

Medical Loss Ratio: A Briefing Paper

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New Mexico Health Policy Commission

Governor Bill Richardson

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INTRODUCTION

The medical loss ratio is a statistic that measures the fraction of total premium revenue that health plans devote to clinical services, as distinct from administration and profit.¹ A higher ratio indicates that more revenue from premiums is devoted to the delivery of care, which includes payments to physicians, hospitals, pharmacists and other healthcare providers.² Each state has the option of establishing a minimum medical loss ratio, which requires insurers to spend a specified minimum percentage of premium revenue on medical care rather than on administration, marketing, and profit. If an insurer does not spend enough on medical care to meet the minimum medical loss ratio, it must either refund consumers or adjust its premiums accordingly for the following year.

MEDICAL LOSS RATIO

Medical loss ratio refers to the percentage of revenues from health insurance premiums that are directed toward medical services covered by the medical insurance health plans.³ MLR is referred to as a ratio such as 0.85, in which 85 percent of premiums are used to purchase medical services (as opposed to administrative costs and profits, in this case 15 percent).

The medical loss ratio is a ratio of medical expenditures to insurance premiums. High ratios can be achieved either through a large numerator (high medical expenditures) or through a small denominator (low insurance premiums). The medical loss ratio, as a ratio of the two, can be measuring the impact of medical market competition on expenditures or of insurance market competition on premiums. For example, a statistical analysis of medical loss ratios in three states found that administrative loss ratios were higher (and medical loss ratios were lower) in plans that relied extensively on capitation rather than on fee-for-service; this difference was attributable solely to the lower total premiums charged by the capitation-oriented plans (the denominator of the medical loss ratio) rather than to differences in administrative expenses per enrollee.⁴ Moreover, neither premiums nor expenditures by themselves indicate quality of care.

The components of the medical loss ratio are derived from internal accounting statistics developed by insurance companies to measure what fraction of premium revenues are paid out in claims (losses). State insurance departments gradually have required insurers to file loss ratios as part of their documentation of solvency and, in regulated contexts, documentation for rate increases. The National Association of Insurance Commissioners (NAIC) has sought to standardize the often inconsistent accounting practices and definition

1 Robinson, J.C. (1997, July/August). Use and abuse of the medical loss ratio to measure health plan performance: This accounting tool was never intended to measure quality or efficiency. *Health Affairs* 16(4), 176-187. Retrieved December 24, 2008 from <http://content.healthaffairs.org/cgi/reprint/16/4/176.pdf>

2 Ibid.

3 Medicallossratio.com. (n.d.). *What is medical loss ratio (MLR)*. Chandler, AZ. Retrieved December 24, 2008 from <http://medicallossratio.net/test.aspx>

4 Robinson, J.C. (1997, July/August). Use and abuse of the medical loss ratio to measure health plan performance: This accounting tool was never intended to measure quality or efficiency. *Health Affairs* 16(4), 176-187. Retrieved December 24, 2008 from <http://content.healthaffairs.org/cgi/reprint/16/4/176.pdf>

of terms (for example, what counts as an administrative expense).⁵ The available data on medical loss ratios, which are collected from state agencies, suffer from the inconsistent nature of the underlying insurer reports, the limits of auditing standards, and the incomplete adoption of NAIC guidelines.⁶ Public access is difficult and time-consuming as a result of the information not being centralized or available in an electronic format.⁷

ESTABLISHING A MINIMUM MEDICAL LOSS RATIO⁸

In the United States, each state has the option of establishing a minimum medical loss ratio. A minimum medical loss ratio is a requirement for insurers to spend a specified minimum percentage of premium revenue on medical care rather than on administration, marketing, and profit. As health maintenance organizations (HMOs) and healthcare insurers initially determine premiums, each entity develops a projected budget for medical claims over the course of a year. In some states, if an insurer's expenses for medical claims are lower than anticipated and do not meet the medical loss ratio, the insurer must refund the excess premium revenue to consumers or adjust its premiums accordingly for the following year.

According to Families USA, without this requirement, insurers can charge very high premiums to individuals and small businesses, and spend a startlingly low proportion of these premium dollars on health care services. In interviews with insurance regulators in 19 states, Families USA found 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 profit. In order to increase the portion of premium revenue dedicated to medical services, some states require insurers to meet minimum medical loss ratios in the small group, individual, Medicare supplement, and long-term care markets. Other states require specific insurers (such as HMOs or safety net insurers) to meet a minimum medical loss ratio.

STATES WITH A MINIMUM MEDICAL LOSS RATIO⁹

In March and April 2008, Families USA conducted a 50-state survey identifying states with laws or regulations that establish a minimum medical loss ratio (see Table 1.).

Families USA's survey asked state regulators if they require a minimum medical loss ratio of 75 percent in the small group and/or individual market. Only a small portion of states require individual and/or small group insurers to maintain a medical loss ratio of 75 percent. In addition, some states provided information regarding other loss ratios

5 Robinson, J.C. (1997, July/August). Use and abuse of the medical loss ratio to measure health plan performance: This accounting tool was never intended to measure quality or efficiency. *Health Affairs* 16(4), 176-187. Retrieved December 24, 2008 from <http://content.healthaffairs.org/cgi/reprint/16/4/176.pdf>

6 Ibid.

7 Ibid.

8 Families USA. (2008, June). Medical loss ratios: Evidence from the States (Health Policy Memo). Retrieved December 24, 2008 from <http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf>

9 Ibid.

that were implemented in their state. For example, Alabama and Virginia reported that they require minimum medical loss ratios in the Medicare supplement market, and Texas and Wisconsin have loss ratios for Medicare supplemental policies and long-term care policies.

Maine

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 (BOI), which can call hearings to evaluate how well insurance companies are complying with the required medical loss ratio. An insurer can avoid the hearing process and file its rates on an informational basis, and without further review only if it agrees to spend an even higher proportion of premiums on medical claims: 78 percent over a continuous three-year period. If the insurer fails to meet the 78 percent medical loss ratio, it must refund the excess premium dollars it has collected to policyholders. In contrast to the small group requirements, individual plans are only required to meet a medical loss ratio of 65 percent.

- As a result of Maine's medical loss ratio requirement, in 2008, one Maine insurance company will refund policyholders \$6.6 million and another will refund policyholders \$1 million.

New Jersey

New Jersey requires a 75 percent medical loss ratio for all insurers in the small group and individual markets. Insurers must report annually, and if they do not achieve the 75 percent loss ratio, they must automatically issue refunds to policyholders. At the beginning of the year, when insurers set their premiums, they file a certification that medical claims will exceed 75 percent of premiums. At the end of the year, if the amount spent on medical claims is less than 75 percent of collected premiums, they must issue refunds to enrollees in their health plans to make up the difference.

The New Jersey Insurance Department reports that this is an easy system for the state to administer—insurers know whether they have met the standard, and they process refunds when they do not. What is more, in recent years, the small group market has been competitive, and on average, insurers actually have a higher medical loss ratio than the minimum 75 percent—they spend about 80 percent of premium dollars on medical care. However, not all insurers meet the requirement, and some insurers do issue refunds in the small group market.

The individual market is less competitive, and the 75 percent medical loss ratio has helped control premiums.

- Between 1993 (when the state implemented the 75 percent medical loss ratio in the individual market) and 2006, insurers that failed to meet the requirement refunded a total of \$11.6 million dollars to consumers.

Minnesota

Minnesota passed regulations in 1993 that initially required insurers in the small group market to meet a 75 percent medical loss ratio and individual market insurers to meet a 65 percent loss ratio. Both medical loss ratios increased by one percentage point each year until 2000, when the loss ratios were 82 percent in the small group market and 72 percent in the individual market. The loss ratios have remained at these levels since 2000.

Each year, when insurers file proposed rate increases, they must include information about the loss ratio they have achieved over the past several years, and the loss ratio they expect to achieve in the following year. If insurers do not achieve the loss ratio they had anticipated the previous year, they are asked to adjust premiums accordingly.

New York

New York approves premium rate increases only if small group insurers are in compliance with a 75 percent medical loss ratio. Individual market insurers must meet an 80 percent loss ratio. Insurers must file annual reports indicating that they are meeting the required loss ratios, and if they are not, they must refund the difference to policyholders. New York has defined the medical loss ratios in such a way that they encourage insurers to undertake cost-containment mechanisms (the costs of which can be counted as medical expenses).

- In late May 2008, New York's Governor and Department of Insurance announced that Oxford Health Insurance will refund \$50 million to 37,000 small businesses in the state because, in 2006, they did not achieve the 75 percent minimum medical loss ratio.

Washington

Washington enforces a minimum medical loss ratio in the individual market. Legislation enacted during the 2008 session increased the medical loss ratio from 72 percent to 77 percent.

Other States Proposing a Medical Loss Ratio¹⁰

In 2008, several state-based efforts that addressed health care reform incorporated proposals to regulate medical loss ratios by insurers. Proposals in California, Pennsylvania, New Mexico, Michigan, Illinois, and Wisconsin have all discussed setting a minimum medical loss ratio, often at 85 percent. While some states currently do impose minimum medical loss ratios, these are significantly lower than the proposed new standards; in some cases, minimum ratios are designed to ensure that the policy is a *bona fide* insurance product, rather than attempting to influence the structure of an insurance policy or the business model of an insurance carrier.

¹⁰ Republican Study Committee. (2008, June). RSC policy brief: Medical loss ratios. Washington, D.C.: Russ Vought. Retrieved December 24, 2008 from http://www.house.gov/hensarling/rsc/doc/pb_063008_medical_loss_ratios.doc

Table 1.
Medical Loss Ratio Requirements

	Individual Market	Small Group Market	Other	Statutory Reference
California			Managed care plans: Administrative costs not to be “excessive,” limited to 15% to 25% based on developmental phase of plan. Administrative costs do not include some factors such as salaries, stock options, etc.	California Health And Safety Code HSC Section 1378, enforced through Cal. Admin. Code tit. 28, § 1300.78
Delaware		75%		Title 18 Chapter 25 § 2506
Kentucky	65%	Groups of 2-10: 70% Groups of 11-50: 75%		KRS 304.17A-095(6)
Maine	65%	Insurers that file rates annually: 75% Insurers that file rates every three years: 78%		Individual: Title 24-A, Chapter 33, §2736-C Small group: Title 24-A Chapter 35, §2808-B 2-C
Maryland	60%	75%		Maryland Code § 15-605
Minnesota	65%	Groups of 2-9: 71% Groups of 10-50: 75%	Large group carriers: 82%	62A.021
Nevada			Nonprofit corporations: 75% Individual dental insurance: 75%	NRS 695B.170 NRS 686B.125
New Jersey	75%			17B:27A-25
New York	80%			§ 3231(3)(2)(A)
North Dakota	55%			26.1-36-37.2
Oklahoma		60%		36 O.S. 6515
South Dakota	65%			Individual: 58-17-64 Small group: 58-18-63
Vermont	70%		Safety net market: 80%	Title 8 Chapter 107 4080b(C)(m)
Washington	77%			SB 5261
Wyoming	60%			Individual: Chapter 33 Article 6C §33-6C-1 Small Group: §33-16D-5

CHARACTERISTICS OF THE MEDICAL LOSS RATIO¹¹

Any statistical measure will reflect differences among plans in organizational form and economic performance. The difficulties are particularly acute, however, for the medical loss ratio, which directly measures the distribution of revenues among administrative and clinical functions that are organized in different ways in different firms. Of central importance are the relationship between the health plan and its providers (vertical structure), the range of networks and utilization management systems it offers (product diversification), the range of buyers to which it markets its services (channel diversification), and the number of states in which it operates (geographic scope).

Vertical Structure¹²

Differences in the medical loss ratio among health plans reflect different allocations of administrative functions between plans and providers. Indemnity insurers assume no responsibility for the management of physician practices, hospital facilities, or other health care delivery organizations. They tend to exhibit comparatively low administrative expenses and, by extension, high medical loss ratios. At the other end of the organizational spectrum is the staff-model HMO, where the health plan directly employs its own physicians and, in some cases, owns hospitals. Whether the staff-model HMO reports a high or a low medical loss ratio depends on how it attributes administrative expenses to its health plan, medical group, and hospital divisions. It is possible for vertically integrated health plans to report almost nothing for administrative expenses (and hence report a very high medical loss ratio).

Between indemnity insurance and the staff HMO lies a heterogeneous mix of health plan types that rely primarily on contractual rather than ownership linkages with providers but that engage in extensive management of utilization and medical expenditures. Some plans, including preferred provider organizations (PPOs) and independent practice associations (IPAs), contract directly with individual physicians and perform utilization management and quality assurance functions in house. These plans tend to exhibit high administrative expenses and low medical loss ratios on the health plan side. Other plans contract with medical groups and delegate to them the primary responsibility for utilization management and quality assurance. These network HMOs will tend to report an intermediate level of administrative expenditures and medical loss ratios, depending on the extent of delegation.

¹¹ Robinson, J.C. (1997, July/August). Use and abuse of the medical loss ratio to measure health plan performance: This accounting tool was never intended to measure quality or efficiency. *Health Affairs* 16(4), 176-187. Retrieved December 24, 2008 from <http://content.healthaffairs.org/cgi/reprint/16/4/176.pdf>

¹² Ibid.

Product Diversification: Plan Types¹³

Differences in medical loss ratios strongly reflect the range of products offered by competing plans. Plans differ in the range of products they offer and in the distribution of their total patient enrollment among products. The medical loss ratio for the plan as a whole will reflect the range of product diversification as well as the distribution of administrative and medical expenditures for particular products.

Health plans with richer benefit packages tend to incur high medical expenses and thereby high medical loss ratios, since administrative expenses do not rise proportionately to medical expenses in response to benefit coverage. High consumer cost sharing influences the medical loss ratio by shifting costs from the plan's books to the consumer (lower premium revenue, the denominator of the medical loss ratio) and by reducing patient-initiated utilization (reduced medical expenditures, the numerator of the medical loss ratio).

Channel Diversification: Distribution Systems¹⁴

Health plans differ substantially in the nature of the distribution systems they use and the consumers they target. They may focus on large employer groups, small firms and self-employed individuals, state Medicaid programs, Medicare beneficiaries, public employees and military personnel, or self-insured corporations. The costs of marketing vary substantially among these distribution channels and will be reflected in administrative expense levels and loss ratios. Marketing costs tend to be lower when plans can gain large blocks of enrollees through a single contract, as in the large-firm market. Where one-on-one marketing is central, as in the Medicare, small-firm, and individual markets, selling costs are much higher.

The influence of channel diversification extends beyond selling costs to revenue potential. Distribution channels such as Medicare and large firms that bring in high revenues per enrollee will produce high medical loss ratios, since administrative expenses do not rise proportionately with medical expenses. The thin benefits that prevail in the small-firm and individual markets will tend to be associated with low medical loss ratios. The interpretation of medical loss ratios is complicated further for health plans that manage the benefit programs of self-insured corporations. This “administrative-services-only” channel reduces the medical loss ratio if medical expenses are booked by the self-insured firm while the health plan books administrative expenses. Product and channel diversification contaminate measures of costs per capita by facilitating multiple counting of enrollees.

¹³ Robinson, J.C. (1997, July/August). Use and abuse of the medical loss ratio to measure health plan performance: This accounting tool was never intended to measure quality or efficiency. *Health Affairs* 16(4), 176-187. Retrieved December 24, 2008 from <http://content.healthaffairs.org/cgi/reprint/16/4/176.pdf>

¹⁴ Ibid.

Geographic Diversification¹⁵

Health plans are spreading across state lines and in many cases are approaching national scope. Efforts to compute the medical loss ratio for any one geographic region require the parent company to allocate central administrative expenses to particular regions. This is particularly problematic when some products, such as those for federal employees or large corporations, are marketed and managed at the national level. The distribution of enrollment among various states and localities will influence the medical loss ratio for particular health plans because of geographic variations in wage and other input costs, physician practice styles, and revenue potential.

For example, HMOs that sell to Medicare beneficiaries receive a monthly payment that is set at 95 percent of the average expenditure for Medicare's fee-for-service enrollees in each county, adjusted for demographic characteristics. These expenditure levels vary across counties by more than 200 percent because of the variation in fee-for-service practice styles. HMOs with large enrollment in counties with expensive fee-for-service systems will receive high revenues (denominator of the medical loss ratio) without needing to incur commensurably high administrative costs. However, high Medicare payment levels may influence medical costs (numerator of the medical loss ratio) by encouraging non-price competition among plans on the basis of ever-richer benefit packages.

¹⁵ Robinson, J.C. (1997, July/August). Use and abuse of the medical loss ratio to measure health plan performance: This accounting tool was never intended to measure quality or efficiency. *Health Affairs* 16(4), 176-187. Retrieved December 24, 2008 from <http://content.healthaffairs.org/cgi/reprint/16/4/176.pdf>

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