



May 13, 2010

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

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act (PHSA)

Dear Mr. Felice:

We are writing to follow up on the comments we offered on yesterday's conference call to respond specifically to the new language you circulated yesterday that defines categories under "Improving Health Care Quality Expenses Incurred."

Reporting on quality of care is a critical activity supporting the improvement of patient care. While some aspects of health quality measure reporting are captured under "Health Information Technology Expenses Related to Health Improvement," this category would not seem to encompass quality measures collected through medical record review or collected through patient surveys, such as CAHPS – a widely used and evidence-based survey of patient experience of care.

We recognize that the list includes a category "other costs approved by the Secretary," however, we would respectfully appreciate your specifically naming the activity of quality measure data collection and reporting in the same level as the other activities listed under "Expenses for Health Improvements other than Health Information Technology."

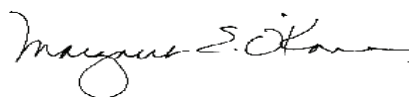
A second point that we would like to restate is that both states and the Federal government have provisions in law that are designed to improve quality – many states call for quality data collection and reporting and for accreditation. Indeed, the new federal reform law calls for health plans in the Exchanges to be accredited in section 1311. This strikes us as a clear recognition that accreditation and quality measurement and improvement have value in supporting policyholder access to high quality care. The medical loss ratio requirements should align with other provisions in the law, as the representative from the American Heart Association commented.

Finally, we support changing the language "hands on" to language that reflects the use of telephone and email to support care coordination, disease management and preventive care and wellness.

Thank you for your consideration of these comments.

Please do not hesitate to contact me or Sarah Thomas, Vice President of Public Policy and Communications at (202) 955-1705.

Sincerely,

A handwritten signature in black ink, appearing to read "Margaret O'Kane". The signature is fluid and cursive, with a large initial 'M' and a distinct 'O'.

Margaret O'Kane
President

Attachment

cc: Richard Diamond, Chair, Actuarial MLR Subgroup
Todd Sells, NAIC Staff
John Englehart, NAIC Staff
Brian Webb, NAIC Staff

Attachment: NCQA Accreditation Process Overview

Achieving Improvement Through Measurement

NCQA Health Plan Accreditation includes two major components on which a plan's performance is scored: standards, an evaluation of the plan's structure and processes to maintain and improve quality in five core areas; and Healthcare Effectiveness Data and Information Set (HEDIS®), an evaluation of the plan's performance on process and outcomes in clinical care and patient experience of care.

NCQA standards evaluate the following categories:

Quality Management and Improvement

- A health plan's systems for continuous improvement of quality of care and service.
- How the plan makes sure that members have access to the care they need.
- Specific plan programs that help members with chronic illnesses (e.g., disease management and complex illness or trauma; case management).

Utilization Management

- How fair, consistent and prompt is the plan when it makes decisions about medical necessity for medical, behavioral health and pharmacy services?
- Does the plan use evidence-based clinical guidelines and clinical staff—including physicians—to make decisions?
- Does the plan have a process for members to appeal its medical necessity and coverage decisions?

Credentialing

- How thoroughly the plan investigates qualifications and practice history before allowing a physician to join its network.
- The plan's process for ongoing evaluation of the physicians in its network.

Members' Rights and Responsibilities

- Does the plan clearly inform its members about how to get care and use its services?
- Does the plan have a process to respond to member concerns and complaints?
- How the plan protects members' personal information.

Member Connections

- How the plan distributes important information to members, such as their health status, plan resources, member care options and the cost of different services and prescription drugs.
- How the plan promotes wellness and prevention to its members.

HEDIS measures evaluate areas of care

- Preventive services, such as child and adult immunizations, cancer screenings, prenatal care and smoking cessation.
- Treatment of acute illnesses, such as respiratory infection and pharyngitis in children and bronchitis in adults.
- Management of chronic illnesses, such as diabetes, high cholesterol, high blood pressure, asthma and depression.

- Patient experience² with the services provided by the plan and by the physicians in the plan's network: how quickly members can access care, how members rate their personal physician, the claims process, customer service and overall rating of the plan.

NCQA's rigorous survey process consists of onsite and offsite evaluations conducted by a team of physicians and managed care experts. The offsite survey reviews the plan's self-evaluation and other materials submitted to NCQA through the Interactive Survey System (ISS), the first Web-based tool for health plan accreditation. The ISS provides guidance and feedback to the plan while it performs a survey-readiness evaluation against NCQA Accreditation standards. The survey team reviews the plan's submitted documentation for compliance with the standards.

The onsite survey is a two-day visit, during which NCQA surveyors interview plan staff and review materials that cannot be submitted via the ISS, such as actual case records, meeting minutes and other confidential documents.

¹HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

²Based on CAHPS®³ (Consumer Assessment of Healthcare Providers and Systems), a standardized survey used by all plans.

³CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).