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MEDICAL LOSS RATIO: HEALTH INSURANCE REGULATIONS MUST BE STRONGER TO BENEFIT THE PUBLIC

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The National Association of Insurance Commissioners has resisted some of the most egregious demands of the insurance industry in defining the medical loss ratio, a key element of the new health care reform law intended to rein in insurance industry abuses and control premiums. The NAIC's proposal now goes to the Department of Health and Human Services.

HHS must take an additional step to protect consumers: Eliminate the "greenwashing" loophole that will let insurance companies count certain marketing expenses as medical care.

The Affordable Care Act (ACA) requires health insurance companies to spend at least a minimum percent of premium dollars on the medical claims of subscribers. Companies that fail this test must provide rebates to those same subscribers. The intent of imposing the MLR is to "bring down the cost of health care coverage" and "ensure that consumers receive value for their premium payments."[1] It should provide incentives to the health insurance industry to actually pay claims instead of denying them, to operate efficiently, and to negotiate assertively with health care providers, rather than simply passing on cost increases to consumers. But companies can frustrate the intent of the law by inflating medical claims to include other expenses, including marketing expenses typically considered part of administration.

The draft regulations include a direct invitation to game the system, proposing to count as medical expenses "Activities that increase the likelihood of desired health outcomes," and specifically "Public health education campaigns that are performed in conjunction with state or local health departments." While buying a lottery ticket might not count, the entire section invites abuse.

This standard goes beyond the law, and opens an entirely new category of expenses that insurance companies can rely on to justify reduced spending on care for subscribers, and thus denials of care. It will frustrate the aims of the law and instead give undue weight to the views and interests of the insurance industry.

The insurance industry has already begun to manipulate the MLR rules for its own gain,[2] and has stated its intention to game the system by raising premiums to make up for any constraints imposed by the new law,[3] The Senate Commerce Committee has documented that, "At least one company,

1 Affordable Care Act, Section 2718.
[2] Noam Levey. *Lawmakers in most states have little control over healthcare premiums*. LA Times, August 12, 2010. "A review of campaign donations shows insurers funneling money to key lawmakers and squelching efforts to expand oversight of premiums."

WellPoint, has already 'reclassified' more than half a billion dollars of administrative expenses as medical expenses, and a leading industry analyst recently released a report explaining how the new law gives for-profit insurers a powerful new incentive to 'MLR shift' their previously identified administrative expenses."[4]

A number of public health department directors have urged that if this section is retained, they should assume the direction of any resulting "wellness" programs which relate to the improvement of population health and are non-proprietary, while costs would be covered by the insurance industry. "As public health officials, we object to being included in initiatives that will be, in effect, proprietary but legitimized by our participation."[5]

Classic Mismatch: Individual Premiums and the Public's Health

This proposal also presents a classic mismatch of policies and purposes. The intent of the MLR is to assure that individual subscribers receive the medical care they pay for through premiums, and to reduce the incentives for insurance companies to unfairly deny claims while diverting premiums into administrative expenses such as marketing and executive compensation. These individual subscribers stand to receive rebates if the MLR ratio is not achieved.

Public health departments, in contrast, are funded by the public, and their programs are not targeted or limited to any commercially defined subset of the population. A wellness campaign involving insurance companies and health departments could contribute to improved health of the community generally, including people who do not pay premiums to the company. This possibly worthy purpose is not the intended use of the subscribers' premiums, or of the numerator of the MLR, which is to assure that individual subscribers get their medical benefits, and measures direct benefits specifically to subscribers.

HHS should discourage efforts by insurance companies to create and benefit from insubstantial programs that masquerade as clinical treatments. These programs should be properly counted as the marketing and administrative expenses that they are. Otherwise, a proliferation of such programs, if regarded as clinical care, would have the exact opposite of the intended effect of the measure: it would cause health care expenditures to balloon and dilute value for consumers.

It is vital that the "medical" and "quality improvement" portion of insurance expenditures be defined strictly, and that standardized reporting requirements be detailed to prevent miscategorization of administrative expenses. A process for public comment to HHS on the NAIC's proposed regulations will offer the groundwork for constructive and equitable adjustments to the rules.

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[3] Judy Dugan, Jerry Flanagan, Carmen Balber. Comments from Consumer Watchdog to NAIC on medical loss ratio rulemaking per Section 2718 of PPACA, May 10, 2010.

[4] 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. http://commerce.senate.gov/public/?a=Files.Serve&File_id=d20644bc-6ed2-4d5a-8062-138025b998ef

5 California Conference of Local Health Officers, submission to NAIC, Oct. 12, 2010. http://www.centerforpolicyanalysis.org/index.php/2010/08/medical-loss-ratio-politico-report-2/

The MLR is a ratio, with all medical claims (in the numerator) divided by total income (in the denominator). Section 2718 of the ACA establishes a minimum MLR that requires health insurance companies in the large market to spend at least 85% of premiums on patient care, and no more than 15% on administration and profit. In the small group/individual market, the figures are 80% for claims and 20% for administration and profit. To fairly achieve an 85% MLR, a company would have to show that the amount spent on medical claims (in the numerator) is high relative to premiums. A high MLR generally means that the insurance company is spending a relatively higher share of premium income on its members' medical care and less for administration and profit. A low MLR means that the insurance company is returning less in medical care benefits to its members while retaining more for executives and shareholders. This can also signal a solid opportunity for investors.

Several states already have MLR standards, and they use the straightforward formula of medical claims in the numerator, and administration in the denominator. [1]

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