

The Importance of HHS Appropriately Defining and Standardizing Reporting of Medical Loss Ratios

And the Games Begin ... WellPoint Reclassifies Costs as “Medical Care”; Consumer Watchdog Calls for an Investigation

In anticipation of federal regulation tightening medical loss ratios (MLRs), health insurers already have begun shifting costs that historically were considered administrative or cost containment in nature to the “medical cost” portion of the MLR, thereby artificially inflating their MLRs. For example, a March 17, 2010, electronic message from WellPoint to its investors stated (*italics added for emphasis*):

“WellPoint’s (WLP) medical cost ratio should rise and its overhead-expense ratio decline this year as the insurer *reclassifies* various types of costs. Disease management, medical management and a nurse hotline, for example, ‘are being *reclassified* because they represent additional benefits provided to our members,’ a representative says. They’ll now be part of the medical cost ratio, the percentage of premium revenue used to pay members’ health-care costs. These are claims-related costs incurred to improve member health and medical outcomes, WLP says. Accounting rules allow the changes, which better align MCR [medical cost ratio] with anticipated health reform guidelines, Stifel Nicolaus [a subsidiary of Stifel Financial Corp.] says.”

This action by health insurers should beg the question from U.S. Health and Human Services: Why all of a sudden are these types of costs being reallocated as “medical costs” if for no other reason than to manipulate the MLR? If they were not counted as a “medical cost” then, why should they be counted as a “medical cost” now?

MLR Minimums: A “Defining” Moment in Health System Reform

The Patient Protection and Affordable Care Act (PPACA) established minimum medical loss ratios (MLRs) for individual/small- and large-group markets (80 percent and 85 percent, respectively). These ratios were intended to ensure that a minimum amount of health insurance premium revenues are expended on actual medical care, rather than on ancillary services and expenses within the exclusive control of and/or largely for the benefit of the insurer (e.g., executive salaries, profits, sales, and administration).

However, to implement a meaningful MLR reporting system and to effectively regulate insurers’ expenditure of consumer funds, the National Association of Insurance Commissioners (NAIC) and U.S. Department of Health and Human Services (HHS) must carefully determine which costs may be considered part of the “medical loss” (i.e., costs related to payment for clinical services and activities that improve health care quality) and which costs fall outside the definition of the “medical loss” (i.e., traditionally those costs that are administrative or related to cost containment). Without carefully constructed definitions, health insurers may game the system in a manner such that the MLR percentage floors established by the PPACA exist in form without substance.

Value-Added Services vs. Medical Loss: HHS Should Realize This Is a Distinction With a Fundamental Difference

First and foremost, it is important to bear in mind that the MLR is intended to measure the performance of the health plan in undertaking its business purpose (i.e., insurance coverage). At its core, **health insurance is simply the promise to pay an amount to or on behalf of the insured person contingent upon the insured person suffering a loss caused by a medical condition or disorder.** Consistent with this purpose, only losses that the insurer has agreed to indemnify and that are suffered by the patient should be considered medical “losses” for MLR purposes. All other expenses are simply ancillary to this insurance-risk-related purpose and potentially are subject to health insurer control and/or manipulation.

The MLR should, therefore, measure the insurer’s performance in providing insurance — NOT value-added or cost-containment services.

Neither of these 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 fact that the insurer has agreed to provide these services does not modify their character or permit them to now become reclassified as an expense for which the insurer has agreed to indemnify.

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Define and Standardize the Reporting of MLRs: HHS Should Be Clear About the Ground Rules to Prevent Manipulation of the MLR

As stated in a March 31 *Think Progress* article by Igor Volsky, the insurer WellPoint's actions (see page 1 side bar) demonstrate both the vulnerability of the MLR metric to manipulation and the need for regulators to be circumspect and precise when defining medical expenses. Mr. Volsky continues by stating that "establishing a medical-loss ratio still allows insurers to shift a disproportionate amount of premium dollars into profits. If anything, plans could pay more for certain services (to meet the benchmark), exclude certain benefits from coverage (benefits which would attract a sicker risk pool), or in the case of WellPoint, reclassify some administrative services as medical care *and still meet the mark without necessarily providing more care.*" (Italics added for emphasis.)

Calculating a Meaningful Medical Loss Ratio: HHS Should Prohibit Health Plans From Reclassifying Cost Containment or Value-Added Services as "Medical Costs"

It is unlikely that WellPoint will be the only insurer to reclassify costs in the near future. In an attempt to minimize the impact of the PPACA MLR requirement, health plans most likely will seek to include or reclassify for purposes of their "medical loss" reporting activities that traditionally were considered administrative or directed at cost containment and that are entirely within the insurers' control, such as:

- **Wellness programs** offered to patients that suggest better food choices, diet, and exercise; reminders to get certain checkups; and preventive screening exams.
- **Disease management/case management programs** in which health plans call upon the physician and patient to coordinate the treatment plan and care related to the patient's chronic disease or illness, such as cancer, diabetes, or a high-risk pregnancy.
- **Utilization review programs** whereby health plans utilize nurses to review requests from a physician for hospitalizations or for certain procedures, then provide an authorization for them to occur.
- **Network development costs** associated with developing a physician health care network to offer employers and patients, including relationship-building activities, contract negotiations, and the like.

All four of these are certainly "value-added" services health plans may offer to employers that assist in "cost-containment" initiatives. However, these services are appropriate for disclosure as "cost-containment" expenses, NOT as medical "loss" expenses. We recognize that these programs and network costs are important for employers and patients to consider. However, the MLR is about comparing the medical costs — the medical claim payout or "loss," if you will — with the premium. That is why there should be separate reporting for cost-containment expenses.



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