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Medical Loss Ratios

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Introduction

StudentInsure is an insurance company offering a popular low-premium, high-deductible health insurance plan on the individual market nationwide. Most of its enrollees are college students. Last year, StudentInsure collected \$100 million from enrollee premiums. \$75 million of that revenue was spent on claims filed for enrollees' medical expenses. The remaining \$25 million went to: salaries and bonuses, profits for shareholders, marketing expenses, a nurse hotline that enrollees could call 24/7 with health questions, fraud-prevention measures including identifying and investigating suspicious claims, establishment of provider networks to ensure that enrollees in each area of the country had access to care, and utilization review to check whether the services that clinicians were carrying out were medically necessary.

The Medical Loss Ratio and PPACA

A "medical loss ratio" (MLR) is a measure of the proportion of the money that an insurer collects from premiums that is spent on medical care. Typically, an MLR is calculated as total claim expenses divided by total premium revenue; by this definition, StudentInsure's MLR is 75% (\$75 million/\$100 million).¹

Prior to passage of the Patient Protection and Affordable Care Act (PPACA), the regulation of MLRs fell to individual states, and there were variations in state definitions of MLRs. About half of all states had minimum MLR requirements for the individual market, and about twenty had minimums for the small-group or large-group markets. State MLR minimums for the individual, small-group, and large-group markets generally ranged from 60% to 75%.²

These regulations originated in concerns that insurance companies spent too much on profits, executive compensation, marketing, "overhead/administrative expenses," and other non-claims expenses perceived to be both lacking value and driving up the cost of coverage. However, aggregate data suggest that the amount of money private insurers spend on nonclaims expenses is quite small relative to the country's total medical spending. According to National Health Expenditure data, the difference between total premiums and total benefits for private health insurance in 2010 was \$96 billion, representing just 3.7 percent of the country's total health care expenditures (\$2.6 trillion). And a variety of sources show that health insurers' profit margins (net incomes divided by revenues) average about 3 percent.

In 2009, the overall nationwide MLR for health insurance in the individual market was 74% for the six largest insurers. For insurance in the small-group market, the overall nationwide MLR was 81.2%, and for the large-group market, the MLR was 85.1%.

As of January 1, 2011, PPACA changed the jurisdiction of MLRs. Jurisdiction was transferred from the state level to the national level.³ PPACA defines the MLR as the ratio of "expenses on reimbursement for clinical services and activities that improve health care quality" to the "total amount of premium revenue, excluding taxes and fees." This definition differs from many state definitions in its inclusion of expenditures to improve the quality of care in the numerator and in its exclusion of certain taxes from the denominator. Expenditures to improve the quality of care are required to be "capable of being objectively measured and producing

verifiable results,” “grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations,” and “not designed primarily to control or contain costs.”⁴

PPACA charged the National Association of Insurance Commissioners (NAIC) with the task of developing additional standards and definitions for the MLR policy.⁵

PPACA requires that an insurer’s MLR be at least 85% in the large-group market and 80% in the individual and small-group markets. A plan that fails to meet these minimums must provide cash rebates to its enrollees; the law counts these rebates in the numerator of the plan’s MLR. The rebates must be large enough for the plan’s MLR to reach the minimum.⁶

Under the PPACA definition, StudentInsure’s MLR is 75%. None of StudentInsure’s non-claims expenses count in the numerator of its MLR. To stay in business, StudentInsure must take \$5 million from its non-claims expenses and send that money to enrollees as rebates, raising its MLR to 80% (\$80 million/\$100 million).

StudentInsure may not be able to stay in business after having to reduce its non-claims expenses by this amount. PPACA anticipates the probable disruptive effect of its MLR minimums; the law gives the HHS Secretary the authority to waive the MLR minimum in a local market if she determines that enforcing the minimum would cause too many insurers to leave that market.⁷

Analysis of PPACA MLR Policy

State insurance commissioners in Florida, Maine, Oklahoma, and Iowa have requested waivers from the 80% MLR requirement in the individual market.^{8,9} The commissioner in Maine said that one of the two insurers that sells individual insurance in Maine “would probably need to withdraw from this market if the [MLR] requirement were increased” from the state’s requirement of 65%. If insurers withdraw from markets in the wake of the new requirements, enrollees may lose access to their current providers and be unable to find any affordable alternative source of coverage.

The MLR requirements put insurers with small memberships at a disadvantage for two reasons. First, these insurers face more random variation than large insurers in their total claims and, therefore, in their MLRs from year to year. The disruptive possibility of jumping above the MLR requirement one year and below the MLR requirement the next year may prompt these insurers to leave markets. Second, insurers’ non-claims expenses increase less than proportionately with their number of enrollees.

The MLR requirement caps the amount of money available for non-claims expenses. The policy will likely encourage insurers to shift administrative expenses to provider groups.

Ultimately, the MLR requirement legislates one view of what kinds of insurance expenses are and are not valuable. All Americans may not share that view. One implication of

this view of insurance is that policies that lower premiums by encouraging enrollees to reduce their consumption of medical care are penalized.

For example, StudentInsure had considered spending \$5 million on a program to reduce enrollees' consumption of care; this money would have been spent on developing new coverage arrangements (that is, covering a different menu of services at different copay and deductible levels), building provider networks that were more cost-effective, and creating online databases to guide enrollees' choice of providers and services. StudentInsure projected that this program would have reduced total claims to \$65 million. Therefore, the company's total non-claims expenses would have risen to \$30 million, and total claims expenses would have fallen to \$65 million, allowing premiums to drop such that total premium revenue would have been \$95 million. Even though this program would have resulted in a decrease in both premiums and total medical spending, StudentInsure chose not to carry it out because it would have caused the company's MLR under the PPACA definition to decrease to 68% (\$65 million/\$95 million).

Conclusion

StudentInsure may not be able to stay in business under the new PPACA regulations on MLRs. Even if StudentInsure can stay in business, its flexibility to innovate is now constrained.

Private markets for health insurance benefit consumers by creatively tailoring options to suit people's different circumstances and preferences. In imposing one view of what kinds of insurance expenses are and are not valuable, the PPACA MLR regulations end up limiting the degree to which private insurance markets can benefit consumers.

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