A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD015

Issue:

Should modifications or other considerations be given to plans that use varied provider contract terms (capitated versus fee for service, etc.)?

Proposed Resolution:

We recommend that no effort be made at this time to recharacterize capitated payments to providers as part claim and part administrative expense. Capitated payments will enter the calculation as clinical services Current statutory reporting requires staff and group model HMOs to accurately report administrative expenses (see Health Blank instructions Statement of Revenue and Expenses and SSAP No. 70 and No. 85). However, we urge Health and Human services and insurance regulators to follow provider contracting trends and keep watch for potential abuses to the intent of the MLR rebate provisions – preliminary resolution 7/8.

Exceptions:

None identified.

Description:

Provider contracts vary significantly among various types of insurers. Managed care organizations involve business models where both insurance risk and some administrative functions are transferred to providers through the provider contracting process. To the extent that these costs involve functions where the expense of the same is prohibited from being included in the numerator of the MLR calculation, issues arise about how these contracts and their costs should be handled.

Expressed concerns related to this IRD include

* whether equity between carriers utilizing different business models is disrupted; and
* whether the minimum loss ratio requirement is effectively violated when administrative expenses are part of the capitated payment.

Documentation in support:

The NAIC working groups have spent a great deal of time identifying what types of expenses may be included in the numerator of the MLR calculation and what types of expenses should be excluded. The American Academy of Actuaries, as well as a number of other entities, has indicated that there are provider contracts in place today that may actually include provisions for functions whose expenses have been identified as not being allowed in the MLR calculation.

Fee-for-service payment methodologies might be characterized as an unbundled business approach. Insurers keep the risks associated with claim severity and utilization. In this model, the insurer would hold and maintain

Subgroup DRAFT

various reserves, including claim reserves and contract reserves. The insurer would incur claim adjudication expenses, as well as any expenses of cost control (such as pre-authorization) and network management.

Towards the other end of the spectrum of payment methodologies, capitation payments might be characterized as a bundled business approach. Insurers transfer to contracted providers risks associated with claim severity and utilization. The need for the insurer to maintain reserves is therefore minimized. Similarly, the insurer's claim adjudication and other expenses are (or can be) greatly reduced.

Continuing along the spectrum of payment methodologies, staff model HMOs are health insurance issuers that employ healthcare providers who are retained by the issuer to provide health care services to enrollees.

According to the Academy, "The fundamental issue with the claims-over-premiums MLR definition… is the difficulty at arriving at a definition of claims that applies consistently across different types of business models." The Academy argues that the MLR rebate requirements weren't meant to give preferential treatment to one business model over another. To this extent, the Academy maintains that the MLR calculation should produce similar results regardless of the business model.

The Academy states, "Generally speaking, insurers that make heavy use of capitation payment mechanisms, and/or directly provide healthcare services to their enrollees via their own employees or facilities, will tend to have a higher claims-over-premium ratio than insurers who do not. This is not because their business models are necessarily more efficient at delivering value to enrollees but, rather, simply because of definitional issues within the MLR calculation."

Several years ago, insurance regulators became concerned over the difficulties in comparing medical loss ratios across various regulated companies. SSAP 85 was the regulator response to these concerns. This accounting a standard defines cost containment expenses (CCE). Loss adjustment expenses (LAE), also known as claims adjustment expenses (CAE), are defined in SSAP 85 to include all CCE and expenses associated with benefit adjudication.

Given these categories of expenses, the Academy argues two possible alternative approaches that could be taken to maintain a level playing field among various business models. The first alternative involves parsing the capitation agreements and or salaried costs into these claims and these expense categories. In this manner, carriers would be using more of a common standard for claims in the MLR calculation, regardless of the provider contract.

The second alternative involves including these categories of expenses as part of claims, e.g. making the definition of claims as broad as possible. With this approach, the arbitrary parsing of capitated contracts is avoided. Hence, the Academy prefers this alternative.

Documentation in opposition:

The BCBSA has expressed its concern that all health plans should report their administrative expenses on a uniform basis for meaningful plan comparisons. . With their comment letter dated May 24, 2010, to Lou Felice, BCBSA attached correspondence from Douglas Sherlock, CFA, President, Sherlock Company delineating a long list of activities included in provider contracts typically associated with group and staff model HMOs.

Subgroup DRAFT

Consumer group representatives have expressed similar concerns on some of the public calls. Failure to reflect administrative expenses that are bundled in capitation payments may allow carriers to use capitation to effectively avoid the minimum loss ratio standards (and associated rebates). A hypothetical example might involve an insurance company that, through capitation, transfers all administrative functions and claims risk to a provider group via capitation. The insurance company, through its calculations, easily demonstrates that it is operating at an MLR well in excess of the MLR standards. However, in this instance, the margin (1 minus the MLR) is entirely available for the insurance company's bottom line.

Evaluation:

We are concerned that absent due consideration of varied business models and provider contracts, issuers and providers may work in concert to undermine the intent of the MLR rebate provisions. However, we agree with the Academy that attempts to artificially parse a capitated arrangement into claims and administrative expense components would be arbitrary, and hence, challenging to regulate.

None the less, this concern was not so great as to cause us to recommend including administrative expense items, commonly included in capitated arrangements, among the calculation of incurred claims. We feel where clear delineations can be made between administrative expenses and claims, such distinctions should be maintained, for example, staff and group model HMOs should allocate salaries and overhead to administrative expenses as medical staff often perform these types of tasks.

Moreover, if properly implemented, these fixed dollar business arrangements can result in reduced utilization and reductions in the provision of unnecessary care. Committee members were hesitant to alter any definitional aspect of the funding associated with these contracts that would cause their use in the market place to be lessened. Consumers may find lower cost or a greater degree of care coordination through coverage backed by capitated agreements.

Therefore, we recommend that no effort be made at this time to recharacterize capitated payments to providers as part claim and part administrative expense. However, we support current statutory reporting that requires staff and group model HMOs to accurately report administrative expenses and be monitored for compliance. We urge Health and Human services and insurance regulators to follow provider contracting trends and keep watch for potential abuses to the intent of the MLR rebate provisions.

With respect to the concern that health insurance issuers could outsource administrative functions to affiliates in order to circumvent the MLR requirements, we considered the fact that that not all capitated arrangements with affiliates are necessarily abusive, and also that existing Form D requirements give state insurance regulators the ability to review all inter-affiliate service agreements and address problematic aspects before those agreements go into effect.

States possess a number of regulatory tools to monitor and prevent potential abuses identified in this IRD. For example, the Form D approval process involves the regulators review and approval of inter-affiliate arrangements.

Exceptions References:

Subgroup DRAFT

Attachments:

Letter dated June 16, 2010 from CA Department of Managed Health Care to Steve Ostlund, Chair, A&H Working Group and Lou Felice, Health Care Reform Solvency Impact Subgroup

Letter dated May 12, 2010 from Kansas Hospital Association to Commissioner Sandy Praeger, Kansas Insurance Department

Letter dated May 12, 2010 from Federation of American Hospitals to US Department of Health and Human Services

Letter dated May 17, 2010 from American Academy of Actuaries to Lou Felice, Chair, Health Care Reform Solvency Impact Subgroup

Letter dated May 14, 2010 from American Academy of Actuaries to US Department of Heath and Human Services

Letter dated May 6, 2010 from BlueCross BlueShield Association to Steve Ostlund and Lou Felice (bcbsa0506.doc)

Letter dated May 24, 2010 from BlueCross BlueShield Association to Lou Felice (BCBSA0524.doc)

Letter dated June 16, 2010 from BlueCross BlueShield Association to Lou Felice (BCBSA0616.pdf)

Letter dated July 6, 2010 from American Specialty Health to Steve Ostlund, Chair, A&H Working Group and Lou Felice, Health Care Reform Solvency Impact Subgroup

Letter dated July 2, 2010 from America's Health Insurance Plans to Steve Ostlund, Chair, A&H Working Group

Subgroup DRAFT

W:\National Meetings\2010\Summer\tf\lha\ahwg\Rebate IRD\IRD0015.doc