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April 30, 2010

Mr. Lou Felice
Chair, Health Reform Solvency Impact Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Medical Loss Ratios – Section 2718 of the Public Health Service Act (PHSA)

Dear Mr. Felice:

On behalf of the more than 200 members of DMAA: The Care Continuum Alliance, I offer the following comments to National Association of Insurance Commissioners (NAIC) regulators and representatives as you consider classification of health plan expenses related to the calculation of Medical Loss Ratio (MLR).

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 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'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(c) of the Public Health Service Act directs the NAIC to establish uniform definitions for activities that health insurance issuers offering individual and group coverage must report under Section 2718(a), including clinical services, activities that improve health care quality and all other non-claims costs and the nature of such costs.

Existing NAIC guidance on this issue —Statement of Statutory Accounting Principle (SSAP) 85, issued in 2002 — identifies case management and disease management programs as "cost containment expenses." NAIC defines "cost containment expenses" as "expenses that actually serve to reduce the number of health services provided or the cost of such services." Additional NAIC guidance directs "cost containment expenses" to be allocated as "administrative expenses" when calculating a health plan's MLR.

DMAA: The Care Continuum Alliance has previously communicated to NAIC representatives its belief that SSAP 85 does not appropriately account for the significant positive impact on quality and health outcomes that disease and case management programs provide. DMAA has previously posited that these activities should more appropriately be classified as costs related to clinical care. In a recent paper developed on minimum loss ratios, 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).

Specifically, wellness, disease and case management services improve and support the health of populations and are important components of population health management programs. These services support a physician-guided health care delivery system and engage and support patients to mitigate illness and improve long-term health. Wellness, disease and case management services are built on a foundation of evidence-based clinical care and are measured by clinical impact on health status. These programs and services educate patients and promote self-management skills; 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 urges the NAIC to support the classification of these services as either "medical expenses" or "quality improvement expenses" for the purpose of calculating a health plan's MLR under the requirements of The Patient Protection and Affordable Care Act (PPACA), PL 111-148.

DMAA: The Care Continuum Alliance looks forward to serving as a resource for NAIC regulators and representatives as you consider these important issues.

Sincerely,

Tracey Moorhead
President and CEO

cc: Richard Diamond, Chair, Actuarial MLR Subgroup
Todd Sells, NAIC Staff
John Englehart, NAIC Staff
Brian Webb, NAIC Staff