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OFFICE OF FINANCIAL AND INSURANCE REGULATION
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
STANLEY "SKIP" PRUSS, DIRECTOR


KEN ROSS
COMMISSIONER

Memorandum

DATE: June 24, 2010

TO: Lou Felice, Chair
Health Reform Solvency Impact (E) Subgroup

Steve Ostlund, Chair
Accident & Health Actuarial Working Group

FROM: Ken Ross 
Commissioner

SUBJECT: Medical Loss Ratio Calculation

By helping HHS establish uniform definitions and standardized methodologies for calculating the medical loss ratio (MLR) and rebates outlined in the Patient Protection and Affordable Care Act (PPACA), the NAIC has undertaken a herculean task of fundamental importance to the ultimate success of the new law.

I want to first thank you for all the time and effort that the Health Reform Solvency Impact (E) Subgroup and the Accident and Health Actuarial Working Group have expended defining the MLR provisions of the PPACA.

NAIC President Jane Cline and CEO Therese Vaughan stated the crux of the challenge associated with coming up with a balanced MLR definition in their June 1, 2010 letter to HHS Secretary Kathleen Sebelius, when they wrote:

The medical loss ratio and rebate program in PPACA have the potential to destabilize the marketplace and significantly limit consumer choices if the definitions and calculations are too restrictive. Equally, the medical loss ratio and rebate program could be rendered useless if the definitions and calculations are too broad. Only through an open, deliberative process can we hope to reach a reasonable consensus that meets the dual objectives of protecting consumers and preserving competitive markets.

Their comments highlight the need for a balanced approach that protects consumers while recognizing that an overly rigid approach would undermine market stability at the ultimate expense of consumers.

Before making brief comments regarding the definition of “activities that improve health care quality,” I would like to draw your attention to an issue concerning mandatory regulatory assessments that is of significance to Michigan and a number of other states that are similarly situated.

Mandatory Regulatory Assessments

As you may know, Michigan law empowers its Insurance Commissioner to mandate assessments on Blue Cross and Blue Shield of Michigan (BCBSM) as part of its ratemaking. These assessments subsidize Medicare Supplemental coverage for Michigan seniors and Group Conversion coverage.

A question has arisen regarding whether these mandatory assessments would fall within the definition of state taxes or regulatory fees within the MLR calculation.

I strongly encourage you to include mandatory regulatory assessments in the definition of federal and state taxes and licensing or regulatory fees. These assessments should be considered a state tax or regulatory fee for purposes of the MLR reporting and rebate methodologies regardless of whether the assessment was paid to a governmental unit prior to subsidizing the individual or Medicare Supplemental markets.

To illustrate the significance of this issue in Michigan, last year I ordered BCBSM to pay 1% of its earned subscription income toward Medicare Supplemental subsidies. This assessment alone amounts to over \$180 million annually.

Michigan law empowers the Commissioner with the discretion to order BCBSM to pay up to 1% of its earned subscription income for this subsidy. Once an order is issued, BCBSM is obliged to apply the subsidy, which is the functional equivalent of a state tax or regulatory fee. Recognition of this should be clearly stated in the MLR definition or any guidance associated with the MLR calculation.

Activities to Improve Health Care Quality

The intense attention that has been focused on properly defining this phrase speaks to its fundamental importance to the MLR definition. Rather than covering well-trod ground, I lend my support to the sentiments well stated by my colleague Mary Jo Hudson, Director of the Ohio Department of Insurance, in her memo dated May 6, 2010. (Attached)

In her letter, Director Hudson cogently set forth the underlying goals that Congress sought to achieve by incorporating MLR requirements in the PPACA and the need to include expenditures that can be demonstrated to improve health care quality (through effective tracking, measuring and assessment) within the definition of MLR.

Thank you for the opportunity to provide you with these comments.

Attachment



MEMORANDUM

To: Lou Felice, Chair, Health Reform Solvency Impact (E) Subgroup
Steve Ostlund, Chair, Accident & Health Working Group

From: Mary Jo Hudson, Director, Ohio Department of Insurance

Date: May 6, 2010

Re: MLR Calculation

Thank you for the work of the Health Reform Solvency Impact Sub Group and the Accident and Health Actuarial Working Group in developing a MLR standard that will be recommended to HHS. I want to comment on the term “activities to improve health care quality” and propose a specific definition for that term.

The Purpose of the New MLR Requirement

In thinking about the Working Groups’ approach to developing an MLR definition, the following goals of health care reform should be kept in mind.

First, the decision of Congress to include health care quality improvement activities in the MLR was an incentive for carriers to move the current, fee-for-service driven health care system to one that invests in performance and outcomes, leading to greater value for dollars spent, improved efficiency, and better health. Ultimately, unless health care costs are better contained through strategies to improve health care quality, coverage expansions will be unsustainable over time.

Second, the MLR standards established by Congress are an attempt to limit administrative costs associated with providing health insurance coverage. Therefore, in applying the new MLR standards, we as regulators must ensure that only verifiable (auditable) expenses for legitimate health care quality improvement activities are included in the MLR calculation.

The task of the Working Groups to define “activities to improve health care quality” largely involves the development of an approach to meet these two goals. This will require insurance regulators to coordinate their review of financial information with health care quality standards and measures. This can be accomplished by drafting the MLR definition of “activities to improve health care quality” in coordination with national quality reporting and performance measures that will be applied to those same activities.

Principles To Consider

The Working Group should consider the following concepts in developing a definition for “activities to improve health care quality”:

1. Health care quality improvement expenses should be reported on the MLR exhibit in the annual statement blank in sufficient detail to allow comparisons to quality reporting measures developed by HHS under Section 2717 of the PPAACA. This Section requires HHS to consult with health care quality experts and stakeholders in developing health plan reporting requirements related to quality improvement. Quality improvement activities on the MLR exhibit in the annual statement blank should be reported on separate lines consistent those listed in Section 2717 as follows:
 - effective case management;
 - care coordination;
 - chronic disease management;
 - medication and care compliance initiatives;
 - prevention of hospital readmissions;
 - activities to improve patient safety and reduce medical errors by using best clinical practices,
 - activities to encourage evidence based medicine,
 - health information technology; and
 - wellness and health promotion activities.

Beyond these categories listed in the statute, separate categories should be provided for all activities for which HHS develops separate quality reporting requirements through regulation.

2. If an activity proves to be ineffective at improving health care quality, the related expenses should not be included in MLR. Plans should be given a limited period of time (3- 5 years) before the quality improvement components of MLR are assessed and compared to health care quality performance measures and outcomes.
3. Health information technology (HIT) investments should be allowed as MLR expenses if they meet criteria established by the Office of National Coordinator within HHS. The economic stimulus package (ARRA) passed by Congress included federal funding for the widespread adoption of an HIT infrastructure and implementation of electronic health records to improve our nation’s health care system. To carry out this national goal, the Office of National Coordinator will establish national standards that all HIT systems must meet. The MLR definition must be consistent with this national priority to support the adoption of HIT to improve the quality and efficiency of our health care system.
4. Health care quality improvement activities should be allowed if they are in accordance with nationally recognized standards and certification and accrediting bodies.

5. The definition should include specific examples of quality improvement expenses that may qualify as an MLR expense.

Ohio's Proposed Definition

With these principles in mind, the Ohio Department of Insurance proposes the following definition:

“Activities to improve health care quality” shall include those activities identified in Section 2717 of the PPAACA, other activities for which HHS has established quality reporting requirements in accordance with Section 2717, and activities generally recognized by national standards or accrediting or certification bodies as improving health care quality and outcomes. These activities may include:

1. effective case management;
2. care coordination;
3. chronic disease management;
4. medication and care compliance initiatives;
5. prevention of hospital readmissions;
6. activities to improve patient safety and reduce medical errors by using best clinical practices ;
7. activities to encourage evidence based medicine;
8. health information technology; and
9. wellness and health promotion activities.

An activity to improve health care quality must be tracked, measured and assessed to determine if it is effective at improving health care quality. If an activity is determined not to be effective, it should not be included as an MLR expense.

Health information technology investments are allowed as MLR expenses if they meet certification standards and programs to be established by the Office of National Coordinator within HHS, which will include meaningful use and the CORE II standards. Once a health information technology system has been adopted and is operational, the ongoing maintenance of that system should not be included as an MLR expense.

Examples of the type of expenses that could qualify as “activities to improve health care quality” include the following:

1. PMPM care management fees (fees paid to providers for care management and other services related to medical / primary care homes);
2. Maternity management programs;

3. Chronic disease management (vendor contracts and/or internal staff);
4. Programs to reduce avoidable hospital readmissions;
5. Medication management (could include reimbursement to pharmacists for medication management; can be linked to medical homes);
6. Patient safety (incentives and programs to increase patient safety in health care facilities and offices);
7. Medical errors (incentives and programs to reduce medical errors);
8. Increased reimbursement for primary care providers including nurse practitioners;
9. HIT investment (to implement medical homes, improve information sharing and coordination of care, reduce duplication of tests and services, reduce gaps in care);
10. Patient compliance (reimbursement to health care workers or for systems that assist patients and assure compliance with treatment plans and medications); and
11. Wellness and health promotion (wellness assessments; nurse hotlines; could include fitness center memberships for members; healthy lifestyle improvement programs including health coaching; preventive care reminders and follow up; incentives for members related to physical activity; obesity reduction; tobacco prevention and cessation)