



15 June 2010

Mr. Lou Felice
Chair, Health Reform Solvency Impact (E) Subgroup
C/- New York Department of Insurance
25 Beaver Street
New York, New York 10004-2319

RE: *Medical Loss Ratios – Exposure Draft of June 9th*

Dear Mr. Felice:

We write today on behalf of America's Health Insurance Plans (AHIP) to provide the Health Reform Solvency Impact (E) Subgroup with input and comments on the Subgroup's charge to develop definitions and a standardized methodology for calculating medical loss ratios pursuant to sections 1001 and 10101 of the *Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010* (PPACA), (*Pub. L. 111-148*) (*referenced hereafter as PPACA Section 2718* for ease of reference). AHIP is the nation's trade association representing nearly 1,300 member companies providing health, long-term care, dental, disability and supplemental coverages to more than 200 million Americans. We appreciate the opportunity to provide comments on this important project. AHIP is committed to the development and maintenance of a strong regulatory structure for policyholders.

The list of programs that provide direct benefit to the policyholders and to the population as a whole is long, and ever evolving. Creating a static list of "quality" programs freezes the ability of carriers to innovate and develop new and better programs for the populations they serve. A decade ago, the idea that health plans would be called upon to fight childhood obesity, for example, was unheard of. Today, the First Lady champions precisely just such a program and has charged all players in the health care delivery and financing system to do their part. The rules we develop today must not penalize health plans for responding to this challenge, or the ones that will arise tomorrow.

We appreciate that the working group has adopted a definition of Improving Health Care Quality Expenses that focuses on the activities designed to improve health care quality including categories of activities under which these quality expenses can be categorized. We suggest some changes to the language, as reflected in the attached document. Our suggestions are intended to assure that innovative quality programs can be recognized, and the dynamics of continuous care improvement permitted and recognized, consistent with the intent of quality improvement activities.

We continue to urge that you include consideration of the quality improvement activities of the care management call lines used by health plans. Those call lines can include hotlines,

help lines, coaching, wellness, and other care management lines to facilitate member access to quality care, and care management, with improved outcomes. This also includes nurse help lines, as well as pharmacy medication management help lines. These programs should be broadly included, not broadly excluded, as they are in the exposure draft of June 9th. For this reason we support the changes noted in the attached redlined changes to the Supplemental Health Care Exhibit Part – 3.

For the same reasons, we argue that to the extent that fraud investigation and prevention activities identify harmful treatment of members, or providers operating in ways that compromise members' care management or health outcomes, such fraud program costs should be included as meeting definition of improving health care quality. Thus we do not believe they should be broadly excluded as not meeting the definition of improving health care quality expenses.

Similarly, the federal government has required health plans and insurers to comply with costly new ICD-10 code reporting implementation standards. This new code set is a leap forward in detail from the ICD-9 codes currently in use, and will provide significantly more detailed descriptions and reporting on levels and types of care rendered. As a result of the adoption of ICD-10 codes, claims will include a significant level of detailed clinical information, such as blood pressure levels and BMI, that will be used to improve quality and health outcomes. The primary purpose of adoption of the new ICD-10 code sets is to provide more relevant and useful medical information here and across the globe with respect to diseases, medical procedures and the nomenclature by which they are reported.

The United States Department of Health and Human Services itself has recognized that this undertaking is not an attempt to build a better claims payment system, but rather, it permits the United States to join the rest of the world in collecting critical information about disease to allow not only study but eventual eradication. Then-Secretary Michael Leavitt in January, 2009 said *"We are taking a giant step forward toward developing a health care system that focuses on quality and affordability through the implementation of health information technology". "The greatly expanded ICD-10 code sets will enable HHS to fully support quality reporting, pay-for-performance, bio-surveillance, and other critical activities.* Conversion to ICD-10 is essential to development of a nationwide electronic health information environment, and the updated X12 transaction standards are a critical step in the implementation of these new codes." *(emphasis supplied)*¹

Health plans continue the detailed, and costly, implementation of these code sets just at the time of more scrutiny on their administrative expenses. Failing to take these mandatory expenditures into account when developing the MLR standards undermines a company's ability to provide access to more and higher quality clinical services for consumers, which is inconsistent with the very purpose of the MLR calculation. We again urge the subgroup to remove the exclusion for the costs associated with ICD-10 implementation from the definition of quality programs.

We are aware that there are those in the regulatory and consumer community who believe that these costs are administrative claims-payment costs; this is in large part incorrect. In

¹ See, <http://www.hhs.gov/news/press/2008pres/08/20080815a.html>

fact, the “ICD” is the “International Classification of Diseases;” ICD-10 is the 10th version. Its precursor was initially developed to track international causes of death and disease. The idea behind ICD-10 and its predecessor “coding” projects is that only through a common language can the world describe, and therefore fight, common diseases.

As background, the World Health Organization (WHO) developed a monograph entitled “History of the development of the ICD,” which traces the development of a standard nomenclature for disease reporting from its earliest attempts in 1777, to its adoption by the American Public Health Association in 1898, to earlier expansion from mortality to morbidity reporting after the Crimean War to its standardized adoption in the United States in 1944. In 1946, the World Health Organization was charged by the International Health Conference to maintain and update the standardized nomenclatures. It was then titled the “International Classification of Diseases, Injuries, and Causes of Death” and was the 6th revision to what would become ICD-10. Revision seven was undertaken by the International Conference for the Seventh Revision of the International Classification of Diseases in 1955. Similar conferences were convened for the eighth revision, in 1965, and the ninth in 1975. The conference to begin the tenth revision was called in 1989. Countries continue to work to implement its provisions, which were a major departure from the earlier version of the ICD.

None of the countries that have undertaken the massive overhaul of their industry coding systems that ICD requires have done so simply to improve their ability to pay claims. They have done so in order to participate in the global conversation to prevent and combat death and disease. ICD by its very nature is a century-old system to classify, understand, and therefore combat and eradicate disease world-wide. To categorize it as “administrative” industry cost or a claims-payment system is to fail to understand the gravity of this undertaking, and its value to the quality of health care on a world-wide basis.

The World Health Organization describes ICD thus:

The ICD is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. These include the analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as the characteristics and circumstances of the individuals affected, reimbursement, resource allocation, quality and guidelines.

It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States. See: <http://www.who.int/classifications/icd/en/>

At least twenty-five countries already use ICD-10, according to the World Health Organization. The United States has not yet joined, but will begin use officially on October 1, 2013. Some of the countries already on-line are Australia (1998), Canada (2000), France (2005), Korea (2008) and Thailand (2007).

As the CDC explains in its *Q&A document*:

1. Why do we use ICD-10?

The United States is required to use the ICD for the classification of diseases and injuries under an agreement with WHO. By using the ICD, the U.S. collects, processes, and presents mortality data in a similar way to other countries around the world. This permits comparison of data across countries. Periodically, new revisions are developed to reflect advances in medical science.²

Nothing in the ICD-10 project is intended to develop a claims payment system. Carriers have undertaken this massive realignment of their coding systems to permit the United States to join the rest of the world in developing deeper understanding of disease, causes of death, and the way to combat both. The United States, according to the HHS, is one of the few remaining countries not using ICD-10.³

There is no foundation for describing this program as one that is purely “administrative” in nature, when the agency responsible for overseeing its implementation itself argues that it is an international quality of health care initiative. The HHS final rule (74 FR 3328-3362) states:

ICD-10-CM and ICD-10-PCS provide specific diagnosis and treatment information that can improve quality measurements and patient safety, and the evaluation of medical processes and outcomes. ICD-10-PCS has the capability to readily expand and capture new procedures and technologies.

CMS developed a procedure coding system, ICD-10-PCS...ICD-10-PCS is sufficiently detailed to describe complex medical procedures. This becomes increasingly important when assessing and tracking the quality of medical processes and outcomes, and compiling statistics that are valuable tools for research. ICD-10-PCS has unique, precise codes to differentiate body parts, surgical approaches, and devices used. It can be used to identify resource consumption differences and outcomes for different procedures, and describes precisely what is done to the patient. (*emphasis supplied*.)

We have located no source or commentator who has described this massive overhaul of the U.S. healthcare reporting system as one designed to improve claims payments. If the system is also used for payments, that is because it is the only internationally recognized system of describing processes, procedures, diagnoses, outcomes and any other metric that can be collected and analyzed throughout the medical community. Claims may be paid without ICD-10. That is not its purpose. Its purpose is to bring the United States into compliance with the standards for international nomenclature of diseases, and to add our knowledge and information into the international conversation and mission to eradicate preventable illness and death. Carriers should not be penalized for undertaking this years-long project, and for bearing the major burden of allowing the United States to engage in this mission.

We thank you for the opportunity to provide comments and request that you consider the changes in the attached document at the next scheduled call. We anticipate providing

² See: <http://www.cdc.gov/nchs/data/dvs/icd10fct.pdf>

³ See, HHS press release, *ibid*.

further comments on outstanding issues such as smaller plans, different types of plans and newer plans. If you have any questions or comments please feel free to contact Randi Reichel at (202) 412.0676 or at rreichel@mwlaw.com or Candy Gallaher at (202) 778-8487 or at cgallaher@ahip.org.

Sincerely,

Sent electronically, RR, CMG

Randi Reichel, AHIP Consultant
Candy Gallaher, Vice President, AHIP State Policy