Testimony
Of
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Oversight and Government Reform Committee

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"Between You and Your Doctor: the Private Health Insurance Bureaucracy"

Mr. Chairman, Congressman Jordan, and other members of the Committee, I am James H. Bloem, Senior Vice President, Chief Financial Officer and Treasurer for Humana Inc., as well as a member of the company's corporate executive committee that determines the company's strategic direction. Humana is a health benefits company headquartered in Louisville, Kentucky offering a wide array of health and supplementary benefit plans for employer groups, government programs, and individuals. We have 10.3 million medical members and 6.8 million specialty-benefit members in 50 states, Washington, D.C., and Puerto Rico.

My testimony today will address: 1) our support for health system reform; 2) how we develop clinical policies and make coverage determinations; 3) our interactions with both physicians and members to ensure collaboration; 4) government oversight of plan activities; and 5) plan innovations designed to simplify administrative processes and provide members with actionable information.

Support For Health System Reform

We appreciate the fact that the Subcommittee's work is intended to complement the effort by Congress and the Administration to provide health coverage for all Americans, while simultaneously lowering costs and improving quality. Humana supports and advocates for reform of our health care system and believes that doing nothing is not an option. We further believe that all Americans should have affordable, quality health care coverage. It is essential that all Americans participate in the system with subsidies for those who cannot afford coverage, and in return, coverage should be guaranteed and not based on pre-existing conditions or health status. To ensure affordability, reform must focus on reducing costs, increasing efficiencies, reducing geographic variations in care and improving health outcomes. Americans deserve a

system that eliminates fraud and abuse, promotes health and wellness and incentivizes the most effective and efficient patient care.

Finally, as a member of America's Health Insurance Plans (AHIP), our industry trade association, we and they began offering such reform plans as early as November, 2006. AHIP's comprehensive reform plan provides for universal coverage with insurance rating reforms. These reforms, voluntarily offered, will obviate the need for business practices that were put into place primarily because there is no requirement that individuals have health insurance coverage. Every aspect of our operations is governed by federal and/or state laws and regulations.

Coverage And Related Claims And Administrative Processes

The Subcommittee has requested that we comment on Humana's processes for making coverage determinations and processing claims as well as physicians' responses to those processes. In responding to the Subcommittee's request, let me start with findings from the most recent PayerView rankings, conducted each year by athenahealth (a physician revenue management company). These findings are based on that organization's independent statistical analysis derived from more than 17,000 physicians representing $7 billion in billed charges, sent to 172 payers in over 40 states. In addition to ranking Humana and our peer companies, athenahealth also ranks Medicare Part B, providing an important point of comparison between private health plans and the government-run Medicare Fee-for-Service program.

For 2009, Humana ranked first among national payers as "easiest to do business with" for doctors and hospitals. Specifically, athenahealth found Humana to have the lowest "denial rate" among all major payers. In contrast, the government's Medicare Part

B ranked fifth. Humana also was ranked as the fastest payer to physicians. Medicare Part B again ranked fifth.

Turning now to our coverage determination process, Humana's process is based on the benefits and provisions defined in a member's certificate of coverage. In that certificate is a list of services or requests that must meet certain evidence-based clinical protocols. In most cases, we have a specific coverage policy that determines Humana's threshold or criteria to cover a particular service. Our coverage policies are posted on our website. Services for which we require prior authorization are also posted on our website. Providers receive a minimum of 90 days' notice of any changes.

Development Of Clinical Policies

In developing clinical policies, our clinical team researches and analyzes new and emerging technologies. Our **Medical Pipeline** infrastructure at Humana ensures that clinical, financial and other non-clinical considerations are forecast for new and emerging medical technologies and procedures. We rely on a number of scientific publications, governmental information and other relevant, independent information in evaluating our clinical protocols. Our medical and clinical teams compile all relevant information to respond to changes in innovation that may require coverage decisions to change.

Through the systematic collection of data, analysis of the information and tracking of future health technologies, Medical Pipeline builds a robust foundation to forecast changes in new products, therapy and treatment regimes. Humana's Technology Assessment Forum (TAF), composed of board-certified Humana physicians, uses this data to evaluate new products coming to the marketplace and to evaluate those products that have a safety profile warning.

We strongly support the development and dissemination of more information on evidence-based medicine to providers, consumers and plans. Because medical technology becomes more complex each day, having the right evidence-based medical information is critical to defining, disseminating, and operationalizing decisions on best-known methods in healthcare. Humana utilizes independent evidence-based technology assessment organizations to help formulate its policy decisions. We incorporate that information into Humana's processes for medical coverage policy (MCP) development. Providing consumer-centric medical information to Humana's members and their physicians allows members to choose medically appropriate procedures that will improve their health and healthcare outcomes.

Clinical evidence must permit conclusions to be made concerning the effect of certain procedures and treatments on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed medical journals in the English language. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Technologies and procedures under review must ultimately have a beneficial effect on patients' outcomes and that beneficial effect should outweigh any known harmful effects on health outcomes. The improvement must be attainable outside investigational settings. Additional information is also sought, as necessary, from external experts and participating providers in an attempt to reach a final conclusion.

A Clinical Advisor (physician) within the Clinical Policy Department oversees this process of conducting an evidence-based review of emerging technologies as well as reviews and rates the overall peer-reviewed available literature. After final approval, the MCPs are posted on Humana's website for easy and immediate access for providers, members, employers and associates.

Making Coverage Determinations

As previously discussed, a member's benefit plan document (certificate of coverage) is the primary document that delineates what services are covered as well as the member's personal financial obligation. There are select services that are covered if they meet specific, evidence-based medical criteria developed and approved by physicians. These medical criteria are entered into our clinical system such that a non-physician at Humana can authorize a service requiring a medical criteria review based the system-generated response. However, only a licensed, board-certified physician medical director can issue a medical criterion denial. Medical directors also have authority to determine that the issues in a case are unique such that exceptions to medical policy are warranted. To the extent that a member disagrees with a decision, there are internal and external processes to receive peer-to-peer input and manage grievances and appeals according to state and federal regulations. Decisions can be appealed to an independent, external review entity whose decision is binding on the plan.

In the end, our goal is to ensure that our benefits are being offered in compliance with state and federal laws and regulations, and that the related MCPs are consistently being applied.

Feedback From Physicians On Our Administrative Processes

The Subcommittee has also asked for comment on physician response to our administrative and clinical processes. Humana highly values its relationships with physicians and hospitals. Positive relations with the provider community are essential for Humana to create provider networks and meet its essential role in the health care system of providing financial protection for our members, assuring access to employer-specific and individual plan benefits, and providing guidance to our members as they access the health care system.

First, Humana has endeavored to simplify and speed the process by which providers' claims are processed. As previously noted, Humana has been recognized by athenahealth, and we have also been recognized by the Medical Group Management Association (MGMA) as the easiest national health plan for providers to work with. We are a leader in administrative simplification, including claims payment and verification of benefits which can be performed on-line. Humana is the first health plan to have real-time claims adjudication (RTA) originating from the physician's practice management system, so that physician practices can know and process Humana's payment and the member responsibility at the time the member receives medical services in the physician's office.

We are driving efficiencies to reduce administrative work that we believe can have a dramatically favorable impact in the industry. For example, with RTA, providers have the opportunity to submit claims in real time and receive the completed response within seconds. Along with RTA, innovative Humana tools and services include Availity, a multi-use, multi-payor electronic data exchange which I will discuss later, and the Humana*Access* Visa Debit Card.

Humana is working on these and similar standardization efforts with national provider organizations like the Medical Group Management Association (MGMA), the Healthcare Financing Management Association (HFMA), the American Medical Association (AMA) and the American Medical Group Association (AMGA). Our goal is to be a collaborative partner in advancing administrative simplification and multi-payer solutions in the industry. Examples of initiatives Humana supports include:

- **Project SwipeIT**: Humana is a leading supporter of this important MGMA initiative with the goal of industry-wide standardized patient identification card acceptance by the 2010 plan year. We were the first plan to publicly pledge support of Project SwipeIT.
- **Healthcare Administrative Simplification Coalition (HASC)**: Humana is an active member of HASC and supports its goal of making healthcare operate more efficiently and effectively through the implementation of administrative simplification strategies that reduce unnecessary healthcare costs.
- **CAQH:** We fully support the Council for Affordable Quality Healthcare (CAQH), a catalyst for industry collaboration on initiatives that simplify healthcare administration. Examples of CAQH initiatives Humana supports (also supported by the HASC) include:
    - The requirement of Universal Provider Datasource™ (UPD) credentialing for contracted providers, as well as the use of the UPD for primary data collection.
    - Encouragement of health plans and PBMs to provide real-time, patient-specific formulary access into e-prescribing functionality.
    - Encouragement of EHR vendors to support SureSripts-RxHub capabilities in their products.
    - Humana is a founding and certified member of the Committee on Operating Rules for Information Exchange (CORE) launched by CAQH to create an all-payer solution that enables provider access to patient insurance information before or at the time of service, with providers using the electronic system of their choice.
- **AMA "Cure the Claims" Campaign**: Humana is an active supporter of the AMA campaign to make claims processing more cost-effective and transparent**.** Humana is working with the AMA to understand how we can improve our claims performance in relation to their new National Health Insurer Report Card that provides objective information on claim payment timeliness, transparency and accuracy of claims processing by health insurance companies. Based on a random-sample pulled from more than 5 million electronically-billed services, the report card provides an in-depth look at the claims processing performance of Medicare and seven national commercial health insurers. In the 2009 Cure the Claims results, Humana

had the highest contracted fee schedule match rate and the lowest percentage of edited claim lines reduced to $0 of all major payers. Humana also had a significantly lower rate of claim lines denied than Medicare.

Engaging Physician Groups In Clinical Policy Development

In developing Humana's medical policies, including assessment of new technologies, Humana works closely with many leading medical professional societies. For example, Humana worked recently with the American Academy of Pediatrics on the development and dissemination of immunization protocols. As effective medical practice evolves at an ever-increasing pace, the professional societies are best positioned to assist us with the implementation of these types of medical policies.

Supporting Members with Actionable Information

We also have been at the forefront of the development of tools to assist members to obtain vital information as they access care. We have worked closely with the medical community to ensure that the information we provide to our members is accurate and consistent with medical standards—whether it is through web-based tools, telephonic reminders to secure preventive services, or telephone interactions with a member of one of Humana's teams of nurses that interact with members. Humana includes on its website the consumer tool from the American Academy of Family Physicians, FamilyDoctor.org, including the "questions to ask your doctor" that the Academy developed.

Humana's comprehensive tools to help members in the selection of their physicians have been developed with the valuable input of many local, state and national medical organizations. We have used physician focus group meetings to assess the value of these tools at localities in Texas, Wisconsin, Ohio, Kentucky and Kansas as examples. We also have incorporated the input of the American College of Physicians, the

American Academy of Family Physicians, the American College of Surgeons, and the American Academy of Pediatrics in developing these tools. In addition, for the past four years, Humana has convened a Physician Advisory Committee, appointed jointly by Humana and by counsel for physicians, which meets semi-annually to discuss issues of joint interest between physicians and Humana.

Care Coordination

Humana actively has pursued methods to coordinate delivery of services for the five percent of Humana's commercial membership who consume almost half of health care costs because of the existence of complex or chronic medical conditions. This mirrors the experience reported by the federal Agency for Healthcare Research and Quality (AHRQ). Due to these conditions, most of these individuals have multiple physicians. Humana's case managers and personal nurses work to coordinate patients' care. At the conclusion of a time of hospitalization of members with serious conditions, a Humana nurse meets with the member to make sure that the individual knows about discharge medications, appointments, and therapies so that continuity of care takes place smoothly after discharge. These steps lead to significantly improved health outcomes, and also can help avoid an unplanned readmission to the hospital.

Support Services For Physician Offices

Because Humana recognizes the wide variation in clinical practice, we know we must develop clinical support programs that meet individual physician office needs. More than fifty percent of Americans receive health care services from clinical practices with five or fewer doctors. Smaller practices tend to have limited technology availability and have needs that differ from a large multi-specialty practice. We are working with

input from physicians and MGMA in developing systems approaches to further support the variety of clinical practices.

Humana has "learning labs" programs in Florida and Kentucky for small practices to help them learn about the value, accuracy, and speed that e-tools, such as the aforementioned e-prescribing and payer-based electronic health records, can bring to patient care.

For medium-sized practices, Humana has developed a Model Practice program designed to help physicians become comfortable with reporting quality measures for their patients.

With larger, more sophisticated, group practices, Humana has assisted with the formation of Medical Homes, which enhances coordination of care. Currently some 17,000 Humana members receive care coordinated through medical homes located in Atlanta, Cincinnati, Florida and Denver. Within a year we expect over 50,000 Humana members to receive care in a Medical Home.

Humana is also working on a project with Dartmouth and The Brookings Institution involving a large, integrated health system to pilot an Accountable Care Organization (ACO) that we expect to be operational in 2010. This pilot is among the first such projects on a commercial health insurance platform. The goal of the ACO is to improve quality while lowering costs for a population of patients.

Quality Improvement Efforts

Our activities also have focused on quality improvement. Humana has been an active participant in the development of standardized, national quality measures through its involvement with the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI) and with the Ambulatory Quality Alliance

(AQA). Humana has focused on 19 current quality measures developed by these organizations that involve common conditions for which physician organizations have recognized that there is a wide variation in adherence. These measures, which are all AQA and National Quality Forum-endorsed, represent the clinical areas of diabetes, asthma, cardiac conditions and preventive health. In fact, the AMA has sought Humana's assistance with its own quality improvement programs.

Nationally, one of the leading causes of hospitalization and illness relates to inappropriate medication use. Many factors cause this, ranging from drug interactions to patients' misunderstandings of their medications, to multiple prescribers unaware of other drugs the patient may be taking. Humana is working with local medical societies on many of these fronts. In Harris County (Houston) Texas, Humana is part of the Medical Society's efforts to help physicians with their prescribing to diverse cultures. In Louisville, Kentucky, Humana has provided information on prescribing patterns to the Jefferson County Medical Society for its patient safety program. Additionally, Humana's pharmacy programs provide point-of-sale alerts to patients and to doctors where prescriptions may be likely to cause drug interactions.

Government Oversight Of Administrative Processes

The Subcommittee also requested that we attempt to put into context anecdotes that purport to represent claim denials, deferrals and policy rescissions by insurers and the adequacy of government oversight of these activities.

With respect to denials, there are a number of reasons why a claim may be denied. The most common reason is that it is a duplicate or miscoded claim. Other reasons include a service or device which is not covered under the policy purchased by or on behalf of the member, for example, experimental treatment or treatment for cosmetic,

rather than therapeutic purposes. A denial may also occur because it appears not to have been medically necessary. Our decisions are subject to an internal, government-prescribed grievance and appeal process. If a member is not satisfied with the decision, the member has access to an independent, external review organization whose decision is binding on our plan.

As for rescissions, we would note, as I discussed earlier, that Humana has strongly supported guaranteed-issue of health plans with no pre-existing condition requirements or health status rating in concert with a personal requirement for coverage. With these requirements, coverage becomes more affordable and the issue of rescissions will no longer exist. Humana has both an internal appeal process for rescission decisions and has contracted with an external review organization to provide a final level of independent, outside review. The decision of this entity is binding on our plan.

Finally, with respect to government oversight of plan practices, we would invite you to review the "Summary of Health Insurance Plan Regulation" developed by America's Health Insurance Plans (AHIP) (*Exhibit 1*). It summarizes the scope and scale of state and federal regulations governing every aspect of our business, from the methods by which we price our products to what benefits are offered, to grievance and appeal processes and other consumer protections, to the substantial reserves that must be set aside to protect policyholders against insurer insolvency. These requirements set standards for claims processing, including denials and pended claims, and for processing coverage requests. We are dedicated to compliance with these laws and regulations and expend substantial resources each year on compliance, including funds expended for training, compliance programs and internal audits.

Plan Innovations In Administrative Simplification And Transparency

As I stated at the beginning of this testimony, Humana has worked diligently over the past few years not only in advocating for health insurance reform, but also in working actively to make it happen. In so doing we've partnered closely with the hospitals and physicians who care for our members, and with our members themselves. For the sake of brevity, I'll offer just two among many examples – the first involving medical providers, and the second involving transparency and actionable information for our members.

First, through **Availity** which I mentioned earlier, the industry-leading, multi-payer, multiuse electronic medical provider information exchange that we co-founded in 2001 with Blue Cross Blue Shield of Florida, we've shown the way to fulfill the President's call for a workable healthcare IT superhighway, with attendant standardization, speed, accuracy, transparency, and significant cost savings. Today, across the country, over 50,000 physicians, 1,000 hospitals, 100 million members, 100,000 employers, 150 direct public/private health plans, 1,150 indirect public/private plans connect and/or access Availity, resulting in 600 million transactions projected this year. There are no charges to providers to use Availity's services.

Availity has digitized most of the frustrating, hassle-riddled and non-standardized administrative processes that providers have endured from payers over the years. It serves as a claims clearinghouse with real-time transactions in the areas of eligibility and benefits, claims submission and status, remittances, authorizations and referral submission and inquiry. Its CardRead function allows for member ID card processing and its financial solutions include CareCostEstimator, allowing for real-time patient responsibility estimation and CareCollect, which uses a combination of ID card, debit/credit card and check processing. Availity's clinical solutions include the

CareProfile, a real-time electronic health record, and CarePrescribe for new, refill and renewal prescriptions.

In terms of streamlined, cost-saving interactions with health plans as well as improved patient safety, a study of doctors who use the Availity CareProfile electronic payer-based health record show a three- to six-minute reduction in patient intake and assessment time, adding critical efficiency to the system while giving physicians critical clinical information about their patients. Providers who use Availity regularly have reduced their phone call interactions with plans by more than ten (10) percent in the first ten (10) months. At a cost of $1.38-$2.70 per call, industry-wide savings can be exponential. And, Availity's CarePrescribe has been shown to reduce preventable adverse drug events by sixty-one (61) percent.

Finally, the State of Florida's Agency for Health Care Administration uses Availity as a health information exchange and health record with its Medicaid program. In addition, the Commonwealth of Virginia has contracted with Availity for its Virginia Health Exchange Network to develop a public/private portal for the state. And, America's Health Insurance Plans selected Availity for a multi-payer portal proof-of-concept in Ohio.

Second, through our **SmartSummary member benefits statements** *(Exhibit #2)*, we have brought to our members cost transparency, clinical information and innovative ways our members can maximize their benefits. Launched in 2004, these personalized statements reach 10 million Humana members every quarter, helping them save money, better understand how to use their benefits, and find ways to improve their health.

Conclusion

Mr. Chairman, in closing, let me say that at Humana, we continue to work closely with the Administration and with Congress to increase the likelihood that measures designed to solve the most significant problems in our nation's healthcare system – the rising costs of care associated with obesity and other chronic conditions, the lack of interconnected electronic systems and coordinated care, and the unsustainability of greater-than-CPI annual increases in health care costs – become the focal points for national health reform efforts.

Humana continually strives to operate our company honorably, in conformance with best practices, statutory and regulatory requirements, and through innovations designed to improve the health of Americans. We are proud of our leadership role in calling for comprehensive health care reform which results in coverage for all of our citizens. We remain committed to reform that brings everyone into the system, guarantees access, and provides help to those who cannot afford coverage.

Thank you.