



Case Management Society of America

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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 11,500 members and 20,000 subscribers of the Case Management Society of America (CMSA), we 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).

CMSA and their members partner with over 300 health care entities providing case management services including chronic care, complex and integrated case management along the continuum of care. Case managers are licensed health care professionals consisting of nurses, social workers, physicians and pharmacists who practice in all areas of the healthcare continuum; hospital, outpatient clinic, rehabilitation, primary and specialty care, long term care, hospice, home care and medical home. They deliver those services through government programs, employers, workers compensation, wellness programs, commercial managed care, physician practice and independent practice to the consumer. Our members are committed to improving health care quality and ensuring patient safety by providing targeted interventions and services to at-risk individuals in order to ensure the patient receives the right care at the right time in the right setting.

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.

CMSA has previously communicated to NAIC representatives its belief that SSAP 85 does not appropriately account for the significant positive impact on clinical quality and health outcomes that disease and case management programs provide in concert with DMAA: The Care Continuum Alliance and URAC. CMSA supports 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 “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, case management programs support the improvement of patient wellness and management of their health care condition(s) through extensive interventions in collaboration with various members of the patient’s clinical team. The case manager performs the primary functions of assessment, planning, facilitation and advocacy, which are achieved through collaboration with the patient and other health care professionals involved in the patient’s care. Key responsibilities of case management have been identified by nationally recognized professional societies and certifying bodies through case management roles and functions research. Role functions of case managers include:

- Conducting a comprehensive assessment of the patients health and psychosocial needs, including health literacy status and deficits, and develops a case management plan collaboratively with the patient and family caregiver
- Facilitating communication and coordination between members of the health care team, involving the patient in the decision-making process in order to minimize fragmentation in the services
- Educating the patient, the family caregiver, and members of the health care delivery team about treatment options, community resources, insurance benefits, psychosocial concerns, chronic condition management, transitions of care, etc so timely and informed decisions can be made
- Empowering the patient to problem-solve by exploring options of care, when available and alternative plans when necessary to achieve desired outcomes
- Assisting the patient and family caregiver in the safe transitioning of care to the next most appropriate level
- Striving to promote patient self-advocacy and self determination

Many aspects of the new healthcare reform law focus on the continued support of chronic care management and care coordination for patients and their caregivers. Yet without the case managers clinical interventions of patient and family assessments, proactive care planning, bi-directional communication, patient and family health coaching, medication adherence management and patient advocacy it will be more of a challenge in meeting positive outcomes for treatment adherence, improved patient safety or enhanced quality of care

Case management, disease management and care coordination 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 the clinical impact on the patient’s health status.

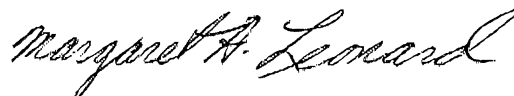
CMSA urges the NAIC to support the classification of these services as either “medical expenses” or “quality improvement expenses” for the purpose of calculating a health plan’s MLR under the requirements of The Patient Protection and Affordable Care Act (PPACA), PL 111-148.

The Case Management Society of America looks forward to serving as a resource for NAIC regulators and representatives as you consider these important issues.

Respectfully,



Cheri Lattimer, RN, BSN
Executive Director
Case Management Society of America



Margaret Leonard, MS, RN-BC, FNP
President
Case Management Society of America

cc: Richard Diamond, Chair, Actuarial MLR Subgroup
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