AMA
AMERICAN
MEDICAL
ASSOCIATION

June 7, 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

Dear Mr. Felice:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for this opportunity to provide the National Association of Insurance Commissioners (NAIC) with comments and recommendations in response to the NAIC Blanks (E) Working Group, Blanks Agenda Item Submission Form.

The AMA has reviewed your recommendations of May 31, 2010. We commend the efforts that your committee has made to promote transparency in the health insurance reporting process and your committee's commitment that only expenses directly attributable to quality initiatives are reported as such. Maintaining a clear division between quality versus cost containment under PPACA is an essential element to ensure that health insurers are spending an appropriate percentage of premium dollars on direct patient care and activities designed to improve individual patients' health. Towards this goal, we have l recommendations that might clarify and/or add specificity to your committee's proposed language.

Health Care Quality Improvements

Line 5 of your proposal cites Section 2717 of PPACA as statutory authority for your recommendations for "Expenses for Health Care Quality Improvements." The recommendations list "effective case management; care coordination; chronic disease management; medication and care compliance initiatives; prevention of hospital readmissions; activities to improve patient safety and reduce medical errors by using best clinical practices; activities to encourage evidence based medicine and wellness and promotion activities" as "activities that may in whole or in part improve quality of care." We believe that the qualifying activities might be better defined using the actual language contained in PPACA, Section 2717, which cites the following four categories of activities for quality improvement reporting under 300 gg-17 (a) (1):

(A) Improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 [3502] of the Patient Protection and Affordable Care Act [42 USCS § 256a-1], for treatment or services under the plan or coverage;

(B) Implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) Implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) Implement wellness and health promotion activities.

We respectfully request that the committee revise Line 5, "Expenses for Health Care Quality Improvements" to reflect the statutory language as listed in Section 2717 (A) through (D) above. We urge the committee to reorganize Line 5 and 5.1 to include the following new criteria that we believe reflects the intent of PPACA.

1. **Improve Health Outcomes.** Examples must involve the direct interaction between the insurer and the enrollee or provider (not just general care management but face-to-face, telephonic or web-based interactions or other modalities with patients and their providers) and may include: *Care coordination* and individually tailored *chronic disease management* programs (for specific chronic conditions); the *coordination of a patient's care* between multiple providers such as making sure medical records are shared between all the patient's physicians; care coordination and chronic disease management activities to *encourage evidence based medicine; medication and care compliance initiatives* such as: (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 the insured in the management program, and (d) provide coaching on dealing with the disease/condition.

2. **Prevent Hospital Readmissions.** Creation of a comprehensive, individualized program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional. *Effective case management* such as making/verifying appointments and medication and care compliance initiatives [not involved with chronic disease management) and arranging and managing transitions from one setting to another such as a hospital discharge to home or to a rehabilitation center to prevent hospital readmissions.

3. **Improve Patient Safety.** Creation of a coordinated program to implement specific activities that result in *improved patient safety* and reduced medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology.

4. **Health and Wellness Promotion**: Programs that interact with the insured (e.g. face-to-face, telephonic or web-based interactions or other modalities with patients and their providers) related to: *Wellness* assessment, wellness/lifestyle coaching programs, coaching programs designed to promote and educate members on clinically effective methods for dealing with a specific chronic disease, and coaching or education programs and *health promotion activities* designed to change member behavior (e.g., smoking, obesity or compliance with physician prescribed evidence based regimens.

Health Information Technology

Utilization of health information technology is an important tool in the development of many quality of care improvement initiatives. We agree that the final requirements should address how quality expenses are defined, as discussed in line 5.2. However, we do not believe that your proposed language has adequate statutory authority under Section 2717 to cover all of the activities listed in your proposal. We also urge you to narrowly define the language in line 5.2 to mandate that any activities using health information technology are primarily and specifically used for, and have a clear nexus to, direct patient benefit activities. If the proposed language were implemented, it could allow for significantly broad inclusion of many different and tangentially related expenses to be included in line 5.2.

Section 2717 specifically states that health information technology be included under (3) above: in quality improvement related activities that "improve patient safety and reduce medical errors." We recommend categorizing any health information technology recommendations under (3) above to reflect Section 2717. Any such expenditures should be clearly defined and narrowly limited only to those meeting the above definition. The current language not only develops an entirely new category for health information technology quality activities, but it also includes broad language that could encompass many non-specific activities that do not improve direct medical care for patients. For example, as written, an insurer could broadly categorize use of health information technology for improving communication methods (line 5.2; 2); or for tracking whether certain services lead to "better outcomes" (line 5.2, 3). Any health care quality cost that utilizes health information technology must have a clear nexus to directly improving patient medical care. For example, how "better outcomes" and increased communication methodologies actually benefit a patient directly are unclear in Line 5.2. We urge you to include our suggested language or other very specific criteria defining how each of these types of activities must utilize health information technology to improve quality.

The AMA appreciates the opportunity to provide its comments about medical loss ratios to NAIC. We look forward to working further with NAIC and HHS on this important matter. Should you have any questions regarding these comments, please contact me at elizabeth.schumacher@ama-assn.org or (312) 464-4783 for more information.

Sincerely,

Elizabeth A. Schumacher
Legislative Attorney
Advocacy Resource Center