More Bang for the Health Care Buck

How an Efficiency Standard for Health Insurers Can Reduce Overhead and Deliver More Patient Care

CALPIRG Education Fund

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Executive Summary

The high cost of health care in California imposes an increasing burden on households, businesses, government, and the state's economy—a burden made heavier by the current economic crisis. The money that insurance companies spend on inefficient administration, billing and marketing—instead of medical care for their enrollees—contributes to the high health care costs Californians must endure. To encourage efficiency and get costs under control, California should require health plans and insurers to spend at least 85 percent of revenue on health care. The majority of California health plans, including small, large, non-profit and for-profit HMOs, already meet this efficiency standard, as do a large percentage of health plans and insurers across the country.

Health care is enormously expensive in California. But a lot of the money Californians spend on health insurance goes toward things that have nothing to do with keeping us healthy, such as inefficient administration and billing practices, marketing, and profits.

- In 2004, insurance companies, the state and federal government, individuals and other payers spent $167 billion on health care in California, equal to 11 percent of the state's gross domestic product.

- For 36 California HMO plans evaluated by the California Medical Association, administrative spending ranged from 4.1 percent of revenue to 16.3 percent.

- Health plans and insurers have an incentive to keep the percentage of revenue they spend on health care low. For example, Great-West Healthcare of California decreased the percentage of revenue it spent on medical costs every year from 2003 to 2007, from 85.8 percent to 69.4 percent. Over the same period the company's profits increased from 0.5 percent to over 10 percent, while the portion spent on administration stayed essentially the same.

Health plans and insurance companies have an incentive to reduce the amount they spend on health care because the stock market favors companies that devote higher portions of their revenue to administration, marketing, and profit-taking.

To get rising health care costs under control, it is critical to encourage greater insurer efficiency and increase the value of coverage by requiring insurers to spend 85 cents of every revenue dollar on health care. Providing incentives for efficiency will reward insurers for finding ways to reduce administrative costs and deliver better value to consumers. Further, data on current practices of California insurers shows that an 85 percent standard is both strong and achievable.

Successful health plans and insurers can, and often do, spend more than 85 percent of revenue on health care.

- While some California health insurers spend too small a share of revenue on health care, many major HMOs achieve a proper balance. More than two-thirds of the major HMOs in California spend at least 85 percent of their revenues on health care (see Figure 1).

- Nationally, many health insurers—including some of the nation's largest and most respected health plans, such as Aetna's plans in Washington and Michigan, and Anthem's plan in New York—spend the bulk of revenue on health care. Nearly half of 53 health plans surveyed nationwide spend at least 85 percent of their revenues on health care (see Figure 2).

Requiring health insurance companies to spend at least 85 percent of their revenue on medical care would ensure that our health care dollars are being spent on health care and could save Californians' money.

- Enforcing a minimum percentage of health care spending encourages

Figure 1: The percentage of revenue that California HMOs spend on health care.[1]

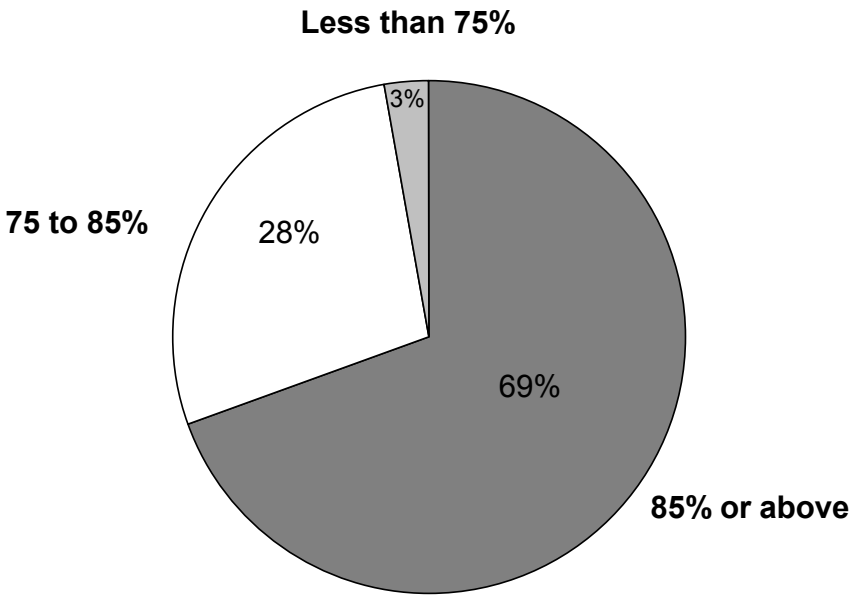
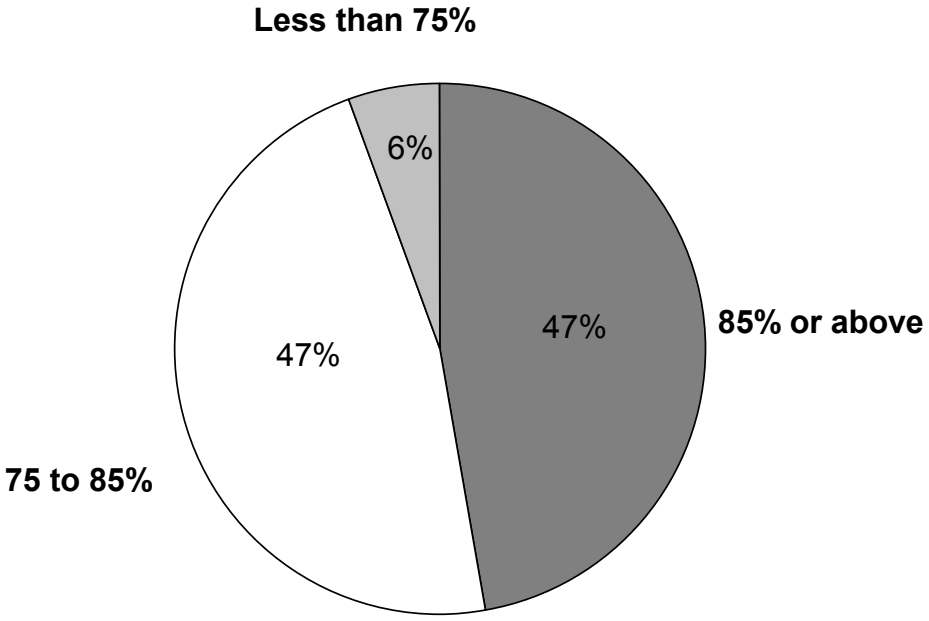


Figure 2: The percentage of revenue that selected health insurance companies outside California spend on health care.[2]



insurance companies to increase their administrative efficiency.

- In 2007, the absence of an 85 percent floor allowed California health insurance companies to spend $1.1 billion on administration and profits instead of health care.[3]

California should require health plans and insurance companies to spend at least 85 percent of revenue dollars on health care to encourage efficiency and ensure that the companies are spending health care money on Californians' health. Furthermore, additional steps should also be taken to help insurance companies increase their efficiency, bring down costs, and ensure that money spent in the health care industry goes to improving Californians' health.

Introduction

To many Californians, "HMO" is a four-letter word.

Scarred by the managed care experiences of the 1990s and deeply worried about soaring health care costs, Californians—like most other Americans—remain deeply skeptical about the motivations and actions of their health insurers. We remember the news stories about patients with medical emergencies whose insurers delayed their care or denied it altogether, leading to long-term health problems and deaths that could have been avoided.

A recent national poll suggests that only 7 percent of Americans view health insurers as generally trustworthy, and only 5 percent trust HMOs.[4] Indeed, Americans are more likely to report that they have personally seen a UFO than that they trust their health insurer.[5]

Among the reasons Californians are skeptical of health insurers is the suspicion that they waste resources on Kafkaesque billing and administrative procedures and bank large profits by squeezing customers. Consumers worry that the money they spend on health care premiums isn't actually being used to improve their health.

That skepticism is deserved. For-profit health insurers face pressure from investors to maximize profits, creating an incentive to devote fewer resources to health care.

Consumers need a backstop to ensure that the money they spend on health insurance premiums is being used efficiently to improve their health. Many states have assumed a watchdog role by setting a minimum threshold for the share of health plan and insurance companies' revenue dollars—revenue gained almost exclusively through premium payments—that are devoted to health care. These fair rules ensure that when health insurers work to increase their profits, they do it by enrolling new customers or making their operations more efficient—not by shortchanging beneficiaries.

Setting a minimum threshold for insurers' spending on health care would protect California consumers and ensure that our health care system is working for us.

Rising Health Care Costs Are Hurting Californians

The high cost of health care in California imposes an increasing burden on households, businesses, government, and the state's economy. In 2004, insurance companies, the state and federal government, individuals and other payers spent $167 billion on health care in California, equal to 11 percent of the state's gross domestic product.[6] Nationally, health care spending rose 56 percent from 2000 to 2006, versus an inflation rate of just 18 percent and wage increases of 20 percent, forcing employers to choose between reducing benefits, limiting wage increases, and hiring fewer employees.[7]

But while costs are rising, we aren't getting better care for our money. The Business Roundtable recently performed a cost-benefit analysis on the American health care system, comparing the amount we spend on health care to the health of American workers, as measured by indicators such as death rates and sick days. Our leading economic competitors like Canada and the United Kingdom spend 63 cents for every dollar we spend on health care, while our health is 10 percent worse; moreover, the health of American workers is 5 percent worse than workers in Brazil, India and China, who spend 15 cents for every dollar we spend on health care.[8]

One reason that our health care continues to be inferior despite rising costs is that much of the money we spend on health care doesn't actually go towards improving our health. Unproductive spending can be found in many areas of the health care industry—among them, insurers' spending on excessive administrative expenses and marketing.

These expenses can make up a significant share of health insurers' total spending. While some administrative spending is necessary and even beneficial to health care, much of it could be made more efficient. The California Medical Association evaluated the spending of 36 HMOs in California. Administrative spending for these plans ranged from 4.1 percent of revenue to 16.3 percent, while the amount kept for profit was as much as 16 percent of revenue.[9] This wide range suggests that the health plans and insurers that spend high percentages of their revenue on administration could make their administrative practices more efficient.

Health plans' and insurers' spending on inefficient administration, marketing,

and profits is not the only problem in California's health care system. However, it is one of a number of places where health care money is being spent in a way that does not improve the health of Californians. Improving the efficiency of health insurers is a necessary part of fixing health care in California.

Health Plans and Insurance Companies Should Prioritize Health Care

Health Plans and Insurance Companies Have an Incentive to Keep Medical Spending Low

The portion of revenue that health plan and insurance companies spend on actual medical care is known in the insurance world as the "medical loss ratio," or MLR (or, sometimes, the "health benefit ratio"). Perversely, the term derives from the fact that from the insurers' point of view, dollars spent on actual medical care are a "loss" to the company. All other things being equal, consumers get the best value when this number is high, with most of their premium coming back to consumers to pay for health costs such as doctor's visits and surgeries and only the minimum necessary being kept for administrative and other non-health costs.

Health plans and insurance companies, however, have an incentive to keep this number low. Stock analysts use the MLR as a rough, inverse indicator of a company's investment potential; since a low ratio can mean higher profits, it often increases an insurance company's stock value.[10]

Because of this incentive, some insurance companies spend extremely low percentages of their revenue on health care, especially in markets where consumers have less bargaining power, such as insurance for individuals or small businesses. Insurers that market healthcare to individuals sometimes spend only 60 percent of premium dollars on health care, devoting the rest to administration, marketing and profit.[11]

The incentive to maximize profits encourages insurance companies to find ways to reduce their spending on medical care in ways that are not always fair to the people to whom they're providing health insurance. For example, an investigation by *BusinessWeek* found that many insurance plans that colleges recommend to their students spend very small portions of their premium money on health care for the students, as little as 10 percent in a semester. Although college students have relatively low medical costs, these insurance companies take advantage of the low competitiveness in this market by offering very limited benefits and keeping the balance of students' premiums.[12] This 10

percent figure does not translate directly into an MLR, since the company presumably would keep another portion of the premium money to build their reserves for health spending. Still, the figure remains shockingly low.

California Can Protect Health Insurance Consumers by Setting an Insurer Efficiency Standard of 85 Percent

To protect consumers, many states require that insurers meet a minimum standard for the percentage of revenue they spend on health benefits. Fourteen states require insurance companies to meet minimum standards ranging from 55 percent for individual health plans in North Dakota to 82 percent for large group carriers in Minnesota (See Table 1).

California has some restrictions on managed care plans' administrative spending, which is limited to 15 to 25 percent of the money HMOs get from premiums, but there is no minimum for the amount spent on health care.[13] Moreover, only HMOs are required to meet these standards—other health insurers are grouped with other types of insurers, such as car or homeowners insurers, and regulated in the same way by the California Department of Insurance (CDI). Large health insurers have plans in both categories, and are working to increase the number of enrollees that they have in unregulated plans. The CDI doesn't track the percentage of

A Floor for Health Spending: An Essential Piece of a Larger Puzzle

Requiring insurers to spend a minimum percentage of revenue on health care can increase the efficiency with which health care is delivered, and protect consumers. But it is not a panacea. A medical loss ratio only tells a consumer so much about the efficiency of a health insurer or quality of the health care coverage they have purchased. For example, a health insurer can boost its MLR by spending more on health care, whether those expenditures are warranted or not, rather than by curtailing administrative expenditures or profits. On the other hand, an insurer that invests in quality preventive care – thereby reducing the need for expensive tests and procedures – might have to cut back further on administrative expenditures in order to meet a minimum MLR floor, a perverse result if the overall goal is to reduce wasteful health care spending.

In other words, requiring California health insurers to achieve a minimum medical loss ratio is but one piece of the much larger puzzle of health care reform. The important purpose that a minimum medical loss ratio serves is to act as an incentive for insurers to prioritize efficiency and as a backstop protection for consumers to ensure that the money they spend on health care premiums is being spent for their benefit.

revenue that the health insurance plans they oversee spend on medical care, but the numbers they do report suggest that these plans keep much larger percentages for administration and profit than their corresponding HMOs.[14]

California decision-makers have considered requiring health insurance companies to spend at least 85 percent of their revenue on health care. This policy would represent the most protective MLR floor in the country.

Table 1: Floors for the percentage of revenue spent on health care, by state (states without protections are not listed).[15]

State	Individual Market	Small Group Market	Other
California			Managed care plans: Administrative costs not to be "excessive," limited to 15% to 25% based on developmental phase of plan. Administrative costs do not include some factors such as salaries, stock options, etc.
Delaware		75%	
Kentucky	65%	Groups of 2-10: 70% Groups of 11-50: 75%	
Maine	65%	Insurers that file rates annually: 75% Insurers that file rates every three years: 78%	
Maryland	60%	75%	
Minnesota	65%	Groups of 2-9: 71% Groups of 10-50: 75%	Large group carriers: 82%
Nevada			Non-profit corporations: 75% Individual dental insurance: 75%
New Jersey	75%	75%	
New York	80%	75%	
North Dakota	55%	70%	
Oklahoma		60%	
South Dakota	65%	75%	
Vermont	70%		Safety net market: 80%
Washington	77%		
Wyoming	60%	73%	

Requiring Health Plans and Insurers to Spend 85 Percent of Revenue on Health Care Is Achievable

An 85 percent floor for the percentage of revenue California health plans and insurers must spend on health care would ensure that health insurance companies are using most of the money they get from premium payments for medical expenses, and incentivize them to be more efficient in their administration and marketing. But these benefits would only be realized if California's insurers are actually able to meet the standard, which is higher than any other state's existing requirement. Data on spending by health plans currently marketed in California and in other states, however, shows that most insurance providers already achieve this ratio, suggesting that those that do not could change their operations in order to measure up to their more efficient fellows.

The California Medical Association (CMA) evaluated 36 HMO health plans in California and calculated the percentage of their revenue that went towards medical care.[16] Of those plans, 25 plans (69 percent) spent 85 percent or more of their revenue on medical care (see Figure 3). Eleven plans (31 percent) spent less than 85 percent of their revenue on medical care. Percentages ranged from 69.4 to 95.3.[17] Among the plans that did not achieve an 85 percent medical loss ratio, most were in the 75 to 85 percent range, suggesting that relatively straightforward changes to operations could result in their meeting the target.

The private health plan that spent the highest percentage of revenue on health care was Scripps, at 95.3 percent. Cigna and Kaiser had the highest MLRs of plans with over 100,000 enrollees, spending 94.3 and 90.3 percent of their revenue on health care, respectively. Great-West Healthcare of California spent the lowest percentage on health care, at 69.4 percent.[18]

Small health insurers, with fewer than 20,000 enrollees, were also able to spend at least 85 percent of their revenue on health care. Out of the five small insurers that CMA looked at, three spent more than 85 percent of their revenue on health care. Of the two that didn't, both spent more than 75 percent on health care. On Lok Senior Health Services, one of those two companies, with 1,049 enrollees, has spent more than 85 percent of revenue on health care for four out of the past five years. These figures suggest that small insurers, equally as well as their larger cousins, will be able

to meet an 85 percent standard.

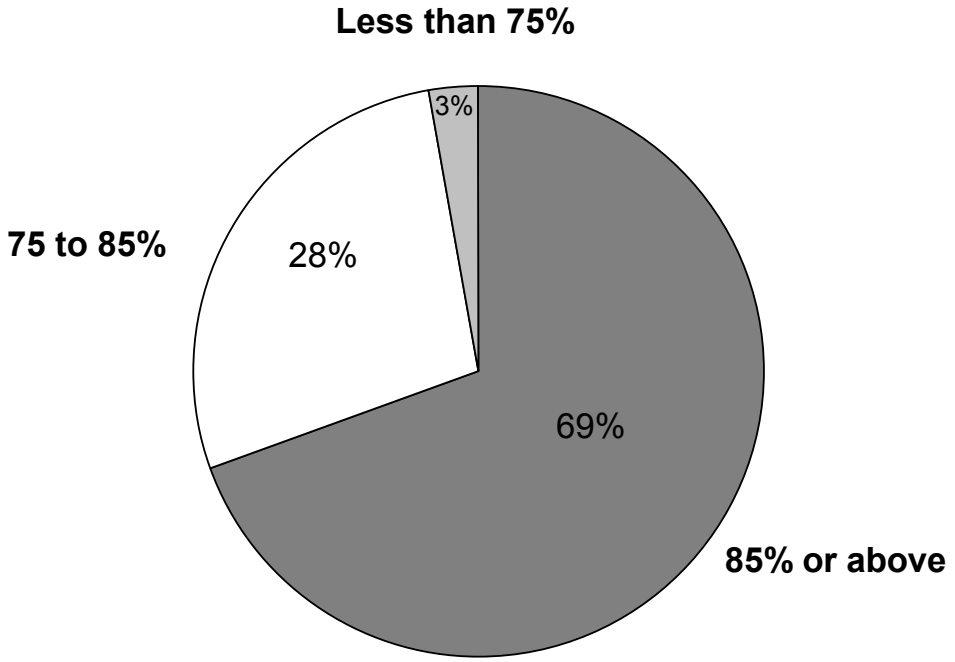
A majority of both non-profit and for-profit health insurance companies spend over 85 percent of their revenue on health care. Of the for-profit companies, 60 percent met this efficiency standard in 2007. Of the non-profit companies, 76 percent met the efficiency standard.

Clearly, there is a such thing as spending too high of a percentage of revenue on health care—companies that spend all of their revenue on health care will not be financially stable.[19] But the data shows that most companies spending between 85 and 90 percent of revenue on health care in California are also making a healthy profit. (See Appendix for full list of California MLRs and profits.)

To examine the experience of other states, we surveyed the percentage of revenue that health plans outside California spent on medical care using the National Association of Insurance Commissioners consumer information source database.[21] We looked at the six largest national health insurers and sought their MLRs for their operations in 10 states across the country, with those states chosen based on their similarity to California either in their geography or demographics. (The 10 states were Washington, Oregon, Nevada, Colorado, Michigan, Texas, New York, Massachusetts, Georgia and Florida.). In addition we sought out one locally important insurer for each state, identifying these either through the *U.S. World and News Report* lists of best health care plans by state, or, where available, through lists of the health insurance companies with the largest market share in a state.[22]

Of the 70 insurers chosen, unique MLRs were listed for 53 in the NAIC database (in some cases, insurers reported the same MLR for their operations in more than one state). Out of these 53 plans, 25 (47 percent) spent 85 percent or more of

Figure 3: The percentage of revenue that California HMOs spend on health care.[20]



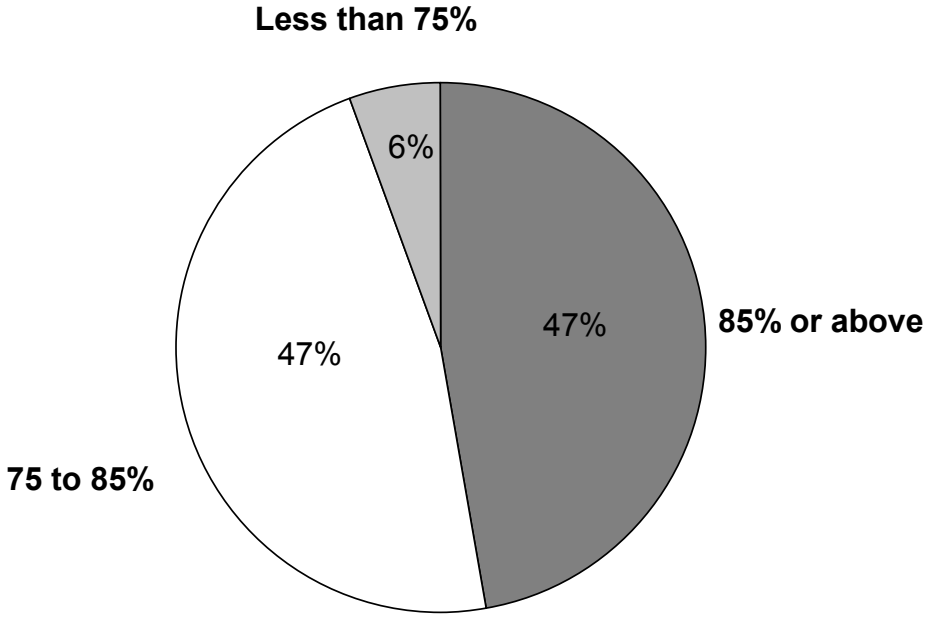
their revenue on medical care (see Figure 4). The remaining 28 plans (53 percent) spent less than 85 percent of their revenue on medical care. Percentages ranged from 56.1 to 95.2 percent.

The plans spending the highest percentage of revenue on health care were Aetna Health of Washington (95.2 percent), Scott and White Health Plan of Texas (90.3 percent), and Empire Healthchoice Assurance of the Anthem group in New York (89.9 percent). The two plans that spent the lowest percentage of their revenue on health were outliers, with all other plans spending at least 70 percent of their revenue on health care. Those two plans were Humana Employers Health Plan in Georgia (56.1 percent) and Aetna Health Insurance Company in Oregon (57.3 percent). The next lowest-spending plan was Pacificare of Oregon (71.6 percent).

Again, among those insurers who did not meet the 85 percent threshold for health care spending, the vast majority achieved MLRs of between 75 and 85 percent, suggesting that they would be able to comply with an 85 percent standard by taking comparatively modest steps to increase their administrative efficiency.

The data presented above should be viewed with a note of caution. There are a few ways to calculate the ratio, depending on what sources of income are counted as revenue and what expenses are counted as medical care, so some of these reported MLRs may be slightly higher or lower than a California regulation would calculate them to be. In any case, the data from around the country show that an 85 percent minimum requirement for medical loss ratios is achievable, and in fact is already met by many leading, profitable health plans and insurers across the country.

Figure 4: The percentage of revenue that selected health insurance companies outside California spend on health care.[23]



California Should Require Health Insurance Companies to Meet a Minimum Standard for Health Care Spending

While many health plans and insurance companies already spend more than 85 percent of their revenue on medical expenses, a number of companies spend less than that. These companies contribute to the high cost of health insurance through inefficient administrative practices, money spent on marketing, and increasing profits. And all private health plans and insurers face consistent pressure to reduce the share of revenue going to care.

A good example of this trend is Great-West Healthcare of California, which had the lowest ratio of any health care plan in California that the CMA surveyed. Great-West's MLR decreased every year from 2003 to 2007, from 85.8 to 69.4, and over the same period its profits increased from 0.5 percent to over 10 percent while the portion spent on administration stayed essentially the same.[24] In effect, Great-West simply decided to pocket a bigger chunk of customers' premiums as profits, reducing spending on care accordingly.

Health plans and insurers with low spending on health care waste millions of their members' dollars in premium payments that go towards inefficient administration, marketing, and profits. The CMA calculated that by not requiring health plans and insurance companies to spend at least 85 percent of revenue on actual health care, in 2007 California allowed companies to spend about $1.1 billion on administration and profits instead of health care.[25]

By enforcing a minimum MLR of 85 percent, California would ensure that most of the money health plan and insurance purchasers spend on premiums goes towards health care, turning that $1.1 billion into administrative savings and health benefits. This floor would provide an incentive for companies to increase their health plans' efficiency and reduce administrative expenses. Current MLRs for health plans and insurers in California and across the United States show that an 85 percent floor is achievable and is already met by many leading health plans.

Policy Recommendations

California should require health plans and insurance companies to spend at least 85 percent of their revenue on health care. This will encourage companies to increase the efficiency of their administrative practices. An 85 percent MLR floor is a necessary step towards making sure that more of the money we spend on health care in California is keeping us healthy.

When setting an 85 percent floor for the amount of money health plans and insurance companies must spend on health care, it will be important to calculate spending and revenue in a way that accurately capture companies' efficiency. The way that California calculates the percentage of revenue that a health insurer spends on health care can change the effectiveness of a minimum standard. One of the biggest sources of discrepancy in calculating MLRs is the money health insurers receive from subcontracts with other health plans and insurance companies. Neglecting to count this money as premium revenue usually only increases MLRs by a few percentage points. However, some companies, such as California's Molina Healthcare, get a large portion of their revenue through subcontracts, and omitting this source of income can make insurers that spend very low percentages of their revenue on health care appear more efficient than they actually are. This sort of revenue source should be included when calculating total revenue for health insurance MLRs.

An efficiency standard will create a universal incentive for health plans and insurers to cut administrative costs and save enrollees money. We can make that incentive even more effective by taking additional steps to help contain these costs:

- Health insurers should develop standardized systems for billing and insurance payment that reduce administrative burdens on both insurers and physicians. The state could offer financial incentives to health care providers who participate in a standard system, could make participation a requirement for insurers who provide health care coverage to state employees, or could simply mandate adoption of a system.

- Widespread adoption of electronic medical record systems, especially if

they are compatible between different hospitals and physicians' offices, can simplify billing and facilitate information sharing among providers. Easier sharing of information can help doctors to make better-informed diagnoses and recommendations, and reduce duplicative efforts.

California should move quickly to establish an 85 percent floor for the percentage of revenue health insurance companies spend on keeping Californians healthy, and take other steps to reduce health care costs. Establishing an efficiency standard for California insurers is not a panacea and will not solve all of the state's health care problems. But it is an important backstop protection for consumers that ensures that they get their money's worth with the hard-earned dollars they spend on health insurance.

Appendix

Health Care Spending For Non-California Health Plans

Medical Loss Ratios (MLRs) for Selected Health Plans and Insurance Companies Outside of California.[26]

Group/Regional	Health Plan or Insurance Company	State operating in	MLR
Aetna	Aetna Health Inc. WA Corp.	WA	95.2
Regional	Scott and White Health Plan	TX	90.3
Anthem	Empire Healthchoice Assurance Inc.	NY	89.9
Aetna	Aetna Health Inc. MI Corp.*	MI	89.7
Regional	Capital Health Plan Inc.*	FL	89.6
Regional	BCBS of MI	MI	89.6
Regional	Group Health Cooperative	WA	89.6
Cigna	Cigna Healthcare of MA Inc.	MA	89.4
Regional	Athens Area Health Plan Select	GA	89.3
Regional	Providence Health Plan	OR, WA	89.1
Cigna	Cigna Healthcare of NY Inc.*	NY	89.0
Aetna	Aetna Health Inc. CO Corp.	CO	88.9
Anthem	HMO CO Inc.	CO	88.9
Health Net	Health Net Insurance Company of NY Inc.	NY	88.9
Regional	Harvard Pilgrim Health Care Inc.	MA	88.4
Anthem	Anthem Insurance Co.	OR, WA, TX, FL	87.7
Anthem	Empire Healthchoice HMO Inc.	NY	87.6
Anthem	BCBS of GA Inc.	GA	87.0
Health Net	Health Net Health Plan of OR Inc.	OR, WA	87.0
UnitedHealth	United Healthcare Insurance Co of NY	NY	86.8

Group/Regional	Health Plan or Insurance Company	State operating in	MLR
UnitedHealth	United Healthcare of GA	GA	86.5
Humana	Humana Health Plan Inc.	NV, CO	86.4
Regional	Rocky Mountain Healthcare Options Inc.	CO	85.7
UnitedHealth	United Healthcare of NY Inc.*	NY	85.7
Cigna	Cigna Healthcare of FL Inc.*	FL	85.3
Humana	Humana Advantagecare Plan	FL	84.4
Humana	Humana Health Plan of TX Inc.	TX	84.4
Cigna	Cigna Healthcare of TX Inc.	TX	84.1
Regional	Rocky Mountain HMO Inc.	CO	83.7
UnitedHealth	United Healthcare of FL*	FL	83.4
Cigna	Cigna Healthcare of GA Inc.	GA	82.7
Health Net	Health Net of NY Inc.*	NY	82.7
Aetna	Aetna Health Inc. TX Corp.	TX	81.8
Anthem	Rocky Mountain Hospital & Medical Service, Inc.	NV	81.6
UnitedHealth	United Healthcare of New England	MA	81.3
Aetna	Aetna Health Inc. FL Corp.*	FL	80.9
Aetna	Aetna Health Insurance Co. of NY	NY	80.6
Anthem	Blue Cross Blue Shield (BCBS) of GA Inc.	GA	80.5
Regional	Oxford Health Plans NY Inc.*	NY	80.5
UnitedHealth	Pacificare of CO	CO	80.2
Regional	Oxford Health Insurance Inc.	NY	79.8
UnitedHealth	Pacificare of NV	NV	79.7
Cigna	Cigna Healthcare of CO Inc.	CO	79.3
Aetna	Aetna Health Inc. GA Corp.	GA	79.2
Aetna	Aetna Health Inc. NY Corp.*	NY	78.9
Aetna	Aetna Health Inc. AZ Corp.*	NV	78.4
UnitedHealth	Pacificare of TX	TX	78.1
Humana	Humana Health Insurance Company of FL Inc.	FL	77.7
Regional	Amerigroup TX Inc.	TX	76.4
UnitedHealth	Pacificare of WA	WA	75.9
UnitedHealth	Pacificare of OR	OR	71.6
Aetna	Aetna Health Insurance Company	OR	57.3
Humana	Humana Employers Health Plan GA Inc.	GA	56.1

* MLR is for 2007, as 2008 data was not yet available for these companies.

Plans from the six largest insurance groups, UnitedHealth, Anthem, Aetna, Humana, Cigna, and Health Net were surveyed in 10 states: Nevada, Oregon, Washington, Colorado, Texas, Michigan, Georgia, Massachusetts, New York and Florida. A number of regionally important plans that were not otherwise represented were also included. Some insurance plans had the same financial data listed for a number of states; in this case, the MLR was only counted once, and the states we surveyed that had the same MLR were all listed together.

Health Care Spending For California Health Plans

MLRs and Percent of Revenue Spent on Administration and Profit/Income for California HMOs. (Data collected by the California Medical Association.)[27]

Health Plan	MLR	Administration	Profit/ Income
L.A. Care Health Plan	97.1	4.1%	-1.3%
Contra Costa Health Plan	95.7	6.4%	-2.1%
Scripps Clinic Health Plan Services	95.3	4.5%	0.1%
CIGNA HealthCare of California	94.3	6.2%	-0.5%[28]
Partnership Health Plan	94.0	6.1%	0.0%
Inland Empire Health Plan	93.1	8.3%	-1.3%
Health Plan of San Joaquin	92.1	10.7%	-2.8%
Kaiser Foundation Health Plan	90.6	3.6%	5.8%
Alameda Alliance for Health	90.6	10.2%	-0.9%
Western Health Advantage	90.5	8.7%	0.6%
Valley Health Plan	90.4	11.8%	-2.2%
San Francisco Health Plan	90.2	10.2%	-0.4%
Universal Care	89.4	28.7%	-0.2%[29]
CalOptima	89.2	4.6%	6.2%
Santa Clara Health Authority	88.2	14.7%	-3.0%
Community Health Group	87.9	8.5%	3.6%
Ventura County Health Plan	87.1	9.6%	3.3%
Sharp Health Plan	87.0	11.2%	1.8%
Inter Valley Health Plan	86.9	8.7%	4.4%
PacifiCare of California	86.5	6.9%	4.2%
Santa Barbara Regional Health Authority	86.4	7.0%	6.6%
Care 1st Health Plan	86.1	10.6%	2.1%
Health Plan of San Mateo	86.1	7.4%	6.5%
Chinese Community Health Plan	85.0	10.5%	2.8%
Health Net of California	85.0	11.2%	2.3%
Molina Healthcare of California/American Family Care	84.2	15.5%	0.2%
Kern Health Systems	84.2	7.8%	7.9%
Central Coast Alliance for Health	83.9	5.1%	11.0%
SmartCare Health Plan	82.5	6.1%	11.4%
Blue Shield of California	82.1	11.5%	6.4%[30]
Aetna Health Care of California	81.4	8.7%	6.3%
SIMNSA Health Plan	80.0	16.3%	2.6%
Community Health Plan	79.4	11.5%	9.1%
Blue Cross of California	79.0	11.1%	6.1%
On Lok Senior Health Services	76.5	7.5%	16.0%
Great-West Healthcare of California	69.4	11.5%	11.3%

Notes

1 California Medical Association, *15th Annual Knox-Keene Health Plan Expenditures Report*, June 2008 (FY 2006-2007).

2 Data were obtained through the National Association of Insurance Commissioners (NAIC) Consumer Information Source, and can be found at https://eapps.naic.org/cis/.

3 See note 1.

4 Harris Interactive, "The Harris Poll: More Regulation for Banks," 3 December 2008. Available at www.harrisinteractive.com/harris_poll/index.asp?PID=979.

5 Thomas Hargrove and Guido H. Stempel III, "Poll Probes Americans' Belief in UFOs, Life on Other Planets," *Scripps-Howard News Service*, 15 July 2008.

6 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *Health Expenditures by State of Provider: State-Specific Tables, 1980-2004*, February 2007.

7 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 2006-1990*, no date.

8 Arnold Milstein and Carrie Hoverman Colla, Mercer Health & Benefits, Prepared for Business Roundtable, *Tracking the Contribution of U.S. Health Care to the Global Competitiveness of American Employers and Workers: 2009 Business Roundtable Health Care Value Comparability Study*, 28 February 2009.

9 See note 1.

10 James C. Robinson, "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance," *Health Affairs*, July/August 1997.

11 "Health Policy Memo: Medical Loss Ratios: Evidence from the States," *Families USA*, June 2008.

12 Ben Elgin and Jessica Silver-Greenburg, "Is Your Kid Covered?" *BusinessWeek*, 8 May 2008.

13 See note 11.

14 California Health Care Foundation, *California Health Care Almanac: California Health Plans and Insurers*, January 2009.

15 See note 11.

16 HMOs, regulated by the Department of Managed Health Care (DMHC) are the only California health insurers for which MLRs are available. CDI, which oversees

most PPOs and other health insurers, does not require companies to separate health plans from other insurance plans in reporting financial statements, making it prohibitively difficult to compare these plans with HMO plans. DMHC-regulated plans account for 61 percent of individual health insurance plan enrollment, and 89 percent of group plan enrollment. CDI-regulated plans account for 39 percent of individual health insurance plan enrollment, and 11 percent of group plan enrollment. Source: California Health Care Foundation, *California Health Care Almanac: California Health Plans and Insurers*, January 2009.

17 See note 1.

18 Ibid.

19 This also suggests that insurers with financial problems will actually have an easier time meeting an 85 percent standard, because their low profits mean that a greater share of their revenues will be devoted to health care.

20 See note 1.

21 See note 2.

22 Best health insurance plans: U.S. News & World Report and the National Committee for Quality Assurance, "America's Best Health Plans: Search By State, *U.S. News & World Report*, 7 November 2008. Available at health.usnews.com/sections/health/health-plans/index.html; health plans with the highest market share, by state: United States General Accounting Office, *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market*, 25 March 2002, available at www.gao.gov/new.items/d02536r.pdf. Note: six plans were identified through the U.S. News ratings, and only four of these had above average ratings. All six plans had MLRs above 85 percent. Though this might bias the data in favor of better plans, if this small data set does affect our overall result that successful insurance companies can meet an 85 percent MLR floor, the fact that insurance companies with high-quality and successful plans had high MLRs only emphasizes the point.

23 See note 2.

24 See note 1.

25 Ibid.

26 See note 2. All numbers are for the year ending December 31, 2008, except for plan names marked by an asterisk, which are for the year ending December 31, 2007.

27 See note 1.

28 Profit percentage does not include a $2.2 million tax credit.

29 Profit percentage does not include a $3.8 million tax credit.

30 Profit percentage does not include a $211million tax credit.