CRITICAL ISSUES IN HEALTH REFORM

Minimum Loss Ratios

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Policymakers are considering implementing federal minimum loss ratio requirements as part of broader health reform efforts. Loss ratios measure the benefits received by policyholders divided by the premiums paid, and are put forth as one dimension to measure value to consumers in the aggregate.

Although loss ratio minimums currently play a role in state health insurance regulation, the minimums suggested as part of federal health reform efforts are typically more stringent and broadly applicable and would impose stiffer penalties than those existing within the current regulatory framework. Whether such stricter loss ratio requirements can enhance value to policyholders depends on the implementation details. This paper highlights relevant issues that policymakers should consider when contemplating the inclusion of minimum loss ratio requirements as part of federal health reform.

Most states currently impose minimum loss ratio requirements.

Setting a minimum loss ratio requirement is one aspect of determining whether premiums are reasonable in relation to the policy benefits. Most states have minimum loss ratio requirements for health insurance plans in the individual market, but such requirements are rare in the group market. The National Association of Insurance Commissioners (NAIC) Model Regulation for Filing of Rates includes minimum loss ratio requirements, which are enforced through the state rate filing processes. Under the model regulation, all insurers must file prospective rates with the state insurance regulator for their individual market plans. Most states also require an actuarial certification that the rates for small group market plans comply with small group rating laws. The penalty in most states for not meeting the loss ratio minimums is that the insurance department will disapprove the rate filing.

Loss ratios vary by market segment.

Loss ratios vary across the different market segments. In particular, loss ratios for plans in the individual market will typically fall below those in the small group market, which in turn will fall below those in the large group market. Several factors contribute to these differences, including:

- **Compensation for bearing risk.** Due in part to relatively lower customer participation rates, the individual and small group markets have higher claims volatility risk than the large group market. As a result, insurers subject to this increased risk often require higher risk margins, leading to lower loss ratios.
- **Administrative expenses.** Administrative expenses are typically higher relative to premiums for individual and small group health insurance products than for large group products. One of the reasons for this is that, on average, benefit levels are lowest for customers in the individual market and highest for those in the large group market. These benefit differences are reflected in the premium levels. For example, the premium for an individual policy with a $2,500 deductible will be lower than for the same policy with a $500 deductible. Therefore, any expenses that are largely independent of the benefit design, such as benefit adjudication expenses, will be a higher share of premiums for plans in the individual market than in the large group market. Another reason for the loss ratio differences is that the individual and

ADDITIONAL RESOURCES

Market Reform Principles
http://www.actuary.org/pdf/health/market_reform_may09.pdf

Risk Pooling
http://www.actuary.org/pdf/health/pool_july09.pdf

Halth Reform Now
http://www.actuary.org/issues/health_reform.asp

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small group markets also incur expenses not typically incurred in the large group market. For instance, agent and broker expenses included in the premiums for individual and small group market plans are typically undertaken by consultants and human resources staff for large group plans, and therefore not included in premiums. In addition, underwriting expenses related to risk assessment and risk classification are incurred to a greater extent in the individual market. Finally, any per-policy administrative expenses, such as the initial policy entry into the insurer's administrative systems, can be spread over more insureds in a large group policy than in a small group or individual policy. Because individuals exhibit greater turnover (lower persistency) than groups, expenses associated with issuance of a policy must be spread over a shorter timeframe.

Current health reform proposals include insurance market reforms and other provisions that could impact not only loss ratios, but also how they vary across market segments. For example, the establishment of health insurance exchanges for the individual and/or small group markets could lead to a reduced role for agents and brokers, leading to lower expenses and higher loss ratios for those market segments depending on the magnitude of the cost allocation for the exchange. A reduced role of underwriting in a reformed insurance market may also reduce administrative expenses, especially in the individual market, thereby increasing loss ratios. In addition, the use of risk adjusters or reinsurance to spread risks across insurers would increase administrative expenses and reduce loss ratios.

Even if health reform provisions reduce some variation in loss ratios by market segment, some differences will remain (e.g., billing expenses). Therefore, it would be appropriate to vary any federal loss ratio requirements by market segment. Otherwise, significant market distortions could arise. For instance, insurers whose business is comprised mostly of large groups rather than individuals and small groups would find it easier to meet minimum loss ratio requirements. As a result, insurers that could not attract significant amounts of large group business could find it difficult to satisfy the loss ratio requirement and exit the market.

Many definitional issues arise when calculating loss ratios.

To calculate loss ratios, the value of benefits received by policyholders is divided by the premiums paid. However, there are myriad technical issues around how to define the benefits and premiums; different definitions may be appropriate for different purposes such as rate regulation or insurer solvency. When using loss ratios to ensure that insurance policies provide value to customers in the aggregate, the following issues should be considered in the calculation:

- **Incurred-basis versus paid-basis.** Premiums received from customers are intended to cover all valid claims incurred in a particular month or year, regardless of when the claim payments are actually made. In

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order to ensure consistency, the benefits value used in a loss ratio calculation should reflect claims on an incurred-basis, rather than a paid-basis. Allowing several months to pass between the end of the premium payment period and the calculation of the loss ratio would reduce inaccuracies caused by reporting lags and the claims adjudication process.

- **Cost containment expenses.** An NAIC regulation defines the concept of cost containment expenses, which are amounts that the insurer spends in order to manage the cost of medical claims.[1] These expenses include case management, disease management, 24-hour nurse hotlines, wellness programs, provider network development, as well as fraud detection and prevention programs. As these expenditures are more akin to benefits than administrative expenses or provisions for risk, it would be appropriate to include cost containment expenses as part of the value of benefits in the loss ratio calculation. Including these expenses in the loss ratio calculation encourages insurers to effectively manage the quality, efficiency, and cost of care for policyholders.
- **Capitation payments.** Provider capitation arrangements may include the provider assuming the responsibility of paying the claims (and other member services). It would be difficult to segment administrative services out of the capitation for the purposes of meeting a minimum loss ratio, but an insurer could manipulate the loss ratio if segmentation is not performed. For example, instead of paying $85 for health care claims and $4 to settle those claims, an insurer pays a capitation payment of $89 to a provider group and it settles the claims. Both transactions are essentially the same but the loss ratio could be very different.
- **Premium taxes.** The actual premium rates charged reflect any premium taxes levied by the state. Premium tax rates vary by state, and in some states by insurer (e.g., insurers domiciled in that state pay one rate while out-of-state insurers pay a higher rate). To make the loss ratio calculation comparable across insurers, it would be appropriate to subtract premium taxes from the value of premiums used in the loss ratio calculation.
- **Income taxes.** Health insurers, excluding some HMOs, are subject to federal income taxes, which are passed through to premiums. To make the loss ratio calculation comparable across all insurers, it would be appropriate to subtract federal income taxes paid from the premiums used in the loss ratio calculation.
- **Reinsurance and risk adjustment payments.** Both the benefits and the premium values in the loss ratio calculation should reflect any reinsurance programs and risk adjustment payments. Additional regulatory scrutiny may be required to ensure that reinsurance mechanisms are not used merely to avoid falling below the minimum required loss ratio.
- **Policy reserves.** With some health insurance policies, a portion of the premiums collected in the current year are intended to pre-fund claims incurred in future years. In these situations, the insurer records a liability, known as a policy reserve, on its balance sheet to reflect amounts collected from past premiums that are designed to pay claims in future periods. For products where policy reserves exist, the change in the policy reserve during the year needs to be added to the value of benefits in the loss ratio calculation.
- **Time period.** There is often significant seasonality in the manner in which medi-

[1]The Statutory Statement of Accounting Principles (SSAP) No. 85, promulgated by the NAIC, stipulates that an insurer is not entitled to classify expenditures as being cost containment expenses unless it can support the contention that claims would have been higher if those expenditures had not been made.

cal claims emerge within a coverage year, due in large part to benefit design issues. Therefore, loss ratio calculations should be based on an annual timeframe, rather than more frequently.

- **Geographic variances.** The current cost of health care has much greater geographic variation than the cost of providing administrative services--as such, it should be expected that loss ratios would vary by geography, such as higher loss ratios in metropolitan areas with high costs of health care and lower loss ratios in areas where the cost of health care is lower. Using a level minimum loss ratio across all regions could result in carriers focusing on markets where the cost of health care (and associated premiums) is higher and a loss ratio target is easier to achieve.

Unless a minimum loss ratio is specific with respect to risk levels, market segments, benefit designs, and geography, it will either be set at a level that is too high for many well-functioning insurers which will cause unnecessary disruption to the market, or be set at a level that is too low to achieve its goals.

Implementation of new medical loss ratio requirements must allow for adequate lag time.

From a practical standpoint, it would be difficult to impose a new minimum medical loss ratio requirement immediately after the enactment of such a policy change. Appropriate time would be necessary for plans to file new rates. Plans typically file their premiums six to 12 months before they become effective, and also need time prior to rate filing in order to develop the rates.

The agent and broker compensation structure would also make immediate implementation of a new medical loss ratio requirement difficult. As noted above, individual and small group market premiums include expenses to cover agent and broker compensation (e.g., fees and commissions), which contribute to the lower loss ratios in these markets. Under typical agent and broker contracts, insurers agree to pay fees and commissions not only the initial year a policy is sold, but also each year that a policy is renewed. Achieving new higher medical loss ratio requirements for existing business will often depend on reducing agent and broker compensation, which is specified by contract. Re-negotiating these contracts for existing business would be very difficult, and would depend on the willingness of agents and brokers to accept lower compensation for business that has already been sold. New compensation rates would also need to be set for policies sold after the new requirements go into affect, which also would take time to negotiate.

In addition, much of the detailed calculation of the medical loss ratio will be left to regulatory development. Therefore, it is important that enough time be left between the enactment of the requirement and its implementation to allow the regulatory process to clarify the medical loss ratio definition before pricing decisions need to be made and filed.

The consequences of non-compliance may be difficult to implement.

Enforcing compliance of minimum loss ratios is fairly straightforward on the state level. In general, the penalty for falling below minimum loss ratio requirements is that the state insurance department will disapprove a rate filing. Federal minimum loss ratio requirements under consideration may require insurers to pay policyholder refunds if their loss ratios fall below the minimum. However, the optimal method of transferring the deficiency to policyholders is unclear, given the likelihood of turnover in the insurer's customer base between the period covered by the loss ratio calculation and the point in time at which the deficiency has been computed.

Minimum loss ratios will not address many public policy concerns.

In and of itself, imposing a minimum loss ratio requirement would not address many of

the public policy concerns surrounding the health system. Minimum loss ratios do not help contain health care spending growth, ensure that health care services are appropriate and accurately billed, or address directly the quality and efficiency of health care services. Therefore, while a well-designed minimum loss ratio requirement may be an appropriate component of a federal health reform package, such requirements should not be viewed as a panacea. Moreover, monitoring compliance with loss ratio requirements may create additional costs for insurers and regulators and, depending on how the requirement is designed, could create insurance market disruptions or distortions that could affect consumers.