Center for Policy Analysis

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COMMENTS ON STANDARDS FOR MEDICAL LOSS RATIOS

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IN RESPONSE TO

Request for Comments Regarding Section 2718 of the Public Health Service Act (Medical Loss Ratios)

DEPARTMENT OF THE TREASURY
Internal Revenue Service

DEPARTMENT OF LABOR
Employee Benefits Security Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICE
Office of the Secretary

45 CFR Parts 146 and 148
Medical Loss Ratios; Employee Benefits Security Administration Request for Comments Regarding Section 2718 of the Public Health Service Act

The Medical Loss Ratio is an Imperfect Measure

The stated objectives of Section 2718 of the Patient Protection and Affordable Care Act (PPACA) are "bringing down the cost of health care coverage" and "ensuring that consumers receive value for their premium payments." In pursuit of these aims, the law requires health insurance companies to spend at least 85% of premiums on patient care, a figure known as the “medical loss ratio” or MLR, and only 15% on administration and profit, in the large group market. In the small group market, the figures are 80% MLR and 20% for administration and profit. Companies must also report the calculations for their MLR. This rule is in effect until 2014, when health exchanges are set to begin.

The aims of Sec. 2718 - low cost care that offers value to consumers – conflict with the financial imperative of the health insurance industry, to maximize profits and returns to shareholders. This complicates the task of calculating the MLR in a way that will achieve the aims of the law. A high MLR means that the insurance company is spending a fair amount of premium income on its members' medical care and perhaps less for highly-overpaid CEOs and shareholders 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. It is important to complement the use of the MLR with effective insurance rate regulation that includes affordability as a criterion for acceptable premiums.

This tension is evident in the definitions of the MLR, which could give insurance companies a gaping loophole. Section 2718 defines clinical services (2718 (a)(1)) **and activities that improve health care quality (2718 (a) (2))** as part of the MLR, while non-claims costs (2718(a)(3)) reside on the administration side.

Defining "Activities That Improve Health Care Quality"

It is a problem that the current law allows companies to count, among the 80 - 85% spent on medical care, "activities that improve health care quality" as a component of the MLR. It could be hard going to define this criterion legitimately, and to distinguish insurance company practices, if any, that provide value, vs. those that are trumped up to manipulate the premium rate. Including "activities that improve health care quality" as a component of the MLR potentially opens the door to a wide range of deceptive practices by insurance companies. This language is barely used at the state level. A review of states' rules on MLR, compiled by the National Association of Insurance Commissioners (NAIC) and published by America's Health Insurance Plans (AHIP), shows that most states define administrative expenses fairly straightforwardly.[1] Only a few, such as Florida, even include in claims such costs as fraud investigations, and this is justified by noting that such programs serve to reduce the overall cost of claims, not to inflate them.

The insurance industry has already stated its intention to game the system by raising premiums to make up for any dents caused by the new law.[2] At this juncture it appears that the industry has already begun to game the MLR rules for its own gain. The Senate Commerce Committee has documented that, "At least one company, 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."[3]

Part of the justification for unfounded charges is the industry's incursion into activities such as alliances with disease management programs, which it attempts to characterize as a clinical benefit rather than administration.

Vigilance will be required to successfully enforce MLR rules in a way that benefits health consumers. A pattern of duplicitous and obstructive strategies by the health care industry giants has already emerged, threatening the success of this part of the PPACA. It is probable that regulators can succeed in this arena only by adopting new paradigms, for example compelling the insurance companies to use their power to negotiate medical costs instead of passing them on to the consumer. The current criteria for justifying rate increases are too porous to withstand the likely flood of increases, now and in the very foreseeable future. Special operational privileges, resulting in great power leverage, have been granted to the health insurance industry. De-institutionalizing these privileges is necessary.

Lessons from the Anthem Blue Cross California case

The recent history of health care insurance rate increases, and the contention around them, highlight the obstacles to effective and feasible regulation based on the concept of theMLR, or lifetime loss ratio under a given plan (LLR). Anthem Blue Cross in California had already notified its subscribers of rate increases, averaging 25% but in some cases up to 39%, without prior approval from the state (none is currently required). Only an emphatic public denunciation of these increases by President Obama, during a time when furious public debate over health care reform was the front page story, caused the state to review the increases. This resulted in an audit by an outside agency that found Anthem to have "incorrectly" applied its own formulas. Had the formulas been applied correctly a 15%, not a 25%, increase would have been calculated.

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Faced with these errors, and the fact that at least one of its products fell below California's 70% MLR, Anthem retracted its rate request, and will submit a new one. At no point before the audit did Anthem even admit the possibility that there was anything amiss in their rate increases. After the audit Anthem dismissed the errors as accidents, and, rather preposterously, claimed that its retraction of the rate increases had nothing to do with the audit.

Yet evidence shows that from the very beginning these were not errors, but deceptions, as documented by the House Commerce Committee: consumerwatchdog.org/resources/PoiznerAnthemRateLetter.pdf. Anthem's strategy seems to have been to ask for an exorbitant increase, so they could then appear cooperative by agreeing to a lower, but still quite healthy increase. Anthem could still succeed

The MLR Should Be Defined Narrowly

Strict regulatory standards defining costs of care and of quality improvement are all the more important because requiring 80 to 85 percent of premiums to be used for care does not demand much of insurers, as two important observations indicate. First, across the nation, an array of health insurers that are highly rated for quality regularly attain medical loss ratios of around 90 percent or more. (For example, major non-profit Massachusetts insurers often achieve and exceed that threshold; in recent years, Fallon, Harvard Pilgrim, and Tufts HMO have annually spent 87-91 percent of their premiums on care.) Many patient advocates supported requiring at least a minimum medical loss ratio of 90 percent, and an 85 percent standard is clearly easily attainable by insurors with large memberships.

Second, the PPACA standard applies only to insurers' premium revenues. Yet patients and payors should be equally concerned about how an insurer uses income from its investment of the sums it extracted from previous years' patient premiums. A more appropriate standard would measure the share of insurers' total revenues devoted to care, as some analysts have urged.[4]

Given this loophole and the modest 80-85 percent standards the law sets, it's 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 -- and also vital that rate review and other pressures be strong enough to prevent insurers from simply raising premiums in order to offset the limit on their administration/profit share.

Continuous Monitoring, and Involvement of Patients and Advocates

It will be important, then, to create an ongoing process to set and review the initial regulations which are required to begin in September, 2010. Public comment on this system's achievements and failures will provide important assessments of the system's success, and should provide the groundwork for adjustments to the rules.

In addition, the public should be encouraged to document and report efforts by insurance companies to drum up and benefit from flimsy programs that masquerade a clinical treatments. These programs should be properly counted as the 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.

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[1] State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations (as of April 15, 2010). AHIP.
[2] 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.
[3] 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
[4] Alan Sager and Deborah Socolar, "A Better Deal for Our Health Care Dollars: Testimony to the Joint Committee on Insurance, Massachusetts General Court, on H. 1208, An Act to Promote the Efficient Use of Health Care Revenues," Health Reform Program, Boston University School of Public Health, April 2, 2001, http://dcc2.bumc.bu.edu/hs/sager/A%20Better%20Deal%202%20Apr%2001.pdf;
Robert Padgug, Rekindling Reform, testimony at state health reform hearings, 30 October 2007, partnership4coverage.ny.gov/hearings/2007-10-30/testimony/docs/robert_padgug_-_rekindling_reform.pdf.

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