



STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

June 16, 2010

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Chair, Accident & Health Working Group
National Association of Insurance Commissioners
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Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup
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Re: NAIC Medical Loss Ratio Blank Form

Dear Messrs. Ostlund and Felice:

The California Department of Managed Health Care (DMHC) appreciates the opportunity to provide the National Association of Insurance Commissioners (NAIC) with California-specific information to assist the NAIC in drafting the blank form to be used by health plans when submitting Medical Loss Ratio (MLR) compliance information to the Secretary of the Department of Health and Human Services (HHS).

Background

In California, the health insurance market is regulated by two separate agencies -- the DMHC and the California Department of Insurance (CDI). The DMHC oversees health services for more than 21 million insured Californians, regulating 108 health care service plans (health plans) and certain preferred provider organization (PPO) products operating in California.

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The CDI regulates all other indemnity health products, and touches approximately 2.5 million lives covered by CDI-regulated health insurance products.¹

The plans regulated by the DMHC are governed by the California Knox-Keene Health Care Service Plan Act of 1975² (Knox-Keene Act) and the regulations therein. The Knox-Keene Act does not expressly provide MLR standards or requirements. Rather, health plans are prohibited from spending an “excessive amount” of their annual revenue from health plan subscribers or enrollees on administrative costs.³ If, in any given period, the administrative costs of an established plan exceed 15 percent of the revenue obtained by the plan from subscribers and enrollees, the plan may be required by the DMHC to demonstrate that its administrative costs are not “excessive,” that the costs are justified under the circumstances, and that the plan has instituted effective procedures to reduce administrative costs. For plans in the developmental phase (generally the first five years), administrative costs should not exceed 25 percent of revenue received from subscribers and enrollees.

Under the Knox-Keene Act, administrative costs include those costs arising out of the operation of the health plan that are not direct, and overhead costs incurred in furnishing health care services. Such costs include salaries and benefits for plan employees (other than those who also provide medical care), the cost of receiving and processing claims, advertising costs, legal and accounting fees, and all other direct costs incurred in the operation of the plan that are not essential to the actual provision of health care services.

Areas Requiring Special Consideration

The DMHC urges the NAIC to consider the various types of health plans and the different reporting issues that may exist for the different types of plans, as well as issues relating to how certain costs are categorized. The MLR thresholds and the enrollee rebates required from health plans that do not meet those MLR thresholds are key cost containment components to the Patient Protection and Affordable Care Act (PPACA). As such, great care must be exercised in determining what goes into the calculation.

Delegated Model

The delegated model has significant penetration in the California market. With the delegated model, the health plan delegates a certain amount of risk to provider groups or “risk bearing organizations” (RBOs). The capitation payment from the plan to the provider group or RBO includes administrative functions along with the responsibility to provide care. These administrative functions typically include utilization management, network development, and claim payment processing functions, among others.

¹ Another approximately 6.8 million lives are covered by Administrative Service Organization (ASO) products. CDI licenses and regulates the ASOs.

² California Health and Safety Code section 1340 et seq.

³ California Health and Safety Code section 1378 and California Code of Regulations, title 28, section 1300.78.

With the delegated model, classifying the entire capitation payment as a medical expense to be included in the MLR calculation is problematic.

- *Uneven Playing Field.* A health plan that delegates administrative or non-clinical functions to another entity through a capitation payment, and is consequently allowed to count the entire capitation payment toward the MLR will be able to comply with the MLR threshold requirements more easily than a non-capitated health plan. As a result, the MLRs for health plans that utilize significant delegation will be skewed higher than those that do not, which is fundamentally unfair. Moreover, permitting such an artificial result seems contrary to the purpose of the MLR requirements. Health plans would be incented to increase the number of services provided in a delegated/capitated manner just to reach the MLR threshold, rather than as an accurate sign of efficiency.
- *Lower Rebates to Enrollees.* If the MLRs for health plans that significantly utilize delegation are artificially high, enrollees of such plans might not receive rebates to which they would otherwise be entitled, due to the delegated model which counts the entire capitation payment as a medical expense. This also seems contrary to the intent of the PPACA.
- *Increased Premiums.* Another possible impact is the potential for increased premiums. With non-clinical services counting towards medical expenses, health insurers and health plans could justify higher premiums, since their MLRs would be skewed artificially high.

Possible solutions to this issue:

- Do not allow health plans to count all of the capitation payment as a medical expense. Instead, they could be limited to a percentage of the capitation payment. For example, 85 percent of the capitation payment could be included as a medical expense.
- Health plans could be required to account for the portion of the capitation payment that is used for administrative functions delegated to the risk bearing provider organization.

Integrated Health Plans

An integrated health plan, such as Kaiser Foundation Health Plan (one of the largest health plans in California), pays relatively few “claims” in the traditional sense, with the health plan, medical groups, and hospitals all functioning interdependently. Because the payment of claims is an essential part of the MLR calculation under section 2718, consideration should be given as to the appropriate manner for calculating MLR for a plan operating under this unique model.

Although the definitions/instructions in the current blank form include in the MLR calculation salaries and fringe benefits paid to both physician and non-physician providers, they provide less clarity as to how the cost of institutional/hospital services such as debt, equipment, or ongoing maintenance would be classified in the MLR calculations for an integrated health plan.

The true MLR of an integrated plan might be distorted if consideration is not given to its unique model, resulting in inequities similar to the ones described above under the delegated model.

Fraud Prevention

The DMHC supports the NAIC's proposed treatment of fraud prevention as an administrative expense. Although such functions are important, they are not specifically related to providing care, and are administrative in nature. As such, these expenses should not be included in the MLR calculation.

Utilization Management

The DMHC supports the NAIC's proposed treatment of Utilization Management as a cost containment expense. Such expenses are separately classified and should not be included in the MLR calculation.

Licensure Certification

The health plans' processes for certifying that providers are appropriately licensed are also a function that is administrative in nature, and should not count toward the MLR.

Health Care Quality Improvement

The DMHC supports the NAIC's current definition of Health Care Quality Improvement, which goes directly into the MLR calculation.

The DMHC classifies National Committee for Quality Assurance (NCQA) certification as an administrative expense. For purposes of the PPACA, the DMHC continues to believe that the costs associated with such certification should not be placed in the Health Care Quality Improvement category and included in the MLR calculation.

Claims Processing

The current blank form does not specify whether the costs associated with claims processing are classified as a medical expense that would be included in the MLR calculation. The DMHC has traditionally viewed such expenses as administrative in nature, and believes that they should not be classified in a manner that would allow them

to be included in the MLR calculation. Claims processing is not directly related to the provision of medical care and is an expense more closely related to other typical administrative functions, such as provider contracting.

Health Information Technology

The DMHC supports the NAIC's proposed definition of health information technology (HIT) and encourages the NAIC to be mindful that in order to be included in the MLR calculation, HIT expenses need to be tied to medical care rather than relating to administrative costs, such as claim processing.

Thank you for this opportunity to provide input regarding the NAIC's development of an MLR blank form, with instructions and definitions. Should you have any questions, please do not hesitate to contact Sarah Ream or Gary Baldwin, both Senior Counsels in the DMHC's Office of Legal Services, at (916) 322-6727 or sream@dmhc.ca.gov and gbaldwin@dmhc.ca.gov, respectively.

Sincerely,

A handwritten signature in black ink that reads "Lucinda A. Ehnes". The signature is written in a cursive style with a large initial "L".

Lucinda A. Ehnes, Esq.
Director
California Department of Managed Health Care