

May 17, 2010

Mr. Steve Oslund
Chair
Accident & Health Working Group

Mr. Lou Felice
Chair
Health Reform Solvency Impact (E) Workgroup

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

Dear Mr. Oslund and Mr. Felice:

We, the undersigned organizations, are pleased to submit comments on the National Association of Insurance Commissioner's (NAIC) development of recommendations related to the calculation of medical loss ratios (MLR) in Section 2718 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act (PPACA).

We appreciate that Congress recognized the need to include activities to improve health care quality in the MLR definition. PPACA requires the Secretary to develop a process for health insurers to report such activities. Appropriate definition in the MLR of activities that improve quality of care is important to promoting initiatives that can yield better patient outcomes and value.

To that end, we support including the cost of efforts designed to improve medication adherence – whether part of a disease management, case management, medication therapy management, or similar program – in the definition of quality improvement activities. Programs that promote adherence to prescribed treatments and therapies are a key element of improving patients' health outcomes and quality of care.

For example, health insurers have implemented medication therapy management (MTM) programs as well as patient and provider education programs to promote improved patient adherence to treatment regimens. These programs may include a variety of approaches to patient counseling and education, from comprehensive in-person medication reviews to written patient education materials. Such programs may also include the use of reminder calls or messaging systems that contact patients by cell phone, text message, or email; electronic pill caps, electronic medication dispensers, or in-home monitoring devices; or similar technologies to help patients adhere to prescribed regimens. Such activities are often an element of care and case management, disease management, or wellness programs.

Activities to promote adherence are particularly important for patients with one or more chronic conditions and can have dramatic implications for both patient outcomes and health costs. Academic research strongly suggests that improved medication compliance and adherence will lead to higher quality care, better patient outcomes, and reduced health care costs:

- Relative to patients with high levels of adherence, the risk of poor clinical outcomes—including hospitalization, rehospitalization, and premature death—among non-adherent

patients is 5.4 times higher among those with hypertension, 2.8 times higher among those with dyslipidemia, and 1.5 times higher among those with heart disease.¹

- People with diabetes who take their diabetes medicines less than 60 percent of the time are 3.6 times more likely to be hospitalized than those who follow their prescribed treatment.²
- Recent analyses suggest that in total, U.S. costs resulting from poor medication adherence may be as high as \$100 billion to \$300 billion annually.³

Continued development and implementation of programs to improve patients' adherence to prescribed regimens is crucial. For example, research shows that:

- Providing multiple forms of educational material to depression patients improved adherence by 25 percent.⁴
- A study of diabetic patients found that a combination of assessment calls and nurse training reduced reports of missed doses by 21 percent.⁵
- A study of patients with heart failure found that non-adherence among those who received monthly pharmacist counseling was less than half of the level among the usual care patients.⁶

We believe that the activities described above directly relate to improving patients' quality of care and achieving better clinical outcomes. Therefore, we recommend that programs designed to increase medication adherence be defined as quality improvement expenses for purposes of PPACA Section 2178.

We appreciate your consideration of these issues. If you have any questions, please do not hesitate to contact Kristina Lunner (APhA) at 202-429-7507 or klunner@aphanet.org, Kip MacArthur (DMAA) at 202-737-1107 or kmacarthur@dmaa.org, Julie Khani (NACDS) at 703-837-4259 or jkhani@nacds.org, John Coster (NCPA) at 703-683-8200 or john.coster@ncpanet.org, or Jenny Bryant (PhRMA) at 202-835-3551 or jbryant@phrma.org.

Sincerely,

American Pharmacists Association
DMAA: The Care Continuum Alliance
National Association of Chain Drug Stores
National Community Pharmacists Association
Pharmaceutical Research and Manufacturers of America

¹ F.H. Gwady-Sridhar et al. "A Framework for Planning and Critiquing Medication Compliance and Persistence Research Using Prospective Study Designs." *Clinical Therapeutics*, February 2009.

² DT Lau and DP Nau, "Oral Antihyperglycemic Medication Nonadherence and Subsequent Hospitalization among Individuals with Type 2 Diabetes," *Diabetes Care* 2004;27(9):2149-53.

³ New England Health Care Institute, Thinking Outside the PillBox.

⁴ Katon W, Rutter C, et al. A randomized trial of relapse prevention of depression in primary care. *Arch Gen Psychiatry*. 2001 Mar; 58 (3): 241-7.

⁵ Lowe, CJ, Raynor DK, Purvis J, et al. Effects of a medicine review and education programme for older people in general practice. *Br J Clin Pharmacol*. 2000 Aug; 50 (2): 172-5.

⁶ Bouvy ML, Heerdink ER, Urquhart J, Grobbee DE, Hoes AW, Leufkens HG. Effect of a pharmacist-led intervention on diuretic compliance in heart failure patients: a randomized controlled study. *J Card Fail*. 2003 Oct;9(5):404-11.