

NAIC Panel Resolves Some MLR Issues, Still Debating Others

Posted: May 26, 2010

A subgroup of the state insurance commissioners working to define the health reform law's medical loss ratio terminology on Monday gave preliminary approval for eight recommendations, including exempting costs associated with adjusting and settling claims from the definition and aggregating information at the state and market level. Both policies were recommended in a letter Senate health committee Chair Tom Harkin (D-IA) and member Al Franken (D-MN) sent to the the National Association of Insurance Commissioners (NAIC) on Thursday (May 20).

Regulators also decided to send four more controversial items to "issues groups" for further review.

The decisions are part of NAIC's ongoing effort to define what activities should be considered part of insurers' MLRs – or the amount of the collected premiums that are allocated to claims. Under the reform law, large groups must have an MLR of at least 85 percent and small and individual plans must have an MLR of at least 80 percent, or the plans must provide rebates to consumers. However, the legislation also says that activities that improve quality should be included in the ratio. Deciding which activities should be categorized as quality improvement has been controversial, with insurers calling for a broad definition while providers and consumers groups advocate a narrow approach.

Although HHS Secretary Kathleen Sebelius had asked the regulators to provide recommendations on the definition to her by June 1, NAIC said last week that it would be unable to do so by that time, and is now aiming to have the final draft to HHS by July.

The issue of whether loss adjustment expenses (LAEs) should be included as part of the MLR had been under discussion for some time because the wording of the section was unclear, according to a background document on the issue. Insurers groups had argued that the LAEs should be included, but the NAIC-funded consumer representatives disagreed.

The issue was clarified by Harkin and Franken, who wrote to offer insight on the congressional intent of the statute. The lawmakers' letter urges NAIC to definite activities that improve quality with a "high degree of specificity" and in such a way that they they can be easily audited.

"Such activities should be proven to improve quality based on evidence and standards developed by the Agency for Healthcare Research and Quality, the National Committee for Quality Assurance, or other independent entities," they wrote. They said the activities should also provide direct services to enrollees or directly improve their health or safety.

Harkin and Franken also noted that some have suggested LAEs, which include cost containment expenses, should count as spending on clinical services and activities that improve quality. "However, while the statute requires reporting of loss adjustment expenses, it is clear that they should not be included for the purpose of determining rebates required under the new law. These expenses do not reimburse for clinical services and they do not improve quality," they wrote.

The senators also said that the NAIC should set minimal percentages at each market segment in each state.

The subgroup Monday approved a recommendation that the MLR ratio should be aggregated at the state level, and by the three insurance pools – large group, small group and individual -- but did not come to a conclusion on whether information should be aggregated by licensed entity. The group gave initial approval to a suggestion that the rebates should be based upon calendar year, and agreed calculation of rebates should not be double counted.

A recommendation that the clinical services should be limited to incurred claims as defined by the Statement of Statutory Accounting Principles (SSAP) was agreed to by the regulators, who said that doing otherwise would be "reinventing the wheel."

The subgroup decided not to make a final decision on whether rebates should be issued to employers rather than employees, instead giving that to an issue group for further review, but they did agree that rebates on canceled policies should be provided to the individual.

The following issues were preliminarily approved by the the actuarial subgroup of NAIC's Accident and Health Working Group on Monday:

- The MLR formula will exclude LAEs.
- Aggregation will be by small group, large group and individual market pools.
- Aggregation will be at the state level .
- Rebates will be based upon calender year experience.
- Calculation of rebates should not be double counted.
- Clinical services should be limited to incurred claims defined by SSAP.
- Claim reserves should be calculated on a run out basis of 3 to 6 months.
- Issuer must send rebate checks to individual enrollees who have canceled plans.

The following issues have been sent to "issues groups" for further discussion:

- Aggregation by licensed entity.
- "Contract" reserve should enter into the calculation as directed within SSAPs.
- Rebates should be distributed by issuer to the employer.
- Premium reductions would be the means of distribution.