

# Consumer Group Wants to Restrict Health IT Investments

BY DANIEL CASTRO | JUNE 2010

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*Policymakers should set the MLR rules so that insurers have the freedom they need to experiment and find the most innovative health IT applications available, rather than worry that their investments in new technology will lead to penalties.*

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Today marked the 90-day anniversary of the signing of the “Patient Protection and Affordable Care Act,” the health care reform signed into law earlier this year by President Obama. One important provision of the Act requires “individual and small group insurers to spend at least 80% and large group insurers to spend at least 85%” of premium dollars on direct medical care and efforts to improve the quality of care.<sup>1</sup> The goal of this provision is to limit the amount of funds that insurance companies can spend on non-healthcare related expenses like administrative overhead, salaries, and bonuses to insurance executives. However, this provision could have a seriously negative impact on health IT if it limits spending in this area, a restriction urged by the Consumers Union.

The law requires the National Association of Insurance Commissioners (NAIC) to create the rules for calculating the medical loss ratios (MLR)—the percentage of premiums that goes to healthcare expenses and quality improvements rather than administrative overhead or profits. The U.S. Department of Health and Human Services (HHS) had requested that NAIC provide these rules by June 1, rather than the original deadline of December 31, 2010, to give the industry more time to implement the rules which go into effect in 2011. NAIC released a statement on June 1, 2010 stating that it has made progress, but will need more time to finish its work.<sup>2</sup>

It is unclear whether NAIC will recommend (or HHS adopt their recommendation) that health IT spending be categorized as a “quality improvement” or as an “administrative expense.” If it is the former, then insurers will have even more of an incentive to spend in

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this area. If it is the latter, then insurers will have to watch every dollar to make sure it does not push them over the MLR threshold. This type of restriction could severely diminish the health IT spending spurred on by the incentives in the HITECH Act in the 2009 stimulus legislation.

Clearly there are many reasons to include health IT spending as a quality improvement. ITIF has documented numerous studies which show how IT is being used to improve quality of care by (1) reducing the number of medical errors; (2) improving our understanding of the effectiveness of health care interventions; and (3) introducing new, more effective diagnostic and treatment interventions.<sup>3</sup> In particular, clinical uses of health IT can help reduce medical error. One study has found that health IT could eliminate around 200,000 adverse drug events in the United States at a national savings of \$1 billion annually.<sup>4</sup>

Moreover, health insurers are often in the best position to implement effective health IT systems since they can have a more complete medical history of a patient than any individual doctor. For example, Medco Health Solutions has developed an electronic prescription-review system to improve patient safety that can recognize potentially unsafe drug interactions that a patient's doctor may be unaware of.<sup>5</sup> Health insurers have also been leaders in developing personal health records for consumers.<sup>6</sup> And the increased number of consumers with smart phones equipped with powerful computer processors and wireless bandwidth like the iPhone means that the cost of developing mobile health care applications has dropped tremendously (since the customers are already paying for the hardware and data networks). Insurers now have many opportunities to invest in health IT applications for their customers to monitor health, improve compliance, prevent diseases, and promote healthy lifestyles.<sup>7</sup>

Yet at least one organization has asked that NAIC not categorize health IT spending as dollars going to quality improvements or health care. The Consumers Union filed comments with the NAIC which stated that IT spending is an example of “expenses that are not likely to meet this rigorous standard—and merit close scrutiny” (emphasis in the original text). The Consumers Union further argued that NAIC place “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.”<sup>8</sup> President Obama's vision of using IT to create a modern health care system would suffer a serious setback if the Consumers Union gets its way.

While certainly the accounting practices of insurers should have oversight and clear standards, broadly speaking, health IT spending results in quality improvements for patients either directly or indirectly. Even non-clinical health IT spending, on areas such as operations, generally leads to better service or reduced costs for patients, such faster patient registration or shorter hospital stays from better coordination of care. Moreover, the health care reforms were crafted, in part, to create a more competitive marketplace which means that IT investments yielding administrative savings will eventually be passed through to

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consumers in the form of lower premiums or better benefits. Scholars, economists and corporations have all found that IT enables companies to significantly improve efficiency.<sup>9</sup> If nothing else, IT investments will drive productivity in health care. Health IT investments are simply not in the same category as corporate profits or executive bonuses.

Applying the brakes now to health IT spending could undo much of the progress we have seen over the past year in the United States as healthcare providers increasingly have gotten behind using IT to improve health care. For example, President Obama's Chief Technology Officer Aneesh Chopra testified that according to the National Venture Capital Association in 2009 "healthcare IT venture capital [is] up 37 percent while overall venture saw a decline by roughly 31 percent." Policymakers should encourage more investment in health IT, not less. The federal government has an opportunity to set flexible MLR rules so that insurers have the freedom they need to experiment and find the most innovative health IT applications available for consumers, rather than worry that their investments in new technology will lead to penalties.

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## ENDNOTES

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1. “Fact Sheet: The Affordable Care Act’s New Patient’s Bill of Rights,” White House, June 22, 2009, <http://www.whitehouse.gov/sites/default/files/Consumer%20reg%20Fact%20Sheet.pdf>.
2. “NAIC Making Steady Progress on MLR Calculations, Definitions,” NAIC, press release, June 1, 2010, [http://naic.org/Releases/2010\\_docs/hhs\\_letter\\_100610.htm](http://naic.org/Releases/2010_docs/hhs_letter_100610.htm).
3. Robert Atkinson and Daniel Castro, eds., “Digital Quality of Life: Health,” Information Technology and Innovation Foundation, October 2009, <http://www.itif.org/files/DQOL-5.pdf>.
4. RAND Corporation, “Health Information Technology: Can HIT Lower Costs and Improve Quality?” Santa Monica, California, 2005, [http://www.rand.org/pubs/research\\_briefs/2005/RAND\\_RB9136.pdf](http://www.rand.org/pubs/research_briefs/2005/RAND_RB9136.pdf).
5. Daniel Castro, “Explaining International IT Application Leadership: Health IT,” Information Technology and Innovation Foundation, September 2009, <http://www.itif.org/files/2009-leadership-healthit.pdf>.
6. Kate Ackerman, “Where Does Health IT Fit Into the Medical Loss Ratio?” iHealthBeat, May 20, 2010, <http://www.ihealthbeat.org/features/2010/where-does-health-it-fit-into-the-medical-loss-ratio.aspx>.
7. “Smartphone Programs to Provide Health Tips, Monitoring Services,” iHealthBeat, June 14, 2010, <http://www.ihealthbeat.org/articles/2010/6/14/smartphone-programs-to-provide-health-tips-monitoring-services.aspx>.
8. “Comments of Consumers Union of U.S., Inc., to the U.S. Department of Health and Human Services on ‘Medical Loss Ratios,’” Consumer Union, May 14, 2010, [http://www.prescriptionforchange.org/2010/05/health\\_insurers\\_to\\_spend\\_a\\_per.html](http://www.prescriptionforchange.org/2010/05/health_insurers_to_spend_a_per.html).
9. For example, see Erik Brynjolfsson, “Wired for Innovation,” Presentation at Information Technology and Innovation Foundation, Washington, D.C., October 16, 2009, <http://www.itif.org/events/wired-innovation>.

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## **ABOUT THE AUTHOR**

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Before joining ITIF, Mr. Castro worked as an IT analyst at the Government Accountability Office (GAO) where he audited IT security and management controls at various government agencies. He contributed to GAO reports on the state of information security at a variety of federal agencies, including the Securities and Exchange Commission (SEC) and the Federal Deposit Insurance Corporation (FDIC). In addition, Mr. Castro was a Visiting Scientist at the Software Engineering Institute (SEI) in Pittsburgh, Pennsylvania where he developed virtual training simulations to provide clients with hands-on training of the latest information security tools. He has a B.S. in Foreign Service from Georgetown University and an M.S. in Information Security Technology and Management from Carnegie Mellon University.

## **ABOUT ITIF**

The Information Technology and Innovation Foundation (ITIF) is a Washington, D.C.-based think tank at the cutting edge of designing innovation strategies and technology policies to create economic opportunities and improve quality of life in the United States and around the world. Founded in 2006, ITIF is a 501(c) 3 nonprofit, non-partisan organization that documents the beneficial role technology plays in our lives and provides pragmatic ideas for improving technology-driven productivity, boosting competitiveness, and meeting today's global challenges through innovation.

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