



July 6, 2010

Commissioner Alfred W. Gross,
Chair, NAIC Financial Conditions (E) Committee
Virginia State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Re: **Key Remaining Concerns Regarding MLR**

- **MLR Health Care Quality Initiatives and**
- **A Transition Plan to Address Potential Market Disruption**

Dear Commissioner Gross:

I write today on behalf of America's Health Insurance Plans (AHIP), the nation's trade association representing nearly 1300 member companies providing health, long-term care, dental, disability and supplemental coverage to more than 200 million Americans. AHIP appreciates the extraordinary effort, time and resources the NAIC and the states have already given to implementation of the provisions of the federal Patient Protection and Affordable Care Act (PPACA) in the states.

We have been offering our comments and contributions throughout this process, and while great progress has been made, we are concerned that a few key concerns remain to be addressed.

Key Remaining Concerns with MLR Health Care Quality Initiatives

I. **Implementation of ICD-10**

The new requirement that the U. S. health care system implement the International Classification of Diseases 10th version (ICD-10) no later than October 1, 2013 imposes costs on insurance companies that will be in the billions of dollars over the next three years. This represents an unusual spike in costs at a time when health plans struggle to find ways to keep health care premiums down and maintain low administrative expenses.

These new mandated quality-based procedure codes should be included in the numerator of the medical loss ratio (MLR) formula as an "activity that improves health care quality." The costs associated with implementing ICD-10 have been recognized by Department of Health and

Human Services (HHS) as designed to improve health care quality and enhance the quality of health care in the United States. All other developed countries have implemented ICD-10 as a way to improve their national and international abilities to combat disease.

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. In 1946, the WHO 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. As the WHO monograph explains with respect to the 9th revision:

The International Conference for the Ninth Revision of the International Classification of Diseases, convened by WHO, met in Geneva from 30 September to 6 October 1975. In the discussions leading up to the conference, it had originally been intended that there should be little change other than updating of the classification. This was mainly because of the expense of adapting data-processing systems each time the classification was revised ... Some subject areas in the classification were regarded as inappropriately arranged and there was considerable pressure for more detail and for adaptation of the classification to make it more relevant for the evaluation of medical care, by classifying conditions to the chapters concerned with the part of the body affected rather than to those dealing with the underlying generalized disease. At the other end of the scale, there were representations from countries and areas where a detailed and sophisticated classification was irrelevant, but which nevertheless needed a classification based on the ICD in order to assess their progress in health care and in the control of disease. (*emphasis supplied.*)¹

None of these countries have undertaken the massive overhaul of their industry coding systems that ICD requires in order to pay claims. 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 costs is to fail to understand the gravity of this undertaking, and its value to the quality of health care in the United States.

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, permits the United States to join the rest of the world in collecting critical information about disease to allow

¹ See, <http://www.who.int/classifications/icd/en/HistoryOfICD.pdf>

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*)²

We do not propose that the administrative expenses related to the maintenance of the ICD-10 system post-implementation be included as a quality initiative. However, the implementation costs of this significant new disease identification and classification system is clearly a key national quality initiative and mandate, and one that should be included in the MLR numerator.

As HHS has noted: “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, see final rule {74 FR 3328-3362}*).

II. Fraud Prevention and Detection Activities that Improve Health Care Quality:

We urge you to include all fraud prevention activities in the numerator of the MLR. Combating fraud is a critical element in the provision of quality health care to all Americans. The federal agencies charged with implementing health reform activities, the Office of the Inspector General, and others have recognized there is a direct link between certain fraud prevention activities and improved health care quality and patient outcomes. There is no good policy rationale for the NAIC to take a different position.

Recognizing that fraud can be dangerous to patients and can undermine the quality of care they receive, health plans have developed aggressive anti-fraud and abuse initiatives as vital components of their quality programs. Health insurance plans devote significant resources to these activities as part of their efforts to promote quality health care for their enrollees. Health plans use a variety of tools – including sophisticated analytics that indicate when an investigation is warranted – to prevent, detect, and remedy fraudulent and abusive conduct that threatens the

² See, <http://www.hhs.gov/news/press/2008pres/08/20080815a.html>

quality of care received by enrollees. Health plan medical directors are deeply involved in these programs, recognizing that patient care is significantly impacted by fraud and abuse. Health plans also enter into partnerships with law enforcement agencies to address abusive billing practices (e.g., billing for services not provided) and other fraudulent activities that are harmful to enrollees in both the commercial market and government programs. These partnerships are based, in part, on the recognition that those engaged in fraudulent activities often target both commercial and government programs. Indeed, health insurance plans often initiate investigations that lead to parallel federal enforcement actions. Such commercial-government collaboration is done extensively on a voluntary basis, and is required in areas such as Part D.

As an example, Blue Cross Blue Shield of Illinois's Special Investigations Department investigated allegations of health care fraud involving "free" allergy tests for Chicago firefighters that were billed along with bills for tests that were never performed. The tests led to unnecessary, and in some instances, inappropriate allergy therapy. In addition, allergy immunotherapy was being prepared in unhygienic conditions and patients were not warned of the risks involved. The plan worked with OIG and other federal agencies to end this fraudulent and harmful practice, resulting in the indictment of ten defendants in federal court.³

Coupled with efforts to protect quality through detection and enforcement, and the resulting prevention through a deterrence effect, plans also protect patient quality through efforts focused solely on prevention. For example, plans devote substantial anti-fraud resources to programs that allow investigators to learn best practices from other experienced investigators and to programs that help providers identify medical identity theft that could lead to medical errors.⁴

Anti-fraud and abuse programs enable plans to detect providers who are providing care with false credentials, delivering medically unnecessary services, or making treatment decisions based on illegal referral relationships. The need for these programs – and their direct relationship to health care quality – is clearly demonstrated by examples of patients whose health and well-being is compromised due to unnecessary surgeries and other medical procedures and falsified medical records. Other practices, such as care provided by unlicensed providers, medical ID theft, and billing for care not provided similarly create significant threats to patient health. All of these activities can have a devastating impact on health care quality.

Another highly problematic area targeted by plan anti-fraud efforts is the diversion, misuse and inappropriate prescribing of narcotic drugs such as OxyContin. At the January 2010 National

³ Blue Works: 2010 Anti-Fraud Awards, BlueCross BlueShield Association, <http://www.bcbs.com/news/bluetvradio/bcbs-companies-2009-aggregate-anti-fraud-statistics/BlueWorks-Anti-Fraud-brochure-2010.pdf>.

⁴ *Id.*

Summit on Health Care Fraud, organized by DHHS and the Department of Justice, the President of Tufts Health Plan described the approach that Tufts and other health plans use in responding to the significant threat to patient health posed by the inappropriate prescribing of addictive and harmful drugs. In these instances, an anti-fraud unit clinical investigator works closely with the plan's Clinical Services Department to address issues that involve the intersection between abusive conduct and quality of care. Providers who prescribe for non-legitimate purposes and pharmacies who continue to fill prescriptions when there is a known provider concern are investigated and referred to appropriate agencies. Such conduct is also addressed at the network contracting level and referred to the plan's quality of care committee. Other plans, such as Aetna, similarly devote substantial resources to combating the harm to patients from fraudulent drug diversion schemes. Indeed, in November 2006, nearly one half of Aetna's member/pharmacy anti-fraud team's active investigations involved prescription benefit cases, such as prescription forgery and overprescribing.⁵ This type of fraud can result in significant health care harm to patients.⁶

An example of the harm uncovered by fraud investigators demonstrates the relationship between fraud and quality:

June 17, 2010 – FBI Indianapolis Website: A medical doctor practicing in Bloomington, Ind., has been indicted by a federal grand jury sitting in Indianapolis with health care fraud, health care fraud resulting in serious bodily injury, and 11 counts of unlawful drug distribution. The indictment sets out 16 patients that specifically illustrate the medically unnecessary procedures and improper drug prescriptions. The indictment goes on to allege 11 counts of illegal drug distribution by setting forth 11 prescriptions of Schedule II controlled substances that were not for a legitimate medical purpose and beyond the bounds of medical practice. "Health Care Fraud poses a potential risk to patients and increases health care costs for all," said Michael Welch, Special Agent in Charge of the FBI in Indiana.

Uncovering and preventing these activities clearly increases the quality of the health care that patients in the United States receive. There is no good policy rationale to deem these expenditures "administrative" and therefore create hurdles for health plans that attempt to protect their members from unqualified or unnecessary services.

It is unquestionable that there is often is a direct relationship between fraud and the quality of care patients receive. Thus, we urge the NAIC to recognize that health plans play key roles in

⁵ Prescription for Peril, Coalition Against Insurance Fraud, Dec. 2007, at 34, <http://www.insurancefraud.org/downloads/drugDiversion.pdf>.

⁶ *Id.* at 35-38 (describing health care services and costs associated with opioid abusers, as reflected, e.g., in much higher rate of hospital inpatient stays and emergency room visits).

preventing and detecting fraudulent care; that portion of fraud prevention expenses apportioned to the prevention and detection of these activities should be included in the numerator of the MLR calculation as quality activities related to actual cases of care.

III. Avoid Narrow Definitions of Activities that Improve Health Care Quality

As a general principle, we urge the NAIC to revise the definition of activities that improve health care quality to move away from a granular, prescriptive approach and toward a function-based approach. To date, the conversation at the Health Solvency Issues working group has focused entirely on refining changes to a prescriptive, list-focused approach to quality initiatives. As a matter of health care policy, this is the incorrect way to analyze activities that improve health care quality. Quality initiatives change over time as our understanding of human behavior and medical advances change and develop. It is critical to ensure that the incentives for health plans and health insurers are aligned in a way that will encourage and reward carriers that implement plans and programs that not only keep pace with fast changing medical advances, but that are designed to bring better quality health care to the most people. A tightly prescribed definition of quality, developed in a matter of only a few weeks with limited public discussion and little input from program participants, and the individuals who create these programs, may be a disservice to consumers across the country and their access to high quality health care programs. Rather, the definitions as they exist now are specifically designed to limit change, or range of innovation. As a result, consumer access to innovative programs and services may be at risk if the insurers who create or participate in them are penalized. The United States health system should not be focused on the names given to activities that promote quality health care, but rather on the benefits they provide to policyholders and consumers nationwide. The NAIC's current approach is ineffective, unwisely limiting, and may prove to be anti-consumer in the long term.

A definition of quality that tracks closely the Institute of Medicine's definition, coupled with the restrictions already existing in the quality definition - such as the requirement that the quality initiatives be designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results - is sufficient to ensure that the programs and initiatives will be real, are intended to produce results, are grounded in evidence based standards and are widely accepted as best clinical practices. They are therefore "activities that improve health care quality." Excluding them from the MLR will create disincentive to quality innovation.

Thank you for considering these comments. I would be happy to discuss these with you, and work with you to help resolve these issues. I may be reached at 202-778-8487 or cgallaher@ahip.org.

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Sincerely,

C.M.(Candy)Gallagher electronic submittal

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America's Health Insurance Plans

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