MISSION: To promote continuous improvement in the quality and efficiency of health care management through processes of accreditation and education.

Member Organizations

Academy of Managed Care Pharmacy

American Association of Preferred Provider Organizations

American College of Physicians

America's Health Insurance Plans

American Health Quality Association

American Hospital Association

American Insurance Association

American Medical Association

American Nurses Association

American Psychiatric Association

Blue Cross Blue Shield Association

Case Management Society of America

National Association of Insurance Commissioners

Pharmaceutical Care Management Association

Marianne Fazen, PhD
Board Chairperson

Alan P. Spielman
President and CEO

June 15, 2010

Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC
New York State Department of Insurance
25 Beaver Street
New York City, NY 10004

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act

Dear Mr. Felice:

We commend you and the other members of the subgroup for your dedicated efforts to define and fully describe quality improvement activities for purposes of determining the calculation of the medical loss ratios under Sec. 2718 of the Public Health Service Act (PHSA). We particularly appreciate your efforts at the top of page 15 to craft an appropriately broad general definition of quality improvement ("QI") expenses. We believe this represents a significant step forward toward carrying out congressional intent to encourage health care quality improvements through a wide range of effective QI initiatives and activities.

As you know, "accreditation bodies" such as URAC are specifically referenced in that general QI definition as one of three types of independent entities – including professional medical associations and government agencies -- that may issue independent criteria for determining whether particular plan expenses constitute legitimate QI expenses.

Additionally, the subgroup has properly recognized NCQA and URAC for the central role that these accrediting organizations play in improving health care quality through our efforts to "monitor, measure or report" on clinical effectiveness under the Health Information Technology expenses in Column 5 at the bottom of p. 16.

The costs associated with "monitoring, measuring or reporting health care quality improvement," are also considered QI expenses in the category of "other expenses as may be approved by the Secretary" at the top of p. 17.

Finally, the latest version of the blanks document specifically includes the costs of "quality reporting and documentation of care" as expenses that improve health care outcomes under Column 1 on p. 15.

We are therefore deeply concerned by a seemingly conflicting provision on p. 17 which excludes "accreditation fees" from the list of plan expenses related to QI. In doing so, the subgroup appears to have separated out the actual *fees* a health plan is

required to pay an accrediting organization to independently verify quality improvements from the *costs* the plan expends to meet those same quality standards.

We do not support this decision, which creates a policy inconsistency that undermines the intent of these provisions. We concur with others who have properly noted on our calls and in written comments that there is no compelling reason to distinguish between independent accreditation compliance costs and the initial fees a health plan pays to participate in the accreditation process. In fact, without the initial payment of the accreditation fee, there is no practical opportunity or basis for a health plan to expense costs to meet the independent accreditation standards.

It strikes us as appropriate to provide health plans, as you have, the direct financial incentive to meet independently established and verifiable health care quality measures, but counterintuitive to exclude the fees necessary to initiate this process. As others have said, pulling these fees out of the allowable accreditation expenses for purposes of QI creates a perverse incentive for plans to forego the accreditation process altogether. If this is the intent, it would appear to undercut one of the very avenues the subgroup chose in its definition of QI expenses to independently verify that such expenses are actually spent on activities that improve health care quality.

We would therefore urge you to delete “accreditation fees” from the list of activities that are excluded from the health care quality criteria on p. 17. We also request that our comments be reflected in the submission forms themselves, to the extent that the forms are inconsistent with the changes we have recommended here.

Thank you very much for the opportunity to offer these comments, as well as your ongoing efforts to carefully and accurately define the expenses properly associated with legitimate health care quality activities in the calculation of the medical loss ratio under Sec. 2718 of the PSHA.

Sincerely,

Alan P. Spielman
President and CEO