



HEALTHCHOICE LOSS RATIO BENCHMARK

INTERIM REPORT

NOVEMBER 2009

Executive Summary

There has been a level of controversy surrounding managed care organizations (“MCOs”), specifically surrounding the question of whether MCOs are spending most of their capitation payments on medical care as distinguished from, for example, administrative costs or profits.

The General Assembly addressed this problem by setting an 85 percent loss ratio benchmark for MCOs; that is, 85 percent of the capitation payment is to be spent on medical care.

MCOs have different reporting requirements for the Department of Health and Mental Hygiene (“DHMH”) and the Maryland Insurance Administration (“MIA”). Based on the information submitted to DHMH and the MIA, there are different loss ratio calculations, each with its advantages and disadvantages.

DHMH’s calculation is based on HealthChoice experience only but is not made publicly available on a consistent annual basis for each MCO. The MIA’s calculation based on the information in the Annual Statement is publicly available but includes earned premium and incurred claims for HealthChoice and PAC, does not reduce premium for the premium tax paid and does not include the costs for medical management expenses.

DHMH’s calculation of the loss ratio is a better measure of the amount of the capitation payment spent on medical care. In the interest of transparency and greater public accountability, the MIA ***recommends 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 (HFMR) after it has been reviewed by the accounting contractor.*** This may be accomplished by annually publishing each MCO’s loss ratio.

Introduction

Chapter 352, Laws of Maryland, 1996, effective July 1, 1996, created Maryland's Medicaid Managed Care Program, known as HealthChoice. HealthChoice was designed to improve the Medicaid Program by helping to control rapidly rising costs, facilitating the coordination of care for costly, high-risk patients, and increasing attention to preventive care. HealthChoice requires Medicaid recipients, with certain exceptions, to enroll in managed care organizations ("MCOs"). MCOs are entities that are certified by the Department of Health and Mental Hygiene ("DHMH") to receive medical assistance capitation payments in exchange for providing medical services to Medicaid recipients.

In order to assure the public MCOs spend most of the capitation payment on medical care, the General Assembly established a loss ratio benchmark. The loss ratio measures the percentage of the premium spent on medical care. Under Maryland law, the loss ratio benchmark for MCOs is 85 percent. That means 85 cents of every dollar received in payment from DHMH must be spent on medical care. In the event a MCO's loss ratio fails to meet or exceed 85 percent, the Secretary of DHMH, in consultation with the Insurance Commissioner, may adjust the capitation payments for the MCO. See *Ins.* §15-605.

Concerned in part about the attainment of this loss ratio by MCOs, the Joint Chairmen's Report on the Operating Budget directed DHMH to request the MIA undertake a market conduct study and a financial examination of all MCOs to assess compliance with §15-605 of the Insurance Article. To accomplish this, the market conduct studies and financial examinations are required to review the payment practices, actuarial reimbursement rates, and compliance with medical loss ratios for each jurisdiction of operation. An interim report is due December 1, 2009 and a final report December 1, 2010.

Nearly a decade ago the MIA undertook a similar review. The MIA conducted a limited scope financial examination of MCOs for the first twelve months of the HealthChoice program, July 1, 1997 through June 30, 1998 and a market conduct examination for the period January 1, 2001 through December 31, 2001.

Among other things, the limited scope financial examination reviewed the loss ratios of the MCOs. The MIA found MCOs followed acceptable actuarial methodology in estimating their medical claims reserves, but noted some inaccuracies with the loss ratios. In part, this was due to errors in estimating medical claims reserves and in part to differences in how MCOs report outreach and case management costs.

The market conduct review of the MCOs focused on claims handling procedures. While the recommendations varied by MCO, generally the MIA recommended MCOs adopt procedures to pay interest at the time payment of a claim is made to a provider and eliminate pending of a claim to ensure processing within 30 days.

Much has changed in the intervening years. To provide an appropriate context for the MIA's financial examinations and market conduct studies, this interim report: (1) summarizes the financial requirements to operate as a MCO; (2) summarizes the applicability of insurance law

to MCOs; (3) summarizes capitation payments to MCOs; (4) summarizes the reporting requirements for MCOs; (5) reviews the loss ratio for MCOs for calendar year 2007; (7) summarizes next steps; and (8) offers a recommendation based on the MIA's review of the loss ratio to promote greater transparency and public accountability.

Financial requirements

A MCO may be a certified health maintenance organization ("HMO") that is authorized to receive medical assistance prepaid capitation payments or a managed care system that is authorized to receive medical assistance prepaid capitation payments. See *Health-General* §15-101.

The surplus requirements for MCOs are set forth in §15-102.4 of the Health General Article. The initial surplus requirement for a MCO is \$1.5 million, unless an adjustment is made by the Insurance Commissioner in consultation with the Secretary of DHMH.

Each MCO must maintain a surplus that exceeds the liabilities of the MCO in an amount that is at least equal to the greater of \$750,000 or 5 percent of the subscription charges earned during the prior calendar year. MCOs must comply with risk based capital standards in accordance with regulations adopted by the Insurance Commissioner. In addition, the Insurance Commissioner is required to examine the financial affairs of each MCO at least once every five years. See *Health-General* §15-102.3 (f).

The Insurance Commissioner adopted regulations to specify how MCOs must comply with risk based capital standards. The regulations adopted by the Insurance Commissioner require MCOs to comply with the risk based capital requirements of Insurance Article, Title 4, Subtitle 3, Annotated Code of Maryland, in the same manner as a health insurer, unless exempted by the Insurance Commissioner. See COMAR 31.12.06.02-1. These risk based capital requirements, as well as the financial requirements and solvency tools contained in the Insurance Article, in the Health-General Article and in regulation allow the Insurance Commissioner to monitor the financial condition of each MCO and to take certain action to try and avert insolvency. The regulations:

- Provide guidance on admitted assets and assets not admitted;
- Require MCOs to maintain general liability insurance and medical malpractice insurance with minimum limits of \$1 million for any one loss and \$3 million in the aggregate;
- Apply the Acquisitions Disclosure and Control Act to MCOs;
- Specify annual and interim financial reports required to be submitted to the MIA;
- Authorize the Insurance Commissioner to conduct an examination of the operations of a MCO as often as the Insurance Commissioner deems necessary to protect the interests of the people of Maryland, but no less frequently than once every 5 years; and
- Stipulate that the rehabilitation or liquidation of a MCO is subject to the requirements of the Health-General Article, §19-706.1, Annotated Code of Maryland.

Applicability of insurance laws to MCOs

Generally, MCOs are not subject to the insurance laws of this State or to the provisions of Title 19 of the Health-General Article. See *Health-General* §15-101.1. However, the General Assembly has expressly required MCOs comply with the following laws applicable to insurers and health maintenance organizations:

- Provider panel requirements *Ins.* §15-112
- Prompt payment of claims *Ins.* §15-1005
- Payment of hospitals on the basis of rates approved by the Health Services Cost Review Commission *Ins.* §15-604
- Retroactive denial of reimbursement of claims *Ins.* §15-1008
- Administrative service provider contracts *Health-General* §§19-712, 19-713.2, and 19-713.3
- Examination of financial affairs *Health-General* §19-718
- Loss ratio benchmark *Ins.* §15-605

Capitation payments to MCOs

DHMH makes capitation payments to MCOs. The statute directs the Secretary of DHMH, in consultation with the Insurance Commissioner, to set capitation payments at a level that is actuarially adjusted to the benefits provided and actuarially adjust the capitation payments to reflect the relative risk assumed by the MCO. See *Health-General* §15-103 (b) (18).

Payment is made to a MCO for each enrollee at a fixed capitation rate. HealthChoice has a sophisticated rate-setting system that incorporates historic MCO expenditures, enrollee health status and prior service utilization, and geographic and demographic data.

The rates are developed annually and are effective January 1. It is a collaborative process between DHMH and the MCOs; monthly rate-setting meetings are held with MCOs between February and August of each year.

Because of DHMH's long-standing commitment to sound actuarial principles, the MIA has not been involved in the capitation rate-setting process other than to periodically attend rate-setting meetings and offer input as appropriate.¹

¹ Initially, the MIA did review certain aspects of the rate-setting process. The Memorandum of Understanding ("MOU") between DHMH and the MIA entered into in July 1996, defined each department's responsibilities concerning the development and implementation of capitation payment levels. DHMH contracted with the University of Maryland, Baltimore County ("UMBC") to develop the methodology for MCO capitation payments. The MOU required UMBC to provide the MIA with certain information including a copy of the Capitation Rate Development Plan, the qualifications of the actuarial firm used by UMBC, and a copy of the actuarial evaluation of the MCO capitation payment. The MOU stipulated the MIA would not render an independent opinion as to the appropriateness or actuarial soundness of the methodology as a whole or particular MCO capitation levels.

Reporting requirements

In order to ensure compliance with financial requirements and the loss ratio benchmark, MCOs are required to submit specific reports to the MIA and to DHMH. Some of the reports required by the MIA and DHMH include the same information for the same reporting period but measured at different points in time.

MIA reporting requirements

MCOs must submit the National Association of Insurance Commissioner's (NAIC) Annual Statements, Quarterly Statements and Annual Risk Based Capital Reports prepared in accordance with the Annual Statement instructions, Accounting Practices and Procedures Manual and Risk Based Capital Instructions adopted by the NAIC to the MIA. The Annual Statement and the Risk Based Capital Report are due each March 1st; the Quarterly Financial Statement is due May 15th, August 15th and November 15th.

The Annual Statement is publicly available and the data included in the Annual Statement may be used to calculate the loss ratio. The MIA uses the Annual Statement to assess the financial solvency of each MCO. The Annual Statement for each MCO is publicly available. It includes information for HealthChoice and the Primary Adult Care (PAC) programs.

In addition, MCOs must submit the Maryland Annual Medicaid Data Request. This report is also due March 1st. The Maryland Annual Medicaid Data Request is used by the MIA to assess each MCO's loss ratio and initially the assessment was forwarded to DHMH for its review and consideration.

The MCO's claims expense reported in the Annual Statement includes the amount paid in the preceding year, plus the change in claims reserves (the provision for claims reported and unpaid and incurred but not reported ("IBNR") as of the financial statement date) from the second preceding year end to the preceding year end. The claims reserves represent management's best estimate of the cost of settling all outstanding medical claims. While this amount is subject to a reasonableness opinion from a qualified actuary, the fact that it is an estimate can cause an understatement or overstatement of claims expenses in the Annual Statement.

DHMH reporting requirements

DHMH also has reporting requirements for managed care organizations. These reporting requirements are detailed in COMAR 10.09.65.15. Among the required reports are monthly encounter data and HFMRs.

Managed care organizations submit two HFMRs each year. The final submission provides the most complete information on the previous year and is due each November 15th.

The HFMR requires MCOs to report premium revenue, member months, medical expenses, medical management expenses, administrative expenses and financial summary data. These

reports are provided in detail down to the regional and rate cell level. Medical management expenses include costs for educational outreach to members, utilization management, case management, disease management and quality management.

DHMH engages an independent certified public accounting (CPA) firm to review the HFMR submitted by each MCO. Each December, the HFMRs are sent to the accounting contractor. The accounting contractor must report the results of its review to DHMH by May 1st. Based on the accounting contractor's report, DHMH may adjust HFMR-reported expenses and revenues in accordance with the opinion of the accounting contractor.

Because of the timing of the report submissions, the MIA financial reports are much more reliant on estimates for claims expenses as well as revenue (e.g., premiums written and premiums earned). Since most activity for the prior calendar year is final at the time of the final HFMR submission on November 15th, the final HFMR does not include the same degree of estimates and provides a more complete summary of the prior year's claim and revenue experience for each managed care organization. In addition, the HFMR includes only financial information from the prior rate (or service) year, whereas the financial information reported to MIA to monitor solvency may include activity for more than one calendar year. The HFMR also includes information to allow this report to be reconciled with the Annual Statement submitted by each MCO to the MIA.

The HFMR reports submitted by each managed care organization to DHMH are not publicly available.

Review of loss ratio

DHMH uses the information submitted by each MCO on the HFMR to ascertain if the MCO meets the loss ratio benchmark. COMAR 10.09.65.19-5 specifies the loss ratio calculation used by DHMH. Under the regulations, the Secretary may adjust the capitation payment for a MCO if its loss ratio does not meet or exceed 85 percent in a service year *and* its loss ratio failed to meet or exceed 85 percent in the three-year period ending with the service year.

The regulation stipulates the loss ratio is calculated by adding net medical expenses and medical management expenses and dividing the total by net premium. Net medical expenses are calculated by summing medical expenses paid and medical expenses unpaid and subtracting from this total reinsurance recoveries. Net premium is calculated by subtracting reinsurance premiums from gross premium and subtracting from this total the premium tax paid because this is a pass-through and is not incorporated in the expenses, profits or losses of the MCO.

As shown in Table 1, based on this calculation, none of the MCOs fell below the loss ratio benchmark in 2007 or the last three years.

Table 1: Loss Ratios: Managed Care Organizations, HFMR		
	2007	2005-2007
Amerigroup	86.6%	87.4%
Coventry	96.7%	91.1%
MedStar	87.3%	86.1%
Jai	96.8%	90.6%
MPC	90.4%	88.5%
Priority	89.6%	88.6%
UnitedHealthcare	91.8%	90.4%
Total	89.5%	88.6%

The information submitted on the Annual Report submitted to the MIA provides another measure of the loss ratio for each MCO. Following NAIC convention, the MIA calculates the loss ratio by dividing incurred claims by earned premium. In this calculation, the earned premium is not reduced for the premium tax paid.

As shown in Table 2, this yields a different loss ratio than that used by DHMH to monitor compliance with the loss ratio benchmark. Using the NAIC convention for calculating loss ratios, only two MCOs met or exceeded the loss ratio benchmark in 2007, Coventry and Jai.

Table 2: Loss Ratios: Managed Care Organizations 2008 Annual Statement (for 2007)	
Amerigroup	83.9%
Coventry	99.8%
MedStar	82.3%
Jai	96.6%
MPC	82.4%
Priority	84.0%
UnitedHealthcare	84.8%
Total	84.4%

The Annual Statement submitted by each MCO to the MIA includes all Medicaid earned premium and incurred claims. Beginning in 2007, DHMH contracted with MCOs for the HealthChoice Program as well as the Primary Adult Care Program (PAC). For calendar year 2007, three MCOs – Jai, MPC and UnitedHealthcare – participated in PAC. Jai separately reported its PAC earned premium and incurred claims on the Annual Statement submitted to the MIA; MPC and UnitedHealthcare did not.

The MIA contacted MPC and UnitedHealthcare and asked each to provide the earned premium and incurred claims for 2007 attributable to PAC to calculate the loss ratio for HealthChoice only. The loss ratio for HealthChoice only based on the Annual Statement is shown in Table 3. In this calculation, three MCOs met or exceeded the loss ratio benchmark in 2007, Coventry, Jai and UnitedHealthcare.

Table 3: Loss Ratios: Managed Care Organizations 2008 Annual Statement (for 2007)	
Amerigroup	83.9%
Coventry	99.8%
MedStar	82.3%
Jai	87.9%
MPC	83.3%
Priority	84.0%
UnitedHealthcare	85.6%
Total	84.4%

Each loss ratio calculation has its advantages and disadvantages. DHMH's calculation is based on HealthChoice experience only. It reduces premium for the premium tax paid, a sum included in the premium paid by DHMH to the MCOs that is not available to pay for medical care for Medicaid beneficiaries. This allows for comparisons that are consistent between years which were prior to the implementation of the premium tax in April 2005. It also allows MCOs to include medical management expenses in net medical expenses as outreach and case management costs may result in more appropriate treatment and a healthier population.

However, DHMH's calculation is not made publicly available on a consistent annual basis for each MCO. This makes it difficult for the public to assess the performance of each MCO and to assure each MCO is appropriately compared to its peers.

The MIA's calculation based on the information in the Annual Statement is publicly available each year for each MCO, allowing the public to assess the performance of each MCO and to compare one MCO to another or to the group as a whole. But, the MIA's calculation includes earned premium and incurred claims for HealthChoice and PAC. Thus, the loss ratio is not comparable across all MCOs. Moreover, the MIA's calculation does not reduce premium for the premium tax paid and does not include the costs for medical management expenses.

Next steps: market conduct studies and financial examinations

The MIA conducts a financial examination of domestic insurers, health maintenance organizations, and managed care organizations once every five years. The MIA completed financial examinations of Jai Medical System, Maryland Care MCO, and UnitedHealthcare of the Mid-Atlantic in 2006; MedStar Family Choice and Priority Partners in 2007; and has scheduled financial examinations for Amerigroup Maryland, Inc. and Coventry Health Care of Delaware for this year. Next year, the MIA will provide an overview of its findings regarding the financial soundness of MCOs based on these routine financial examinations.

The MIA has scheduled targeted market conduct examinations for each MCO beginning in October of this year and ending the second quarter of next year. The targeted market conduct examinations focus on the claims payment practices of each MCO. Next year, the MIA will provide an overview of its findings regarding the claims payment practices of MCOs based on these examinations.

Conclusion

Under Maryland law, both the MIA and DHMH have responsibilities for the regulation and oversight of the HealthChoice Program. DHMH is responsible for ensuring appropriate payment to MCOs, the provision of quality care to Medicaid recipients and the success of the HealthChoice Program in meeting its goals. The MIA is responsible for assessing the financial solvency of MCOs and is available to DHMH in the event DHMH would find it valuable to have technical assistance from the MIA regarding capitation rates and loss ratios.

Historically, the MIA had expertise to offer DHMH to help guide its regulatory and programmatic activities in a new endeavor modeled in large part on the commercial health insurance market. But as time has passed, DHMH has developed sophisticated monitoring tools.

As the record indicates, the loss ratio benchmark has proven controversial. Initially, the challenge was to develop a reporting tool accurately capturing claims costs and revenues. As the previous MIA limited scope examinations document, because the Annual Report requires MCOs to estimate incurred but not reported claims, there can be measurement differences between MCOs and these measurement differences may make it difficult to accurately compare a loss ratio between MCOs. A similar measurement problem exists for the Maryland Annual Medicaid Data Request.

DHMH has skillfully addressed this measurement problem through the HFMR. With this data collection tool, DHMH is capturing actual claims expenditures. The annual review by the accounting contractor ensures the validity of this data.

The medical loss ratio as calculated using the HFMR is not perfect. It includes medical management expenses in the loss ratio calculation. Because there is no industry standard for calculating medical management expenses, MCOs may account for these expenses in different ways. But the MIA does not believe the inclusion of medical management expenses has had a material impact on the loss ratio.

The MIA believes, in part, the controversy surrounding the loss ratio benchmark for MCOs is attributable to the fact that DHMH is now responsible for calculating the loss ratio and assessing whether each MCO has met the loss ratio benchmark. But because the HFMR is not publicly available, transparency is more limited resulting in more questions.

To promote transparency and greater public accountability, the MIA recommends DHMH disclose the loss ratio for each MCO on an annual basis for the previous calendar year based on the information submitted through the HFMR after it has been reviewed by the accounting contractor. This may be accomplished by annually publishing each MCO's loss ratio.