Medical Loss Ratio

Institute for Health Plan Counsel
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Presenters:

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Introductions

Melissa Hulke is an Associate Director in Navigant's Healthcare and Life Sciences Disputes, Compliance and Investigations practice and a Certified Public Accountant. She is experienced in litigation, investigations and compliance matters. Melissa has authored numerous articles within the legal community and presented on the impact of the Affordable Care Act's medical loss ratio (MLR) regulations.

Scott Jones is a Consulting Actuary for Milliman and has 12 years of actuarial experience. He serves on the American Academy of Actuaries' MLR Work Group and contributed to the Milliman study which formed the basis for the Commercial MLR credibility adjustments. His client work includes rate filings and actuarial valuations for commercial clients as well as health care budget projections for government agencies.

Agenda

- Background and 2011 MLR Data
- Audits and Litigation in 2013
- MLR Calculation
- MLR Implementation 2011 to 2017

Background

- What is Medical Loss Ratio (MLR)?

$$\text{Traditional MLR} = \frac{\text{Medical care claims}}{\text{Premiums}}$$

- MLR existed long before the Affordable Care Act (ACA) and commonly has been used for evaluating the performance and soundness of managed care companies.

- Prior to the ACA, many states had established their own MLR requirements or guidelines.

U.S. Gov't Accountability Office, GAO-11-711, Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements 4 (2011). See also, "State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations," as of April 15, 2010, America's Health Insurance Plans.

Impact of ACA on MLR

- ACA creates consistent federal standard and modifies the calculation

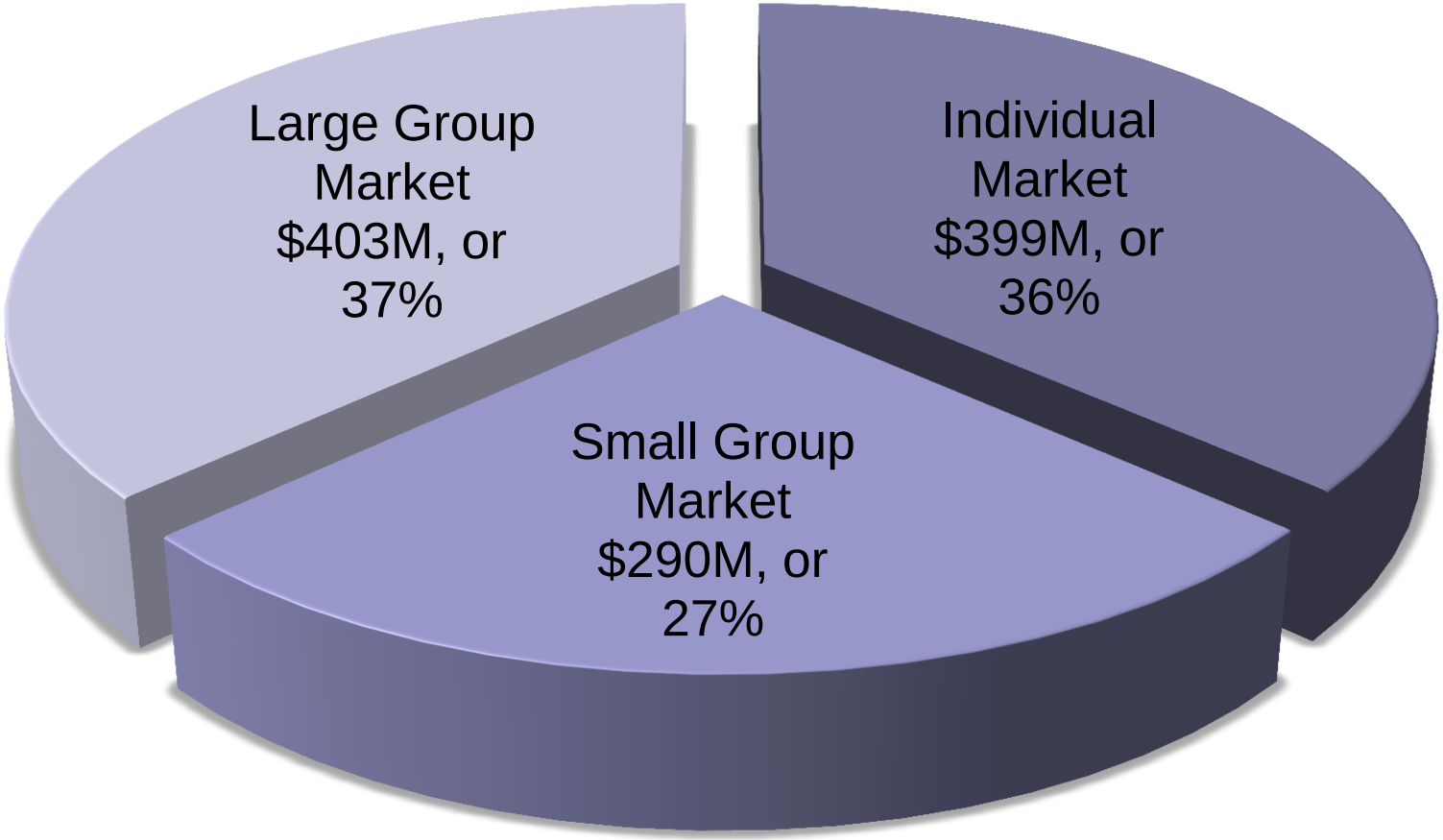
$$\text{ACA MLR} = \frac{\text{Medical care } \textbf{claims} + \text{Expenses for activities that improve health care } \textbf{quality}}{\textbf{Premiums} - \text{federal and state } \textbf{taxes} \text{ and licensing or regulatory fees}}$$

- ACA MLR reported by market and by state
  - Individual market, 80%
  - Small group market, 80%
  - Large group market, 85%

- Deadlines
  - June 1 deadline for reporting prior year data
  - August 1 deadline for rebates

Section 2718 of the PHSA and 45 C.F.R. § 158.110, 210, 221, and 240.

$1.1 Billion in Rebates for 2011 – Where Did it Go?



Figures were developed using MLR submission data published by CMS as of November 26, 2012 (http://cciio.cms.gov/resources/data/mlr.html)
See also, "The 80/20 Rule: How Insurers Spend Your Health Insurance Premiums," February 15, 2013, HHS.

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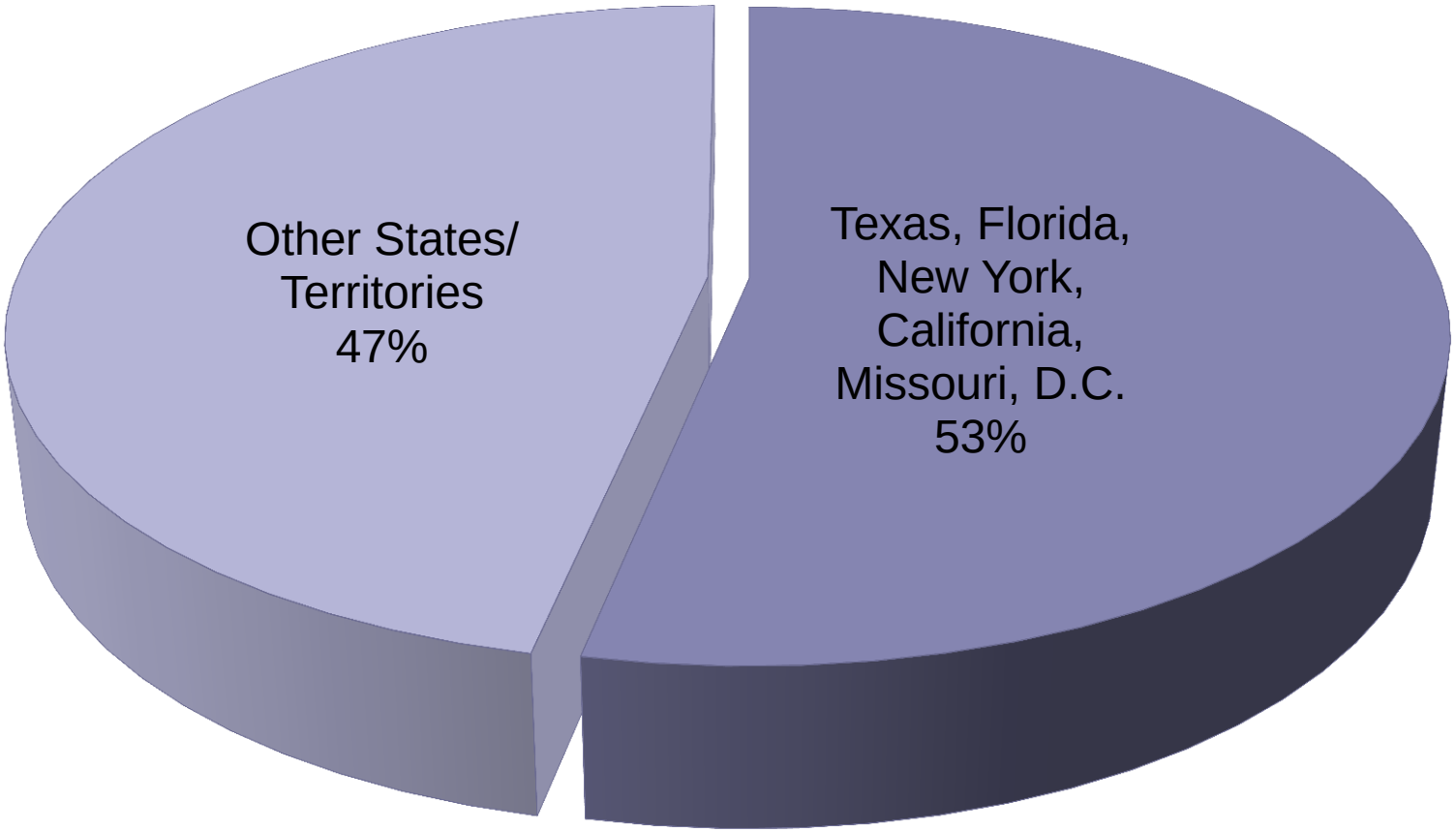

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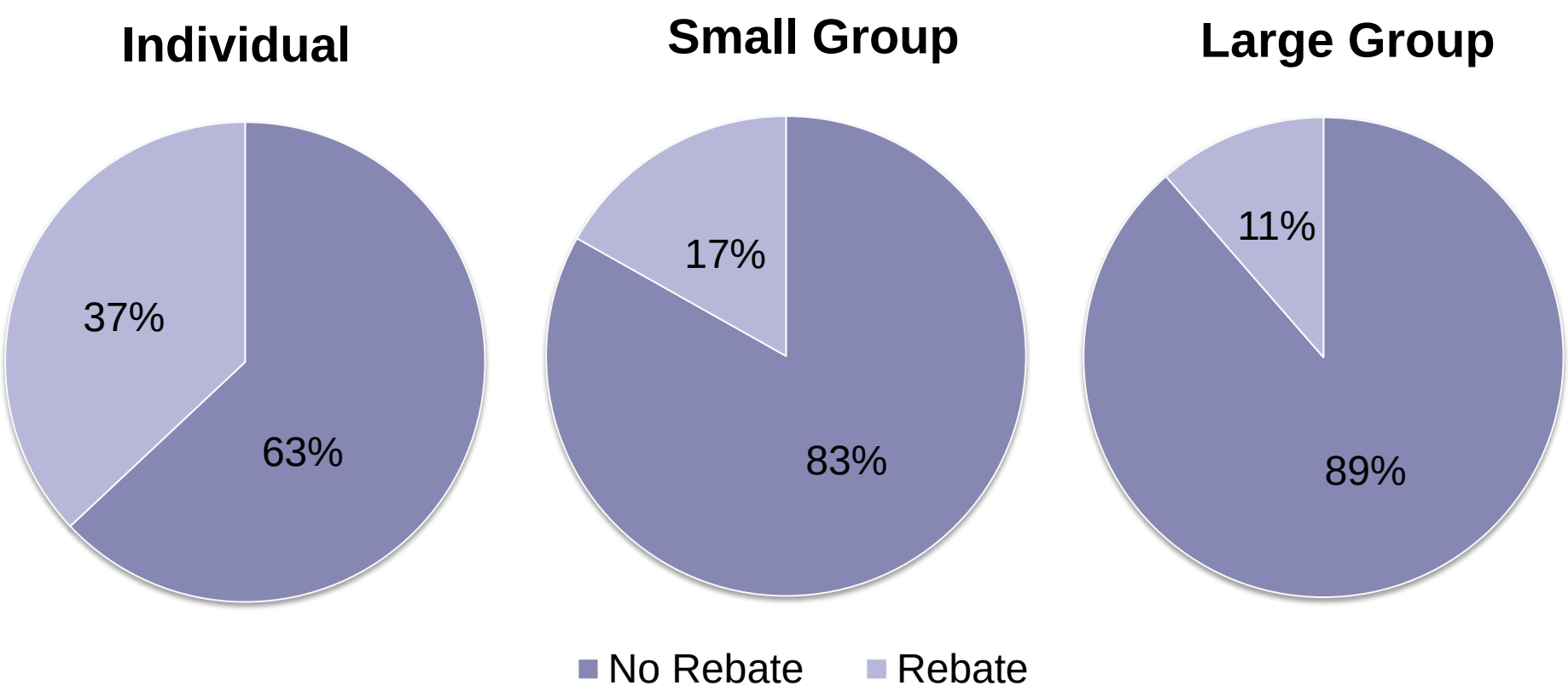
% of Enrollees Received Rebates



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Recent Audits and Litigation

- HHS currently auditing 2011 data
  - In coordination with States
  - Mitigating factors
  - *OIG study, "Oversight of Private Health Insurance Submissions…" April 2013*
- Private right of action?
  - *GAO Report to Congressional Recipients: Causes of Action under PPACA, March 23, 2012*
  - *"Affordable Care Act's Medical Loss Ratio Provision: Is There a Private Right of Action?" by Thorp Reed Armstrong LLP Pittsburgh Office, November 15, 2012*
- Indictment
- Litigation

Annual Reporting Form - Attestation

Department of Health and Human Services

Medical Loss Ratio Attestation

Group Affiliation:	Federal EIN :	Issuer ID:
Company Name:	A.M. Best Number:	Business in the State of:
DBA/Marketing Name:	NAIC Group Code:	Domiciliary State:
Address:	NAIC Company Code:	

Merge Markets - Ind/SmGrp (MA Only)	
Not-for-Profit	
MLR Reporting Year:	

Attestation Statement

The officers of this reporting issuer being duly sworn, each attest that he/she is the described officer of the reporting issuer, and that this MLR Reporting Form, the Company/Issuer Associations, and any supplemental submission that the issuer includes are full and true statements of all the elements included therein for the MLR reporting year stated above, and that the MLR Reporting Form has been completed in accordance with the Department of Health and Human Services' reporting instructions, according to the best of his/her information, knowledge and belief. Furthermore, the scope of this attestation by the described officer includes any related electronic filings and postings for the MLR reporting year stated above and which are required by Department of Health and Human Services under section 2718 of the Public Health Service Act and implementing regulation.

_____

Chief Executive Officer/President

_____

Chief Financial Officer

Overview of the MLR Calculation

ACA MLR =

$$\frac{\text{Medical care } \textbf{claims} + \text{Expenses for activities that improve health care } \textbf{quality}}{\textbf{Premiums} - \text{federal and state } \textbf{taxes} \text{ and licensing and regulatory fees}}$$

45 C.F.R. § 158.221.

Claims + Quality

Premiums –Taxes

- **Premiums:** all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer.

- **Taxes:** State and Federal Taxes and statutory assessments to defray operating expenses of any State or Federal department.

45 C.F.R. § 158.130, 161, 162.

Claims + Quality

Premiums –Taxes

- **The allocation methodology makes a difference**
  - Assessments that are tied to premium
    - Health Insurer Fee (prior year)
    - Premium tax
  - Assessments that are per head
    - PCORI
    - Federal Reinsurance
    - Risk Adjustment Fee
  - Taxes
    - Attribution to LOB apparently cyclical
  - QIA

Premiums –Taxes

- **Provider Reimbursement Arrangements Make a Difference**
  - Risk Sharing with a target loss ratio
    - Granularity by LOB
    - Departure of risk sharing metric from MLR formula
  - Related Party Issues

Claims + Quality
Premiums –Taxes

Include	Exclude
• Medical care claims paid to providers, including capitation contracts with physicians • Current year's unpaid claims reserves • Change in contract reserves • Claims related portion of reserves for contingent benefits and lawsuits • Experience-rated refunds	• Prescription drug rebates • Overpayment recoveries received from providers • Administrative fees paid to third party vendors • Other administrative (salaries, benefits, G&A, broker fees, etc.)

Other Adjustments

- Market stabilization payments or receipts
- Incentive and bonus payments made to providers
- The amount of claims payments recovered through fraud reduction efforts not to exceed the amount of fraud reduction expenses

45 C.F.R. § 158.140.

Claims + **Quality**
Premiums –Taxes

Must be designed to:
Improve health quality
Increase likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results and achievements
Be directed toward individual enrollees or for the benefit of specified segments
Be grounded in: • Evidence-based medicine; • Widely accepted best clinical practice; or • Criteria issued by recognized entities, such as government agencies, medical associations, accreditation bodies, etc.

45 C.F.R. § 158.150.

Claims + **Quality**
Premiums –Taxes

Must be primarily designed to:	Examples (not inclusive)
Improve health outcomes	• Effective case management • Care coordination • Chronic disease management • ICD-10 code sets (2012 & 2013)
Prevent hospital readmissions	• Comprehensive discharge planning • Patient-centered education and counseling • Personalized post-discharge reinforcement & counseling
Improve patient safety, reduce medical errors, and lower infection and mortality rates	• Prospective prescription drug utilization review • Identify and encourage the use of evidence-based medicine in identifying and documenting clinical errors or safety concerns • Identification and use of best clinical practices to avoid harm • Activities to lower the risk of facility-acquired infections
Implement, promote and increase wellness and health	• Wellness assessments • Wellness/lifestyle coaching programs • Public health education campaigns • Incentives and bonuses not already in premiums or claims

Note: all categories include health information technology to support these activities. See 45 C.F.R. § 158.150 for additional examples.

Claims + **Quality**
Premiums –Taxes

Exclusions:
1. Activities primarily designed to control or contain costs
2. Pro rata share for products not being reported (e.g. self-funded plans)
3. Paid for with separate funding (e.g. grant revenue)
4. Provider care delivery reimbursed as clinical services
5. Claims adjudication, including health information technology to improve claims payment
6. Health care hotlines not meeting the definition of improving health care quality
7. Retrospective and concurrent utilization review
8. Fraud prevention activities
9. Cost of developing and executing provider contracts and fees associated with establishing or managing a provider network
10. Provider credentialing
11. Marketing expenses
12. Other administrative costs

45 C.F.R. § 158.150.

Carving Out Expenses

Included in MLR

IT expenses	• Needed to improve healthcare quality	Quality
Utilization review	• Prospective prescription drug utilization review aimed at identifying potential drug abuse interactions	
Marketing expenses	• Activities primarily designed to implement, promote, and increase wellness and health activities	
Fraud expenses	• Fraud reduction expenses up to the amount recovered that reduces incurred claims	Claims

MLR Implementation 2011 to 2017

Requirements for Different Plan Types

Plan Type	Data Aggregation	Time Period	Documentation Requirement
Commercial	By state and market (individual, small group, large group)	3 Years	6 Years
Student Health	Nation-wide	3 Years	6 Years
Medicare Advantage / Part D	By contract	1 Year	10 Years

Medicare Advantage and Part D (2014)

- Commercial Plans and Student Health:

- Medicare Advantage and Part D: ACA contains several levels of sanctions for failure to meet the 85% minimum MLR:

  - Any given year: remittance to the Centers for Medicare and Medicaid Services (CMS) the product of: total revenue of the contract for the contract year and the difference between 85% and the contract's MLR.

  - Three consecutive years: a penalty of not being able to enroll new participants for one calendar year.

  - Five consecutive years: termination of the MA/PD contract with CMS.

QUESTIONS?