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May 17, 2010

Mr. Lou Felice
Chair, Health Reform Solvency Impact (E) Subgroup
C/- New York Department of Insurance
25 Beaver Street
New York, New York 10004-2319

RE: *Health Reform Blanks Proposal – exposure May 12*

Dear Mr. Felice:

We write today on behalf of America's Health Insurance Plans (AHIP) to provide the Health Reform Solvency Impact (E) Subgroup with input and comments on the Subgroup's exposure of a new Blanks proposal relating to the reporting of Medial Loss Ratio information pursuant to sections 1001 and 10101 of the *Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010* (PPACA), *(Pub. L. 111-148) (referenced hereafter as PPACA Section 2718* for ease of reference*)*. AHIP is the nation's trade association representing nearly 1,300 member companies providing health, long-term care, dental, disability and supplemental coverages to more than 200 million Americans. We appreciate the opportunity to provide comments on this important project. AHIP is committed to the development and maintenance of a strong regulatory structure to oversee United States insurers, particularly those in the health sector.

PPACA Section 2718 tasks the NAIC with developing uniform definitions of the activities reported under 2718(a), as well as the standardized methodologies for calculating "measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2) (of Section 2718)." We reviewed the blanks proposal exposed by the Subgroup and offer the following comments.

Proposal Form

1. **File annually**. We do not believe that this Blank supplement needs to be filed on a quarterly basis. The expanded reporting segmentation in this supplement is not consistent with the reporting in the normal quarterly blanks and so will require the allocation of innumerable values in the quarterly statement without the amount of time companies expend to complete the more involved annual statement. We believe that the reporting, without separation by line of business, of certain key expense components should be sufficient for regulators to make any actionable determination of solvency concerns. The loss ratio results for the quarterly statement (on a state-by-state basis) would be of little value for solvency and would

be of no value with respect to the reporting of MLRs. The impact of rate increases, annual deductible and seasonal variations means that MLRs will vary by quarter even if the amount of business could be credible on a quarterly basis.

Supplemental Health Care Exhibit - Part 1

1. With respect to the *Earned Premium* section, we note again our concern that the use of direct business with only novation-based assumption reinsurance is not consistent with the goals of solvency or the desire to require rebates when credible loss ratios are below the required levels. In a recent letter from the Academy of Actuaries to Steve Ostlund, Chair Accident & Health Working Group (AHWG), they proposed approaches to reflect credibility while promoting speed in the development of such credible experience in order that rebates not be delayed. One of those was to allow pooling to spread the impact of the highest claim amounts. One of the ways this is available to all companies is reinsurance. Another is for companies within the same affiliated group to pool these highest claims. We recognize that the AHWG continues to review this, and note this would also apply to Incurred Claims.

2. *Rebates* (**line 4.3**) - We recommended in our earlier proposed changes to this exhibit that rebates paid during the year be added as a line below the net gain or (loss) line. This allows the net gain or (loss) to relate to the current year unaffected by rebates. This is important for both the solvency aspects of regulatory review but also so the supplement can be useful to regulators involved in the rate review aspects of PPACA.

3. *Medical Loss Ratio* (**line 6**) - As we proposed in our prior comments, we recommend that this section add lines to reflect adjustments that would address the statutory requirement concerning special circumstances. This would include adjustments to address a potential lack of credibility from random variability in incurred claims (e.g., related to smaller plans), durational issues related to "newer plans," and circumstances related to "different types of plans" such as coverage issued prior to enactment of PPACA or during the 2010-2014 time period in order to provide for a smooth transition.

4. *Administering Self-Insured Business* (**lines 11 - 11.3**) - The current blanks require the reporting of the fees as an offset to detailed expenses by category so that there is no separation of these detailed expenses between those used by self-insured plans and insured plans. There is nothing reported as "income" for line 11.1. Notes are required to demonstrate that the fees are consistent with the overall expenses to provide the necessary services, but there is no current requirement for separation and reporting of many of these expenses by the various columns of the supplement. We recommend that this portion of the supplement be dropped.

Supplemental Health Care Exhibit - Part 2

1. We recommend that there be a conforming change in Exhibit- Part 2 by adding a *separate subsection to deal with Incurred Medical Incentive Pools and Bonuses*, only because they generate a separate line in Part 1 (line 3).

2. We also note that certain items that only appear in Part 2, because they feed into the calculation of earned premium and incurred claims are described in the instructions for Part 1. We believe this may prove confusing and suggest providing instructions in the Part where the term is used. For example, "Change in Contract Reserves" no longer appears in Part 1 while the beginning and ending values of "Direct Contract Reserves" are lines in Part 2. As we have proposed in our previous comments, the contract reserve amounts for this supplement could possibly be on a different basis than what is reported for in the main blank.

Supplemental Health Care Exhibit - Part 3

We support the development of sufficient detail with respect to "Improving Health Care Quality Expenses" – the subject of this exhibit. We further note that this Exhibit includes important quality activities permitted in the "Coverage Expense" column. However, we are concerned it appears that these items would have to be reported in a narrow range of choices, in one of five buckets of quality care, as specified in the columns on the right in an overly constrained way. The "Instructions" section on pages 10-11 appears to support that grouping. We are concerned that these groupings are too limited to support the broad scope of quality activities that companies are both engaged in today, and will be required to engage in tomorrow in order to build a 21st century, evidence based health care system.

In particular, we support clarifying the inclusion of these eligible quality expenses in the columns provided in this exhibit (*emphasis* added to identify those quality activities that were dropped in the Instructions section):

- 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 (HIT)
- Wellness and Health Promotion Activities
- *24 Hour Nurse Hotline*

We anchor our suggestions to the widespread agreement among health care experts, stakeholders, and policymakers that our nation needs to move to a 21st century, evidence-based health care system that promotes quality, rewards value, and incentivizes prevention and wellness. In fact, as part of the new health care reform law, policymakers are experimenting with new quality initiatives in Medicare, such as patient-centered medical homes, medication management programs, pay-for-quality initiatives, and the development and maintenance of high-quality, accountable provider networks.

Health plans have pioneered these important initiatives. Patients today rely on health plans' care coordination, disease management, continuous quality improvement, prevention, network credentialing to include programs like fraud detection that help ensure proper licensing and improve patient safety, and wellness programs. These programs have yielded significant results in improving health outcomes, reducing medical errors, reducing complications, and enhancing patients' quality of life. In addition, many health care experts believe that by improving health outcomes and advancing quality care, these programs and services will also help to reduce the long-term growth rate of health care costs.

In short, we are concerned that there unintended consequences associated with overly constraining the groupings and definitions related to activities that improve health care quality. Discouraging these activities would be to the detriment of the broad aims underlying health care reform.

Our other comments will be focusing on the instructions portion of the exposure.

Instructions

Page 10. Expenses related to improving health care quality

PPACA adds quality requirements that the Instructions that guide the elements in the Supplemental Health Care Exhibit - Part 3. simply do not recognize.

For example, in **SEC. 2717. ENSURING THE QUALITY OF CARE.** (a) QUALITY REPORTING.— (1) The Secretary will require reports from health plans that will include:

(A) improve health outcomes through the implementation of *activities such as quality reporting, effective case management*, care coordination, chronic disease management, and *medication and care compliance initiatives*, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, *for treatment or services under the plan* or coverage;

(B) implement *activities to prevent hospital readmissions through a comprehensive program for hospital discharge* that includes *patient-centered*

> ***education and counseling, comprehensive discharge planning, and post discharge reinforcement*** by an appropriate health care professional;
> (C) implement ***activities to improve patient safety and reduce medical errors*** through the appropriate ***use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage***; and
> (D) implement wellness and health promotion activities.
> (*Emphasis ours*).

The language of the act states activities "such as"... and includes quality reporting (which we would read to mean HEDIS and CAHPS, fall under that rubric), case management, medication and care compliance, patient-centered education and counseling – often undertaken by nurse coaches or 24-hour nurse lines, and the use of health information technology, to improve payment for evidence-based medicine and best clinical practices. Future use of ICD-10 codes will be essential to identifying the discrete level of procedures, and has been recognized by the administration as an essential element to quality medical care and tracking care coordination in the future – as outlined in comments on HITECH, the Health Information Technology for Economic and Clinical Health Act.

Thus, we strongly urge that the Instructions on pages 10 and 11 (actually referring to Exhibit 1, but which are, in fact, related to Exhibit 3) provide for all of those elements to be permitted, and included in the Expenses reported in columns 1-5 of the Supplemental Health Care Exhibit-Part 3.

Unfortunately, the current Instructions Section would result in the need for many of those eligible quality expenses to be included in the "Other Approved Expenses" Column -4 of Exhibit – Part 3. If no other column change is made, using Column 4 will allow for the reporting of eligible expenses which have been referenced by the language of PPACA as activities to improve quality and required to be reported to the Secretary. We have made recommended changes to the Instructions sections on pages 10-11, and provide those recommended changes in the attached pages from the Blanks proposal to address that option.

We are disappointed that this does not, unfortunately, include all of the programs that fight fraud, and all of the programs that monitor utilization for quality outcomes. It will, however, include the programs that have been affirmatively recognized in the language of PPACA as directly related to quality initiatives intended in the letter and spirit of the law.

Conclusion

Both the reporting ratios and the rebate ratio recognize that health plans and insurers engage in many activities that improve the quality of the care that health plan members and beneficiaries receive, or that provide for a safer, more efficient health care experience for the patient. These initiatives are required by some states, and are strongly encouraged by the

federal government through various PPACA provisions and the American Recovery and Reinvestment Act of 2009 ("the Stimulus bill") (Pub. L. 111-5)

It is critical that the medical loss ratio not be used as a vehicle to remove quality programs and their benefits from policyholders. In its response to the HHS MLR Request For Information, AHIP submitted a list of quality care and quality improvement programs that provide direct benefit to policyholders. We've also enclosed a copy of that document with this letter.

We thank you for the opportunity to provide comments. We anticipate providing further comments on outstanding issues such as smaller plans, different types of plans and newer plans. If you have any questions or comments please feel free to contact Bill Weller at (623) 780.0260 or at omegasquared@msn.com, Randi Reichel at (301) 774.2268 or rreichel01@comcast.net, Candy Gallaher (202)641-2492 (candy.gallaher@ahip.org).

Thank you.

Sincerely,

Bill Weller
Candy Gallaher

Enclosures

Cc: Randi Reichel
Todd Sells

Proposed Revisions to the Blanks Instructions

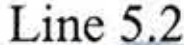
Line 5.1 – Type A: Expenses for Health Improvements other than Health Information Technology

Expenses, other than those billed or allocated by a provider for care delivery (i.e. claims costs), that are designed to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care in ways that can be objectively measured and verified. The following are items that will included as quality of care expenses meeting these criteria:

1. **Care coordination** (not just general care management) - the active hands on participation and other quality activities to coordinate a patient's care between multiple providers (such as making sure medical records are shared between all the patient's physicians, making/verifying appointments, and medication compliance) and arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center and prevention of hospital readmissions).
2. **Chronic Disease Management** Hands on individually tailored programs for specific chronic conditions that interact with the insured (in person or via the phone) and other quality activities to (a) remind insured of doctor appointment, (b) check that insured is following a medically effective prescribed regimen for dealing with the specific disease/condition, (c) incorporating feedback from insured in the management program, (d) provide coaching on dealing with the disease/condition.
3. **Preventive Care and Wellness Programs**: Hands on programs that interact with the insured (in person or via phone) and other quality activities related to: Wellness assessment, wellness / lifestyle coaching programs, coaching programs designed to educate individual members on clinically effective for dealing with a specific chronic disease, and coaching or education programs designed to change individual members behavior (e.g. smoking, obesity).
4. **Other ~~costs~~ Expenses:** Programs that accomplish the quality goals outlined in PPACA, such as case management, medication and care compliance initiatives, 24 hour nurse hotlines, prevention of hospital readmissions, activities to improve patient safety, reduce medical errors using best clinical practices, and activities to encourage use of evidence-based medicine. And any other expenses a approved by the Secretary, in consultation with the NAIC, which in her discretion~~, upon an adequate showing that the costs improve the quality of healthcare; the burden shall be on the proponent to show that the costs~~ improve the quality of healthcare.

~~E.g., 24 Hour Nurse Hotlines: Expenses for 24 hour nurse hotlines should be included in care coordination, chronic disease management, and preventive care and wellness programs to the extent they meet those expense requirements. Any other expenses for 24 hour nurse hotlines 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 this criteria:
- Utilization Review
- Fraud Prevention activities, except those related to patient safety
~~- Any function not expressly included in Type A items 1 through 4, above.~~



Line 5.2 – Type B: Health Information Technology Expenses Related to Health Improvement

Expenses for Health Information Technology (HIT), consistent with the purposes described in A, above, defined as depreciation on hardware and expenses for software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for use by health plans, health care providers, or patients for the electronic creation, maintenance, access, or exchange of health information and the personnel costs associated with implementing those technologies or licenses, but limited to the following expenses;

1. Monitoring or reporting clinical effectiveness;
2. Advancing the ability of providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently, including via the use of the ICD-10 code sets, and the costs of implementation thereof;

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3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
4. Other costs approved by the Secretary, in consultation with the NAIC, which in her discretion, ~~upon an adequate showing that the costs~~ improve the quality of healthcare~~; the burden shall be on the proponent to show that the costs improve the quality of healthcare~~.

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Quality Initiatives

Quality Improvement Programs that Provide Direct Benefit to Policyholders

From AHIP's Response to MLR RFI submitted May 14, 2010

APPENDIX A.2

Activities Referred to as Quality Activities in the Health Care Law

Many of the categories of activities listed on pages 10-11 have been referred to as quality activities in the health care law. For example:

- ***Section 2717 Activities.*** Section 1001 of PPACA, Amendment to Section 2717 of the PHSA, "Ensuring the Quality of Care" lists a number of quality improvement activities which health plans would have to report to the Secretary. These activities – which, as the title of Section 2717 indicates, would ensure quality of care – include:
  - Quality reporting;
  - Effective case management;
  - Care coordination;
  - Chronic disease management;
  - Medication and care compliance initiatives;
  - Patient-centered education and counseling, comprehensive discharge planning, post discharge reinforcement by an appropriate health care professional, and other activities to prevent hospital readmissions;
  - Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and
  - Wellness and health promotion activities.

  It is also important to note that this section's language, when listing the activities, uses the terms "such as" and "including". These terms indicate that the activities listed are not exclusive.

- ***Value-Based Purchasing Initiatives, Such as Pay-For-Quality Initiatives.*** The programs and activities under Title III, Subtitle A, Part I, "Linking Payment to Quality Outcomes Under the Medicare Program" are, as the title suggests, aimed at improving quality outcomes. They include quality reporting programs and providing financial incentives to hospitals and physicians to deliver higher quality care to patients.

- ***Patient-Centered Medical Home and Continuous Quality Improvement Activities, such as Medication Management.*** The programs in Title III, Subtitle F, "Health Care Quality Improvements", are, as the title indicates, activities which improve health care quality. They include establishing community health teams to support the patient-centered medical home (Section 3502) and medication management services in the treatment of chronic disease (Section 3503).

- ***Activities Related to the Development and Maintenance of Provider Networks.*** The language in Section 10327, "Improvements to the Physician Quality Reporting System", refers to Maintenance of Certification Programs – an activity related to the development and

maintenance of provider networks – as an activity that "advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism."

Examples Which Demonstrate the Benefits of Health Plan/Issuer Quality Improvement Activities to Patients

Plans and health plans have developed and implemented countless initiatives aimed at improving health care quality and patient outcomes. Below are examples of how the activities listed on pages 10 - 11 of this letter benefit consumers by improving health care quality and patient outcomes.

Programs to Ensure Patient Safety. Health plans have developed e-prescribing programs to improve patient safety by reducing the risk of errors due to illegible handwriting and a reduction in adverse drug events. One plan reports that approximately 104,000 prescriptions had been changed or cancelled as a result of e-prescribing messages that flagged possible safety issues. Newly published research has demonstrated that this prevented an estimated 724 potential adverse drug events (ADEs).

Investments in Health Information Technology. A health plan launched a state-wide infection control program involving 22 acute care hospitals. The program uses sophisticated surveillance technology to detect patterns and provide tools for infection prevention in hospitalized patients. From fall of 2005 to summer 2008, there has been a 15 percent reduction in the rate of hospital acquired infections.

Wellness and Prevention.

- A health insurance plan's tobacco cessation program provides tobacco users with web-based and telephonic counseling services to help them quit. Health coaches/counselors are nurses, health behavioral specialists, and other health professionals who go through a rigorous training program and receive continuing education. In addition to counseling, participants have access to other materials as well as over-the-counter nicotine patches or nicotine gum at no extra cost. Almost 4,000 tobacco users access the program every year, and after 6 months, 86% of those who quit are still tobacco free, while 12% show reduced use.

- A health plan provides a health coaching program that enables participants to receive personalized, tailored counseling and coaching services to reduce their risks and improve their health. Participants who have chronic conditions work with a personal nurse, while participants who wish to improve their lifestyles work with certified health educators. Over 52% of participants remain smoke-free after 6 months; over 57% of participants lost weight and of those participants who have a body mass index of >30 and therefore are classified as obese, 29% lost more than 5% of their body weight; and 47% of participants improved and can better manage back pain.

- A health plan recently developed a program to promote immunizations. Interactive Voice Response (IVR) systems telephone parents with the lists of vaccines that their children need to receive to be up-to-date on current recommendations. Strategies such as developing and providing resources for vaccine providers (physicians, nurses and clinicians) and health insurance plan members have resulted in increased (increases of approximately 10-15%) health measure performance that fall within national health objectives goals of childhood, adolescent and adult immunization over a two-year timeframe.

Care Coordination and Disease Management.

- To address avoidable hospital readmissions among members with heart failure, a health plan enhanced its disease management program in 2007 by doing additional outreach to members discharged from hospitals with heart failure, chronic obstructive pulmonary disease, coronary artery disease and asthma. The program's approach included conducting post-discharge follow-up calls, arranging in-person visits to review medications, encouraging patients to participate in a health tracking program where patients work with a multidisciplinary team of professionals including nurse health coaches, behavioral health case managers and pharmacists, and conducting in-home monitoring. From 2007-2008, hospital admissions related to heart failure dropped by: (1) 37% for members with commercial HMO coverage; and (2) 45% for Medicare Advantage members.

- Community asthma educators at a health plan work with primary care providers to implement comprehensive asthma management in provider offices leading to 42 percent decrease in members with asthma using the ER for asthma-related treatment and a 31 percent decrease in asthma-related hospitalizations. Additionally, asthma health coaches, who are referred by a PCP, work one-on-one with members to achieve self management and empowerment. Overall, the plan has achieved a 58 percent decrease for asthma related hospitalizations and 44 percent decrease in medical costs for members who have specifically worked with the plan's health coaches.

- To increase life expectancies for members who have had heart attacks, nurse case managers at a health plan contact heart attack patients within seven days of their hospital discharge to verify that beta-blocker medications were prescribed. The health plan also offers ongoing case management to help heart attack patients develop care plans, access services such as smoking cessation and rehabilitation programs, and live healthy lifestyles. From 2004 to 2006, 100% of members who had heart attacks received beta-blockers, a treatment based on an evidence-based clinical guideline, within seven days of their hospital discharge.

Value-Based Purchasing Initiatives, Such as Pay-for-Quality Initiatives. A plan developed a primary care physician incentive program which offers incentives for achieving quality goals and provides physicians with the data and tools they need to reach these goals. The program uses adult process and outcome measures, including chronic care measures for hypertension (blood pressure values), cardiovascular (LDL-C and blood pressure values), and diabetes (Hemoglobin A1c, LDL-C and blood pressure values). It also uses pediatric process and outcomes measures, including well child and well teen visits and weight control. The program has seen positive results. For example, well adolescent visits improved from 56% in 2000 to 76% in 2007, and diabetic HbA1c tests improved from 85% in 2000 to 93% in 2007.

Consumer Education Programs, Including Programs to Address Health Care Disparities.

- A health plan created a faith-based wellness program to improve the quality of life of African American women through education and healthy living. African Americans' incidence of diabetes is more than twice that of Caucasian Americans, and the incidence rate of heart disease and stroke is 30 percent higher than for non-minorities. The program collaborated with churches and community organizations to focus on nutrition education, exercise, water intake, and medication compliance, which resulted in positive health improvements among women with diabetes. Findings of the program resulted in a nearly 20 percent drop in triglycerides; a 22 percent decrease in LDL cholesterol; a 17 percent reduction in fasting blood sugar; and a 4.6 percent weight reduction (3 percent for women with type 1 diabetes) among participants. The women also reported high satisfaction, and on average reported a 73 percent improvement in pain and 81 percent improvement in mobility and flexibility.

- Using multiple provider and member intervention strategies, a Medicaid health plan addressed low preventive screening rates among African American men resulting in an increase, from 7 percent to 19.4 percent, in preventive exams and recommended testing. The health plan worked with targeted provider offices in high-disparity geographic areas to educate practitioners on US preventive service guidelines and proper claims coding to monitor outcomes. Male outreach reminder calls, personalized health messages and disease management brochures to encourage preventive screenings and health visits were also provided to members. Specific testing rates increased from 17.4 percent to 41.8 percent for prostate cancer screening in men age 40 and over; 15.9 percent to 49.5 percent for cholesterol, and 8.6 percent to 19.7 percent for colorectal cancer screenings among African American men 50 and over.

Continuous Quality Improvement Activities, Such as Medication Therapy Management (MTM). Members in a health plan who received MTM services at six ambulatory care clinics received substantial benefits, as compared with similar patients who did not receive services. Approximately 640 drug therapy problems were resolved among almost 300 patients, and the percentage of patients who achieved therapy goals increased from 76% to 90% during one year of MTM services.

Patient-Centered Medical Homes. Many health plans are establishing medical home initiatives to improve primary care for patients and physicians. One health plan initiative, among other things, built new information systems that enabled electronic health records and registries to track care for patients with chronic conditions; increased the range of services that primary care practices provide; offered additional support for patients with chronic conditions; focused on providing patients who have been hospitalized with a smooth post-discharge transitions; provided on-site support for nursing home patients; and provided medical home practices with bonus payments for meeting quality and efficiency goals. Among patients at the medical home sites from 2006-2008: (1) the number of hospital readmissions fell by 20 percent; and (2) the number of hospital admissions fell by 18 percent.