



PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

June 15, 2010

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

Dear Mr. Felice:

On behalf of the Pharmaceutical Care Management Association (PCMA), we appreciate this opportunity to offer our comments to the Health Care Reform Solvency Impact Subgroup as it continues to consider uniform definitions for calculating the “medical loss ratios” (MLR) provisions of § 2718 – “Bringing Down the Cost of Health Care Coverage” – of the Public Health Service Act added by the Patient Protection and Affordable Care Act (PPACA).

PCMA is the national association representing America’s pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 210 million Americans with health coverage provided through Fortune 500 employers, health insurers, labor unions, Medicare, Medicaid, and the Federal Employees Health Benefits Program.

PCMA commends the Subgroup for the progress that the Subgroup has made on this difficult project and we thank the Subgroup for the important changes that have already been made to the Supplemental Health Care Exhibit. Although significant progress has been made, PCMA believes that important changes are still needed, changes that will ensure that quality improvement programs will continue to develop and evolve. A copy of proposed “industry revisions” is enclosed with this letter. PCMA supports these revisions.

We believe that the blanks and accompanying instructions are still too focused on what we refer to as labeled-based regulation. By that we mean that the major thrust of the proposed blanks is to identify and label permitted quality improvement activities. Rather than attempting to come up with a complete list of permitted functions, PCMA believes a better approach is what we would refer to as function-based regulation, i.e., properly defining what is meant by quality improvement and then allowing any program that meets that definition. To that end, the “industry revisions,” which are attached, include a revised general definition of quality improvement that accomplishes that goal.

The industry revisions retain the examples contained in the NAIC draft, but also allow for any other program that meets the general definition. The industry revisions place the burden on the proponent to show that the expenses for a program conform to the definition. Ultimately the enforcement of the MLR rules will come through audit and examinations. By basing the MLR rules on function-based regulation the examiners and auditors will simply have to satisfy themselves that the incurred expenses were for quality improvement activities rather than whether the programs were labeled as a permitted program.

PCMA also believes that the proposed blanks and instructions take too “static” an approach to defining and regulating quality improvement. It is imperative that any definition or listing of activities that improve health care quality should be flexible and should outline the *types* of “activities to improve health care quality” to be included, but should not be intended as an exhaustive list. It is impossible to take into account every program that would improve patient safety, reduce medical errors, or increase adherence to treatment. It is also impossible to predict important quality improvement activities that might be developed in the future. We believe that the proposed changes in the industry revisions address the need for flexibility.

Finally, although improvements have been made regarding programs that directly improve quality for individual versus population-based quality improvement programs; PMCA believes the current NAIC draft still needs improvement in this area. The industry revisions borrow from existing NAIC language to make it clear the quality improvements that are targeted towards specified populations fall within the definition of quality improvement programs. These population-based programs should be encouraged as they serve the goals – outlined in health care reform – of improving health care quality while providing broad health care coverage.

Thank you for the opportunity to comment. If you have any questions or comments please feel free to contact Barbara Levy at (202) 207-3604 or blevy@pcmanet.org.

Sincerely,



Barbara A. Levy
Vice President and General Counsel
Pharmaceutical Care Management Association

cc: Todd Sells, NAIC
Brian Webb, NAIC