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PPACA: Agent Groups Fear Effects Of Medical Loss Ratio Rules

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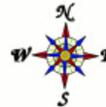
WASHINGTON BUREAU -- Health agent groups are urging the U.S. Department of Health and Human Services to take a flexible approach when implementing the minimum medical loss ratio provisions in the new Affordable Care Act.

ACA is the legislative package that includes the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act.

Commenters have submitted more than 100 responses to an initial MLR notice put out by the Centers for Medicare and Medicaid Services, an arm of the HHS.

CMS is supposed to work with state insurance regulators to make sure that insurers spend at least 85% of the premiums collected from large groups and at least 80% of the premiums collected from small groups and individual insureds on medical costs.

The health agent groups say in their comment letter that they are "extremely concerned" about the possibility that putting a narrow MLR definition in the final regulations would hurt important health plan activities.



"If they are somehow diminished due to narrow MLR definitions and enforcement, the quality of care delivery for consumers will deteriorate and health care costs will surely increase," the agent groups write in their comment.

A narrow MLR definition could cut spending on health plan activities such as case management, wellness, disease management, and fraud and abuse prevention, the agent groups write.

The agent groups ask HHS to consider NAIC accounting rules relating to "medical loss" when defining "medical loss" in the new regulations, but to widen the definition to reflect congressional intent.

The NAIC MLR accounting standard defines "medical loss" as the value of medical claims an insurer actually pays, or "incurred claims," plus "contract reserves," or the amount of money the insurer sets aside to pay future claims.

The new federal minimum MLR law "takes a broader view of MLRs," the agent groups write.

The groups note that Congress included the cost of activities that improve health care quality as well as the cost of clinical services in the ACA minimum MLR provision.

The groups that submitted the comment are the Council of Insurance Agents and Brokers, Washington; the Independent Insurance Agents and Brokers of America, Alexandria, Va.; the Council of Insurance Agents and Brokers, Washington; the National Association of Health Underwriters, Arlington, Va.; and the National

Association of Insurance and Financial Advisors, Falls Church, Va.

NAHU “strongly believes that health care consumers will best be served by a definition of clinical services and activities that improve health care quality which is comprehensive and inclusive,” NAHU Chief Executive Janet Trautwein told National Underwriter.

The definition needs to be comprehensive and inclusive “so that it adequately accounts for the wide spectrum and types of insurer activities that contribute to better health outcomes and health care delivery and provides a level playing field among different types of insurers and products,” Trautwein said.

OTHER REACTIONS

CMS officials already have posted dozens of the comments they have received. Many of the comments are more than 10 pages long, and many have been submitted by groups, insurance regulatory agencies or other organizations that have based their recommendations on the results of extensive policymaking processes of their own.

Texas Insurance Commissioner Michael Geeslin, for example, submitted 29-pages of comments.

The Texas Department of Insurance “held a stakeholders meeting consisting of issuer, provider and consumer representatives,” Geeslin writes.

Geeslin suggests in his comment that a minimum MLR standard could cause smaller carriers to flee from the individual market, especially if they believe the minimums could threaten their solvency.

The **Texas Medical Association**, Austin, Texas, has submitted a comment letter objecting to the idea that insurers might include cost-control efforts in medical expense totals.

A medical loss ratio should “measure the insurer’s performance in providing insurance — not value-added or cost-containment services,” Dr. Christopher Crow, chair of a TMA council, writes. “Neither value-added nor cost-containment services are losses or expenses that would be ‘suffered’ by the patient/insured person nor are they items for which the insurer has agreed to indemnify.”

The **California Hospital Association**, Sacramento, Calif., also is calling for a narrow MLR definition.

“CHA believes that MLR should not include payer activities or functions such as marketing, enrollee education, quality programs, information technology, claims or eligibility activities, administration, provider relations, preparation or distribution of materials or information to providers or others, underwriting or actuarial expenses, regulatory compliance costs, provider or enrollee appeals expenses, litigation costs, contracting or negotiating expenses, electronic records or enrollee interactions, provider instruction/education or other costs incurred that are not directly attributable to actual health care services rendered to enrollees by health care providers,” John Rigg, a CHA vice president, writes.

Advocacy for Patients with Chronic Illness Inc., Farmington, Conn., a nonprofit group that represents patients with chronic illnesses, says regulators should require insurers to show how much of the money spend on administration is going to pay for utilization review and the processing and defense of claim denial appeals.

“We understand and appreciate the role that utilization review plays in controlling costs...,” Jennifer Jaff, the group’s executive director, writes. “If we are to control health care costs in the United States, frivolous, expensive treatments that do not hold great promise for positive health outcomes can and should be prohibited by insurers. However, in our experience, not all insurers limit denials of coverage to circumstances in which the treatment truly is experimental or investigational, or not medically necessary.”

America’s Health Insurance Plans, Washington, is asking CMS to work quickly to come up with permanent rules, rather than relying on makeshift interim rules.

“This is a very technical and complex area that has a significant impact on consumers, employers, and ‘health insurance health plans’ for the group and

individual markets,” Jeffrey Gabardi, an AHIP senior vice president writes. “As a result, it is critical that the public receive as much advance notice as possible of the [HHS] secretary’s proposed rulemaking to establish and implement the process and rules under which the MLRs will be calculated. This, in turn, will ensure that the secretary has sufficient time to fully digest and consider comments. If the less deliberative interim final rulemaking with a comment period is utilized, then the secretary should include some time period endpoints so that there is review by the relevant agencies of the filed comments and subsequent final rulemaking. Any interim final rules should be considered a temporary gap measure toward final rulemaking and not remain as interim final for any extended period of time.”

The **Council for Affordable Health Insurance**, Alexandria, Va., is asking HHS to give small insurers special consideration.

“Smaller insurers should be exempted from the tighter MLR rules,” CAHI Acting Executive Director J.P. Wieske writes.

If smaller insurers are subject to the rules, they “should be given more flexibility in MLR calculations between blocks of business, and in combining blocks of business for MLR purposes,” Wieske writes. “Reinsurance expenses should be considered as a medical expense and not an administrative expense.”

American General Life Companies, Houston, a unit of American International Group Inc., New York (NYSE:AIG), notes that health insurers may be out of luck if regulators make inaccurate rate rulings.

“Appeals are generally made highly visible to the public and are structured so that companies are discouraged from appealing,” American General says in its comment. “Companies that believe they are ‘in the right’ may not appeal because of fear of retaliation, such as in the form of future product disapprovals.”

For earlier coverage of the MLR provision, please see [ACA: Ohio Regulators Weigh In On Quality Improvement Definition](#) and [ACA: Commenters Parse Medical Cost](#).



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