Statement of Sid Hebert
Humana
On Behalf of America's Health Insurance Plans
to the
National Committee on Vital and Health Statistics'
Subcommittee on Standards
Regarding the Implementation of ICD-10
June 20, 2012

Overview and Introduction

My name is Sidney Hebert, and I am the ICD-10 Program Manager for Humana Inc. with primary responsibility for assisting my company with implementation of the revised HIPAA electronic transaction standards, ICD-10 code sets and Administrative Simplification mandated by The Patient Protection and Affordable Care Act (ACA). Humana Inc. is one of the nation's largest publicly traded health and supplemental benefits companies; as of December 31, 2011, we had approximately 11.2 million members in our medical benefit plans, as well as approximately 7.3 million members in our specialty products. Humana is a full-service benefits solutions company, offering a wide array of health and supplemental benefit plans for employer groups, government programs, and individuals.

Today I'm testifying on behalf of America's Health Insurance Plans whose members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our industry processes millions of claims, eligibility requests, payments, and other administrative and clinical transactions on a daily basis. The migration to the upgraded HIPAA electronic transaction standards and ICD-10 code sets will have a major impact on the business and administrative operations of health plans and will require significant financial and human resources for successful implementation.

In my testimony, I was asked to address:

- the most critical industry milestones to achieve between now and the proposed new compliance deadline to ensure a successful transition;
- how to maintain industry momentum on the transitioning to ICD-10, and avoid organizations moving to put-off ongoing work due to the delay; and
- What can be done to facilitate end-to-end testing during the remaining transition period

Humana began planning and execution for ICD-10 remediation in 2009, recognizing that this complex coding system requires careful and systematic management for successful

implementation. Humana will expend 58% of its projected ICD-10 implementation budget by year end 2012, and anticipates an additional 11-15% increase in total expenditures to support the one year ICD 10 delay.

On behalf of AHIP, I want to let the Subcommittee know that the health insurance industry is committed to the implementation of ICD-10 which will allow practitioners to identify and report conditions and condition management in more specific ways that will lead to more effective measurements of quality and outcomes. The recent delay puts implementation momentum in serious risk and as acknowledged by CMS in the proposed rule increases implementation costs. In order for the industry to be successful on October 1, 2014, and not see any additional delays, we recommend the following take place:

The Department should work with the NCVHS to develop a detailed ICD-10 testing and implementation plan. To keep the implementation momentum, we recommend that the NCVHS to develop additional recommendations for a testing program that would allow for covered entities to begin testing around October 1, 2013 and continue until the revised implementation date. This program should also include milestones and metrics that would be monitored to better understand the state of the industry.

In tandem, we recommend the Subcommittee consider recommending the use of other non-monetary incentives to ensure all stakeholders can meet the new deadline. One approach would be to leverage the momentum towards achieving "meaningful use" by ensuring that certified EHR vendors are required to comply with ICD-10 as well as SNOMED CT. We understand that there are available tools to help with the crosswalk between the two coding systems.[1]

We understand that the small practice provider community will need a place to go to get answers to questions concerning the clinical documentation needed to determine the correct or most appropriate diagnoses code. While large institutions and provider practices may not need such assistance, the small practice provider community will need assistance to determine if their current documentation practices will enable the selection of an appropriate ICD-10 code. In addition a main frame version of the DRG grouper should be available to the industry for testing purposes as soon as possible. Finally, we recommend that the code freeze be extended until October 1, 2015.

We recommend that the Department commit to not moving the implementation date again. NCVHS should recommend that HHS stand firm and not move the date again. The continued uncertainty regarding the enforcement deadline for 5010 over the first 6 months of 2012 have demonstrated the high costs associated with delayed enforcement dates that are often extended at the last minute. The implementation of v5010 was extended when it became clear at the very last moment that certain entities were not prepared. Further changes to the ICD-10 compliance date or similar "enforcement delays" throughout 2013 and 2014 prior to the October 1, 2014 deadline would cause significant costs for health plans and ultimately for their customers at a time when the industry will be preparing for the implementation of health insurance exchanges and all of the other ACA-mandated changes. Health plan systems naturally evolve over time, thus an

[1] See March 3, 2012 Letter from the NCVHS to the Honorable Kathleen Sebelius, available at: http://ncvhs.hhs.gov/120302lt4.pdf

extended delay will require an extension of testing activities and prolonged maintenance of the testing environment. We stand ready to ensure that member plans will be able to meet the October 1, 2014 deadline and thus strongly encourage HHS to not make any further changes to the implementation date. To achieve this and to avoid last minute delays, HHS needs a mechanism to assess the readiness (not a survey) of the provider community to hit a certain date. If implementation is highly likely, then set that date and do not change it. Health plans view October 1, 2014 as achievable, but if other stakeholders will not be ready we are setting ourselves up for serious challenges ahead.

In meeting its commitment to 2014 implementation, we strongly recommend against any dual implementation periods for ICD-10 as some stakeholders have suggested. We have heard recommendations for either different implementation dates for health plans and providers to which we have to ask: "what is the point?; while others have suggested phasing in the implementation of ICD-10 procedure codes and diagnostic codes. Among other costly impacts this option would require a new set of hybrid DRG definitions; and would also cause a two phased approach to changing impacted hospital contracts. Phase one would recognize ICD-10 Procedure Coding and Phase two to recognize both ICD-10 code sets. Both of these approaches would be nearly impossible to implement from an operational perspective and would cause great challenges both in the development of health plan and provider contracts as well as the implementation of quality improvement strategy reporting, which depends on ICD-10 diagnostic and procedure codes. It would also add significant costs and marketplace confusion to the implementation of ICD-10.

We recommend that a comprehensive review of upcoming administrative simplification and other regulatory and statutory deadlines take place. The implementation of Section 1104 of the ACA along with ICD-10 requires significant changes to health plans IT infrastructure and impacts almost every facet of a health plan's operations. Given the proposed delay, we believe it is prudent for the NCVHS to conduct such a review determine if the forthcoming compliance dates for operating rules related to the electronic remittance advice, electronic funds transfer and future operating rules related to enrollment, authorizations and referrals and claims should be adjusted. This review should also include a holistic review of all forthcoming implementation dates related to the ACA, administrative simplification, and other regulatory and statutory requirements with significant business and information technology impact on the industry that require significant changes to health plans' IT infrastructure and impact multiple facets of health plan operations.

We can currently support concurrent implementation of HPID and ICD-10, so long as the HPID approach described in the Proposed Rule is retained in the Final Rule. Significant changes to the HPID implementation approach will require reconsideration of the HPID compliance date occurring concurrently with ICD-10 implementation.

The Department should provide allowances in the Medical Loss Ratio (MLR) Final Rule to account for impact of ICD-10 delay. In the MLR Final Rule published in the *Federal Register* last December HHS recognized that ICD-10 conversion implementation costs are quality improvement activities. However, the rule proposed to limit the amount of ICD-10 conversion

costs to those costs incurred in 2012 and 2013, which are capped at 0.3 percent of earned premium in the relevant state market.

In our comments on the ICD-10 proposed rule we asked HHS to 1) adjust the .03% cap and 2) allow health plans to include 2014 because of the proposed delay. However, companies should be able to track and include their ICD-10 implementation costs on later year MLR Reports since health insurers will incur additional implementation related costs beyond the implementation date. Should there be any unforeseen delays beyond October 2014 the approach should be flexible to synch up the accounting of ICD-10 implementation costs with the ICD-10 implementation date, consistent with the current regulatory and compliance requirements.

Closing

I want to reiterate the health insurance industry's support for the implementation of ICD-10, which has numerous benefits including greater precision in the identification of diagnoses and procedures, improved reporting for public health and bio surveillance, and support for quality improvement programs. Health plans have expended significant resources to date in implementation and it critical that this momentum is sustained and that October 1, 2014 is the last deadline for implementation of ICD-10. There is considerable change coming with the implementation of the ACA, which will stress health plan systems and resources. It is critical that the industry come together to make this happen.

I thank you for the opportunity to provide input to the Subcommittee's deliberations.