July 18, 2016

Director Dean Cameron
Chairman, MLR Quality Improvement Activities (B) Subgroup
444 North Capitol Street NW, Suite 701
Washington, DC 20001

Dear Director Cameron:

The undersigned companies appreciate the opportunity to provide comments regarding quality improvement (QI) activities in the Medical Loss Ratio (MLR) calculation. Your review is important, as, over time, new programs, advancements and innovations arise for quality healthcare, and it is also important that prior recommendations and existing rules be re-evaluated. Consequently, we thank you, and the rest of the Subgroup, for recognizing that regulators have an opportunity to recommend changes to the definition of QI in a way that facilitates issuers’ future investment in programs designed to improve quality outcomes for consumers and the efficient use of health care resources.

Recently, we marked the sixth anniversary of the passage of the Affordable Care Act (ACA) – and in these six years, we have seen significant changes in the health insurance marketplace. While we are all familiar with the impacts of the ACA, there are a few specific changes that are worth noting in the context of the MLR formula. Notably, health insurers (1) operate in a guaranteed-issue environment, (2) have increased their investments in the development of value-based reimbursement models, and (3) have leveraged technological advancements to improve quality and patient safety. In response to these market dynamics, we know that more consumers are using their insurance to get the care they need to improve their health.

As part of this Subgroup’s review process, we specifically ask that the Subgroup members consider removing three specific exclusions under section 45 CFR §158.150(c): Sections (7) all retrospective and concurrent review; (8) fraud prevention activities; and (10) provider credentialing.

In our view, health insurance issuers should be encouraged to invest in these programs and activities because they address central health care quality issues – overuse, underuse, and misuse of health care services – and improve the health of all Americans. The best validated third party data from NCQA demonstrates that these programs and activities improve quality above and beyond that which is provided by the health care delivery system in a fee-for-service setting. We hope that the Subgroup will consider the misalignment of incentives related to these programs, and take steps to encourage further issuer investment in these areas.

All Retrospective and Concurrent Review
Utilization review is one of the original benchmarks used by the health insurance industry to ascertain and ensure its providers deliver quality care to their patients. Both retrospective and concurrent reviews are important. While retrospective review provides statistical information to support decisions to improve future care, concurrent review of patient health information provides real-time information to support decisions made while the patient is still receiving care. This type of review provides critical health care information that is continuously used to improve the quality of care among providers.
It is important that “all retrospective and concurrent review” be removed from the list of exclusions under 45 CFR 158.150(c) since it is one area that is rigorously monitored and statistically evaluated by accrediting associations—such as NCQA and URAC. These organizations have created quality benchmarking products that reflect the latest changes in health care and provide a symbol of excellence for organizations to showcase their commitment to quality and accountability. In addition, they use evidence-based measures and standards that are developed through inclusive engagements with a broad range of stakeholders committed to improving the quality of health care. Steeped in measurable data, retrospective and concurrent review is one area that definitely should be included in QI initiatives.

**Fraud Prevention and Patient Safety**

With respect to fraud prevention expenditures, the current rule only allows for expenses up to the amount of the recovery and leaves out the key components of anti-fraud measures, which are prevention and the efforts to detect it. In other words, the current federal rule discourages health insurance issuers from investing in anti-fraud activities that would reduce the cost of health care coverage. To fix this issue, the NAIC could recommend a removal of the current blanket exclusion of fraud prevention activities from 45 CFR §158.150, recommend to HHS that it should amend 45 CFR §158.140 to permit the counting of a health insurance issuer’s investment in fraud prevention and detection programs as an expense attributable to incurred claims, or limit issuers’ expenses on fraud prevention to a certain percentage of earned premium, similar to the limitation on expenses attributable to ICD-10 implementation in the HHS MLR regulation. We would also be happy to work with this Subgroup to develop an assessment methodology for quantifiable fraud prevention and detection data that meets regulatory objectives.

By illustration, we offer the following examples of actual fraud investigations conducted by health insurers where the early detection of dangerous treatment practices have improved quality for our customers prospectively.¹

- A substance abuse treatment facility employed patients, who were recovering addicts actively receiving treatment and not qualified to administer detoxification services, to render services to other patients. As a direct result, patients reportedly have died in their facility. This carrier also found that the substance abuse facility denied re-entry to its patients who left the premises without permission until the following day, thereby preventing access to required medications or other resources necessary for survival.

- A dermatologist was convicted of falsifying medical records by reflecting treatment for pre-cancerous lesions that actually did not exist. These patients now have a false medical history of pre-cancerous lesions, thereby negatively affecting the patients’ eligibility for premium rates for life insurance coverage or other policies dependent upon pre-existing conditions. Although, the patients will try to correct their medical records, the false medical history may still persist in some facilities and consequently result in erroneous medical treatment in the future.

- Many private health insurers have been at the forefront of efforts to address the problem of prescription drug abuse. For example, since 2007, a nationwide health insurer has been preparing “Operation Pillbox” quarterly reports for law enforcement officials to identify the top opioid prescribers in each of California’s counties. The insurer is also providing individual reports detailing the total prescriptions and payments made to the most egregious prescribers and the pharmacies used. These reports identify consumers who are receiving large quantities of narcotics who may be accomplices in fraud schemes. Many of these individual reports have led the California Medical Board to suspend or revoke the medical licenses of providers engaged in practices that facilitate prescription drug abuse. While the extensive expenditure of health carrier

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¹ In all cases, the appropriate law enforcement officials are engaged and working with company investigation personnel to protect the public at large, as well as our customers.
staff time and resources has helped to curb the opioid epidemic in California, Operation Pillbox does not bring about financial recoveries.

- A national health carrier worked with law enforcement in California to find and end the fraudulent provision of medically unnecessary services in ambulatory surgery centers. Last year, the United States Attorney for the Central District of California announced the conviction of three principals behind the Vista Surgical Center. These defendants had submitted billings for more than $71 million in medical procedures performed on insurance beneficiaries who received free or discounted cosmetic surgery. After payment was received for the unnecessary procedures, patients were given free or discounted cosmetic surgeries, including “tummy tucks,” breast augmentations, rhinoplasties (“nose jobs”) and liposuction. Tummy tucks were billed as hernia repair surgeries, and rhinoplasties were billed as deviated septum repair surgeries. This and similar matters, investigated by the Department of Labor and FBI, depended heavily on private carriers for data analysis, undercover insurance cards, subpoena responses, and testimony.

Health insurers in all states have similar examples of how insurer fraud detection programs have identified quality and patient safety issues. More broadly, healthcare fraud has an emotional and psychological impact on patients. Patients typically place a great deal of faith, trust and confidence in their physicians. When patients become victims of healthcare fraud schemes, they feel betrayed. Their experience breeds distrust and suspicion of the healthcare system, resulting in these patients not seeking or delaying the receipt of effective treatment when needed. With estimates of the overall impact of fraud on healthcare in the tens of billions of dollars each year\(^2\), the collateral impact of fraud has an enormous impact upon the delivery of quality healthcare services to every eligible individual each and every day – and insurers should be properly incentivized to detect fraud for the benefit of consumers and the overall healthcare system.

In closing, we would like to take this opportunity to address the familiar argument that the above referenced programs are cost-control initiatives, not QI. We submit that the two goals are not mutually exclusive; they are expressly and necessarily conjunctive. For years, the health insurance industry has led innovations to improve quality and reduce costs for the health care system. The success of these programs to achieve both well-established public policy goals of lowering costs and improving outcomes should not bar them from being classified as QI, as some would suggest. That interpretation is punitive in nature and inconsistent with the stated purpose of the MLR requirement. If insurers are succeeding in improving quality outcomes, the fact that insurers are also succeeding in reducing costs to the healthcare system is equally beneficial for all. We strongly urge the Subgroup to reject the notion that QI programs must be one or the other.

Thank you again for your reconsideration of this issue. Insurers are on the cutting edge of developing programs and services that are improving quality, lowering cost, and increasing access to the healthcare system. Our ability to continue to innovate in the area of QI depends largely upon the proper alignment between QI and accurate claims reimbursement. We look forward to the continued dialogue and sincerely hope we can work together on expanding the definition of QI in the MLR formula.

**Provider Credentialing**
Another area that should be removed from the exclusions list is provider credentialing. Credentialing is the process of checking the practitioner’s and facility’s credentials in order to protect consumers from

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fraud by ensuring that providers have the proper qualifications to deliver health care services. Many health plans use associations such as NCQA or CAQH that verify a practitioner’s claimed qualifications against primary sources. Health plans also verify with a state or designated certification body that a practitioner is licensed to practice medicine and issue medication. It is through this process that a provider’s quality is specifically measured and health plans are able to assist their customers in finding the most qualified provider for care. Provider credentialing is an extremely important quality improvement initiative that goes to the heart of quality patient care. Without proper credentialing, patients are left in the dark on who may be the most qualified to perform their service and provide the best health outcome.

Thank you for considering our comments. We look forward to working with this Subgroup on this issue in the future.

Sincerely,

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