



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

Health plan financial data reporting: *A call for transparency*

Commissioned by Massachusetts Medical Society

Prepared by

Amy M. Lischko

Assistant Professor

Tufts University School of Medicine

John Biebelhausen

MD/MBA, Class of 2011

Tufts University School of Medicine

Table of Contents

Executive Summary	2
Introduction and Background	4
Methodology	6
Results and Findings	7
Recommendations and Next Steps	20
Appendix	22

Executive Summary

This report was commissioned by the Massachusetts Medical Society (MMS) in order to provide background research and analysis for the “development of a standard reporting process” for health plan financial data in Massachusetts.¹ The report describes two issues related to health plan financial data reporting: 1) requirements for standardized reporting of health plan financial data, and 2) the value of medical loss ratio requirements.

For this report, a number of publicly available data sources were used to review the current health plan reporting standards in Massachusetts. A literature review of government and private organization publications on medical loss ratio reporting, health plan administrative costs and health plan transparency was performed to provide background and context for the report. Findings were supplemented by a number of key informant interviews as well.

Some of the key findings include:

- Health care transparency efforts in Massachusetts, including price and quality information provided by the Division of Health Care Finance and Policy (DHCFP), Health Care Quality and Cost Council (HCQCC) and Massachusetts Health Quality Partners (MHQP), focus primarily on providers.
- Licensed Massachusetts health carriers submit quarterly and annual financial statements, based upon forms from the National Association of Insurance Commissioners (NAIC), to the Massachusetts Division of Insurance (DOI). These statements are primarily used for solvency and premium rate review, although the DHCFP reproduces some of this information in its quarterly report *Health Care in Massachusetts: Key Indicators*.
- In 2007, the average medical loss ratio (ratio of medical expenses to premium revenue) for the 12 Massachusetts health plans was 87 percent; the average administrative expense ratio (ratio of administrative expenses to premium revenue) was 11 percent.

¹ Massachusetts Medical Society. Resolution: 109, I-06 (A).

- Additional, non-financial, health plan transparency efforts at the national level include the National Center for Quality Assurance's (NCQA's) Health Effectiveness Data and Information Set (HEDIS) and the American Medical Association's (AMA's) National Health Insurer Report Card (NHIRC).
- The medical loss ratio has limited utility as a measure of health plan value or efficiency due to its dependency on a number of factors including health plan size, product type and geographic diversification, as well as its susceptibility to actuarial manipulation.

In order to augment the existing measures in place for health plan financial reporting in Massachusetts, it is recommended that the Massachusetts Medical Society pursue legislation in support of the development and implementation of an additional annual financial data reporting requirement for Massachusetts health plans.

Introduction and Background

This report was commissioned by the Massachusetts Medical Society (MMS) in accordance with MMS Resolution 109, I-06 (A) stating:

“That the MMS pursue the development of a standard reporting process that delineates how insurers should report items as medical or administrative expenses when providing annual financial reports, and that following the development of this standard reporting process, the MMS pursue legislation to require all insurers to adhere to this reporting process and report their administrative expenses on an quarterly basis.”

The resolution was referred to the Task Force on Medical Cost Control and the Committee on Legislation for report back at I-08.

There is a growing movement towards increased price and quality “transparency” in health care.^{2,3} Over thirty states have passed or proposed legislation relating to health care pricing transparency.⁴ Proponents of transparency (employers, policymakers) believe that providing consumers with information on the price and quality of health care providers will make the health care system more accountable, help fuel consumerism in health care, and create a more competitive market with the potential for cost containment. Yet, transparency has largely remained elusive. Providers and health plans are generally supportive of transparency but have expressed concern about the accuracy of the data used to develop the cost and quality metrics. In addition, they are concerned about the comparability of the information across different provider types and populations of patients, as well as how patients and others will use the information in making health care decisions.

The current transparency efforts in Massachusetts have focused primarily on providers. The state launched a health care quality and cost website in October 2005 containing quality and cost information by hospital. The website uses metrics developed by federal agencies and presents quality along with cost information for a variety of inpatient procedures and stays. Information regarding the volume of certain inpatient surgical procedures by surgeon was also added to the website in 2006. In April 2006, the Massachusetts Health Care Quality and Cost Council (HCQCC) was established by Chapter 58 of the Acts of 2006. The HCQCC is

² “Health Care Price Transparency: A Strategic Perspective for State Government Leaders.” Deloitte Center for Health Solutions, 2007.

³ Colmers, J.M. “Public Reporting and Transparency.” The Commonwealth Fund. No. 998. January 2007.

⁴ National Conference of State Legislatures. State Legislation Relating to Disclosure of Hospital and Health Charges, June 2008. < <http://www.ncsl.org/programs/health/Transparency.htm>>

responsible for establishing “statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care.”⁵ As part of their efforts, the HCQCC will design a new website for consumers to compare common medical procedures at hospitals and outpatient facilities.⁶

Quality information on physicians in Massachusetts has been developed by the Massachusetts Health Quality Partners (MHQP). MHQP is a broad-based coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies working together to promote improvement in the quality of health care services in Massachusetts.⁷ MHQP provides clinical quality reports on medical group performance on selected measures, such as high blood pressure control or diabetes care, and on patient experiences with physicians.

While the movement towards transparency in health care is gaining momentum, much of the current focus is on provider-specific information, although this is not where efforts began. In 1993, the National Center for Quality Assurance (NCQA) began measuring health plan performance using the Healthcare Effectiveness Data and Information Set (HEDIS), formerly known as the Health Plan Employer Data and Information Set. Reports by health plan are available from the NCQA, and the Division of Health Care Finance and Policy (DHCFP) also produces summaries of these reports by plan each year. These reports are of limited use in states like Massachusetts though, where health plans contract with most providers. Thus, their scores on any of the quality indicators may not be a good indicator of anything the plan is doing but are simply reflective of the percent of the plan population using particular providers. Moreover, in addressing the rising cost of health care, it may be important to compare plans across a number of financial or cost indicators. Accordingly, this report discusses two specific issues related to health plan reporting: 1) requirements for standardized reporting of health plan financial data, and 2) the value of medical loss ratio requirements.

This report begins with an overview of the existing financial data reporting standards in place for Massachusetts health plans as well as a discussion of the existing metrics for health plan assessment and evaluation. Next, an overview of health plan financial performance reporting in Massachusetts is provided. A discussion of the medical loss ratio, specifically its

⁵ HQCC website. <http://www.mass.gov/?pageID=hqccutilities&L=1&sid=Ihqcc&U=Ihqcc_welcome>

⁶ The launch of the HCQCC consumer website was set for June 2008. However, delays in the development of the website have postponed its launch with no formal release date announced at the time of this report.

⁷ MHQP website. <<http://www.mhqp.org/aboutus/AboutUs.asp?nav=020000>>

utility as a measure of health plan performance and consumer value follows. Based upon an analysis of Massachusetts' current reporting standards, and evidence from states with existing minimum medical loss ratio requirements, this report concludes with Massachusetts-specific recommendations concerning health plan financial transparency.

Methodology

This report is based upon a review of the current health plan reporting standards in Massachusetts, including a review of data availability, reporting requirements, and publications by the Massachusetts Division of Insurance (DOI), Division of Health Care Finance and Policy (DHCFP), and National Association of Insurance Commissioners (NAIC). A literature review of publications on medical loss ratio reporting, health plan administrative costs and health plan transparency was also conducted to provide background and context for the report. Publicly available research reports and publications by government agencies and private organizations were reviewed along with interviews with key informants in Massachusetts and Minnesota. Massachusetts-specific recommendations were formulated based upon analysis of the reviewed material and informant discussions.

Results and Findings

Health Plan Reporting Standards and Evaluation in Massachusetts

The Massachusetts Division of Insurance (DOI) is responsible for the licensing, regulation and oversight of the insurance industry in Massachusetts, including health insurance carriers. Licensed health insurance companies in Massachusetts are required to file quarterly and annual financial statements with the DOI in accordance with standards specified by the National Association of Insurance Commissioners (NAIC). The NAIC is the national organization of insurance regulators in the United States which establishes uniform reporting and policy standards for the insurance industry. The NAIC financial reporting standards are a set of actuarially based instructions and financial forms designed to provide cross-plan consistency in reporting. Yet, the forms are cumbersome, numbering in excess of 30 pages per health plan, thus complicating any potential review. Furthermore, administrative expense itemizations are extremely limited, providing little insight as to what constitutes this category of spending. Cross-plan consistency is also presumed based upon the itemizations defined within the NAIC instructions; however, the potential for actuarial manipulation exists regardless of such standards.

The DOI monitors insurers' quarterly and annual financial statements as a means of ensuring financial solvency and for product rate approvals. Additionally, the DOI collects membership and utilization data to assist in its review of premium rate increases and insurer solvency. The level of financial detail provided in the NAIC forms is sufficient for the DOI to carry out this financial oversight of health carriers. However, the utility of this information for an examination of health plan spending by various health and/or non-health categories is extremely limited.

The financial, membership and utilization information that the DOI collects is within the public domain, however, it is largely not available online. Furthermore, the information is available as filed and, therefore, is not accessible to a lay-person audience, making analysis and cross comparisons among insurers difficult. The Division correctly views itself as a regulatory agency that oversees these reporting requirements, but works with other agencies to make the data it collects more accessible.

For example, the Massachusetts Division of Health Care Finance and Policy (DHCFP) has begun publishing a quarterly report entitled *Health Care in Massachusetts: Key Indicators*. Included within the *Key Indicators* report is an examination of health plan financial performance as measured by the medical expense ratio, administrative expense ratio, profit margin and days in reserve for Massachusetts health plans. Results of the most recent DHCFP report will be discussed in the next section of this report (*Massachusetts Health Plan Financial Performance*).

It is also relevant to note that the Massachusetts Association of Health Plans (MAHP) currently reports aggregate financial data for its member plans on its website, as does Blue Cross Blue Shield of Massachusetts (BCBSMA).

In addition to financial measures of performance, the quality performance of health plans is measured by the National Committee for Quality Assurance (NCQA) which administers the Healthcare Effectiveness Data and Information Set (HEDIS). The NCQA sets national standards for the quality of care and service provided by health plans and subsequently provides NCQA Accreditation to health plans that meet these standards. Using results from the HEDIS, the NCQA also produces a consumer-oriented Health Plan Report Card that allows consumers to review health plan performance based upon metrics such as access and service and qualified providers. As mentioned above, though, due to the nature of the reporting system and metrics, the HEDIS measures tend to be more reflective of the providers within the health plan network. Thus, while valuable, NCQA accreditation and HEDIS measures are primarily useful to consumers and employers/purchasers, and do not provide a measure of health plan financial transparency.

In June 2008, the American Medical Association (AMA) released its first ever National Health Insurer Report Card (NHIRC). The report card measures Medicare and seven national commercial health insurers on 14 metrics, grouped into 5 categories: payment timeliness, accuracy, transparency of contracted fees and payment policies on payer Web sites, compliance with generally accepted pricing rules, and denials.⁸ The NHIRC was created “to provide physicians and the public with an objective and reliable source of information on the timeliness, transparency and accuracy of claims processing” by health insurance companies.⁹ The NHIRC is part of the AMA’s overall effort to reduce inefficiencies in the existing health insurance claims

⁸American Medical Association. (2008). “Health Insurers’ Report Cards Show Need for Improvement.” < http://www.ama-assn.org/ama1/pub/upload/mm/368/nhirc_flyer.pdf>

⁹ Ibid.

processing system via its “Heal the Claims Process” campaign. The formation of the NHIRC by the AMA represents an additional, physician-oriented, step towards health plan transparency.

Massachusetts Health Plan Financial Performance

Each year, health plans collect premium revenue from which they pay for medical services and treatments (medical expenses) and cover the cost of administering such services (administrative expenses). The remaining amount of premium revenue after medical and administrative expenses have been paid is used for surplus/reserves and investment or shareholder profit depending on the status of the company (not-for-profit or for-profit). The majority of Massachusetts health plans are local plans and are not-for-profit. The medical loss ratio, also known as the medical expense ratio or care-share ratio, represents the portion of premium dollars paid-out by insurers for medical expenses. The administrative expense ratio represents the portion of premium dollars spent by insurers to administer medical services and process claims.

The medical loss ratio is often used as a measure of consumer value since it represents the portion of premium dollars collected by health plans that are spent on medical care. Additionally, the administrative expense ratio is used as a general measure of administrative efficiency by health plans since higher administrative expense ratios are often seen as wasteful. While useful in aggregate, these ratios are subject to relatively large variations among health plans as well as annual fluctuations within an individual health plan based upon a number of factors, including type of product(s) administered, geographic location, plan size, and age of product(s). In reality, some of these spending differences represent real “value” variations among plans. For example, “Health plans with richer benefit packages tend to incur high medical expenses and thereby high medical loss ratios...[while] Higher administrative expenditures may reflect a greater investment in management and coordination of care, which reduces clinical expenses.”¹⁰ Conversely, some of the between-plan variation reflects differences in expense categorization.

Figure 1 shows the medical loss ratios for Massachusetts health plans in 2007. Health plan medical loss ratios ranged from a low of 79 percent (United Health) to a high of 93 percent

¹⁰ Robinson, J.C. “Use and Abuse of the Medical Loss Ratio To Measure Health Plan Performance.” *Health Affairs*. 1997; 16:176-187.

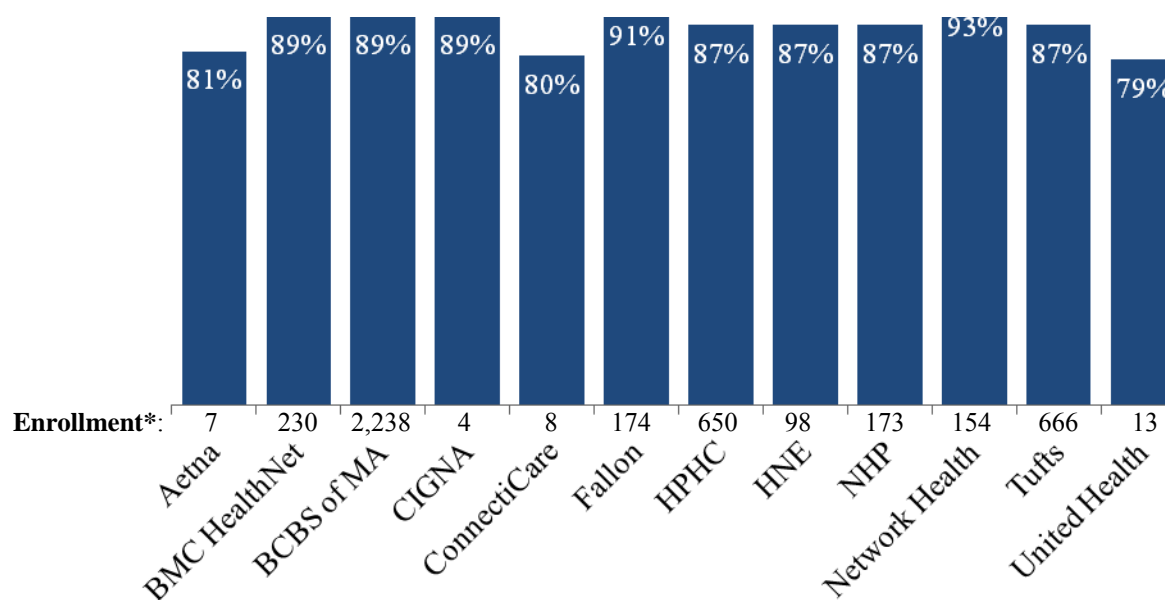
(Network Health), with an average of 87 percent across the 12 health plans. The four largest health plans by membership in Massachusetts—Blue Cross Blue Shield of MA, Tufts, Harvard Pilgrim Health Care, and Boston Medical Center HealthNet—had an average medical loss ratio of 88 percent.

Figure 2 shows the administrative expense ratios for Massachusetts health plans in 2007. Health plan administrative expense ratios ranged from a low of 6 percent (Network Health) to a high of 17 percent (ConnectiCare), with an average of 11 percent across the 12 health plans. The four largest health plans had an average administrative expense ratio of 10.5 percent.

An additional measure of health plan financial performance is profit margin—a plan’s net income divided by its total revenue (including investment gains/loss). Profit margin represents the net margin available to health plans after paying medical and administrative expenses.

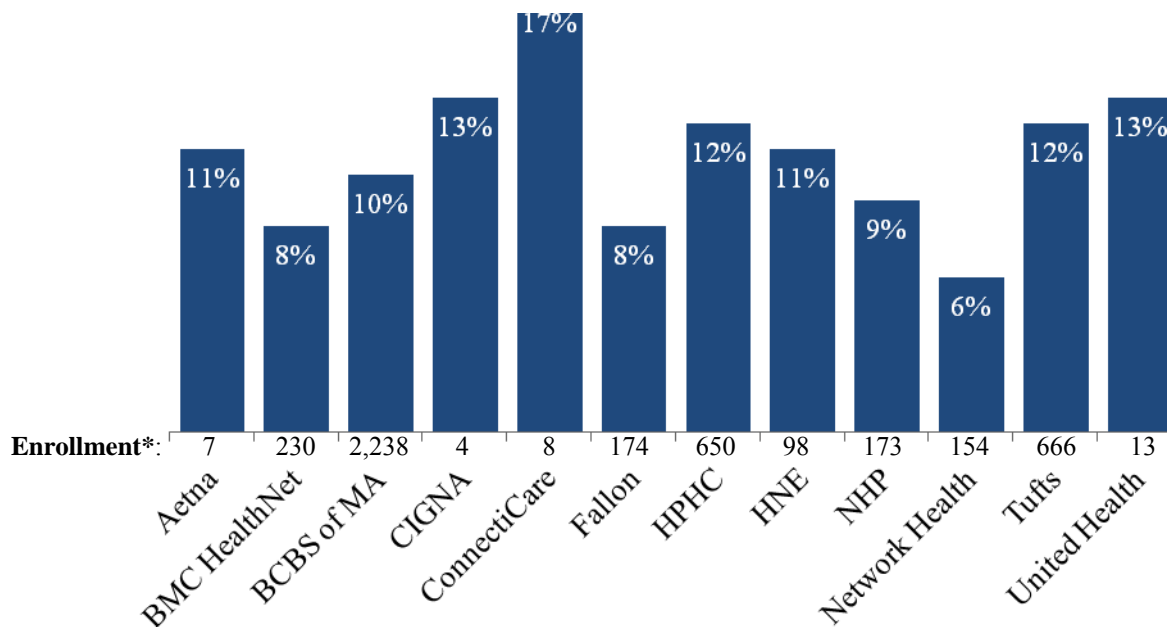
Figure 3 shows the profit margins for Massachusetts health plans in 2007. Health plan profit

Figure 1. Massachusetts Health Plan Medical Loss Ratios, 2007



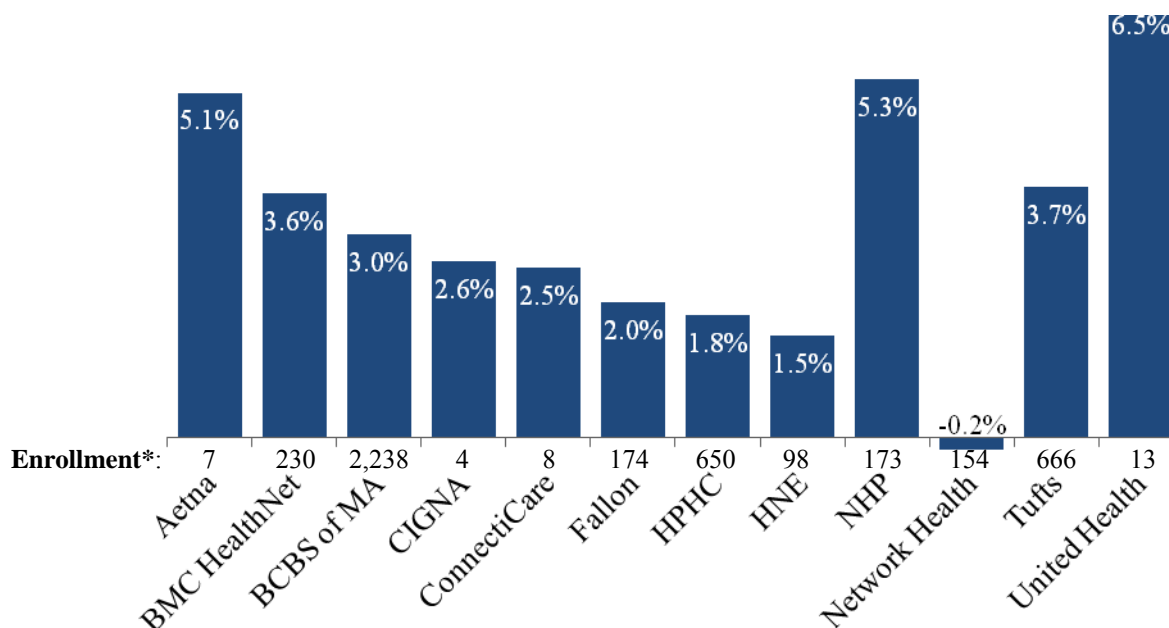
*Enrollment data (total Massachusetts members in thousands) as of 12/31/07 have been provided for comparison. Source: Division of Health Care Finance and Policy. “Health Care in Massachusetts: Key Indicators.” June 2008. Health plan key: BMC (Boston Medical Center), BCBS (Blue Cross Blue Shield), HPHC (Harvard Pilgrim Health Care), HNE (Health New England), and NHP (Neighborhood Health Plan).

Figure 2. Massachusetts Health Plan Administrative Expense Ratios, 2007



*Enrollment data (total Massachusetts members in thousands) as of 12/31/07 have been provided for comparison.
Source: Division of Health Care Finance and Policy. "Health Care in Massachusetts: Key Indicators." June 2008.

Figure 3. Massachusetts Health Plan Profit Margins, 2007

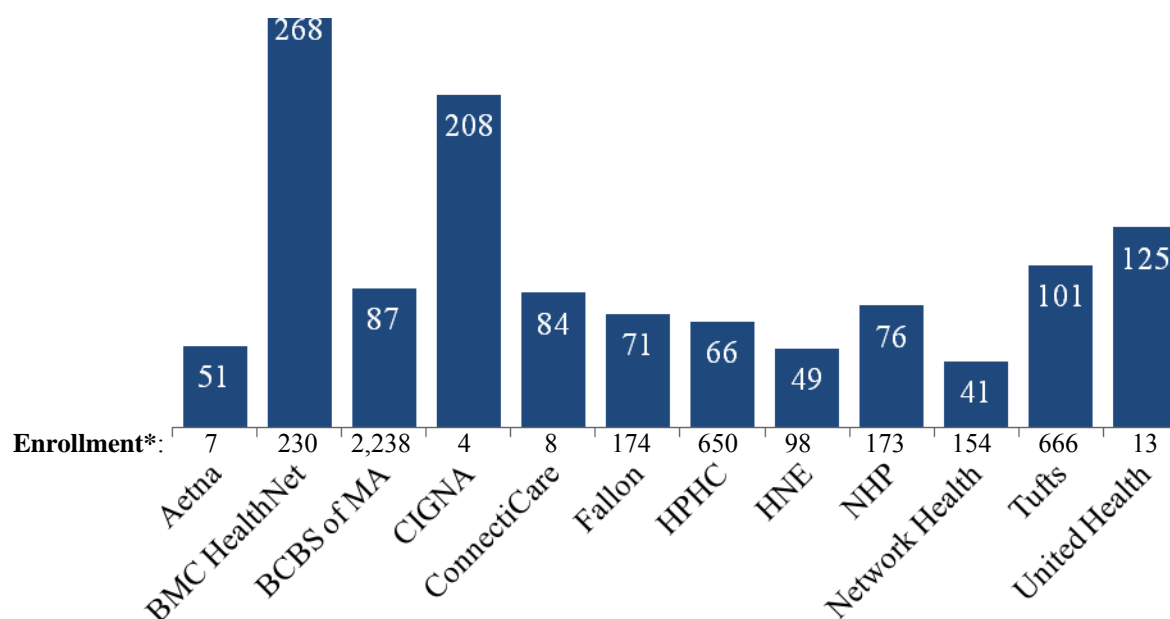


*Enrollment data (total Massachusetts members in thousands) as of 12/31/07 have been provided for comparison.
Source: Division of Health Care Finance and Policy. "Health Care in Massachusetts: Key Indicators." June 2008.

margins ranged from a low of -0.2 percent (Network Health) to a high of 6.5 percent (United Health), with an average of 3.1 percent across the 12 health plans. The four largest health plans had an average profit margin of 3 percent.

Days in reserve—the number of days of medical expenses a health plan could fund from its net worth—is an additional measure of health plan performance and serves as a measure of overall solvency. Figure 4 shows the days in reserve for Massachusetts health plans in 2007. Total days in reserve ranged from a high of 268 (Boston Medical Center HealthNet) to a low of 41 (Network Health), with an average of 102 days across the 12 health plans. The four largest health plans had an average days in reserve of 131 days.

Figure 4. Massachusetts Health Plan Days in Reserve, 2007



*Enrollment data (total Massachusetts members in thousands) as of 12/31/07 have been provided for comparison. Source: Division of Health Care Finance and Policy. "Health Care in Massachusetts: Key Indicators." June 2008.

The financial performance of Massachusetts health plans is variable and differs by total plan enrollment. The average medical loss ratio for Massachusetts health plans is near 90 percent; thus, nearly 90 cents of every premium dollar is spent on medical expenditures. Overall, the level of Massachusetts health plans' medical loss ratios mirrors national estimates. PricewaterhouseCoopers estimated a medical loss ratio of 87 percent for private health insurance

plans in 2006.¹¹ Furthermore, the Kaiser Family Foundation reports median HMO medical expense ratios ranging from 86-89 percent from 1995-2002, with fairly constant levels throughout the period.¹²

In the following section, the usability and value of the medical loss ratio as an indicator of health plan performance and value is discussed.

The Medical Loss Ratio

Concern exists about what is included in “medical expenses” in the medical loss ratio. In his seminal paper on medical loss ratios, James Robinson—professor of health economics in the School of Public Health, University of California, Berkeley—notes that “the medical loss ratio has achieved in recent years a remarkable amount of publicity and even notoriety,” but cautions that “the medical loss ratio is an accounting monstrosity that enthralls the unsophisticated observer and distorts the policy discourse.”¹³ While Robinson’s words may appear animated, his cautionary use of the medical loss ratio is substantiated by an in-depth review of the various elements that affect a health plan’s medical loss ratio. A comprehensive report by the American Academy of Actuaries Loss Ratio Work Group highlights many of the same issues concerning medical loss ratios as Robinson. While advising individual users to consider who is producing the medical loss ratio and to determine the objective of that user, the report concludes that “the loss ratio, when used and interpreted correctly, does represent a valid method of observing trend in a [health plan’s] business over time, and should not be discarded as an important evaluation tool.”¹⁴

The reporting and interpretation of medical loss ratios is complicated by many factors. To begin with, the target medical loss ratio of a not-for-profit health plan compared to a for-profit health plan might vary considerably since for-profit plans are inherently designed to minimize the amount of premium revenue paid out as medical expenses. Thus, for-profit plans can be expected to achieve relatively lower medical loss ratios, which may be interpreted as

¹¹ “The Administrative Costs of Public and Private Health Insurance.” PricewaterhouseCoopers for America’s Health Insurance Plans, 2008.

¹² Kaiser Family Foundation (2005). “Trends and Indicators in the Changing Health Care Marketplace.” Exhibit 6.10. <<http://www.kff.org/insurance/7031/ti2004-6-10.cfm>>

¹³ Robinson, J.C. “Use and Abuse of the Medical Loss Ratio To Measure Health Plan Performance.” *Health Affairs*. 1997; 16:176-187.

¹⁴ American Academy of Actuaries Loss Ratio Work Group. “Loss Ratios and Health Coverages.” November 1998.

disadvantageous to the consumer. The geographic distribution of a health plan can also affect its medical loss ratio. Multi-state carriers may have an advantage in producing higher medical loss ratios since they can spread administrative costs over several states. Another determinant of a health plan's medical loss ratio is the nature of the product(s) offered by that carrier. For example, a high-deductible, high-copayment plan will equate to a lower medical loss ratio when compared to a more first-dollar coverage plan. To further illustrate, a \$5,000 premium that pays out \$4,250 would yield a medical loss ratio of 85 percent; however, the same \$5,000 premium in a high-deductible plan might only pay out \$4,000, yielding a medical loss ratio of 80 percent.

The numerous regulations and economics of the particular health insurance market further complicate medical loss ratio comparisons. Table 1 provides an overview of the specific characteristics of the three major insurance market segments—large group, small group, and individual—that are present in most states.¹⁵ As seen, the respective effect of the various

Table 1. Characteristics of Insurance Market Segments

Market segment	Definition	Economic attributes	Regulatory attributes
Large group	Groups of more than fifty persons	Cohesive Economies of scale Subsidized No adverse selection No individual underwriting Experience-rated among groups, community-rated within group Some plan choice 85-95 percent MLR	ERISA preemption for self-insured group
Small group	Groups of fifty or fewer persons	Lesser version of large groups Limited plan choice 75-85 percent MLR	Small-group reform laws Mandated benefits Managed care protections
Individual	Nongroup	No cohesion No economies of scale Unsubsidized Strong adverse selection Intense medical underwriting Risk-rated Full choice 60-75 percent MLR	Limited reform laws Mandated benefits Managed care protections Rate regulation

Adapted from: Hall, M.A. "The Geography of Health Insurance Regulation." *Health Affairs*. 2000; 19: 173-184.
Note: ERISA is Employee Retirement Income Security Act.

¹⁵ Hall, M.A. "The Geography of Health Insurance Regulation." *Health Affairs*. 2000; 19: 173-184.

economic and regulatory attributes of each market segment is such that large groups, with economies of scale and purchasing power, tend to have the highest medical loss ratios. On the other extreme, individual plans tend to have the lowest medical loss ratios due to high marketing costs, reduced economies of scale, and decreased market competition.¹⁶ Notably, Massachusetts merged its individual and small group markets in 2007. However, the effect of this hybrid market on health plan medical loss ratios and the overall insurance market is yet to be determined.

Integral to the medical loss ratio is the administrative expense ratio, which is the ratio of administrative expenses to premium revenue. Health plans with higher medical loss ratios will consequently have lower administrative expense ratios. However, it is equally difficult to make comparisons across carriers regarding the administrative expense ratio because the administrative costs necessary to administer different types and lines of products differs widely. Table 2 presents an overview of the cost inputs and functional outputs of health insurance administrative costs.

On the whole, a number of administrative expenses are necessary and useful. For example, health plans' efforts to fight fraudulent claims are beneficial to the consumer, as well as care management services which are seen as potentially cost-reducing. However, certain administrative expenses, such as inefficiencies in claims processing and excessive marketing costs, are seen as adding additional, wasteful spending to premiums. Furthermore, the question remains as to whether or not increases in administrative expenses need to rise proportionately with increases in medical expenses. Analysis of Massachusetts' three largest health insurers (Blue Cross Blue Shield of MA, Tufts, and Harvard Pilgrim Health Care) by Nancy Turnbull, of Harvard's School of Public Health, revealed discrepancies in the rate of growth of plans' administrative and medical expenses. Turnbull's analysis showed that from 2003 to 2006, average per member annual spending on medical expenses for fully insured products rose 33 percent while average per member annual spending on administrative expenses rose 47 percent.¹⁷ Disproportionate growth such as this raises questions about health plans' administrative spending and is deserved of further analysis. Full assessment of health insurance administrative costs is

¹⁶ Ibid.

¹⁷ Turnbull, N. —The Cost Containment Dividend: What would you have done with an extra \$392—or \$727— last year? Web Blog, posted December 31, 2007. Available at: <http://www.wbur.org/weblogs/commonhealth/?p=320>

beyond the scope of this report, but the interplay between the medical loss ratio and the administrative expense ratio is pertinent to the general discussion herein.

Table 2. Health Insurance Administrative Costs and Outputs

Function/input output	Examples of costs	Influence on administrative costs
Transaction-related	Transfer of various levels of risk from individual employer to insurer	Applications processed Claims processing Billing
		Scope of services covered (drugs, home health, ambulatory surgery) Extent of cost sharing and managed care Percent of claims filed electronically or by paper
Benefits management	Support services (for example, coordination of benefits, information services)	Plan design activities Data reporting, analysis Management information systems (MIS)
		Extent of local market competition Sophistication of MIS Reliance on conventional versus prepaid plan
Selling and marketing	Support services	Commissions Medical underwriting/screening
		Conventional or self-insured plan Firm size, extent of pooling (whether firm is treated individually) For profit, not-for-profit, or public plan Health status of group, industry
Regulatory/compliance	Support services	Interest credit (reserves) State premium taxes
		Public versus private plan and profit status of health plan State premium laws Self-insured versus conventional plan

Adapted from: Thorpe, K.E. "Inside the Black Box of Administrative Costs." *Health Affairs*. (Summer 1992): 41-55.

While the "medical loss ratio stands out among the other data elements in its simplicity and its ostensible link to [health] plan efficiency and medical service quality," it is subject to actuarial manipulation and the broad variability across health plans presented above.¹⁸ While considerations of health plan specific components such as product and coverage mix and market penetration should be considered when analyzing medical loss ratios, the current reporting of Massachusetts health plans' medical loss ratios aggregates plan data into a single figure. In his condemnation of medical loss ratios, Robinson concludes: "Consumers need access to better information on provider networks, benefits packages and cost-sharing requirements, methods of

¹⁸ Robinson, J.C. "Use and Abuse of the Medical Loss Ratio To Measure Health Plan Performance." *Health Affairs*. 1997; 16:176-187.

utilization management, and satisfaction scores. Public and private purchasers need economic data on enrollment, revenues, costs, and profits, in addition to data on plan structures, processes, and outcomes, in order to reward efficient organizations with increased market shares.”¹⁹

Physicians may need and/or desire better transparency on the part of health plans as to payment timeliness and accuracy, clarity of contracted fees and payment policies, compliance with pricing rules, and claims denials.²⁰ In general, though, medical loss ratios and administrative expense ratios, while of certain value in evaluating health plans, do not provide the exhaustive evaluation of health plans pertinent to consumers, employers or physicians.

A Review of Medical Loss Ratio Requirements

From the discussion above, it is clear that use of the medical loss ratio in the evaluation of health plans can become complicated when contributing factors are considered. However, the relative ease of use of the medical loss ratio has made it the target of health plan regulation and legislation in certain states. A June 2008 report by *Families USA* identified 15 states with minimum medical loss ratio requirements.²¹ Medical loss ratio requirements for individual markets range from a low of 55 percent (North Dakota) to a high of 80 percent (New York), while small group market requirements range from 60 percent (Oklahoma) to 75 percent (multiple states).²² It is important to note that a caveat of state-level medical loss ratio regulation is that only fully insured individual, small and large group market plans are affected by such legislation since the Employee Retirement Income Security Act (ERISA) preempts self-funded large group plans from state regulation.

Overall, medical loss ratio requirements vary by state, plan type and by insurer type (e.g. HMOs or safety net insurers). Variations in the extent of regulation exist as well, with some states such as Maine and New Jersey requiring health plans to refund excess premium dollars to policyholders if minimum medical loss ratio requirements are not met. One Maine insurance company will refund policyholders a total of \$6.6 million in 2008, while Oxford Health Insurance in New York will refund \$50 million to small businesses for not achieving the

¹⁹ Ibid.

²⁰ This list of recommendations is based upon the primary metrics used by the American Medical Association’s National Health Insurer Report Card, 2008.

²¹ Families USA. “Medical Loss Ratios: Evidence from the States.” Health Policy Memo, June 2008.

²² Ibid.

minimum medical loss ratio in 2006.²³ Other states require insurers to adjust premium rates down during the subsequent rate renewal period if minimum medical loss ratios were not achieved in the previous rate period.

Minnesota serves as a model state for minimum medical loss ratio regulation. The state began requiring a minimum medical loss ratio for the individual and small employer health plan markets as of July 1, 1993.²⁴ Minimum medical loss ratios were set at 65 percent for the individual market and 75 percent for the small employer market, and rose by 1 percent annually until 2000 when they reached their current levels of 72 percent and 82 percent respectively. As part of the Minnesota Statutes, the Minnesota Departments of Health and Commerce is required to publish a public report each year listing the actual medical loss ratios of the state's individual and small group health plans. The 2007 report reveals medical loss ratios for individual market health plans ranging from 29-154 percent and small employer market health plans ranging from 56-150 percent.²⁵ The respective market averages were 91 percent and 87 percent.²⁶ The wide variation in reported medical loss ratios is primarily a reflection of the susceptibility of "small, non-credible blocks of business" to significant or reduced claims payouts in a single year.²⁷ The validity and utility of the medical loss ratio, as discussed above, is prefaced in the report by the following statement: "In reality, due to many reasons related to operation and measurement, loss ratios are not necessarily an indicator of value for a specific health plan company in any one year." This is clearly demonstrated by the wide range of reported medical loss ratios, including ratios over 100 percent which indicate that a health plan paid out more money than it collected in premium revenue for a specific product.

The determination of the value of minimum medical loss ratio requirements was informed by interviews with three Minnesota state officials in the Departments of Health and Commerce. The general consensus among these officials was that the medical loss ratio is of limited utility in analyzing the overall quality and value of a health plan, with one official citing "marginal to modest value of the [annual loss ratio report]." Rather, the significance of the medical loss ratio as a measure of solvency was highlighted. Officials noted that the medical

²³ Ibid.

²⁴ Laws of Minnesota 1992. Chapter 549-H.F.No. 2800, Sec. 8. 62A.021.
< <https://www.revisor.leg.state.mn.us/laws/?doctype=Chapter&year=1992&type=0&id=549>>

²⁵ Minnesota Department of Commerce. "Report of 2007 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets." June 2008.

²⁶ Ibid.

²⁷ Ibid.

loss ratio is useful on aggregate, across plans, for the gross examination of how much plans are paying out versus bringing in. In speaking more generally about health plan transparency, one official spoke of “measuring plans on what they actually have control over,” such as time to payment of claims.

Minimum medical loss ratio requirements are aimed at providing better value to consumers, as measured by more dollars spent on medical expenses. Presumably, medical loss ratio requirements are further intended to help slow the growth of health insurance premiums. However, a Minnesota state official noted that the “loss ratio requirements [in Minnesota] have had very little impact on the cost of health insurance, if any.” If requirements are too high, companies may stop performing beneficial administrative functions in order to achieve required medical loss ratios. Overall, the medical loss ratio was described as an imperfect measure with limited interpretive value; and, the overwhelming consensus was for the consideration of other factors in evaluating the financial performance and value of health plans.

Alternative Health Plan Financial Data Collection Model

Minnesota also serves as a model for health plan financial data collection and reporting. The Minnesota Department of Health (MDH) collects annual financial data from health plans in its Health Plan Financial and Statistical Report (HPFSR). Specifically, the report includes “Health Care Expenses” and “Indirect Health Care Expenses” sections, each of which provides specific expense itemizations. This provides a more precise breakdown of medical and administrative expenses and allows for better analysis of each of these expense categories.

Using the data collected from the HPFSR, the MDH also produces an annual report entitled “Administrative Costs at Minnesota Health Plans.” Included within the report is the “Indirect Health Care Expenses” section of the HPFSR for each Minnesota health plan (see *Appendix* for sample section and definitions). This section of the report includes 14 indirect expense categories which fall within the overall administrative expense category, such as claim processing and customer service. Thus, the report allows for between plan analysis as well as an overall examination of administrative spending amongst plans.

Recommendations and Next Steps

This report discussed two key issues related to health plan reporting: 1) requirements for standardized reporting of health plan financial data, and 2) the value of medical loss ratio requirements. Examination of the current health plan financial data reporting standards in Massachusetts as well as review of the medical loss ratio and its potential use as a health plan regulatory measure have led to the recommendations below.

Issue 1— Requirements for standardized reporting of health plan financial data

The existing health plan financial data reporting system in Massachusetts is designed primarily for the purposes of solvency and premium rate review. The system does not provide the in-depth itemization of expenditures that is necessary to track health plan medical and administrative expenses from year-to-year. However, it is not feasible to change the NAIC reporting requirements for Massachusetts. Yet, the collection and public reporting of more specific components of medical and administrative expenditures would facilitate the elucidation of whether or not increases in health plan administrative expenses are value-added for the consumer, as well as if they are in line with increases in medical expenses. Thus, it is recommended that the Massachusetts Medical Society pursue legislation backing the formation and implementation of an adjunct set of financial data collection forms for Massachusetts health plans.

This additional set of online financial data collection forms can be modeled off of the state of Minnesota's existing health plan financial reporting requirements. MMS should pursue legislation that models the Minnesota Health Plan Financial and Statistical Report (HPFSR). The relative facility of implementing an additional set of online forms for health plans to submit annually is seen as non-prohibitive and should provide additional value to existing health plan transparency efforts.

Issue 2— The value of medical loss ratio requirements

Pursuant to our discussion of medical loss ratios above, it is recommended that Massachusetts *not* pursue a legislative requirement for a minimum medical loss ratio in the future. Such efforts would undoubtedly elicit terse reaction from Massachusetts health plans, which currently have an average medical loss ratio of 87 percent. In response to a regulated loss

ratio, health plans might: a) raise premiums in an effort to cover the more costly, comprehensive products required to achieve the specified loss ratios and to maintain current surplus levels, and/or b) eliminate certain beneficial administrative functions such as chronic care management or fighting fraudulent claims that serve as cost controls. The potential pitfalls of a medical loss ratio requirement outweigh the perceived benefits of such regulation.

Appendix

Minnesota Department of Health, 2007 Health Plan Financial and Statistical Report (HPFSR), Section 8

Section 8: Indirect Health Care Expenses (Medical and Dental)			Calendar Year 2007
General Instructions	Only for salary and benefits of central office staff not providing direct patient care	Other than for salary and benefits of central office staff not providing direct patient care	
Indirect Expense Category	Salaries and Benefits	Other Expense	Total Indirect Health Care Expense (by category)
Billing and Enrollment			0
Claim Processing			0
Detection and Prevention of Fraud			0
Customer Service			0
Product Management and Marketing			0
Underwriting			0
Regulatory Compliance and Government			0
Lobbying			0
Provider Relations and Contracting			0
Quality Assurance and Utilization Management			0
Wellness and Health Education			0
Research and Product Development			0
Charitable Contributions			0
General Administration			0
Total Indirect Health Care Expenses	0	0	0

Source: Minnesota Department of Health. "2007 Health Plan Financial and Statistical Report Form and Instructions." Accessed August 25, 2008.

<<http://www.health.state.mn.us/divs/hpsc/dap/cdireports/grppurch/index.html>>

Minnesota Department of Health, 2007 Health Plan Financial and Statistical Report (HPFSR) Section 8 Definitions

Sec 8	Section 8: General Instructions	The data required for section 8 may be estimated from existing accounting methods with allocation to specific categories.
Sec 8	Billing and enrollment expenses	These are all costs associated with group and individual billing, member enrollment and premium collection and reconciliation functions. This may include costs for the collection and reconciliation of cash, group and membership set-up and maintenance, contract, identification card, and directory preparation and issuance, electronic data interchange expenses pertaining to billing and enrollment, and enrollment materials. Traditional expense categories that your company might allocate <i>in whole or in part</i> to billing and enrollment expenses include finance and information systems.
Sec 8	Claim processing expenses	These are all costs associated with the adjudication and adjustment of claims, coordination of benefits processing, maintenance of the claim system, printing of claim forms, claim audit function, electronic data interchange expenses pertaining to claim processing, and fraud investigation. Traditional expense categories that your company might allocate <i>in whole or in part</i> to claims processing expenses include information systems and legal.
Sec 8	Customer service expenses	These are all costs associated with individual, group, or provider support relating to membership, open enrollment, grievance resolution, claim problems, and specialized phone services and equipment. Traditional expense categories which your company might allocate <i>in whole or in part</i> to customer service expenses include information systems, finance, legal, and sales and marketing.
Sec 8	Detection and Prevention of Fraud	These are all carrier costs relating to detection and prevention of fraud.
Sec 8	Product management and marketing expenses	These are all costs associated with the management and marketing of current products. This may include costs relating to product promotion and advertising, sales, pricing, broker fees and commissions, internal commissions and commissions processing, marketing materials, account reporting, changes or additions to current products, and enrollee education regarding coverage. Traditional expense categories that your company might allocate <i>in whole or in part</i> to product management and marketing expenses include information systems, underwriting, legal, finance, actuarial, public relations, and network management.
Sec 8	Underwriting	These are all carrier costs relating to underwriting.

Sec 8	Regulatory compliance and government relations expenses	These are all costs associated with federal and state reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, and costs associated with the preparation and filing of all financial, utilization, statistical, and quality reports, and administration of government programs. Traditional expense categories that your company might allocate <i>in whole or in part</i> to regulatory compliance and government relations expenses include information systems, finance, actuarial, sales and marketing, underwriting, contract, legal, utilization management, quality assurance, and compliance.
Sec 8	Lobbying	These are all carrier costs relating to lobbying.
Sec 8	Provider relations and contracting expenses	These are all costs associated with contract negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, and administration of provider capitations and settlements. Traditional expense categories that your company might allocate <i>in whole or in part</i> to provider relations and contracting expenses include finance, legal, accounting, actuarial, and information systems.
Sec 8	Quality assurance and utilization management expenses	These are all costs associated with quality assurance, practice protocol development, utilization review, peer review, credentialing, outcomes analysis related to existing products, nurse triage and other medical care evaluation activities. Traditional expense categories that your company might allocate <i>in whole or in part</i> to quality assurance and utilization management expenses include information systems and legal.
Sec 8	Wellness and health education expenses	These are all costs associated with wellness and health promotion, disease prevention, member education and materials, provider education, and outreach services. Traditional expense categories that your company might allocate <i>in whole or in part</i> to wellness and health education expenses include marketing, medical services, and printing.
Sec 8	Research and product development expenses	These are all costs associated with outcomes research, medical research programs, product design and development for products and programs not currently offered, major systems development, and integrated service network development. Traditional expense categories that your company might allocate <i>in whole or in part</i> to research and product development expenses include actuarial, information systems, marketing, finance, underwriting, and wellness programs.
Sec 8	Charitable contributions expenses	These are all costs related to contributions made for charitable purposes.

Sec 8	General administration expenses	These are all costs not outlined or allocated to the other categories. Traditional expense categories that your company might allocate <i>in whole or in part</i> to general administration expenses include human resources, facility maintenance, payroll, general accounting, finance, executive, internal audit, treasury, actuarial, finance, information systems, office management and occupancy costs, general office supplies and equipment, legal, board, outside consulting services, membership fees in trade organizations, public relations, and mail room. Taxes and assessments are not included in these costs.
Sec 8	Total indirect health care expenses	This grand total should be equal to the sum across columns (product categories) for the indirect expenses line in section 7.

Source: Minnesota Department of Health. "2007 Health Plan Financial and Statistical Report Form and Instructions." Accessed August 25, 2008.

<<http://www.health.state.mn.us/divs/hpsc/dap/cdireports/grppurch/index.html>>