HEALTHCHOICE LOSS RATIO BENCHMARK

FINAL REPORT

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Executive Summary

Financial examinations of Managed Care Organizations (MCOs) domiciled in Maryland did not disclose any adjustments to the MCO financial statements that would have changed their reported medical loss ratios. Each MCO examined met minimum capital and surplus funds requirements under Maryland law.

The market conduct examinations of MCOs suggests that there is no reason to assume various payment practices or service areas has a material impact on observed differences in the loss ratio reported by each MCO.

As the nation moves to a new definition of loss ratio, the Maryland Insurance Administration (MIA) encourages the Department of Health & Mental Hygiene (DHMH) to consider the feasibility and desirability of adopting the federal Department of Health & Human Services' definition of quality of care improvement expenses.

Introduction

Managed Care Organizations are certified by DHMH and receive capitation payments for providing healthcare services to Medicaid recipients. MCOs are required by Maryland law to maintain an 85% loss ratio, meaning they must spend at least 85 cents of each dollar on medical care (as opposed to administrative or other expenses).

During the 2009 legislative session, the budget committees directed the Secretary of DHMH to request MIA conduct a market conduct study and financial examination of all MCOs, in part to assess compliance with the 85% loss ratio (also to review payment practices and actuarial reimbursement rates).[1]

The MIA submitted an interim report in November 2009 which:

(1) summarized the financial requirements to operate as a MCO;
(2) summarized the applicability of insurance law to MCOs;
(3) summarized capitation payments to MCOs;
(4) summarized the reporting requirements for MCOs; and
(5) reviewed the loss ratio for MCOs for calendar year 2007.

In that report, the MIA recommended that, to promote transparency and greater accountability, DHMH disclose the loss ratio for each MCO on an annual basis for the previous calendar year based on the information submitted through the HealthChoice Financial Monitoring Report after it has been reviewed by the accounting contractor.

This report summarizes the MIA's findings from the financial and market conduct examinations of each MCO.[2]

[1] See Joint Chairmen's Report – Operating Budget, April 2009, Page 93
[2] The financial examination and the market conduct examinations for each MCO is available on the MIA's website, www.mdinsurance.state.md.us under the "available public information" link.

Financial Examinations

The MIA conducts a financial examination of domestic managed care organizations once every five years. See *HG §15-102.3(f).* The MIA completed financial examinations of Jai Medical System, Maryland Care MCO, and United Healthcare of the Mid-Atlantic in 2006. MedStar Family Choice and Priority Partners were examined in 2007. Amerigroup Maryland, Inc. was examined in 2008. All Reports are available on the MIA's website, www.mdinsurance.state.md.us under the "available public information" link.

The MIA is currently conducting a financial examination of Coventry Health Care of Delaware. In this regard, Coventry is domiciled in Delaware, and is currently being examined by the Delaware Insurance Department. In order to minimize the cost of its examination, the MIA is coordinating its examination with the Delaware Insurance Department. As a result, the MIA plans to limit its examination work to the Maryland Medicaid business, and will otherwise rely on the examination work performed by the Delaware Insurance Department. The MIA examination will not be completed until the middle of 2011. The MIA will inform the budget committees should its examination disclose any adjustments to the financial statements that would have changed Coventry's reported medical loss ratio.

Each examination report concluded that the MCOs met their minimum capital and surplus funds requirements under Maryland law. ***The financial examinations of the six MCOs mentioned above did not disclose any adjustments to the MCOs financial statements that would have changed their reported medical loss ratios.***

Market Conduct Examinations

In response to the request that the MIA study claims payment practices for all seven MCOs participating in HealthChoice, the MIA reviewed a sample of claims from each MCO from calendar year 2008, to assess compliance with §§15-1005 and 15-1008 of the Insurance Article.

A total of 200 randomly selected files were reviewed for each MCO examination as follows:[3]

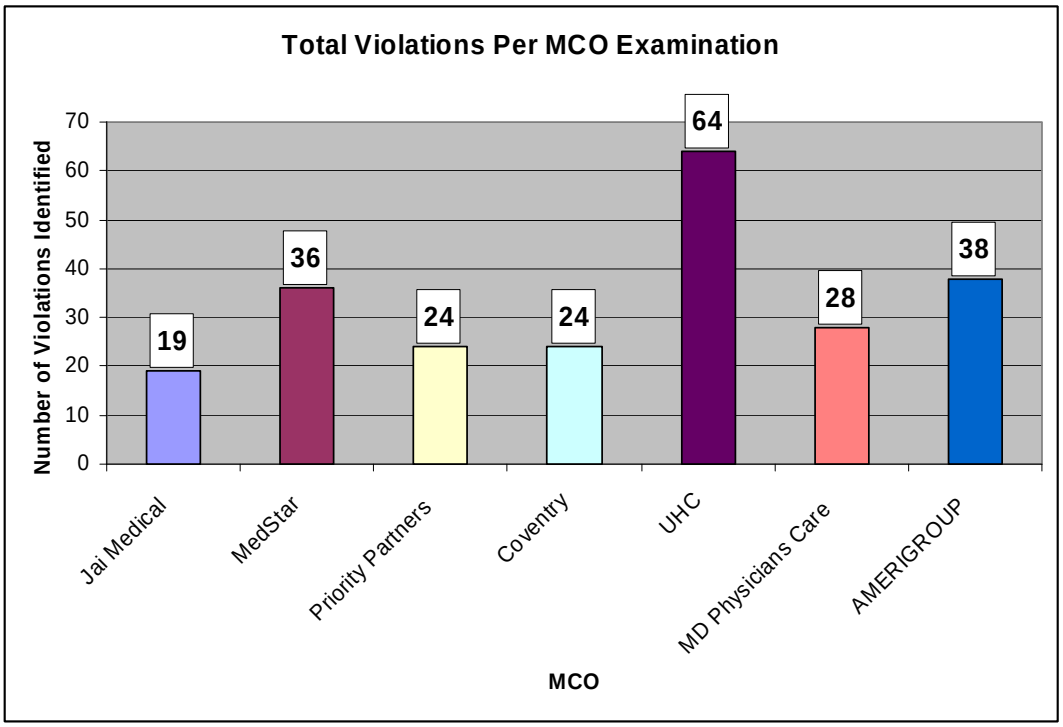
- 100 Paid Claims
- 50 Denied Claims
- 25 Adjusted Claims
- 25 Retrospective Claims

[3] One MCO was unable to provide 200 claims for review because the MCO did not conduct retrospective denials. As a result, a total of 175 claims were examined. Additionally, one other MCO could only provide 190 claims for review because it was only able to retrieve 15 retrospective claims from the MCOs population.

The chart below denotes which violation(s) were identified in each MCO examination:

MCO	§ 15-1005 (c) (1) & (2)	§ 15-1005 (f) (1)	§ 15-1005 (c) (2) (i)	§ 15-1005 (c) (1) (ii)	§ 15-1005 (c) (2) (i) & (ii)
Jai Medical	**X**	**X**	**X**		
MedStar	**X**	**X**	**X**		
Priority Partners	**X**	**X**	**X**		**X**
Coventry	**X**	**X**	**X**		**X**
UHC	**X**	**X**	**X**	**X**	
MD Physicians Care	**X**	**X**	**X**		**X**
AMERIGROUP	**X**	**X**	**X**		
Total	**7**	**7**	**7**	**1**	**3**

Specifically, the total number of violations identified per each MCO examination is noted in the chart below. It is important to remember that one incorrectly processed claim by an MCO generally has multiple violations. The total number of violations – but not of incorrectly processed claims – is shown below.



The chart below illustrates each MCO's participation out of 24 Maryland counties. The majority of MCOs participate in almost all 24 Maryland Counties. Only two out of the seven MCOs have a limited service area participation in three counties or less.

Service Area Participation By County

Service Area	Jai Medical	MedStar	Priority Partners	Coventry	UHC	MD Physicians Care	AMERIGROUP
Allegany County		X	X		X	X	
Anne Arundel County		X	X		X	X	X
Baltimore County	X	X	X	X	X	X	X
Baltimore City	X	X	X	X	X	X	X
Calvert County		X	X		X	X	X
Caroline County		X	X		X	X	X
Carroll County		X	X		X	X	X
Cecil County		X	X		X	X	X
Charles County		X	X		X	X	X
Dorchester County		X	X		X	X	X
Frederick County		X	X		X	X	X
Garrett County		X	X		X	X	X
Harford County		X	X	X	X	X	X
Howard County		X	X		X	X	X
Kent County		X	X		X	X	X
Montgomery County		X	X		X	X	X
Prince George's County		X	X			X	X
Queen Anne's County		X	X		X	X	X
Saint Mary's County		X	X		X	X	X
Somerset County		X	X		X	X	X
Talbot County		X	X		X	X	X
Washington County		X	X		X	X	
Wicomico County		X	X		X	X	X
Worcester County		X	X		X	X	X
Total MCO Participation out of 24 Maryland Counties	**2**	**24**	**24**	**3**	**23**	**24**	**22**

Throughout each examination, several observations were noted and recommendations for improvement were suggested to each MCO. The MIA recognizes these issues as problematic or having the potential to be problematic and non-compliant with specific laws and regulations. These observations included claims with individual incidents of one of the following:

- A prolonged appeal processing time;
- Faulty system policies and procedures subsequently resulting in unnecessary and inappropriate denials for medical records;
- Claims processing errors resulting from claims received with multiple dates of services and/or procedure codes;
- Inability to link pertinent claim information to the original claim submission after receiving the additional information requested to complete claim processing;
- Vague and misleading denial codes;
- Explanations for denial codes omitted on provider remits;
- Failure to send the required notification to health care providers as a result of retroactive claim denials due to coordination of benefits and/or failure to retain copies of such letters;
- Inaccurate record keeping of received dates and/or the actual mailed dates for provider reimbursement checks; and
- Faulty procedures in calculating and applying applicable interest.

Medical Loss Ratio

As noted in the interim report, DHMH regulations dictate that the loss ratio is calculated by adding net medical expenses and medical management expenses and dividing the total by net premium. The MIA follows the historic formula used by the National Association of Insurance Commissioners (NAIC), incurred claims divided by earned premiums. Both formulas have advantages and disadvantages.

The Affordable Care Act (ACA) required the NAIC to develop uniform definitions and standard methodologies to calculate the loss ratio. The NAIC drafted a Model Regulation (available at http://www.naic.org/index_health_reform_section.htm) and for the most part the Department of Health and Human Services adopted this new formula for calculating the loss ratio.

As we move toward health care reform and seamless consumer transition, MIA suggests that DHMH consider using the definition of quality of care improvement expenses that will be used in the commercial market to measure medical management expenses.

Conclusion

Financial examinations confirm that each MCO met minimum capital and surplus funds requirements under Maryland law.

Based on the results of the market conduct examinations, there is no reason to assume various payment practice or service areas has a material impact on observed differences in the loss ratio reported by each MCO.

As the nation moves to a new era from definition of loss ratio, the MIA encourages DHMH to consider the feasibility and desirability of adopting HHS definition of quality of care improvement expenses.