The Medical Loss Ratio

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From the ACPE Daily Digest, 2010-08-18:
Commissioners Unanimously Approve Plan For Insurers' Medical Spending.

Politico (8/18, Kliff) reports, "The National Association of Insurance Commissioners approved Tuesday morning a preliminary outline of what insurers will be able to count as medical costs, a document necessitated by the health reform bill's requirement that insurers spend at least 85 percent of subscriber premiums on medical costs in the large group market and 80 percent for small group and individual plans." Although they had "divided political views on the health reform law, all commissioners voted together to approve the document, a move forward that drew the ire of insurers." Notably, "they approved amendments that narrow inclusions of utilization review in the calculation and expand the definition of 'wellness and health promotion activities' to include 'public health marketing campaigns that are performed in conjunction with state or local health departments.'"

The Hill (8/18, Pecquet) reports in its Healthwatch blog, "The health insurance industry on Tuesday criticized state regulators for adopting a narrow category for what health plans can count as medical care and quality improvements when calculating their medical loss ratios. Barring health plans from counting fraud prevention and other investments, insurers say, hamstrings their ability to keep costs down."

CQ HealthBeat (8/18, Reichard, subscription required) reports that in response to the NAIC's action, America's Health Insurance Plans President Karen Ignagni said, "The NAIC is conducting a transparent and thorough process as it develops the MLR definition, but the current proposal could have the unintended consequence of turning back the clock on efforts to improve patient safety, enhance the quality of care, and fight fraud." Still, "a managed care industry consultant said insurers have made some gains in the NAIC process," such as the inclusion of "programs to prevent potential adverse drug reactions."

There must be reasons why “fraud prevention” would or would not be counted in the “MLR” or “medical loss ratio” of a health insurance plan. But this discussion rests on an initial discussion of what a “medical loss ratio” is, what can make a difference in the MLR and why it begins to matter when you put a floor under the MLR.

First, I must point out how much healthcare providers hate the very label “medical loss ratio” because it implies that everything that they do is a “loss.” MLR is an insurance term; insurance companies have a “loss ratio” that is calculated as the amount spent compensating insured individuals for “losses” divided by the amount collected in premiums for the coverage provided. When we are talking about, for instance, homeowner’s insurance or life insurance, we have no disagreement that when the family home burns down or dad dies, that is a “loss” to the survivors as well as a financial loss (cost) to the insurance company. But healthcare services are frequently positive things – the loss (to the extent there is one) is a loss of health, which medical services are intended to restore; the insurance company does not pay for the loss (the loss of health) but for the services to restore it. Somehow, medical service providers find it insulting to have their fees classified by the insurance company as a “loss.” Some prefer to use the term “medical expense ratio” which I shall use henceforth – as MER.

So, what is the MER? Grossly, it is the number of dollars the insurance company paid out in fees to providers divided by the number of dollars collected by the insurance company in premiums. This seems simple, doesn’t it? Why would there be any discussion on something so obvious?

The reason for the discussion is the establishment of a floor under the MER in the healthcare reform law. The floor regulation indicates that if the MER of an insurance company for its individual or small group policy line of business is less than 0.8 (less than $0.80 paid in medical expenses per dollar of premium collected in a particular year), then the excess must be returned to the person who paid the premium; similarly, if the MER for large group insurance is less than 0.85, the same action must be taken. This means that the entire operating cost and profit of the insurance company, including the creation or maintenance of reserves, must be no more than the 15-20% of premium as indicated. This is a problem in two basic ways:

First, it creates a major obstacle to entry into the health insurance business. A new company must look first to building reserves to cover expenses that are certain to come, but have not yet arrived. Initially, some of that cost is covered by purchasing reinsurance, which limits the liability experienced by the direct insurer, but sooner or later, the direct insurer will want to decrease the reinsurance and take on more and more liability – which it can do only if it has sufficient reserves to cover the high cost cases that will arrive.

This requires a bit of unpacking. Reinsurance is a kind of insurance that the health insurance company can buy to reduce its risk. Just as the consumer buys health insurance to reduce the risk of financial disaster in the case of a severe (expensive) illness or accident, the insurance company can buy coverage that will pay for expenses above a specified threshold – usually expressed as cost for any single member per year. If the insurance company, for instance, buys a $250,000 threshold policy and Mrs. Jones' expenses for 2010 are $550,000, then Mrs. Jones will pay her deductible and coinsurance amounts ($5,000, for example), the insurance company will pay the remaining $545,000, and the reinsurance company will repay the insurance company $295,000 – representing the amount above $250,000 paid by the insurance company. A new insurance company might set the threshold at $75,000 the first year, and raise it as able (the premium is less when the insurance company has a higher threshold, so raising the threshold increases risk but decreases cost). The question is: should the cost of reinsurance be considered to be a medical expense or an overhead expense? Clearly, the money paid by the insurance company for medical expenses (that is eventually repaid by the reinsurance company) is a medical expense – but what about the premium for the reinsurance?

The second issue regarding the entry of a new insurance company into the market has to do with building reserves – and the question of what is that and how does it work. The premium set for a health insurance policy represents a statement of the risk of how much the policy will cost the company in medical care payments over the course of the year. We know that to some extent, the medical cost amount is predictable and to some extent it is a random variable – we can know that someone with a specified condition – diabetes or high blood pressure, for instance – will have costs that AVERAGE about a certain amount, but we cannot predict who will be involved in an auto accident or who will be hit by lightning. Many people who buy health insurance will have medical costs that are less than the premium charged, and for a significant portion of them, the company will spend little or nothing over the course of the year. On the other hand, there will be a few people who, for a premium cost of $5-10,000 a year, get over $100,000 of medical care covered. If the average premium is $6,000 a year, it takes 20 members'

premiums to cover one member's costs of $120,000 – provided that the other 19 have no costs at all. Members with very high costs (however you want to define it – over $50,000 or over $100,000) are few, fortunately – less than 1% of any large and random population (though the proportion is rising). A small, new insurance company might have several hundred enrollees and not experience even one such catastrophic case in its first year – and it would feel justified in booking the expenses that it anticipated but did not experience as reserves, rather than returning them to the enrollees. This increase in reserves of a few hundred thousand dollars will allow the company to decrease (raise the threshold on) its reinsurance and maintain or lower premiums. But if the company is required by law to return the excess to the enrollees, this will impair its ability to grow its business base and to offer lower premiums, because it will not have the reserves to permit it to be a more aggressive competitor to the other insurance companies in the market.

The second problem with the definition of MER relates to activities undertaken by the health insurance company to reduce medical cost.

Some of those activities will be directed at screening potential enrollees to be sure that the premiums charges are appropriate to the health status of the applicant. In a market where underwriting is allowed, this allows the company to charge lower premiums to healthy people; in a market where underwriting is not allowed, healthy people will pay a higher premium to cover the costs of people with pre-existing conditions, whose costs will be higher but whose premiums will be the same as the premiums of the healthy people. Healthcare reform has regulations aimed at curbing individual underwriting and rescission policies, so I will not discuss these.

There are still several cost-reducing tactics employed by health insurance companies: they are aimed at preventing payments for services that were never rendered (fraud detection and avoidance), preventing payment for services that were or might have been rendered but which had no value to the patient (utilization management), and helping patients with self-management so that they do not need services they might otherwise have required (case management and disease management activities). All three of these activities can be expensive, but will generally produce several to many dollars in reduced medical expenses for each dollar invested in the activity. Insurance companies would argue that, since these activities are intended to reduce medical cost, and since they do so efficiently (it costs less to do the control than the money saved in medical cost), their costs should be included in medical expenses. A skeptic might think that this is an artful way for the insurance company to argue a point that will allow it to have greater profitability. But let's look more carefully.

For the sake of simplicity, let us call the total amount of premium collected 100. Of this 100, 80% must be spent on medical services. For the purposes of illustration, let us indicate that without doing fraud detection and avoidance, the company would spend 80 on medical services, 16 on operating expenses, 2 on profit, and put 2 into reserves against catastrophic claims that never happened. But instead, the company chooses to forego 1 of profit and invest it in fraud detection and avoidance activities that have a return of 8 to one in reducing the cost of medical

claims. For the one percent of gross premium invested in fraud work, eight percent of gross premium was saved in medical claims cost, so the actual net cost of medical claims is 80 less 8 or 72. But that 72 must be at least 80% of premiums - the maximum the company can retain of premiums is 72 divided by 0.8, which is 90. Looking then at costs:

Medical Services	72
Operating expenses	16
Fraud avoidance	01
Reserves	02
Total expenses	91

Since the company is only allowed to retain 90 in gross premium, we have reduced the company profit from 1 (2 minus the 1 spent on fraud avoidance) to -1! By investing 1% of gross premium in fraud detection and avoidance, the company has reduced its margin not from a profit of two to a profit of one, but to a loss of one. While we may agree that fraud detection and avoidance is a good thing, especially as it will reduce the overall cost of healthcare services, no company will risk its own financial survival to perform this important but optional task.

The problem is that the cost and the recovery are in different baskets: The cost is taken from company overhead and the recovery is accounted against medical cost. If you want to encourage the activity, it is necessary to account both the cost and the recovery in the same basket, so that spending more from that basket on the cost-reducing activity results in there being more money in the basket at the end of the day. Even this accounting does not necessarily save the day for the insurance company, however:

Medical service expenses	72
Fraud prevention expense	01
Total medical expense	73
Divide by 0.8 for gross premium Expenses	91.25
Total medical expense	73
Operating expenses	16
Reserves	02
Total expenses	91

Note that the company retains profit of 0.25 (instead of 1) by spending this money on fraud avoidance – but at least there remains a profit.

The same kind of arithmetic may be applied to the other activities – utilization management, case management and disease management. Investing in these activities may improve outcomes and can certainly reduce medical costs, but if it does so at the price of preventing the insurance company from at least breaking even at the end of the year, why would the insurance company do this? It would be much easier just to let the medical expenses climb, reduce overhead by not engaging in medical cost saving activities and keep the margin as profit.

I don't really think this is what we wanted from healthcare reform.

