June 25, 2010

TO: Mr. Lou Felice, Chair, NAIC Health Reform Solvency Impact (E) Subgroup

Dear Mr. Felice: I would like to follow up on comments I made on Thursday’s conference call on behalf of the Alliance of Community Health Plans, regarding the Instructions for Line 1.7 of the revised Exhibit for reporting of Medical Loss Ratio. Health plans that are members of ACHP are non-profit plans or subsidiaries of non-profit health systems; these plans are grounded in their communities and are either integrated delivery systems and/or organized networks that deliver highly coordinated care.

As I mentioned, non-profit health plans incur community benefit (CB) expenditures in response to their obligations as tax-exempt entities under the Internal Revenue Code. These CB activities are conducted by substantially all non-profit organizations in order to qualify for tax-exempt status, while only a small number of states may have explicit requirements tying CB expenditures to deferral of state premium taxes. The language in sentence #1 of the Instructions already has a limitation on the amount that can be subtracted, tied to the state premium tax rate that otherwise would be applicable. We believe this limitation may act as a disincentive for health plans to conduct CB activities at a higher level, but we are willing to accept the limitation if the Subgroup thinks that comparability is necessary.

As I pointed out on the call, the second sentence negates the first sentence in the large majority of states and creates an unlevel playing field. For-profit plans will be able to subtract taxes they are obligated to pay. Non-profit plans will be disadvantaged without the ability to subtract the CB expenses they are similarly obligated to pay under federal law. Such disparate treatment will have the perverse policy result of discouraging health plans from organizing as non-profit entities and encouraging those that do to minimize their CB expenditures. We recognize that some for-profit plans also make some level of CB expenditures, and we have no objection to amending sentence #1 to allow those plans to include CB expenses on Line 1.7.

Another unintended consequence of not allowing the subtraction of CB expenses in most states is that, if a health plan has a non-profit HMO and a for-profit PPO subsidiary, the incentive may be to shift people into the PPO – where taxes can be subtracted – and out of the HMO, where CB expenses cannot be subtracted. If medical expenditures are harder to constrain in the PPO, given the nature of its structure and function, the effect of sentence #2 could be to push medical costs higher – an outcome that no one wants.
We believe that sentence #1 is a sufficiently limited subtraction that can and should stand alone. Please let me know if you have any questions about the points above or wish to consider alternative language that might address your concerns and still allow nonprofit plans to fairly account for their CB expenditures.

Thank you very much for your consideration of these comments.
Sincerely,
Howard Shapiro

Howard Shapiro  |  Director, Public Policy  |  Alliance of Community Health Plans
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28 June 2010

Mr. Jake Garn
Chair
Blanks Working Group
c/- Utah Insurance Department
State Office Building, Suite 3110
Salt Lake City, Utah 84114-6901

RE: Blanks Exposure

Dear Mr. Garn:

We write on behalf of America’s Health Insurance Plans (AHIP), the nation’s trade association representing nearly 1300 member companies providing health, long-term care, dental, disability and supplemental coverages to more than 200 million Americans. AHIP appreciates the opportunity to provide comments on the Supplemental Health Care Exhibit that was recently exposed for comment.

The following comments are based on the exposed version of the healthcare supplement that includes the Fraud Detection Expense lines. We support the alternative proposal, as it reflects the Fraud and Abuse Detection/Recovery Expenses which we believe should be included in the supplement as a part of the numerator for the medical loss ratio (MLR). Given that the Health Solvency work group continues to work on issues regarding definitions of quality, we include here only those comments relating to the structure and process for filing the supplement document.

We note that the current proposal has a filing date of April 1 for the healthcare supplement. It is our understanding that rebates will be calculated based on data available as of a later date in order to permit appropriate claims development within the medical loss ratio, with the expectation that rebate calculations will reflect pooling of large claims, and that there will be formula adjustments for partial credibility. We understand that the healthcare supplement includes the language “Not for Rebate Payment” in the heading. However, we are concerned that both the media and the public will develop false expectations about the potential for rebate payments based on this preliminary, and incorrect, information. This will create a perception problem for both state insurance departments and the companies, when incorrect data is placed in the public domain. There is no reason that the supplement must be filed on April 1, other than the fact that all other supplements are filed on that date. No critical work or analysis can be performed on the numbers reported on a state-specific basis if the forms are required by April 1. We recommend that the healthcare supplement be filed to coincide with the calculation of the rebates and avoid a public relations nightmare for companies and regulators.

We have some suggested changes to Parts 1 and 2 of the supplement. In Part 1, we believe that lines 1.10 and 1.11 which are both related to reinsurance should have “XXX” in all columns except column 7 (total of columns 1 through 6). Reinsurance is not captured by state but by legal entity. In addition, reinsurance is not included in the calculation of the MLR rebate so it is not needed in columns 1 through 6. We make the same comment with regards to Part 1 lines 5.1 and 5.2 and Part 2 lines 1.9 to 1.12 and 2.11 to 2.14.

Line 8.1 of Part 1 should have “and Fraud and Abuse Detection expenses in line 4” added at the end.

There are three lines which should be added to section 10 to reflect reinsurance activity:
1. Line 10.6 – Reinsurance assumed expense allowance including premium tax allowance.
2. Line 10.7 – Reinsurance ceded expense allowance including premium tax allowance.
3. Line 10.8 – General and administrative expenses net of reinsurance (Line 10.5+10.6-10.7).

Line 11 of Part 1 (Underwriting Gain) includes Incurred Claims after reinsurance (line 5.7) but utilizes Premiums Earned before reinsurance (line 1.9). It would seem more appropriate that both premiums and losses should be based on an after reinsurance number. We recommend that line 1.13 be used rather than line 1.9, that line 4 be included as a subtraction and that line 10.8 rather than 10.5 (per the above change) be used.

We thank you for the opportunity to provide input and look forward to discussing these issues with you further. If you have any questions or comments please call any of the undersigned.

Sincerely
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Candy Gallaher, AHIP
COMMENTS
OF
AMERICAN INSURANCE ASSOCIATION
ON
JUNE 18, 2010 DRAFT
OF
SUPPLEMENTAL HEALTH CARE EXHIBIT

The American Insurance Association and its member insurers much appreciate the opportunity to submit additional comments on the proposed Supplemental Health Care Exhibit. Our comments reflect the twin objectives of achieving full compliance with the letter and spirit of all applicable laws but also to avoid unnecessary administrative burdens that ultimately put upward pressure on insurance premiums for consumers.

Our companies are not, as a general matter, engaged in the kind of health insurance business that is the target of, and reason for, this exhibit. However, the language of the exhibit is so broad that it would sweep in lines of insurance never intended to be covered and thereby force the unproductive expenditure of resources. In this connection, we have appreciated the willingness of the NAIC to listen to and modify the forms and/or instructions to avoid negative results.

While we would much prefer the deletion of Columns 5 and 6, we realize that result may not feasible at this time and that our issues are now best resolved through the instruction language. Accordingly, we respectfully request the addition of this or equivalent language in the instructions: “Insurers reporting no premium in Columns 1, 2, and 3 are not required to complete the exhibit. If the total amount of premium reported under Part 1, Line 1.1 for Columns 1, 2, and 3 does not exceed 5% of the total premium reported under Part 4, Line 6 of the Accident and Health Policy Experience Exhibit, reporting is not required for Columns 5 and 6.”

The proposed language will achieve a beneficial balance of meaningful reporting and avoidance of unnecessary costs. We are available to answer any questions you may have. Thank you.
Lou/Steve, I am responding to comments made during the Thursday June 24th Health Reform Solvency (E) subgroup conference call regarding the instructions for the MLR Supplemental exhibit. I am responding as an interested party and employed by Assurant. I may not be able to listen in as an interested party during the upcoming week so I wanted to provide my comments to you via this email message.

A comment was made concerning the treatment of deficiency reserves in the supplemental exhibit. Steve, I am including you in this message as Lou referred to your workgroup's effort with respect to the recommendation on treatment of these reserves.

Lou, you made the comment that there was a change in the Supplemental exhibit, part 2 to exclude Premium Deficiency Reserves from the calculation of incurred claim (as shown below):

Line 2.6 – Direct Contract Reserve Current Year

Report the amount of reserves required when due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves. Refer to SSAP 54 – Individual and Group Accident and Health Contracts for guidance.

Include: Contract reserves and other claims related reserves.

Exclude: Premium deficiency reserves.

You indicated that this was to be consistent with the direction that Steve's actuarial workgroup was taking with the MLR rebate calculation work. I believe excluding premium deficiency reserves from the MLR Rebate calculation is an appropriate action and consistent with intent of the MLR. However, there is no mention of where the change in premium deficiency reserves should be added back into the overall calculations on Part 1 in determining the Net Gain or Loss. All other items reflecting income statement related items are included in Part 1 so it is unclear why the change in premium deficiency reserves would be excluded. It was mentioned in prior conference calls that the intent of inclusion of many items in part 1 (including information for products not subject to the MLR) was so that tying back to the other statutory exhibits in the annual statements could be achieved. Excluding the change in premium deficiency reserves would make that reconciliation more difficult. Calculating a net gain or loss without the change in premium deficiency reserves would lose the impact on solvency that may result from establishment of a premium rebate and MLR requirements under PPACA. A premium deficiency reserve may be generated due to either the requirement of a premium rebate in 2011+ or the inability to achieve the lower expense margins necessary under the MLR limitations or both, thus generating statutory losses (which require the establishment of a premium deficiency reserve). Lou, you had indicated that a primary use of the Supplemental exhibit would be for the impact on solvency and levels of statutory losses would impact levels of company surplus and in turn, solvency.

It may be possible to include the change in premium deficiency reserves in Line 12 "Net investment and other gain/(loss)" on part 1 as there are no specific instructions on what all is to be included there and that may have been your intent.

There may be additional areas within the definition of incurred claims that may chose to be inconsistent with the work that Steve's workgroup is involved with. Currently, I believe the direction that Steve's workgroup is headed with respect to Claim Reserves reported under Exhibit 6B in Life Company Blanks (i.e. IRD 37) is to exclude them from the MLR Refund calculation. However, the current instructions for the Supplement Exhibit for Part 2 will include them in the Supplemental Exhibit MLR (as shown below for Line 2.4 for Part 2).

Line 2.4 – Direct Claim Reserves Current Year

Report reserves related to healthcare services for present value of amounts not yet due on claims and the
claims related portion for reserve for future contingent benefits.

I realize that direct 100% consistency between the definition of incurred claims used in the Supplement exhibit and the Rebate calculation is not possible (due to claim runout, only including paid claims for the rebate year versus all years, adjustments for transition, small plans, etc.). However, if the intent of the Supplement Exhibit is to tie back to other Exhibits in the Annual Statement, it would appear important that if an item is excluded from one section for MLR purposes, it would need to be added back in another to reconcile net gain/loss.

I appreciate your time and efforts in taking these comments. If possible, I will try to be listening in on the calls during this upcoming week if there are questions on my comments or respond via email if you respond that way. Thank you.

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June 23, 2010

VIA ELECTRONIC MAIL TO tselis@naic.org

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

RE: Calculation of Medical Loss Ratio Recommendations

Dear Mr. Felice:

As CEO of CareNex Health Services, I am pleased to have the opportunity to share my company’s experience in providing neonatal care management services and the impact programs like ours have on improving the quality of care and outcomes for the precious infants on which we focus our programs. I firmly believe that well-conceived regulations to define medical care v. administrative services for medical loss ratio reporting can help improve health care outcomes and lead to incredible financial savings to the system.

It is my understanding that your subgroup is currently considering permitting certain aspects of utilization management (UM) to be included as “activities that improve health care quality” for purposes of the medical loss ratio calculation under the Patient Protection and Affordable Care Act. I further understand that you are soliciting examples of discrete UM activities that improve quality for the subgroup to consider. As I explain below, neonatal care management services improve health outcomes, improve patient safety, reduce medical errors, and lower infection and mortality rates, putting neonatal care management squarely within the goals of the quality improvement activities definition that the subgroup is developing. Therefore, I urge you to include neonatal care management services as the type of UM activity that a health insurer may properly claim as a quality improvement activity for purposes of the federal medical loss ratio calculation.

Today, 12 percent of babies born in the United States become Neonatal Intensive Care Unit (NICU) patients, with preterm births up 36% between 1980 and 2006. Although the national preterm birth rate decreased slightly during 2007 and 2008, one out of eight births each year is premature.

We founded CareNex Health Services in 2005 upon observing vastly disparate treatment protocols and resulting outcomes for prematurely born and clinically complex infants across the nation. Not only did the outcomes, complications and lengths-of-stay for these infants vary significantly by institution, but the cost of providing highly specialized care for these infants was (and largely remains) exorbitant. In fact, today average health care costs for premature babies in the first year of life exceed $50,000. With more than 540,000 premature infants born in the US each year the resultant financial burden is well over $27 billion. NICU births represent more than 40% of highest-dollar insurance claims nationally. Adding to the problem is a systemic disproportional focus on adult conditions and care and a lack of neonatal specialists who can treat NICU babies most effectively, which can result in less-than-optimal, or even compromised, care.

The new medical specialty of Neonatology emerged as a clinical discipline during the 1960’s. Nearly 50-years later, there continues to be only a limited number of nationally recognized and adopted clinical guidelines and care protocols used in the care of premature and clinically complex newborns across hospitals in the US. There are also few clinical guidelines that are approved by a governing authority that can be used by local treating Neonatologists to provide evidence-based support for treatment decisions.
The CareNex Health Services Neonatal Support and Advocacy Program combines attributes and activities from traditionally separate functions (i.e. Case Management, Utilization Management, Disease Management, Decision Support), which coordinated together offer new opportunities for improving quality. CareNex believes that disciplined, scientific, evidence based, and standardized approaches to the delivery of care to clinically complex infants can favorably impact the overall outcome of neonatal patients.

Drawing on its experience on neonatal clinical case management at over 500 hospitals with a NICU facility (out of a total of 1500 hospitals with NICU facilities nationwide) and over 30,000 cases in its database, CareNex has developed and is continuously refining a proprietary set of clinical guidelines which cover specific areas of neonatal clinical care where significant variation in practice has been identified. CareNex Neonatal Clinical Guidelines for Neonatal Management were developed with the input and support of a distinguished group of practicing physicians representing both academic and clinical practice.

CareNex Case Managers collect an extensive set of clinical and psychosocial data on every infant and family, encompassing maternal, neonatal and postnatal time periods. CareNex Advantage™, our proprietary clinical database and decision support system is used by our specialist clinicians to capture maternal and neonatal data and decision support tools to monitor and map the actual course of care against CareNex Proprietary Guidelines and Milestones. CareNex Case Managers and Neonatologists then interact with the local treating Neonatologists and Clinical Team to help identify and reduce unwarranted clinical variation from standards outlined in the guidelines. Specific guidelines include:

- **Thermoregulation Guideline** - Provides guidance for weaning premature and low birth weight infants from incubators. In the past, premature infants were removed from incubators and discharged to home when they reached a predetermined weight – typically 2000 grams. Randomized clinical trials have shown that discharge at a lower body weight is possible without adverse effects as long as specific clinical parameters are met.

- **Respiratory Care Guideline** - Respiratory problems in the neonate can range from pulmonary aspiration to Respiratory Distress Syndrome (RDS) and to transient tachypnea of the newborn. Management must be individualized to each patient and to the specific disease condition. The goal of this guideline is not to outline clinical management of most disease states but rather provide certain general principles to support appropriate treatment decisions related to RDS, Bronchopulmonary Dysplasia (BPD), Meconium Aspiration and Home Oxygen Therapy.

- **Hyperbilirubinemia & Phototherapy Guideline** - This guideline outlines the criteria which should be used for the management of the infants admitted for Phototherapy in the Special Care Nursery or to the Neonatal intensive Care Unit with intent of timely and appropriate hyperbilirubinemia management supporting optimal nutrition and hydration while minimizing the risk of bilirubin encephalopathy.

- **Feeding and Nutrition Guideline** - This guideline provides criteria which should be applied for nutritional planning for neonates at various stages of growth and maturity. This includes guidelines for determining readiness for oral feedings, exclusion to enteral feedings, and criteria guidelines for advancing of nipping (Per Oral) feedings and encourages neonatal breast milk use vs. artificial formula. Through this disciplined approach, we have been able to improve neonatal feeding of breast milk in the NICU environment.

- **Apnea and Bradycardia of Prematurity Guideline** - Apnea and bradycardia of prematurity encompass events of many types. These events can occur in association with feeding or independently of neonatal feeding. It is important to have as much information as possible on exactly what types of alarm triggering events are occurring, and when they occur, in order to manage them effectively. This guideline provides suggested protocols for dealing with these infants based upon the type of event experienced by the neonate.
Letter to Mr. Lou Felice  
June 23, 2010  
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- **Medication Error Guideline** – The neonate in the NICU is at risk of 10 to 100 fold medication dosing error. NICU medication dosing errors often lead to serious medical complications. Medication errors in the NICU are common, substantial and are often preventable. Medication protocols focus on efforts to help hospitals monitor and reduce these medical complications.

- **Hospital-Acquired Infections Guideline** – Hospital acquired infections are a serious and growing problem leading to serious morbidity and mortality in the NICU. Premature babies have an immature immune system, are often handled by caregivers many times during the day and have multiple monitoring and invasive treatment access lines that provide a fertile source of infection. This protocol focuses on best practices at over 500 hospitals with NICU facilities in the US and helps with transfer of knowledge, best practices and decision support throughout the NICU community.

- **Discharge Guideline** - This protocol outlines the criteria which should be met to discharge a baby from the NICU or specialty care nursery. The guideline focuses on physiologic maturity, resolution of medical problems identified during the NICU admission, parental preparation, and arrangements for follow up care.

CareNex maternal and neonatal data indicates a great deal of promise for improvement in the quality of care and clinical outcomes. We expect ongoing analysis will identify additional areas of clinical variation from which we will build new evidence-based care guidelines. Continued timely and uniform capture of all clinical data related to the population of premature and clinically complex infants we manage will help map the actual trajectory of care against milestones, validate improvement in quality of care and clinical outcomes and provide the base of knowledge required to drive continuous quality improvement initiatives.

CareNex provides neonatal care management services to health plans, managed care organizations and insurance companies in 14 states, with active and continued dialog with more than 50 companies covering an additional 25 states. CareNex’s NICU trained nurses, registered respiratory therapists and Board-certified Neonatologists work directly with local clinical professionals responsible for the infants’ care, and advocate for the infant and his/her family pre- and post-discharge.

Although CareNex clinicians do not directly provide care, they work actively with the treating clinicians to rigorously support and coordinate the infant’s care; to provide evidence-based best-practice information; and to support the care team in treatment decisions. We are continuously focused on improving the quality of care and clinical outcomes. The CareNex program provides elements of physician and patient support, clinical research driven methodologies, and home health and family counseling/education delivered primarily through our network of onsite clinical specialists.

Because CareNex nurses and physicians are specialists and have worked with thousands of NICU babies, they offer the care team a wealth of knowledge and experience in dealing with the most complicated cases. NICU care management is crucial in supporting continuity of care, helping to avoid delays in fulfilling the clinical plan of care that can occur as treating staff rotate through the NICU. They also ensure that care is progressive, expediting procedures and services that ultimately improve the infant’s health more quickly, ensuring they achieve critical clinical milestones on a timely basis and reduce the rate of unplanned readmissions.

Although we at CareNex recognize and strongly believe in the need for NICU Care Management Services given their ability to improve clinical and financial outcomes, we wanted to make sure to directly provide you with this background information and urge the subgroup to specify that neonatal care management/coordination services like these are classified as “activities that improve health care quality” rather than as an administrative expense.
Letter to Mr. Lou Felice
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The current draft exhibit instructions developed by your subgroup clearly state that “quality improvement expenses” should:

- 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.

The subgroup’s draft also states that quality improvement expenses should “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.”

CareNex’s services clearly fall within these goals. We believe they should be included as “activities that improve health care quality” and not be deemed “administrative” in nature, because the services will legitimately lead to improved health outcomes as well as cost savings. In addition, such a determination will encourage more health insurance companies and other organizations to institute neonatal care management practices, ultimately resulting in systemic improvements to quality of care and outcomes.

Thank you again for your willingness to consider this important issue. Our experience has shown that highly coordinated care of complicated patients can save and improve the quality of lives and eliminate unwarranted cost simultaneously. We urge the NAIC to support this trend for the good of our country’s youngest patients, their families and the system, which clearly needs to realize savings and quality improvement opportunities in nearly all sectors.

We would welcome and appreciate the opportunity to further discuss CareNex Health Service’s unique capabilities and experience with the health care system with you and your team. If you should require any additional information or clarification prior to my call, please don’t hesitate to contact me directly. My direct phone number is 818-205-2555 and email is psalimpour@carenex.com

Sincerely,

[Signature]
Pejman Salimpour, M.D.
Chairman and CEO
June 28, 2010

Lou Felice, Chair
Health Care Reform Solvency Impact Subgroup, NAIC

Steve Ostlund, Chair
Accident & Health Working Group

National Association of Insurance Commissioners
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Kansas City, Missouri 64198-2662

Re: MLR Quality Definition

Dear Mr. Felice and Mr. Ostlund:

We appreciate the extensive and inclusive process that the NAIC has undertaken to develop the minimum loss ratio formula. We are submitting these comments regarding three of the remaining discussion areas of the quality definition: utilization review; provider contracting/network management; and ICD-10. We believe that the pending decisions on the quality definition will impact the ability of insurers to advance evidence based medicine on the behalf of health care consumers. If we are going to be able to get at the issue of insurance affordability we need to ensure these elements of the MLR definition are valued.

I. Utilization Review

Utilization review (UR) is the process by which Aetna ensures that health care consumers are provided with evidence-based medical treatments which are best suited to their specific needs, conditions and situations. The methodologies we use for our utilization review programs are based on clinical guidelines, evidence based medicine, peer review literature and methods, and are credentialed programs. Our goal is to ensure patients get the care they need.

UR activities protect consumers from undergoing unnecessary procedures that could threaten their health and ensure they get the procedures and medical protocol they need to stay well. Utilization review uses medically-approved standards of care to identify and reduce unnecessary services – which according to some experts, such as Dartmouth physicians Elliot Fisher and John Wennberg estimate, constitute up to 30% of health care. These unnecessary services can cause otherwise preventable adverse events. In fact, deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516). U.S. estimates of the combined effect of errors and adverse effects that occur because of iatrogenic damage not associated with recognizable error, include 12,000 deaths per year from unnecessary surgery.

Additionally, the benefits associated with UR are consistent with the Affordable Care Act text, specifically, Section 2717, which cites quality improvement as implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices and evidence based medicine.
Government programs also recognize the quality improvement impact of utilization review. The Department of Defense Medical Management Guide issued by the Office of the Assistant Secretary of Defense defines utilization management as a "...key process within Medical Management ...for improving the quality of health care..." Additionally, government contracts with insurers generally require performance of utilization review (e.g., FEHBP, TRICARE, state contracts).

There are many specific activities that comprise the Utilization Review function, as a whole, and contribute directly to quality improvement. They fall within the categories of clinical policy development, policy awareness generation, and clinical guideline implementation, which are described in detail below.

Clinical Policy Bulletin Development. Aetna’s clinical policies and guidelines, known as its Clinical Policy Bulletins (CPBs), define the appropriate management of medical conditions and the indications for a medical intervention that are supported by reliable evidence. Health technology assessment and clinical guideline development are recognized among diverse healthcare systems worldwide as an important public health function. Including health technology assessment and clinical policy/guideline development in the definition of quality improvement activities will better ensure that adequate resources are devoted to these activities to ensure their continued rigor and integrity.

Creating and maintaining these policies involves highly specialized, clinical support to:

- **Critically and exhaustively review the medical literature**: Aetna has dedicated, medically trained staff to conduct an intense review of the peer-reviewed published medical literature, as well as FDA notices and approvals.

- **Develop policies that are supported by reliable evidence**: Guideline development helps to determine a procedure’s or therapy’s proven effectiveness, since the use of procedures or treatments without such demonstration can delay the use of effective interventions. As a result, our CPBs have been recognized as a reliable source of medical technology assessment by the Institute for Health Economics and the Alberta Heritage Foundation for Medical Research (independent research agencies funded by the Canadian government that periodically publish a guide to reliable sources of health technology assessment), and by Health Technology Assessment International, the leading international health technology assessment society. Aetna’s assessments have also been cited in technology assessments of national and international technology assessment agencies, including assessments for the Centers for Medicare & Medicaid Services, the Institute for Clinical Effectiveness and Health Policy, the Washington State Department of Labor and Industries Technology Assessment Program, the Veterans Administration Technology Assessment Program, and the Canadian Coordinating Office for Health Technology Assessment. Aetna currently has over 650 active medical CPBs, as well as dental policy bulletins, Pharmacy Commercial Clinical Policy Bulletins, Pharmacy Medicare Clinical Policy Bulletins, and pharmacy formulary evaluations.

- **Conduct independent procedure and technology assessments**: To support the development of our guidelines, Aetna also conducts our own assessments of procedures and technologies. These assessments have been cited in technology assessments of national and international technology assessment agencies, including assessments for the Centers for Medicare & Medicaid Services, the Institute for Clinical Effectiveness and Health Policy, the Washington State Department of Labor and Industries Technology Assessment Program, the Veterans Administration Technology Assessment Program, and the Canadian Coordinating Office for Health Technology Assessment. Health technology assessment and clinical guideline development is recognized among diverse healthcare systems worldwide.
as an important public health function. Including health technology assessment and clinical policy/guideline development in the definition of quality improvement activities will better ensure that adequate resources are devoted to these activities to maintain their continued rigor and integrity.

- **Convening Medical Review Panels and Vetting Proposed Policies:** Aetna convenes several groups of clinical experts to create policies and oversee regular updates. Aetna's Clinical Policy Council (CPC) is composed of Aetna medical directors representing the various clinical functions and regions within the company. The Quality Advisory Committees (QACs), organized in each region, are composed of independent physicians who participate in Aetna's networks. One of the responsibilities of the QACs is to review and provide feedback on new and revised Clinical Policy Bulletins, both before and after the CPB is published. Aetna's Clinical Policy Unit provides responses to their feedback, and one potential result is additional revisions to the CPB.

- **Incorporating external feedback:** Evidence submitted by providers and members in appeals is forwarded to Aetna's Clinical Policy Unit for consideration and fed into the CPB review process. Aetna reviews the outcomes of appeals to external review organizations, where cases are reviewed by a physician in the relevant specialty that is not employed or selected by Aetna, which may result in a change to our clinical policies. Changes to our clinical policies may be the result of feedback from Aetna medical directors who are involved in review of individual cases.

- **Conducting regular reviews of CPBs:** As noted above, Aetna has more than 650 active medical CPBs, all of which are reviewed and updated at least once each year. Last year alone, Aetna had more than 300 new and revised medical policies (i.e., new policies or changes to existing policies), while the remainder of the policies were reviewed and maintained. All Pharmacy Clinical Policy Bulletins also are updated each year.

**Generating CPB Awareness:** These clinical policies and guidelines are made available to members, providers, and the general public, and are used to support utilization management activities and other Aetna clinical programs. Awareness of these policies serves to better ensure that the care that is provided to Aetna members is consistent with evidence-based medicine, and thereby "improve health outcomes." Generating this awareness involves:

- **Informing providers and consumers about policies and their supporting literature:** The primary vehicle for provider education on Aetna's evidence-based policy are the Clinical Policy Bulletins themselves. Aetna CPBs are published on the internet, making them available to members and providers, as well as the general public. Members, providers, manufacturers, medical professional organizations and other constituents can submit evidence or other information for consideration in our CPB review, which may result in a revision to Aetna's CPB policy. The annual CPB review schedule is also publicly available and published on the internet.

- **Communicating guidelines to professional groups:** Aetna also receives inquiries or other input on CPBs from state regulatory agencies. Additionally, Aetna medical directors serve as liaisons to each of the leading medical professional organizations, and Aetna actively solicits input from these organizations on controversial or complex medical policy issues. Aetna also has specific transplant advisory committees, such as the Solid Organ Transplant Advisory Committee and the Stem Cell Transplant Advisory Committee. One of the functions of these committees is to provide input on Aetna's transplant policies.
**CPBs Implementation:** Clinical utilization review represents the implementation of clinical policies, guidelines and care pathways. Aetna employs hundreds of physicians and thousands of nurses to accomplish this clinical review, with the goal of better ensuring that the care provided to its members is consistent with evidence-based medical practice.

- **Pre-certification:** Pre-certification is the process by which clinical review prospectively determines the medical appropriateness of the care that is provided to members. This activity is performed by clinicians (physicians, nurses and pharmacists), and improves clinical quality by assessing whether the care that is provided to members is medically appropriate and of proven clinical effectiveness. It is important to note that Aetna’s pre-certifications are based on our CPBs and are therefore procedure, not dollar based.

- **Concurrent Review:** Concurrent review provides guidance about the appropriate site of care for a clinical condition (intensive care unit, general inpatient care, rehabilitation facility, outpatient care, etc.), as well as the appropriate interventions and their sequence. Aetna uses Optimal Care Guidelines for this portion of the UR process, which are based on published evidence and empirical data and offer the opportunity to improve the quality and appropriateness of the care that a member is receiving. For example, if a person is admitted to the hospital for a hip replacement, the guideline will indicate when a person undergoing hip surgery should begin physical therapy. If on concurrent review, the utilization review nurse finds out that the member has not begun physical therapy at the appropriate time, he or she can alert the member’s physician. By ensuring that physical therapy is initiated, utilization review has the potential to both decrease the duration of hospitalization and facilitate earlier recovery.

- **Retrospective Review:** It has also been suggested in some of the Subgroup discussions that post-service reviews (claims and post-service medical record reviews) should not be considered quality improvement activities, while pre-service reviews may be included in the definition. This sentiment is reflected in the new alternative proposal exposed at the June 24 Subgroup meeting. Aetna believes that the pre-service review and post-service reviews are directed at accomplishing the same goals, albeit with different mechanisms, and is therefore an inappropriate dichotomy to lay out in the quality improvement definition. A rule that would include only pre-service reviews as quality improvement activities would create incentives to prefer one type of utilization review mechanism over another, even in situations where post-service review would be the most appropriate mechanism for accomplishing utilization review. It would mean the loss of an important tool to drive provider behavior. This process attracts the attention of aspects of the provider community that may not have responded to the other aspects of the transparent CPB education process.

In addition, retrospective review can help identify adverse events that were not reported and signals the need for processes that will reduce their incidence in the future. In this way, retrospective reviews influence future behavior, helping to improve the quality and safety of future care delivery.

II. **NETWORK MANAGEMENT / PROVIDER CONTRACTING**

Network Management activities improve health care quality for members and advance the delivery of patient care by establishing provider measurement criteria; forming networks and programs that require or encourage providers to deliver evidence based and safe care that is aligned with recognized clinical guidelines; and monitoring adherence to the criteria. These functions are performed to achieve optimal health outcomes.
Provider Credentialing and Quality Management:

- Validating provider credentials for patient safety, includes performance of due diligence of appropriate provider licensure, training, education, work history and malpractice claim history; recredentialing occurs every three years.

- Monitoring adverse actions rendered by regulatory authorities for patient safety, includes reviewing all state license boards weekly and federal actions monthly (e.g., Office of Inspector General and Office of Personnel Management, etc.) for any adverse actions against providers.

- Conducting professional review (e.g., peer review) involving professional competence or conduct of practitioners; determines whether a provider’s conduct (e.g., provider’s health issues, malpractice claim, etc.) adversely affects or could adversely affect the health of members.

- Monitoring member complaints against providers regarding quality of care, or professional competence; triggers a review of whether a provider’s delivery of care could adversely affect the health of members.

Performance-Related Networks:

- Determining standards for network inclusion creates the baseline for quality health care delivery, requiring delivery of health care designed to improve patient outcomes, including:
  - Use of technology (electronic medical records, etc.); Board certification/re-certification; alignment with Institutes of Quality; certification by external entity (e.g., NCQA); and claims based measures, among other standards for inclusion in Aexcel Network.
  - Use of clinical performance, access and efficiency metrics for bariatric, orthopedic, or cardiac care for inclusion in Institutes of Quality.
  - Meeting specific criteria such as volume of transplants and outcomes measures for facilities to be approved on a transplant-specific basis for Institutes of Excellence.
  - Meeting scorecard measures designed by comprehensive Aetna working groups (e.g., medical directors, peer providers, informatics experts, etc.), and based on NCQA recognition programs that include breast cancer screening rates, drugs for lowering LDL cholesterol, among many other measures for participation in NYC and Illinois Performance Networks by select large multispecialty medical groups and faculty practices or IPAs.
  - Identifying and quantifying the value of clinical integration models such as the Patient-Centered Medical Home, to replace episodic care based on illness and patient complaints with a coordinated, long-term care program through a personal physician and an integrated healthcare team. See Attachment 1.

- Determining whether providers or facilities meet the quality standards for these programs, to implement the delivery of higher quality care for our members.
Pay for Performance:

- Creating performance-based components for physicians who will measure whether their patients are getting standard of care, improves patient outcomes. Clinical effectiveness measures are evidence based; recognized clinical guidelines; administratively efficient; safe; member-focused; and achieve optimal health outcomes. They are nationally recognized; National Quality Forum endorsed, and meet NCQA Physician Hospital Quality standards when applicable or feasible.

  - Benefits include quality of life improvements and savings associated with prevention, early detection and treatment of illness that averts long-term, high-cost health needs.

  - Specific Programs are attached as Attachment 1.

III. ICD-10
The Subgroup specifically requested our projections for the amount Aetna will spend on ICD-10 adoption. We expect to spend on average between $50 million and $70 million on ICD-10 adoption each year for 2011, 2012 and 2013. This represents a significant cost for us that could squeeze out the ability for investment in other innovations — if the MLR penalizes insurers for ICD-10 adoption.

Additionally, it is during this same time frame in which we will, for the first time, have to meet minimum loss ratio requirements and will be expending significant administrative sums on ACA implementation. In this way, we would like to clarify that we are only requesting including ICD-10 adoption as part of the quality definition on a transitional basis, after which we agree that it can be considered a systems maintenance, and therefore, administrative, cost.

There are many quality aspects of ICD-10 adoption. Among its improvements, it will enable providers with clinical trend data on which they can base their medical decisions. ICD-10 will also provide a significantly increased granularity of data and in turn, enhance clinical effectiveness research. By more effectively capturing data about signs, symptoms, risk factors, and co-morbidities, its adoption will better describe clinical issues, as well. Not only will it facilitate quality improvement inside the United States, but it will allow the exchange of information across country borders, as the United States is the only industrialized country that has not yet adopted ICD-10. In turn, it will vastly improve our collective understanding of disease states and better address public health concerns such as epidemics and disease outbreaks.

Thank you for your continued willingness to receive and consider our comments during your process. Please let me know if you have any questions or we can be of assistance.

Thank you,

Christina Nyquist
Vice President
Specific Quality Performance Programs (Pay-For-Performance) described below:

High Performance Provider Initiatives (HPPI)
HPPIs represent the next generation of network options to use physician and provider performance measurement. They are an innovative, strategic move to work together with doctors and hospitals to bring about substantive improvement in the delivery of health care. These long-term initiatives have a great potential to deliver higher quality, more affordable health care. Examples include: practice variation in the management of ischemic heart disease, hypertension, and ears, nose and throat (ENT) conditions; optimizing generic drug prescription; appropriate use of high-tech imaging; appropriate use of NICU; and appropriate post-partum hospital confinement.

Medicare Provider Collaborations
These collaborations focus on strong partnerships between Aetna case managers and providers for case management of complex and chronically ill Medicare members. Aetna provides an on-site case manager for these providers. Offices are paid a bonus by meeting certain quality measures and member visit requirements.

Local Market Program (for IPAs, Medical Groups, and Hospitals)
Our internally-developed program began in 2005 by contracting with IPAs, several large physician groups, and hospitals in several states. In order for providers to earn additional compensation, they must achieve improvements in measures of clinical effectiveness and efficiency. Targets for these measures are set collaboratively with each physician group using baseline information on members of all network-based plans, including full-risk and self-funded HMO, POS and PPO plans (excluding Medicare). We use specific Aetna member experience with these physicians to show a more direct benefit for our members and provide a return for our customers.

Components of our Provider Quality Program (PQP) are:
- Use standardized, industry-accepted measures that are integrated into our core business as well as our unique quality performance initiatives;
- Reward both Top Performers and those showing improvement;
- Provide tools and strategies for Health Delivery (network, medical leadership, quality management);
- Promote continuous improvement in all programs and initiatives;
- Use Population based approach, encompassing all product lines and funding types.

Patient Centered Medical Home
Multi-Health Plan collaboratives were established to integrate performance and payment reform to achieve better outcomes from more and better use of health information technology. The Patient Centered Medical Home (PCMH) is a model of care that is designed to improve quality and achieve efficiencies by recognizing and supporting the value of care that is provided to patients by PCPs, working in practices that have the information systems needed to achieve the best outcomes. The 7 Principles of Patient Centered Medical Home are:
• Personal Physician (ongoing relationship)
• Physician-directed medical practice (lead team that is collectively responsible)
• Whole Person Orientation (all stages of life)
• Coordinated / Integrated Care (across entire health system – acute, non-acute, etc.)
• Quality and Safety (evidence-based medicine, use of HIT, continuous improvement, require Recognition status)
• Enhanced Access (non-visit care, expanded hours, e-mail, web portal)
• Payment (3 components: Coordination of Care, FFS, Reward share of lower costs and improved outcomes)

Bridges to Excellence
Our overall Provider Quality Performance Programs framework includes an ongoing commitment to improving the quality and efficiency of care. In 2006, we entered into a licensing agreement with Bridges to Excellence (BTE) to encourage quality care by providing financial rewards to providers delivering safe, timely, effective, efficient, equitable and patient-centered care.

As a licensee, we are implementing programs as first to market and joining other health plans in collaborative efforts in various markets across the country. From our executive management to local network leads, we have embraced BTE as an industry-leading program and are actively pursing programs in all our regions.

We currently participate in the Diabetes Care Link and Cardiac Care Link which focus on meeting evidenced-based standards for treating chronic conditions. To participate in BTE, physicians must meet NCQA’s criteria for its Physician Recognition Programs: the Diabetes Physician Recognition program and the Heart/Stroke Physician Recognition Program.

Integrated Healthcare Association
IHA is a partnership with several other plans in California. Through this initiative, we have contracts with many IPAs that are assessed on a variety of measures within clinical performance, member satisfaction and technological advances. The IHA consists of health plans, physician groups, hospitals and healthcare systems, as well as purchaser, pharmaceutical, technology, consumer and academic representatives.
June 23, 2010

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

Re: NAIC Health Reform Solvency Impact Subgroup.

Dear Lou,

Thank you for your ongoing efforts as Chair of the Health Reform Solvency Impact (E) Subgroup. As the group moves forward with consideration of changes to the Blank and accompanying instructions to accommodate the new requirements of the medical loss ratio (MLR) reporting requirements included in the Affordable Care Act, we encourage and request a balanced approach to reporting requirements for not-for-profit insurers and for-profit insurers.

As you well know, the Affordable Care Act permits insurers to subtract some state taxes from the calculation of an MLR. However, many not-for-profits are tax exempt due to the presumptive benefit a non-profit provides to the community. Although not-for-profit health insurers are not presently offering health insurance products in Illinois, we anticipate that insurance reform will lead to new market opportunities for existing and to-be-formed insurers to enter the Illinois market. Because it has a currently dysfunctional health insurance market, Illinois needs additional competition. Recognizing that marketplace change is inevitable -- and necessary -- we oppose any approach disadvantageous to not-for-profits relative to for-profit entities with respect to medical loss ratios. Therefore, for purposes of calculating the medical loss ratio, we support an approach that permits not-for-profits to subtract community benefit expenses in the same manner that for-profit insurers can subtract paid state income taxes, with a limit that matches the state taxes from which the not-for-profit is exempt (as applicable on a state-by-state basis).

Please do not hesitate to contact me if you have any further questions.

Very truly yours,

Michael T. McRaith  
Director

MTM:srb
June 27, 2010

Mr. Lou Felice
Chair, Health Solvency Issues (E) Subgroup

Mr. Steve Ostlund
Chair, Accident and Health Working Group

RE: Medical Loss Ratio (MLR)

Dear Mr. Felice and Mr. Ostlund:

I am writing on behalf of Kaiser Foundation Health Plan (“Kaiser”), which is part of Kaiser Permanente, America’s largest private integrated health care delivery system, which both directly provides health care services (through 36 hospitals, 431 medical offices, 164,000 employees, most of whom are involved in the provision of health care services, and 14,600 physicians) and organizes the financing of care for its members. We would like to thank you for your consideration of our previous comments and appreciate the opportunity to provide additional comment.

As a 501(C)(3) charitable organization with a mission to improve the health of the communities we serve, Kaiser is exempt from federal income taxes. To maintain this tax-exempt status, federal law requires Kaiser to provide benefit to the communities we serve. If these community benefit (CB) expenditures are not appropriately accounted for in the MLR calculation, it will have a disproportionate and unfair impact on nonprofit, tax-exempt health plans, like Kaiser. Tax-exempt health plans are required to provide CB expenditures, just as for-profit insurers are required to pay taxes. Under Section 2718(b) (1) (A), taxes are deducted from the premium calculation for the MLR. PPACA recognizes that taxes are not discretionary expenses and thus should not count against health insurance issuers. Likewise, community benefit expenses for nonprofit health plans should be similarly treated. If these community benefit expenses are treated as administrative expenses under the MLR regulations, nonprofit tax-exempt health plans would be placed at a disadvantage relative to for-profit health insurers, thus creating a disincentive for health insurers to be organized as nonprofits and a strong incentive for health insurers to minimize community benefit expenditures, which is counter to sound public policy.

We greatly appreciate the Subgroup’s recognition of the need for comparable treatment of CB expenses and taxes. We are concerned, however, that this recognition was recently limited to CB required by states in lieu of state premium taxes. CB is not generally required under state law, so this limitation, in practical effect, means that the
vast majority of tax-exempt, nonprofit plans will not be able to deduct any of their CB expenditures from the MLR denominator.

We are not objecting to capping the amount of deductible CB expenditures to the state premium tax rate. We accept that the Subgroup wants to make this provision more comparable by limiting the CB deduction to the amount of taxes that taxable insurers pay, and agree that the premium tax rate is a far simpler substitute for the convoluted federal tax rate.

We urge you to delete the limitation to state required CB and allow a deduction for those CB expenditures that must be made to maintain an exemption from federal income taxes.

**Recommended Language:**

**Line 1.7 – State and Local Premium Taxes**

Include: State and local premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes.

Payments by not-for-profit health plans for community benefit expenditures limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. These payments must be state-based requirements to qualify for inclusion in this line item.

Thank you for consideration of our comments. We welcome the opportunity to discuss these matters with you further. If you have questions or concerns, please contact me at julie.h.stoss@kp.org or (510) 271-6430.

Sincerely,

Julie Hutcheson Stoss
Lou and Todd,

With regards to the June 24 alternative version of the QI instructions, which provides that "other expenses" not listed for Columns 1-5 of Part 3 of the Supplemental Health Schedule may be added to Quality Improvement Expenses, I would suggest a few clarifying revisions to the alternative version language, which are shown in bold:

Elements of the following items are excluded to the extent they do not meet the General Definition of Quality Improvement expenses set forth above and are designed solely or primarily to control or contain costs. The burden shall be on the proponent to show that the expenses for the programs conform to the definition (and this must be included in the description of the separate, supplemental filing described above):

- 24 Hour Medical Professional Hotlines (except as noted above);
- Utilization Review (all retrospective and concurrent review is excluded from QI); [Comments will be taken on concurrent U/R activities]
- Fraud Prevention activities (all activities related to recoupment of fraudulent payments are excluded from QI – only expenses that can be directly tied to Column 3, Improve Patient Safety and Reduce Medical Errors, expenses may be included in QI);
- Network Management (all fees and expenses related to establishing or maintaining the network are excluded from QI);
- Provider Contracting and Credentialing (the cost of developing and executing provider contracts would be excluded from QI);
- Accreditation Fees (under Subgroup review);
- Costs associated with calculating and administering individual enrollee or employee incentives. (rewards or bonuses associated with wellness or health promotion programs are excluded from QI) The e.g., reductions in individual enrollee or group health plan copays, deductibles or premiums based on achieving specified health outcomes or engaging in specified health promotion activities) [if clarifications need to be made, submit suggested language]; and
- Any function not expressly included in Columns 1 through 5.

I just suggest adding the "from QI" language so that the parenthetical language is parallel throughout. Otherwise certain of the instructions may be misinterpreted (e.g., when I first read the "provider contracting and credentialing" instruction, I thought that "the cost of developing and executing provider contracts..." were excluded from the exclusion and could be a QI expense).

With regards to the penultimate bullet point - "Costs associated with calculating and administering ... incentives..." - am I correct in assuming that the intent is to exclude amounts paid for rewards or bonuses from being accounted for as QI expenses? If my assumption is correct,

1. If an insurer provided a premium discount as an incentive, would you would allow that discount to be accounted for as a deduction from premium, thus reducing the denominator in the MLR calculation?
2. If a premium discount incentive was allowed to reduce premiums, the MLR denominator, to the extent an incentive or reward was paid in cash in lieu of a premium discount, wouldn't it be acceptable to include the cost of that incentive or reward as a QI expense? If so, then perhaps the parenthetical exclusion language in the penultimate bullet point could read (rewards or
bonuses associated with wellness or health promotion programs are excluded from QI if such rewards or bonuses are reflected as reductions of premiums).

Also, the last bullet point instruction, as currently drafted, seems to override the other bullet point instructions in that it is requires any function NOT EXPRESSLY included in the column 1-5 instructions be excluded. If you end up using this alternative version in the instructions, you probably need some additional language at the end of the last bullet point like "or expenses as described in the foregoing bullet points that conform to the general definition of QI expenses."

Thank you for the opportunity to comment and best regards,
Norris

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Atlanta, Austin, Chicago, Dallas, Houston, London, Los Angeles, New Orleans, New York,
Sacramento, San Francisco, Washington DC
Memorandum

DATE: June 24, 2010

TO: Lou Felice, Chair
Health Reform Solvency Impact (E) Subgroup

Steve Ostlund, Chair
Accident & Health Actuarial Working Group

FROM: Ken Ross
Commissioner

SUBJECT: Medical Loss Ratio Calculation

By helping HHS establish uniform definitions and standardized methodologies for calculating the medical loss ratio (MLR) and rebates outlined in the Patient Protection and Affordable Care Act (PPACA), the NAIC has undertaken a herculean task of fundamental importance to the ultimate success of the new law.

I want to first thank you for all the time and effort that the Health Reform Solvency Impact (E) Subgroup and the Accident and Health Actuarial Working Group have expended defining the MLR provisions of the PPACA.

NAIC President Jane Cline and CEO Therese Vaughan stated the crux of the challenge associated with coming up with a balanced MLR definition in their June 1, 2010 letter to HHS Secretary Kathleen Sebelius, when they wrote:

"The medical loss ratio and rebate program in PPACA have the potential to destabilize the marketplace and significantly limit consumer choices if the definitions and calculations are too restrictive. Equally, the medical loss ratio and rebate program could be rendered useless if the definitions and calculations are too broad. Only through an open, deliberative process can we hope to reach a reasonable consensus that meets the dual objectives of protecting consumers and preserving competitive markets."
Their comments highlight the need for a balanced approach that protects consumers while recognizing that an overly rigid approach would undermine market stability at the ultimate expense of consumers.

Before making brief comments regarding the definition of “activities that improve health care quality,” I would like to draw your attention to an issue concerning mandatory regulatory assessments that is of significance to Michigan and a number of other states that are similarly situated.

**Mandatory Regulatory Assessments**

As you may know, Michigan law empowers its Insurance Commissioner to mandate assessments on Blue Cross and Blue Shield of Michigan (BCBSM) as part of its ratemaking. These assessments subsidize Medicare Supplemental coverage for Michigan seniors and Group Conversion coverage.

A question has arisen regarding whether these mandatory assessments would fall within the definition of state taxes or regulatory fees within the MLR calculation.

I strongly encourage you to include mandatory regulatory assessments in the definition of federal and state taxes and licensing or regulatory fees. These assessments should be considered a state tax or regulatory fee for purposes of the MLR reporting and rebate methodologies regardless of whether the assessment was paid to a governmental unit prior to subsidizing the individual or Medicare Supplemental markets.

To illustrate the significance of this issue in Michigan, last year I ordered BCBSM to pay 1% of its earned subscription income toward Medicare Supplemental subsidies. This assessment alone amounts to over $180 million annually.

Michigan law empowers the Commissioner with the discretion to order BCBSM to pay up to 1% of its earned subscription income for this subsidy. Once an order is issued, BCBSM is obliged to apply the subsidy, which is the functional equivalent of a state tax or regulatory fee. Recognition of this should be clearly stated in the MLR definition or any guidance associated with the MLR calculation.

**Activities to Improve Health Care Quality**

The intense attention that has been focused on properly defining this phrase speaks to its fundamental importance to the MLR definition. Rather than covering well-trod ground, I lend my support to the sentiments well stated by my colleague Mary Jo Hudson, Director of the Ohio Department of Insurance, in her memo dated May 6, 2010. (Attached)

In her letter, Director Hudson cogently set forth the underlying goals that Congress sought to achieve by incorporating MLR requirements in the PPACA and the need to include expenditures that can be demonstrated to improve health care quality (through effective tracking, measuring and assessment) within the definition of MLR.

Thank you for the opportunity to provide you with these comments.

Attachment
MEMORANDUM

To: Lou Felice, Chair, Health Reform Solvency Impact (E) Subgroup
    Steve Ostlund, Chair, Accident & Health Working Group

From: Mary Jo Hudson, Director, Ohio Department of Insurance

Date: May 6, 2010

Re: MLR Calculation

Thank you for the work of the Health Reform Solvency Impact Sub Group and the Accident and Health Actuarial Working Group in developing a MLR standard that will be recommended to HHS. I want to comment on the term “activities to improve health care quality” and propose a specific definition for that term.

The Purpose of the New MLR Requirement

In thinking about the Working Groups' approach to developing an MLR definition, the following goals of health care reform should be kept in mind.

First, the decision of Congress to include health care quality improvement activities in the MLR was an incentive for carriers to move the current, fee-for-service driven health care system to one that invests in performance and outcomes, leading to greater value for dollars spent, improved efficiency, and better health. Ultimately, unless health care costs are better contained through strategies to improve health care quality, coverage expansions will be unsustainable over time.

Second, the MLR standards established by Congress are an attempt to limit administrative costs associated with providing health insurance coverage. Therefore, in applying the new MLR standards, we as regulators must ensure that only verifiable (auditable) expenses for legitimate health care quality improvement activities are included in the MLR calculation.

The task of the Working Groups to define “activities to improve health care quality” largely involves the development of an approach to meet these two goals. This will require insurance regulators to coordinate their review of financial information with health care quality standards and measures. This can be accomplished by drafting the MLR definition of “activities to improve health care quality” in coordination with national quality reporting and performance measures that will be applied to those same activities.
Principles To Consider

The Working Group should consider the following concepts in developing a definition for "activities to improve health care quality":

1. Health care quality improvement expenses should be reported on the MLR exhibit in the annual statement blank in sufficient detail to allow comparisons to quality reporting measures developed by HHS under Section 2717 of the PPAACA. This Section requires HHS to consult with health care quality experts and stakeholders in developing health plan reporting requirements related to quality improvement. Quality improvement activities on the MLR exhibit in the annual statement blank should be reported on separate lines consistent with those listed in Section 2717 as follows:

- effective case management;
- care coordination;
- chronic disease management;
- medication and care compliance initiatives;
- prevention of hospital readmissions;
- activities to improve patient safety and reduce medical errors by using best clinical practices,
- activities to encourage evidence based medicine,
- health information technology; and
- wellness and health promotion activities.

Beyond these categories listed in the statute, separate categories should be provided for all activities for which HHS develops separate quality reporting requirements through regulation.

2. If an activity proves to be ineffective at improving health care quality, the related expenses should not be included in MLR. Plans should be given a limited period of time (3-5 years) before the quality improvement components of MLR are assessed and compared to health care quality performance measures and outcomes.

3. Health information technology (HIT) investments should be allowed as MLR expenses if they meet criteria established by the Office of National Coordinator within HHS. The economic stimulus package (ARRA) passed by Congress included federal funding for the widespread adoption of an HIT infrastructure and implementation of electronic health records to improve our nation's health care system. To carry out this national goal, the Office of National Coordinator will establish national standards that all HIT systems must meet. The MLR definition must be consistent with this national priority to support the adoption of HIT to improve the quality and efficiency of our health care system.

4. Health care quality improvement activities should be allowed if they are in accordance with nationally recognized standards and certification and accrediting bodies.
5. The definition should include specific examples of quality improvement expenses that may qualify as an MLR expense.

**Ohio's Proposed Definition**

With these principles in mind, the Ohio Department of Insurance proposes the following definition:

"Activities to improve health care quality" shall include those activities identified in Section 2717 of the PPAACA, other activities for which HHS has established quality reporting requirements in accordance with Section 2717, and activities generally recognized by national standards or accrediting or certification bodies as improving health care quality and outcomes. These activities may include:

1. effective case management;
2. care coordination;
3. chronic disease management;
4. medication and care compliance initiatives;
5. prevention of hospital readmissions;
6. activities to improve patient safety and reduce medical errors by using best clinical practices;
7. activities to encourage evidence based medicine;
8. health information technology; and
9. wellness and health promotion activities.

An activity to improve health care quality must be tracked, measured and assessed to determine if it is effective at improving health care quality. If an activity is determined not to be effective, it should not be included as an MLR expense.

Health information technology investments are allowed as MLR expenses if they meet certification standards and programs to be established by the Office of National Coordinator within HHS, which will include meaningful use and the CORE II standards. Once a health information technology system has been adopted and is operational, the ongoing maintenance of that system should not be included as an MLR expense.

Examples of the type of expenses that could qualify as "activities to improve health care quality" include the following:

1. PMPM care management fees (fees paid to providers for care management and other services related to medical / primary care homes);
2. Maternity management programs;
3. Chronic disease management (vendor contracts and/or internal staff);

4. Programs to reduce avoidable hospital readmissions;

5. Medication management (could include reimbursement to pharmacists for medication management; can be linked to medical homes);

6. Patient safety (incentives and programs to increase patient safety in health care facilities and offices);

7. Medical errors (incentives and programs to reduce medical errors);

8. Increased reimbursement for primary care providers including nurse practitioners;

9. HIT investment (to implement medical homes, improve information sharing and coordination of care, reduce duplication of tests and services, reduce gaps in care);

10. Patient compliance (reimbursement to health care workers or for systems that assist patients and assure compliance with treatment plans and medications); and

11. Wellness and health promotion (wellness assessments; nurse hotlines; could include fitness center memberships for members; healthy lifestyle improvement programs including health coaching; preventive care reminders and follow up; incentives for members related to physical activity; obesity reduction; tobacco prevention and cessation)
June 28, 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. (Post-June 24th Health Care Solvency Impact E Subgroup Call)

VIA ELECTRONIC MAIL

Dear Mr. Felice:

Your Consumer Representatives to the NAIC, representing millions of patients, consumers and workers, are writing to follow-up with you in writing after the June 24th call to provide our comments and recommendation regarding the proposed and alternative language for Improving Health Care Quality Expenses distributed at the June 24th conference call. We would also like to reiterate our positions on several other provisions discussed during the call including Sections 1311 and 1301, definitional issues around the use of specific populations, the removal of the Secretary’s discretion to define “other expenses”, and continuing concerns regarding the broad inclusion of ICD-10 expenses. These comments are in addition to and complement the comments we offered on June 17th and June 14th on the 2010 NAIC Life and Accident & Health Blank June 10, 2010 Discussion Draft (NAIC Blank) and our first comment letter dated May 20, 2010. At your request, we are also attaching an additional document to this comment letter that offers specific edits in the current discussion draft.

Supplemental Health Care Exhibit – PART 3 Improving Health Care Quality Expenses – General Definition

Loss Adjusted Expenses
We continue to support the position that both the Health Reform Solvency Impact (E) Subgroup and the PPACA Actuarial Subgroup of the AHWG (IRD001) have adopted that loss adjustment expenses are not included in the 2718(b) rebate formula. This position is based on the plain language of the statute, which requires the disclosure of loss adjustment expenses under 2718(a), but does not include them in the rebate formula in 2718(b). This is only one of several differences between the 2718(a) disclosure formulas and the 2718(b) rebate formula.

Agent/Broker Commissions
Congress intended agent/broker commissions to be counted as administrative costs for purposes of the MLR. Section 1301(a)(1)(C)(iii) of PPACA, states that the issuer of a qualified health plan must agree “to charge the same premium rate for each qualified
health plan of the issuer without regard to whether the plan is offered through an 
Exchange or whether the plan is offered directly from the issuer or through an agent.” 
Obviously Congress understood that agent/broker commissions were part of the premium 
rate charged by health insurers. We support the Subgroup in maintaining this position.

**Sections 1311 and 3011**

We continue to support exclusion of Section 3011 from General Definition of Improving 
Health Care Quality Expenses. The Solvency Impact Subgroup has properly focused on 
section 2717 as the primary provision of PPACA dealing with the responsibilities of 
health plans for quality of care. Section 1311(g) addresses the payment strategies that 
qualified health plans are encouraged to pursue to improve quality lists similar quality of 
care factors and could also be seen as relevant to 2718. Section 3011, however, addresses 
a much broader topic, “a national strategy to improve the delivery of health care services, 
patient health outcomes, and population health,” and is not relevant to 2718, which only 
considers “activities [of insurers] that improve health care quality.

**Specific Populations**

We continue to be generally supportive of the addition of specified populations and 
appreciate the concerns expressed regarding an adequate definition of specified 
populations that is attributable back to the enrollees in the specific health plan. Further 
development of a standard definition or methodology and rationale that could be used by 
all insurers to demonstrate the value of including the health care initiatives involving 
specified populations and individuals that are not enrolled in the health plan as an 
allowable expense would be useful to insurers, consumers and regulators. It would also 
provide more transparency about the programs and their value as partnerships with 
employers, providers, hospitals, community programs or state health initiatives.

We believe that it is not reasonable to expect the individual, small and large employer 
fully insured plans to cover all the costs of ‘community benefit” activities for specified 
populations. Self-funded health plans that contract with carriers through administrative 
services only (ASO) contracts are not included in the MLR calculation. The insurer’s 
self-funded plans should cover their fair share of the cost of “community benefit” 
activities, too. If these activities are going to be allowable expenses, the fully insured 
plans should only cover their fair share of the expenses.

Therefore, we support retaining the existing language, but would like to propose the 
modifications included in the attached document to assure that the expenses related to 
individuals and populations that are not enrollees of the insurance plan are fairly 
allocated across the carrier’s entire covered lives. We also want to stress the importance 
of making QI information available to consumers and the general public to provide 
transparency and ensure that these expenses are ultimately benefiting individual enrollees 
and/or segments of the enrolled population.

**Role of the Secretary of Health and Human Services**

While we believe the current definition provides more transparency and accountability 
for Health Care Quality expenses than previous iterations, we continue to believe that is 
essential to retain an appropriate oversight role of the HHS Secretary in certifying the QI
activities. We recognize and appreciate the concerns expressed regarding HHS’s resources to implement this requirement and the potential for the certification process becoming either a rubber stamp or causing a log jam in the approval of legitimate innovative new programs. One of the goals of the law is to be able to compare the quality activities to promote health outcomes, improve patient safety and reduce medical errors. The HHS Secretary can use the expense information and outcomes generated by the process of certifying quality health care activities to compare the performance and value of the insurance coverage provided by the various insurers. We continue to believe the HHS Secretary’s responsibilities play a key role in protecting consumers.

So while we remain open to recommendations that could streamline the certification process or give “deem” status to activities that have been approved by the Secretary for one insurer in the event that another insurer wants to implement the same activity, we would strongly recommend retaining the Secretary’s authority in this section and encourage additional dialogue between the NAIC and HHS to ascertain the appropriate role for the Secretary, the NAIC and state insurance commissioners. We also continue to be concerned about the impact of a diminished standard on what is required to demonstrate quality improvement and the lack of public notice and transparency with regard to the process to make these determinations.

**ICD-10 Expenses**
We continue to believe that all costs directly relating to ICD-10 should be considered an administrative expense. We acknowledge that ICD-10 includes standardization of certain clinical codes and clinical values that will facilitate better tracking and reporting of clinical information in the patient’s electronic medical record and important metrics such as outcomes, severity, medical complications and safety issues. And while these metrics are important to monitor and evaluate quality initiatives, the primary purpose of ICD-10-CM and ICD-10-PCS remains claims processing which is a core competency of an insurer. So unless there is an objective means and formula to attribute a portion of these expenses to be considered quality improvement (which we are not aware of), we continue to recommend all ICD-10 costs be defined as administrative expenses.

**Accreditation Expenses**
General accreditation expenses, and all Quality Assurance (QA) program costs, should be considered administrative costs. We believe that 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 considered. Health plans have and we believe will continue to seek accreditation to secure a competitive advantage in the marketplace and to meet state quality regulations that are required as a condition of licensure. We do, however, continue to support the inclusion of distinct QI activities that may be a part of the accreditation process as long as they meet the established definitions.

**Attribution of Cost Containment Expenses**
Finally, we want to vigorously reinforce and stress our previous comments that costs associated with cost containment and cost control initiatives must be excluded. We envision great definitional difficulties with determining what are “primarily attributable”
and “solely attributable” costs and perhaps more convincingly, the tremendous practical challenge of uniformly interpreting and enforcing any definition that attempts to objectively segment and quantify a subset of cost containment expenses that may arguably have some downstream impact on quality of care.

We appreciate this opportunity to submit additional comments after the June 24th call and look forward to the continued opportunity to be actively engaged in the deliberations of the Health Reform Solvency Impact (E) Subgroup this week as you work to finalize the Blank instructions. If you have any questions, please contact Timothy Jost at JostT@wlu.edu or Mark Schoeberl at mark.schoebel@heart.org.

Sincerely,

Mark Schoeberl
Timothy Jost
Wendell Potter
Stephen Finan
Part A of this exhibit is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for the Individual, Small Group and Large Group amounts. Part B of this exhibit is intended to show the amount of qualifying HIT expenses, reported separately for the Individual, Small Group and Large Group amounts, broken down into the four categories of Quality Improvement expenses (see below); similarly, the Other than HIT qualifying Quality Improvement expenses are disclosed for each of the four categories of Quality Improvement expenses. The definitions of Individual, Small Group and Large Group are found in the instructions for Parts 1 and 2 of this supplement exhibit.

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), for health services that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and which produce verifiable results and achievements. The expenses must be directed toward for individual enrollees or costs may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage. Non-enrolled specified populations may include potential enrollees; a definable community reached by essential community providers and/or public health entities, or the general public. The portion of the carrier’s expenses for developing and implementing activities that benefit common non-enrolled populations shall be prorated between the fully insured and self-funded business of the carrier.

Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, and improvement must be capable of being objectively measured and produce verifiable results and achievements. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- 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;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes.

To ensure that expenses are being objectively measured and achieving verifiable quality improvement for enrollees or segments of enrollees, a detailed description of these metrics and results must be included in the supplemental filing made by the insurer providing descriptions of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. This information shall be released annually and available to consumers and the general public at any time upon request.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.
PARTS 3A and 3B

COLUMNS:

Expense Allocation: A separate, regulator only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. Additionally, companies reporting QI expenses in columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. For a new initiative that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an “X” in the “New” column of the supplement and include in the detailed description the QI activity including rationale, expected timeframe for the activity to accomplish, and the objective, verifiable healthcare quality improvement to be achieved and metrics that will measure results. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes. As part of this review for adherence, these metrics and results must be included in subsequent filing made by the insurer and available to consumers, organizations representing consumers and the general public.

The following items are broadly excluded as not meeting the criteria of this section:
- 24 Hour Medical Professional Hotlines (except as noted above);
- Utilization Review;
- Fraud Prevention activities;
- Network Management;
- Provider Contracting;
- Accreditation Fees [Available for comments];
- Costs associated with calculating and administering individual enrollee or employee incentives. This includes rewards or bonuses associated with wellness or health promotion programs (e.g., reductions in individual enrollee or group health plan copays, deductibles or premiums based on achieving specified health outcomes or engaging in specified health promotion activities); and
- Any function not expressly included in Columns 1 through 5.

[see NAIC Consumer letter dated June 28th, 2010 for additional comments on alternative approach]
June 28, 2010

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

Mr. Steven Ostlund
Chair, Accident & Health Working Group

c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Dear Mr. Felice, Mr. Ostlund, and Subgroup Members:

I am the President and CEO of Roadrunner Food Bank, the largest private sector distributor of food in the state of New Mexico. For many years we have received support for our work from Blue Cross Blue Shield New Mexico. This support has allowed us to distribute millions of pounds of healthy nutritious food to make a positive difference in the lives of tens of thousands of our neighbors who would otherwise suffer from the many deleterious effects of malnutrition. In 2009 alone we distributed more than 20 million pounds of food to reach families in need. Blue Cross Blue Shield has been particularly helpful in funding the initial stages of our new Mobile Food Pantries. These deliveries now take millions of pounds of food into hard hit rural communities and into urban neighborhoods where the increased need from the recession has completely swamped the existing resources.

I am writing to urge the National Association of Insurance Commissioners (NAIC) to weigh the value of community-based donations strongly in your deliberations and ultimate recommendations to the Department of Health and Human Services. In these times of government cutbacks and deficits, contributions from the private sector, like the ones we receive from Blue Cross Blue Shield New Mexico, are vital in the critical fight against malnutrition that we face every day. Without such help we will undoubtedly face more health problems created by the lack of an adequate diet.

Thank you for your consideration.

Sincerely,

Melody Wattenbarger
President and CEO
June 25, 2010

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

Mr. Steven Ostlund  
Chair, Accident & Health Working Group

National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, Missouri 64108-2662

Re: Calculation of Medical Loss Ratio Recommendations

Dear Mr. Felice, Mr. Ostlund, and Subgroup members:

I am writing on behalf of Samaritan Counseling Center in Albuquerque, New Mexico. I am currently the Director of Quality Outcomes, but will assume the position of President and CEO on July 1, 2010. Samaritan has a staff of 21 licensed behavioral health providers and seven professional staff that provide prevention, education, consultation and related services to the community.

I am writing to urge the National Association of Insurance Commissioners (NAIC) to consider and recommend to the Department of Health and Human Services (HHS) a definition of medical loss ratio (MLR) that will encourage health plans to continue their tremendous support of community-based health initiatives and programs.

The membership of NAIC is state-based and so should understand well the important contributions that local organizations make to the overall health of communities and populations. I want to make sure that health insurers will continue their critical participation in these efforts.

Three years ago, Samaritan received a grant from an insurance company in the community that enabled us to expand, and more importantly, provide much more accessible behavioral health services to the traditionally underserved population in Southeast Albuquerque. So we are very familiar and supportive of continuing effective contributions to develop and enhance services. We know how important this is.
It is my understanding that if the definitions around MLR are too narrow, health insurers will not be encouraged to support community-based health initiatives and could, in fact, be penalized for such support if their contributions are counted as administrative expenses. Penalizing support of my organization’s program and similar community-based programs across the nation would not be wise public policy.

I strongly urge the NAIC to recommend to HHS that for the purpose of calculating MLR, quality initiatives include health insurers’ involvement and investments in public health initiatives.

We further recommend two things:

1) That the future contributions are clearly and specifically targeted to enhance accessibility to services for health care consumers, and
2) That behavioral health services are specifically included in the targets for receiving these funds. Unfortunately, behavioral health services sometimes receive a smaller proportional share of funds in these types of projects, despite the ever increasing need for these services.

Thank you for consideration on this important issue.

Sincerely,

Thomas K. Sims, Ph.D.
Director of Quality Outcomes
Samaritan Counseling Center
Albuquerque, New Mexico
June 28, 2010

Mr. Lou Felice
Chair, Health Care Solvency Impact Subgroup

Dear Mr. Felice:

Thank you for the opportunity to comment on the latest draft of the Blanks form. Using the present structure of the Blanks for QI activities, we have provided some red-line suggestions. In addition to these comments, we continue to believe, as we noted in our last set of comments on June 14, 2010, that the present formulations of QI do not address the full range of quality activities engaged in by payors. We urge you to consider re-working the present draft and use the accepted definitions of quality developed by the Institute of Medicine ("IOM"), the National Priority Partnership ("NPP") and other collaborative organizations (including those supported by Health and Human Services) who have considered how to drive system transformation. Those organizations have affirmed the role of the payor in driving change and in ways not recognized by the present draft. As a matter of framework, we suggest:

- The replacement of the present definitional elements as expressed by the Columns with the six standards developed by IOM (safety; timeliness; efficiency; effectiveness; equitable care and patient-centered care).

- The use of the NPP elements to help flesh out and define the IOM standards through examples of consumer engagement with education; improving population health; coordinating care of patients; patient safety; managing appropriate use and over-use of services and enhancing care and outcomes in life-limiting illnesses.

- The use of some of the present Columns as further examples.

The following are a few examples of important quality efforts not recognized by the present Blanks but which are consistent with IOM and NPP's standards. We have not edited the Blanks to address these topics in as fulsome a way as would be warranted if IOM and NPP standards were employed.

- **Equitable care.** Addressing disparity in care between different populations (such as race, ethnicity, language, gender) is not only a health issue, it is ultimately a pressing social issue. The present Blanks do not address this issue.

- **Efficiency.** Elimination of over-use and waste is included in the IOM’s six aims of quality. Preventing hospital readmissions is absolutely essential, but represents but one example of the overall goal of eliminating over-use and waste. In addition to the IOM, the NPP and the NCQA accreditation programs address the need to eliminate over-use, mis-use and under-use of services. Furthermore, effective UM/UR programs are explicitly intended to address improvement in health outcomes and reduce unnecessary costs. Any reduction in hospitalization rates, potentially avoidable hospitalizations, lengths of stay in hospitals and readmission rates are all correlated with increases in quality. Medical research has documented a 6% daily complication rate during hospitalization, regardless of diagnosis or procedure.
• **Fraud and abuse.** If, in fact, efficiency and appropriate use are legitimate aims of quality, which the IOM, the NCQA, and the NPP all contend, then fraud prevention are legitimate services required to improve quality. For example, duplicate or extraneous services and operations represent an adverse impact on the quality of patients, and that can be detected through fraud prevention programs.

• **Network Activities.** In pay for performance and other performance-based contracting programs, quality measures are an essential component of the reimbursement model – and changing the reimbursement model has been recognized as an essential quality effort that can transform the system by eliminating waste. Improving quality and managing costs are an explicit objective of network contracting. Moreover, credentialing is a program wholly dedicated to quality, including review and confirmation of professional training and experience, review of any adverse judgments or determinations made against a provider, and monitoring of any corrective action plans.

• **Measurement.** There are many appropriate programs that may not produce verifiable results. For example, there are many examples of wellness programs and care management programs, such as smoking cessation, weight management, immunization campaigns, diabetes prevention, or other chronic disease management programs, which may not produce desired results, but, nonetheless, are integral to a health care quality improvement program. Additionally, requiring measurement presents the inevitable problems of the period, the metrics at issue, the ability to detect change, the measurement standard and of stifling innovation. If by measurement the concern sought to be addressed is the validity of the program, that issue would seem to be already addressed by QI definition's requirement that the programs be grounded in the best medical evidence.

We believe that if the driving aim of PPACA is to drive quality care at a lower price the IOM and NPP standards (and the full role of the payor in those efforts) needs to be embraced.

Sincerely,

[Signature]

Thomas J. McGuire  
Senior Deputy General Counsel

**ALTERNATIVE APPROACH FOR HANDLING OTHER QI EXPENSES**

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), for health services that are designed to improve health care quality and increase the likelihood of desired health outcomes, in ways that are capable of being objectively measured and which produce verifiable results and achievements. These expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional...
medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost(s), and the improvement must be capable of being objectively measured and produce verifiable results and achievements. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Eliminate overuse and waste while ensuring delivery of appropriate care, including preventing hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;
- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

PARTS 3A and 3B

COLUMNS:

Column 1 – Improve Health Outcomes

Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined above. This category can include costs for associated activities such as:

- Effective case management, Care coordination, and Chronic Disease Management, including:
  - Patient centered intervention such as:
    - Making/verifying appointments,
    - Medication and care compliance initiatives,
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center), and
    - Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;
Incorporating feedback from the insured to effectively monitor compliance;

Providing coaching to encourage compliance with evidence based medicine;

Activities to identify and encourage evidence based medicine, including enrollee, physician and hospital engagement programs;

Use of the medical homes model as defined for purposes of section 3602 of PPACA; and

Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;

- Centers of Excellence programs;
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
- Quality reporting and documentation of care;
- Peer review and quality of care reviews;
- 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,
  - Performance measurement to identify and help close any gaps in quality of care and appropriate use of services; 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

- Quality improvement programs to assure appropriate systems, processes, and outcomes are implemented and to ensure continuous compliance, review, measurement and improvement of all clinical management programs.

Column 2 - Activities to eliminate overuse and waste while ensuring delivery of appropriate care, including preventing hospital readmissions

Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions as defined above, including:

- Pre-service review and authorization to assess appropriateness of diagnostic or treatment services, based on scientific evidence and subscriber agreements;
- Comprehensive concurrent hospital review to ensure care treatment plans are consistent with clinical guidelines and effectuated expeditiously, as well as to mitigate hospital-acquired conditions;
• Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
• Post discharge reinforcement of care instructions by an appropriate health care professional; and
• Health information technology expenses to support these activities (report in Column 5 – see instructions) including,
  o Data extraction, analysis and transmission in support of the activities described above, and
  o Performance measurement to identify and help close any gaps in quality of care and ensure appropriate use of services; and
  o 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
• Activities to identify and encourage evidence based medicine, including enrollee, physician and hospital engagement programs;
• Assessment of emerging medical technology to ensure that consumers have access to credible and appropriate services;
• Development of medical policies to ensure coverage for appropriate services;
• Payment accuracy programs, including detection and management of fraud and abuse, as well as coordination of benefits, subrogation, claim coding management programs, etc.

Column 3 – Improve Patient Safety and Reduce Medical Errors
Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:
• The appropriate identification and use of best clinical practices to avoid long term harm;
• Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;
• Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
• Post discharge reinforcement of care instructions by an appropriate health care professional; and
• Activities to identify and encourage evidence based medicine, including enrollee, physician and hospital engagement programs:
Activities to lower risk of facility acquired infections;

Column 4 – Wellness & Health Promotion Activities
Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition; and
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); or

Column 5 – HIT Expenses for Health Care Quality Improvements
The PPACA also contemplates “Health Information Technology” as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information in the following ways:

1. Measuring and monitoring of utilization, cost, and quality data on a real-time basis to ensure appropriate use of services, comportment with evidence-based medicine and clinical guidelines, as well as alignment with benefit designs;
2. Measuring and monitoring of performance assessment of physicians and hospitals and other care providers, in order to assess quality and cost results, including hospital readmissions and potentially preventable conditions, so that continuous improvement can be managed;
3. Development of Electronic Medical Records and Personal Health Records, in order to improve health outcomes and eliminate over-use of inappropriate use of services—e.g., e-prescribing programs to reduce adverse drug events, or drug-drug interactions, or selection of cost-effective choices for patients;
4. Development of HIT programs to comply with “meaningful use criteria” established by the Office of the National Coordinator (ONC) in HIT, including clinical decision support, longitudinal patient registries, and appropriate use criteria;
5. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or
URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;

6.2—Advancing the ability of enrollees, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include Personal Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient’s medical history;

7.3—Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes; or

8.4—Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements).

Expense Allocation: A separate, regulator only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. Additionally, companies reporting QI expenses in columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. For a new initiative that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an “N” in the “New” column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable healthcare quality improvement. For the QI portion of each item generally excluded listed below, such as 24 Hour Medical Professional Hotlines and Utilization Review, include a separate description and include an “E” in the “New” column of the supplement. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.
Note: 24 Hour Medical Professional Hotlines: Expenses for 24 medical professional
nurse hotlines should be included in Improve Health Outcomes,
Activities to Prevent Hospital Readmissions, Improve Patient Safety
and Reduce Medical Errors, and Wellness & Health Promotion
Activities. Any other expenses for 24 hour medical professional
hotlines (e.g., answering member questions) should be excluded
from Improving Health Care Quality Expenses and instead included
in Claims Adjustment Expenses.

Elements of the following items are excluded to the extent they do not meet the General
Definition of Quality Improvement expenses set forth above and are designed solely or
primarily to control or contain costs. The burden shall be on the proponent to show that
the expenses for the programs conform to the definition (and this must be included in the
description of the separate, supplemental filing described above). Please See Comment
Letter

- 24 Hour Medical Professional Hotlines (except as noted above);
- Utilization Review [4] (all retrospective and concurrent review is
excluded from QI); [Comments will be taken on concurrent U/R
activities]
- Fraud Prevention activities (all activities related to recoupment of
fraudulent payments are excluded – only expenses that can be directly
tied to Column 3, Improve Patient Safety and Reduce Medical Errors,
expenditures may be included in QI);
- Network Management (all fees and expenses related to establishing or
maintaining the network are excluded from QI);
- [5] Provider Contracting and Credentialing (the cost of developing and
executing provider contracts would be excluded [6]);
- Accreditation Fees (under Subgroup 6 [7]);
- Costs associated with calculating and administering individual enrollee
or employee incentives. (rewards or bonuses associated with wellness or
health promotion programs are excluded) The e.g., reductions in
individual enrollee or group health plan copays, deductibles or
premiums based on achieving specified health outcomes or engaging in
specified health promotion activities) [if clarifications need to be made;
submit suggested language], and
- Any function not expressly included in Columns 1 through 5.
June 28, 2010

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

Subject: Specific language recommendations providing that Value-Based Insurance Design is a quality improvement measure in Supplemental Healthcare Exhibit – Part 3

Dear Mr. Felice,

Thank you for your leadership in ensuring that the regulations implementing the Patient Protection and Accountable Care Act (PPACA) advance quality improvement initiatives to improve health outcomes. We write today to demonstrate that value-based insurance design (VBID), an innovative approach to benefit design that aligns incentives to promote patient health, is widely regarded as a quality improvement initiative, and to share with you specific language clarifying this aim. Prior to the NAIC call on June 24, we sent a letter containing general comments noting that VBID is a quality of care initiative that should be explicitly included in the numerator calculation of the MLR definition. Following the discussion of changes to Supplemental Healthcare Exhibit – Part 3, we now respond to your request for specific language as provided below.

VBID plans reduce or eliminate financial barriers to the purchase of “high-value” drugs or services in order to increase patient compliance and improve health outcomes. This quality enhancing approach to benefit design was recognized in the recent health reform legislation. Section 2713(c) of the PPACA explicitly permits the Secretary of Health and Human Services to develop guidelines for the use of value-based insurance design in advancing preventive care; VBID language was included in every version of the legislation throughout the legislative process. Numerous other sections of the law reference its principles as well. In addition, Senators Stabenow (D-MI) and Hutchison (R-TX) have introduced legislation (S. 1040) to establish a demonstration program requiring the utilization of VBID in order to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected medications can increase adherence to prescribed medication. Value-based insurance design is widely regarded among Members of Congress and their staff as a quality improvement measure directly related to better health outcomes.
As insurers are the point of coordination and customization for individual member benefits to implement VBID, we believe the MLR rules must not discourage insurers from investing in and implementing these applications to benefit members/consumers. As a result, we strongly assert that VBID should be included in the numerator of the MLR calculation. To that end, we believe that the language (as currently edited) in Column 5 under the exceptions list (on page 18), is contrary to the goal of improved health outcomes and the language in and intent of the PPACA. We urge you to delete this language in the Blanks Document:

“Costs associated with calculating and administering individual enrollee or employee incentives. This includes rewards or bonuses associated with wellness or health promotion programs (e.g., reductions in individual enrollee or group health plan copays, deductibles or premiums based on achieving specified health outcomes or engaging in specified health promotion activities);”

In its place, we believe this language explicitly allowing VBID should be added to the bulleted list in Column 1 on page 15:

“Expenses associated with the implementation and deployment of value-based insurance designs, including incentives and rewards for high-value health activities;”

**Supporting Details for VBID Recommendation**

In addition to the bipartisan support for VBID as a quality improvement mechanism noted above, extensive research conducted by academics at the University of Michigan Center for Value-Based Insurance Design, Harvard Medical School, and other institutions overwhelmingly supports the premise that VBID should be considered a quality improvement initiative and demonstrates that VBID contributes to the improvement of health outcomes. As you are likely aware, most common measures of quality focus on the use of services demonstrated by clinical research to improve health. For example, the Health Care Effectiveness Data and Information Set (HEDIS) is among the most widely accepted quality measurement systems and is founded on measurement of utilization of certain high value services. These include a wide range of services such as cancer screening services (e.g., mammography) and prescription drugs designed to improve management of chronic disease (e.g., diabetes and heart disease).

The published academic evidence is very clear that charging patients more for such services reduces their use. For example, research suggests that higher cost sharing will reduce quality as measured by HEDIS.\(^1\)

More specifically, researchers have documented that:

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\(^1\) Chernew and Gibson. *Med Care Res Rev*. 2008;65:713
Mammography is reduced following increases in copayment rates.\(^2\)

Relatively modest increases in cost sharing reduces utilization of important medications for managing chronic disease.\(^3\)

A doubling of copayments reduced use of anti-diabetes medications by patients with diabetes by 23% and reduced use of anti-hypertension medications by patients with hypertension by 10%.\(^3\)

When an employer increased cost sharing requirements by about $10 to $20 per prescription (depending on the exact medication), 21% of patients stopped taking their medication for high cholesterol (compared to 11% in a control group).\(^4\)

Higher cost sharing for prescription drugs had worse physiological outcomes (e.g. blood pressure), more visits to the emergency room, and even greater mortality.\(^5\)

Increases in cost sharing for ambulatory physician visits led to increased hospitalizations.\(^6\)

Equally worrying is that the impact of high copayments is concentrated on low income populations, and therefore worsening health care disparities.\(^7\)

As noted above, value-based insurance design, which entails reducing copayments for such high value services, is demonstrated to have the opposite effect - improving quality. For example, evidence suggests that reduction in copayments of about $10 per prescription increased patient adherence to treatment regimes for chronic disease.\(^8\) Recent reviews of the literature confirm these conclusions. Moreover, while research has not demonstrated this yet, it is likely that VBID can reduce health disparities.

Important industry stakeholders have confirmed the importance of VBID as a quality improving strategy. For example, in 2007, a VBID program adopted at the University of Michigan was awarded a Driving Value in HealthCare award by the National Business Coalition on Health, The Leapfrog Group and Bridges to Excellence. This award recognized the important role that VBID plays in promoting high quality care.

We are deeply concerned that the proposed language will discourage, and perhaps prevent insurers from adopting VBID programs that will improve the quality of care and reduce disparities. We believe that insurers interested in promoting the use of such valuable services as mammograms and chronic disease medications should not be discouraged from doing so. As the health care system moves forward and strives to address both cost and quality, programs such as VBID will be increasingly important to ensure that quality does not suffer.

Thank you for your attention to this matter. Please contact us if you require any additional


information.

Sincerely,

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Center for Value Based Insurance Design
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cc: Kathleen Sebelius, Secretary, Department of Health and Human Services
Richard Kronick, Deputy Assistant Secretary for Health Policy, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services
Steve Larsen, Deputy Director for Oversight, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services
We appreciate the Alternative language introduced at the subgroup’s meeting on June 24, 2010, and the opportunity to comment upon the draft currently exposed for comment. Overall, we are pleased that the Alternative would give health insurers the opportunity to demonstrate that certain aspects of previously-excluded categories like Utilization Review and Anti-Fraud Programs do in fact meet the quality categories that the subgroup has already proposed. These initiatives drive quality in the health care system, and there is no doubt that if insurers ended these programs, overall quality would decline.

There are just a few suggestions we’d like to make at this time, and we are grateful for the subgroup’s consideration of our comments. (Most of the comments also pertain to language in the currently exposed Blanks instructions, and we note where that is the case.)

1. **Expense allocation: New Quality Initiatives** (in both in Alternative and exposed Blanks instructions)

We appreciate that we would be able to provide the expected timeframe for new quality initiatives to deliver results, particularly because with many quality initiatives, it sometimes does take several years before results can be shown.

However, we would like clarification of the “new initiatives” language, which states that

For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an “X” in the “New” column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable healthcare quality improvement.

From this language it is not clear whether, at the end of the expected timeframe, a new initiative would need to show actual improvement in health care quality. If no improvement in quality is shown, is the intent that the health insurer would then not be able to include those new initiative expenses as quality related costs? If that is the case, then few if any health insurers would begin new initiatives, because of the chance that those expenses would need to be reported as administrative expenses. Insurers should not be penalized for trying to improve the quality of their members’ health care in new ways, particularly when experts in the area of health care quality agree that initiatives hold promise.

It is important to understand that at times, quality initiatives do not deliver improvements in health care quality, despite high expectations that they would do so. Starting a quality program is not unlike engaging in clinical research: both start out with a hypothesis based upon prior medical research, and both attempt to prove the hypothesis. Sometimes those hypotheses are proven true; sometimes not. Both medical science and quality initiatives advance in testing those hypotheses.
We suggest the following revisions to this language, which is consistent with the language in the general quality definition:

For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an “X” in the “New” column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable results, healthcare quality improvement.

2. **Improve Patient Safety and Reduce Medical Errors** (in both Alternative and exposed Blanks proposal)

Recently the highlighted language below was added to two of the bullets in Column 3, Improve Patient Safety and Reduce Medical errors:

Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:

- The appropriate identification and use of best clinical practices to **avoid long term harm**;
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;

The reason for adding this language is unclear, but we believe it is unnecessary and ultimately confusing. It’s not necessary to modify “use of clinical practices” with “to avoid long term harm.” The lead-in to the bullet specifically says that the activity of using best clinical practices must improve patient safety and reduce medical errors. Additionally, “long term harm” is needlessly restrictive – the patient could also be exposed to short-term harm such as hospital acquired infections, respiratory failure, or even death.

The additional phrase “in addressing independently identified and documented clinical errors or safety concerns” is similarly misplaced. Currently there is no governmental agency or private entity that independently identifies and documents medical errors. At both federal and state levels, health care providers and facilities are responsible for identifying errors that occur in their practices and taking steps to avoid future errors. Federal law merely requires voluntary reporting of medical errors.¹ About half of the states require hospitals to report medical errors, with a large variance in the state’s actions after it receives such a report.² Again, it’s clear from the preceding language that

the activities to identify and encourage evidence based medicine must be to improve patient safety and reduce medical errors.

We thus suggest the following revision to that language:

Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:

- The appropriate identification and use of best clinical practices to avoid long term harm;
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;

3. **Wellness programs** (in both Alternative and exposed Blanks proposal)

We agree that it is important to include wellness programs in the quality definition. However, a health insurer’s costs of providing rewards to members who participate in wellness programs cannot be excluded; to do so would provide a great disincentive for health insurers to continue to offer their members wellness programs, which have been growing in popularity due to their success in improving health outcomes. We ask that the entire exclusion on wellness programs be omitted.

The federal HIPAA nondiscrimination regulations\(^3\), which include requirements for wellness programs, require that all participants in a wellness program be eligible to receive a reward once per year; a reward has to be made available to all similarly situated individuals; and the reward cannot be made contingent upon an individual meeting a health status goal. Example 2 in the HIPAA regulations shows how this is so:

**Example 2.** (i) **Facts.** A group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.

(ii) **Conclusion.** In this Example 2, the program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard or waive the cholesterol standard. . . . Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

PPACA codifies the HIPAA nondiscrimination wellness regulations in Section 1001, adding Section 2705 of the Public Health Service Act, but increases the amount of

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premium rebate that an insurer may provide to a wellness program participant as a reward for participating.

Failing to permit insurers to include, as a wellness/quality activity, their expenses incurred in awarding wellness program incentives will have a perverse effect -- it would penalize insurers for their enrollees who participate in wellness programs, by requiring insurers to include in administrative expenses costs incurred in awarding wellness program incentives. Ironically, it would then be more financially advantageous for insurers to discourage enrollees from participating in wellness programs, so they would not incur expenses for awarding the incentives. Simply put, calculating the incentives and rewards to program participants is integrally part and parcel of establishing and running wellness programs.

Congressional intent in PPACA is to strongly encourage health insurers to offer wellness programs. Congress felt so strongly about encouraging the inclusion of wellness programs in group health insurance plans that in PPACA it increased the premium discount for wellness program participants to 30%, with HHS given the discretion to increase it up to 50% in the future. By means of a demonstration project, before 2014 HHS intends to expand the benefits of wellness programs to the individual market. Permitting insurers to include some costs of wellness programs in the MLR calculation, while excluding other costs, will thwart this clearly articulated Congressional intent.

4. **Concurrent review** (in Alternative proposal only)

Many activities encompassed in “concurrent review” align very closely with the activities specified under Column 1, Improving Health Outcomes. In addition to case management, care coordination, and chronic disease management, concurrent review also includes the following activities which help promote the right care to patients at the right time at the right level of care, to improve health outcomes:

- Identifying and addressing gaps in care with patient
- Identifying and addressing transition of care issues
- Depression screening -- assessing patient for depression along with medical condition and referring to behavioral health resources
- Assessing and addressing educational, cultural, language barriers—providing language lines
- Assessing alcohol/substance abuse and referring to AODA providers
- Assisting patient with selecting a primary care physician and obtaining timely appointment
- Assisting hospital, physician, and patient with selecting a skilled nursing facility before hospital discharge
- Discussing with member and treating primary care doctor what the hospitalist\(^4\) recommended

\(^4\) A hospitalist is a physician who monitors patients while in the hospital, particularly if the patient’s treating physician does not have privileges at that particular hospital.
• Informing primary care doctor what our home health aide saw during in-home assessment
• Facilitating communication with school nurse with a child with special needs
• Referring patient to social worker, community resources, behavioral health, end of life resources
• Ensuring access to care—patient needs urgent specialist appointment
• Arranging transportation to health care providers
• Supporting Medical Home—supporting physician offices, as example, case management single point of contact
• Supporting coordinated behavioral health care
• Discussing with physician member care gaps (peer to peer UM physician reviewer)
• Educating member on condition, procedures, medications.
• Providing nutritional counseling (e.g., children with obesity, patients with diabetes or cancer)
• Guiding member to provider care comparison resources
• Giving provider feedback on treatment plan compared to evidence-based treatment guidelines
• Monitoring behavioral changes demonstrating that member is achieving goals
• Measuring improvement in functional status and impact on health
• Assessing patient for adverse signs and symptoms and communicating with attending physician
• Monitoring specialty pharmacy treatment and side-effects
• Assisting member in navigating complex health care system
• Avoiding delays in services, working staff at hospital/home health aide health care professionals
• Discharge planning with hospitals, home health, DME, physicians, to ensure no duplication of effort
• Promoting adherence to standard of medical care, evidence based guidelines
• Promoting member safety through of use of evidence based medical guidelines
• Identifying provider quality of care issues and reporting to appropriate entity
• Facilitating continuation of care when a member changes providers or health care plans
• Identifying child, elder, spouse abuse and reporting to appropriate entity
• Using data analytics to determine which members would benefit most from case management efforts to improve their quality

These initiatives drive quality in the health care system, and there is no doubt that if insurers ended these programs, overall quality would decline.

In sum, WellPoint thanks the Health Care Reform Solvency Impact subgroup for its continuing work on the definition of “activities that improve the quality of health care.”