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May 14, 2010

Mr. Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup
and
Mr. Steven Ostlund
Chair, Accident & Health Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

RE: Establishment of Definitions of Medical Loss Ratios under
Section 2718 of the Public Health Service Act

Dear Mr. Felice and Mr. Ostlund:

The Network for Regional Healthcare Improvement (NRHI) appreciates the opportunity to provide input as the National Association of Insurance Commissioners works to fulfill the responsibility given to it by Congress under Section 2718 of the Public Health Service (PHS) Act, which was added by Sections 1001 and 10101 of the Patient Protection and Affordable Care Act (P.L. 111-148).

As a result of the amendments in PPACA, Section 2718(b) of the PHS Act establishes standards for the minimum percentage of premium revenues that must be spent by health insurance issuers on (1) reimbursement for clinical services provided to enrollees and (2) “activities that improve health care quality.” Section 2718(c) directs the National Association of Insurance Commissioners (NAIC) to define which activities constitute activities that improve health care quality, subject to the certification of the Secretary of HHS.

We urge that in establishing the definition of “activities that improve health care quality,” you include financial contributions which health insurance issuers make to support the activities of non-profit, multi-stakeholder, Regional Health Improvement Collaboratives in the communities where the health insurance issuers’ enrollees reside.

Non-profit, multi-stakeholder Regional Health Improvement Collaboratives have been formed in dozens of states and metropolitan regions to improve the quality and reduce the cost of healthcare services in their communities. These Collaboratives bring

together four types of stakeholders – healthcare providers (physicians, hospitals, and other providers), payers (health plans, state Medicaid agencies, etc.), purchasers (both businesses and state and local government employee healthcare purchasing agencies), and consumers – to collaboratively design and implement important programs and initiatives such as:

- public reports on the quality of care delivered by physicians and hospitals in the community;
- education for consumers on how to select high-quality healthcare providers and services;
- technical assistance for healthcare providers on ways to improve the quality of care they deliver;
- redesign of payment and delivery systems to support higher-quality care.

The types of programs operated by Regional Health Improvement Collaboratives are directly consistent with other provisions of PPACA. For example, Section 3015 requires collection and reporting of quality data and provides for grants to “multi-stakeholder entities that coordinate the development of methods and implementation plans for the consistent reporting of summary quality and cost information,” which is precisely the role that many Regional Health Improvement Collaboratives play in their communities. Section 3501 authorizes federal funding for local quality improvement collaboratives to provide technical support to health providers to improve the quality of care they deliver, which is again one of the key roles that Regional Health Improvement Collaboratives play in their communities.

The importance of the work Regional Health Improvement Collaboratives do has been nationally recognized. Twenty-four Collaboratives have been designated as Chartered Value Exchanges (CVEs) by HHS and receive technical assistance from the Agency for Healthcare Research and Quality. Seventeen of the Collaboratives participate in the Robert Wood Johnson Foundation’s Aligning Forces for Quality program. The leading Regional Health Improvement Collaboratives in the country are members of the Network for Regional Healthcare Improvement, which provides a mechanism for Collaboratives to share best practices among themselves and to work jointly on national quality improvement issues.

Despite the critical role that Regional Health Improvement Collaboratives have played and will continue to play in improving healthcare quality, there has been no federal financial support for their work to date. The Collaboratives rely primarily on contributions from local healthcare stakeholders to support the quality measurement and quality improvement programs they operate. In particular, health insurance issuers have been major sources of funding for Collaboratives, since these issuers serve as efficient mechanisms for equitably distributing the burden of financial support for community quality improvement initiatives across all of the healthcare providers and recipients in the community. (In many cases, these contributions are referred to locally as “dues,” even though the Collaboratives are 501(c)(3) entities, simply as a way of

reinforcing the need for all stakeholders in the community to contribute.) The loss of these contributions from health insurance issuers would jeopardize the continued viability of the programs operated by Collaboratives at a time when those programs are needed more than ever.

Consequently, it is essential that in the definition of “activities that improve health care quality” under Section 2718, there be nothing which precludes or discourages health insurance issuers from contributing funds to support the work of non-profit Regional Health Improvement Collaboratives. We would urge that the definition explicitly identify such contributions as an “activity that improves health care quality” so that there is no ambiguity about that.

Attached to this letter are specific changes we would recommend be made in NAIC’s Draft Blanks Proposal to achieve this goal.

We appreciate the opportunity to provide these comments, and we would be happy to answer any questions or provide any additional information that you would find helpful. We would be pleased to work with you to help establish an appropriate definition of quality improvement activities to ensure that the critical work of Regional Health Improvement Collaboratives is not jeopardized.

Please feel free to contact me if we can be of assistance as you implement the provisions of the law.

Sincerely,

A handwritten signature in black ink, appearing to read "H. D. Miller", written in a cursive style.

Harold D. Miller
President and CEO

Attachment

cc: NRHI Members

RECOMMENDED CHANGES TO NAIC DRAFT BLANKS PROPOSAL

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 (a) to measure and report on the quality of health care in the community or (b) 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, including through the measurements and reports under (a). 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. Funding for Regional Health Improvement Collaboratives: Grants, contributions, and contracts to non-profit, multi-stakeholder entities that (a) collect and issue public reports on the quality of healthcare services delivered in the community, or (b) provide assistance to healthcare providers in improving the quality of services they deliver.

54. 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, measurement and reporting programs operated by non-profit, multi-stakeholder collaboratives, or patients for the electronic creation, maintenance, access, reporting, 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. Collecting, analyzing, and reporting data on the quality of healthcare services delivered in the community to providers, purchasers, patients, and multi-stakeholder collaboratives;

54. 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.