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POLICY & ACTION FROM CONSUMER REPORTS

November 17, 2015

Dean Cameron, Chair
Medical Loss Ratio Quality Improvement Activities (B) Subgroup
Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

Cc:

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Re: Comments to the MLR Quality Improving Activities (B) Subgroup, NAIC Fall National Meeting

Dear Mr. Cameron,

The “quality improvement” definition recommended by NAIC for medical-loss ratios (MLRs) and adopted by HHS in 2010 was designed to ensure that insurers only classify as quality improving expenditures those that improve health care quality. At the time, consumer groups and advocates urged HHS to “develop a definition for ‘quality improving activities’ that is not so broad that issuers may improperly classify administrative activities as improving quality.”[1]

HHS separated quality improvement expenses from claims expenses in the MLR numerator (medical expenditures) and narrowly defined what constitutes quality improvement expenditure. In finalizing its definition, HHS asserted that it had created a “definition, or foundational criteria, of a quality improvement activity [that is] … specific enough so as to provide clear guidance without overly prescribing acceptable activities and possibly stifling future innovative quality improvement activities.”[2]

Over the past three years, however, as implementation has rolled out, insurers have very broadly applied the “quality improvement” classification and categorizing some activities as “medical” that are questionable. For example:

- Fees paid to the New Jersey Health Care Institute for membership to NJ state quality council.

[1] Federal Register Vo. 75 No. 230 at 74876.
[2] *Id*.

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- Salaries for staffing CAHPS audit, HEDIS audit, and NCQA audit expenses.
- Salary for headquarters and finance to "provide overarching support to all other quality departments".
- Leadership training.
- Software upgrades and associated expenses of becoming ICD-10 compliant. (In direct conflict with HHS's exclusion of the conversion to ICD-10 as a quality improvement activity.)[3]

The liberal application carriers have given to the "quality improvement" classification in the MLR setting has cost the health system and consumers money. In California, where details of quality improvement efforts is a required component of the rate filing justification,[4] insurers have historically failed to provide enough detail to demonstrate that the expenditures are legitimate quality improvement expenses. In some cases, carriers explicitly apply the "quality improvement" classification to expenses that are surely not, such as ICD-10 conversion.[5] Often the reviewer is left guessing the amount the carrier is claiming in quality improvement expenses.[6]

Consumers Union supports including quality improvement expenses in the numerator of the MLR calculation as a medical expense in order to motivate insurers to allocate a percentage of expenses to quality improvement activities that benefit consumers. However, it is apparent that insurers are abusing the leeway provided by a less precise definition, to their own benefit. <u>Quality improvement and improved patient outcomes should be tightly bound, not simply tangentially or theoretically related.</u> Where it is not prima facie evident, insurers must be required to supply supporting evidence.

When revisiting the MLR quality improvement definition, we urge NAIC not to let insurers classify expenses as "quality improvement" unless they prove that the activities improve patient outcomes or can be reasonably expected to improve patient outcomes within a limited timeframe.

Expenses that are <u>not</u> likely to meet this rigorous standard—and therefore merit close scrutiny—include the following:

- Utilization review nurses and other administrators whose job it is to review and often deny physician-recommended treatments.
- Quality assurance programs and provider credentialing activities that are administrative functions. Insurers have not considered these direct medical expenses in the past and should not be allowed to be reclassified as such now.

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[3] *Id*.
[4] Health and Safety Code Section 1385.03(c)(3).
[5] Anthem Blue Cross Actuarial Memorandum for 2016 Plan Year at p.46.
[6] In 2014, Blue Shield of California provided dollar amounts in per member per month expenditures for quality improvement but failed to provide information on the actual programming involved.

- “Medical management,” to the extent it includes purely administrative functions as well as the salaries of employees whose work does not improve quality. Many “medical management” expenses, including expenses related to “nurse hotlines” and proprietary disease and care management programs, are related more to cost control or expense management than to improving quality. While nurse hotlines can be a useful tool for consumers, there is the potential for them to be used by insurers to reduce utilization without regard to medical necessity.
- Information technology (IT) spending that has not been proven to improve patients’ medical quality. Insurers invest in IT to enhance underwriting capabilities, reduce expenses pertaining to paying claims and even to identify unprofitable accounts.[7] We suggest placing the burden of proof on insurers to prove what fraction, if any, of their IT investments constitute quality improvement expenditures –with rigorous oversight. In addition, regulations will need to define the accounting period they are permitted to count—i.e. the annualized or amortized portion of costs that improved individual health.

Whether the quality improvement classification compels insurers to make expenditures that benefit policyholders or if it is used by insurers for their own benefit may be a matter of regulatory oversight. We therefore urge the NAIC to recommend strict enforcement of the definition of “quality improvement” in the MLR calculation (and elsewhere). Based on insurers’ application of the classification to date, it is apparent that the reigns need to be tightened. We recommend that the data submitted by insurers be independently audited at the expense of the insurer and the audited results reported to HHS and the relevant state insurance regulator. The audit must be conducted in accordance with generally accepted auditing standards and shall be signed by a certified public accountant or a member of the American Academy of Actuaries, and attested to by the carrier’s official as meeting the new quality improvement standards to-be-developed.

Consumers Union thanks the NAIC for the opportunity to testify during the NAIC MLR Quality Improvement Activities (B) Subgroup meeting and welcomes any questions.

Sincerely,

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7 While some insurers make substantial investments in IT, it appears that only a small fraction of that cost is attributable to clinical treatment.