June 14, 2010

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Re: PPACA Medical Loss Ratio Definition

Dear Mr. Felice and Mr. Ostlund:

As one of the nation's oldest and largest providers of health care benefits, we understand the critical role that the NAIC has been asked to play in the development of minimum loss ratio (MLR) definitions and standards under the Patient Protection and Affordable Care Act (PPACA). These definitions and standards will determine the manner and extent to which health plans invest in activities to improve care quality and safety, reduce fraud, support members with chronic illnesses or complex health conditions, and maintain networks that offer both broad provider choice and affordability.

We are concerned that the current exposure draft continues to include a definition of quality and claims that is much narrower than the statute directs NAIC to develop. We are concerned that an overly narrow definition will lead to higher premiums for consumers, less choice, and lower overall quality of care. We have two global concerns with the current draft:

(1) The current quality categories fail to take into account the multiple sections in PPACA that define quality – including sections 3011 and 3013. The attached outline from Avalere provides a more comprehensive list of the federal quality definitions included in PPACA – including "improving research and dissemination of strategies and best practices….."; "addressing gaps in quality and health outcomes measures, comparative effectiveness information and data aggregation techniques"; and "enhancing the use of healthcare data to improve quality, efficiency, transparency and outcomes." We recommend that all of the quality definitions of sections 3011 and 3013 also be reflected in the NAIC exposure draft.

(2) The current NAIC exposure draft requires that quality activities must "produce results and achievements that can be verified." Quality programs are investments in the long

term health of subscribers. They may not result in short term health gains of members. In addition, some quality programs are community based where the insurer may not even have data to show specific quality gains.

In addition, we have several specific recommendations for modifications to the current exposure draft. We specifically ask the NAIC to recognize the following when developing its minimum loss ratio proposal:

ICD-10 Adoption
It is critical that the costs of adopting the 10th version of the ICD code set are recognized for their contributions to quality improvement. The ICD-10 migration, including both the initial implementation and regular maintenance and updates, will provide an additional level of detail regarding patient care that will enhance providers' ability to maximize quality for patients and to further research that can improve aggregate patient outcomes.

HHS officials have routinely highlighted the positive impact of ICD-10 migration on quality and patient outcomes as a key rationale for requiring the industry to spend billions of dollars on these extensive systems changes. According to a regulation released by the current Administration, "We anticipate that the use of ICD-10-CM, with its greater detail and granularity, will greatly enhance our capability to measure quality outcomes."[i] It would be ironic if one of the most significant and expensive federal quality initiatives in the last decade were excluded from the NAIC quality definition.

Failure to include ICD-10 as a quality activity could cause the MLR rule to "squeeze out" the ability of the insurance industry to implement other critical health information technology initiatives advocated by the Administration and demanded by the market. For instance, initiatives to streamline provider and consumer interactions could face slower implementation.

ICD-10 is also consistent with definitions and priorities for quality as outlined in PPACA: Sec 3011: Addressing gaps in quality and health outcomes measures, comparative effectiveness information and data aggregation techniques and enhancing the use of healthcare data to improve quality, efficiency, transparency and outcomes and Sec 3013: the meaningful use of technology.

Utilization Review: Some experts, such as Drs. Elliot Fisher and John Wennberg of Darthmouth University Medical School, estimate that up to 30% of health care is unnecessary.[ii] According to OMB Director Peter Orszag, as much as $700 billion could be expended in the U.S. on unnecessary health care services.[iii] This means that many consumers are undergoing dangerous surgical and other procedures unnecessarily -- one study estimated as many as 12,000 deaths per year due to unnecessary surgeries.[iv]

Using evidence based utilization review helps assure that patients undergo the right treatment at the right time – and are not subjected to unnecessary risks. Utilization review is widely used in Medicare and Medicaid for this very reason. Utilization review that is based upon clinical guidelines, evidence based medicine, peer review or are credentialed programs should be recognized as quality improvement activities. The fact that these programs also

reduce premiums for consumers should be viewed as an added benefit – not as a rationale to dismiss their quality enhancing properties.

Loss Adjustment Expenses: Given that the general rule in section 2718(a) requires that loss adjustment expenses be included along with claims expenses, we are very concerned that the current NAIC proposal does not include loss adjustment expenses.

The rebate provision in section 2718 (b) builds on the calculation in 2718 (a). It is true that section 2718(b) does not specifically refer to the general rule to report incurred loss plus loss adjustment expense to earned premiums. Instead it simply refers to the ratio of a(1) and (2) to premium revenue. However by referencing a (1) and (2), the statute imports into 2718 (b) the same method by which a(1) and (2) are calculated for purposes of 2718 (a) which should include the general rule providing for the use of the loss adjustment expense. This is because a(1) and a(2) are not stand alone provisions – they are elaborations of the general rule in 2718 (a) which requires reporting that takes into account loss adjustment expenses. The only logical way to read the statute in its totality is to include loss adjustment expenses in the numerator of the minimum loss ratio calculation for both reporting and rebate calculations.

While the best legal reading of the statute would include loss adjustment expense, there is also a critical policy reason to include it as well. Preferred Provider Organizations (PPOs) are one of the most popular benefit designs demanded by consumers and employers. If loss adjustment expenses are not included in the numerator, PPOs would be at a competitive disadvantage to the HMO model. The unintended consequence could be that PPO models become less available to consumers.

Fraud and Abuse Detection and Prevention
In order to ensure that the goals of PPACA are realized, defining "quality improvement" appropriately will be particularly important. The current NAIC Blanks proposal excludes all anti-fraud expenses from the quality definition. According to the National Health Care Anti-Fraud Association's letter to the NAIC, however, "[Their] experience has taught [them] that while fighting fraud is most often described in economic terms, the most significant impact is felt in human terms. Health care fraud often causes patient harm, sometimes with devastating results. Undoubtedly, efforts to eradicate this insidious problem do have a direct correlation to health care quality and the quality of life of all Americans."

As their statement attests, fraud harms patients and does so in numerous ways – some schemes pay healthy individuals to undergo needless procedures, dilute pharmaceuticals, alter medical records with fake diagnoses without patient knowledge, facilitate "doctor shopping" by drug addicts, and hide unlicensed physicians.

The efforts of Aetna's Special Investigations Unit (SIU) highlight these activities' ability to improve the overall quality of healthcare. By identifying healthcare fraud schemes and fraudulent providers, SIU is able to remove these providers from insurer provider networks and refer them to law enforcement agencies, further deterring other providers from committing the same actions. As a result, consumers are safer and enjoy a higher level of quality care.

In one specific instance, Aetna's SIU worked with the FBI and other insurers to investigate a provider who received patient self referrals from around the country via the internet and also

from employed “runners” for surgical treatment of supposed hyperhidrosis (sweaty palms). The procedure involved is called laparoscopic thoracic sympathectomy and involves cutting the chest nerve that controls sweat glands and dilation of blood vessels near the surface of the skin of the face and fingers.

This provider never saw patients until the day of their planned outpatient surgeries. More importantly, there was no post-operative care arranged, as the physician also never saw patients postoperatively. Out-of-state patients either went home or stayed in a hotel for several days and never saw the provider after the procedure. Possible complications from this procedure are pneumothorax (collapsed lung), hemothorax (bleeding into the lung) or compensatory disabling excessive sweating. The FBI ultimately raided this provider’s home, office and offices of his employees because of these issues.

The cost savings to the health care system resulting from insurer anti-fraud activities is significant. At Aetna, the return on investment of its SIU was 18.6 to 1 in fiscal year 2009. But these activities also save costs and lives outside of our own plans, including Medicare and Medicaid, since these providers generally treat a wide variety of patients.

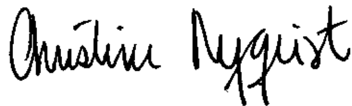
Anti-fraud programs support the quality definitions and priorities identified in PPACA Sec. 2717, which encourages implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology. NAIC’s proposal should be consistent with how quality is defined throughout the legislation to best support the achievement of its goals.

We appreciate the NAIC’s diligent and open process as you address the critical issues surrounding the development of a federal MLR. We urge the NAIC to take into consideration our concerns in order to avoid:

- unnecessary premium increases to consumers,
- a reduction in choice and the availability of PPOs, and
- reduced investment in critical activities such as fraud prevention and health information technology innovation.

Please let us know if we can provide additional assistance in this complex endeavor.

Sincerely,



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[i] 74 Fed. Reg. 3332 (January 16, 2009).

[ii] Kaiser Family Foundation U.S. Health Care Costs. July 2009.; John E. Wennberg and others, "Geography and the Debate Over Medicare Reform," *Health Affairs,* Web Exclusive (February 13, 2002), pp. W96–W114; and Elliott Fisher, "More Care Is Not Better Care," *Expert Voices,* Issue 7 (National Institute for Health Care Management, January 2005) .
[iii] U.S. Congress. Senate Finance Committee. March 10, 2009. (Testimony of Peter Orszag).
[iv] Leape L. Unnecessary surgery. Annu Rev Public Health. 1992;13:363-383.

The Affordable Care Act (ACA) includes a number of new requirements and programs to promote quality healthcare. Many health plans have been participating in similar quality-focused initiatives for some time. The enactment of the ACA provides the government authority to implement quality initiatives across the healthcare system, including Medicare and Medicaid.

Below is a section-by-section description of the quality improvement activities included in the law.

Section 2717: Ensuring the quality of care

- Developing activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance activities, including the use of medical homes
- Implementing activities aimed at preventing hospital readmissions
- Encouraging and implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology
- Establishing wellness and prevention programs. These may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a healthcare provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face to face telephonic or web-based intervention efforts for each of the programs participants

Section 1311: Rewarding quality through market-based incentives

- Implementing activities to reduce health and healthcare disparities, including the use of language services, community outreach and cultural competency training
- Including the activities listed above under "Ensuring the quality of care"

Sec 3011: National Strategy to Improve Healthcare Quality Priorities

- Addressing the health care provided to patients with high cost chronic diseases
- Improving the research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections
- Identifying those items with the greatest potential for improving health outcomes, efficiency, and patient centeredness of healthcare
- Reducing health disparities
- Addressing gaps in quality and health outcomes measures, comparative effectiveness information and data aggregation techniques
- Identifying areas in the delivery of healthcare services that have the potential for rapid improvement in the quality of patient care

- Improving federal payment policy to emphasize quality and efficiency
- Enhancing the use of healthcare data to improve quality, efficiency, transparency, and outcomes

Section 3013: Quality Measure Development

- Developing measures that assess:
  - Health outcomes and functional status of patients
  - The continuity, management, and coordination of healthcare and care transitions, including episodes of care for patients across the continuum of providers, healthcare settings and health plans
  - The experience, quality and use of information provided to and used by patients, caregivers, and authorized representatives to Inform decision making about treatment options
  - The meaningful use of health information technology
  - The safety and effectiveness, patient centeredness, appropriateness, and timeliness of care
  - The efficiency of care
  - Health disparities across health populations and geographic areas
  - Patient experience and satisfaction
  - The uses of innovative strategies and methodologies

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