

May 24, 2010

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

**RE: NAIC Life and Accident & Health Blank (May 20th Discussion Draft)
SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1, Line 3 & Line 5.**

VIA ELECTRONIC MAIL

Dear Mr. Felice:

As Consumer Representatives representing millions of patients, consumers and workers, we appreciate the diligent and disciplined process that the NAIC has used to ensure meaningful participation of all stakeholders in developing definitions and instructions for recording the various expenses related to implementing the immediate market reforms pursuant to the Patient Protection and Affordable Care Act of 2009 (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA).

As requested, we are writing to provide you with our comments and proposed modifications to the definitions in the May 20th Discussion Draft of the NAIC BLANKS (E) WORKING GROUP SUPPLEMENTAL HEALTH CARE EXHIBIT –PART 1 Line 3--Incurred Medical Incentive Pools and Bonuses and Line 5--Improving Health Care Quality Expenses Incurred. The expenses reported in Line 3 and Line 5 relate to Section 2718 in the new law that requires health plans to report on the proportion of premium dollars spent on clinical services and activities to improve health care quality and other costs, and provide rebates to consumers if the amount of the premium spent on clinical services is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.

Our comments focus on general principles that should be incorporated into the definition of activities to improve health care to meet the legislative intent of the law. In general when implementing the MLR requirements, the NAIC Blank Instructions should:

- Provide clear and consistent definitions and a methodology to be used by insurers that will allow unambiguous and transparent allocation of expenses to the categories recognized by the rule. In particular, “activities that improve health quality” must be clearly defined so as to exclude general administrative expenses including fraud prevention and cost containment activities.
- Not create unintended disincentives for insurers to reduce their investment in evidence-based preventive services, disease management, case management, and

quality improvement programs that may currently be considered administrative or medical costs, depending on the legal structure of the health plan and the product.

- Include evidenced based clinical performance, outcomes and patient experience measures that are evaluated annually and reported in the annual Quality Improvement Program Report to the Secretary and applicable state regulatory entity or exchange.
- Distinguish between quality improvement activities consistent with PPACA's quality agenda and reporting requirements (e.g., chronic disease case management quality reporting, patient-centered health promotion and counseling, care compliance, etc.) and those associated with quality assurance (QA) that are basic health plan administrative functions (e.g., network development and provider credentialing expenses, utilization review, etc.)

The proposed modifications to the May 20, 2010 Discussion Draft SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1 Instructions are shown below:

Line 3 – Incurred Medical Incentive Pools and Bonuses

Line 3.1 – Shared Savings Arrangements

Arrangements with contracted providers and other risk sharing arrangements whereby the reporting entity agrees to share savings.

Line 3.2 – Provider Reimbursement Structures

Arrangements with contracted providers to improve health outcomes through provider reimbursement structures including but not limited to pay for performance, bundled payments, medical homes models and other activities that involve reimbursement of contracted providers including physicians, hospitals, pharmacists or other licensed health care professionals as part of implementing activities to improve health care quality

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, reduce medical errors, reduce health disparities, and advance the delivery of patient-centered medical care in ways that can be objectively measured and verified. These activities should be grounded in evidence-based medicine, widely accepted best clinical practice, or standards issued by medical professional associations, accreditation bodies or government agencies. Section 2717 of the PPACA 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 5 -categories that ~~will~~ may be included as quality of care expenses for the purposes of reporting in this supplemental filing and calculating the

medical loss ratio (MLR) if the expenses are demonstrated to be achieving the intended quality purposes (either through external oversight or internal evidence available in an auditable format):

1. Care coordination (not just general care management) - the direct interaction between 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) 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 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 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. Quality improvement and quality improvement reporting: Expenses related to measuring, reporting quality, aggregating and using data to assess and improve clinical performance, health outcomes and patient experience to comply with federal and state regulatory, accreditation or Health Plan QI Program requirements that are not included in Line 5.2. This allowance is intended to promote and ensure that quality, outcomes and patient experience data are consistently measured and in a manner that is available for appropriate oversight bodies and the consumer. Examples may include maintaining and reporting the certified health plan's local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS), or patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey by any entity recognized by the Secretary for the accreditation of health insurance issuers.

5.4. 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 criterion:

- 24 Hour Nurse Hotlines, except as noted above
- Utilization Review

- Fraud Prevention activities
- Network Management
- Provider Contracting
- Quality Assurance Activities
- Costs associated with calculating and administering individual enrollee or employee incentives. This includes rewards or bonuses associated with wellness or health promotion programs (e.g., reductions in individual enrollee or group health plan copays, deductibles or premiums based on achieving specified health outcomes or engaging in specified health promotion activities).
- 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.

Line 5-2 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates “Health Information Technology” as a function that may in whole or in part improve quality of care. Include health information technology expenses required to accomplish the activities reported in Line 5.1, that are designed for use by health plans, health care providers, or patients for the electronic creation, maintenance, access, or exchange of health information in the following ways;

- Monitoring, measuring, or reporting clinical effectiveness;
- Advancing the ability of providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently;
- Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

Exclude:

Costs directly related to upgrades in HIT that are required to be made in order to comply with new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended. (Discuss – Exclude as administrative or include as Fed requirement)

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.

We appreciate this opportunity to submit comments. We thank you for your effective leadership in facilitating the Health Reform Solvency Impact (E) Subgroup to ensure that the work is completed in accordance with the required timeframes. If you have any questions, please contact Wendell Potter at wenpotter@gmail.com or Mark Schoeberl at mark.schoeberl@heart.org.

Sincerely,

Mark Schoeberl
Wendell Potter
Timothy Jost
Barbara Yondorf
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