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Careful monitoring and regulation of medical loss ratios will be crucial as health reform is implemented

Medical loss ratios for health insurance companies are the portion of each premium dollar the companies spend on medical care for their customers. To outsiders, it's a seemingly arcane measurement of insurance companies' financial strength. But medical loss ratios (MLRs) are also a key indicator of how well the companies are serving consumers.

How the companies define MLR and, in particular, what spending may be classified as an administrative expense, is critical to ensuring consumers receive maximum value for their premium dollar. A regulatory process is under way now where insurance officials are developing a new technical definition of MLR. That process would benefit from close attention and participation by consumer advocates.

What MLR means now

MLR is the percentage of each health insurance premium dollar a health insurance company spends on medical care for their customers. A medical loss ratio of 85 percent, for example, means 85 cents of every dollar is spent on medical expenses, and 15 cents is spent on salaries, profits, agent commissions, overhead, marketing and other nonmedical expenses.

Nationally, about 85 cents out of every large-group premium dollar was spent on medical care, about 81 percent in the small-group market and about 74 percent in the individual market, 2009 data for the largest insurers show.

Current rules issued by the National Association of Insurance Commissioners (NAIC) define "medical loss" as the value of medical claims an insurer actually paid (incurred claims), plus the amount of money the insurer sets aside to pay future claims (contract reserves).

Effect of national health insurance reform on MLR

A recent report issued by the majority staff of the U.S. Senate Committee on Commerce, Science and Transportation discussed the fact that insurance companies now have a powerful incentive to reclassify administrative expenses as medical expenses in order to enhance their MLRs.

According to the report, at least one company, WellPoint, has already reclassified more than half a billion dollars of administrative expenses as medical expenses. From the consumer perspective: "Boosting medical loss ratios through creative accounting will not fulfill the new law's goal of helping consumers realize the full value of their health insurance payments," the report said.

National health reform, passed under the Patient Protection and Affordable Care Act (PPACA) will potentially allow insurers to classify a broader set of expenditures as medical as the new law allows “activities that improve health care quality” to be included as medical expenses.

In response to concern that insurers were not spending enough of health care premiums on actual medical care, the national health reform bill requires the following changes with respect to medical loss ratios:

- NAIC must establish uniform definitions and standardized methodologies for calculating MLRs, subject to certification by the secretary of the U.S. Department of Health and Human Services no later than Dec. 31, 2010. Health and Human Services Secretary Kathleen Sebellius has asked NAIC to complete its work by June 1, 2010.
- Health insurance companies must meet MLR targets: 85 percent in the large-group market and 80 percent in the small-group and individual markets. Plans must begin reporting medical loss ratios in 2010.
- Insurers that do not meet the thresholds must provide rebates to consumers, effective January 2011.

As described above, WellPoint used an accounting reclassification in April 2010 to move more than a half billion dollars from the 2010 administrative expenses into medical expenses. Other insurance companies are expected to follow WellPoint’s lead.

Considerations for developing a new definition

Any new definition of MLR should not allow insurers to classify expenses where there is little or no evidence the activities improve quality. For example, most consumers and medical professionals would not consider “utilization review” nurses and administrators whose job is to review and often deny physician recommended treatments to be medical expenses or “improving quality” of health care.

Quality assurance programs, provider credentialing, nurse hotlines and the general “medical management” term have been defined as administrative expenses and should remain so.

Health insurance companies should be encouraged to offer evidence-based and care management programs. No program should be allocated as a medical expense when there is insufficient empirical data showing it improves the health of enrollees.

A group of consumer representatives affiliated with NAIC recommend that NAIC consider the following as allowable quality-improvement expenses:

- Expenses related to implementing and maintaining the Quality Improvement program required by Medicare, Medicaid, the Child Health Insurance Program and other government programs.
- Expenses related to establishing and updating the data collection and reporting required to comply with the national strategy to improve the delivery of health care services, patient health outcomes and the general population’s health.
- Expenses related to government Quality Improvement demonstration projects.
- Insurers should be required to provide cost and outcome results for programs listed.

Among the consumer representatives' other recommendations:

Information technology

Information technology is a broad category, and there should be close attention to specific investments in this area and how the spending affects quality before reclassification as medical expenses is allowed. The Centers for Medicare and Medicaid Services recently issued definitions for “meaningful use” requirements related to information technology investments in electronic medical records. Information technology investments can lead to streamlined operations, fewer medical mistakes and duplication and therefore better patient outcomes and lower medical costs.

Other information technology spending may have nothing to do with improving quality. Insurers have invested in information technology to enhance internal underwriting procedures, reduce expenses related to paying claims and to identify unprofitable accounts. Insurers have not included information technology expenses as medical costs in the past.

General reporting requirements

- Insurers should not be allowed to group their plans together to mask the low MLRs of some of their plans.
- Each legal entity in each state must report separately. Insurers should not be allowed to combine results. Why did insurers create separate entities? To limit liabilities.
- Medicare Part D, Medicare supplemental, vision only, dental only should be separated from the MLRs calculation, so commercial health insurance products are evaluated on their own.
- NAIC should not allow insurers to pool their MLRs across different product lines/markets at the discretion of the carrier.
- “Administrative services only” contracts should not be included in the MLR calculation for commercial health insurance.
- MLRs should be reported separately for each state. Carriers should not be allowed to pool data across different states.
- The MLR should be based on paid claims. Insured claims are the sum of claims paid and changes in reserves (not paid claims plus all reserves). The MLR review is historical, therefore actual claims paid is reasonable and avoids the potential for manipulation of reserve data.
- The cost of settling claims are not payments for health services and should not be considered medical expenses.
- If NAIC and the Department of Health and Human Services allow any “quality improvement” expenses to be defined as medical costs, the insurers must be required to show that amount separate from the amount spent on medical claims payment.
- PPACA changes the definition of small-group markets, which gives an advantage to insurers. Small groups are currently defined as groups with 50 or fewer employees. The new law changes the definition to 100 employees. Historically, small groups have more generous MLRs to carriers — a lower MLR. This definition will move groups of 51-100 from large to small groups, providing additional insurer margins.

Reaction of insurance companies

Comments to NAIC filed in early May 2010 by the health insurance industry included the following:

- Aetna recommended a single MLR calculation at the holding company level for the large-group market and three-year rolling MLR averages beginning with the initial MLR calculation.

- Aetna requested a “wide array of insurer functions that provide value for consumers” as it is related to quality and clinical services.
- Aetna requested the exclusion of “state and federal assessments, taxes and other costs” from premium revenues. Many states created high-risk pools because insurers denied coverage to people with pre-existing conditions, and many states fund the high-risk pools with assessments on insurers.
- Aetna requested that 90 percent of broker commissions be excluded from premium revenue in the 2011 MLR calculation. It further requested the exclusion to be 66 percent in 2012, 33 percent in 2013 and 0 percent in 2014.
- Assurant Health requested that the determination of adequate providers “who agree to a fair and reasonable rate for services” be included as a medical expense.
- America’s Health Insurance Plans, the health insurance trade organization, argued in their comments that medical expenses related to improving health care quality be defined in broad terms. Some examples are “Investments in health information technology, that are designed to improve health care quality, reduce medical errors, reduce health disparities and advance the delivery of patient-centered medical care”.
- America’s Health Insurance Plans requested that “costs associated with the development and maintenance of networks of centers of excellence or provider excellence networks, direct patient safety programs including formulary management, medical management and drug safety” be defined as medical expenses.

Both requests from America’s Health Insurance Plans are very broad and would likely include many administrative costs associated with developing an adequate provider network and many administrative costs associated with rate negotiations with hospitals and doctors.

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