

VIA EMAIL ONLY

May 14, 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: May 12, 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 May 12, 2010 draft of the Supplemental Health Care Exhibit and Instructions. Our comments are reflected in a redlined version of the applicable Instructions in the Blanks Agenda Submission Form, which is enclosed with this letter, and relate exclusively to the current definitions of Health Care Quality Expenses in Lines 5, 5.1 and 5.2 of the Instructions being developed by your Subgroup.

As you may know, Healthways is the largest and most experienced health, wellness and chronic care management company in the world. Healthways works with over 1000 employers and more than 100 health plans, and impacts approximately 40 million people a day. Its specialized, comprehensive solutions help people improve their health and well-being, and have been proven to reduce overall health care costs.

Although the enclosed redlined document suggests specific revisions and edits to the Subgroup's language in Lines 5, 5.1 and 5.2 of the Instructions, to assist in your review of our suggested changes, we summarize below the rationale for our various suggestions.

- The categories of Health Care Quality activities should not be narrower than the activities identified in the provisions of the Public Health Service Act (the "PHS Act") which were added by Section 1001 of the Patient Protection and Affordable Care Act.

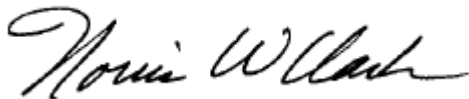
- By implication, Section 2717(a) of the PHS Act identifies health care quality activities as those designed to: (A) *improve health outcomes* through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model; (B) implement activities to prevent hospital readmissions; (C) implement activities to improve patient safety and reduce medical errors; and (D) implement wellness and health promotion activities.
- Wellness and health promotion activities identified above are specifically defined in Section 2717(b) of the PHS Act.
- Our comments to the Subgroup's draft language are intended to ensure that *all* of these types or categories of items are taken into consideration in the definition of Health Care Quality Expenses.
- The types of individuals and organizations who or which are eligible to furnish or arrange for Health Care Quality activities should not be limited to physicians or other health care providers.
 - Consistent with Section 2717(b) of the PHS Act these individuals and organizations should include wellness and prevention plan managers and health, wellness or prevention services organizations, in addition to health care providers.
 - To avoid confusion or inconsistency in reporting, we believe that the Instructions should expressly provide for the foregoing.
- The level of interaction with patients and health care providers involved in Health Care Quality activities should not be limited to "hands-on" or "face-to-face" interaction. Permissible interactions should include telephonic interaction and web-based interaction, consistent with the language in Section 2717(b) of the PHS Act.
- Although we agree that there should be appropriate parameters for determining whether activities are truly Health Care Quality activities, we do not believe that it was Congress' intent to require one or more peer reviewed studies applicable to each such activity, which might only be available after years or even decades of research. Furthermore, while we acknowledge that Health Care Quality activities should be evaluated on an ongoing basis to determine their efficacy, requiring "verification" could not only delay the appropriate treatment of Health Care Quality activities, but could result in debates over whose research is more sound or credible.

- Such a standard is not applied to health care provider claims. Arguably, a health care provider may furnish services or treatments that are not efficacious and may not be deemed efficacious by his or her peers. Nonetheless, a health insurer's costs for such claims services would be included in the numerator of the medical loss ratio ("MLR") calculation.
- To address concerns raised by the Subgroup, we propose that the standard imposed on Health Care Quality activities be a reasonable basis for determining that such activities are designed to achieve the intended goal.
- In Line 5.1, we do not believe that it is accurate to conclude that items #1 through #4 constitute the exclusive universe of Health Care Quality activities. Instead, we believe that items #1 through #3 are descriptive categories within which the Subgroup has furnished examples of activities which satisfy the general description. We believe that the better position is that items #1 through #4 are examples given within each category and constitute only a representative sample.

We appreciate all of the hard work you and your Subgroup have done to date in developing the definitions for Health Care Quality Expenses, and recognize the extremely short timeframe that you have been given to finalize those definitions. We do, however, hope that you will consider the comments in this letter and in the enclosed redlined document in crafting your final recommended definitions for the HHS. I look forward to further discussions on these matters next week.

Very truly yours,

LOCKE LORD BISSELL & LIDDELL LLP



Norris W. Clark

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

Suggested Revisions to Instructions to Lines 5, 5.1, and 5.2

Line 5 – Improving Health Care Quality Expenses Incurred

Expenses, other than those billed or allocated by a provider for care delivery (i.e., claims costs), of activities that are designed to improve health care quality, improve a patient's health or his or her health outcomes, reduce or mitigate the risk factors of disease, increase patient compliance with treatment plans or medication adherence, reduce medical errors, reduce health disparities, and/or advance the delivery of patient-centered medical care. The following shown in lines 5.1 and 5.2 are the items that will be considered quality of care expenses if they are designed to improve ~~health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care.~~ any of the goals in the foregoing sentence.

Exclude: Cost containment expenses that do not directly relate to the quality of health care. These are reported in line 7.1.

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~~of activities which are designed to improve health care quality, improve a patient's health or his or her health outcomes, reduce or mitigate the risk factors of disease, increase patient compliance with treatment plans or medication adherence, reduce medical errors, reduce health disparities, and/or 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~~ and for which there is a reasonable basis to determine that such goals may be achieved. Health and health care quality improvement activities described in this Line 5.1 may be furnished or arranged by a health care provider, a wellness and prevention plan manager or a health, wellness or prevention services organization. The following are categories of quality of care expenses meeting these criteria and examples of items that fit within the categories:

- Care coordination** (not just general care management) - the active ~~hands-on~~ participation (e.g., face-to-face, telephonic or web-based interactions with patients or their providers or arrangers of care) to coordinate a patient's care between or among multiple providers (such as making sure medical records are shared ~~between~~among 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), or ensuring that a patient is receiving appropriate medical care, medications or treatment plans.

2. **Chronic Disease Management** ~~Hands-on individually~~Individually tailored programs for specific chronic conditions or patients with such chronic conditions that interact with the insured (~~in person or via the phone) to~~using, e.g., face-to-face, telephonic or web-based interactions) to, among other things, (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 or (e) monitor and assess the insured's medical condition to determine that he or she is stable and/or that the insured's medical condition is not potentially harmful or life threatening.
3. **Preventive Care and Wellness Programs:** ~~Hands-on programs~~Programs that interact with the insured (~~in person or via phone e.g., using face-to-face, telephonic or web-based interactions~~) 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). These programs shall include, but not be limited to, those "Wellness and Prevention Programs" specifically identified in Section 2717(b) of the Public Health Service Act.
4. **Other costs** approved by the Secretary, in her or his discretion and after 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.~~when there is a reasonable basis to determine that the activities giving rise to the costs satisfy any of the goals in the preamble to Line 5.1.

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
- ~~- 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 [the Type A expenses](#), 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, [wellness and prevention plan managers or health, wellness or prevention services organizations](#) or patients for the electronic creation, maintenance, access, [analysis](#) or exchange of health information and the personnel costs associated with implementing [or maintaining](#) those technologies or licenses, but limited to the following expenses;

1. Monitoring or reporting ~~clinical effectiveness~~ [health status or condition of patients, clinical effectiveness of treatments or medications furnished by health care providers or the results, outcomes, data or other information which may be generated from the health care quality or health improvement activities identified in Line 5.1.](#);
2. Advancing the ability of [health care](#) providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently;
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.