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REPORT

Defining the Medical Loss Ratio: What Is It Good For?

RANDI REICHEL, ESQ.

Introduction

While issues revolving around medical loss ratios have been discussed for many years in many states, that discussion now has moved into the federal ''health reform'' debate. As members of Congress seek to develop the rules setting a minimum medical loss ratio and federal and state regulators are faced with defining and implementing the appropriate components of that ratio in the context of reform, it is critical that there be a common understanding of what the ratio consists of, and what it can – and cannot – accomplish. It is also critical that there be a uniform language, so that the elements that make up the loss ratio are carefully considered and generally understood by all stakeholders.

Many states, the federal government, and some members of Congress have spent significant time and energy in a futile attempt to impact the cost of health insurance through use of a concept called a ''medical loss ratio,'' or MLR. The underlying – although incorrect – premise has been that an insurance company which spends a higher percentage of its premium income on ''medical claims'' provides more, or better, coverage and service than one that spends less. States have thus adopted varying requirements that carriers meet a specific MLR target, ranging from 50%[1] to as high as 85%[2]. Percentages vary not only from state to state but also within a state, where they may differ according to type of policy, type of carrier, or size of group. Carriers that do not meet the prescribed loss ratio are oftentimes required to refund premiums to policyholders.

The use of a mandated ''loss ratio'' has generated no appreciable decrease in the cost of health care, or the correlative cost of health insurance, where premiums are determined largely by provider fees and utilization. The reason the MLR has been unsuccessful: it is, unfortunately, an artificial, ill-defined, threshold that provides no true measure of the quality — or quantity -- of the services and drugs provided by physicians, hospitals or other medical professionals that are covered under the policies. Governmental entities are unable to clearly articulate precisely how the ratio can be useful to curtail an ever-increasing medical cost trend and therefore the cost of the insurance premised upon those costs. There has been much rhetoric regarding ''excessive'' administrative expenses, and how MLRs will provide some rigor to health insurance operations. This rhetoric, however, avoids reasoned discourse about the nature and types of expenses that health insurers carry on their books. There is considerable potential that these artificial, randomly specified MLRs will do more harm than good to the overall health care delivery system and stifle any debate regarding true reforms to the way we deliver health care.

The wide variation in state laws defining MLRs is evidence of a lack of both a clear definition of ''medical loss ratio'' as well as the lack of a common understand-

Reichel is a government relations and health policy consultant in Washington. She was formerly a state insurance regulator in Maryland and worked for many years as an insurance litigator and insurance advocacy professional. She currently is the president of Reichel Consulting Ltd. She can be reached at (301) 774-2268 or at Randi@reichel-consulting.com.

[1] *See Pennsylvania Administrative Code: 31 Pa. Admin. Code Sec 89.83*

[2] *See Colorado Revised Statutes, Colo. Rev. Stat. Sec 10-16-102; 10-16-107 and 3 Colo. Regs. Sec. 702-4.*

 ISSN 1528-2953

ing of what information the ratio is intended to provide.[3] This article attempts to discuss the appropriate use of, and definitions for, a medical loss ratio in hopes of inspiring a worthwhile common framework for both carriers and regulators.

State Rating Oversight: The Need for a Defined Ratio

State insurance regulators are responsible for ensuring that the carriers they regulate remain solvent, that the benefits that those carriers provide are not illusory, and that the rates charged for those benefits are neither inadequate (which could lead to insolvency) or excessive (which would unfairly charge consumers for benefits not received). Rate approval is a key regulatory tool to ensure that rates are adequate, but not too high. Documentation contained in the actuarial memorandum submitted as part of most rate filings provides detailed information which state regulators can – and do — review to determine whether the trends and assumptions carriers use in setting rates are actuarially sound.

Determining whether rates are inadequate in the face of medical cost trends, the general waxing and waning of returns on investments and membership or enrollment, and other expenses necessary to the operation of an ongoing business is relatively straightforward. Determining whether rates are excessive is a more complicated endeavor requiring more sophisticated analysis and judgment. To assist regulators in making these judgments, the NAIC developed a model to provide guidance for determining whether rates in the individual market are reasonable in relation to premiums. That model, entitled *Guidelines for Filing of Rates for Individual Health Insurance Forms,* contains an appropriate, nuanced analysis for determinations of rate reasonableness in relation to premium collected. The NAIC model recognizes and incorporates appropriate actuarial assumptions, including the experience data for the filing company, the variability in policy types in the individual market, the costs associated with the sales and servicing of policies in the individual market, and the overall need for flexibility based on specific company circumstances. The NAIC's guidelines attempt to provide a true measure of premium to benefits received, taking into consideration appropriate company-specific operations and experiences.

In contrast to the rather complex and refined analysis in the NAIC's model, most existing state requirements for a static loss ratio ignore the environment in which the company operates, including each individual company's unique markets, the existing requirements for payments, taxes, and infrastructure that the state (or federal government) will desire or require. These ratios are ostensibly intended to ensure that ''sufficient'' premium dollars are spent directly on medical care rather than on other, non-medical expenses. They have no applicability, however, to solvency regulation, and over the long run these unsophisticated MLR requirements not only give no true measure of the benefits that individuals can expect to receive for their premium payments, but indeed may inadvertently cause significant social harm.

Since the failure of AIG's Financial Products Division in mid-2008 and the cascading financial system meltdown that followed, more, and more intense, scrutiny of company expenses such as executive salaries and corporate spending has been aimed at the insurance market. This is surprising, given that state regulators regularly exercise their ability to review compensation and company spending as part of company rate filings. Recent debates, both state and federal, regarding the use of ratios have indicated a desire to use them in a punitive manner, to ensure that executives are not over compensated. This intent to punish, while socially understandable is not necessarily good long-term regulatory policy. It is possible to create a meaningful and useful loss ratio. To date, public policy debates that continue to focus on ''overcompensation'' for executives rather than overarching, big picture regulatory policies, have failed to do so.

Components of a Meaningful Loss Ratio

A loss ratio is most meaningful as a solvency tool rather than as a social mechanism to monitor claims payments. Regulators need to know the claims that a company expects to pay in relation to the premium that it expects to receive. The key is to find an appropriate balance that encourages companies to expand, to enter new lines of business, to upgrade systems, and to embrace new information technology. Arbitrary ratio goals penalize carriers for taking on new initiatives. To achieve the goal of a useful MLR for policy, as opposed to solvency, oversight must incentivize appropriate company behavior, should not be a roadblock to innovation, and must carefully disincentivize inappropriate corporate behavior. The key to meeting these goals is defining the components of the MLR and the expenses that make up those components.

A ratio is a comparison of two things. In a medical loss ratio it is intended to be a comparison of medical claims to premiums. An expense ratio is a comparison of expenses to premiums. Many policymakers attempt to use a MLR, which measures medical claims, as a way to curtail what they deem to be ''excessive'' expenses. This unsophisticated measure does not reflect the reality of how an insurance company does business, nor is it good social policy. In truth, if the goal is to curtail expenses, then the ratio should be an expense ratio rather than a MLR. Policymakers, however, have shied away from this calculation focusing instead on the ''benefits'' ratio, rather than the ''expenses'' despite the ratio's underlying goal.

If policymakers wish to develop a medical, rather than expense, ratio, then the critical operation is to appropriately define the components. At the same time, it is important to avoid the six most common misconceptions about insurance company claims and expenses:

Six Misconceptions

The existing policy discussions regarding MLR take as their starting point the underlying, and incorrect as-

[3] *See, for example* Ariz. Admin. Code R20-6-604 and R20-6-607, which use the phrase ''actual loss ratio'' defined as ''incurred claims divided by earned premiums; Colo. Rev. Stat. Sec. 1016-102 and 10-16-107 as amended, which use the phrase ''targeted loss ratio'' to mean ''the ratio of the expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage to the expected earned premium over the same period;'' Conn. Agencies Regs 38a-478u-5 and Conn. Gen. Stat. 38a-478c and 38a-478g, which define ''medical loss ratio'' as ''the percentage of the total premium revenues spent on medical care compared to administrative costs and plan marketing and how it compensates health care providers at its premium level.''

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sumption that all premiums, all expenses and all ''medical claims'' are the same.

Misconception #1: ''Too many'' expenses are bad.

Recent congressional inquiries[4] have railed against both the insurance and banking industries for what are perceived to be excessive amounts of executive compensation. But clearly expenses are not all of a like kind. No one would consider taking a similarly critical tone, for example, to investments in sophisticated technology. Both are categories of expense (as are medical claims), but one is perceived to be socially pernicious, while the other is perceived to be socially beneficial. A blunt-edged requirement, then, to curtail ''expenses'' without a clear discussion of what those expenses actually are is irresponsible and leads inevitably to creating disincentives for beneficial industry investments.

Misconception #2: All expenses are under the company's control.

When a company is required to spend a fixed percentage – 85%, for example – of its premium on medical claims, then by definition, it is permitted only to spend 15% on anything else. This calculus, however, fails to take into account the fixed costs a company must bear, including state premium taxes, federal taxes, state guaranty fund assessments, state high risk pool assessments, and state bonding requirements. Local taxes, including property taxes and utilities similarly are not truly under the entity's control. Fixed expenses that companies are required to pay either by law or to remain operational should be removed from the calculation.

Misconception #3: All compensation is alike—and is bad.

Fixed definitions of medical loss ratios that do not take into account the human factor of running and operating a business fail as a matter of policy. The American Recovery and Reinvestment Act of 2009 (the ''stimulus bill'') provides for a $22 billion investment in health information technology. It is nonsensical to think that none of these stimulus dollars are going to be used to pay the individuals who install, use or develop the technology. A broad definition of ''compensation'' or even ''executive compensation'' is, again, a blunt instrument whose use will undermine the very purpose of the MLR. If policymakers wish to control executive compensation – a topic beyond the scope of this paper – then they should do so directly rather than through an arbitrary loss ratio requirement.

Misconception #4: Premiums are premiums are premiums.

In the health insurance industry, premium dollars are collected long after they are contracted for. At the inception of a contract year, carriers have unearned premium balanced against a premium receivable. Actual payment generally only occurs on a monthly basis, and is subject to cancellation at any time, at the policyholder's discretion. Carriers are also required by state law to hold reserves to cover the unearned premiums; these reserves can be quite significant. Regulators concerned with solvency generally speak in terms of ''earned premiums'' when examining loss ratios.[5] They also review ''net premium income'' which is defined in the NAIC Annual Statement Blank's *Statement of Revenue and Expenses*[6]. Either term is more precise than simply requiring reporting of ''premiums.'' Reports based on earned premium, net premium income, and gross premiums will produce vastly different ratios. Earned premiums plus the change in premium reserves provide the most accurate measure of ''premium.''

Misconception #5: Higher medical claims are good.

The idea behind a medical loss ratio is to maximize the amount of premium dollars spent on medical claims. That, however, is not necessarily a good thing. Maximizing dollars spent on duplicate claims, fraudulent claims, or just plain inappropriate medical treatments or pharmaceutical use does not create or encourage a responsible regulatory environment or a cost-effective health care system overall. Loss ratio calculations must incentivize companies not only to aggressively pursue fraud, but also to assure the medical appropriateness of the covered treatments and devices.

Misconception #6: All products are the same.

In order for a medical loss ratio to have any utility it must accurately reflect the nature of the policies to which it will be applied. Individual and group insurance products are sold, delivered and serviced in very different ways and an accurate MLR must take this into account. Individual policies are by their very nature sold singly, rather than in large numbers, and therefore take significantly more labor and time to sell, deliver and service than do group insurance policies. A ratio that does not take this into account creates an artificial ''cap'' on expenses that will negatively impact how the policies are serviced or delivered. This can ultimately cause a spike in premiums, rather than an increase in benefits. An appropriate MLR must, then, take the differential in distribution costs into account.

Create Appropriate Incentives

In order to ensure that health insurers and health plans are provided with incentives that remain aligned with those of their policyholders, policymakers must create appropriate MLR calculations. The NAIC's *Accounting Practices and Procedures Manual* is a good starting point for discussions. Over the course of many years, the regulatory community recognized that legislators and others needed to be able to differentiate between ''general'' expenses, such as executive compensation, and more targeted expenses, including those incurred to pay claims, to combat fraud and to coordinate care. Once the appropriate ''buckets'' have been created, then the appropriate ratio can be determined.[7]

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[4] *See: http://bennelson.senate.gov/press/press_releases/122208-01.cfm; http://help.senate.gov/Maj_press/2009_11_03.pdf; http://franken.senate.gov/press/?page=release&release_item=Franken_Rockefeller_Secure_Medical_Loss_Ratio_Provision_in_Managers_Package*

[5] The NAIC defines ''earned premium'' as ''the portion of the total premium amount corresponding to the coverage provided during a given time period. Unearned premium is, then, the portion of premium that has not been ''earned'' and is attributable to the portion of the contract that is subject to cancellation at the policyholder's discretion.

[6] The *Statement of Revenue and Expenses* provides a calculation for ''net premium'' which includes direct written premiums, plus reinsurance assumed less reinsurance ceded. Few, if any MLR requirements take reinsurance payments or recoverables into account.

[7] The NAIC Annual Statement Blank *Accident and Health Policy Experience Exhibit* arguably already contains the best and most precise definition of a ''loss ratio.'' For each line of

Medical Claims: A claim should be classified as ''medical'' when it is incurred while providing care to a subscriber, member or policyholder, including inpatient claims, physician claims, other medical claims, and resisted or other claims in the course of settlement. This should include the amount a carrier estimated for incurred but not reported claims, and for unpaid medical costs ''resulting from failed contractors under capitation contracts and provision for losses incurred by contractors deemed to be related parties for which it is probably that the reporting entity will be required to provide funding.''[8]

Premium: Premium for the purposes of MLR should include only earned premium as of the date of the required report. Premiums should also include the changes in claim or contract reserves for that same reporting period.

Expenses: Expenses should be broken down and analyzed in three categories.

1. *Cost Containment*: Arguably the most important category of expense, cost containment items are those expenses that carriers should be encouraged to increase, not decrease. Items in this category should perform one of three functions: they should either decrease the number of health services an individual will need, decrease the cost of the services provided, or increase the quality of health care being provided. From an accounting standpoint, the NAIC has agreed to date that the first two categories are defined as ''cost containment'' and in the *Accounting Practices and Procedures Manual,* they are described as:

> Cost containment expenses: Expenses that actually serve to reduce the number of health services provided or the cost of such services. The following are examples of items that shall be considered ''cost containment expenses'' only if they result in reduced levels of costs or services:
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> i. Case management activities;
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> ii. Utilization review;
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> iii. Detection and prevention of payment for fraudulent requests for reimbursement;
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> iv. Network access fees to Preferred Provider Organizations and other network-based health plans (including prescription drug networks), and allocated internal salaries and related costs associated with network development and/or provider contracting;
>
> v. Consumer education solely relating to health improvement and relying on the direct involvement of health personnel (this would include smoking cessation and disease management programs, and other programs that involve hands on medical education); and
>
> vi. Expenses for internal and external appeals processes.

Policymakers want to encourage, rather than punish carriers for engaging in anti-fraud activities, utilization review, medical education, creating internal and external appeal mechanisms, developing networks and operating case management programs. Similarly, quality advancement in general, expenditures for health information technology[9], quality measurements such as HEDIS reporting, patient satisfaction surveys, costs associated with compliance with meaningful use requirements, claim validation and the salaries and related costs associated with all of these measures should be included as the third category of cost containment. A loss ratio requirement – either medical or expense - must therefore remove these costs from any calculation attempting to limit expenses. If it does not exclude these expenses then it creates significant impediments for companies to create or participate in what are clearly socially beneficial activities.

2. *Claims Adjustment Expenses:* The next most important category of expenses encompasses claims adjustment expenses, namely those expenses carriers incur in order to ensure that claims are appropriately paid. Again a socially beneficial category of expense, this one is defined by the NAIC's *Accounting Practices and Procedures Manual* as:

> those costs expected to be incurred in connection with the adjustment and recording of accident and health claims defined in subparagraphs 6a. and 6b. of SSAP No. 55[10]. Further Claim Adjustment Expenses for Managed Care Reporting Entities are those costs expected to be incurred in connection

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business it writes a carrier is required to report, on an aggregate basis, the following:

Premiums Earned, Incurred Claims Amounts, Changes in Contract Reserves and the Loss Ratio, which is defined as [Incurred Claims Amount + Changes in Contract Reserves]/ Premiums Earned. If what the regulatory and legislative community wishes to learn is the proportion of premium dollar spent on true medical claims, then this formula, which is available for every insurer that files an annual statement blank is readily available without the need for legislative or regulatory intervention.

[8] *See,* NAIC's *Accounting Practices and Procedures Manual (2009)*, Statement of Statutory Accounting Principle No. 55, paragraph 7.

[9] HIT is defined in the stimulus bill as: ''hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information.''

[10] *SSAP No. 55 6a:* Accident and Health Claim Reserves: Reserves for claims that involve a continuing loss. This reserve is a measure of the future benefits or amounts not yet due as of the statement date which are expected to arise under claims which have been incurred as of the statement date. This shall include the amount of claim payments that are not yet due such as those amounts commonly referred to as disabled life reserves for accident and health claims. The methodology used to establish claim reserves is discussed in SSAP No. 54.

SSAP No. 55 6b: Claim Liabilities for Life/Accident and Health Contracts:

i. Due and Unpaid Claims: Claims for which Payments are due as of the statement date;

ii. Resisted Claims in course of Settlement: Liability for claims that are in dispute and are unresolved on the statement date. The liability either may be the full amount of the submitted claim or a percentage of the claim based on the reporting entity's past experience with similar resisted claims;

iii. Other claims in the Course of Settlement: Liability for claims that have been reported but the reporting entity has not received all of the required information or processing has not otherwise been completed as of the statement date;

iv. Incurred but Not Reported Claims: Liability for which a covered event has occurred (such as death, accident, or illness) but has not been reported to the reporting entity as of the statement date.

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with the adjustment and recording of managed care claims defined in subparagraph 7a. of SSAP No. 55.

As with cost containment, it is difficult to conceive of a socially beneficial reason to require companies to curtail the costs reasonably incurred to ensure that their claims are paid timely and accurately. A loss ratio that does not exclude these costs up front is not designed, ultimately, to assist policyholders.

3. ***Other Expenses:*** This third category includes all other expenses. Again, this category must be subdivided in order to avoid unnecessarily penalizing carriers for carrying out required functions. Expenses that should be removed from any calculation of medical loss ratio or expense ratio include at a minimum all the mandatory expenses for taxes, licenses, fees or assessments, whether state or federal, as outlined above.

Conclusion

Medical loss ratios, expense ratios or other ratios based on a calculation of income to expenditures can certainly be useful regulatory tools, both for solvency and other purposes. They must, however, be carefully crafted tools, designed to encourage carriers to make beneficial expenditures (disease management, patient education) and not create disincentives for investments in new technology, streamlining operations and combating fraud. It is hoped that as public policy debates regarding the use of MLRs continue, either federally or in the various state legislatures, that policymakers look beyond the traditional punitive aspects of the ratio and create a uniform and workable tool that benefits the public.