

Medical Care Ratio

Issue Overview

A medical care ratio, or medical loss ratio (MLR), as it is also known, is a measure of percentages of premium dollars that health insurers spend on medical care and on related administrative expenses. A key provision in the new health reform law, the Patient Protection and Affordable Care Act (PPACA), is a requirement that health plans spend a specified percentage of premiums on “clinical” services and “activities that improve health care quality,” rather than on “non-claim costs.”

HCSC Position

Health Care Service Corporation (HCSC) believes that if a narrow definition of MLR is written, health plans could be discouraged from supporting a number of programs that produce tremendous benefits for members, communities and employer group customers. For example, if the definition of “activities that improve health care quality” is too restrictive, the result could be reduced support for childhood obesity and immunization programs, reductions in quality improvement initiatives like condition management and wellness programs and less effective anti-fraud programs.

An overly restrictive MLR definition endangers many features of health plans that consumers have come to expect and value, but may be considered “administrative expenses” when lawmakers set regulations. HCSC advocates an MLR definition that supports the many programs we use to promote high quality care for our over 12.4 million members.

The National Business Group on Health states, “Employers and insurers have vast experience with, and rely heavily upon, a range of clinically proven tools and services that promote high-quality health care focused on improving care for the patient (consumer), including: care coordination, patient decision aids, patient support services and health information technology (HIT) for clinical care and population health management. It is vital that these clinically proven services are included in the clinical services/health care quality categories of expenses under MLR to continue to improve health care outcomes for the patient and to reduce harms, disease burden, disparities, waste and costs...”

Examples of HCSC Quality Initiatives

- ❖ HCSC is taking the initiative to address **Metabolic Syndrome** because of both the realized and unrealized impact it has on the health of its members and communities, as well as the effect it has on the overall cost of health care. Criteria for Metabolic Syndrome include meeting three or more of the following clinical markers: elevated waist circumference, elevated triglycerides, reduced HDL-C, elevated blood pressure and elevated fasting glucose. By identifying the risk factors and engaging in a program to

help manage them as early as possible, a person can address a minor health concern before it becomes a debilitating costly health complication.

HCSC is pursuing an aggressive approach to managing the issue of Metabolic Syndrome. The program launched in early 2009 and is showing initial positive results in health and lifestyle impacts, as well as return on investment. *Program outcomes:*

- 24% decrease in the number of participants considered at-risk for Metabolic Syndrome
- 34% of participants reported that they reduced or eliminated their medication usage
- Participants saw an average weight loss of 9.6 pounds

❖ **Condition Management** programs can help members manage their medical conditions, change unhealthy behaviors and stay as healthy as possible. Designed for people diagnosed with chronic conditions such as asthma, diabetes, heart problems and others, these voluntary programs work together with members, their health plan and their physician to identify the best ways to manage their chronic health conditions, and stay as healthy as possible. *Program outcomes:*

- Utilization outcomes for engaged vs. non-engaged members
 - 9.7% decrease in outpatient visits
 - 12.9% decrease in ER visits
 - 24.9% decrease in inpatient days
- Condition Management program engagement rate increased from 43% to 47% (over an 8-month period)
- Gap closure rates for medication compliance increased 37%, screenings increased 29% and office visits increased 17%

❖ **HCSC's Special Investigations Department (SID)** is often the first line of defense for a member who believes they have been treated or billed inappropriately. On each Explanation of Benefit form received by a member, the HCSC Fraud Hotline number is displayed and the number is available 24 hours-a-day, 7 days-a-week and is answered by a live operator.

The SID has a dedicated Data Intelligence Unit staffed by highly skilled analysts who use sophisticated software to data mine the claims in HCSC's electronic data warehouse to identify aberrant billing and treatment patterns. While many cases originate with allegations of billing fraud, in the course of the investigation, there are almost always related findings that, to perpetuate the fraud, the provider has either:

- provided unnecessary services or tests for which diagnoses may be altered to justify the services/tests; and/or
- falsified records to justify the increased number/level of services.

Both of these actions result in the creation of false medical records which can impact future treatment protocols by other physicians, future health or life insurance coverage and, in certain occupations, affect future employment. These activities contribute to the increased cost of health care and are equally detrimental to the quality of care and to patient safety,

both in the present and in the future. A robust and high-quality health care fraud identification and investigation program is integral to ensuring quality of care, patient safety and the integrity of a health plan's provider network. Below are two examples where our Special Investigations Department uncovered intentional deception or misrepresentation by health providers resulting in inappropriate patient care, potential patient harm and the creation of false medical records.

- A physician husband/wife team was convicted of conspiring to commit health care fraud over a 10-year period. They fraudulently billed for medical procedures that were not performed, overprescribed pain medication – placing patients at risk – and falsified medical records to facilitate their schemes. Both face lengthy prison sentences along with anticipated restitution to Medicare, Blue Cross and Blue Shield of Texas and other private insurance carriers.
- A Chicago physician targeted a specific immigrant community seeking male patients with insurance benefits, with the intention of taking advantage of the subjects' lack of medical knowledge. The physician performed high risk, medically unnecessary services which were unrelated to the patients' original complaints. Not only did the treatments subject the members to unnecessary and invasive procedures, it also created false medical records.

These, and many similar programs, can significantly improve patient health outcomes. Furthermore, such programs may have the additional benefit of reducing the overall cost of health care. If the definitions around MLR are too narrow, health insurers may be discouraged from supporting these kinds of quality improvement initiatives. Health plans play a critical role in administering these types of quality care programs. Imposing an inflexible and arbitrary MLR definition provides a disincentive for health plans to implement initiatives that directly benefit patients.

About Health Care Service Corporation

Health Care Service Corporation, a Mutual Legal Reserve Company, is the largest customer-owned health insurer in the United States and the fourth largest health insurer in the country overall, with 12.4 million members in its Blue Cross and Blue Shield Plans in Illinois, New Mexico, Oklahoma and Texas. The company is an independent licensee of the Blue Cross and Blue Shield Association. HCSC also has a rating of AA- (Very Strong) from Standard and Poor's, Aa3 (Excellent) from Moody's and A+ (Superior) from A.M. Best Company. For more information, visit www.HCSC.com.