

The Medical Loss Ratio: A Core Component of Reform



Sarah F. Fontenot, BSN, JD is the health law professor for Trinity University (San Antonio) MHA Program in the Department of Health Care Administration and has been a member of the ACPE faculty since 2006.

The Affordable Care Act (ACA) was intended to achieve two main goals: reduce the cost of health care and lead to better health outcomes for the country. Insurance reform is a critical component of both endeavors.

As we move through 2014, the most noticeable aspects of insurance reform are quite visible, such as the end of pre-existing condition exclusions, the individual mandate, minimum standards for what policies must cover, and implementation of insurance exchanges.

Behind all that there is a far more important aspect of insurance reform: mandated medical loss ratio (MLRs) or, as the White House commonly refers to it “the 80-20 rule.” It has not received as much attention by the public, but has far more impact on how health care reform moves forward.

Physician leaders will want to understand the MLR and the arguments made by its proponents and opponents. This one, small section of the ACA has enormous implications and encapsulates much of the debate over the ACA in its entirety.

It may surprise many in health care to learn that everything we do to prevent disease, cure the sick and improve the health of our patients is considered a “loss,” but that is the reality from the insurance perspective, as money spent on patients cannot be invested in administrative costs (such as salaries, overhead, and marketing) or returned to investors as profits. At the end of the day, everything of which we are proud in medicine — delivering safe, efficient and patient-centered care — is a loss.

Loss ratios made public

The ACA, by amending the Public Health Service Act, requires insurance companies that offer group or individual health insurance coverage to annually disclose their

MLR, which is the percentage of premium dollars spent on administrative costs and profits divided by direct health care services.

If a company collects premiums totaling \$100,000 but only has to return \$85,000 on services to their insured (e.g., paying medical claims and investing in improvements to the quality of their care), they have an MLR of 85 percent. It is this calculation that the ACA defines, limits and discloses to the public as part of meeting the ACA’s intention to ensure “that consumers receive value for their premium payments.”

This information will be made publicly available through the U.S. Department of Health and Human Services’ website.¹ Insurers of large companies (defined by the ACA as those with more than 100 employees) that do not spend at least 85 percent of premium dollars on patient care and quality must refund their customers for the remaining amount; for those that cover individuals and smaller employers, the MLR is set lower at 80 percent.

In March 2014, however, HHS indicated that the Obama administration might be willing to temporarily relax these ratios to reflect additional administrative costs incurred by insurance companies during the rocky rollout of insurance exchanges.²

The ACA’s MLR provisions apply to fully funded health plans in which the insurer assumes full risk for medical costs incurred. Self-funded plans, in which an employer assumes part of the risk (cost) for employees’ health care needs, are exempt from the MLR requirement, which is 57.5 percent of private sector insurance enrollees.

Medicare Advantage plans must also meet the minimum, 85 percent MLR requirement in 2014, and if they do not comply, the portion of their revenues over the limit will be rebated to HHS.³

As is so often true with the ACA, the idea of limiting MLRs did not originate with the law. Many states had legislated limits on MLRs before Congress enacted federal health care reform.⁴

Although some states have higher minimum MLR percentages than those mandated by the ACA, other states

allowed companies to operate with an MLR as low as 60 percent.⁵ States may also differ on the delineation between “large” and “small” insurance markets, with the threshold for higher MLR limits set for groups as small as 50 employees. All states must use the definition of market size contained in the ACA by 2016.⁶

The formula for calculation of the MLR also differs among states and the ACA, as many states measure only actual medical claims while the ACA allows insurers to include quality improvement expenditures (activities such as case management, reduction of readmissions initiatives, health information technology, and medication compliance initiatives) as part of the percentage of their “loss,” and not all states allow companies to subtract licensing and taxes from their expenditures, as the ACA does.

Although developed by HHS with significant input from the National Association of Insurance Commissioners (NAIC), the industry group expressed “concerns about the potential for unintended consequences” and doubts that consumers would benefit “from higher medical loss ratios if the outcome is destabilized insurance markets where consumer choice is limited and the solvency of insurers is undermined.”⁷

Along that same argument, states that had reasonable evidence to demonstrate that the implementation of the 80 percent MLR would destabilize the market or otherwise make it more difficult for residents to procure insurance could apply for waivers from HHS for insurance carriers offering individual policies in their state. Of the 17 states that applied, seven waivers were granted for a maximum period of three years.³

It may be a dim memory in our current political climate, but the rebates required under the ACA’s MLR provisions were happy news for about 12.8 million U.S. consumers who received \$1.1 billion in August



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of 2012. Although the amount of the rebates averaged \$151 per qualifying household, some families in Arkansas, Alaska and Vermont saw checks averaging \$600 to \$800 per family.³ Rebates were smaller in 2013, as the industry adjusted to the mandate, but 8.5 million U.S. families still received a rebate in the summer of 2013.⁵

Health care concerns

In a 2012 Kaiser poll, the cost of health care was the second greatest concern among those polled (44 percent) second only to the current job market (59 percent),⁸ so any mechanism to reduce that burden should presumably meet widespread approval.

However, when the MLR and its impact was described to those same poll participants, 62 percent reported a “very favorable” or “favorable” opinion (including 45 percent of participants that identified themselves as Republican); only 18 percent of those polled held a “very unfavorable” view

of the restriction of profits in the insurance industry. Interestingly, only 42 percent of respondents even knew that the MLR was a component of the ACA.

This seemingly positive political climate, as well as any goodwill generated by rebates, quickly dissipated in the heated political debates that have accompanied every stage of the ACA’s creation and implementation. A brief review of the arguments for and against the MLR will demonstrate that this one issue mirrors the dissension and confusion generated by the ACA as a whole; the arguments go to the heart of the debate over health care reform itself.

Advocates of the ACA hold the 80-20 rule as being one of the most specific, effective means to rein in health care costs, arguing that by reducing the cost of insurance coverage, care becomes attainable for more Americans.⁹ Institutional providers benefit when more people have insurance, as uncompensated

care in hospitals will plummet; government programs that currently help defray the burden of charity care will become unnecessary.

Proponents of the MLR also anticipate relief for small business owners, as the insurance industry adjusts by reducing administrative costs and premiums.¹⁰ In the 80/20 “camp,” the benefits of the ACA come full circle. As insurance becomes the norm, the greatly expanded pool of beneficiaries more than makes up for any drop in insurance industry profits.

Insurance agents

At the same time, some consumer advocates are going so far as to celebrate the negative implications of the MLR on insurance companies. Described as a core component of the ACA that “should have a long lasting and powerful impact on the future of health care in our country,” the 80-20 rule will ultimately “lead to the death of large parts of the private, for-profit health insurance industry.”

The destruction of the private for-profit insurance industry will have “more impact on the future of how medical care is paid for in this country than anything we’ve seen in quite some time” as “we are now on an inescapable path to a single-payer system for most Americans and thank goodness for it.”¹¹

As supporters point to the loss of profit in the insurance industry as a win, opponents disagree. The level of profits in this sector, it is argued, are already minimal as compared to other industries, so the MLR will actually require insurers to raise their premiums accordingly. Smaller companies may not be able to survive the tumult of the MLR, which will result in an increased domination of the largest private insurers, and in the end “Obamacare’s MLR mandates will make health care more expensive and harm those who are most in need of health coverage.”¹²

The calculation of what will be included in the MLR is also part of the ongoing controversy, as the heated lobbying made clear while the formula was being defined.⁵ In particular, the attribution of costs related to preventing fraud to overhead, not care (as requested by the insurance industry) leads those against the rule to forecast the 80-20 rule as increasing, not decreasing, health care costs. In addition, opponents of the MLR predict it to be especially harmful to the low-cost, high-deductible plans currently favored by so many employers.⁹

The MLR debate brings to the fore the question of whether any profits in health care are a good thing. A truly odd movie (for design, not content) available on YouTube argues that although health care is a basic need, so are food and housing, where profits are not questioned.

Arguing against the claims of efficiency by the government, the film projects increased taxes as the country moves toward a government-run system (negating any benefit from a reduction of premiums); objects to public outcry against high reimbursement of CEOs in the insurance industry, when celebrities such as Oprah and Tiger Woods make so much more; and argues that — without insurance agents — the average American will lose a middle man who can guide them to their best insurance option.¹³

The loss of the insurance agent is not a small issue. In a Congressional subcommittee hearing titled “New Medical Loss Ratios: Increasing Health Care Value or Just Eliminating Jobs?” held on Dec. 15, 2011, testimony was offered that brokers’ earnings may have decreased as much as 50 percent, causing many to leave the industry.⁹

Finally, in reviewing the controversy, it should be noted that both sides of this debate use the state-level, and often more restrictive, MLR limitations that predate the ACA as an argument in their favor. Advocates

point to prior state law as evidence that the federal government is not creating new initiatives out of whole cloth, while detractors point out that MLR legislation before the ACA did not turn out to be the panacea envisioned by MLR proponents.

The flip side (and unstated) parallel argument is, of course, that state-mandated MLR limitations did not prove to be the poison pill envisioned by its detractors, either. An impartial view of the impact of state legislated MLRs would appear to undercut both sides of the debate over the 80-20 rule in the ACA.

Profit or not?

The MLR controversy points to a fundamental divide in philosophy in our country: should health care be a profitable business or a break-even utility?

Physicians have always been recognized as people who earn comparatively more than others in their communities, but the perception of the public seems to have shifted over the past decades from a place of well-earned prominence to one that is more commonly scrutinized and resented.

Pharmaceutical companies and inventors and producers of durable medical equipment — widely lauded in the 1970s for cutting-edge, inspiring research and development — have become targets for public distrust against CEO salaries and investors’ profits. As hospital administrators’ salaries have become more transparent, more press attention has brought public backlash against them, too. All of these individuals and corporations, however, are working to meet the health care needs of America.

Given the public’s skepticism of profit going to people and companies actually involved in health care, it is not surprising that many are firmly opposed to profits in health care removed from the delivery system; the public is debating the virtue of

health care as an investment vehicle and whether the cost of care should be an item in an investor's portfolio like a publicly traded company or mutual fund.

At the same time, it is investment dollars that allow for research and development that open the doors for increased knowledge, diagnostic tools and treatments. A publicly traded company that maximizes profit is not doing wrong, it is exercising its duty to shareholders. This is the goal, design and nature of business. Why, then, should health care be different?

The question is not whether American health care is ultimately a business, but whether American health care should be just like any other business. We must recognize the dual nature of money being invested in health care. It's necessary, yet the public doesn't like it. We cannot ignore it and the ACA attempts to control it, which to many sounds very un-American.

To be sure, there is a double-standard operating here. Americans recognize and embrace the significant fortunes that have been drawn from successes in other marketplaces, such as transportation, energy, manufacturing, computer technology, or retail sales. Individual efforts that achieve unimaginable fortunes are fodder for grocery store tabloids and 24/7 media voyeurism of entertainment and sports stars. There is something undeniably American about celebrating those who gain from society's activities and advancements.

The double-standard we hold for profits in health care extends also to other public services, such as education, clergy and government, although the incomes of college presidents, pastors and politicians disdainfully reported by the press are small compared to Hollywood celebrities.

Perhaps the best reason to spend time reflecting on the MLR issue is that, at its core, it goes to the question central to the future of the

American health care system. Should there be profit in health care? Would a government-run, single-payer system, as reflected by the gleeful proclamation of at least one MLR proponent,¹¹ be the answer or would it be the ruin for America?

This is, of course, an option that the majority of the country has rebuked. Is the ACA the last best gasp for trying to balance a privately run health care system with controls that reduce the cost while also increasing the actual health of our country? Or is it a guise to bring us to a European model of health care?

The question about the merits of the ACA's 80-20 rule encapsulates the noise on both ends of the political spectrum. There is not a right answer, but there are strongly held personal opinions. This is the linchpin of the entire debate over health care reform for our country; and as such all physician leaders should be aware and informed on this issue. The survival of the MLR may ultimately be the key to the success, or failure, of the ACA itself.



References

1. ACA §1001, amending Public Health Service Act §2718
2. Hancock J, Appleby J. Insurers May Get Cost Break Thanks to Rocky ACA Rollout. *Kaiser Health News*, 2014. <http://capsules.kaiserhealthnews.org/index.php/2014/03/insurers-may-get-cost-break-thanks-to-rocky-aca-rollout/>
3. Kirchoff SM, Mulvey J. Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress. Congressional Research Service, 2012.
4. Glossary: Medical Loss Ratio (MLR). Healthcare.gov, 2014. <https://www.healthcare.gov/glossary/medical-loss-ratio-MLR/>
5. Kliff S. The Obamacare Provision that Terrifies Insurers. *Washington Post*, 2013. <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/07/18/the-obamacare-provision-that-terrifies-insurers/>
6. Aetna. Health Care Reform's Commercial Minimum Medical Loss Ratio. 2014. <http://www.aetna.com/health-reform-connection/reform-explained/MLR-overview.html>
7. Cline, J, Voss S, McCarty K, Holland K, Savigny R, Praeger S. Letter to HHS Secretary Kathleen Sebelius. 2010.
8. Cox C, Claxton G, Levitt L. Beyond Rebates: How Much Are Consumers Saving from the ACA's Medical Loss Ratio Provision? Kaiser Family Foundation, 2013. <http://kff.org/health-reform/perspective/beyond-rebates-how-much-are-consumers-saving-from-the-acas-medical-loss-ratio-provision/>
9. 80-20 Rule Delivers More Value to Consumers in 2012. U.S. Department of Health and Human Services, 2013. <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf>
10. Hansard S. Congressional Panel Concerned About MLR as HHS Denies Florida's Adjustment Request. Health Insurance Report, 2011. <http://www.bna.com/congressional-panel-concerned-n12884906600/>
11. Ungar R. The Bomb Buried in Obamacare Explodes Today—Hallelujah! *Forbes*, 2011. <http://www.forbes.com/sites/rickungar/2011/12/02/the-bomb-buried-in-obamacare-explodes-today-hallelujah/>
12. Roy A. Obamacare's MLR "Bomb" Will Create Private Insurance Monopolies and Drive Premiums Skyward. Hallelujah! *Forbes*, 2011. <http://www.forbes.com/sites/theapothecary/2011/12/06/obamacares-mlr-bomb-will-create-private-insurance-monopolies-and-drive-premiums-skyward-hallelujah/>
13. http://www.youtube.com/watch?v=3PPAtuv6-_w