Healthcare BUSINESS STRATEGY™

Traditional Medical Loss Ratio Differs from ACA-MLR

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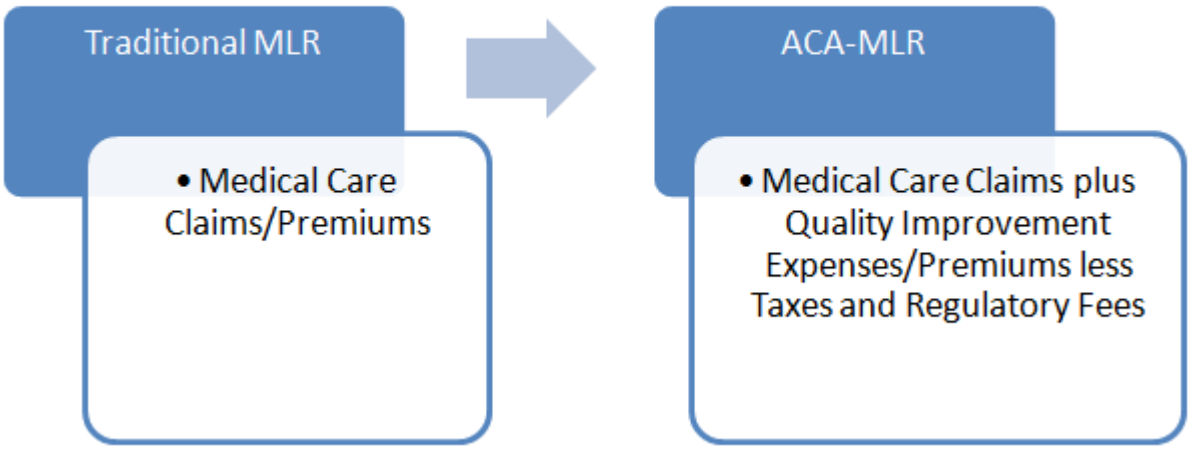
by Debra A. Donahue

Regulating medical loss ratios (MLR) is one way Congress is attempting to lower the cost of health care through the Patient Protection and Affordable Care Act of 2010 (ACA). Earlier this month the Department of Health and Human Services (HHS) released final regulations concerning the provision (section 2718) regarding "bringing down the cost of health care" in the ACA. The policy became known as the "medical loss ratio" (MLR) provision because it requires insurers to provide a "rebate to consumers if the percentage of premiums for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small and individual markets."[1] The stated purpose of the ACA-MLR provision is to ensure that millions of Americans who rely on private insurance for health care coverage receive value for their premium dollar.[2] As of September 2011, 83.6 million Americans that receive health insurance through individual, small or large group, fully-insured major medical products sold by carriers are impacted by the regulation.[3] The ACA required the National Association of Insurance Commissioners (NAIC) to develop definitions and methodologies for calculating the insurance companies' medical loss ratios or ACA-MLRs. HHS adopted the model regulations submitted by the NAIC however controversy remains regarding the impact this regulation has on the overall industry, particularly on insurance brokers and agents. On December 3, 2011, HHS released its final medical loss ratio rule, without changing the calculations originally developed and placed in use in November 2010. The regulation broadens the traditional definition of the term medical loss ratio and alters its use from measuring profitability to assessing punitive charges.

Loss ratios have traditionally been a way for insurers and underwriting agents to assess the profitability of their business, an insurance policy or even a relationship with a partner or client company; typically the lower the loss ratio number, the better the performance. A loss ratio is the relationship between income and outgoings, which in insurance terms means Premiums compared to Claims. For medical insurers this is usually referred to as the medical loss ratio (MLR). However, the MLR formula specified in the ACA differs from the traditional definition. The ACA-MLR includes insurers' expenses for activities that improve health care quality along with traditional claims expenses and deducts federal and state taxes and licensing or regulatory fees from Premiums.[2] It also factors in information technology expenses.

Traditional and ACA-MLR Formula Comparison



While the terminology appears similar, the use and intent of the traditional MLR calculation and the ACA-MLR calculation are very different. In the traditional sense and from an investor perspective the purpose of an MLR is to assess a particular business line and determine if premiums are covering claims as intended. If claims get too high premiums either need to be raised or in some cases the business is considered untenable or unsustainable. In the traditional use of the term, a lower MLR is considered better. It means an insurer is managing its claims costs in relationship to the premiums it is charging. The new ACA-MLR calculation, which is more of a medical benefit ratio rather than a loss ratio, is used to determine the relationship of premiums to the costs of claims and other related expenses for the provision of care. The regulations place a threshold that plans must meet or pay a penalty in the form of a rebate to their customers if their ACA-MLRs are not high enough. For the ACA-MLR, a higher ratio is considered better. The premise behind the ACA-MLR regulations is that the consumer receives more value for their dollar if an insurer spends more of its premiums on claims expense.

It is perhaps easier to think of the traditional MLR and the ACA-MLR as two different precepts. Given that the ACA-MLR definition is something plans must comply with now, it may help to understand some of the factors, benefits and issues impacting carriers as they develop their ACA-MLR compliance strategies. The first of these is the level of reporting required by plans.

More Precise ACA-MLR Reporting in 2011

Prior to the ACA-MLR reporting requirements, enrollment and financial data on individual, small group and large group commercial segments were difficult to obtain, particularly on a state level for comparison among plans. The Supplemental Health Care Exhibit developed by the NAIC and adopted by HHS now requires standardized reporting, making it easier to assess market share by segment within each state and benchmark data on premiums, claims, quality, and information technology. These data elements, which are filed each April 1 and available in Mark Farrah Associates' Health Coverage Portal™, even allows for the comparison of in-house sales versus broker or agent customer acquisition strategies by segment within each state.

One of the past issues with this type of data was the lack of reporting standardization; however more precise data is expected in 2011. Carriers began reporting data for the ACA-MLR calculation for year-end 2010 but many plans had to estimate data elements. Regulations were not established until late 2010 so internal reporting mechanisms may not have spliced the data in the same format as NAIC required. For 2011, a full year of data will be collected according to the new ACA-MLR categories. Another issue with the previously reported data was many health plans had difficulty assessing previously centralized quality and information technology resources into specified markets in 2010. The 2011 numbers are expected to be different than what was previously reported but should allow for better trending of data from 2011 onward.

Impacts of the ACA-MLR provision

HHS explicitly listed agents' and brokers' commissions and fees as non-claims expenses which means these fees would be considered administrative costs under the ACA-MLR calculation. Reducing administrative costs is one option to increase ACR-MLR results. Most insurers either reduced broker commissions or adjusted premiums, which impact brokers' commissions, almost immediately after the regulations came out causing a significant impact on agents and brokers throughout the U.S. The value brokers add by assisting small business and the consumer is a hotly debated issue. Brokers lobbied to have their fees exempted from the calculation of administrative costs. In late November 2011, the members of the NAIC decided, in a close decision, to adopt a resolution urging Congress to amend the ACA-MLR calculation to mitigate the impact on brokers. However, when the HHS released its final regulations this month it did not address the broker issue or make changes to the calculation.

Another area that has been impacted by the ACA-MLR calculation concerns how quality improvement activities are defined. Many health plans are considering reducing activities that HHS did not consider quality improvement activities for the ACA-MLR calculation such as retrospective utilization review (reviewing a patient's records after a treatment has occurred) or preauthorization of inpatient admissions. A subsector of the health care industry has evolved to handle pre-authorizations and retrospective reviews. Should health insurers cease using these cost control activities, it will obviously hurt these businesses. It may also lead to increased medical expenses when unnecessary services are utilized and an increase in fraud which is often uncovered in retrospective reviews.

Where an insurer chooses to do business may also be influenced by the ACA-MLR regulations. Carriers may choose to exit markets due to an inability to reach ACA-MLR thresholds. This has been a concern for Insurance Commissioners in many states and some consumer advocate groups. The ACA-MLR regulations allow states to petition for waivers if they believe the MLR requirements may result in destabilization of the individual and small group markets in their respective states. Several states have already requested waivers to the regulations. HHS has approved adjustments to the ACA-MLR levels in six states and denied requests from four states; decisions are still pending for seven states.[4] Inconsistent state regulations are not new to insurers but this may further complicate analysis of future data or administration of the ACA-MLR regulations.

It remains to be seen how disincentivizing health insurers from controlling claims expenses with the ACA-MLR regulations will actually help bring down the cost of overall health care. Congress has already revised the ACA to amend a controversial 1099 reporting requirement. The Supreme Court will be reviewing the constitutionality of the individual mandate portion of the ACA soon and additional changes should be expected. However, as 2011 winds down — health insurers will soon be submitting their Annual 2011 statutory filings with the NAIC. In April 2012, more precise Supplemental Health Care Exhibit data will be available. For anyone with an interest in analyzing this data please contact Mark Farrah Associates to see how to obtain it.

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[1]ACA Section 1001; Statutory section PHSA 2718

[2]United States Government Accountability Office, Report to Congressional Requesters, "Private Health Insurance, Early Experiences Implementing New Medical Loss Ratio Requirements", July 2011, GAO-11-711

[3]Mark Farrah Associates' Health Coverage Portal™ Commercial Risk Major Medical Total Enrollment; data was aggregated from NAIC statutory reports

[4]Sam Baker, The Hill Healthwatch blog, "HHS finalizes regulations on insurers' spending," 12/2/2011

About the Data

Health plans file statutory data on a quarterly and annual basis with state insurance regulators. Financial statements are prepared using statutory accounting rules as defined by the National Association of Insurance Commissioners (NAIC). For companies seeking comprehensive market data, MFA offers the Health Coverage Portal™ (/products/health-coverage-portal.aspx), a unique online application that integrates NAIC statutory and MFA self-insured datasets. The Health Coverage Portal™ provides easy access to financials, PMPM comparisons, ratios, membership and market share.

About Mark Farrah Associates (MFA)

Mark Farrah Associates (MFA) is a leading data aggregator and publisher providing health plan market data and analysis tools for the healthcare industry. We are a licensed redistributor of NAIC data. MFA's Health Coverage Portal™ includes both risk-based and administrative services only membership and detailed financial data by plan, parent, state, region and nationally. Committed to simplifying analysis of health insurance business, our products include Health Coverage Portal™, Health Insurer Insights™, Medicare Business Online™, Medicare Benefits Analyzer™, Health Plans USA™ and the new County Health Coverage™, which offers population and health plan enrollment data by county nationwide.

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