

**MEDICAL LOSS RATIOS:
AN OVERVIEW OF ACCOUNTING & PUBLIC POLICY
ISSUES**

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Abstract

In the Patient Protection and Affordable Care Act of 2010 (PPACA), there are requirements to measure the percentage of premiums received by insurers that are used to provide medical care (called the “medical loss ratio” or MLR). If the MLR is below certain thresholds (80% for individual and small group markets and 85% for large group markets), the PPACA requires insurers to refund the difference to their insurance customers. This paper reviews the rationale for the minimum MLR provisions, presents an example of a pre-PPACA manipulation of the MLR ratio, and discusses the controversy surrounding measurement of the MLR. The paper concludes with some implications of the minimum MLR requirements for both health insurance executives (including corporate accountants) and auditors.

1. INTRODUCTION

Health insurers spend much of their revenue on health care expenditures for the people they insure. Premium revenue is also used pay administrative expenses and (if they are for-profit insurers) to generate a profit or loss. State insurance commissioners have longed been concerned about the nature and size of insurers' administrative costs and profits. As a result, some states had imposed requirements for state-funded plans that insurers must pay a certain percentage of the state-provided revenue for medical expenses. If the insurer failed to spend the specified minimum percentage on medical expenses (generally called the Medical Loss Ratio (MLR)), the insurers faced a penalty, such as a requirement to refund the excess premiums back to the state. Minimum MLR requirements and rebate provisions were included in the Patient Protection and Affordable Care Act (PPACA),¹ and were expanded beyond state-funded plans to include private and employer-based plans.

This paper examines some of the accounting and public policy issues surrounding the measurement and use of MLRs. The paper first presents some accounting and financial reporting issues related to MLRs and premium rebates. This is followed by a case in which a health insurer misclassified administrative expenses and health benefit expenses to meet a minimum MLR and improperly reduce the amount paid back as a refund. The MLR provisions of the PPACA are then discussed, including some issues surrounding the passage of the act, the process by which the MLR measurements criteria were determined, and some controversies around the measurement of MLR. The paper closes with a presentation of some professional issue of relevance to accountants and auditors, and some public policy implications of the use of MLRs.

¹ Also known as "Obamacare."

2. BACKGROUND LITERATURE

There is a limited body of literature on accounting issues related to health care (e.g., Byrd et al. 2013; Lynch 2003; Eldenburg and Kallapur, 1997 and 2000). Much of this literature relates to the potential accounting effects of changing health care regulations, especially how hospitals may have reacted to regulatory changes (Mensah 2000).

Some studies examined a change in the Medicare reimbursement practice for inpatients from a cost-based to a fixed fee per patient system in 1983. Among the costs included in the previous cost-based system were interest charges on hospital debt. Lynch (2003) found that hospital debt decreased after the regulatory change, and that the percentage of the hospitals' business with Medicare patients was a significant factor in explaining the decreased use of debt, suggesting that the change in reimbursement practices may have influenced hospital's financing decisions.

Eldenburg and Kallapur (1997 and 2000) examined the mix of inpatient and outpatient care provided after a 1983 Medicare change from cost-based fee payment to fixed fee payments for inpatient services, while many outpatient services continued to be paid by Medicare on a cost-based basis. Eldenburg and Kallapur (1997) found that the inpatient/outpatient mix changed after this Medicare payment change, with hospitals providing a larger portion of outpatient care. They also found that costs allocated to outpatients services were higher after the change than before the change, consistent with hospitals trying to maximize the costs allocated to outpatient services that were paid for based on the cost of the service. Eldenburg and Kallapur (2000) found that the direct (unallocated) costs associated with the inpatient service actually increased (relative to outpatient costs) after the 1983 payment process changes. The Eldenburg and Kallapur (2000) results suggest that the 1983 Medicare payment changes were not effective in containing the costs of inpatient care, and that public

policy research should consider the implications of accounting practices in assessing the effectiveness of health care regulations.

Kennedy et al. (2010) examined a requirement passed in Texas in 1993 that hospitals² spend at least 4% of their net patient revenue on charity care. They found that hospitals previously spending below this level increased their spending, while those hospitals spending above 4% saw a marginally significant decrease in spending. In 1995, an amendment was passed allowing for the deduction of bad debt expense in computing net patient revenue, and this amendment was associated with a reduction in spending in charity care, as the 4% minimum threshold was easier to achieve.

Overall, there is evidence that health care entities may respond to regulations by making modifications to their practices in ways that allow them to take advantage of some aspects of the changing regulations.

3. ACCOUNTING ISSUES RELATED TO MLR

The basic calculation of MLR is as follows:

$$\frac{\text{Eligible medical expenses}}{\text{Total premiums}}$$

Measurement of the MLR requires insurance companies to have control processes that can measure and properly classify eligible medical expenses (i.e., benefits), with the other major category of expenses being administrative expenses. Measurement of medical expenses is the subject of some controversy and is discussed further below.

From a financial reporting perspective, insurers segregate medical and administrative expenses in their financial statements, and this information may be misleading to financial statement users if medical expenses are misclassified as administrative expenses or vice-versa. Under the PPACA, if a health insurer fails

² This requirement applied to not-for-profit hospitals, which are granted tax exemptions in Texas (as well as under the US Federal tax system).

to meet a minimum MLR they are required to refund the difference back to their customers. Such rebates are treated as reductions of revenue in the financial statements.

4. A PRE-PPACA MLR MISSTATEMENT

WellCare Health Plans, Inc. is an insurance provider based in Tampa, Florida that understated its administrative expenses by inappropriately classifying them as eligible medical expenses to increase its MLR.³ These events occurred before the enactment of the PPACA and its MLR provisions. However, under Florida state law, WellCare was required to meet a minimum MLR for plans funded by the state of Florida. WellCare contracted with two agencies of the State of Florida (the Florida Agency for Health Care Administration (AHCA) and Florida Healthy Kids) to provide health service to eligible patients covered under Florida State health care plans.

The Florida AHCA contracts with WellCare were for the provision of behavioral health care services. These contracts were covered by Florida State § 409.912(4)b, also known as the 80/20 statute. The statute required the health care plans to spend at least 80% of the premium revenue received from the state on eligible mental health expenditures. Like the MLR under PPACA, if the 80% threshold were not reached, the company was required to refund back to the Florida AHCA that portion of the premiums that fell below the 80% threshold. In 2004, the company did submit a refund to the Florida AHCA because the company failed to reach 80% mental health spending level. However, they misreported the amount by which they failed to reach the ratio, and thereby understated the amount of the refund due to the Florida AHCA by approximately \$6 million by overstating medical benefits expenses by the same amount. The \$6 million overstatement of the medical expenditures was brought about by reporting items including

³ Unless otherwise noted, this case discussion is based on SEC (2012) and WellCare (2009).

“administrative costs related to one of WellCare’s ... offices” (SEC 2012, ¶ 59) as health care expenditures.

WellCare also did business with Florida Healthy Kids. The Healthy Kids contracts provided health insurance to uninsured children whose families were not eligible for Medicaid. These contracts were governed by Florida statute § 624.91, which required the health care plans to spend at least 85% of premium revenue on eligible health expenses. If the MLR fell below that threshold, the companies were required to pay back half of the portion of the premiums that fell below the 85% threshold. Like the AHCA contracts, the companies did report and pay required refunds. However, the required refunds were underreported (and underpaid). For example, in calculating its 2005 required refund to Healthy Kids, the company classified over \$11,000,000 of administrative expenses as medical expenses, resulting in a refund of only \$0.3 million, when the refund should have been \$5.8 million (SEC, 2012, ¶ 86 & 87).⁴

On October 24, 2007, U.S. Federal law enforcement agents executed a search warrant at WellCare’s headquarters, apparently in response to allegations made by a whistle blower within the company.⁵ Shortly thereafter, WellCare’s CEO, CFO and General Counsel were fired from the company (Hundley, 2008) and the board established a special committee to investigate the required refund issue. On August 18, 2008, WellCare agreed to pay restitution to the AHCA and Healthy Kids (WellCare/AHCA/Attorney General of Florida/US Attorney’s Office, 2008).

⁴ The \$5.5 million difference between the disbursed refund and the appropriate refund is half of the misclassified administrative expenses because Florida Healthy Kids required refunds of one half of the difference between the actual medical benefits expenses and the minimum expenses based on the MLR.

⁵ Based on the disclosure of whistle-blower qui tam lawsuits in WellCare (2009).

5. MLR PROVISIONS IN THE PPACA

The Patient Protection and Affordable Care Act was passed by the US Congress and signed into law on March 23, 2010. The Act has a variety of provisions, including a mandate for individuals to purchase health insurance. To ensure that the premiums paid to the insurance companies under the coverage mandates are used to provide health *care* (rather than just health *insurance*), provisions of the Act require that a minimum level of the premium revenue be used for health care expenditures. If insurers' administrative expenses were high (resulting in a low MLR), these high administrative expenses would leave fewer resources for health benefits, and thereby limit the ability of policy holders to get health *care*. If the health care expenditures fall below the minimum level (MLR), the insurers are required to refund the difference to their customers.

The inclusion of an MLR minimum requirement was a component of the Federal Health Care Bill very early in the legislative process. In 2009, Senator Al Franken proposed that the MLR requirement be set at 90% (Congressional Record, 2009). Eventually, the bill adopted an 80% or 85% minimum MLR, depending on the plan market. Senator John D. Rockefeller was one of the more outspoken proponents of the minimum MLR provision:

I'm going to say one word about medical loss ratio, because it's sort of a crazy name but it's a really good concept. What we say is that—the health insurance industry says that they spend 87 percent of all of their revenues from premiums or any investment that they might have on health care. That doesn't work out quite that way. For large businesses, they do a much better job, but for small businesses and the individual market, they're down, in West Virginia, in the high sixties and the low seventies.

So how do you stop that? You can't stop that by asking them to. You stop that by having a law, which is a good law, saying that you have to spend between 80 and 85 percent of everything you take in in revenue on medical care for your patients. And if you don't, we will know about it because we'll be tracking it. And then you have to rebate that difference to the people. (Administration of Barak H. Obama, 2010, p. 11)

On the other side of the debate, there have also been concerns expressed about unintended consequences of minimum MLR requirements, including higher premiums and fewer insurers participating in certain markets (Harrington, 2012). Pre-PPACA observers of the measurement of MLRs have expressed concern that MLRs may not reflect the quality or efficiency of the organizations (e.g., Robinson 1997) due to natural variations in insurer types, such as fee-for-service and managed care organizations.

Under the Health Care Law as eventually enacted, the minimum MLR is 80% in the small group/individual market and 85% in the large group market. The differentiation between these two markets recognizes that economies of scale exist in health care administration expenses which should reduce the per member cost of administration for larger plans.⁶ If the MLR is below the minimum requirement, the insurer must “provide an annual rebate to each enrollee ... on a pro rata basis” and the rebates (in total) must equal the dollar amount by which the MLR falls short of the minimum MLR (HHS, 2010, D(4)).

⁶ The law permits the secretary of HHS to grant waivers of the MLR minimums in special circumstances. For example, the State of Maine (which at the state level has imposed a 65% MLR minimum) has requested a waiver of the MLR requirement (Igelhart, 2011). Maine's concerns include the possible loss of one of the two insurers doing business in the state and because the small population (and low population density) may inhibit the economies of scale necessary to reduce administrative expense ratios.

6. MEASURING MLR

6.1 MLR measurement regulations

Congress delegated the responsibility for defining the MLR to the National Association of [State] Insurance Commissioners (NAIC), as some state insurance regulators had experience with MLR measurement issues (Jost, 2010).⁷ Based on the NAIC's criteria, The U.S. Department of Health and Human Services (HHS) issued its final regulations on the calculation of MLRs (HHS, 2010). The report came to the following conclusions:

1. Reports on the insurer's MLR must be submitted by June 1 of the following year

2. Reporting basis: The insurer must report MLRs and determine rebates by state and health insurance market, regardless of the insurer's organizational structure. The health insurance markets within each state are the individual market, small group market and large group market.

3. If the insurer is new or new to the state or health insurance market, the insurer can defer their MLR report until the following period, as it may be difficult to measure MLR for a new market with less than a full year of data.

4. Premium revenue, which is the denominator in the MLR calculation, is defined as "...the sum of all monies paid by a policyholder as a condition of receiving coverage from a health insurance issuer..." (HHS, Subpart A, ¶ 4).

5. Reimbursements for clinical services (i.e., medical benefit expenses) are defined as "the sum of direct paid claims incurred ... unpaid claim reserves associated with claims incurred ... the change in contract reserves, reserve for contingent benefits

⁷ In the pre-PPACA era, some states required rebates for a limited group of *state-funded* insurance plans based on some measure of MLR. For example, the state MLR provisions in Florida were presented earlier in the discussion of the WellCare misstatement. The PPACA substantially expanded the minimum MLR requirement beyond *state-funded* plans to include most privately-funded plans.

... the claim portion of lawsuits, and any experienced rating [i.e., non-MLR] refunds paid or received” (HHS, Subpart A, ¶ 5).

6. Activities that improve health care quality, which includes activities designed to:

- a. Improve health outcome through better patient care management
- b. Prevent hospital readmissions
- c. Reduce medical errors
- d. Implement wellness and health promotion activities.

Note that the sum of # 5 (reimbursements for clinical services) and # 6 (activities that improve health care quality) is the numerator (i.e., medical benefit expenses) in the MLR calculation.

7. Other non-claims costs include expenses such as “sale expenses, agents and brokers fees and commissions, ... community benefit expenditures and general administrative expenses” (HHS, Subpart A, ¶ 7). These expenses are excluded from the numerator of the MLR calculation. In effect, the 15% or 20% remaining above the MLR can cover these expenses (plus the insurer’s profit).

8. State and Federal taxes are excluded from both the numerator (medical expenses) and the denominator (premium revenue).

6.2 Areas of controversy and/or concern

Reflecting their desire to avoid and/or minimize the refunds required if the minimum MLR is not met, the insurance industry viewed the measurement of MLR as a critical issue. An analyst at Barclay’s notes that (Raskin, 2010):⁸

the definition of the medical loss ratios for the purpose of health care reform will be one of the most important events this year for managed care stocks

⁸ Reflecting the industry viewpoint, note that the analyst’s report is subtitled: “First Sign of MLR Language Positive”

There are three main areas of controversy regarding the measurement of the MLR: the reporting basis, measurement of medical benefits expenses, and measurement/inclusion of activities that improve health care.

6.2.1 Reporting Basis. The determination of an appropriate reporting basis (point # 2 of the HHS regulations) can lead to different MLR and rebate outcomes. Pre-PPACA, Robinson (1997) expressed concern that the MLR cannot be meaningfully compared across different types of markets and across states. The PPACA and HHS regulations recognize the state-by-state differentiation in the insurance business and further divide the insurance business within states into three different markets: the individual market, the small group market, and the large group market. The insurance industry favored aggregating the individual and small group markets. HHS (2010, p. 74871) notes that they had “received comments from . . . [the health insurance] industry supporting the consolidation of the individual and small group markets.” The HHS (2010, p. 74871) noted that this consolidation of individual and small group markets “could . . . deprive consumers in one of these markets of the value of the statutory MLR standard.” The final rule required separation of the individual and small group markets.⁹

Exhibit 1 illustrates how either keeping the individual and small group markets separate or consolidating the two markets could affect MLRs and the required rebates. In this exhibit, one of the markets (the individual market) has an MLR below the minimum required MLR, while the other market (the small group market) has an MLR above the minimum.¹⁰ Note that when the

⁹ Note that the individual and small group markets can be consolidated in individual states if, in those states, “the two markets [are] combined [by the state insurance regulator] for rating purposes” (HHS, 2010, p. 74871).

¹⁰ If both markets had an MLR above the minimum, no rebate would be due in either the two separate markets or the consolidated market. If both markets had

markets are separated, a rebate is due for one of the markets (the individual market). When the markets are consolidated, the MLR of the consolidated exceeds the minimum MLR, so no rebate is due in that state. In effect, consolidation of the individual and small group markets permits insurers to offset a potentially low MLR in one of the two markets (i.e., either individual or group) if they have a higher MLR in the other market.

6.2.2 Medical benefits expenses. With regard to medical benefits payments (point # 5 of the HHS regulations), some of these expenses (e.g., unpaid claim reserves and reserve for contingent benefits) are subjectively determined, and thus are potentially subject to error and/or manipulation. As an example of the magnitude of these expenses, Wellpoint (a large health insurance company) reports estimated medical claims payable of \$6,127.2 (in millions) at December 31, 2013 and total claims paid for the period ended December 31, 2013 of \$55,338.7 (in millions). Thus, estimated claims at December 31, 2013 represented 11.1% of claims paid during 2013. The average over the three year period ended December 31, 2013 of estimated claims at year end to total claims paid during the year was 11.9%.¹¹

6.2.3 Activities to improve health care. The most controversy has centered on activities to improve health care quality (point # 6 of the HHS regulations). Concerns were expressed that insurers could shift costs that are of an administrative nature into this category. The American Medical Association recognized this concern and noted that cost containment initiatives may be reported as “activity to improve quality” which would increase the reported MLR without

an MLR below the minimum, the total rebate in the two markets would be the same as the rebate due in the markets were combined.

¹¹ Author’s calculations based on data provided in footnote 12 to the financial statements contained in Wellpoint’s 2013 10-K (Wellpoint, 2014).

enhancing patient care. Specifically, the AMA (2010, p.1) notes that:

the potential [exists that] health insurers will attempt to shift expenses that have long been categorized as "cost containment" expenses to the "quality improvement" side of the ledger which ... will be counted in the numerator along with payments for medical services in the medical loss calculation.

Senator Rockefeller (one of the advocates of an MLR requirement) expressed similar concerns (Rockefeller, 2010, p. 5): "...insurers are actively reviewing their accounting practices and attempting to shift expenses from the administrative to the medical side." He further notes that the intent of the law was not to "provide health insurance companies new opportunities to cook the books" (Rockefeller, 2010, p. 5).

To illustrate the potential influence of how medical benefits expenses were defined for MLR calculations, consider the financial results of WellPoint, a publicly-traded health insurance company. The company announced in 2010 that they were reclassifying some expenses¹² which had previously been considered to be administrative expenses as benefits expense. Their 2010 10-K noted that:

Beginning January 1, 2010, we began classifying certain claims-related costs, which were historically classified as administrative expenses, as benefit expense to better reflect costs incurred for our members' traditional medical care as well as those expenses which improve our members' health and medical outcomes.

To ensure comparability in their financial statement presentation, they restated their 2009 income statement to reflect this new classification, which allows for the measurement of the size of

¹² Note that (unlike the WellCare misstatement case discussed earlier), WellPoint was operating within the definitions approved by HHS. WellPoint reclassified (not misstated) their administrative and benefit expenses to make their GAAP reporting closer to the PPACA measurement regulations.

this reclassification.¹³ The 2009 expense restatement/reclassification is summarized in Table 1. The table indicates that the company reclassified \$548 million of expenses from administrative expense to benefits expense. The reclassification increased the benefits expense ratio by 1% from 82.6% to 83.6%, while decreasing the reported selling,¹⁴ general and administrative expense ratio by 0.9%¹⁵ from 15.9% to 15.0%.

Note that the restated MLR is between the minimum MLRs for the individual and small group markets (80%) and the MLR for the large group market (85%). Depending on the breakdown of the company's business between these three markets, the reclassification could affect the required rebates. For example, subsidiaries of WellPoint were required to pay \$12 million in rebates to customers in California (Terhune, 2013) and \$61.1 million in rebates to customers in New York (Indianapolis Business Journal, 2011).

¹³ Note, however, that the MLR regulations under the PPACA did not change GAAP reporting requirements. For example, Wellpoint's 2013 10-K notes that:

Where appropriate, we adopted HHS' classification of costs . . . to further align our GAAP basis benefit expense to that used in the calculation for determining MLR rebates under HHS guidance. However, certain components of the MLR computation as defined by HHS cannot be classified consistently under GAAP. Accordingly, benefit expense ratios shown in our GAAP basis presentation are different than the MLRs used to calculate rebates under HHS guidance.

I therefore cannot determine how such reclassifications could have affected the MLR under the HHS rules. However, given the statement that "certain components of the MLR computation as defined by HHS cannot be classified consistently under GAAP," the figures presented in this paragraph are probably conservative estimates of the potential effects of the reclassification.

¹⁴ Selling expenses were not affected by the reclassification.

¹⁵ The different in the increase in the report benefit expense ratio (1%) and the decrease in the reported SG&A expense ratio is due to rounding.

7. IMPLICATIONS

7.1 Implications for executives

The use (and misuse) of MLRs could have implications for insurance company executives, including the corporate accountants. Executives need to be sensitive to the definition of medical benefits vs. administrative expenses in reporting to regulatory oversight bodies (and in their financial statements). Misclassification can affect the amount of refund due to the government and/or policy holders. Accountants should also be aware that they can be held personally liable for any misclassification that affects the refund amount.¹⁶

7.2 Implications for auditors

Auditors need to consider and respond to the misstatement incentive their clients may have (PCAOB Auditing Standards (AS) # 8, ¶5 to 8).¹⁷ The incentives include the motivation to misclassify expenses as medical benefits rather than as administrative expenses or to overstate the claims contingency, both of which would reduce the required refund and result in higher reported income and operating cash flow.

When assessing materiality, auditors often view misstatements of classification to be of less concern than other types of misstatements (Costigan and Simon, 1995; Wright and Wright 1997), because reclassifications ordinarily do not affect reported net income; all of the expenses are still reported, they are just misclassified. For a misclassification of administrative as medical expenses, the first order effect would not affect net income, as the expense is still reported on the income statement. However, if there is an MLR requirement, there is a second order

¹⁶ Note that in the WellCare case, three executive are being personally sued by the SEC.

¹⁷ Generally Accepted Auditing Standards have essentially the same requirements.

effect that does affect net income: the misclassification reduces the required refund which does affect net income. Auditors should therefore be sure to consider the second order (and ultimate) effect of a misclassification which will increase in net income. A reclassification between administrative and benefits expense can change the required refund, which would change reported net income.

Auditors should also consider the *nature* of the misstatement, not simply the amount of the misstatement in deciding whether the financial statements are materially misstated (PCAOB AS # 11). Qualitative factors should also be considered by the auditor (SEC Staff Accounting Bulletin # 99). Appendix B to PCAOB AS # 14 provides some factors the auditor should consider when assessing whether a misstatement (even if small) could be material. These factors include:¹⁸

- d. The potential effect of the misstatement on the company's compliance with loan covenants, other contractual agreements, and regulatory provisions.
- e. The existence of statutory or regulatory reporting requirements that affect materiality thresholds.
- g. The sensitivity of the circumstances surrounding the misstatement, for example, the implications of misstatements involving fraud and possible illegal acts, violations of contractual provisions, and conflicts of interest.
- l. The motivation of management with respect to the misstatement

Each of these factors could raise concerns regarding the materiality of an expense misclassification, even if the misstatement were small. Auditors also need to be sensitive to the possibility of illegal acts that could have a direct and material effect on the financial statements (PCAOB AU 317).

¹⁸ The lettering of the factors to consider is from the original document (i.e., Appendix B to AS # 14).

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Exhibit 1**Effects of aggregation v. disaggregation on potential premium rebates**Assume:

- a. A health insurance company has insurance plans for the individual, small group and large group markets in a certain state.
- b. Total premium revenues are evenly divided among the three markets.
- c. The minimum Medical Loss Ratio (MLR) for the individual and small group markets is 80%, while the minimum MLR for the large group market is 85%.
- d. The health insurance company's MLR varies by market, with the individual market having an MLR below the minimum required MLR, while the small group and large group markets have MLRs above the required MLR.

Possibility 1: Separation of individual and small group markets:

	Individual	Small group	Large group	Total
Premium Revenue	\$30,000,000	\$30,000,000	\$30,000,000	\$90,000,000
Medical Expenses	\$23,550,000	\$25,230,000	\$25,530,000	\$74,310,000
Medical Loss Ratio (MLR)	78.50%	84.10%	85.10%	82.57%
Market MLR \geq Required MLR	No	Yes	Yes	
Required rebate	\$450,000*	None	None	\$450,000

* Premium revenue (\$30,000,000) * required MLR (80%) = \$24,000,000 – Medical Expenses (\$23,550,000) = Required reimbursement (\$450,000)

Exhibit 1 (continued)

Possibility 2: Consolidation of individual and small group markets:

	Individual and Small group	Large group	Total
Premium Revenue	\$60,000,000	\$30,000,000	\$90,000,000
Medical Expenses	\$48,780,000	\$25,530,000	\$74,310,000
Medical Loss Ratio (MLR)	81.30%	85.10%	82.57%
Market MLR \geq Required MLR	Yes	Yes	
Required reimbursement	None	None	None

Table 2
WellPoint's reclassification of 2009 administrative expenses as
benefits expense

	2009, restated	2009, as reported	Difference
Administrative expense (\$ millions)	\$7,424.9	\$7,973.6	(\$548.7)
Benefits expense (\$ millions)	\$47,119.8	\$46,571.1	\$548.7
Selling, general and administrative expense ratio (as % of revenue)	15.0%	15.9%	
Benefits expense ratio (as % of revenue)	83.6%	82.6%	
Source:	WellPoint 2010 10-K	WellPoint 2009 10-K	