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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 insurers can spend on other business activities and how much they can keep as profits. On November 22, 2010, the federal government issued regulations that instructed 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.

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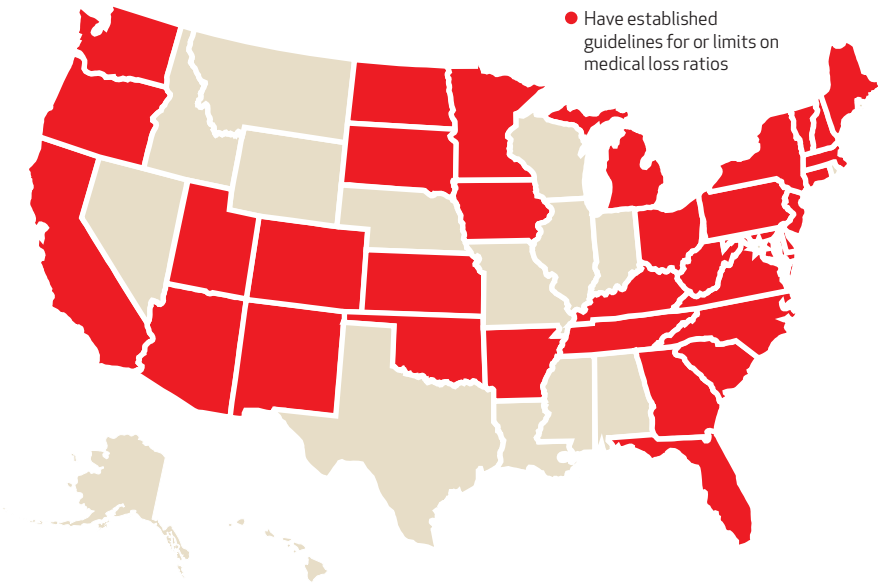
EXHIBIT 1

States That Have Established Guidelines for or Limits on Medical Loss Ratios



SOURCE America's Health Insurance Plans, April 2010.

STATE REQUIREMENTS VARY: State-imposed medical loss ratio requirements have varied widely. They reflect differences in rural and urban markets as well as in markets that have different levels of competition. In general, in markets where more insurers are competing for business, regulators have set higher medical loss ratios. For instance, North Dakota requires a 55 percent medical loss ratio for insurers in the individual market, and New Jersey requires an 80 percent ratio.

According to an April 2010 report prepared by the Democratic staff of the Senate Committee on Commerce, Science, and Transportation, the nation's largest health insurers in 2009 had medical loss ratios ranging from 68 percent to 88 percent in the individual market; 78 percent to 84 percent in the small-group market; and 83 percent to 88 percent in the large-group market. Because states have defined what constitutes medical care differently, their medical loss ratios differ even more than these numbers would suggest.

"At issue now is how to enforce the mandated medical loss ratios by determining what constitutes health care services."

Health reform proponents who wanted higher medical loss ratios imposed on commercial insurers often pointed to the contrasts with public health insurance programs. Medicare, the government program that provides health care services to people aged 65 and older and to the nonelderly disabled, maintains a medical loss ratio of 97–98 percent. Some people argue that Medicare has different requirements for maintaining reserves (available cash to meet claims) than do private health plans, and that Medicare has lower administrative costs. Medicare has also been criticized by many health care providers for underpaying them for their services.

WHAT'S IN THE LAW?

The Affordable Care Act created federal minimum medical loss ratios for all insurers. The minimum ratios are scheduled to take effect in 2011. The law also directed the National Association of Insurance Commissioners (NAIC)—an organization of elected and appointed state insurance commissioners—to create the formula for calculating medical loss ratios.

The group was charged with drafting uniform definitions of medical and quality improvement activities within the insurance industry that would count toward the medical spending requirement and administrative activities that would not. The "quality" language in the law was aimed at encouraging insurers to maintain programs that help consumers remain healthy and have better health care outcomes, such as a care management program to help a diabetes patient stay on medication.

On September 23, 2010, a subcommittee of the NAIC issued recommended draft rules for how medical loss ratios would be computed and how insurance company activities are defined and categorized. After receiving feedback from insurance companies, consumer groups, and others, the full NAIC adopted the recommendations—with few changes—on October 21, 2010.

IMPROVING QUALITY: The NAIC also established five quality improvement objectives, each of which includes "activities that improve health care quality" that constitute eligible medical costs. These are programs that address improving health outcomes and reducing health disparities across specified populations; preventing hospital readmissions; improving patient safety, reducing medical errors, and lowering rates of infection and mortality; increasing wellness and promoting health activities; and increasing the use of health care data through information technology to improve quality, transparency, and outcomes (Exhibit 2).

The NAIC's recommendations were then forwarded to Health and Human Services Secretary Kathleen Sebelius for her review. She

certified the recommendations and released an interim final rule on November 22, 2010.

85%

Ratio for large-group plans
Health insurance policies covering 100 or more employees must maintain this medical loss ratio.

WHAT'S THE DEBATE?

In its simplest form, proponents of a strong medical loss ratio wanted 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 would improve quality of care and keep premium prices low for consumers by limiting administrative spending and profits and improving transparency. Patient advocates and others cautioned 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 wanted as many things as possible included under the "medical" and "quality improvement" categories in order to more easily meet the minimum spending requirements. They argued 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.

The NAIC resolved several controversial issues during its work. These include the following:

EXCLUDING COMMISSIONS: Insurance agents and brokers wanted their commissions to be excluded from medical loss ratio calculations because of concern that insurers would cut their pay to improve medical loss ratios. The NAIC initially was split; it was inclined to side

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.

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. HHS upheld the decision.

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. HHS agreed with the NAIC decision.

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. HHS approved the move. 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 and HHS ruled that fraud prevention activities must not be included as a quality measure, except for certain costs that lead to recovered money.

WHAT'S NEXT?

The public will have 60 days to comment on the interim final rule released on November 22, 2010, and it will go into effect on January 1, 2011. 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 the system, since penalties will not be assessed for company activities during 2010.

In early 2012, insurers will file medical loss ratio forms for their business in 2011. If these 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, Maine, Georgia, and South Carolina have already asked HHS to grant waivers to temporarily reduce the requirements in their states. Other commissioners are expected to follow with similar requests.

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

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

DEBATE WILL CONTINUE: 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.■

RESOURCES

Davis, Patricia A., Jim Hahn, Paulette C. Morgan, Holly Stockdale, Julie Stone, and Sibyl Tilson, "Medicare Provisions in PPACA (PL 111-148)," Washington (DC): Congressional Research Service, April 21, 2010.

Jost, Timothy, "The NAIC's Effort To Find Balance In Its Medical Loss Ratio Regulation," *Kaiser Health News*, September 30, 2010.

National Association of Insurance Commissioners, "Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plan Years 2011, 2012, and 2013 per Section 2718 (b) of the Public Health Service Act," Adopted by the Life and Health Actuarial Task Force, October 21, 2010.

Robert Wood Johnson Foundation, "Recognizing Destabilization in the Individual Health Insurance Market," *Issue Brief*, July 2010.

Sebelius, Kathleen, "Making Sure Your Premiums Pay for Care," HealthCare.gov (blog), August 17, 2010.

"State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations," America's Health Insurance Plans, April 15, 2010.

US Department of Health and Human Services, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act (45 CFR Part 158)."

US Senate, Committee on Commerce, Science, and Transportation, Office of Oversight and Investigations, Majority Staff, "Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers," Staff report for Chairman Rockefeller, April 15, 2010.

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.

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