



American Association of Preferred Provider Organizations

May 17, 2010

VIA EMAIL tsells@naic.org

Lou Felice

Chair, Health Care Reform Solvency Impact Subgroup

Steven Ostlund

Chair, Accident & Health Working Group

RE: Categorization of Network Access Fees as Expenses for Health Improvements

Dear Mr. Felice and Mr. Ostlund:

I am writing on behalf of the American Association of Preferred Provider Organizations (AAPPO), the leading national association of preferred provider organizations (PPOs) of insurers and non-risk PPO networks. AAPPO's 1,065 members seek to advance the awareness of the benefits — greater access, more choice and flexibility — that PPOs bring to over 199 million Americans covered by PPOs today. Sixty nine percent of all Americans having health care coverage today are covered by PPOs.

It is vital that the health improvement aspects of network development and management are recognized as part of medical loss ratios. The percentage of network fees that can be documented and verified by insurers pertaining to network quality standards with respect to accreditation standards, state network adequacy requirements, medical/case management and specialty provider standards should be considered as expenses improving health care quality in any medical loss ratio.

The majority of PPO networks are non-risk, that is, they do not assume the financial risk for an enrollee's medical costs. The network's primary focus is to contract with providers in a geographical area to form an interconnected, efficient, and quality network of providers and services that are marketed to payers, insurers and Third Party Administrators (TPAs).

Network development is very costly because of the quality components that are inherent to the process. Therefore, many insurers especially mid size insurers, self-insured employers, union trusts, third-party administrators, business coalitions and associations make the decision to "lease/rent" networks to ensure they can offer quality networks as the platform for their benefit programs that meet all the same quality standards that would be part of network owned by an insurer, in fact depending on the insurer and their specific network requirements, "leasing/renting" a network may prove to be more cost effective than developing or owning their own network. While "leasing/renting" a network may be viewed as a cost containment measure it is also very important to recognize that a portion of any network access fee represents the cost

associated with ensuring network quality standards are met. Networks that are “leased/rented” must meet accreditation quality standards that measure network adequacy standards, specialty provider standards, medical/case management criteria and credentialing and appeal standards. These quality standards in many states are required by law. Whether mandated by state law or through URAC or NCQA accreditation, networks must establish and maintain quality management programs to improve the delivery of healthcare services.

Finally, most non-risk PPO networks are long-established businesses serving a local community, state, or region. This allows each of them to understand the unique needs of their geographic area – and make certain much needed quality treatment options are available. Non-risk PPO networks also allow insurers to offer coverage in rural communities with so few covered lives that building a dedicated network would not be feasible. In short, non-risk PPO networks offer quality solutions for meeting statutory requirements and provide seamless coverage to consumers, whatever their needs, wherever they need service.

I appreciate your consideration of our comments and if AAPPO can provide any additional resource information to substantiate our comments please do not hesitate to contact me.

Thank you for your consideration.

Very truly yours,

A handwritten signature in cursive script that reads "Karen L. Greenrose".

Karen Greenrose.
President and CEO

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 be included as quality of care expenses meeting these criteria:

1. **Care coordination** (not just general care management) - the active hands on participation 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) 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) 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. Network access fees to Preferred Provider Organizations and other network-based health plans engaged in maintaining network adequacy, network accreditation, provider credentialing, medical/case management, or specialty provider standards
5. **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.

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 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;
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.

Line 7.1 – Cost Containment Expenses not Included in Quality of Care Expenses in Line 5.4

Include: Expenses that actually serve to reduce the number of health services provided or the cost of such services. Exclude cost containment expenses which improve the quality of health care reported in line 5.4. The following are examples of items that shall be considered “cost containment expenses” only if they result in reduced levels of costs or services:

Post and concurrent claim case management activities associated with past or ongoing specific care;

Utilization review;

Detection and prevention of payment for fraudulent requests for reimbursement;

Expenses for internal and external appeals processes.

~~Network access fees to Preferred Provider Organizations and other network based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting~~