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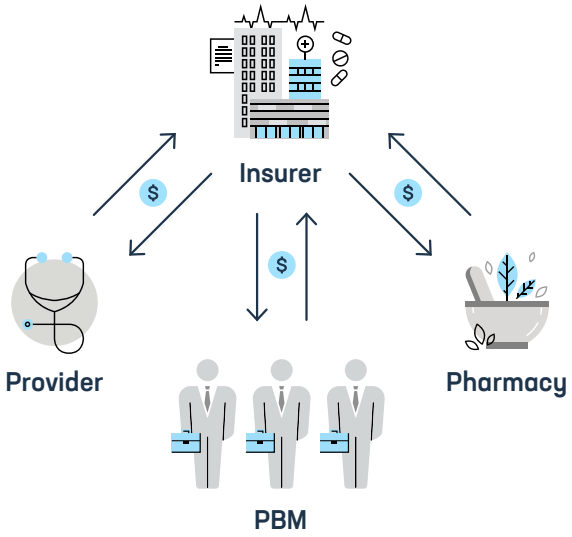
# Explainer: Vertical Integration May Allow Insurers to Skirt Medical Loss Ratio Requirements

Three health care conglomerates–United Health Group, CVS Health and Cigna–have amassed significant influence and control of the U.S. health care system. These giants don't just own the three largest health insurers and three largest Pharmacy Benefit Managers (PBMs), they also own their own pharmacies and providers.

The aggressive approach by these companies to vertically integrate across almost every aspect of the health care system has raised serious questions about the impact their model has on the system and could lead to patients paying more. A prime example is how business arrangements between affiliated entities are treated when calculating the medical loss ratio (MLR), or amount of money insurers spend on patient care compared to administrative costs, profits, executive compensation, marketing and other expenses.

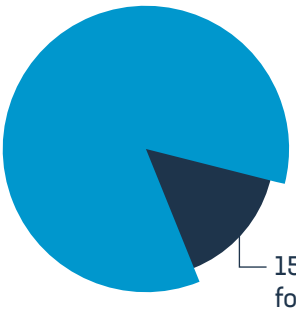



## Medical Loss Ratio (MLR) Explained

- The Affordable Care Act set requirements for the share of premium dollars insurers can spend on patient care vs. profits and admin costs under Medicare Advantage, Part D, Medicaid managed care organizations and certain commercial health coverage.
- Generally, insurers are required by law to spend at least 80 or 85 percent of premiums and other revenue on patient care. The remaining 15 or 20 percent may go to administrative costs and profit.
- After all patient care is paid, insurers are required to return any amount above the 15 or 20 percent threshold back to patients or to CMS for Part D plans in the form of rebates and passing them onto patients.

### Insurer revenue utilization from premium dollars by percentage

**80% - 85%**
of premium dollar revenue required to be spent on **patient care**



15% - 20% eligible for admin costs and profit

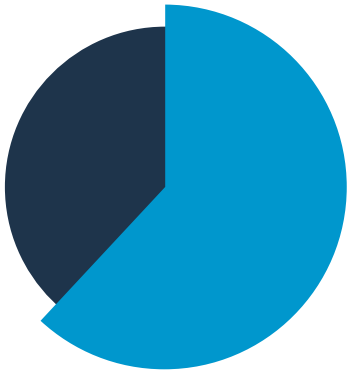
## Vertical Integration and MLR

- Due to the vertical integration of these stakeholders, they are able to play a shell game that allows them to move funds subject to MLR requirements in the form of rebates and passing them on to patients to other parts of their business that don't have to meet the same standards.
- The vertically integrated insurers achieve MLR requirements from moving funds that would be subject to MLR requirements to other entities to not count essentially. They're maximizing profits and failing to pass extra funds back to patients.

## What's currently happening?

- Instances of vertically integrated insurers directing payments to other parts of their business have increased in recent years and now account for a significant share of vertically integrated organizations' total revenue.
- For example, nearly two-thirds of the revenue to OptumRx, the PBM owned by UnitedHealth Group (UHG), comes from other UHG affiliated businesses. Transactions between CVS Pharmacy and CVS Health services generated nearly $50 billion in revenue.

### OptumRx (PBM) Revenue

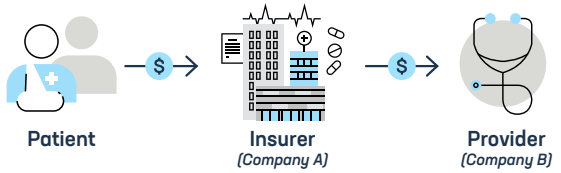


**62%**
of revenue from all UHG vertically integrated entities

## How it works

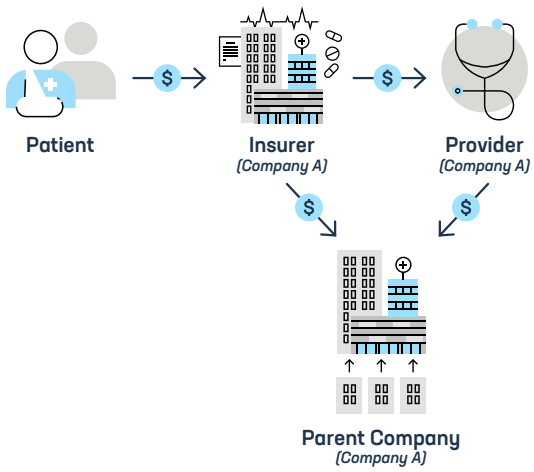
Here is a hypothetical example of how a vertically integrated health insurer could evade their MLR requirements in comparison to a non-vertically integrated insurer. In example A, the money moving from insurer to provider goes towards the MLR but moves from Company A to Company B. In example B, the insurer evades the MLR by intercompany eliminations between the insurer and the provider, as the money goes towards the MLR but stays within the parent company.

### Example A: Non-Vertically Integrated Insurer




VS.

### Example B: Vertically Integrated Insurer




**The growing vertical integration among insurers, PBMs, pharmacies and providers expands these massive conglomerates' control over the health care system and increases their profits at the expense of patients.**