



# Implementing Medical Loss Ratio (MLR) Requirements to Improve Quality, Promote Choice, and Avoid Disruptions in Coverage

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The “Patient Protection and Affordable Care Act” (PPACA) requires health plans, beginning in 2011, to meet a medical loss ratio (MLR) requirement of 80 percent in the individual and small group markets and 85 percent in the large group market. This means that plans must spend a specified percentage of premium revenue on either reimbursement for clinical services provided to enrollees or “activities that improve health care quality.” The law establishes an important role for the National Association of Insurance Commissioners (NAIC) in developing recommendations to the Department of Health and Human Services (HHS) for the implementation of the new MLR requirements.

To improve quality, promote choice, and avoid disruptions in coverage, the implementation of the MLR requirements should address four key goals:

- ▶ **GOAL #1:** Ensure that existing efforts to improve quality are allowed to continue and new initiatives to support the goals of PPACA are not discouraged;
- ▶ **GOAL #2:** Recognize that quality improvement efforts will be advanced by ICD-10 implementation;
- ▶ **GOAL #3:** Include fraud prevention and detection activities in the definition of activities that improve health care quality; and
- ▶ **GOAL #4:** Implement a plan for transitioning from the existing state system to the new federal standards to maximize consumer choice.

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## GOAL #1

**ENSURE THAT EXISTING EFFORTS TO IMPROVE QUALITY ARE ALLOWED TO CONTINUE AND NEW INITIATIVES TO SUPPORT THE GOALS OF PPACA ARE NOT DISCOURAGED**

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To ensure that individual patients receive the best care based on the latest available evidence, the phrase “activities that improve health care quality” should be defined to ensure that current and future patients receive the most up-to-date and innovative support programs and tools that health plans have available.

This can be accomplished by using the framework and criteria established by the Institute of Medicine (IOM) and the Agency for Healthcare Research and Quality (AHRQ), entities whose primary goal is to promote high quality health care for consumers. In *Crossing the Quality Chasm*, the IOM stated that enhancing quality in our health care system requires a focus on six core aims for improvement: (1) safe; (2) effective; (3) patient-centered; (4) timely; (5) efficient; and (6) equitable. AHRQ, which consistently references the IOM’s criteria, notes that there are similar facets to health care quality.

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A definition of quality that tracks the IOM's definition closely and includes consumer protections, such as the use of evidence-based standards, will ensure that programs and initiatives are grounded in research and will yield intended results for specific populations. Examples of the types of health plan initiatives that are improving the quality of patient care include:

- ▶ initiatives in which nurse care managers contact enrollees who are at high risk of hospital admissions and readmissions, and help them identify their health goals and make the health and lifestyle changes needed to achieve these goals;
- ▶ maternity programs that pregnant women and new mothers can use at any time, as well as coaching services to help ensure that pregnant women receive high quality prenatal and postpartum care; and
- ▶ initiatives that reduce inappropriate use of imaging services and help prevent exposure to unnecessary radiation by providing physicians with the latest evidence-based guidance and expert recommendations when a test is being ordered, so no waiting or extra steps are required.

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## GOAL #2

### RECOGNIZE THAT QUALITY IMPROVEMENT EFFORTS WILL BE ADVANCED BY ICD-10 IMPLEMENTATION

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The startup costs associated with implementing the International Classification of Diseases 10 classification system (ICD-10) by 2013 should be defined as an “activity that improves health care quality.”

Health insurance plans face costs that are estimated to total billions of dollars over the next three years as a result of a new requirement to implement and utilize the ICD-10 classification system. This represents an unusual spike in required expenditures at a time when rising medical costs are forcing premiums higher and placing a heavy burden on working families, employers, and government health

programs. Health plans are concerned that these startup costs, which must be incurred to comply with the new ICD-10 requirements, could crowd out other important quality initiatives at a time when the country is trying to build a reformed health care system.

ICD-10 is a quality, not a claims payment, initiative.

According to the World Health Organization (WHO), at least 25 countries already use ICD-10. None of these countries have undertaken this massive overhaul of their industry coding systems simply to improve their ability to pay claims. They have done so in order to participate in the global conversation to prevent and combat death and disease.

Health insurance plans should not be penalized for undertaking this long-term project and for bearing the major burden of allowing the United States to engage in this mission. The adoption of ICD-10 by the United States will bring our nation into compliance with the international nomenclature of diseases, help promote a deeper understanding of disease and the causes of death, and support the worldwide mission of eradicating preventable illness and death.

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## GOAL #3

### INCLUDE FRAUD PREVENTION AND DETECTION ACTIVITIES THAT IMPROVE QUALITY

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The definition of “activities that improve health care quality” should include the expenses health plans are required to make for fraud prevention activities.

Excluding these expenses would be contrary to the goals of PPACA, the public interest goal of developing a system that delivers consistently higher quality care and makes optimal use of health care resources, and the federal policy of enhancing anti-fraud cooperation between private and public entities. Excluding these expenses also would contradict the universal recognition – by the Administration, the HHS Office of the Inspector General, the FBI, and other leaders in both the public and private sectors – that there is a direct link between fraud prevention activities and improved health care quality and patient outcomes.

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Health plans use a variety of tools – including sophisticated analytics that indicate when an investigation is warranted – to prevent, detect, and remedy fraudulent and abusive conduct that threatens and undermines the quality of care received by enrollees. Recognizing that those engaged in fraudulent activities often target both commercial and government programs, health plans also enter into partnerships with law enforcement agencies to address abusive billing practices (e.g., billing for services not provided) and other fraudulent activities that are harmful to enrollees in both the commercial market and government programs.

Anti-fraud and abuse programs enable plans to detect providers who are providing care with false credentials, delivering medically unnecessary services, or making treatment decisions based on illegal referral relationships. The need for these programs – and their direct relationship to health care quality – is clearly demonstrated by examples of patients whose health and well-being is compromised due to unnecessary surgeries and other medical procedures and falsified medical records. Similarly, significant threats to patient health result from care provided by unlicensed providers and medical ID theft. All of these activities can have a devastating impact on health care quality.

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## **GOAL #4**

### **IMPLEMENT A TRANSITION PLAN TO MAXIMIZE CONSUMER CHOICE**

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The transition period between 2010 and 2014 will be especially critical to the success of health reform, and the NAIC is uniquely positioned to take a leadership role in advancing a transition plan that meets the best interests of consumers. By addressing transition issues of market disruption now, the NAIC can perform a vital service by promoting stability of health plan choices in the individual and small group markets. The consequence of not providing for an effective transition is a potential disruption of coverage for millions of Americans prior to implementation of the 2014 market reforms.

PPACA provides for the implementation of comprehensive insurance market reforms in 2014, including the creation of state health insurance exchanges. Until that time, consumers in the individual market will rely on brokers to review their insurance options and consider which ones best suit their needs. For health plans, four-fifths of the individual market will remain medically underwritten, guided by the rules and regulations in each state. A transition policy is needed to move from the current system to the new system that will be created in 2014 and to allow individuals to maintain their coverage.

The NAIC is charged with the responsibility to develop MLR methodologies that take into account special circumstances. This means that Congress intended for the NAIC to exercise its expertise to make adjustments to the MLR to ensure that consumers are not harmed and that competition is not decreased. The NAIC actuaries already have indicated that there could likely be harm and a decrease in competition if a transition is not implemented. The NAIC should exercise its expertise and outline the standards by which to measure the market disruption so that the transition is made smoothly and similarly situated states are treated similarly.