

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 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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VIA EMAIL ONLY

June 23, 2010

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

Re: June 22, 2010 Draft of Supplemental Health Care Exhibit and Instructions Blanks
Agenda Submission Form from Health Reform Solvency Impact (E) Subgroup;
Health Care Quality Expenses

Dear Mr. Felice:

On behalf of our client, Healthways, Inc., we are submitting the enclosed comments on the Subgroup's June 22, 2010 draft of the Supplemental Health Care Exhibit and Instructions. Our comments are reflected in a redlined version of the applicable Instructions in the Part 3 section of the Instructions, which is attached to this letter, and relate exclusively to the current Health Care Quality Expenses Instructions (including the instructions for Lines 1.2, 2.2, 3.2-Outsourced Services) being developed by your Subgroup.

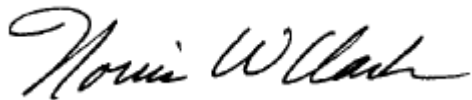
We realize that your Subgroup is in the final stages of drafting the Instructions and appreciate the diligence and progress you have made in crafting the definitions for Health Care Quality Expenses. We do, however, hope that you will consider the suggested revisions and comments in the enclosed redlined document, which relate primarily to clarifying that Health Care Quality services, as defined in the Instructions, may be delivered by outsourced suppliers (e.g., wellness and prevention plan managers and health, wellness or prevention services organizations, such entities specifically mentioned in Section 2717(b) of the PHS Act). We would hope that you would consider and adopt the revisions noted in the attached redlined version.

Lou Felice
June 23, 2010
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We look forward to further discussions with you on these matters on your June 24 Subgroup conference call.

Very truly yours,

LOCKE LORD BISSELL & LIDDELL LLP

A handwritten signature in black ink, appearing to read "Norris W. Clark". The signature is written in a cursive, flowing style.

Norris W. Clark

attachment

cc: Todd Sells, NAIC
Clay Richards, Esq.
Anne Wilkins
Bob Stone
Vicki Shepard
Shane Doucet
Denise Hanna, Esq.

SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3

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.

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 for individual enrollees or specified segments of enrollees that are designed to increase the likelihood of desired health outcomes, and that are grouped 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. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 [*Lou wants to review Sections 1311 and 3011, which were recommended for inclusion here*] PHSA; improvement must be capable of being objectively measured and produce results and achievements that can be verified to:

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

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

COLUMNS:

Column 1 – Improve Health Outcomes

Expenses for the ~~direct~~ interaction of the insurer, whether provided directly by the insurer or through an outsourced supplier engaged by the insurer, providers and the enrollee (e.g., face-to-face, telephonic, web-based interactions or other means of communication ~~between and among patients and their providers~~) to improve health outcomes for the ~~patient~~enrollee or for specified segments of enrollees under the plan or coverage. This category can include costs for associated activities such as:

- Effective case management (not just general 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;
 - 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;
- 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;
- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:

- Data extraction, analysis and transmission in support of the activities described above, and
- Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; and
- Other expenses for programs designed in ways that can be objectively measured and verified to increase the likelihood of desired health outcomes for individual enrollees or specified segments of enrollees that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the programs conform to the definition.

Column 2 – Activities to Prevent Hospital Readmission

Expenses for implementing activities for individual enrollees or specified segments of enrollees to prevent hospital readmissions, including:

- 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.
 - Data extraction, analysis and transmission in support of the activities described above, and
 - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; and
- Other expenses for programs designed to prevent hospital readmissions for individual enrollees or specified segments of enrollees that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the programs conform to the definition.

Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities for individual enrollees or specified segments of enrollees to improve patient safety and reduce medical errors under the patient’s plan or coverage through:

- The appropriate identification and use of best clinical practices;
- Activities to identify and encourage evidence based medicine;
- Activities to lower risk of facility acquired infections;
- Health information technology expenses to support these activities (report in Column 5 – See instructions), including:
 - Data extraction, analysis and transmission in support of the activities described above, and
 - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient’s care; or
- Other expenses for programs designed to improve patient safety or reduce medical errors for individual enrollees or specified segments of enrollees that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the programs conform to the definition.

Column 4 – Wellness & Health Promotion Activities

~~Programs~~ Expenses for programs for individual enrollees or specified segments of enrollees that provide interaction with the enrollee (e.g., face-to-face, telephonic or web-based interactions or other forms of communication ~~between and among patients and their providers~~) that promotes:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate members 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
- Health information technology expenses to support these activities (Report in Column 5 – See instructions).
- Other expenses for wellness and health promotion activities for individual enrollees or specified segments of enrollees that meet the General Definition of Quality Improvement above. The burden shall be on the proponent to show that the expenses for the programs conform to the definition.

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 patients for the electronic creation, maintenance, access, or exchange of health information in the following ways;

1. 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;
2. Advancing the ability of patients, 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 patients and appropriate providers to monitor and document an individual patient’s medical history;
3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes; or
4. Other expenses as may be approved by the Secretary in her or his discretion, in consultation with the NAIC, upon an adequate showing that the costs support the activities described in columns 1 through 4 or otherwise support monitoring, measuring, or reporting health care quality improvement. The burden shall be on the proponent to show that the expenses meet these criteria.

Exclude: Costs associated with maintaining a compliant claims adjudication system, including cost directly related to upgrades in HIT that are required to be made in order to comply with 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. (Discuss – Exclude as administrative or include as Fed requirement)

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 4 must include a detailed description of such expenses. 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 Nurse Hotlines: Expenses for 24 hour 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 nurse hotlines (e.g., answering member questions) should be excluded from Improving Health Care Quality Expenses and instead included in Claims Adjustment Expenses.

The following items are broadly excluded as not meeting the criteria of this section:

- 24 Hour Nurse Hotlines (except as noted above);
- Utilization Review;
- Fraud Prevention activities;
- Network Management;
- Provider Contracting;
- Accreditation Fees;
- 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.

LINES:

The Sections for Individual, Small Group and Large Group are defined as per the Individual, Small Group Employer and Large Group Employer columns in Parts 1 and 2 of this supplement.

For questions on definitions, refer to the instructions for the Annual Statement Expenses Schedule, i.e., the Underwriting and Investment Exhibit, Part 3 for P/C and Health, and Exhibit 2 for Life and Fraternal, for the line references provided below.

DIFFERENT FROM A/S EXPENSE REPORTING: for non-affiliated management agreements/outsourced services, report all amounts in the supplement's Line 1.2, 2.2 or 3.2 for Outsourced Services (not just those amounts less than 10% of total expenses). Continue to allocate all affiliated management agreements/outsourced services to the appropriate expense lines as if the costs had been borne directly by the insurer.

Lines 1.1, 2.1, 3.1- Salaries

Life/Fraternal:

Exhibit 2, Line 2 Salaries and wages
Exhibit 2, Line 3.11 Contributions for benefit plans for employees
Exhibit 2, Line 3.12 Contributions for benefit plans for agents
Exhibit 2, Line 3.21 Payments to employees under non-funded benefit plans
Exhibit 2, Line 3.22 Payments to agents under non-funded benefit plans
Exhibit 2, Line 3.31 Other employee welfare
Exhibit 2, Line 3.32 Other agent welfare

Health:

U&I Part 3, Line 2 Salaries, wages and other benefits

P/C:

U&I Part 3, Line 8.1 Salaries
U&I Part 3, Line 11 Directors' fees

Lines 1.2, 2.2, 3.2- Outsourced Services

Include: All non-affiliated expenses for administrative services, claim management services, new programming, membership services, and other similar services, regardless of amount. Thus, non-affiliated amounts greater than the 10% threshold that are reported in the various expense categories (e.g., salaries, rent) for A/S Expense Exhibit reporting will be backed out of the expense categories and reported in Outsourced Services in the Supplemental Health Care Exhibit, Part 3. In addition, the non-affiliated amounts less than the 10% threshold will be included in Outsourced Services (reported as follows in the A/S Expense Exhibit):

[\[Question: If an insurer contracts with a third-party vendor to provide Quality of Care services such as those, for example, delineated for Column 4 - Wellness & Health Promotion Activities, is it the intent of the Subgroup that the insurer would need to look through the services being provided and ONLY include "expenses for administrative services, claim management services, new programming, membership services, and other similar services" on lines 1.2, 2.2, & 3.2?\]](#)

[\[That intent would seem rather limiting, and we would think that if an insurer contracts with a third party to provide, for example, smoking cessation educational programs, the fees paid to the third party to provide the educational program would all be part of the outsourced services expense.\]](#)

Life/Fraternal:

Exhibit 2, Line 4.5 Expense of investigation and settlement of policy claims
Outsourced portion of Exhibit 2, Line 7.1 Agency expense allowance

Health:

U&I Part 3, Line 14 Outsourced services including EDP, claims, and other services

P/C:

Outsourced portion of U&I Part 3, Line 1.4 Net claim adjustment services
Outsourced portion of U&I Part 3, Line 2.8 Net commission/brokerage
Outsourced portion of U&I Part 3, Line 3 Allowances to manager and agents

Exclude: Services provided by affiliates under management agreements.