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June 15, 2010

Mr. Lou Felice
Chair, Health Reform Solvency Impact Subgroup
New York Department of Insurance
25 Beaver Street
New York, NY 10004-2319

Re: Medical Loss Ratios – June 9th exposed draft blanks

Dear Mr. Felice:

On behalf of the more than 200 members of DMAA: The Care Continuum Alliance, I am writing to offer suggestions (see attached redlined document) to the draft blank and supplemental health care exhibit instructions document exposed last week by your subgroup.

DMAA: The Care Continuum Alliance represents organizations providing services along the continuum of care to more than 160 million Americans through wellness, chronic care management and complex case management. DMAA: The Care Continuum Alliance members include wellness, disease management and population health management organizations; health plans; labor unions; employer organizations; pharmaceutical manufacturers; pharmacy benefit managers; health information technology innovators and device manufacturers; physician groups; hospitals and hospital systems; academicians; and others. These diverse organizations share DMAA: The Care Continuum Alliance's vision of aligning all stakeholders toward improving the health of populations. Our members seek to improve health care quality and contain health care costs by providing targeted interventions and services to individuals who are well, at-risk or managing one or more chronic conditions.

We are pleased to see that the changes to column headings in the quality expense definition conform to those categories for quality improvement spelled out in Sections 1311 and 2717 of the Patient Protection and Affordable Care Act (PPACA). As revised, the column headings more appropriately address broad quality improvement goals and provide examples of activities that would qualify as such.

Population health management programs are designed to address the health needs of specific and targeted populations while providing services at the individual patient. Further, such programs are designed, implemented and evaluated at the population level. Population health management programs strive to address health needs at all points along the continuum of health and well being, through participation of,

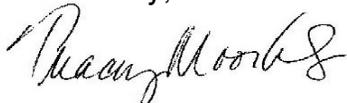
engagement with and targeted interventions for the population. The goal of a population health management program is to maintain and/or improve the physical and psychosocial well being of individuals through cost-effective and tailored health solutions. Currently, the blanks document definitions appear to be focused solely on patient level care rather than on population based programs and approaches. DMAA: The Care Continuum Alliance urges the NAIC to incorporate both patient level and population based concepts into the language. Our suggested changes in the attached redlined document address these concerns. We believe the column headings on improvement goals and initiatives designed to improve health outcomes, reduce hospital admissions, improve patient safety and reduce medical errors, and encourage wellness and health promotion represent stated health reform goals for both individuals and populations.

In addition, DMAA: The Care Continuum Alliance believes that the “other” expense category currently contained in columns 1, 2, 3 and 5 would establish a process that goes beyond statutory intent for the approval of additional items to qualify as quality improvement expenses. To that end, we recommend language in the attached redlined document representing a different approach that allows for innovation and evolution with respect to future programs in each of the expense columns.

Again, we commend you, members of the subgroup and the NAIC staff for the open and expeditious manner in which the process is being conducted.

Thank you for your consideration of these comments. Please do not hesitate to contact me or Kip MacArthur, Director, Government Affairs at (202) 737-5980.

Sincerely,



Tracey Moorhead
President and CEO

Cc: Todd Sells
Brian Webb