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VIA EMAIL ONLY

May 24, 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 19, 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 19, 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 and 5.1 of the Instructions being developed by your Subgroup.

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.

We note and appreciate the progress that has been made by you and your Subgroup in developing and refining the definition of health care quality expenses. We believe some further minor amendments to the definition will more adequately capture the intent of 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, and further clarify the intent of the Subgroup.

In the preamble paragraph of the Line 5 instruction, we would suggest a broader description of the recipients of health care quality services. The current language in the instruction focuses on "patient" health care which may be inferred to suggest that health care quality services are only for those who are sick or injured, while, for example, wellness and prevention programs may well be focused on a health plan's/insurer's "members, insureds or enrollees".

We would also suggest clarifying that the list of services included in categories 1-3 meet the general requirements for health care quality expenses stated in the first, preamble paragraph of

the line 5 instruction. We believe this may be necessary in light of the questions that have arisen during previous Subgroup conference calls as to what is intended by the terminology "that can be objectively measured and verified."

In the current definition of "care coordination", interaction is required between the insurer and the enrollee. However, insurers may well contract with other entities to handle certain care coordination. The Subgroup has recognized that certain services are outsourced by including outsourced services as an expense in lines 1.2, 2.2, and 3.2 of the Supplemental Health Care Exhibit – Part 3. We recommend conforming the definition to include recognition that care coordination may be outsourced.

In the definition of chronic disease management, we recommend that the methods of interaction be expanded to include other modalities which would encompass email and web-based communication.

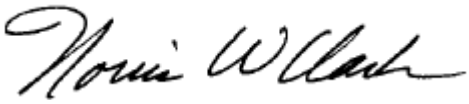
In the definition Preventive care and Wellness programs, we recommend deletion of "hands on" so that interaction in person, via the telephone, or by other modalities would be considered acceptable methods of interaction for providing the described preventive care and wellness services.

While, we believe that it can be inferred from the current definitions that health care quality services are not only those delivered by providers (physicians, nurses, therapists, etc.), we would still recommend that a listing of the types of other acceptable service providers be provided in the definition.

Again, we appreciate all of the effort and thought that you and your Subgroup put into developing the definitions for Health Care Quality Expenses. 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 in the coming weeks.

Very truly yours,

LOCKE LORD BISSELL & LIDDELL LLP



Norris W. Clark

cc: Todd Sells, NAIC
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Suggested Revisions to Instructions for Lines 5 and 5.1

Line 5 – Expenses for Health Care Quality Improvements

Expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), that are designed to improve health care quality of members, insured or enrollees, 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. ~~Section 2717 of the PPACA~~Health and health care quality improvement activities described in this Line 5 may be furnished or arranged by a health care provider, a wellness and prevention plan manager or a health, wellness or prevention services organization. Section 2717 of the PHS Act lists the following activities that may in whole or in part improve quality of care as follows:

- 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,
- wellness and health promotion activities.

These activities are embedded in the following 4 categories ~~that will~~have been determined to fall within the parameters described above and shall be included as quality of care expenses for the purposes of reporting in this supplemental filing and calculating the medical loss ratio (MLR):

1. **Care coordination** (not just general care management) - the direct interaction between the insurer, or an entity who provides these services under contract on behalf of the insurer, and the enrollee to coordinate a patient's care between multiple providers (*care coordination* such as making sure medical records are shared between all the patient's physicians and *activities to improve patient safety* and *reduce medical errors by using best clinical practices*, and *effective case management* such as making/verifying appointments and *medication and care compliance initiatives* [not involved with chronic disease management]) 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*); care coordination *activities to encourage evidence based medicine*; and *health information technology* expenses to support these activities.
2. **Chronic Disease Management** Individually tailored *chronic disease management* programs for specific chronic conditions that interact with the insured (in person ~~or~~, via the phone or by other modality) to provide *medication and care compliance initiatives* such as: (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; chronic disease management *activities to encourage evidence based medicine*; and *health information technology* expenses to support these activities.

3. **Preventive Care and Wellness Programs**: ~~Hands-on programs~~Programs that interact with the insured (in person~~ or~~, via the phone or by other modality) related to: *Wellness* assessment, wellness/lifestyle coaching programs, coaching programs designed to educate individual members on clinically effective methods for dealing with a specific chronic disease, and coaching or education programs and *health promotion activities* designed to change individual member behavior (e.g., smoking, obesity); preventive care and wellness program *activities to encourage evidence based medicine*; and *health information technology* expenses to support these activities.
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.

Note: 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:

- 24 Hour Nurse Hotlines except as noted above
- Utilization Review
- Fraud Prevention activities
- Network Management
- Provider Contracting
- Any function not expressly included in Type A items 1 through 4, above

Line 5.1 – Expenses for Health Care Quality Improvements other than HIT

Include expenses meeting the Line 5 definition that are not health information technology expenses.