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July 2, 2010

Alfred W. Gross, Chair  
Financial Condition (E) Committee  
National Association of Insurance Commissioners  
Tyler Building  
1300 E. Main St.  
Richmond, Virginia 23219

Dear Chairman Gross:

While California is not a member of the Health Reform Solvency Impact Subgroup (Subgroup), that has provided its recommendations for the revised Health Care reporting forms, we have participated in the discussions, and generally approve of the hard work that has gone into an excellent product.

There are, however, several outstanding issues this committee will be asked to review, and we would like to offer our thoughts on a couple of them.

#### 1. BACKGROUND

The NAIC has been asked to help the Secretary implement several key provisions of the Patient Protection and Affordable Care Act (PPACA). Among the most immediate and consequential of these is assisting in the calculation of a modified Medical Loss Ratio (MLR). The Supplemental Health Care Exhibit will include the first rough estimate of that figure, and thus, the Subgroup had the initial opportunity to explore in some depth the issues that the MLR raises.

The NAIC has the obligation to implement the law that Congress wrote. While most of us are familiar with a traditional MLR, Congress has charged us with implementing a modification to that usual calculation. In fact, the modification embodies one of the most significant changes in PPACA – an explicit emphasis on quality.

We are all familiar with one of the dominant problems in the current health care system: its economic incentives favor quantity of medical services over quality of care. Insurers, governments, academics and even medical professionals themselves have devised a number of approaches to this perverse, system incentive to privilege more care over better care; research is showing that some of these ideas have been effective in improving the quality of care patients receive.

PPACA adds an enormously powerful tool to that toolbox. An insurance company's efforts to improve the quality of care will not be counted in the MLR formula as traditional "administrative expenses." They are, of course, not "claims costs" either, but in PPACA, Congress concluded that quality improvement efforts are so important they should receive an economic incentive that will counter the current incentives to sheer quantity of care.

There is, of course, enormous opportunity for insurers to exploit this new incentive. Insurers have every reason to try and categorize as many expenses as they can get away with as “quality improvement” because of its effect on the bottom-line calculation of their MLR. The working group has done a very successful job of placing objective and workable limits in its well-crafted definition of “Quality Improvement” (QI) that will restrict that abuse. However, we will all need to be vigilant in reviewing the actual expenses submitted.

In guarding against insurance industry abuses, we also have to keep uppermost in our minds that the MLR’s emphasis on quality – which, in fact, runs throughout PPACA – is a crucial first step to change the focus of health care from what it has been. We have an enormous and growing array of new ways to monitor and affect quality today that could not even have been dreamed of even twenty years ago.

It is in that context that we make our comments.

## 2. COMMENTS

### A) ICD-10 Codes

The Subgroup decided to broadly exclude costs for companies to update their system to accommodate a new federal requirement to use ICD-10 Codes. “ICD” is the acronym for International Classification of Disease. ICDs are published and updated by the World Health Organization. While ICD-10 was finalized in 1992, the U.S. has been clinging to the outdated ICD-9 and its variants. However, in 2008, the Department of Health and Human Services formally required all HIPAA covered entities to adopt ICD-10 by 2013.

ICD-10 will move Health Information Technology (HIT) in this country to an entirely new level. HIT is not only woven into the fabric of PPACA, it is, in fact, the infrastructure that the new health care system will operate on. HIT is the superhighway for virtually all quality improvement going forward, and it is clear that HHS views ICD-10 implementation as the necessary foundation for that. In its 2008 press release, HHS described the ICD-10 mandate this way:

“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,” HHS Secretary Mike Leavitt said. “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.”

The Subgroup clearly understood ICD-10 to involve claims payment, and the Secretary’s glancing reference to “affordability” supports that view. As a more granular reporting format, ICD-10 can improve a company’s ability to pay claims and monitor them for accuracy.

But that is the tail wagging the dog. ICD-10’s value is in its ability to monitor care, report results, analyze them, and better determine what works and what doesn’t. Not only will it open the way to give academics and clinicians a better and unprecedented view of medicine as it is actually practiced, it will pave the way to change our entire reimbursement structure from one based on trial and error to one based on a far more comprehensive knowledge of what interventions are most effective under which conditions. While physicians, nurses and other medical professionals will still have to rely on judgments in the hard cases, the world that ICD-10 opens up will reduce the number of hard cases, and increase the percentage of problems we can view as routine. This is precisely the profound change that PPACA is making possible, and intends to encourage.

It is true that ICD-10 does and will have value to insurers in the claims payment arena, as well as in other more administrative matters. But the one virtue should not cancel out the other. Its value as a quality improvement tool is not undermined by its value as a supplemental administrative aid. Broadly excluding it from QI expenses works against, not only the policy that Congress unambiguously intended, but also the dynamics of a changing health care landscape.

At the very least, ICD-10 costs should be apportioned between their value for claims paying and their value for QI. The broad exclusion misses the core reason that QI is given special treatment in the MLR calculation. We urge that these expenses be included as QI to some extent.

(B) Accreditation Costs

The mixed issues of quality and efficient administration also come up in the question of whether the costs of insurer accreditation should be excluded from QI. Again, we think the balance should be struck in favor of classifying them as QI.

Insurer accreditation by third parties such as the National Committee on Quality Assurance and URAC serves a number of valuable purposes. Some of them are not directly related to quality of care, but NCQA, in particular, has been leading the charge in this country for specific quality measurement and normative grading for two decades, and the fruits of its efforts are now both visible and tangible. Last year, California became the first state to report on and issue grades to both its PPOs and its HMOS. These are publicly available on our website, as well as on the website of the Department of Managed Health Care.

Our decision to do this is due, in no small part, to the movement NCQA has been leading to make insurance companies, as well as their providers, accountable for specific quality measures, both clinical measures such as HEDIS, and the consumer satisfaction measures included in CAHPS. HEDIS and CAHPS have become the standards for objective, responsible and consumer friendly reporting on quality. More important, they provide exactly the baseline data specified in the work group's definition of QI from which improvement can be measured.

As with ICD-10, the costs of accreditation include some measures that are more administrative than clinical, and as with ICD-10, we would argue that the baby should not be thrown out with the bathwater. NCQA, in particular, can, in fact, quantify exactly how much of its accreditation costs can be attributed to quality improvement (44%), and it seems inconsistent with the intent of Congress in PPACA to exclude that cost from QI simply because 56% is related to monitoring an insurer's administrative effectiveness and other matters.

3. CONCLUSION

Overall, we are very satisfied with the thorough and attentive work of Lou Felice and his Subgroup members, as well as the voluminous and thoughtful comments from consumer groups, industry and other parties. We look forward to a fuller discussion of these and other issues, in order to provide our best and most considered recommendations to the Secretary on health care reform under PPACA.

Sincerely,



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