



May 24, 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 respond specifically to the new exposure draft blank and instructions you circulated. We strongly support the new language you have added to the exposure draft that would align NAIC's medical loss ratio instructions with some of the federal definitions of activities that improve quality. However we remain concerned that some important activities – namely a full accreditation program and some types of data collection and reporting on quality -- may not count as activities that improve quality. This would discourage plans from this important investment.

The Institute of Medicine, in its important report on Crossing the Quality Chasm, defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." The six aims for quality improvement are that health care has the following attributes:

- Safe
- Effective
- Patient centered
- Timely
- Efficient
- Equitable

NAIC's consumer representatives have strongly supported quality improvement activities that include a performance measurement strategy. All of NCQA's programs rely on measurement – all programs measure structures in place, and we put a premium on developing, collecting, and reporting measures of clinical and patient experience. For new programs, we have learned that a mixture of structure and process measures is usually the place to start, and we add clinical and patient experience measures over time. In our health plan accreditation program, for example, the weight given to clinical and patient experience measures in calculating a plan's score has grown to 44 percent. But we have found that the other structure and process measures continue to be important to make sure that policyholders have access to care – a sufficient number of high quality providers, information about their benefits and plan rules and making sure that utilization review programs rely on evidence rather than being arbitrary in nature.

A very recent study published in the International Journal for Quality in Health Care by Laurence Baker and David Hopkins has found that health plans are able to affect quality above and beyond what the providers in the network are able to achieve¹. This study underscores the importance of holding health plans accountable for engaging in quality improvement work. It also emphasizes the value of private,

¹ "The Contribution of Health Plans and Provider Organizations to Variations in Measured Plan Quality," *International Journal for Quality in Health Care* 2010; pp. 1-9.

state and federal activities to provide requirements and incentives to challenge health plans to make the investments in and commitments to improving the quality of care.

Measuring and reporting quality of care is a critical activity that supports the improvement of patient care and is an essential requirement for evaluation of many delivery system reform initiatives at the state and federal level. You have added new language to the definition of HIT Expenses for Health Care Quality Improvement to include:

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

These would seem to include the measures that we and others would want to hold plans accountable for high quality care. However, we recommend that you modify the title of the category to read “Data Collection and HIT Expenses for Health Care Quality Improvement” to make sure that measures collected through chart review and telephone and mail surveys are included.

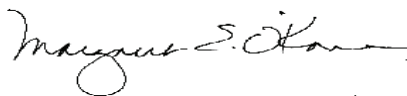
We are pleased to see that you are allowing health plans to allocate accreditation and certification expenses to some of the activities that improve quality. We recommend that the draft blank clarify that all of the cost of accreditation (the direct cost and the cost of actually complying with our standards) be allowed to count in this category. Accrediation is making sure that all these functions meet challenging standards that assure that patients have access to care. It may be interpreted from the draft blank that some portion of accreditation fees would be counted as administrative costs. This would have the unintended consequence of discouraging plans from undergoing the entire accreditation program and instead only accredit some aspects of their program.

NCQA would be pleased to meet with the NAIC and the Administration to let you know about the programs – including performance measures -- we have developed to evaluate care management and the other activities listed on the forms. We also would be happy to work with you to develop a strategy for reviewing quality activities that plans might propose going forward – for example, developing consistent evaluation frameworks.

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,



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®1), 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.

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

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

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