



Medical Loss Ratios: Making Sure Premium Dollars Go to Health Care—Not Profits



Around the country, health insurance consumers are facing large premium hikes. At the same time, insurance company profits have increased.¹ This begs the question: Are Americans getting a good deal for their money? One of the important ways to gauge whether consumers are getting high-value coverage is by examining an insurance plan's

“medical loss ratio,” or MLR. Medical loss ratios measure the share of premiums that an insurer actually spends on delivering care to policyholders, rather than on administrative costs, marketing, and profits.

Currently, there is a patchwork of rules across the country regarding whether insurance companies must report what their medical loss ratios are and whether insurers must meet minimum requirements for these medical loss ratios. The result is that the availability of information on insurance company medical loss ratios varies widely from state to state. Federal health reform will address this problem and make sure that consumers are getting good value for their premium dollars by requiring insurers to report their medical loss ratios and setting minimum requirements for medical loss ratios that must be met by insurance companies nationwide.

In this brief, we discuss medical loss ratios, state requirements regarding medical loss ratios, and why medical loss ratio requirements (like those in the health reform proposals that Congress and the President are considering) are so important for protecting consumers.

What is a minimum medical loss ratio requirement?

A minimum medical loss ratio requirement demands that insurers spend at least a specified percentage of the premium dollars they collect directly on medical care rather than on administrative costs, marketing, and profits. If an insurer does not spend enough on medical care to meet the minimum medical loss ratio, it must either provide a refund to consumers or adjust its premiums accordingly for the following year.

Without a strong minimum requirement, what do medical loss ratios look like?

Without an adequate medical loss ratio requirement, some insurers charge very high premiums and spend a shockingly low proportion of these premium dollars on health care. This problem is most prevalent in insurance policies that are sold directly to individuals and to small businesses. For example:

- In 2008, Families USA interviewed insurance regulators in 19 states and learned that insurers in the individual market sometimes maintain medical loss ratios of only 60 percent, retaining 40 percent of premium dollars for administration, marketing, and profits.²
- A review of medical loss ratios for Texas small and large group insurers between 2003 and 2006 found drastic variation in the proportion of premiums that companies spent on delivering care: Medical loss ratios ranged from an astoundingly low 22 percent to a high of 267 percent (a loss).³

Insurance companies have an incentive to decrease the share of premiums that they spend on medical care: As their medical loss ratios have fallen, their stock prices have risen.⁴ However, consumers' health care and their wallets suffer when medical loss ratios are too low.

How are medical loss ratios calculated?

Perhaps the purest way to calculate a medical loss ratio is to see how much money a health plan is spending on medical claims compared to what it spends on everything else.

Insurers report this information on a National Association of Insurance Commissioners (NAIC) form called the "Accident and Health Policy Experience." To get an accurate picture of their insurance markets, policy makers and regulators may have to ask that this information be separated out for the individual and small group markets and by specific insurance policies. For example, a regulator may want to see numbers specific to a company's HMO product that is sold in the individual market.

There are several factors that have led some policy makers and regulators to develop more complex reporting requirements for medical and non-medical expenses.

- First, consumers and policy makers may want health insurers to take steps to help improve the quality of medical care. Therefore, policy makers or regulators may decide to take expenses that are related to quality improvements out of the medical loss ratio equation altogether—that is, they subtract quality improvement expenses from insurers' premium dollars and then require insurers to spend a specific percentage of the remaining

premium dollars on medical care. When officials take this approach, consumer groups should weigh in on what regulators should consider to be legitimate quality improvement expenses and whether health plans should be required to meet even higher medical loss ratio requirements if these expenses are excluded. (Note that in addition, regulators generally allow insurers to exclude from their medical loss ratio calculations fees and taxes that insurers are required by law to pay.)

- Second, some health insurers subcontract for certain types of medical care. For example, an insurer might directly pay providers for physical health care services but subcontract with a behavioral health plan to manage and pay mental health care claims. In that kind of case, it is important to also require the subcontracting plan to account for the share of revenue that it devotes to actually providing care.
- Third, some analysts have raised concerns about whether national or regional health plans accurately attribute their revenues and expenses to each particular state in which they operate. Establishing national medical loss ratio requirements like those in the health reform proposals that Congress and the President are considering would help address this concern.

Why are medical loss ratio requirements good policy?

Medical loss ratio requirements foster transparency and accountability in how insurance companies spend enrollees' premiums. Americans deserve to know where their insurance premiums are going, and they deserve a guarantee that they are getting good value for their dollars. This is especially important

because health insurance premiums have been rising much faster than workers' wages, and many families and small businesses are struggling to afford coverage at all. Furthermore, the coverage that consumers receive for these rising premiums is growing thinner, and out-of-pocket costs are rising, which makes health care even less affordable. Americans deserve to know that these higher costs aren't just being used to cover insurers' marketing costs or to pad their profit margins.

In addition, medical loss ratio requirements make it possible to take action against outlier companies that are not acting as fair players in the marketplace. For example, in Minnesota in 2008, small group insurance plans overall had an average medical loss ratio of 87 percent—5 percentage points more than they were required to spend directly on care under state law. However, one company's medical loss ratio was a very low 66 percent, and another's was only 69 percent. The state's medical loss ratio requirement ensures that enrollees in plans with such low medical loss ratios be compensated fairly.⁵

Medical loss ratio requirements also provide special protection to individuals and small businesses. The individual and small group markets are where low medical loss ratios are most problematic. This is in part because individuals and small businesses have less negotiating power over premium rates compared to large employers, which gives insurers less incentive to make sure that they deliver high-value coverage for premiums in the individual and small group markets. Medical loss ratio requirements encourage insurers to deliver value for premium dollars in the individual and small group markets, as well as in the large group market.

What should policy makers consider when setting medical loss ratio requirements?

When setting a standard for medical loss ratios in the private individual and group markets, a good starting point is to examine current “best-practice” insurers. A reasonable medical loss ratio that one or more insurers currently meet can create a base level for a medical loss ratio requirement. From this base level, a higher standard can be phased in over time (see the Minnesota example on page 5). In addition, certain controversial expenses can be exempted initially when counting non-medical expenses in medical loss ratio calculations (see “How are medical loss ratios calculated?” on page 2). These steps can make it easier to achieve the ultimate goal of ensuring that the highest portion of premiums possible goes directly to medical expenses and not to administration, marketing, or profits.

How will health reform make sure more premium dollars are spent on health care?

The health reform bills passed by the House and the Senate will create a federal “floor” for medical loss ratio requirements. This will guarantee consumers in every state that an adequate share of their premium dollars will be spent directly on medical care. Under the Senate bill, insurers will be required to spend at least 85 percent of premium dollars for large employer policies on medical care and quality improvement. In the small group and individual markets, that standard will be set at 80 percent. States may choose to set standards that are higher than this federal floor, requiring that insurers spend an even greater share of

premiums on medical care for policyholders. Under the Senate bill, if insurers spend less on medical care than is required by the medical loss ratio standards described above, they must refund the difference to enrollees. Also, to get certain tax breaks, nonprofit Blue Cross plans must spend at least 85 percent of premium dollars on clinical care and quality improvement.

In addition, health reform will actually help insurers bring down their administrative costs, thereby making it even easier for insurance companies to increase their medical loss ratios from their current levels and meet medical loss ratio requirements. The health reform bills currently under consideration in Congress include two major provisions that should decrease the amount of non-medical costs that insurers incur.

1. A prohibition against basing premium rates and offers of coverage on health status and pre-existing conditions should lower administrative expenses, as underwriters will no longer have to perform an in-depth analysis of every person who applies for coverage. Insurers sometimes spend 20-25 percent of premiums in the individual market and 10-15 percent in the small group market on such medical underwriting.⁶
2. Creating health insurance exchanges will decrease the extent to which insurers need to spend premium dollars on marketing their products, because many new consumers (with and without subsidies) will be coming to them through the exchanges. If exchanges directly enroll consumers into health plans, insurers’ administrative costs should decrease even more.

What do state medical loss ratio requirements look like?

As of September 2009, 13 states require insurers to meet minimum medical loss ratios in the individual market, and 13 states have established medical loss ratio requirements in the small group market. Five states have established requirements in the large group market.⁷ States may also have medical loss ratio requirements in the Medicare supplement or long-term care markets. In some states, only specific insurers (such as HMOs or safety-net insurers) must meet a minimum medical loss ratio requirement.

In at least five states with medical loss ratio requirements, insurers must provide rebates to policyholders if they fail to meet the minimum standards.⁸ The Senate Committee on Commerce, Science, and Transportation found that over the past five years, four of the nation's largest health insurers refunded a total of \$73.2 million to consumers in order to comply with such laws.⁹

A handful of states require individual and/or small group insurers to maintain a medical loss ratio of 75 percent or more. This medical loss ratio still leaves room for improvement, but it is preferable to lower standards. We discuss some of these states below.

- **Maine** requires small group insurers to spend at least 75 percent of the premiums they collect on medical claims. Insurance companies are subject to rate review by the Bureau of Insurance, which can call hearings to evaluate how well insurance companies are complying with the medical loss ratio requirement. An insurer can avoid the hearing process and file its rates on an informational basis, without further review, if it agrees to meet a higher medical loss ratio requirement of 78 percent over a continuous three-year period. If such an insurer fails to meet the 78 percent standard, it must refund the excess premium dollars it has collected to policyholders. Individual plans in Maine are required to meet a medical loss ratio of 65 percent. In 2008, as a result of state's medical loss ratio requirements, one Maine insurance company refunded \$6.6 million to policyholders, and another refunded \$1 million.¹⁰
- **Minnesota** passed regulations in 1993 that initially required high-volume insurers in the small group market to meet a 75 percent medical loss ratio and high-volume individual market insurers to meet a 65 percent loss ratio. Both medical loss ratio requirements increased by 1 percentage point each year until 2000, when the ratios were set at 82 percent in the small group market and 72 percent in the individual market for high-volume insurers. Medical loss ratio requirements have remained at these levels since. In addition, insurers must demonstrate that the premiums they seek are low enough to achieve the required loss ratios *before* the Insurance Commissioner will approve proposed rates.¹¹ Each year, the Insurance Commissioner prepares a public report showing the medical loss ratios achieved by health insurers in the state.¹²
- **New Jersey** requires an 80 percent medical loss ratio for all insurers in the small group and individual markets. (This is an increase from the state's original medical loss ratio requirement, which was set at 75 percent for both markets.) Insurers must report their medical loss ratios annually, and if they are less than 80 percent, they must issue refunds to health plan enrollees to make up the difference.¹³

- **New York** has a medical loss ratio requirement of 75 percent for the small group market and 80 percent for the individual market. Insurers must file annual reports indicating that they are meeting these ratios, and if they are not, they must refund the difference to policyholders or reduce premiums accordingly.¹⁴ From 2000 to 2007, New York insurers refunded \$48 million to policyholders based on their own reports of whether they met the required medical loss ratios, and they refunded an additional \$105 million to policyholders after the Department of Insurance further investigated their actual medical loss ratios.¹⁵
- **Washington** increased its medical loss ratio requirement for the individual market in the 2008 legislative session. Individual insurers that decline coverage to 8 percent or more of their applicants must meet a medical loss ratio of 77 percent.¹⁶

In addition to the states mentioned above, **California** has a 70 percent medical loss ratio requirement in its individual market. Although this requirement is not as high as those in the other states mentioned, the requirement plays an important role in assessing the rate hikes of insurers in the individual market.¹⁷ For example, in February 2010, one California individual market insurer informed policyholders that their rates were going to go up by as much as 39 percent starting in March 2010.¹⁸ The state's medical loss ratio requirement gives its Insurance Commissioner the authority to request that this rate hike be delayed so that actuaries can investigate whether the insurer is meeting the medical loss ratio requirement, and, if it is not, to disapprove the premium hike accordingly.¹⁹

How do you find out about medical loss ratios for insurers in your state?

It can be very difficult to obtain information about medical loss ratios in states where there are no minimum medical loss ratio or reporting requirements. Especially when it comes to medical loss ratio information for the individual or small group markets, insurers may claim that their ratios are “proprietary” and refuse to disclose such information to consumers.²⁰ However, 32 states require insurers to provide some sort of reporting on their medical loss ratios.²¹ For example, in some states, state-licensed insurance companies must file their medical loss ratios with the insurance department each year. Some of these states' insurance departments then make the information available online or through annual reports to consumers. In other states, it may be more difficult to get information on medical loss ratios, especially if you are seeking information that is specific to the individual or small group markets.²²

What other regulations are necessary to keep premiums reasonable?

It's important for policy makers to be aware that medical loss ratio requirements are just one of many critical policy tools that are necessary to make sure that health insurance premiums are fair and reasonable for consumers. Other important measures that should be used to protect against unfair premiums include instituting prior approval and public review of premium rates and rate increases, as well as establishing standards that are designed to ensure that insurance company profits and surpluses are reasonable over time. It's important not just that laws

provide insurance regulators with the authority to enforce these provisions, but also that insurance departments and other officials have the resources necessary to do so.

A number of states have implemented at least some of these practices, and the health reform bills under consideration in Congress will require or encourage all states to do so.

Conclusion

The enactment and enforcement of medical loss ratio requirements, along with other important measures for holding insurers accountable, can help make premiums affordable for consumers in all 50 states.

¹ U.S. Department of Health and Human Services, *Insurance Companies Prosper, Families Suffer: Our Broken Health Insurance System* (Washington: HHS, February 2010).

² Families USA, *Medical Loss Ratios: Evidence from the States* (Washington: Families USA, June 2008).

³ Center for Public Policy Priorities, *Testimony on HB 531: Minimum Medical Loss Ratios* (Austin, TX: CPPP, March 24, 2009). Calculations are based on insurers' filings with the Texas Department of Insurance.

⁴ Wendell Potter, *Testimony before the U.S. Senate Committee on Commerce, Science, and Transportation* (Washington: U.S. Senate, June 24, 2009). Wendell Potter is a former health insurance executive.

⁵ Minnesota Department of Commerce, *Report of 2008 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for Insurance Companies, Nonprofit Health Service Plan Corporations, and Health Maintenance Organizations* (St. Paul, MN: Minnesota Department of Commerce, August 1, 2009), available online at http://www.state.mn.us/mn/externalDocs/Commerce/Current_Loss_Ratio_Report_052104013421_LossRatioReport.pdf.

⁶ Professor Mark Hall, *Testimony of Mark Hall: Hearing on 47 Million and Counting: Why the Health Care Marketplace Is Broken* (Washington: U.S. Senate Committee on Finance, June 10, 2008), as cited in Senator John D. Rockefeller, *Letter to CIGNA Chairman H. Edward Hanway* (Washington: U.S. Senate Committee on Commerce, Science, and Transportation, November 2, 2009), which compiled data from Accident and Health Policy Experience filings with the National Association of Insurance Commissioners for Aetna, CIGNA, Coventry, Humana, UnitedHealth, and Wellpoint.

⁷ America's Health Insurance Plans, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations* (Washington: AHIP, September 2009), as cited in Senator John D. Rockefeller, op. cit.

⁸ Ibid.

⁹ Senator John D. Rockefeller, op. cit.

¹⁰ Maine Revised Statutes: Title 24-A, Chapter 33, §2736-C; Title 24-A Chapter 35 §2808-B 2-C.

¹¹ Minnesota Statutes: 62A.021.

¹² Minnesota Department of Commerce, op. cit.

¹³ New Jersey Statutes: 17B:27A-25, 17B:27A-16.5.

¹⁴ New York Consolidated Laws: Insurance §§3231 and 4308.

¹⁵ Eric Dinallo, *The Price of Deregulation: How 'File and Use' Has Undermined New York State's Ability to Protect Consumers from Excessive Health Insurance Premiums* (Albany, NY: New York Insurance Department, June 8, 2009).

¹⁶ Revised Code of Washington: RCW 48.20.025. Plans with lower rates of declination of applicants still must meet a MLR requirement. The lowest MLR requirement in Washington is 74 percent for individual market plans that have a declination rate of 6 percent or less.

¹⁷ California Administrative Code Title 10, § 2222.12.

¹⁸ Linda A. Johnson, "Anthem to Delay Insurance Rate Hike amid Criticism," *The Washington Post*, February 14, 2010, available online at <http://www.washingtonpost.com/wp-dyn/content/article/2010/02/13/AR2010021302713.html>.

¹⁹ California Administrative Code, op. cit.

²⁰ Senator John D. Rockefeller, op. cit.

²¹ America's Health Insurance Plans, op. cit.

²² Senator John D. Rockefeller, op. cit.

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