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August 26, 2010

Mr. Jay Angoff
Director, Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Hubert H. Humphrey Building
Room 737 S-07
200 Independence Avenue, SW
Washington, DC 20201

Dear Director Angoff:

On behalf of the more than 200 members of DMAA: The Care Continuum Alliance, I write to urge you to certify the National Association of Insurance Commissioners (NAIC) recommendations on the definitions of medical loss ratio (MLR) expense categories as contained in the health plan annual blanks reporting statement approved by a joint NAIC Executive Committee and Plenary session on August 17th.

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.

Section 2718 of the Affordable Care Act (ACA), PL 111-148, directs the Department of Health and Human Services (HHS) to require that health insurance issuers annually report on the percentages of premiums spent on clinical services and activities that improve health care quality. Further, ACA directs the NAIC to establish uniform definitions for expense categories that comprise the MLR for certification by HHS.

As we stated in our response to the request for information on MLR in March, DMAA: The Care Continuum Alliance previously voiced concern that NAIC guidance and the classification of disease and case management programs as administrative expenses was outdated and failed to appropriately account for and reflect the significant positive impact on quality and health outcomes that wellness, disease and case management programs provide. With the enactment of the ACA and the introduction of new terminology, "activities that improve health care quality" with respect to MLR expense

category, we continue to be encouraged at the attempts to ensure a broader commitment to delivering high-quality health care.

As HHS moves toward certifying NAIC uniform/standard definitions of MLR, DMAA: The Care Continuum Alliance urges the Department to recognize the continuous innovation and evolution of health care delivery systems toward the goals of improved quality and health outcomes and greater efficiency. To that end, HHS should establish a transparent and ongoing process with state regulators and other stakeholders that recognizes the need for flexibility in classifying services for the calculation of the MLR and that avoids stifling the development, continued evolution and broader adoption of population health improvement initiatives. Specifically, as the Department develops a regulatory definition of "activities that improve quality," DMAA: The Care Continuum Alliance cautions against defining too narrowly the services in this category. The definition should recognize the evolving nature of the delivery and financing of health care and not inadvertently suppress innovation by restricting the category to a limited set of activities.

DMAA: The Care Continuum Alliance has previously defined “quality improvement” as an essential element and fundamental goal of population health management. The definition we adopted states: quality improvements flow from population health management strategies that “support the physician or practitioner/patient relationship and plan of care; emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and evaluate clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.”[i]

Wellness, disease and case management services improve and support the health of populations and are important activities that improve quality and result in better health outcomes. These services support an efficient and effective health care delivery system that facilitates the engagement and support of providers and patients to mitigate illness and improve long-term health. Further, these services are built on a foundation of evidence-based clinical care and measured by their clinical impact on health status. Such programs and services educate patients and promote self-management skills and behavior change; provide coaching and nurse support; ensure safe transitions in care; improve medication adherence and management; coordinate care between providers and care settings; and enhance quality through evidence-based decision support, data analytics, disease registries and other technologies. These services are primarily provided by licensed, clinical health care practitioners in and across numerous health care delivery settings and offer benefits far beyond cost containment and claims adjustment activities.

DMAA: The Care Continuum Alliance believes costs associated with these services should be classified as either “medical expenses” or “quality improvement expenses” for the purpose of calculating a health plan’s MLR under the requirements of ACA. A recent paper developed on minimum loss ratios by the American Academy of Actuaries describes “case management, disease management, 24-hour nurse hotlines, 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 services have proved efficient and effective in improving the quality and cost of care, as demonstrated by the continued investment in population health management by

commercial insurers. We have worked with numerous external stakeholders to develop measurement methodologies to guide evaluation of population health management programs and services. (*Outcomes Guidelines Report Volume 4.* DMAA: The Care Continuum Alliance, 2009; attached) We recommend that the Department refrain from setting evaluation guidelines and, instead, support the private sector's continued work on measurement design and evaluation of these services. DMAA: The Care Continuum Alliance is glad to serve as a resource to the Department and share its experience developing scientifically sound, consensus measures for population health management programs.

The NAIC did exemplary work in developing the MLR expense category definitions in an open and transparent fashion and we were pleased to work closely with them throughout the process.

DMAA: The Care Continuum Alliance stands ready to serve as a resource to HHS on population health management, medical claims costs and costs associated with activities that improve health care quality, including those regarding the efficacy or measurement of such services. We would be pleased to provide any additional information.

Sincerely,

Tracey Moorhead
President and CEO

[i] Dictionary of Disease Management Terminology, Second Edition. p. 152. DMAA: The Care Continuum Alliance. 2006.