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Health Policy Brief

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Medical Loss Ratios. Health insurers will soon be required to spend a specific share of the premiums they collect on health care for policyholders.

WHAT'S THE ISSUE?

Beginning in 2011, the Affordable Care Act will require health insurance companies to spend a minimum percentage of the premiums they collect on health care services and quality improvement activities for the people they insure. This percentage is called the medical loss ratio. Insurance companies that sell policies to groups of 100 people or more must spend at least 85 percent of their premiums on health services. Insurers selling policies to individuals or small groups with fewer than 100 people must spend at least 80 percent on health services. Companies that fail to meet these medical loss ratio requirements will have to issue rebates to their customers starting in 2012.

At issue now is how to enforce the mandated medical loss ratios by determining what constitutes health care services. These services have to be separated from administrative expenses, marketing costs, and other insurance company activities to make certain that the law's requirements are being met. However, it's sometimes difficult to determine what a health service is and what an administrative expense is. For example, if a health insurer employs nurses to remind chronically ill patients to take their medications, is that a medical cost or an administrative expense?

The definition of what constitutes a medical cost will determine how much money insur-

ers can spend on other business activities and how much they can keep as profits. The federal government will soon issue regulations that will instruct health insurers how to make these calculations. The regulations will have a significant impact on medical care costs, consumers' premiums, and the kinds of health care services that insurance companies will cover in the future.

WHAT'S THE BACKGROUND?

When health insurers sell policies, they charge the buyers premiums. The share of premiums that insurers ultimately pay out on health care claims is the medical loss ratio. The rest—what they don't pay out in claims—goes toward administrative expenses, marketing costs, and profits. Proponents of health care reform argued that insurers spent too much of every premium dollar on administration and profits, and too little on medical claims.

Until recently, there has been little publicly available information on precisely how much insurers do spend on medical costs. Insurance has traditionally been regulated at the state level, and thirty-four states have established medical loss ratios or other reporting requirements, or have imposed limits on insurers' administrative expenses (Exhibit 1). More states have established medical loss ratios in the small-group and individual markets than in large-group markets.

85%

Ratio for large-group plans

Health insurance policies covering 100 or more employees must maintain this medical loss ratio.

the law, the secretary is required to “certify” the association’s work by the end of 2010 by issuing it as a federal regulation.

WHAT’S THE DEBATE?

In its simplest form, proponents of a strong medical loss ratio want the National Association of Insurance Commissioners and the US Department of Health and Human Services (HHS) to list as many insurance company activities as possible under “administrative” categories. Senate Democrats who wrote the legislation say that this will improve quality of care and keep premium prices low for consumers by limiting administrative spending and profits and improving transparency. Patient advocates and others caution that if the medical loss ratios aren’t stringent enough, insurers won’t do enough to reduce administrative costs and premiums won’t come down for consumers.

By contrast, health insurers want as many things as possible included under the “medical” and “quality improvement” categories in order to more easily meet the minimum spending requirements. They argue that overly stringent ratios will stifle innovation and eliminate quality measures that fall in between the administrative and medical categories, such as 24-hour nurse hotlines and investigating insurance fraud.

DRIVE INSURERS OUT OF BUSINESS?: If the medical loss ratios are overly stringent, companies and many state commissioners are concerned that insurers will leave markets with too few enrollees to make it worthwhile, leaving consumers with few coverage options. They also fear that small insurers will be driven out of business because the requirements don’t account for market volatility from one year to the next.

In addition, there is concern that the across-the-board medical spending requirements will specifically harm insurers that serve the individual insurance market. These insurers typically set aside a large portion of premiums as reserves in the early years of a policy to cover the costs of people who will become very sick and incur large medical claims. This so-called front loading leads to lower medical spending ratios, but insurers maintain it’s necessary to protect them against what could be considerable downside risks.

ARGUMENTS CONTINUE: The NAIC resolved several controversial issues during its work. But the arguments continue, and HHS could still back away from the group’s recommendations and issue final regulations that look far different. These controversial areas include the following:

EXCLUDING COMMISSIONS: Insurance agents and brokers wanted their commissions to be

EXHIBIT 2

Allowable Expenses that Improve Patient Health Care Quality

The National Association of Insurance Commissioners has identified five quality improvement objectives for which activities constitute eligible medical expenses.

Objective	Examples of eligible activities
Improve health outcomes	Direct interactions among insurers, providers, and enrollees. Can be face-to-face, by telephone, via Internet, etc. Includes case management, care coordination, and chronic disease management; identifying and addressing ethnic, cultural, or racial disparities in effectiveness of best clinical practices; quality reporting and documentation of care.
Prevent hospital readmissions	Comprehensive discharge planning; personalized post-discharge counseling; quality reporting and related documentation.
Improve patient safety and reduce medical errors	Identifying and using best clinical practices to avoid harm and address documented clinical errors; lowering risk of facility-acquired infections; prospective prescription drug utilization review; quality reporting and related documentation; promoting medical record-sharing.
Promote health and wellness	Wellness assessment; lifestyle and other coaching programs to achieve specific and measureable improvements; public health education campaigns with state and local health departments; quality reporting and related documentation.
Improve health care quality through information technology	Monitoring, measuring, reporting clinical effectiveness; reporting and analysis of costs for maintaining nationally recognized accreditation; advancing ability of enrollees, providers, and insurers to use electronic health records; tracking services for improved outcomes; reporting to government entities; providing electronic health records and patient portals.

SOURCE National Association of Insurance Commissioners.

80%

Ratio for small-group plans

Health insurance policies covering fewer than 100 employees and covering individuals must maintain this medical loss ratio.

“There is concern that insurers will leave markets that are expensive to operate in.”

excluded from medical loss ratio calculations because of concern that insurers would cut their pay to improve their medical loss ratios. The NAIC initially was split; it was inclined to side with the agents but also interpreted the law as saying that commissions should be counted as administrative expenses. Yet state insurance commissioners worried that, without insurance agents who could earn commissions, their own state insurance departments would be flooded with consumer inquiries about how to purchase coverage and file complex claims. Ultimately, the NAIC approved a resolution to establish a working group with HHS to find some kind of solution to ensure that agents and brokers can remain in the market. In a letter to HHS, NAIC officials underscored the importance of making sure insurance agents and brokers are not short-changed as the rules are implemented.

AGGREGATING PLANS IN DIFFERENT STATES: Insurers wanted to calculate their medical loss ratios by combining plans in different states. The commissioners noted that each state market is different, and consumer advocates worried that insurers would be able to “hide” low medical loss ratio areas in one region by combining them with other regions. The NAIC decided that insurers can only combine the business they underwrite in one state. So, for instance, an insurer’s large-group business in Texas will be one medical loss ratio calculation, and its small-group business in Illinois will be another calculation.

EXCLUDING FEDERAL TAXES: The Affordable Care Act states that “federal and state taxes and licensing or regulatory fees” should be excluded when calculating the medical loss ratio. The NAIC voted in October that this provision should be construed to include all federal taxes, such as income taxes, except for taxes on investment income and capital gains. But the House and Senate committee chairs who drafted the law have maintained that the provision referred only to new federal taxes on insurers that were put in place through the reform law, and not to other taxes. The lawmakers’ definition would have made the ratios more difficult for insurers to achieve and would disadvantage insurers that contribute more in taxes. Although HHS has the authority to overturn the NAIC’s decision in its final regulation, it is not expected to do so.

HANDLING ANNUAL FLUCTUATIONS: Small insurers are particularly susceptible to significant changes in their medical loss ratios from year to year. If few medical claims are filed in

one year, an insurer’s ratio could fall below the federal threshold, forcing the company to issue rebates. In the next year, if many people are sick and file claims and the insurer’s medical loss ratio goes far above the threshold, the insurer could struggle to recoup those costs. To help smaller health plans, NAIC proposed allowing *credibility adjustments*, in which an insurer could get additional credits—based on the amount of their business—added to the amount of premiums spent on medical claims and quality improvement activities. The adjustments are designed to even out the ups and downs that small insurers could see from year to year.

EXCLUDING ANTI-FRAUD EFFORTS: Insurers wanted fraud control programs to be counted as quality improvement measures. They also wanted other activities, such as “utilization review” (in which a company decides whether or not to cover a particular medical treatment), to be considered medical expenses. The NAIC decided against both.

WHAT’S NEXT?

As this brief is published, HHS is set to certify the NAIC recommendations before the end of 2010. Early in 2011 insurers will have to file the medical loss ratio forms for their 2010 business. But this first year will just be a “dry run” to test a system that will take full effect in 2011. Then, in early 2012 insurers will have to file medical loss ratio forms for their business in 2011.

If insurers’ medical loss ratios fall short of the federal standards, they will have to pay out rebates to policyholders. If an insurer fails to meet the ratio for three consecutive years, HHS could ban the company from signing up new customers. If it goes five years without meeting the requirement, HHS could terminate the contract of the particular health plan in question.

In the short term, there are some potential resources for insurance companies, however. The NAIC expressed concern about what could happen in a “destabilized” insurance market if insurers determine it’s too hard to meet the spending requirements and stop writing new policies. To prevent this, Iowa and Maine have already asked HHS to grant waivers to temporarily reduce the requirements in their states. Other commissioners are expected to follow with similar requests.

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Quality improvement areas

The NAIC outlined five quality objectives for which activities constitute eligible medical expenses.

About Health Policy Briefs

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DEBATE WILL CONTINUE: The debate won't end when the medical loss ratios rules are set. NAIC officials caution that their methodologies are well researched, but not perfect. In an October 2010 letter to Secretary Sebelius, they expressed concern "...about the potential for unintended consequences arising from the medical loss ratio rules." They recommend viewing the rules as a "living and breathing" document that will have to be adjusted as medicine and insurance evolves. In addition, insurance commissioners say they will be establishing some means by which to test the quality improvement measures that insurers are counting against medical costs. The process has yet to be created, but officials want to

ensure that the quality measures actually improve health standards.

The Affordable Care Act gives the HHS secretary authority to adjust the medical loss ratios if they have the potential to destabilize the individual market. Because the law is silent on the secretary's ability to adjust the ratios for the small-group and large-group markets, it's unclear whether she could adjust those medical loss ratios as well. Secretary Sebelius has said publicly that HHS wants to ensure a "smooth transition" as it implements the Affordable Care Act leading up to 2014, when state exchanges will guarantee insurance coverage. ■

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CLARIFICATION

The original version of this brief published on November 12, 2010 stated that insurers must issue rebates if their medical loss ratios "exceed" federal

standards. This version clarifies that rebates must be issued if the medical loss ratios "fall short of" federal standards.