Health & Human Services Committee

Wednesday, September 21, 2011
1:30 PM
Morris Hall (17 HOB)

Dean Cannon
Speaker

Robert C. "Rob" Schenck
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time:	Wednesday, September 21, 2011 01:30 pm
End Date and Time:	Wednesday, September 21, 2011 03:00 pm
Location:	Morris Hall (17 HOB)
Duration:	1.50 hrs

Update on implementation of CS/CS/HB 7095 (Ch. 2011-141, Laws of Florida) related to controlled substances

Update on implementation of CS/HB 7107 (Ch. 2011-134, Laws of Florida) and CS/HB 7109 (Ch. 2011-135, Laws of Florida) related to Medicaid

Presentation on Achieved Savings Rebate and Medical Loss Ratio

NOTICE FINALIZED on 09/14/2011 16:10 by Iseminger.Bobbye

Update on Implementation
Of CS/CS/HB 7095

Implementation of

House Bill 7095

Relating to Prescription Drugs

Florida Department of Health

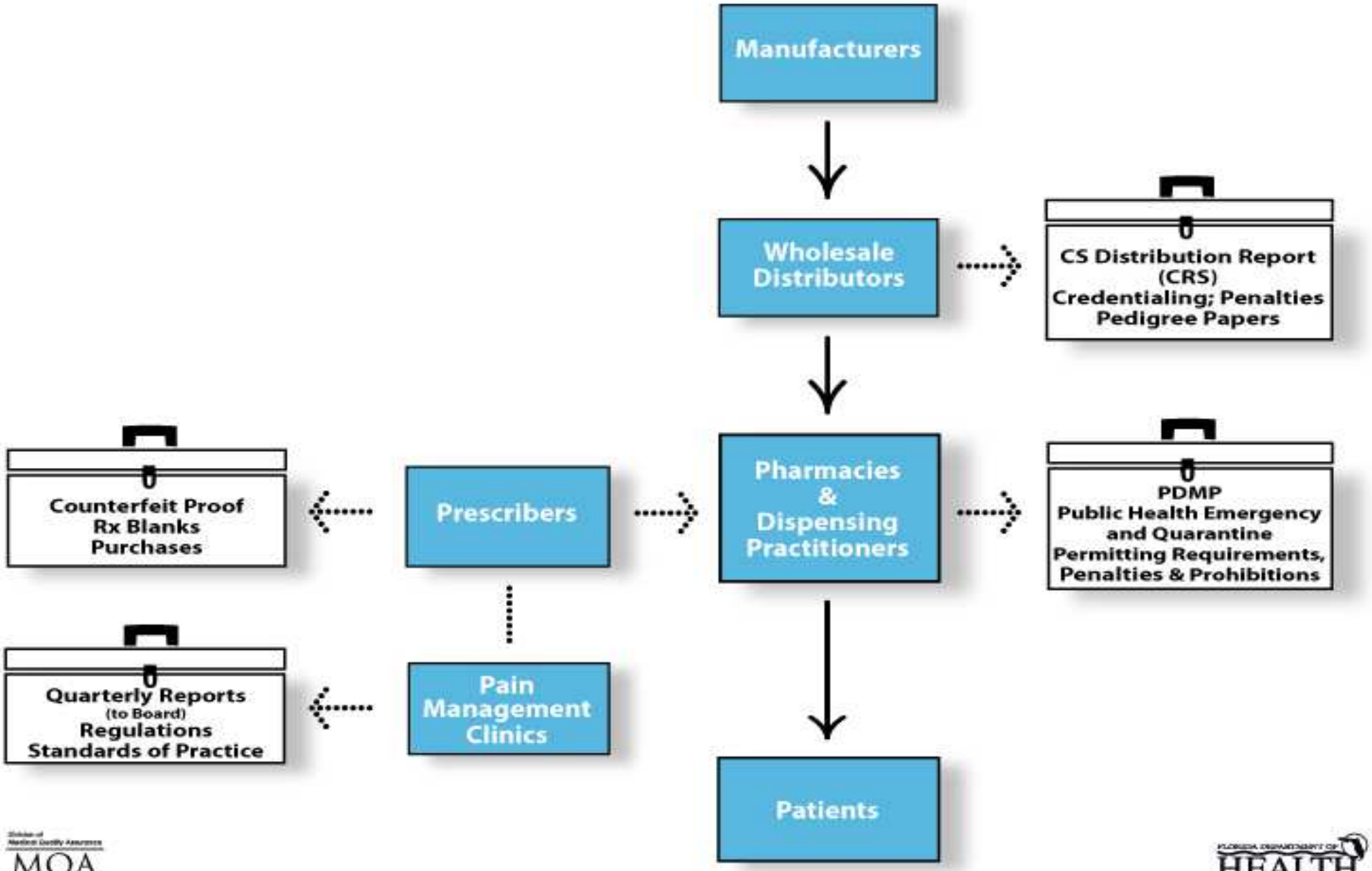
Florida House of Representatives
Health and Human Services Committee

September 21, 2011

FLORIDA DEPARTMENT OF HEALTH

Division of Medical Quality Assurance
MQA

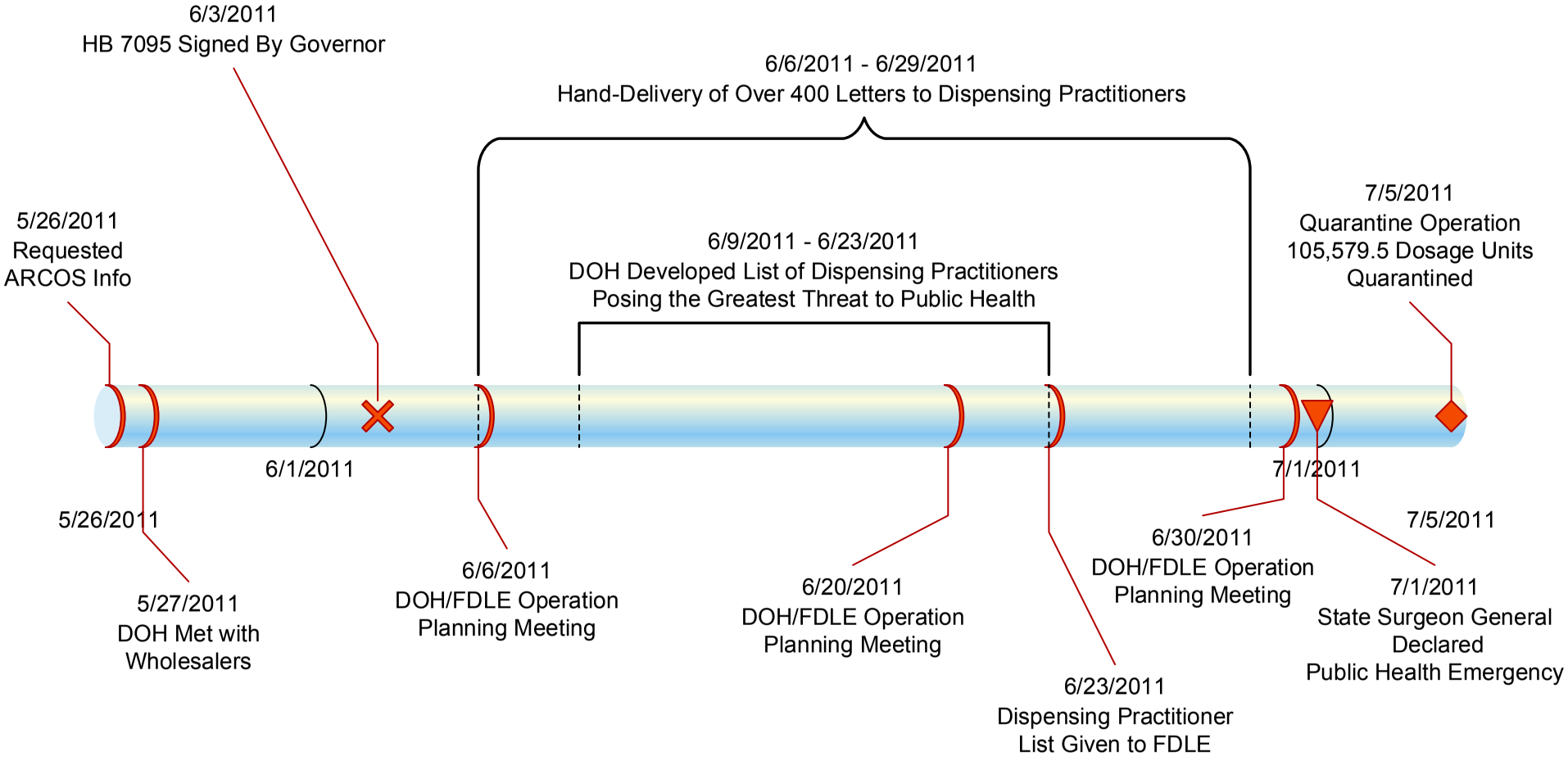
FLORIDA'S DRUG DISTRIBUTION SYSTEM TOOLBOX



Division of Medical Quality Assurance
MQA

FLORIDA DEPARTMENT OF HEALTH

Public Health Emergency & Controlled Substance Quarantine Operation Timeline



FLORIDA DEPARTMENT OF HEALTH

Division of Medical Quality Assurance
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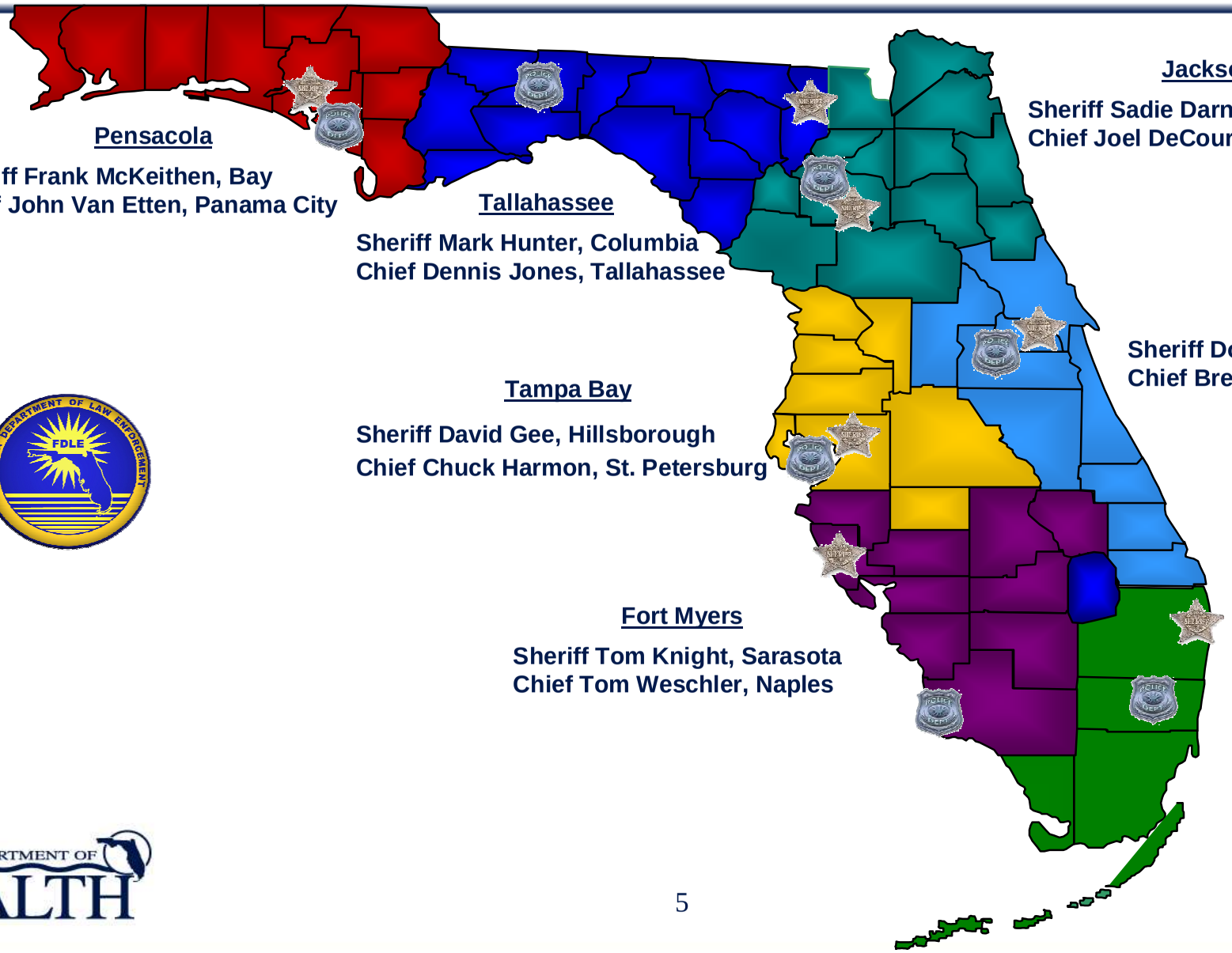
Public Health Emergency & Controlled Substance Quarantine Operation

Criteria for Identification of Dispensing Practitioners

- Risk of Non-Compliance
- Purchase Amounts
- Manner of Medical Services
- Other Factors:
  - Complaint history of controlled substance prescribing or dispensing violations
  - Wholesaler reports of suspicious purchasing
  - Law enforcement reports of suspicious behavior
  - Dispensing practitioner inspection information

Regional Strike Force Co-Chairs



Pensacola

Sheriff Frank McKeithen, Bay
Chief John Van Etten, Panama City

Tallahassee

Sheriff Mark Hunter, Columbia
Chief Dennis Jones, Tallahassee

Jacksonville

Sheriff Sadie Darnell, Alachua
Chief Joel DeCoursey Jr., Alachua

Orlando

Sheriff Don Eslinger, Seminole
Chief Brett Railey, Winter Park

Tampa Bay

Sheriff David Gee, Hillsborough
Chief Chuck Harmon, St. Petersburg

Fort Myers

Sheriff Tom Knight, Sarasota
Chief Tom Weschler, Naples

Miami

Sheriff Ric Bradshaw, Palm Beach
Chief John Brooks, Sunrise

FLORIDA DEPARTMENT OF HEALTH

Division of Medical Quality Assurance
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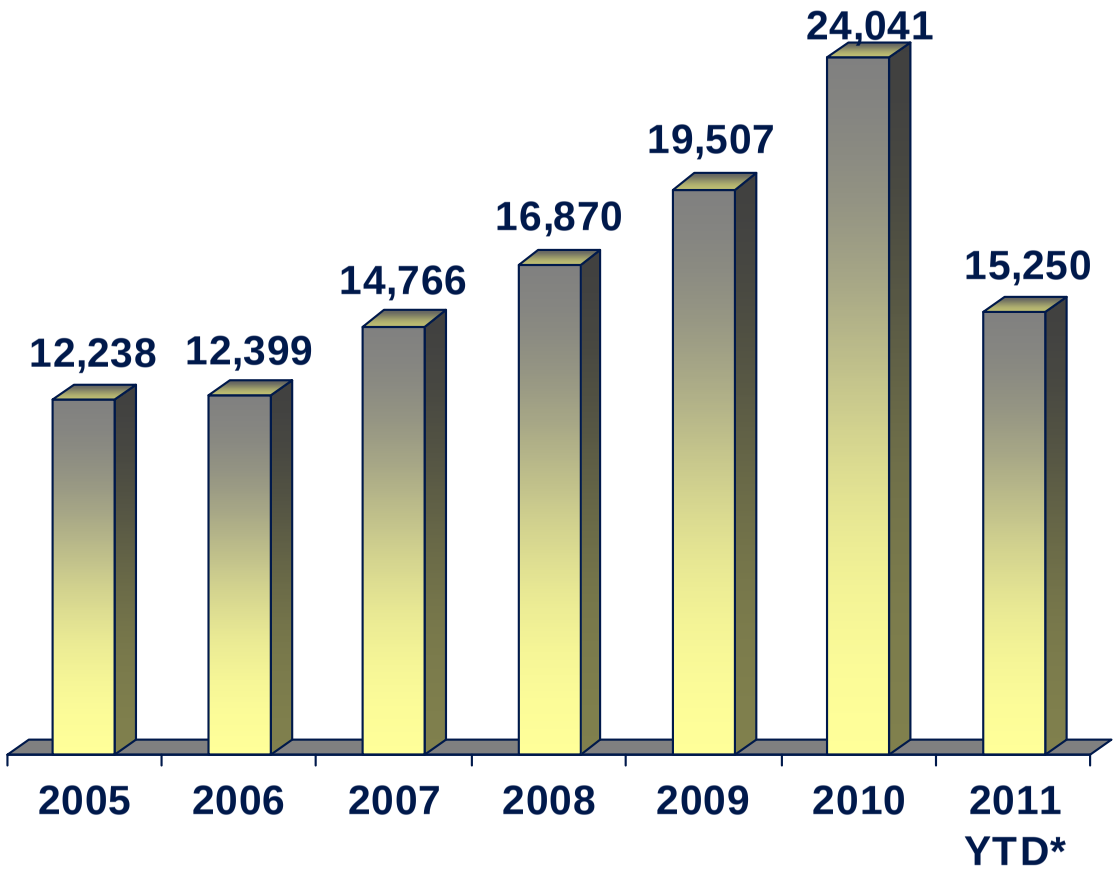
Florida Prescription Drug Arrests
2005 – 2011 Year to Date



FLORIDA DEPARTMENT OF HEALTH

*As of 09/01/2011

Division of Medical Quality Assurance
MQA

Regional Drug Enforcement Strike Force
Regional Activity

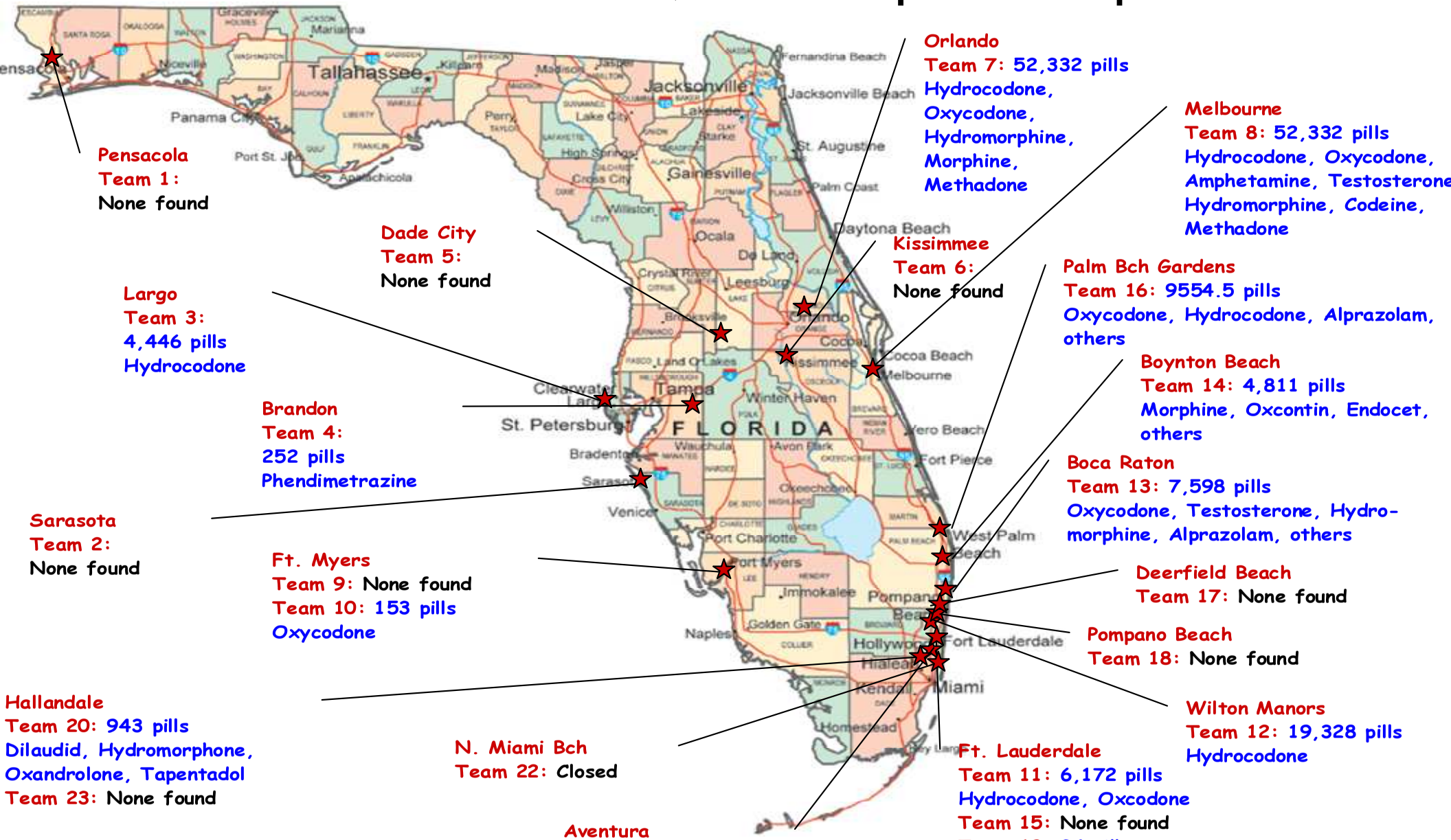
September 15, 2011

Region	Arrest	Pills	Vehicles	Weapons	Currency	Clinics Closed	Doctors Arrested
Pensacola	64	4,516	1	0	31,129	1	0
Tampa	51	5,619.5	1	9	34,919	0	0
Jacksonville	86	5,934.5	3	3	14,418	0	1
Orlando	435	76,606.5	3	17	1,275,906	4	9
Tampa	243	20,511	11	7	82,251	20	2
Ft. Myers	65	2,593	0	3	3,500	0	1
Miami	155	154,859.25	16	12	815,486	0	5
TOTAL	**1,099**	**270,639.75**	**35**	**51**	**2,257,609**	**25**	**18**

HB 7095 General Revenue Allocations & Federal Justice Assistance Grants

	Justice Assistance Grant Allocation	General Revenue Allocation	Total
Local Reserve Funds	0	500,000	500,000
Ft. Myers	91,668	254,316	345,984
Jacksonville	104,056	222,189	326,245
Miami	201,470	987,344	1,188,813
Orlando	135,026	330,290	465,316
Pensacola	64,640	125,128	189,768
Tallahassee	56,757	107,101	163,858
Tampa	174,442	473,633	648,074
Total	828,059	3,000,000	3,828,059

Controlled Substance Quarantine Operation Map



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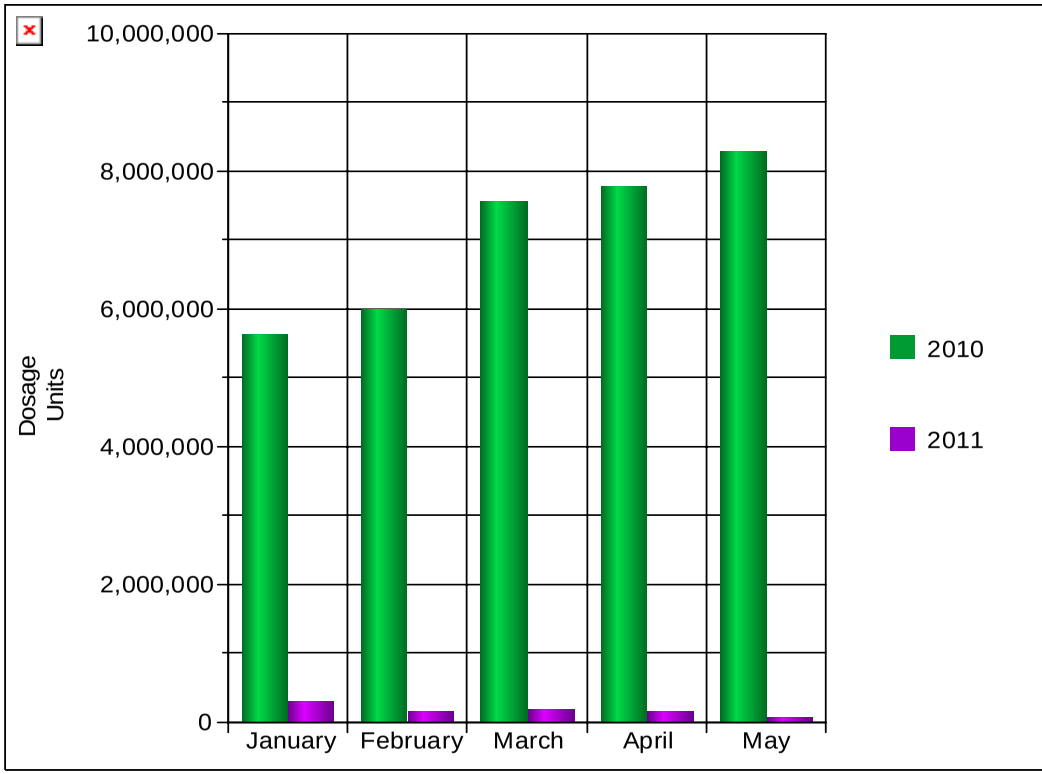
Public Health Emergency & Controlled Substance Quarantine Operation

- 105,579.5 Pills Found
  - 6,172 Transported to UPS by FDLE for Reverse Distributor
  - 99,407.5 Quarantined Off Site by FDLE

Florida Practitioners Trends~Monthly Purchases of Oxycodone

MDs, DOs, Podiatrists, & Dentists		
Month	2010	2011
Jan	5,629,672	307,670
Feb	5,994,694	177,780
March	7,568,606	197,674
April	7,787,033	163,350
May	8,283,396	78,800
	35,263,401	**925,274**



FLORIDA DEPARTMENT OF HEALTH

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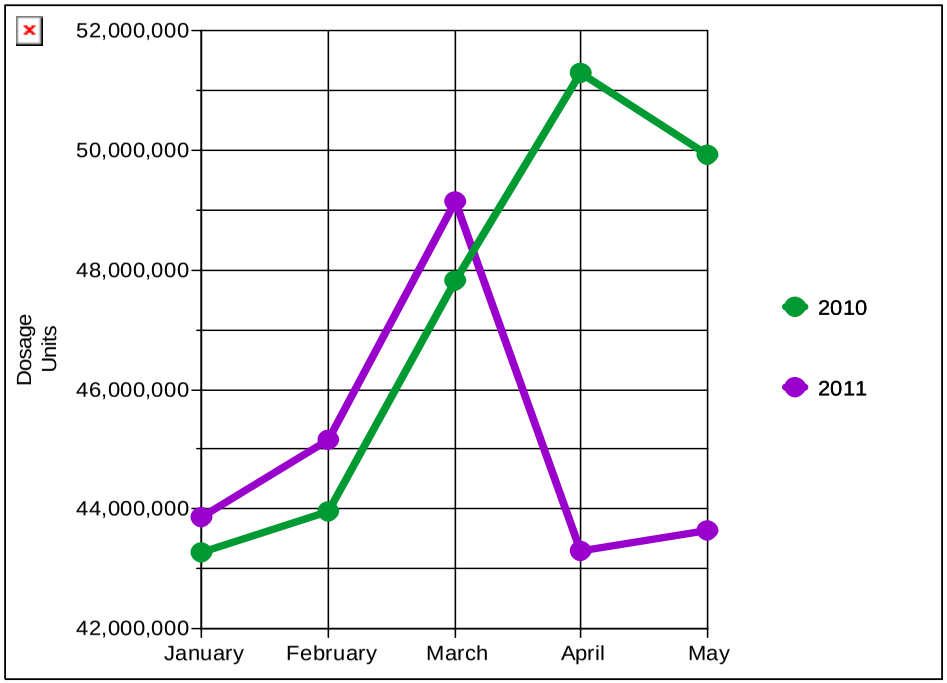
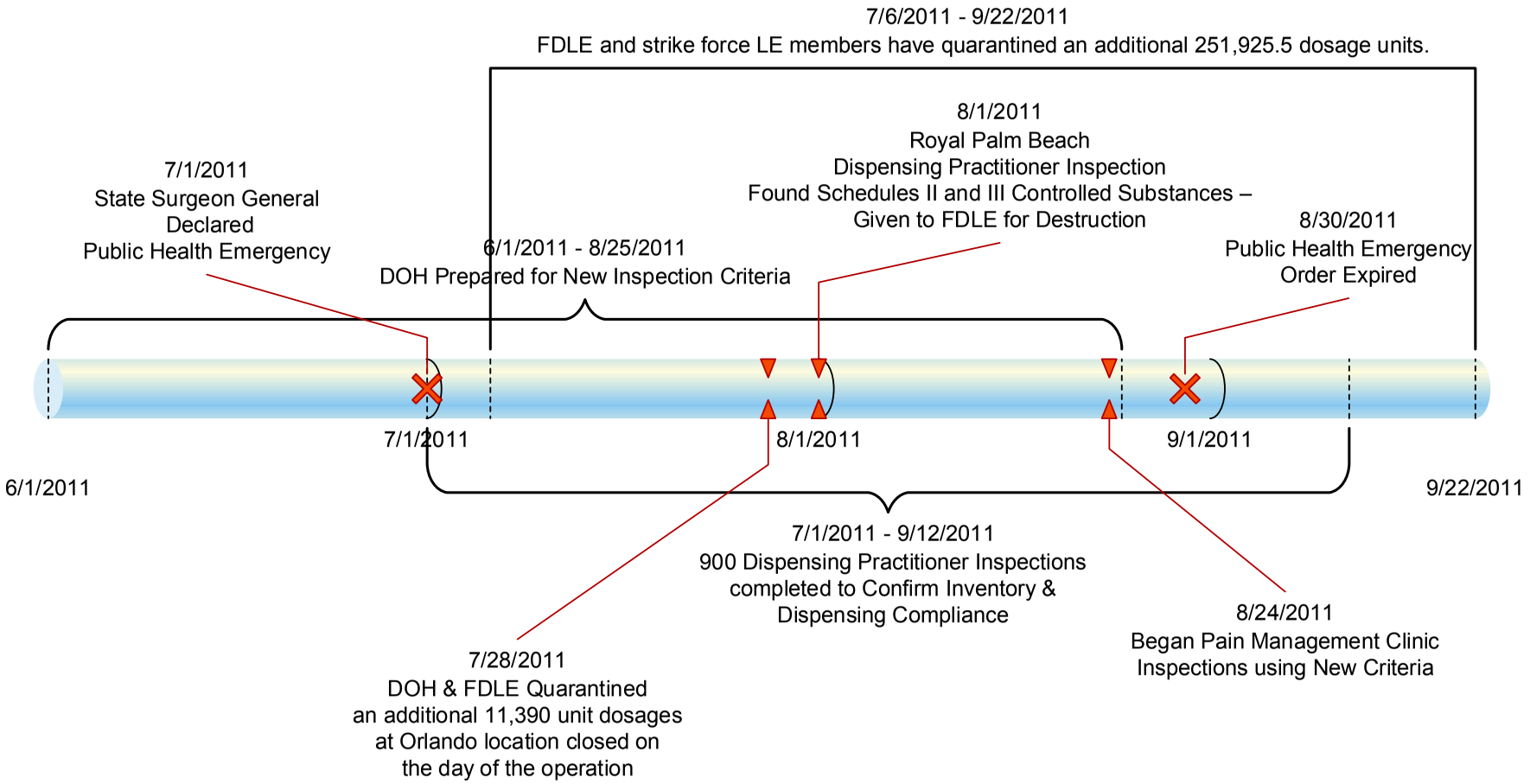
Florida Pharmacies
Trends~Monthly Purchases of Oxycodone

Month	2010	2011
Jan	43,290,530	43,865,092
Feb	43,967,400	45,160,780
March	47,823,130	49,145,100
April	51,290,320	43,304,430
May	49,926,600	43,650,850
	236,277,980	**225,126,252**

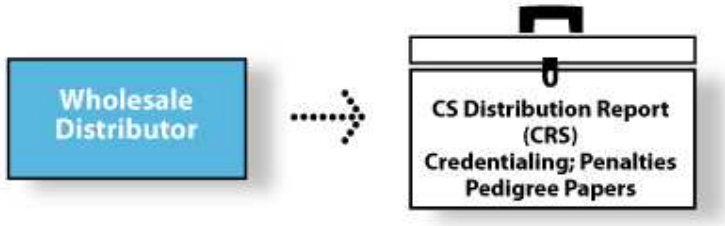


Post-Quarantine Timeline

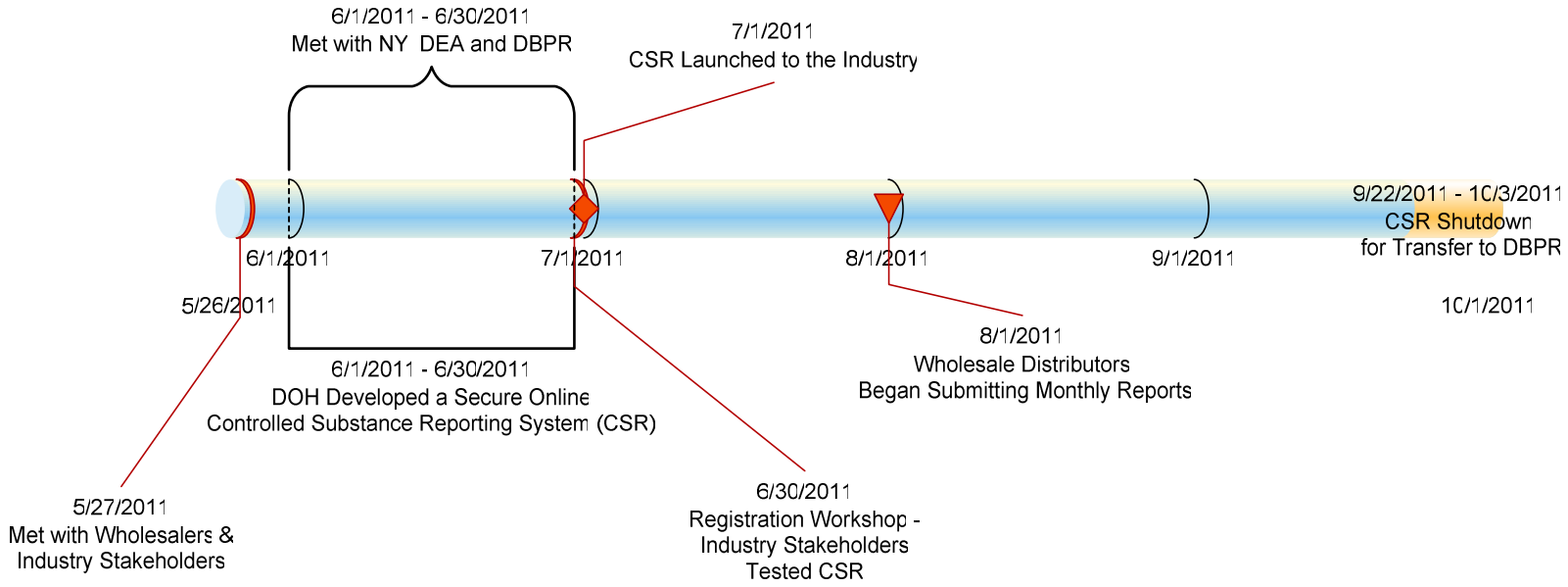


Wholesale Distributors

- Document credentialing policies and procedures with application
- Report receipts and distributions of Schedules II-V controlled substances
  - DEA number
  - National drug code
  - Quantity
  - Unit
  - Recipient DEA number
  - Transaction date
  - Strength



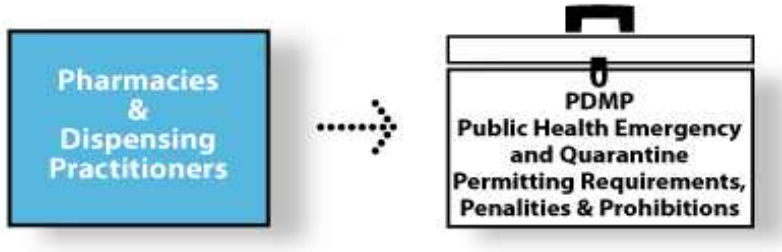
Wholesale Distributor Controlled Substance Reporting Timeline



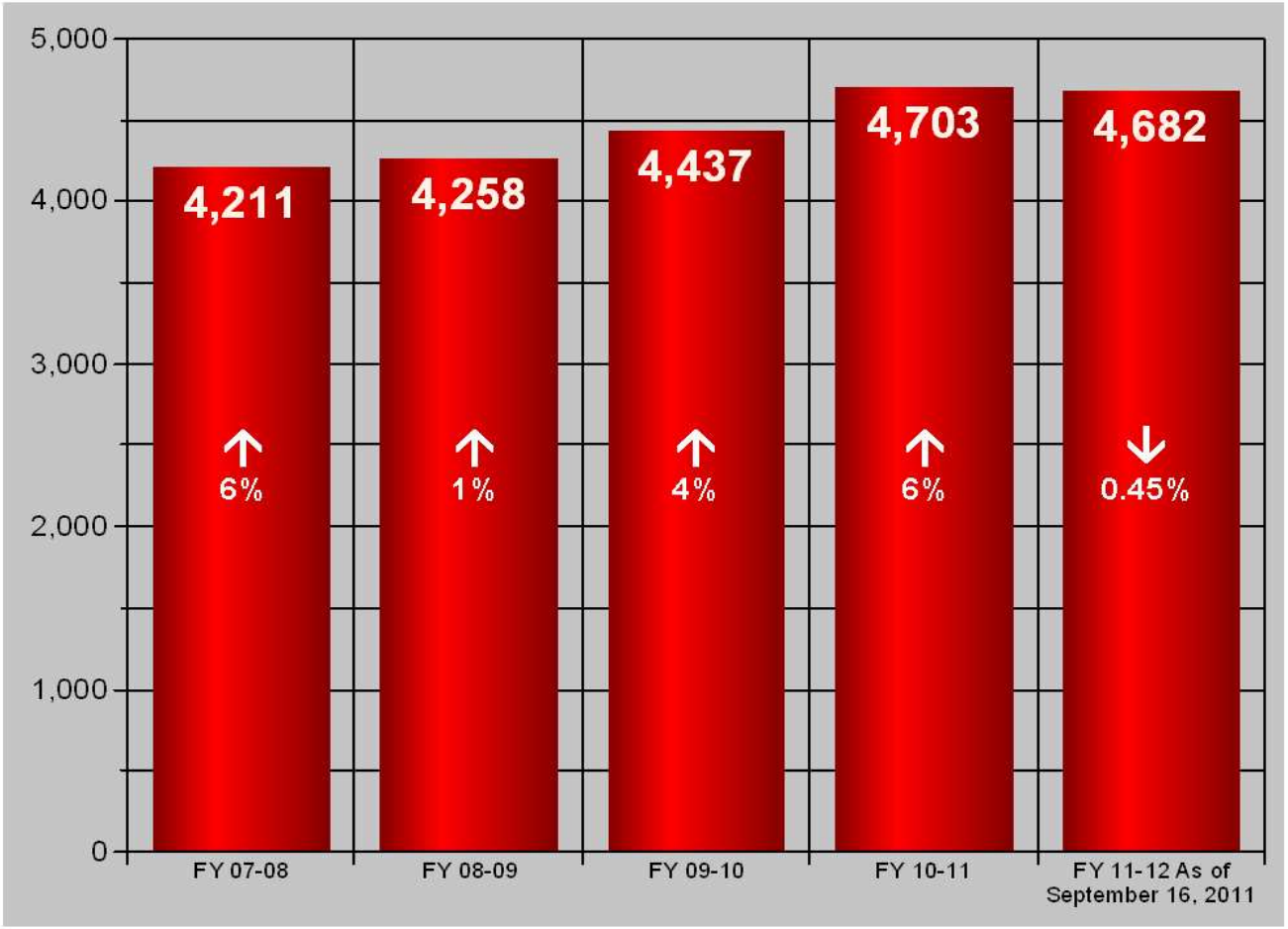
Community Pharmacies

As of July 1, 2012, community pharmacies must be permitted under new requirements to dispense controlled substances listed in Schedules II or III

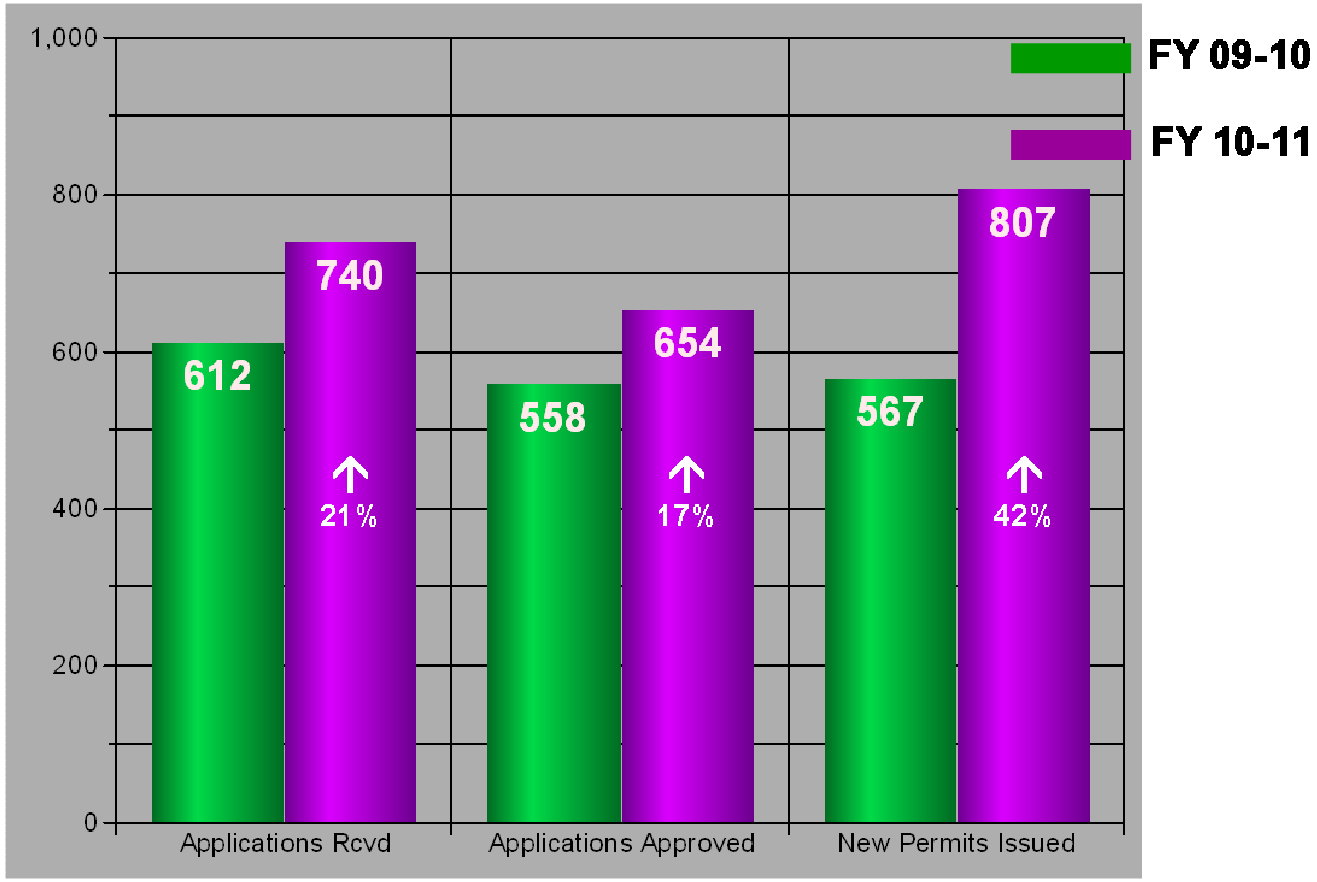
- Requires fingerprints and background screens
- Requires on-site inspection within 90 days
- Prohibits pharmacy permit transfer
- Grants authority to deny or revoke a permit for prescription processing errors
- Establishes additional grounds for denying a permit
- Requires pharmacists to report to law enforcement within 24 hours any attempt to obtain a controlled substance from a pharmacy by fraud.



of Community Pharmacies Permitted with DOH
% Increase and Decrease
July 1, 2008 – September 16, 2011



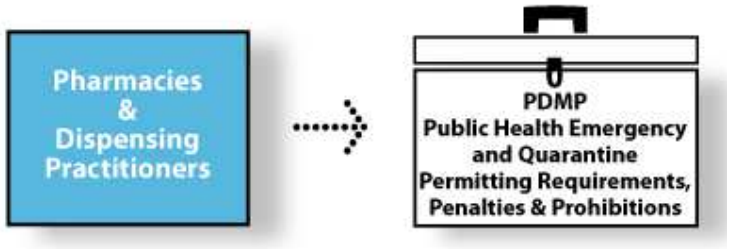
of Pharmacy Applications Received, # of Pharmacy Applications Approved & # of New Pharmacy Permits Issued July 1, 2009 – June 30, 2011 by Fiscal Year



Dispensing Practitioners

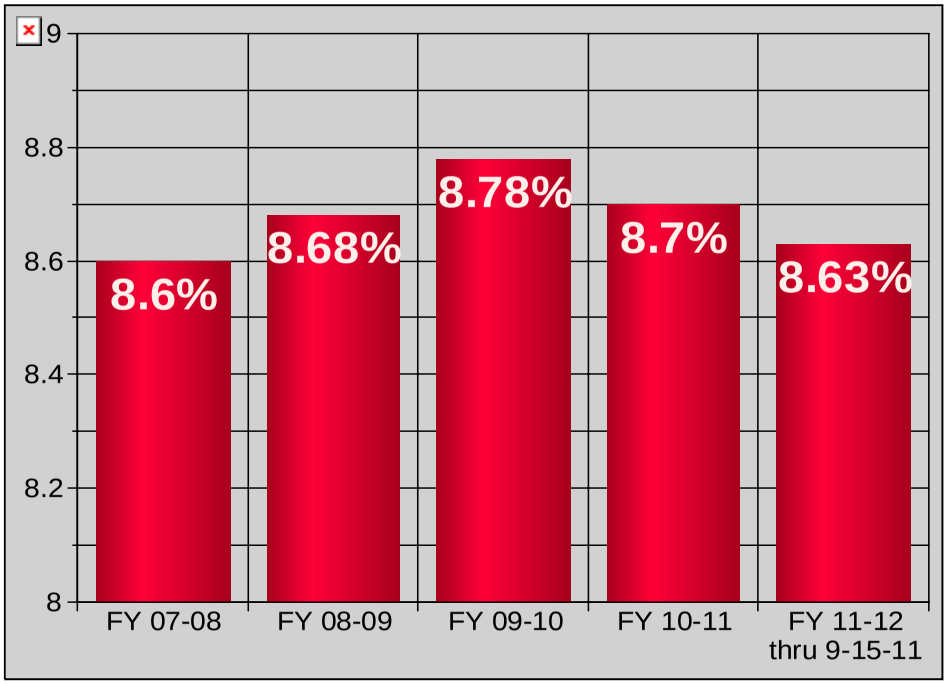
HB 7095 prohibits dispensing of Schedules II or III controlled substances by practitioners except:

- Complimentary packages of medicinal drugs
- Department of Corrections
- Surgical Procedures
- Clinical Trials
- Methadone Facilities
- Hospices

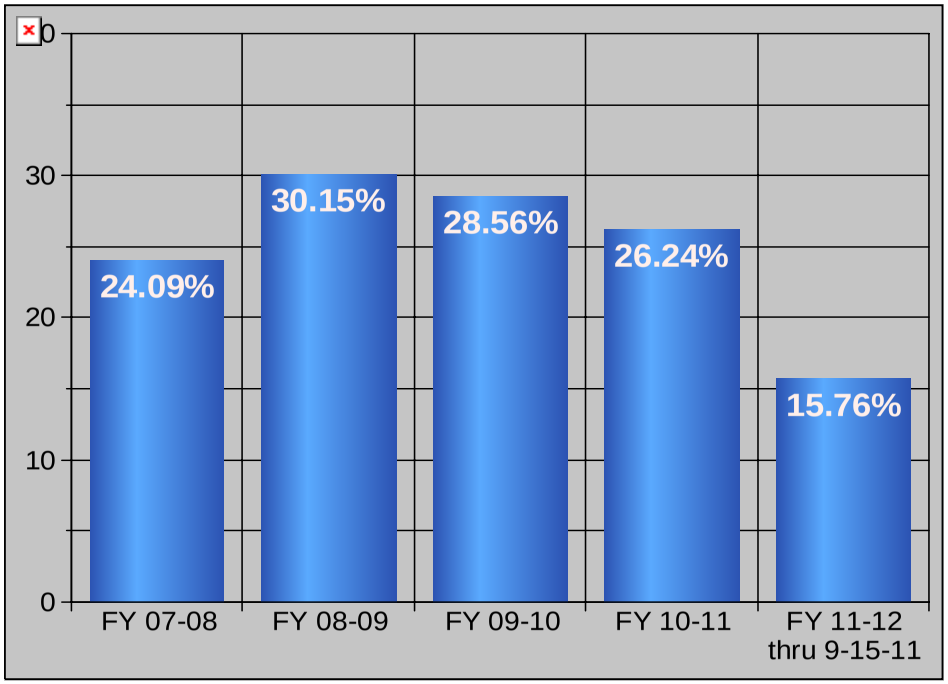


Dispensing Practitioner Trends

% of total licensed physicians that are dispensing practitioners by fiscal year



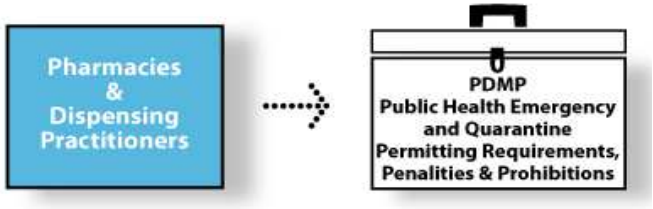
% of new physician applications requesting to be dispensing practitioner by fiscal year



FLORIDA DEPARTMENT OF HEALTH

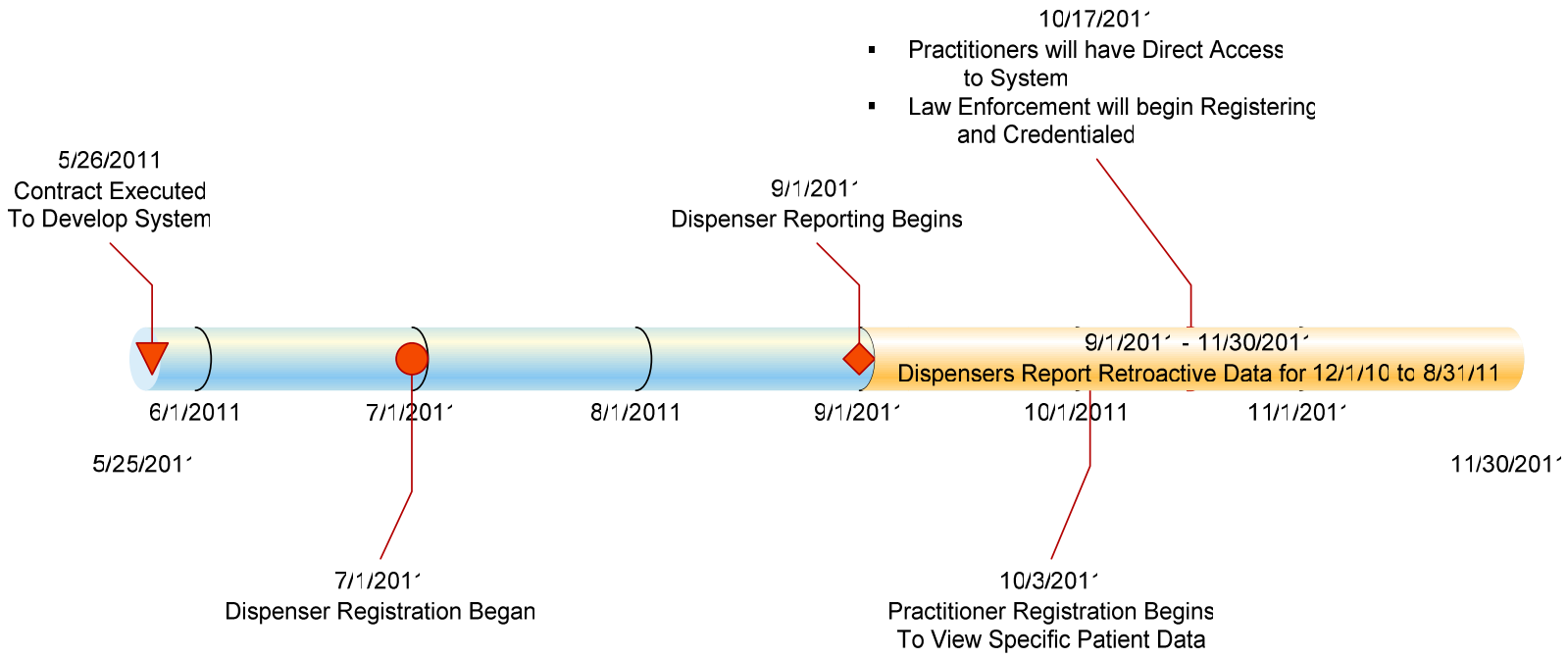
Division of Medical Quality Assurance MQA

Prescription Drug Monitoring Program



- Must report within 7 days
- Comply with state and federal privacy laws and regulations
- Required to report weekly
- Requests that dispensers report retroactive data by November 30, 2011, from December 1, 2010 to August 31, 2011.

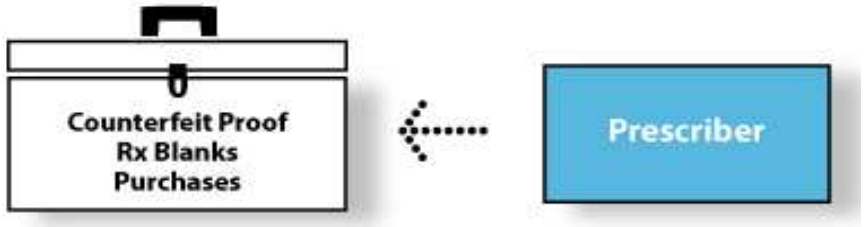
Prescription Drug Monitoring Program Timeline



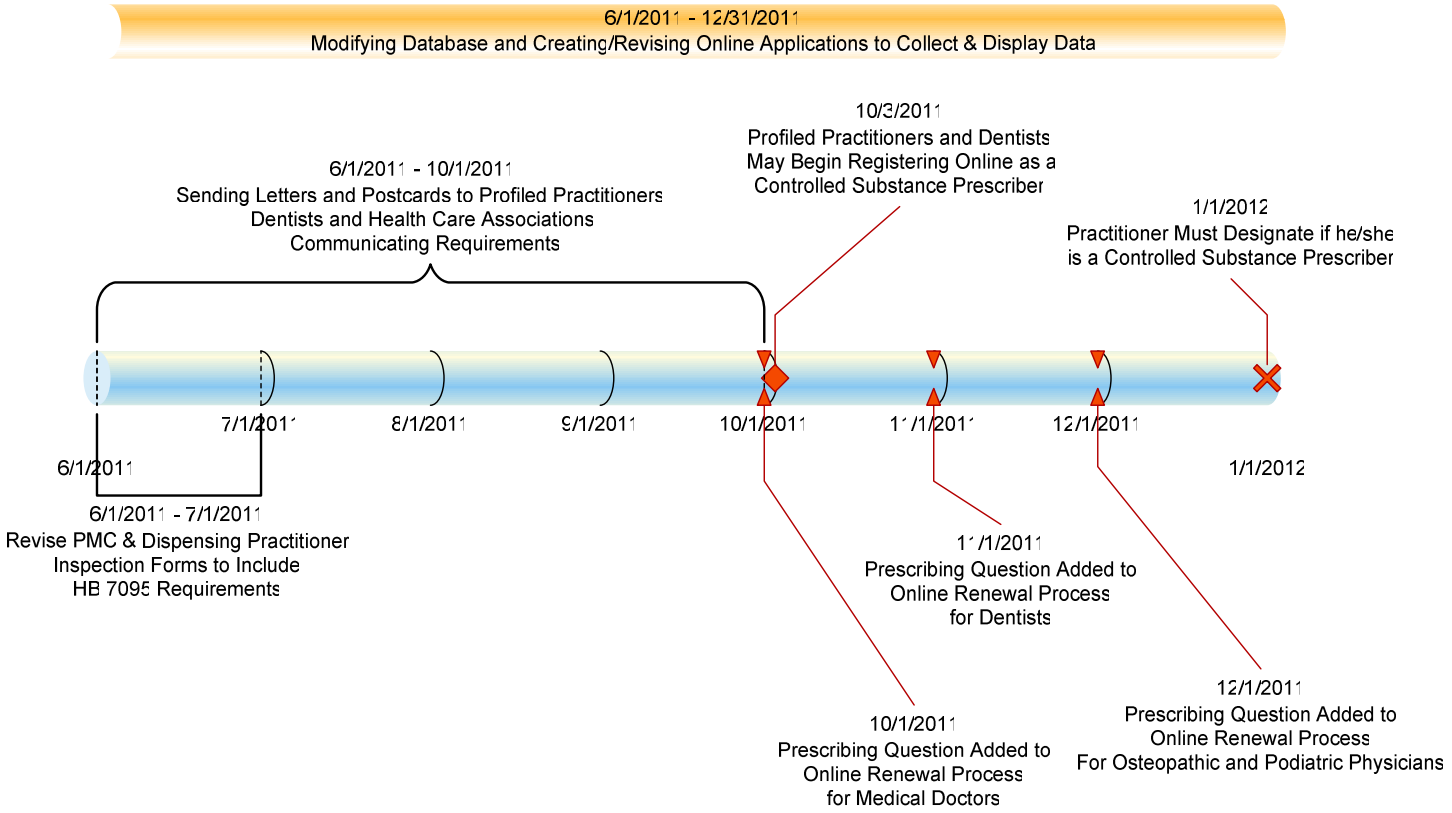
Controlled Substance Prescriber Registration

By January 1, 2012, practitioners who prescribe controlled substances for the treatment of chronic nonmalignant pain are required to:

- Register with the Department
- Comply with new standards of practice

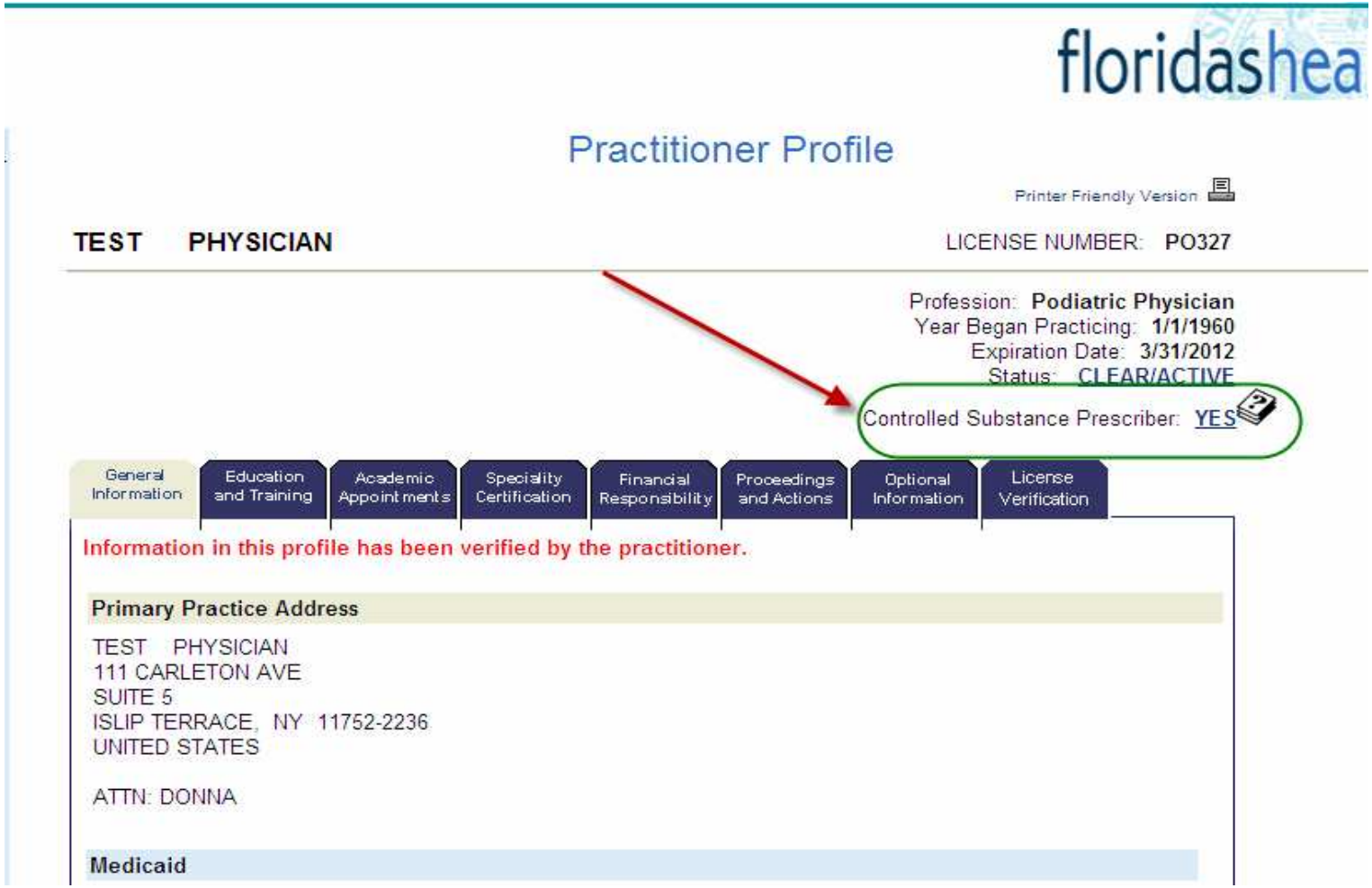


Controlled Substance Prescriber Registration Timeline



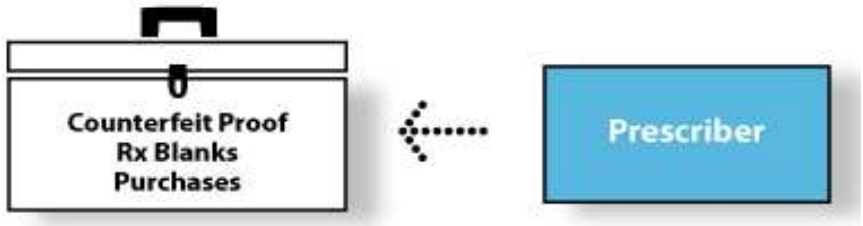
Controlled Substance Prescribers

Displayed on Practitioner Profile

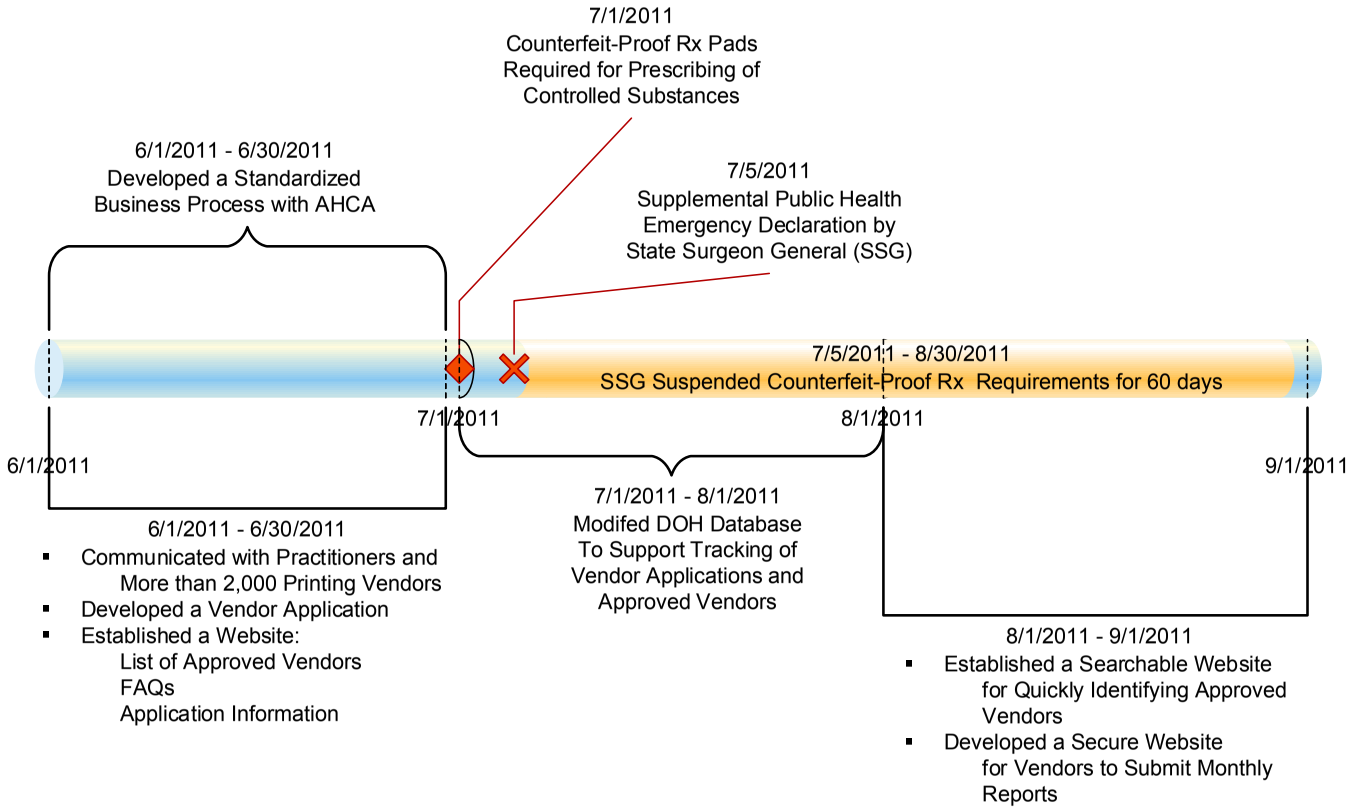


Counterfeit-Proof Prescription Pad Vendors & Reporting

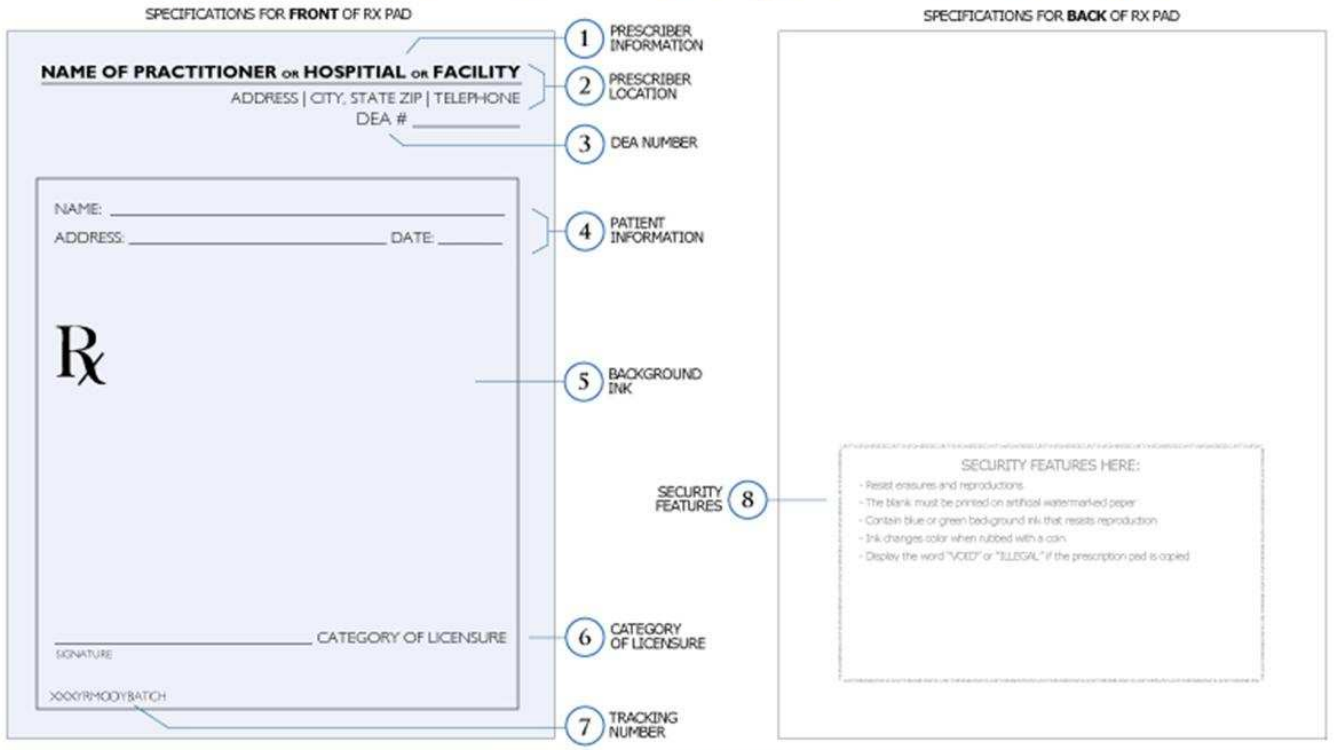
- A written prescription for controlled substances must have certain information, be on a counterfeit-proof prescription pad and be produced by an approved vendor or electronically prescribed
- The approved vendor must also submit monthly reports that include the number of pads printed and to whom it is provided



Counterfeit Proof Prescription Pads Timeline



Counterfeit-Proof Prescription Sample

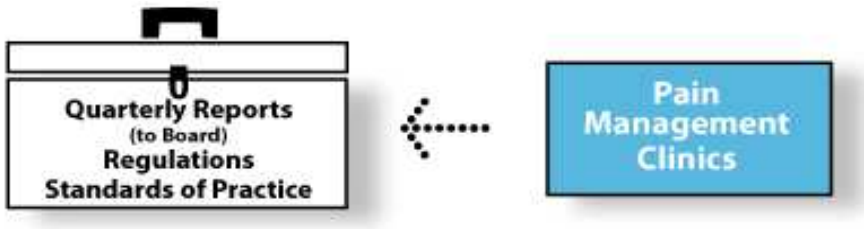


DETAILS OF EACH SPECIFICATION BELOW

1) The name of the healthcare practitioner or hospital or facility
2) Physical Address of the healthcare practitioner or hospital or facility
3) A space for the DEA number (this information can also be printed on the script)
4) A space for patient information and the date the prescriptions was written
5) Blue or Green background ink that resists reproduction
6) Category of Licensure for prescribing practitioner
   (may be abbreviated or spelled out e.g. MD or Medical Doctor)
7) The print vendor's unique tracking number must include three subsets:
   1. a unique alphabetic prefix that readily identifies the vendor
   2. the date of printing (YRMODY)
   3. a batch number assigned by the vendor
8) List of security features, which must be printed on the front or back of prescription pad (features listed on sample above are the minimum requirements

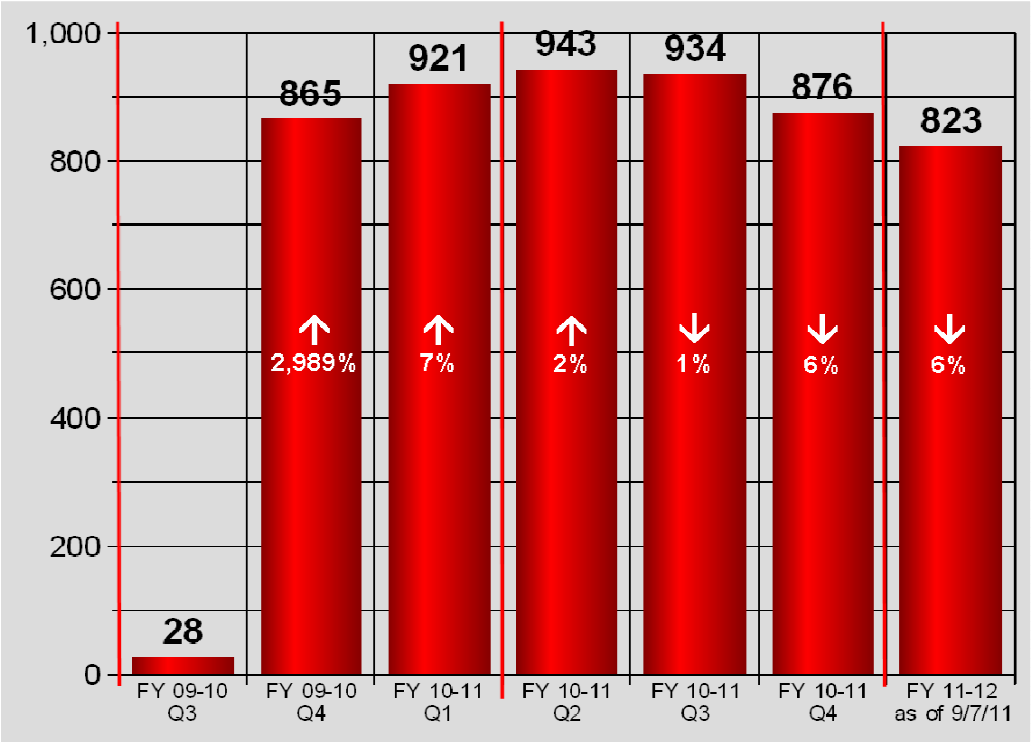
Pain Management Clinic Registration

- New requirements for practicing in and registration of pain management clinics
- Definitions
- Added exemptions from registration
- Designated physician responsible for compliance with quality assurance requirements, data collection and reporting

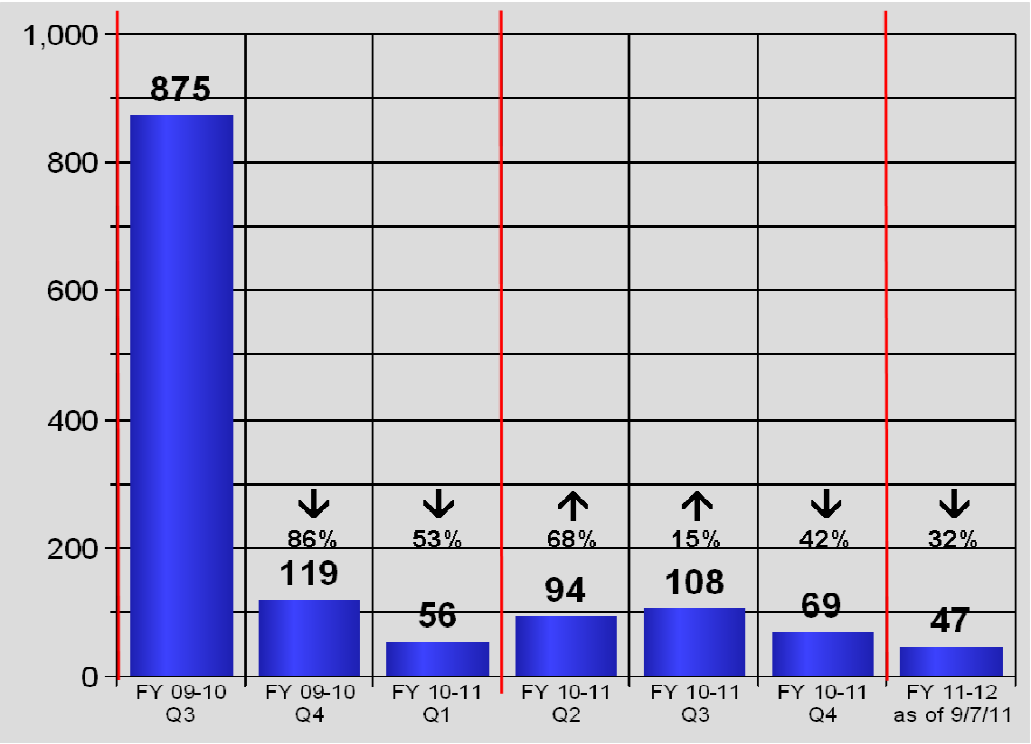


Pain Management Clinic Registrations
January 1, 2010 – September 7, 2011

Total # of Registered Pain Management Clinics by Fiscal Year
% ↑ or ↓



Total # of Approved Pain Management Clinic Applications by Fiscal Year
% ↑ or ↓



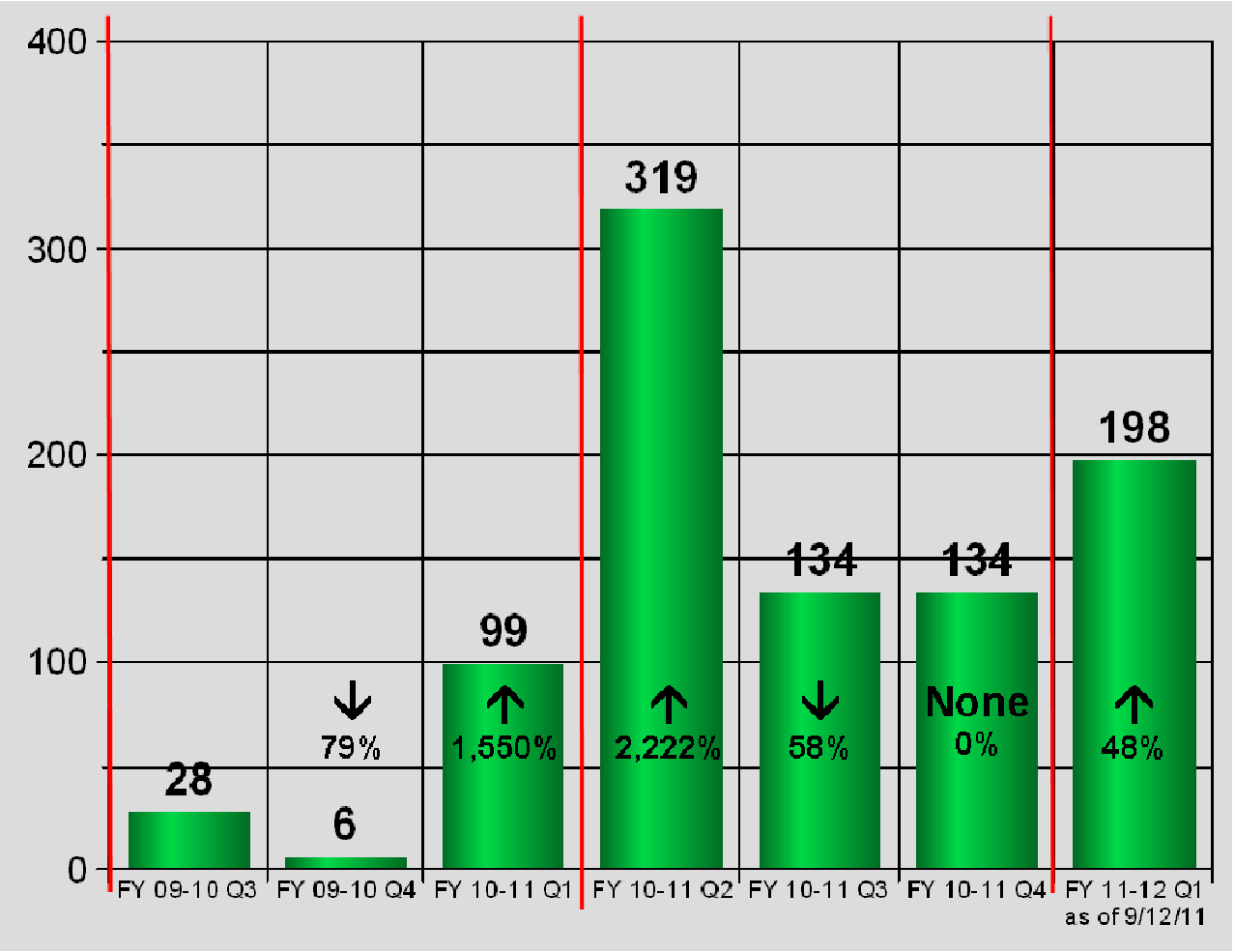
FLORIDA DEPARTMENT OF HEALTH

Division of Medical Quality Assurance
MQA

of Pain Management Clinic Closures by Quarter

% ↑ or ↓

January 1, 2010 – September 12, 2011



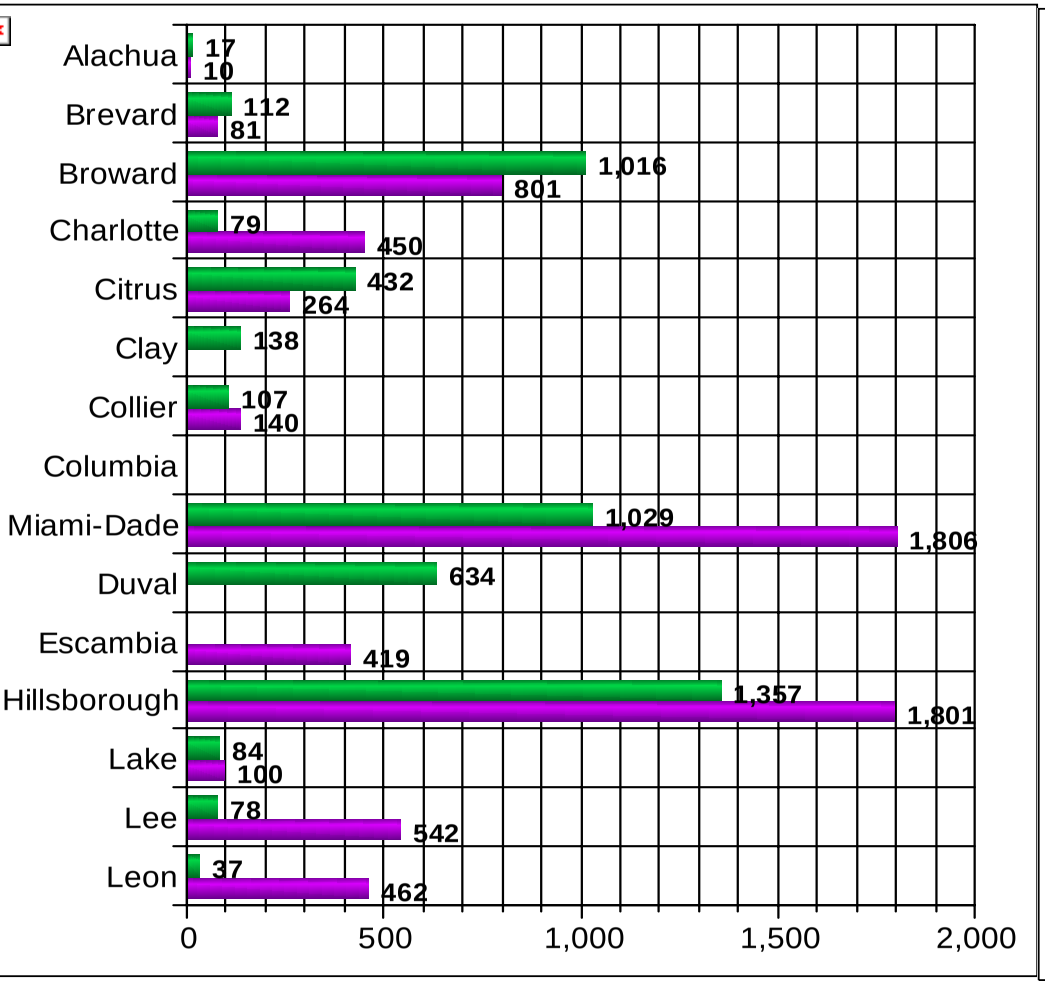
Pain Management Clinic Closures by Fiscal Year

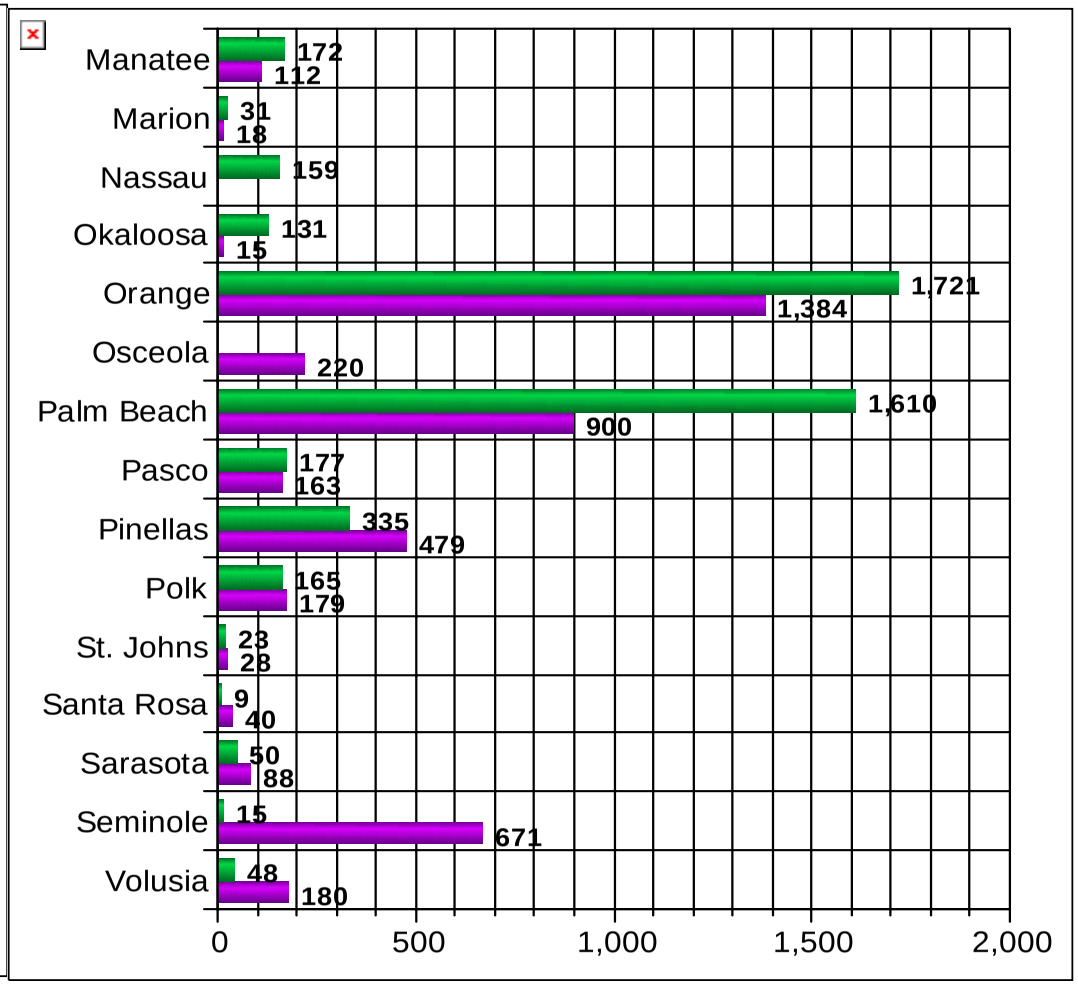
Reason for Closure	FY 09-10 Q3	FY 09-10 Q4	FY 10-11 Q1	FY 10-11 Q2	FY 10-11 Q3	FY 10-11 Q4	FY 11-12 to 9/12/11	Total
Voluntary Relinquishment	0	0	0	1	7	0	128	**134**
Disciplinary Relinquishment	0	0	0	1	0	4	4	**9**
Administratively Revoked	28	6	6	2	15	6	5	**68**
Closed	0	0	93	90	101	121	62	**467**
Intent to Administratively Revoke	0	0	0	225	11	3	1	**240**
Totals	28	6	99	319	134	134	198	**918**

Pain Management Clinic Quarterly Report

of New Patients by Quarter by County

January 1, 2011 – March 31, 2011 | April 1, 2011 – June 30, 2011

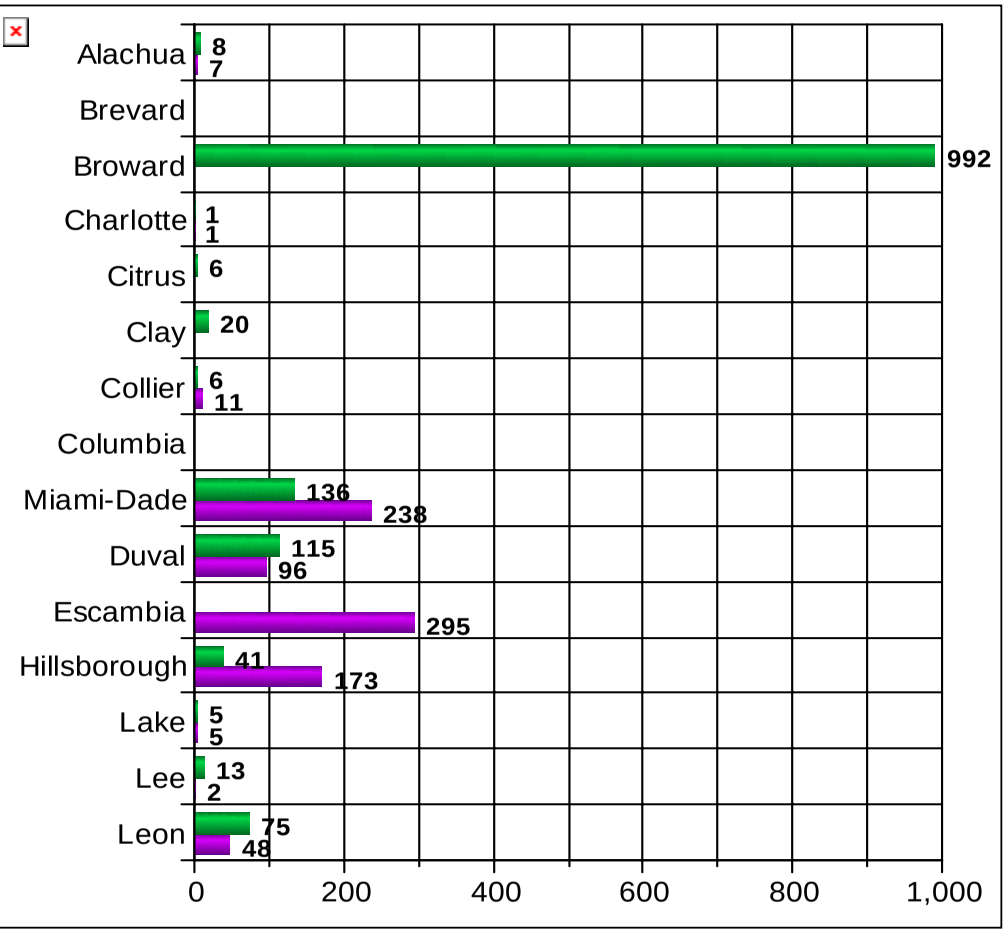


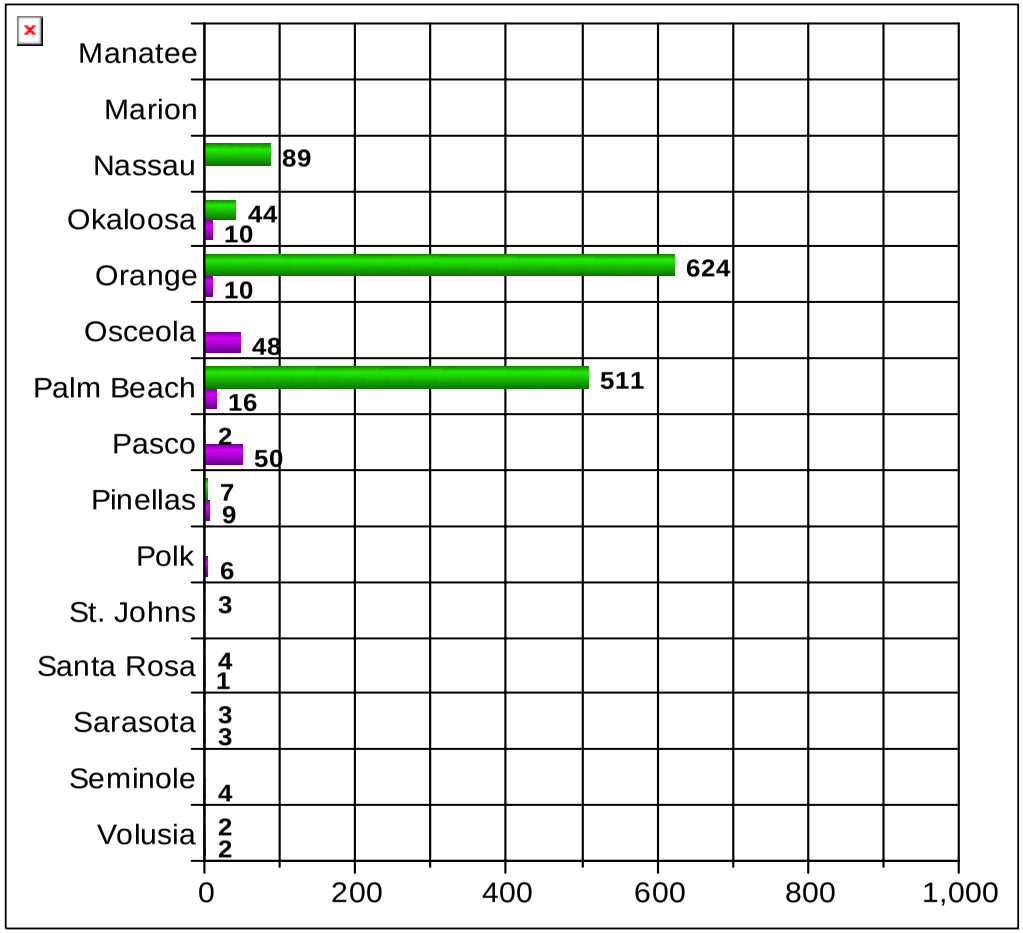


Pain Management Clinic Quarterly Report

of Out-of-State Patients by Quarter by County

January 1, 2011 – March 31, 2011 | April 1, 2011 – June 30, 2011





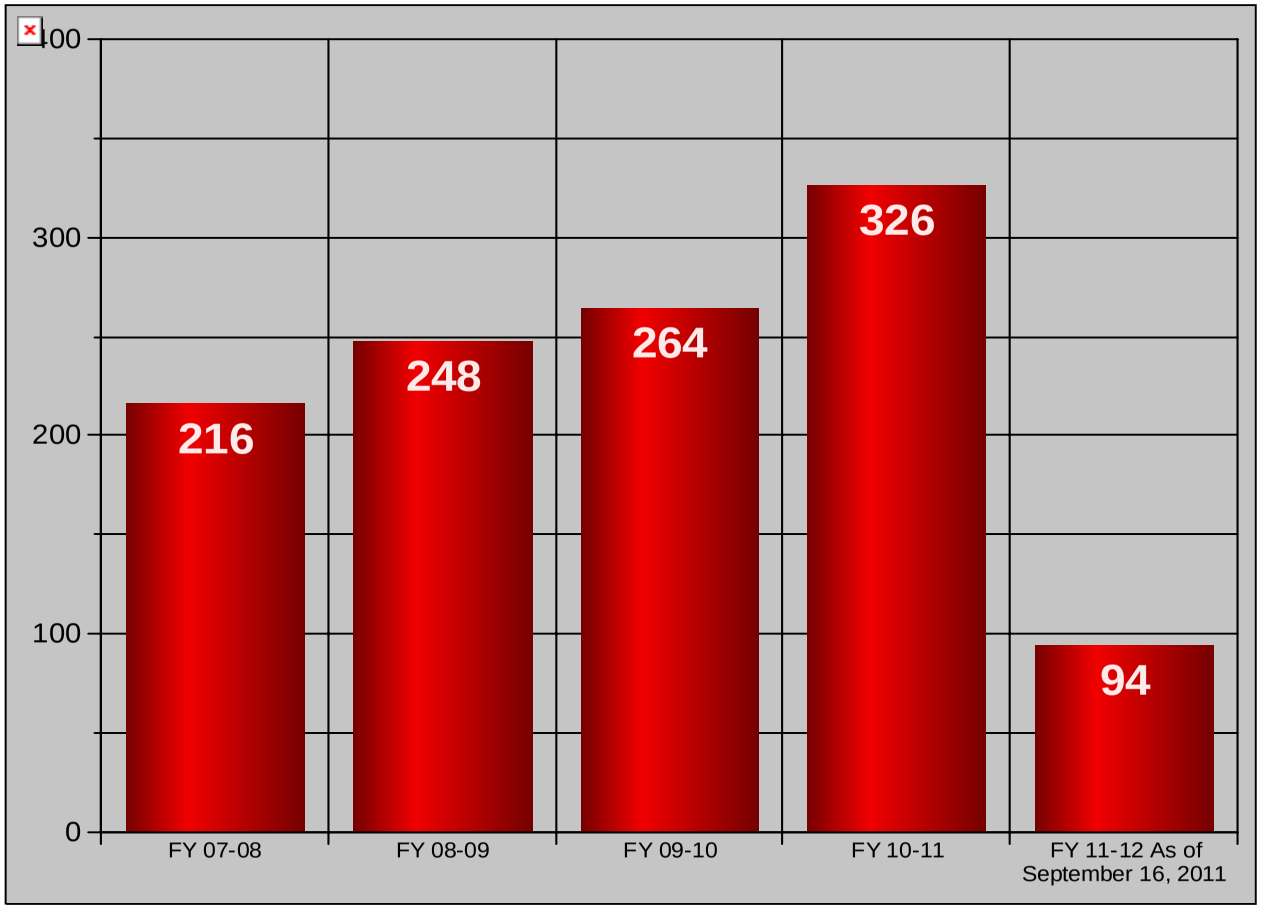
FLORIDA DEPARTMENT OF HEALTH

Division of Medical Quality Assurance MQA

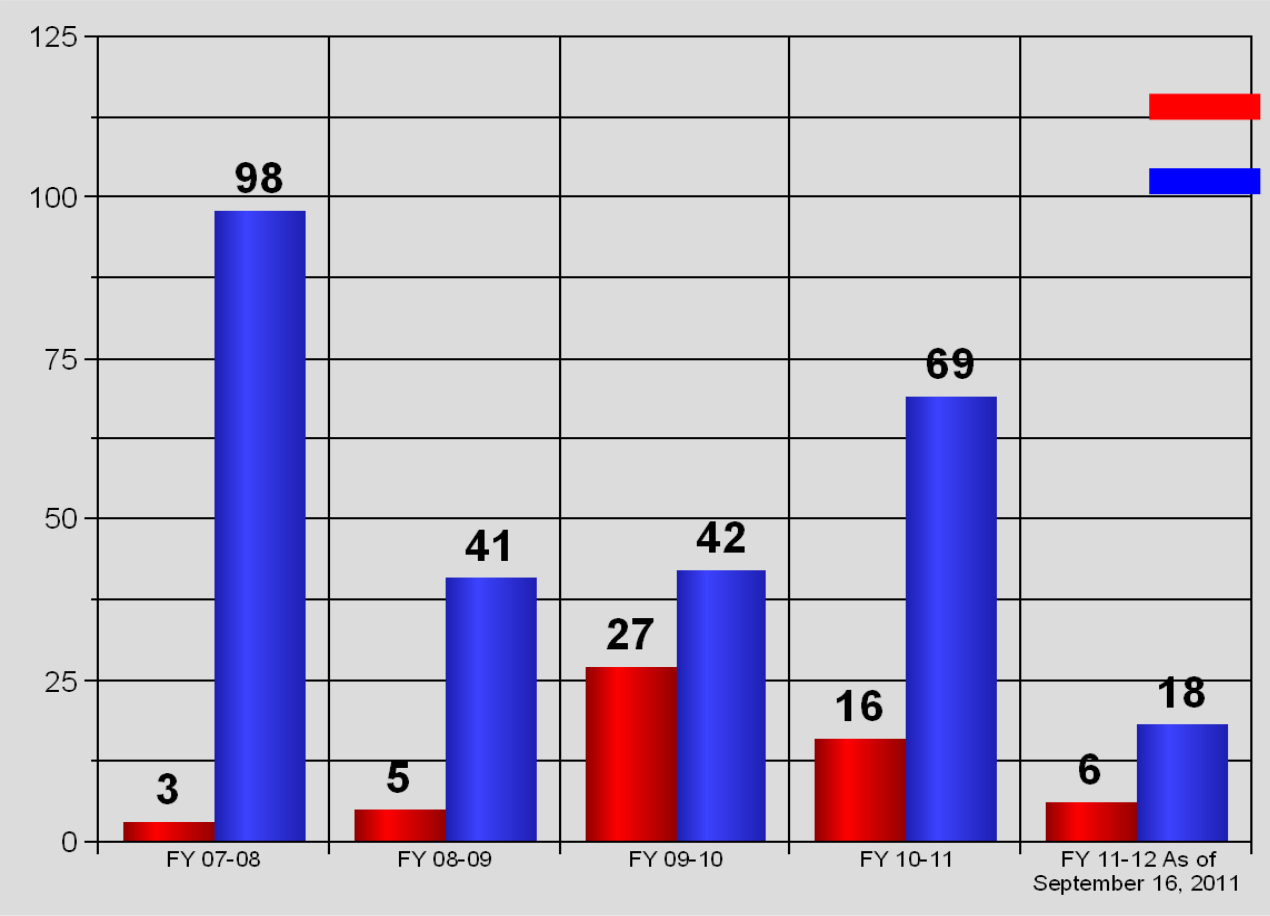
Emergency Action Improvement Target

Priority 1 Cases That Do Not Require Supplemental Investigation, Expert Witness, or Order to Compel Mental and Physical Examination		
Current	**Target**	**Time Savings**
115.9 days	**19 – 25 Days**	**91.9 – 97.9 days**

of All Emergency Actions by Fiscal Year



of Disciplinary & Emergency Actions Related to Over- and Inappropriate-Prescribing of Controlled Substances by Fiscal Year



Tool Box Report Card

Complaints with HB 7095 related allegations

- # of complaints received
- # of disciplinary actions
- # of emergency actions

Dispensing Practitioners

- # of new registrations issued
- # of new registration requests denied

Community Pharmacies

- # of new permits issued
- # of applications denied
- # of complaints received
- # of disciplinary actions
- # of emergency actions
- # of reports to law enforcement for theft or fraudulent prescriptions

Pain Management Clinics

- # of new registrations
- # of applications denied
- # closed
- # of complaints
- # of disciplinary actions
- # of emergency actions
- # of Inspections

Counterfeit-Proof Prescription Pads

- # of orders by purchaser

HB 7095 Related Websites

- DOH HB 7095 General Information: **www.floridashealth.com/mqa/HB7095.html**
  - Public Health Emergency Orders
  - Correspondence to Licensees
  - Frequently Asked Questions
- DOH Counterfeit-Proof Pad Vendors: **www.floridashealth.com/mqa/counterfeit-proof.html**
  - Vendor Reporting
  - Approved Vendor Search
  - Vendor Applications
  - Frequently Asked Questions
- Press Releases: **http://esetappsdoh.doh.state.fl.us/pressreleasesearch/search.aspx**
- Prescription Drug Monitoring Program (E-FORCSE): **www.eforcse.com**
- Controlled Substance Reporting System: **https://ww2.doh.state.fl.us/CSR/login.aspx**

Questions?

Lucy C. Gee, M.S., Director
Florida Department of Health
Division of Medical Quality Assurance
(850) 245-4224
Lucy_Gee@doh.state.fl.us

Update on Implementation
of CS/HB 7107 and CS/HB 7109

Justin Senior Bio

On September 12, 2011, Justin Senior became the Acting Deputy Secretary for Medicaid. Mr. Senior began working at the Agency for Health Care Administration in 2007 as the Chief Appellate Attorney in the General Counsel's Office. In October 2008, Mr. Senior became General Counsel for AHCA and served in that position until becoming Acting Deputy Secretary.

Mr. Senior grew up in Gainesville, Florida, and has a B.A. in history from McGill University and a Juris Doctor with honors from the University of Florida College of Law.

Mr. Senior began his professional career in 1996 in Ft. Lauderdale in the litigation department of Panza, Maurer, Maynard & Neel, P.A. After his stint at Panza Maurer, Mr. Senior worked in the Boca Raton office of Proskauer Rose, LLP. After that, Mr. Senior worked for more than seven years in his own law office in Gainesville, Florida, where his practice emphasized federal civil rights litigation, employment law, and appellate practice.

2011 House Bill 7107: Florida Statewide Medicaid Managed Care Program Status Update

Overview:

On May 6, 2011, the Florida Legislature passed House Bill (HB) 7107, relating to Medicaid Managed Care. The bill outlines a comprehensive expansion of managed care for most Medicaid recipients throughout Florida. This program is known as the Statewide Medicaid Managed Care (SMMC) program.

The SMMC program had two main components: (1) the Long-Term Care Managed Care program and (2) the Managed Medical Assistance program. HB 7107 directed the Agency for Health Care Administration (Agency) to apply for state plan amendments and federal waivers necessary to implement the program.

The Legislation contained timelines for implementation of the SMMC, including deadlines for public meetings, for submission of requests for federal authority, for release of invitations to negotiate to secure health plans, and for actual program implementation.

Deadlines:

Statutorily Mandated SMMC Deadlines		
	LTC Component	**MMA Component**
Public Meetings	Allow for 30 day comment period after meeting/ before submission of requests for federal authority	Allow for 30 day comment period after meeting/ before submission of requests for federal authority
Submission of Requests for Federal Authority	August 1, 2011	August 1, 2011
Release of Invitations to Negotiate	July 1, 2012	January 1, 2013
Program Implementation	July 1, 2012 - October 1, 2013	January 1, 2013 - October 1, 2014

Public Meetings:

The Agency held a public meeting in each of the 11 regions created by the legislation between June 10 and June 17, 2011.

The opportunity for public comment will continue throughout the implementation process. The Florida Medicaid program is open to feedback from any stakeholder, including recipients, providers, advocates and researchers. Based on feedback, Florida Medicaid has taken advantage of opportunities to adapt and improve and will continue to do so.

2011 House Bill 7107: Florida Statewide Medicaid Managed Care Program Status Update

Submission of Requests for Federal Authority

On August 1, 2011, the Agency submitted the required documents requesting various authorities to implement the program. An overview of those authorities follows:

Managed Medical Assistance Program	
Amendment Vehicle	**Subject**
1115 Medicaid Reform Demonstration Waiver	• Request for authority to mandatorily enroll the vast majority of individuals in managed care plans statewide. This includes children with chronic conditions, children in foster care and children who receive an adoptive subsidy, as well as Medicare/Medicaid dual eligible recipients. • Request for authority to allow health plans to develop customized benefit packages targeted to specific populations. • Request for authority to implement an Employer Sponsored Insurance program in which maximum payment will be the Medicaid authorized premium.
1115 Medicaid Reform Demonstration Waiver	Requests the authority to impose a $10 monthly premium on recipients enrolling in the SMMC program.
1115 Medicaid Reform Demonstration Waiver	Requests the authority to require a $100 copayment for non-emergency ER visits.
1115 MEDS AD Demonstration Waiver	• Premium option for Medically Needy population • Seeking 1115 authority to require a premium not to exceed share of cost after the first month of qualifying as a medically needy recipient and enrolling in a plan. The recipient would pay a portion of the monthly premium equal to the enrollee's share of the cost. • Continuous Enrollment –seeking 1115 authority to provide Medically Needy recipients with continuous enrollment for up to six months.
	• Seeking state plan authority relating to cost effective methods for employer-based group health plans • The Health Insurance Premium Payment Program (HIPP) program will enable Medicaid recipients to participate in employer-sponsored insurance. • The Medicaid MCO capitation payment that would have been paid for a Medicaid recipient will be used to pay the recipient's share of their employer-sponsored health insurance. • Medical services that are not covered by the recipient's employer-sponsored health insurance will be submitted to Medicaid by the Medicaid provider. Medicaid will pay the provider up to its allowable amounts. This is known as wrap-around services.

Long Term Managed Care Program	
Amendment Vehicle	**Subject**
New Waiver (1915 b/c combo)	The Agency is seeking a 1915(c) waiver from federal CMS for the authority to identify and allow qualified individuals to receive home and community based care services in lieu of nursing home care services. AHCA will also be seeking a 1915(b) wavier for the authority to enroll individuals in managed care plans statewide, and to allow for selective contracting of those plans.

2011 House Bill 7107: Florida Statewide Medicaid Managed Care Program
Status Update

Timeline for Requests for Federal Authority to Implement the SMMC program

1915(b)/(c) and state plan amendment have three 90 day periods:

- The Agency submitted its 1915(b)/(c) waiver application and state plan amendment on August 1, 2011. Starting on that date, CMS has 90 days to review these materials and approve, deny or request clarification
- Upon receiving CMS' response, the Agency has 90 days to respond.
- Once CMS receives the Agency's completed responses, they have 90 days to make a final decision.
- CMS must approve sate plan amendments that comply with federal Medicaid law.

1115 waivers have no time periods to which either CMS or the Agency must comply.

2011 HB 7109: Report on Realignment of Administrative Resources of the Medicaid program to Respond to Changes in Functional Responsibilities and Priorities Necessary for Implementation of the Statewide Medicaid Managed Care program

During the 2011 legislative session, the Florida Legislature passed Committee Substitute for House Bill 7107 (CS/HB 7107) directing the Agency for Health Care Administration (Agency) to implement the Medicaid managed care program as a statewide, integrated managed care program for all covered medical assistance services and long-term care services. This program is hereafter referred to as the Statewide Medicaid Managed Care (SMMC) program.

Committee Substitute for House Bill 7109 (CS/HB 7109) was also passed by the Florida Legislature during the 2011 session. The bill contained conforming sunset provisions, outlined several programs ancillary to the SMMC program, established interim programs designed to sunset with full SMMC program implementation, and required the Agency to develop a reorganization plan in concert with the program's transition to the SMMC program. Both bills were signed into law by Governor Scott on June 2, 2011.

HB 7109 required the Agency to develop a reorganization plan, due to the Governor, Speaker of the House of Representatives, and the President of the Senate by August 1, 2011, for "realignment of administrative resources of the Medicaid program to respond to changes in functional responsibilities and priorities necessary for implementation of HB 7107." The plan is required to "assess the Agency's current capabilities, identify shifts in staffing and other resources necessary to strengthen procurement and contract monitoring functions, and establish an implementation timeline."

On August 1, 2011, the Agency submitted the required report, which contained an initial assessment of the likely administrative changes and the anticipated resulting realignment of administrative resources for the Agency and the Medicaid program in terms of roles and responsibilities that will be necessary for the transition to and full implementation of the SMMC program in October of 2014.

The initial assessment contained in the August 1, 2011, report is intended to provide a framework for the Agency to continuously evaluate its functional capabilities as they relate to the administration of the Medicaid program during the transition to and implementation of the SMMC program.

The phased nature of the managed care program implementation is a key component in determining the staff roles and responsibilities and the Medicaid administrative structure over the next four years as the Agency is required to simultaneously maintain operations of current programs, establish interim (bridge) programs, and prepare for the implementation of the SMMC program.

The report did not attempt to identify specific staffing levels in the future, but instead to provide an analysis of the potential shifts in staff roles and functional responsibilities, to identify likely changes in administrative focus, and to provide a discussion of current or potential gaps in necessary skill sets.

2011 HB 7109: Report on Realignment of Administrative Resources of the Medicaid program to Respond to Changes in Functional Responsibilities and Priorities Necessary for Implementation of the Statewide Medicaid Managed Care program

The analysis in the August 1, 2011, report is based on a baseline assessment of current staffing (as of June 2011), including a review of key tasks performed by all Medicaid related staff.

Those tasks were collapsed into seven broad functional categories with an indication of the percent of resources associated with those core functions along with an assessment of the allocation of those resources to FFS versus managed care programs. These seven functional areas include:

- Policy
- Recipient Assistance
- Provider Assistance
- File/System Maintenance
- Program Monitoring
- Contracting
- Administration

Based on the baseline assessment, the Agency evaluated current workload and functions related to the current managed care and FFS programs. It is notable that the work distribution is very similar between current managed care and FFS programs for the following activities:

- Administration
- Policy
- Recipient Assistance
- Provider Assistance
- File/System Maintenance

Consistent with a survey of other states' Medicaid managed care programs, the major shift in transitioning to managed care is anticipated to be related to the following:

- Increase in contracting
- Decrease in program monitoring of FFS providers
- Increase in data analysis
- Increase in outreach, education and training materials

Additional review was conducted for the sunset provisions included in HB 7107 and HB 7109, to determine the impact of those provisions on staffing levels.

Resource needs associated with maintenance of unaffected programs, bridge programs created within HB 7107 and HB 7109, and with the development and implementation of the SMMC were then considered.

As a result of the full implementation of the SMMCP program in 2014, enrollment in the Florida Medicaid program is likely to shift from its current level of 47 percent enrolled in managed care to nearly 85 percent enrolled in managed care. During the implementation period, now through full program implementation in October 2014, the Agency will generally seek to implement the Long-term Care Managed Care program and the Managed Medical Assistance program in the following three phases: pre-implementation, transition, and post implementation.

2011 HB 7109: Report on Realignment of Administrative Resources of the Medicaid program to Respond to Changes in Functional Responsibilities and Priorities Necessary for Implementation of the Statewide Medicaid Managed Care program

Since this initiative spans multiple years, the Agency is making the following initial recommendations:

1. Increase Agency staffing and contract resources during the pre-implementation and transition periods to evaluate current and new functions and processes to implement and monitor contracted plans. Specific resources will be needed for data analysis, auditing, and enhanced quality focus.

2. Develop an internal evaluation process to update the staffing analysis, as Medicaid moves through pre-implementation and transition to the SMMC program.

    a. Years 1, 2, and 3: Focus on reallocation of roles and responsibilities to manage "bridge" needs as well as maintaining current programs and preparing for implementation of the SMMC program, as program components are transitioned. Analysis will include the need to reclassify and/or request new positions to ensure the Agency has the right skill sets. Anticipated resources and skill needs include contract compliance, data analysis and fraud and abuse prevention and detection.

    b. Year 4: Focus on transition of staff from programs scheduled to sunset to procurement and contract monitoring functions.

3. Make annual recommendations to the Governor, Speaker of the House of Representatives and President of the Senate utilizing current legislative proposal and budget request processes. Specifically, the Agency anticipates annually evaluating and seeking appropriate authority based on the following:

    a. Staffing requests necessary to procure, implement and monitor interim activities, maintain necessary activities, and implement necessary changes for transition to the SMMC program.

    b. Need for contract resources for implementation.

    c. External changes that impact Medicaid enrollment and transition activities.

    d. Policy and budget changes necessary for program transition.

2010 SB 1484: Extension of the 1115 Reform Demonstration Waiver

Overview:

The 2005 Florida Legislature directed the Agency for Health Care Administration (Agency), through Section 409.91211, Florida Statutes, to implement a Medicaid Managed Care Pilot Program. This statute directs the Agency to implement the pilot program in five Florida counties: Baker, Broward, Clay, Duval, and Nassau.

Pursuant to this statute, the Agency requested an 1115 Demonstration Waiver to implement the program. The federal government approved the request for a five year period from July 1, 2006 through June 30, 2011. Under an 1115 waiver, states have the option to request a 3 year extension after the initial 5 year approval period.

On April 30, 2010 the Florida Legislature passed Senate Bill 1484. Within this bill, the Florida Legislature directed the Agency to seek approval of a 3 year waiver extension to continue operation of the pilot program in Baker, Broward, Clay, Duval and Nassau Counties. The Legislature directed the Agency to submit the extension request by no later than July 1, 2010.

Request for Extension:

The Agency submitted a request to extend the pilot program to the federal Centers for Medicare and Medicaid Services (CMS) on June 30, 2010, as well as several follow up extension requests. The Agency currently has authority to continue the pilot program through September 30, 2011.

On August 17, 2010, CMS advised the Agency that they would review and process the State's request to renew the Reform Demonstration under section 1115(a) authority, rather than under section 1115(e) authority as originally requested by the State. By this decision, CMS notified the state that they will request changes/ amendments to the terms and conditions of the waiver. In addition, while there are timelines for CMS to respond to a state waiver requested under the 1115(e) authority, no timelines exist for CMS to respond under section 1115(a). Since that time, the Agency has been involved in ongoing discussion, provision of information and negotiation with CMS with regard to the waiver extension.

Key outstanding issues include:

- Whether or not CMS will require a medical loss ratio for participating managed care plans; and
- Changes to the requirements of the State's Low Income Pool (LIP) program.

Of particular concern is that CMS indicated that the federal Office of Management and Budget is evaluating an early sunset date for Florida's Low Income Pool program. CMS noted that they and OMB are considering a sunset date of December 31, 2013. The changes in the effective date would provide a partial year funding for LIP of $500 million during the last year of the renewal period instead of the $1 billion annual allotment currently authorized.

Additional details regarding the waiver extension and the Agency's interaction with CMS are available on the Agency's website: http://ahca.myflorida.com/Medicaid/index.shtml#reform

Presentation on Achieved
Savings Rebate & MLR

Accountability for Medicaid Managed Care

Medical Loss Ratio and Achieved Savings Rebate

September 21, 2011

Measuring Plan Performance

Goals	Measures

• Access	• Network adequacy
	  ◦ Number/distribution of providers; 409.967(2)(c), F.S.
	• Utilization patterns/rates
	  ◦ Service specific use rates; 409.967(2)(d)2, F.S.

• Quality	• Patient satisfaction
	  ◦ Surveys and other feedback; 409.967(2)(e)1,F.S.
	• HEDIS/other benchmarks
	  ◦ Disease/condition/age specific services; 409.967(2)(e)2.F.S.
	• Outcomes
	  ◦ Examples: preventable hospitalizations; re-admissions; emergency department use

• Cost	• Expenditures
	  ◦ Total and by type of spending; 409.967(3), F.S.
	• Spending rates/ratios
	  ◦ Amount per enrollee
	  ◦ Amount compared to target

Medical Loss Ratio (MLR)

- MLR compares two numbers:
  - Medical spending

    Divided by

  - Premium revenue

- MLR is expressed as a percent (%)

- MLR benchmarks depend on what counts
  - Paid or Incurred claims?
  - What is medical care and what is administration?
  - Deductions, caps, exclusions and other regulations?

Medical Loss Ratio (MLR)

- MLRs are used by state insurance regulators:
  - To monitor insurers' financial positions
    - High ratios may indicate problems covering liabilities
  - To assess requests for premium rate increases
    - High ratios may justify higher premiums

- MLR regulations are not standardized across states
  - Different reporting procedures
  - Various benchmarks

Limitations of MLR

- MLRs do not measure quality
- MLRs do not cap administrative spending;
  - Higher administrative spending is permitted with higher medical spending
  - High ratios can be reached by more medical spending or by lower premiums
- Some expenses are both medical care and administration
  - Disease management/ case management
  - Health information systems
- Multiple factors drive administrative expenses
  - Organizational structure (staff model HMO)
  - Care management functions (internal or contracted)

Achieved Savings Rebate (ASR)

Requirements of HB 7107

- Annual financial reports; 409.967(3), F.S.
- Financial data available for inspection; 409.967(3)(d), F.S.
- Annual independent audit; 409.967(3)(b) and (c), F.S.
- Income calculated after determination of "allowable" costs (medical and other expenses); 409.967(3)(h), F.S.
  - Certain expenses excluded (reserves, incentive payments, bonuses, lobbying)
  - Certain expenses capped (bad debt, reinsurance, interest payments, depreciation)
- Rebates to state if income exceeds specific thresholds; 409.967(3)(f),F.S.
  - Profit capped at 7.5% of premium unless quality exceeds benchmarks (then 8.5%)

Achieved Savings Rebate (ASR)

Income	Rebate
Up to 5% of revenue	None
> 5% ≤ 10% of revenue	50% of income
> 10% of revenue	100% of income

Comparison of MLR and ASR

	PPACA	ASR
Total Countable Revenue	1,000	1,000
Claims based expenses	850	850
Expenses to improve quality	10	10
Subtotal of Medical Expenses	860	860
Administrative Expenses	130	130
Total Expenses	990	990
Income	10	10
Raw MLR	86.0%	86.0%
Risk Adjustment (to Revenue)	0	
Risk Corridor Adjustment (to Revenue)	0	
Public Reinsurance Benefit		
Adjusted Revenue	1,000	
Net Income	10	
Adjusted MLR	86.0%	
Rebate	0	0
Net Income After Rebate	10	10
Excluded Expenses		0
Net Income After All Expenses	10	10

Use And Abuse Of The Medical Loss Ratio To Measure Health Plan Performance

This accounting tool was never intended to measure quality or efficiency.

BY JAMES C. ROBINSON

ABSTRACT: This paper examines the use and abuse of the medical loss ratio in the contemporary health care system and health policy debate. It begins with a survey of the ways in which the medical loss ratio has been interpreted to be something it is not, such as a measure of quality or efficiency. It then analyzes key organizational features of the emerging health care system that complicate measures of financial performance, including integration between payers and providers, diversification of payers across multiple products and distribution channels, and geographic expansion across metropolitan and state lines. These issues are illustrated using medical loss ratios from a range of nonprofit and for-profit health plans. The paper then sketches a strategy for improving the public's understanding of health plan performance as an alternative to continued reliance on the flawed medical loss ratio. This strategy incorporates data on structure and process, service quality, and financial performance.

THE MEDICAL LOSS RATIO serves as a Rorschach test for the American health policy debate. In principle, this statistic measures the fraction of total premium revenue that health plans devote to clinical services, as distinct from administration and profit. In practice, however, purchasers, providers, consumers, investors, and regulators interpret the medical loss ratio in quite different and mutually inconsistent ways as measuring what they most like or dislike about managed care. Some view a low medical loss ratio as an indicator of health plan efficiency, solvency, and creditworthiness. Others denounce a low ratio as proof of quality shading, risk skimming, and profit mongering. The debate reflects widespread anxiety over the current turmoil and future trajectory of the health care system as it plunges into a brave new world of integrated medical groups, large hospital systems, and diversified health insurance plans.

The great irony of the medical loss ratio debate is that public interest in it is peaking at precisely the moment when this obscure statistic is losing whatever meaning it once held. In the traditional world of indemnity insurance, the medical loss ratio provided a reasonable approximation of the division of revenues between the delivery of care, on the one hand, and insurance functions, on the other. In the indemnity context, insurers engaged in marketing, investing, and actuarial activities but limited their engagement with medical care to the processing and payment of claims. Physicians and hospitals incurred administrative expenses in managing their practices and institutions, but they did not engage in significant insurance functions.

In the rapidly emerging context of integrated delivery systems and managed health care, this once clear distinction between func-

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tions has become hopelessly blurred. Insurers now have assumed responsibility for managing the efficiency and quality of the services they cover. Medical groups and hospital systems are assuming insurance risk through capitation payment and are marketing their services directly to purchasers and consumers. Health plans are offering a wide range of managed care products to a broad mix of customers. The rapid geographic expansion of health plans and provider systems spreads core managerial functions and expenses across state lines. Medical loss ratios computed for particular products marketed to particular purchasers in particular states are subject to somewhat arbitrary accounting conventions. As consumers, purchasers, regulators, and investors pressure health plans to ensure that their ratios are neither "too low" nor "too high," this arbitrariness increasingly will be supplemented by strategic accounting manipulations.

"The medical loss ratio has achieved in recent years a remarkable amount of publicity and even notoriety."

This paper begins with a survey of the ways in which the medical loss ratio has been interpreted to be something it is not. It then analyzes the key organizational features of the emerging health care system that complicate any attempt to measure financial performance. Finally, it sketches a strategy for improving the public's understanding of health plan performance as an alternative to continued reliance on the flawed medical loss ratio. This strategy is quite modest, since it abandons the quest for a single measure of financial performance that is both easily interpretable and analytically valid. Yet it is also quite ambitious, since it necessitates an expansion in the data on expenses, organizational structures, and service quality that are being collected by purchasers and consumer advocates. The traditional system of indemnity insurance and fragmented delivery lacked economic accountability and is collapsing under its own weight. The new system of integrated financing and delivery will deliver the efficiency it promises only if it develops meaningful standards of performance to which it can be held accountable.

Through The Glass Darkly

The components of the medical loss ratio are derived from internal accounting statistics developed by insurance companies to measure what fraction of premium revenues are paid out in claims ("losses"). State insurance departments gradually have required insurers to file loss ratios as part of their documentation of solvency and, in regulated contexts, documentation for rate increases. The National Association of Insurance Commissioners (NAIC) has sought to standardize the often inconsistent accounting practices and definition of terms (for example, what counts as an "administrative" expense). The available data on medical loss ratios, which are collected from state agencies, suffer from the inconsistent nature of the underlying insurer reports, the limits of auditing standards, and the incomplete adoption of NAIC guidelines. Public access is difficult and time-consuming, since the information typically is neither centralized nor provided in electronic format.

Despite the difficulties in access and interpretation, the medical loss ratio has achieved in recent years a remarkable amount of publicity and even notoriety. Some provider and consumer groups have accused health plans with low medical loss ratios of skimping on the quality of medical services. Critics of the health care system have used low medical loss ratios as an index of administrative waste. Investors have used low medical loss ratios in a quite different manner, as an indicator of financial solvency, creditworthiness, and potential profitability.

■ QUALITY OF CARE. The medical loss ratio is often referred to in discussions about health care quality, with the implicit if not explicit inference that a low ratio indicates

underprovision of needed services. By extension, a high ratio indicates good quality of care. For example, a consumer-oriented report advocates use of the medical loss ratio as a "reliable measure" of the "level of service" provided by health maintenance organizations (HMOs) and advocates particular attention to the ratios of for-profit plans. "The essence of the problem is this: by rationing care, HMOs achieve lower expense ratios thereby leaving a larger slice of the pie for profits."[1] Physician organizations have assailed low medical loss ratios as indicators of reduction in the quality of care provided to enrollees and sponsored legislation mandating minimum ratios.[2] This sentiment has been echoed by some consumer advocacy organizations.[3]

This is politically the most volatile and analytically the least valid use of the statistic. The medical loss ratio is a ratio of medical expenditures to insurance premiums. High ratios can be achieved either through a large numerator (high medical expenditures) or through a small denominator (low insurance premiums). The medical loss ratio, as a ratio of the two, can be measuring the impact of medical market competition on expenditures or of insurance market competition on premiums. For example, a statistical analysis of medical loss ratios in three states found that administrative loss ratios were higher (and medical loss ratios were lower) in plans that relied extensively on capitation rather than on fee-for-service; this difference was attributable solely to the lower total premiums charged by the capitation-oriented plans (the denominator of the medical loss ratio) rather than to differences in administrative expenses per enrollee.[4] Moreover, neither premiums nor expenditures by themselves indicate quality of care. More direct measures of quality are available, including patient satisfaction surveys, preventive services use, and severity-adjusted clinical outcomes. Although each of these is limited in scope, they at least shed light on quality of care. The medical loss ratio does not.

■ MEDICAL EXPENDITURES AND ADMINISTRATIVE WASTE. The nation is engaged in a manhunt for the culprit behind rising health care costs, with the hope that the miscreant can be eliminated without forcing consumers, payers, and providers to relinquish any of the things they cherish. Consumers want full coverage and unrestricted choice without any premium contributions or cost sharing at the point of service. Providers want high incomes and a "hassle-free" practice environment where they can pursue professional goals without interference. Purchasers want low premiums and no complaints from employees and retirees. Everyone wants the medical loss ratio to measure whether the health plans are delivering on these mutually incompatible demands. For some, a high medical loss ratio means that health plans are spending lots of money on medical care services, which is a good thing.[5] For others, spending lots of money on medical services is a bad thing. In fact, the medical loss ratio does not measure medical expenditures in any direct form, since it is a ratio of spending to revenues.

The search for easy solutions to the health care cost dilemma has heightened attention to "waste." For some, especially health care providers, expenditures on administrative functions such as marketing, utilization management, and financial management constitute wasted social effort that should be minimized if not eliminated. They interpret low medical loss ratios as proof of administrative waste. Others, especially health insurers, interpret the variation in rates of medical and surgical procedures across U.S. geographic areas as indicators of inefficiency within the medical care delivery system. They interpret high medical loss ratios as proof of medical waste. The medical loss ratio sheds no clear light on medical or administrative expenditures and so cannot illuminate the much murkier issue of medical or administrative waste.

■ FINANCIAL SOLVENCY AND CREDITWORTHINESS. State regulatory agencies have traditionally been responsible for ensuring the fiscal solvency of health insurance companies and, more recently, of managed care plans. It is clearly a matter of public concern and expectation that the premiums paid for health care coverage will be available to

actually pay for services when needed and not lost to unsound investments and bankruptcy. In a quite different context, bankers, pension plans, and individual investors are interested in the financial solidity of the firms to which they offer loans and whose equity offerings they purchase. It is sometimes claimed that the medical loss ratio offers valuable information to these public and private overseers of the health insurance system.

For traditional indemnity insurance, the medical loss ratio provided some indication of whether medical expenses were rising in a way that necessitated commensurate increases in premiums. Some state insurance regulators calculated allowable premium increases based on the ratio of premiums to a target medical loss ratio; if the actual medical loss ratio rose above the target, the regulators would allow insurers to raise premiums. This constituted a form of the cost-plus pricing that has undermined efficiency incentives in industries regulated along "public utility" lines.[6] It is of rapidly diminishing importance as states shift from rate regulation to competition.

The role of the medical loss ratio as a measure of future profitability for investors is more subtle. The equity markets respond to any piece of unexpected information. In some well-publicized instances, unpredicted increases in medical loss ratios have been interpreted as indicators of increased future liabilities (numerator of the medical loss ratio), thereby precipitating an equity sell-off.[7] A high ratio also can be interpreted as an indicator of price competition that reduces plan premiums and revenues (denominator of the medical loss ratio). Needless to say, more direct measures of revenues, market shares, costs, and profits are available to investors. For example, one company developed an extensive analysis of health plan performance based on twenty-three measures and did not deem it important to include the medical loss ratio.[8] Key indicators of performance included number of shares outstanding, earnings per share, value of intangibles and tangible book value, price-to-earnings ratios, price-to-tangible-book values, total income, total debt, and year-to-year changes in many of these measures. However, another company included the medical loss ratio in its extensive analysis of current and future HMO performance.[9] Low medical loss ratios are interpreted favorably as indicators of future HMO profit potential.[10]

THE NATURE OF THE BEAST

Any statistical measure will reflect differences among plans in organizational form and economic performance. The difficulties are particularly acute, however, for the medical loss ratio, which directly measures the distribution of revenues among administrative and clinical functions that are organized in different ways in different firms. Of central importance are the relationship between the health plan and its providers (vertical structure), the range of networks and utilization management systems it offers (product diversification), the range of buyers to which it markets its services (channel diversification), and the number of states in which it operates (geographic scope).

■ VERTICAL STRUCTURE: PLANS AND PROVIDERS. Differences in the medical loss ratio among health plans reflect different allocations of administrative functions between plans and providers. Indemnity insurers assume no responsibility for the management of physician practices, hospital facilities, or other health care delivery organizations. They tend to exhibit comparatively low administrative expenses and, by extension, high medical loss ratios.

At the other end of the organizational spectrum is the staff-model HMO, where the health plan directly employs its own physicians and, in some cases, owns hospitals. Whether the staff-model HMO reports a high or a low medical loss ratio depends on how it attributes administrative expenses to its health plan, medical group, and hospital divisions. It is possible for vertically integrated health plans to report almost nothing for administrative expenses (and hence report a very high medical loss ratio).

Between indemnity insurance and the staff HMO lies a heterogeneous mix of health plan

types that rely primarily on contractual rather than ownership linkages with providers but that engage in extensive management of utilization and medical expenditures. Some plans, including preferred provider organizations (PPOs) and independent practice associations (IPAs), contract directly with individual physicians and perform utilization management and quality assurance functions in-house. These plans tend to exhibit high administrative expenses and low medical loss ratios on the health plan side. Other plans contract with medical groups and delegate to them the primary responsibility for utilization management and quality assurance. These network HMOs will tend to report an intermediate level of administrative expenditures and medical loss ratios, depending on the extent of delegation.

There are important differences among health plans in their administrative and medical expenditures. It is not clear, however, that lower administrative expenses are socially more desirable than higher expenses, once the causes of the differences are understood. Higher administrative expenditures may reflect a greater investment in management and coordination of care, which reduces clinical expenses. Administrative expenses also reflect the size of the provider network. HMOs with very narrow networks (for example, staff models that only permit enrollee access to employed physicians) will tend to incur lower administrative expenses. The rapid enrollment growth in IPA- and network-model HMOs strongly indicates that many consumers prefer broad networks despite the higher administrative costs they incur.

■ PRODUCT DIVERSIFICATION: PLAN TYPES. Differences in medical loss ratios strongly reflect the range of products offered by competing plans. In the not-so-distant past, health plans tended to offer only one product, either indemnity insurance or an HMO. Now many health plans offer a range of distinct plans. Plans differ in the range of products they offer and in the distribution of their total patient enrollment among products. The medical loss ratio for the plan as a whole will reflect the range of product diversification as well as the distribution of administrative and medical expenditures for particular products. If medical loss ratios are reported for individual products, the allocation of joint administrative expenses, such as marketing and medical management, opens the door to "creative" accounting practices.

The interpretation of medical loss ratio differences among plans is complicated even more seriously by the wide range in benefit packages and consumer copayment levels across health insurance products and the tendency of health plans to offer products such as life and disability insurance, dental plans, and "carved-out" pharmacy benefits. Health plans with richer benefit packages tend to incur high medical expenses and thereby high medical loss ratios, since administrative expenses do not rise proportionately to medical expenses in response to benefit coverage. High consumer cost sharing influences the medical loss ratio by shifting costs from the plan's books to the consumer (lower premium revenue, the denominator of the medical loss ratio) and by reducing patient-initiated utilization (reduced medical expenditures, the numerator of the medical loss ratio).

■ CHANNEL DIVERSIFICATION: DISTRIBUTION SYSTEMS. Health plans differ substantially in the nature of the distribution systems they use and the consumers they target. They may focus on large employer groups, small firms and self-employed individuals, state Medicaid programs, Medicare beneficiaries, public employees and military personnel, or self-insured corporations. The costs of marketing vary substantially among these distribution channels and will be reflected in administrative expense levels and loss ratios. Marketing costs tend to be lower when plans can gain large blocks of enrollees through a single contract, as in the large-firm market. Where one-on-one marketing is central, as in the Medicare, small-firm, and individual markets, selling costs are much higher. These costs may be incurred by the plan directly, through employed sales representatives, or indirectly, through brokers and agents. Selling

costs can be reduced in areas where small firms and/or individuals may obtain coverage through purchasing cooperatives. Most large health plans now sell in all major market segments, but the mix of enrollment across segments varies widely. In California, for example, Blue Cross, Blue Shield, and Foundation are strong in the individual and small-firm markets, PacifiCare dominates the Medicare HMO market, Health Net is very successful in the large-firm market, and Kaiser has a considerable presence in all markets.

The influence of channel diversification extends beyond selling costs to revenue potential. Distribution channels such as Medicare and large firms that bring in high revenues per enrollee will produce high medical loss ratios, since administrative expenses do not rise proportionately with medical expenses. The thin benefits that prevail in the small-firm and individual markets will tend to be associated with low medical loss ratios. The interpretation of medical loss ratios is complicated further for health plans that manage the benefit programs of self-insured corporations. This "administrative-services-only" channel reduces the medical loss ratio if medical expenses are booked by the self-insured firm while the health plan books administrative expenses. Product and channel diversification contaminate measures of costs per capita by facilitating multiple counting of enrollees. The same individual can be counted once for the basic health product, once for the pharmacy product, once for the workers' compensation product, and several times more.

■ GEOGRAPHIC DIVERSIFICATION. Many users of the medical loss ratio are interested in the distribution of administrative and medical expenses in particular states and metropolitan areas. Health plans, however, are spreading across state lines and in many cases are approaching national scope. Efforts to compute the medical loss ratio for any one geographic region require the parent company to allocate central administrative expenses to particular regions. This is particularly problematic when some products, such as those for federal employees or large corporations, are marketed and managed at the national level. The distribution of enrollment among various states and localities will influence the medical loss ratio for particular health plans because of geographic variations in wage and other input costs, physician practice styles, and revenue potential. For example, HMOs that sell to Medicare beneficiaries receive a monthly payment that is set at 95 percent of the average expenditure for Medicare's fee-for-service enrollees in each county, adjusted for demographic characteristics. These expenditure levels vary across counties by more than 200 percent because of the variation in fee-for-service practice styles.[11] HMOs with large enrollment in counties with expensive fee-for-service systems will receive high revenues (denominator of the medical loss ratio) without needing to incur commensurably high administrative costs. However, high Medicare payment levels may influence medical costs (numerator of the medical loss ratio) by encouraging nonprice competition among plans on the basis of ever-richer benefit packages.

EXAMPLES OF MEDICAL LOSS RATIOS

The problems of interpretation inherent in medical loss ratios are illustrated in Exhibit 1, which reports 1994–1995 data for selected health plans. There is wide variation in medical loss ratios, even among plans with similar tax and organizational structures. Medical loss ratios for the nonprofit Blue Cross and Blue Shield plans range from a low of 58.4 percent in Nevada to a high of 95.1 percent in central New York. Even within one health plan, there are huge differences across states. The Kaiser Foundation Health Plan in California, for example, has a medical loss ratio of 96.8 percent, which is frequently cited by the press as evidence that nonprofit and/or staff-model HMOs return a high percentage of premium revenue to enrollees in medical services.[12] But the Kaiser plan in Georgia has a medical loss ratio of only 76.2 percent, and the other Kaiser state and regional plans report a

EXHIBIT 1
Medical, Administrative, And Profit Ratios From Selected Health Plans, 1994–1995

Health plan	Tax status	Medical loss ratio	Administrative loss ratio	Profit ratio
Blue Cross and Blue Shield				
Central New York	NP	95.1%	8.3%	–[a]
Colorado	NP	64.0	25.5	–[a]
Georgia	NP	91.3	12.3	–[a]
Nevada	NP	58.4	22.6	–[a]
Kaiser Foundation Health Plan				
California	NP	96.8	2.1	1.1%
Georgia	NP	76.2	14.0	–[a]
North Carolina	NP	98.7	4.2	–[a]
Colorado	NP	82.7	13.3	–[a]
WellPoint Health Networks				
Blue Cross of California	NP	93.5	4.2	2.4
CaliforniaCare	FP	73.0	16.3	10.6
Aetna Health Plans				
California	FP	77.4	9.6	13.0
Florida	FP	90.1	12.9	–[a]
New York	FP	95.3	10.3	–[a]
Tennessee	FP	72.8	14.3	–[a]
Illinois	FP	93.1	12.3	–5.4
CIGNA Healthcare				
California	FP	83.2	13.7	3.1
Illinois/Indiana	FP	78.1	11.1	10.8
Illinois/St. Louis	FP	47.2	37.0	15.8
Massachusetts	FP	98.1	16.8	–[a]
Delaware	FP	97.7	17.0	–[a]
MetraHealth Care Plans				
Chicago	FP	108.4	25.6	–34.0
Illinois	FP	74.3	14.3	11.3
St. Louis	FP	69.0	12.7	18.3
CareAmerica				
Southern California	FP	78.3	19.1	2.6
Life Insurance	FP	110.0	24.1	–[a]
FHP Health Care				
California	FP	83.8	12.3	3.9
Illinois	FP	81.0	13.2	5.8
Colorado	FP	81.7	12.6	–[a]
New Mexico	FP	82.1	17.0	–[a]
Utah	FP	89.9	12.4	–[a]

SOURCES: California Medical Association, *Knox-Keene Health Plan Expenditures Summary, FY 1994–95* (San Francisco: CMA, February 1996); Weiss Ratings, *Which Health Insurers Give You the Most for Your Money? Which Give You the Least?* (Palm Beach Gardens, Fla.: Weiss Ratings, July 1996); and Illinois State Medical Society, *Illinois Health Maintenance Organizations* (Chicago: Illinois State Medical Society, November 1996).
NOTES: NP is nonprofit. FP is for-profit.
[a] Not available.

range of values.

Similar disparities are apparent among state plans operated by for-profit HMOs. The Aetna medical loss ratios range from a low of 72.8 percent in Tennessee to a high of 95.3 percent in New York. At CIGNA, medical loss ratios range from 47.2 percent in St. Louis to 98.1 percent in Massachusetts. And MetraHealth reports remarkable variation in medical loss ratios for one small region: 74.3 percent for the Illinois plan, 108.4 percent for the Chicago plan, and 69.0 percent for the St. Louis plan.

It is difficult to discern any systematic variation in the medical loss ratio figures across states within particular companies, whether nonprofit or for-profit, staff model or IPA. Also, the distinction between nonprofit and for-profit plans, which always receives considerable publicity in medical loss ratio discussions, is not apparent in these figures. The Blue Cross/Blue Shield and Kaiser numbers, on the one hand, and the Aetna, CIGNA, and MetraHealth numbers, on the other, clearly overlap.

Close analysis of particular numbers reveals even more difficulties of interpretation. WellPoint Health Networks has received the brunt of adverse publicity in California, mostly at the hands of the California Medical Association.[13] In 1994 its for-profit subsidiary, CaliforniaCare Health Plans, reported the lowest medical loss ratio in the state (73.0 percent). However, the WellPoint company in 1994 was wholly owned by a nonprofit firm, Blue Cross of California, which reported a medical loss raio of 93.5 percent, the second highest in the state (after Kaiser). The juxtaposition of low medical loss ratio with for-profit status and high medical loss ratio with nonprofit status has fed the flames of HMO bashing but is completely without substance. In 1994 WellPoint's accountants included all in-network expenditures by enrollees in the PPO subsidiary, Prudent Buyer, under CaliforniaCare Health Plans (along with enrollees in the HMO subsidiary, CaliforniaCare). All out-of-network expenditures were considered indemnity rather than managed care, however, and thus were reported under the Blue Cross of California parent.[14] Not surprisingly, the indemnity medical loss ratio is very high.

Another example of the dubious relevance of tax status for understanding medical loss ratio reports is found in CareAmerica, a for-profit plan that is wholly owned by the nonprofit hospital system UniHealth America. CareAmerica also runs a life and disability insurance company, which is largely an indemnity carrier and reports a medical loss ratio of 110.0 percent, in contrast to its HMO medical loss ratio of 78.3 percent.

"Juxtaposition of low medical loss ratio with for-profit status has fed the flames of HMO bashing but is completely without substance."

The difficulties posed by multiproduct health plans are illustrated in the figures for FHP Health Care, which operates a combination of staff-, group-, network-, and IPA-model HMOs plus other entities in various western states. The medical loss ratio data published by consumer advocacy groups and physician organizations and shown in Exhibit 1 are obtained from annual reports filed by FHP with state regulatory agencies. The reports for each state, however, mix data from multiple states and products.[15] Exhibit 1 presents the numbers filed with state agencies in five states, including California. The California medical loss ratio, however, is based on revenue and expense data from California, Arizona, Nevada, and Guam (which are part of FHP, Inc., of California), plus data from several (but not all) state-specific subsidiaries. The California medical loss ratio includes the financial data from various non-HMO subsidiaries, including FHP, Inc., Reinsurance Limited (Bermuda); FHP Life Insurance Company of California; Ultralink, Inc. (a third-party administrator company in California); Employees Choice Health Option (a

PPO in Utah); and Providers Protective Insurance Company (a workers' compensation company in Guam). The California medical loss ratio also is based on financial data from Hippodrome Galleries Corporation, an art gallery in California owned by FHP.[16]

Beyond The Medical Loss Ratio

Much of the interest in and demand for medical loss ratios has come from consumers, purchasers, and regulators seeking measures of health care value, efficiency, and quality. These persons and organizations are pressuring health plans to expand the range and improve the reliability of the data needed for making informed choices. The medical loss ratio stands out among the other data elements in its simplicity and its ostensible link to plan efficiency and medical service quality. It is thus with particular reluctance that any of the current users will relinquish the statistic; there is no single substitute available. Nevertheless, consideration of the determinants of medical loss ratios across plans, products, and states necessitates the conclusion that this number is not what it is interpreted to be.

The most important users of health plan information in coming years will be individual consumers and organized purchasers of health benefit programs, including employers, business alliances, Medicaid programs, and Medicare. Consumers increasingly are paying for health care coverage with their own money and facing health plan choices during open enrollment. Purchasers have the organizational capability to understand the performance of health plans to a degree that individual consumers do not. Consumer and purchaser data requirements can be grouped into measures of plan structure and process, clinical quality, and financial performance. Each of these goes far beyond the medical loss ratio.

■ STRUCTURES AND PROCESSES. The single greatest gap in the health care data system is in descriptive information on the structure of the provider networks and the mechanisms for utilization management used by competing health plans. It is often difficult to obtain a well-organized, up-to-date listing of physicians, medical groups, hospitals, and other providers that are included in the various networks offered by health plans. Providers can be dropped from networks after purchasers and consumers have made plan choices. Even more obscure are the rules imposed by health plans concerning patients' movement within a network, including choice of and switching among primary care physicians; access to specialists; admission to hospitals, nursing homes, and rehabilitation facilities; and referral to home health care. The most obscure of all are the methods used by health plans (and their contracting provider organizations) to monitor and manage the utilization patterns of individual patients and physicians. These include clinical services provided directly by primary care physicians, specialty referrals, procedures by specialists after referral, hospital services, and many more. Needless to say, this information is complex, difficult to codify, difficult to quantify, easily misinterpreted, and subject to rapid obsolescence. Nevertheless, it is what consumers and purchasers really want to know. Comparable measures of plan structure and conduct need to be developed for purposes of initial comparison. These can be supplemented with more detailed information for particularly interested parties. The development of both aggregate and specific descriptors will encourage a salutary increase in cooperation between health plans and providers.

■ QUALITY OF CARE. The medical loss ratio never was and never will be an indicator of clinical quality. While the holy grail of severity-adjusted outcomes statistics for all clinical services is yet to be found, important steps have been taken in the quest to develop direct measures of quality.

Consumer surveys yield quantifiable and comparable measures of satisfaction with the services provided by plans, physicians, and hospitals. When supplemented by self-assessed measures of health status and functioning, these surveys yield measures of quality from the perspective of those who matter most.

Surveys of random samples of plan enrollees need to be supplemented with special surveys of those with the greatest experience, including enrollees with chronic diseases and those with hospitalization or other major procedures during the previous year. Satisfaction surveys have been pioneered by large corporate purchasers and are now being adopted by small-employer alliances, Medicaid and Medicare, and health plans. Studies have found that self-assessed measures of changes in health status are strongly correlated with clinical measures of health status and thus provide valid indicators of service quality.

Enormous efforts have been devoted in the past five years to the development of process measures of health plan quality such as rates of child immunization, mammography among older women, and participation in smoking-cessation programs. These are being supplemented by more extensive measures through the efforts of the National Committee for Quality Assurance (NCQA), The Medical Quality Commission (TMQC) of the American Medical Group Association (AMGA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Foundation for Accountability (FACCT), and other organizations. Where available, severity-adjusted outcomes for selected procedures, such as coronary artery bypass graft (CABG) surgery, can be added to these process measures. The combination of process and outcomes measures constitutes a historical move from a focus on isolated providers and "bad apples" to provider systems and continuous quality improvement. NCQA accreditation, which is based on satisfactory performance on these measures, is an important determinant of purchasing decisions by large firms and is increasingly used in the individual and Medicare markets. Extension and refinement of these measures will provide the foundation for quality comparisons in years to come.

"The medical loss ratio is an accounting monstrosity that enthralls the unsophisticated observer and distorts the policy discourse."

■ FINANCIAL PERFORMANCE. The best indicator of current and expected future value in a market economy is the willingness of the consumer to purchase and retain the product. In health care, this translates into measures of growth in enrollment and revenues, adjusted for disenrollments and changes in prices. Plans that are growing are offering something for which purchasers are willing to vote with their dollars and consumers are willing to vote with their feet. Publicly traded health plans and provider organizations are subject to continual market valuations, measured through changes in share prices, price-to-earnings ratios, and numerous indicators of tangible and intangible book values. Bankers, mutual funds, institutional investors, and individual speculators have stronger incentives to demand financial data than do consumers, purchasers, and regulators. A judicious piggybacking on Wall Street performance indicators would give a better means of evaluating the solvency and creditworthiness of health plans than would any independent compilation by purchasers and regulators. The medical loss ratio offers limited or no value in this respect. Whereas the public debate focuses on the differing levels of medical loss ratios among health plans, the stock market cares only about unanticipated changes in medical loss ratios for particular plans. By the time anyone in policy circles has heard the news, the equity markets have long ago adjusted to whatever information resides in the medical loss ratio.

Any measure of costs is subject to accounting difficulties, which are compounded as health plans mix provider relationships, product networks, distribution systems, and geographic coverages. One step in the direction of reliable cost information can be achieved through requests for per-member-per-month expenditures for particular services (for ex-

ample, physician, inpatient hospital, outpatient hospital, and pharmacy) for particular products (for example, HMO, POS, and PPO) for particular distribution channels (for example, commercial, and Medicaid/Medicare) in particular states. These measures are subject to many of the distortions discussed earlier, including dependence on benefit package and cost-sharing differences, the extent of self-insurance among purchasers, marketing and distribution systems, and within-state differences in costs and practice patterns. Many large corporate purchasers demand per-member-per-month cost data by product and type of service, but these data are controversial because they are of uneven quality. The Pacific Business Group on Health no longer requests detailed cost data from contracting HMOs, but it continues to demand revenue, profit, and other financial information; it judged that the cost data were inherently unreliable.[17] The NCQA has considered including demands for per-member-per-month costs in the Health Plan Employer Data and Information Set (HEDIS) reporting process but has refrained so far.[18] Nevertheless, an incremental approach to cost reporting on a per-member-per-month basis holds more promise than attempts to fix the medical loss ratio.

CONCLUSION

The managed care system will not generate the improvements in efficiency and quality that it promises unless better data on health plans and providers are available to consumers, purchasers, and policymakers. Consumers need access to better information on provider networks, benefit packages and cost-sharing requirements, methods of 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. As they move away from direct command and control regulation, policymakers need data on health plan solvency, accessibility, and quality to fulfill the oversight role that the citizenry continues to expect.

More data are needed, but caution must be exercised lest misinterpretation confuse rather than inform health care choices. In particular, quality should be evaluated using data on quality; costs should be evaluated using data on costs; and profits should be evaluated using data on profits. The medical loss ratio is not a straightforward indicator of either medical or administrative expenditures. It certainly is not a measure of clinical quality or social contribution. The medical loss ratio is an accounting monstrosity, a convolution of data from myriad products, distribution channels, and geographic regions that enthralls the unsophisticated observer and distorts the policy discourse. The hard but inescapable conclusion is that informed choice and sophisticated purchasing of health care must rely on a more extensive set of performance measures, no one of which is as comprehensive as the medical loss ratio is purported to be but each of which has some of the analytic validity that the medical loss ratio lacks.

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School of Public Health), Carl Volpe (WellPoint Health Systems), and Larry Casalino (Stanford Coastside Medical Clinic). These persons, and the organizations with which they are affiliated, are not responsible for the views expressed here.

NOTES

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10. Health plan medical loss ratios are also cited by investment analysts who follow the stock prices of physician practice management (PPM) firms, which contract with HMOs to provide physician services from the medical groups and independent practice associations owned and/or managed by the PPMs. These analysts interpret high HMO medical loss ratios as a favorable indicator for PPM profitability, since HMOs under market pressure to lower medical loss ratios are increasingly contracting with PPMs. For example, see UBS Securities LLC, "FPA Medical Management Inc.: Buy," *UBS Securities Equity Research* (New York: UBS Securities, LLC, 25 July 1996).
11. J. Wennberg and M. Cooper, *The Dartmouth Atlas of Health Care in the United States* (Chicago: American Hospital Publishing, 1996).
12. This is the combined figure for the northern and southern California Kaiser regions.
13. For a recent example, see P. Sinton, "How Much HMOs Spent on Patients," *San Francisco Chronicle*, 22 February 1997, D1.
14. The following year the value of the assets owned by the nonprofit organization was transferred to two charitable foundations. Blue Cross of California then converted into a for-profit company. It is now the California subsidiary of WellPoint Health Networks. In summary, Blue Cross of California was the nonprofit parent of the for-profit WellPoint Health Networks, which controlled CaliforniaCare Health Plans, which marketed the Prudent Buyer PPO and CaliforniaCare HMO; now WellPoint is the for-profit parent of Blue Cross of California, a for-profit subsidiary, which markets a range of HMOs and PPOs in California using such names as Blue Cross of California, Prudent Buyer, and CaliforniaCare, with non-California plans formed under the for-profit subsidiary UniCare, which formerly was the nonprofit workers' compensation subsidiary in California. Any questions?
15. Richard A. Caldwell, director, Medical Informatics, FHP Health Care, personal communication, December 1996.
16. For the relationship between art and medicine at FHP, see R. Gumbiner, *FHP: The Evolution of a Managed Care Health Maintenance Organization, 1955–1992* (Berkeley, Calif.: University of California Press, 1995).
17. Patricia E. Powers, executive director, Pacific Business Group on Health, personal communication, December 1996.
18. Pamela Krol, health plan manager, Human Resources, Southern California Edison, and chair, HEDIS Users Group Finance Panel, National Committee for Quality Assurance, personal communication, December 1996.