



June 18, 2010

Jacob Garn, Chair  
Blanks (E) Working Group  
c/o National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, MO 64108-2662

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

Dear Mr. Garn:

We are writing to respond to the draft blanks for the medical loss ratio that you exposed for comment last week. In particular, we are requesting that you remove the XXXs from the rows for accreditation and certification fees and allow these costs to be added to the other costs associated with the designated activities to improve quality for purposed of calculating the medical loss ratio.

Accreditation fees should be included as a cost associated with activities that improve quality. Our accreditation program is an excellent example of development of independent standards and measures that can be used to assess the evidence base for the activities that count towards “activities that improve quality” for purposes of the medical loss ratio calculation. It would seem short sighted to not include the accreditation costs associated with that assessment. Further, if the fees are not included as counting towards improving quality, there is a very real risk that health plans will decide not to pursue accreditation, leading to an increase in states’ burden in auditing and reviewing all of the activities and a loss of consumer protection.

NCQA’s accreditation program requires quality improvement (as opposed to quality assurance) in several ways:

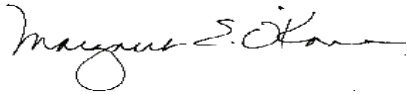
- 1) The results of HEDIS and CAHPS make up 44 percent of the scores. We have seen upward trends in many of these measures over time. Accredited plans have higher scores than non accredited ones. We are constantly moving the bar because on many measures we score plans relative to each other.
- 2) We add new standards, measurements and requirements over time. Typically, we introduce new “modules” that start out voluntary but then are mandatory for all plans. For example, we are just introducing a new module called “CLAS,” which stands for “Culturally and Linguistically Appropriate Services.” At this time, this module is voluntary, but the usual pattern would be to add this to the regular program. The module includes not only standards but measures; we routinely add new measures over time as well. We also drop standards and measures that we think all plans meet or do well on.

3) Plans that have not been accredited before actually have to invest a lot of time and money to comply with our standards and requirements. Those investments have made plans better – that is, accreditation has improved the quality of care of enrollees.

Even plans that already meet our existing standards and continue to do so have to report and be scored on new measures and standards over time. We use a rigorous and transparent process to develop the standards and measures of plan performance that involves multiple stakeholders (including public sector advisors, researchers, and consumers as well as affected entities) that draws on the best clinical and scientific evidence available.

Thank you for your consideration of these comments. Please do not hesitate to contact me or Sarah Thomas, Vice President of Public Policy and Communications at (202) 955-1705 if you have any questions or wish to discuss these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Margaret O'Kane". The signature is fluid and cursive, with a large initial 'M' and 'O'.

Margaret O'Kane  
President

Attachment

cc: Todd Sells, NAIC Staff  
Mary Caswell, NAIC Staff