

Comments of WellPoint, Inc. to Alternative Quality language introduced 6/24/10

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

¹ Patient Safety and Quality Improvement Act of 2005. See <http://www.ahrq.gov/qual/psact.htm> (last visited 6/29/10).

² U.S. Department of Health and Human Services, Office of Inspector General, *Adverse Events in Hospitals: State Reporting Systems* (December 2008), found at: <http://www.oig.hhs.gov/oei/reports/oei-06-07-00471.pdf> (last accessed 6/29/10).

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 regulations³, 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

³ 29 CFR 2590.702(f); see Department of Labor Field Assistance Bulletin No. 2008-02 (February 14, 2008), found at: <http://www.dol.gov/ebsa/regs/fab2008-2.html> (last accessed 6/28/10).

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 hospitalist⁴ 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.”