



MISSION: To promote continuous improvement in the quality and efficiency of health care management through processes of accreditation and education.

May 5, 2010

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National Association of
Insurance
Commissioners

Pharmaceutical Care
Management
Association

Marianne Fazen, PhD
Board Chairperson

Alan P. Spielman
President and CEO

Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC
New York State Department of Insurance
25 Beaver Street
New York City, NY 10004

Dear Mr. Felice:

I am writing on behalf of URAC to offer comments in response to National Association of Insurance Commissioners (NAIC) draft response to a joint request for information published by the Department of Health and Human Services (HHS), Department of Treasury, and Department of Labor in the *Federal Register* on April 14th concerning the implementation of Section 2718 of the Public Health Service Act, as amended by Section 1001 and 10101 of the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148). URAC would like to offer comments to the calculation of medical loss ratio for individual and group coverage.

URAC accreditation can serve as a valuable resource in vetting clinical services and activities to improve quality as defined by the NAIC. Through the URAC accreditation process insurers can demonstrate that the service provided meets the NAIC cost category identified. For example, the NAIC discussion draft lists case management services in the health care quality expense category (line 5.1) and the cost containment category not included in quality of care (line 7.1). URAC accreditation could be utilized as independent verification of services which clearly fall into the health care quality expense category. A second example is how URAC accreditation could be used to verify prevention of adverse effects of drugs and biological products (NAIC other health care quality expense line 5.2) through the URAC pharmacy benefit management and drug therapy management accreditations.

URAC recommends that:

- (1) NAIC forms and definitions include a statement that the existence of a valid accreditation from a nationally recognized not-for-profit accrediting body for specific clinical or quality programs or functions will establish presumptive compliance with the NAIC definitions; and**
- (2) The cost of accreditation be counted as a quality cost for medical loss ratio calculations.**

This approach would provide to regulators assurance that, where applicable, clinical and quality functions meet nationally recognized standards and provide those insurers who have demonstrated their commitment to quality improvement with clarity and certainty on the treatment of the costs of accredited programs and functions.

Accreditation is widely recognized and utilized by both federal and state regulators as a quality assurance process and quality improvement tool. URAC is currently recognized by four federal agencies and 42 states, as well as the District of Columbia, as a symbol of excellence in the health care industry. Accredited companies have adopted prevailing industry standards pertaining to health care quality, organizational quality, and consumer protections. Legislators and regulators typically recognize accreditation for the quality management program requirements included in URAC's core organizational quality standards. Additionally, URAC accreditation aids regulators by independently verifying that health care organizations are implementing the highest quality and safety standards in clinical activities.

Accreditation costs are clearly related to ensuring quality in the delivery of health care and should be counted as a direct quality cost for purposes of medical loss ratio calculations. It is important to note that the cost of accreditation is inclusive the costs of preparing for and undergoing accreditation review, in addition to the application costs of accreditation.

Companies undergo URAC review on a two- or three-year cycle to establish compliance with contemporary standards and encourage adoption of leading health management approaches. URAC's educational approach to accreditation yields conclusive results; accredited companies regularly emerge ahead of the curve in adopting practices that protect and empower consumers, as well as ensure clinical and organizational quality.

Through the accreditation process, URAC galvanizes health care organizations to keep pace with emerging evidence-based clinical and quality improvement standards more readily than if undertaken by legislation or regulation. During the accreditation review, URAC's team of clinical reviewers examines key internal processes with implications for both quality of care and patient experience.

In addition, URAC is supportive of the conclusions a recent paper developed on minimum loss ratios by the American Academy of Actuaries where they describe case management, disease management, 24-hour nurse hotlines, and wellness programs as more "akin to benefits than administrative expenses" and appropriately factored into the value of benefits for the calculation of medical loss ratio (American Academy of Actuaries, February 2010). These programs and their pharmacy counterparts, drug therapy management and medication therapy management are critical components of population health management programs which support a physician-guided health care delivery system, which supports, engages, and empowers patients to adhere to treatment protocols, reduce the likelihood of illness and improve health care.

Thank you for your time and consideration of URAC's comments concerning medical loss ratio calculations.

Sincerely,

A handwritten signature in black ink that reads "Alan P. Spielman". The signature is written in a cursive, flowing style.

Alan P. Spielman
President and CEO