

FCA Risks Related to Medical Loss Ratio (MLR) Requirements

SUMMARY: Medical Loss Ratio (MLR) requirements have been enacted at the state and federal levels with the stated purpose of promoting transparency and accountability. The specter of large MLR rebates has led health plans to take steps to increase their MLR ratio in ways that could create risks under the False Claims Act. Even legitimate payments from health plans to hospitals—if they are inaccurately reported or misclassified by the health plan—could be viewed by an opportunistic whistleblower as kickbacks or part of a broad scheme to defraud federal health care programs.

I. Background on MLR

A health plan's MLR is calculated by measuring (a) the share of enrollee premiums that health insurance companies spend on health care and quality improvement against (b) the share of enrollee premiums spent on expenses, such as administration or profits. Section 1001 of the Affordable Care Act imposes a federal uniform minimum MLR requirement on fully funded health plans. Some state Medicaid managed care organizations, such as California's Medi-Cal, have incorporated their own MLR requirements into their Medicaid managed care contracts.

II. Rebates Are Used to Reduce Non-Medical Expenses

Under the MLR program, health plans must issue rebates to policyholders or Medicaid programs each year that they do not meet state or federal MLR standards for individual, small-group and large-group policies. According to Centers for Medicare & Medicaid Services (CMS) data from 2015, health plans were required to pay \$469 million in MLR rebates to about 5.5 million policyholders in 2015—bringing the total over four years to more than \$2.4 billion.

III. Recent CMS Audits Were Generally Positive But Reveal Risks

On March 29, 2016, the CMS posted the results of the first audits that it has conducted of insurers under the MLR program. Although these reports were generally positive, they revealed risks that include the misclassification of expenses by health plans as "quality improvement" expenses and the inaccurate reporting of incurred health care claims.

IV. Plan Efforts to Reduce MLR Rebates Could Create Risk

Health plans have started to take proactive steps to elevate its MLR and thereby reduce the amount of rebate owed to policyholders. For example, it is becoming increasingly common for health plans to make lump-sum payments to hospitals to fund health care initiatives (such as readmission reduction) and to report these payments as "Allowed Medical Expenses" under the MLR program. In addition, health plans can reduce its MLR in a given year by making retroactive or prospective payments to hospitals.

In many cases, these proactive steps are legitimate. However, a potential whistleblower could misconstrue these payments to hospitals as kickbacks or as part of a conspiracy to manipulate MLR and defraud policyholders and Medicaid programs. This risk is heightened because the regulations that define "Allowed Medical Expenses" are vague and are often open to interpretation, and because it can be difficult to monitor the accuracy of all incurred health care claims.

CONCLUSION: Health plans should be vigilant about lump-sum payments to hospitals and develop compliance programs designed to ensure the accuracy of MLR data.