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September 2, 2010

Jane L. Cline
Commissioner, West Virginia Insurance Commission
President, National Association of Insurance Commissioners
2301 McGhee Street
Suite 800
Kansas City, MO 64108-2662

Dear Commissioner Cline:

On behalf of the more than 200 members of DMAA: The Care Continuum Alliance, I commend you for your leadership and the NAIC's thoughtful deliberations on medical loss ratio expense category definitions that are reflected in the final health plan annual statement blanks approved 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. 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.

With the enactment of the Affordable Care Act (ACA) and the introduction of new terminology, "activities that improve health care quality" with respect to MLR expense category, we continue to be encouraged by efforts to improve health care quality. Section 2718 of the ACA presented the opportunity to revisit previous NAIC guidance presented in SSAP 85 with regard to the classification of disease and case management programs as administrative or cost containment expenses. We have long been concerned that the guidance was outdated and failed to appropriately account for and reflect the significant positive impact on quality and health outcomes that wellness, disease and case management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.

As the Department of Health and Human Services (HHS) moves toward certifying NAIC uniform/standard definitions of MLR, we will continue to urge them 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, we support a transparent and ongoing process between HHS officials, 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.

The NAIC's work on this issue was both transparent and exemplary and we were pleased to work closely with Commissioners and staff throughout the process. We stand ready to provide additional resources and expertise, as needed.

Sincerely,

Tracey Moorhead
President and CEO

Cc: Susan Voss, President-Elect, NAIC
Kevin McCarty, Vice President, NAIC
Kim Holland, Secretary-Treasurer, NAIC
Sandy Praeger, Vice Chair, Health Insurance and Managed Care (B) Committee
Alfred W. Gross, Chair, Financial Condition (E) Committee
Lou Felice, NY Insurance Department
Todd Sells, NAIC staff