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POLICY & ACTION FROM CONSUMER REPORTS

January 12, 2016

Dean Cameron, Chair
Medical Loss Ratio Quality Improvement Activities (B) Subgroup
Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

Re: Follow-up to MLR Quality Improving Activities (B) Subgroup meeting, NAIC Fall National Meeting

To Director Cameron and members of the MLR Subgroup:

The subgroup has been urged to reopen the definitions used to calculate the medical loss ratio (MLR) under the federal Affordable Care Act (ACA). At this time, we do not agree that current definitions require new debate. Rather, the multi-stakeholder efforts to develop those definitions in 2011 remain valid and complete.

In November 2015, Consumers Union submitted written testimony to the Subgroup, urging it to keep the definition of "quality improvement" in the MLR calculation and to encourage more vigorous enforcement using those definitions. As we noted in that letter, over the past three years, insurers have broadly applied the "quality improvement" classification in the MLR setting, costing the health system and consumers money.

Through written and oral[1] testimony, the Subgroup heard testimony from representatives of health insurance plans and health underwriters associations that recommended the Subgroup broaden the definition of "quality improvement activities" to include:

- funding for PROMETHEUS, a payment and benefit design program;
- fraud detection and prevention programs;
- medical identity fraud prevention;
- a portion of credentialing costs;
- value-added payment models;
- adding care coordination and case management to the "improve health outcomes" category.[2]

[1] Medical Loss Ratio Quality Improvement Activities (B) Subgroup, 20 November 2015, meeting minutes draft for adoption dated November 30, 2015.
[2] Association for Community Affiliated Plans, Comments submitted via email to the Subcommittee, 19 November 2015.

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In both the written and oral testimony, these industry representatives made a number of assurances, namely that broadening the definition of quality improvement and easing the path for plans to be credited for expenses in the MLR ratio will incentivize innovation and benefit consumers. They did not, however, provide evidence to justify their promises. Absent any new evidence and with circumstances unchanged, there is no basis to revisit a definition that was settled five years ago.

The intent behind the MLR is to compel plans to spend adequately for the care of their policyholders, not to underwrite administrative tasks and expenses for innovations considered part of normal business operations. As was emphasized at the November meeting—the focus of quality improvement should be quality of *care*, not health plan operations. Other activities such as fraud prevention and credentialing are considered a normal business expense not meriting inclusion in the quality improvement part of the MLR calculation.

Health plan presenters also argued that work to oversee innovations such as ACOs, value-based payments to providers and Value-based insurance designs (whereby cost-sharing is varied for enrollees to direct them to high value services) should be considered quality improving activities. However, the evidence is mixed with respect to their impact as evidence reviews by our own Health Care Value Hub show (HealthCareValueHub.org). Therefore, we do not recommend including these as quality improving activities at this point.

The MLR rule has been shown to benefit consumers to the tune of $5 billion in terms of both rebates to consumers and reduced overhead. What's more, these consumer gains have not come at the cost of substantially reduced competition or choice among insurers.[3] We therefore strongly urge the Subcommittee to remain skeptical of any recommendations to broaden the definition of "quality improvement" in the absence of substantial evidence that doing so will directly benefit consumers and their health care.

Sincerely,

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[3] The Commonwealth Fund, *The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3*, March 2015. Available at http://www.commonwealthfund.org/publications/issue-briefs/2015/mar/medical-loss-ratio-year-three.