of appeals, and network access fees from the definition of quality activities. These are important activities for insurers to pursue, but they are not quality improvement activities. We believe that this is absolutely consistent with the original purpose and legislative intent of Section 2718 and should not be construed to guarantee insurers 15 to 20 percent of their premium income.

We would also express support for accurate comparison of all plans types – especially HMO and PPO plans. Given the operations of a staff or group model HMOs, certain functions are inherently performed by the provider entity as opposed to the insurer (i.e., provider credentialing, network development, utilization review controlled by referrals in an HMO). In this case, part of the capitated payment to the provider is for the performance of this function. All of these costs are now reported as clinical costs, but some should be captured as administrative costs.

**Comments on Specific Lines or Provisions of Part 3**

Our comments on specific lines or provisions of the June 10, 2010 Discussion Draft SUPPLEMENTAL HEALTH CARE EXHIBIT – PART are shown below:
NAIC Blank Form and Instructions

Line 3 – Incurred Medical Incentive Pools and Bonuses

Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers to promote quality improvements as defined in the PPACA (section 2717).

Comment: We were pleased to note the revisions to this line which address the recommendations provided in our letter of May 20th, 2010. With that said, we want to reiterate our previous recommendation to separate the shared savings expenses and incentive payments to providers. We continue to believe that separating these expenses into subcategories 3.1 and 3.2 respectively is important to increase transparency and accountability for these expenses.

Line 5 – Expenses for Health Care Quality Improvements

See the definitions included in Part 3 of this Exhibit.

Line 5.1 – Expenses for Health Care Quality Improvements other than HIT

Include expenses meeting the definition of Improving Health Care Quality in Part 3 that are not health information technology expenses. The amounts represented in Line 5.1 should agree with the amounts reported in Part 3, Columns 1 through 4.

Line 5.2 – HIT Expenses for Health Care Quality Improvements

Include expenses meeting the definition of Improving Health Care Quality in Part 3 that are health information technology expenses. The amounts represented in Line 5.2 should agree with the amounts reported in Part 3, Column 5.

Comment: We strongly support the addition of detailed language as defined in Part 3 to provide disclosure of major expenses by major type of activity that improves health care quality.

SUPPLEMENTAL HEALTH CARE EXHIBIT –PART 3

Comments: We support the new structure, language and use of columns for quality reporting. The format is easier to understand and the linkage to the quality reporting structure in the federal statute that HHS will be using for quality reporting will be more efficient and allow the expense data to be used for multiple purposes without additional work. The addition of the health information technology column is also a valuable enhancement for transparency and disclosure purposes going forward. Our specific comments and proposed modifications are below.

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), that are designed to improve health care quality for health plan enrollees and advance the delivery of patient-centered medical care. Qualifying QI activities are primarily
designed to achieve the following goals set out in Section 2717 of PPACA; improvement must be capable of being objectively measured and produce results and achievements that can be verified to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates, or;
- Increase wellness and promote health activities.

QI Standards: QI expenses should be based on standards developed independent of any particular health insurer, and be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies or government agencies. They should not be designed solely or primarily to control or contain cost.

Comments: We strongly support this definition and the enhancements from the earlier version, particularly the language related to reducing health disparities among specified populations. We were pleased to see that the QI Standards definition incorporated the language or intent of the language in our May 20th letter.

Columns 1 through 5 Subcategory Health Information Technology Expenses

- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:
  - Data extraction, analysis and transmission in support of the activities described above, and
  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; and

Comments: “Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care" is very broad. We would strongly recommend defining “activities” more narrowly to ensure that the not all technology expenses associated with data linkages are considered here.

Quality Definitions: The following quality definitions from The Health Care Quality Glossary (Russia-USA Joint Commission on Economic and Technical Cooperation; 1999) http://www.ahrq.gov/qual/hcqgloss.htm and 32.1-137.2 C of the Code of Virginia may be of value to the Workgroup.

*Quality of medical care --The understanding of quality applied to health care; the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

*Quality improvement --The attainment, or process of attaining, a new level of performance or quality that is superior to any previous level of quality.

*Quality assurance --The activities and programs intended to provide adequate confidence that the quality of patient care will satisfy stated or implied requirements or needs.
"Quality assurance program" means the systems, standards and processes including, but not limited to, reasonable and adequate systems to assess, measure, and improve the health status of covered persons, necessary to obtain a certificate of quality assurance from the department in accordance with this chapter and in accordance with §32.1-137.2 C of the Code of Virginia.

Comments: These definitions as well as other quality assurance and quality improvement definitions in the Virginia regulations may be useful to NAIC staff and could be used to distinguish between types of quality activities. NCQA, The Joint Commission, URAC or Medicare may also have quality assurance or quality improvement definitions that would be of value to these discussions.

We appreciate this opportunity to submit comments. We thank you, again, for your effective leadership in facilitating the Health Reform Solvency Impact (E) Subgroup and developing Blank instructions that are thorough and address the issues in a transparent and effective manner so that all parties will have the same understanding of the definitions and allowable expenses. If you have any questions, please contact Wendell Potter at wenpotter@gmail.com or Mark Schoeberl at mark.schoeberl@heart.org.

Sincerely,

Mark Schoeberl
Wendell Potter
Timothy Jost
Sabrina Corlette
Georgia Maheras
Bonnie Burns
Elizabeth Abbott
Stephen Finan