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In the Spotlight: Health Care Reform and Medical Loss Ratios

The Affordable Care Act of 2010 (ACA) requires individual and group health plans to report publicly their medical loss ratios (MLR), which represent the percentage of each premium dollar that is spent on health care services and quality improvement. ACA also requires such plans beginning on January 1, 2011, to provide an annual rebate to enrollees if the MLR for large group subscribers is less than 85 percent or if the MLR for small group and individual market subscribers is less than 80 percent.

Beginning 2014, for Medicare Advantage contracts, if an insurer's MLR is below 85 percent, the insurer will pay to the U.S. Department of Health and Human Services (HHS) a percentage of the insurer's annual Medicare Advantage revenue equal to the MLR percentage shortfall. For example, if an insurer has an 80% MLR and $1 million contract revenue in a given year, the insurer will have to pay HHS $50,000 (i.e. five percent of $1 million). If a Medicare Advantage insurer is below the standard for three years, they will no longer be allowed to accept new enrollees; if they fall below for five years, their contract will be terminated.

Though ACA directs a national standard for all insurance carriers' MLR, some states may require more stringent ratios. ACA's MLR requirements will serve as a floor, below which insurance carriers may not fall without being penalized as noted above.

NAIC's Role and Key Issues

ACA requires the National Association of Insurance Commissioners (NAIC) to establish uniform definitions and standardized methodologies for calculating MLR and rebate amounts, subject to HHS certification. While ACA directs that insurance regulators make recommendations by December 31, 2010, the Secretary of HHS (the Secretary) requested them by June 1, 2010 – a request that NAIC was not able to honor.

By a unanimous vote on August 17, 2010, the NAIC approved changes to the "blanks" form (the Blank) that insurers use to submit financial statements in order to capture detailed information that can be used to calculate MLR. The Blank will be used to report 2010 financial data, due March 2011. The definition of Quality Improvement (QI) that is used in the Blank captures many, but not all, activities that carriers use to improve care and avoid claims for inappropriate care and includes numerous activities for which both the BCBS Association and BCBSNC advocated.

An NAIC subgroup continues work on additional, more technical MLR issues related to the calculation of MLR and the refund when an MLR is not met, with a goal of completing its work by the end of the summer. This subgroup will use the definition of QI that is now in the Blank, but other issues considered will impact how the MLR requirement is implemented. The full NAIC will then take up the final MLR recommendations before submitting them to HHS. And, per PPACA, HHS may adopt and/or revise the NAIC the recommendations provided.

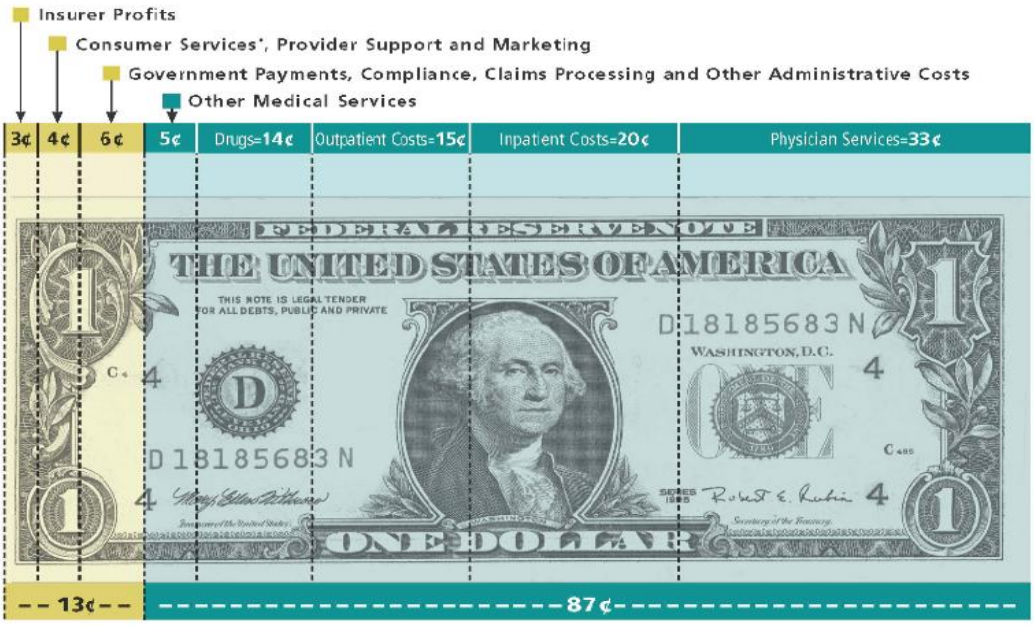
BCBSNC and Medical Loss Ratio

In 1980, the NAIC adopted the *Guidelines for Filing of Rates for Individual Health Insurance Forms (Guidelines).* The Guidelines established loss ratios as a standard for determining whether benefits under individual medical expense policies are reasonable in relation to premiums; generally, under the Guidelines loss ratios between 50 and 60 percent were indicative of reasonable premiums. North Carolina currently follows the NAIC model.

With respect to BCBSNC, in 2009, 87 percent of each premium dollar was spent on medical care. The remaining 13 percent was spent on taxes, overhead, incidentals, administrative costs, and maintaining reserves. BCBSNC has steadily grown its MLR almost eight percent per year since 2005.[1]

[1] BCBSNC 2009 data, excluding self-funded business. **BCBSNC earnings add to reserves strengthening the company's financial stability.

Typical Premium Distribution, National Data, 2008



*Includes prevention, disease management, care coordination, investments in health information technology and health support.
Based on a PricewaterhouseCoopers' analysis, *Factors Fueling Rising Healthcare Costs 2008.* © 2008 America's Health Insurance Plans

AHIP

BCBSNC Views

BCBSNC strongly believes that expenses related to improving health care quality should be adequately captured under the QI component of the final MLR definition, consistent with the definition in the revised NAIC Blank. Over the past few decades, BCBSNC and other health plans have demonstrated that such initiatives are critical to any insurer's ability to positively influence the health of its customers. BCBSNC has strived to improve the overall health of as many members as possible rather than focusing more narrowly on small, targeted populations. It is important that such activities be counted as QI to ensure appropriate resources remain available for such activities, which improve the health of, and in turn lower the costs for, our members.

What to expect long-term

Some Wall Street analysts believe that the MLR requirements will prove to be less onerous than market expectations, however much is still unknown. New product launches, benefit design changes, efforts to make administrative and data systems more efficient, and other market demands, in combination with the implementation of other ACA provisions, increase the uncertainty related to insurers' ability to meet the minimum MLR requirements, According to the Wall Street Journal, Assurant, a health insurer primarily in the individual market, has publicly debated whether it has a future in health care. AHIP and others in the insurance industry are concerned that MLR requirements could have some unintended, negative consequences for consumers. For instance, restrictive MLR definitions could hamper insurers' investment and innovation in health information technology – which has the potential to dramatically reduce long-term costs by reducing medical errors and improving the quality of care – as well as in care coordination, disease management, prevention and wellness, and health information technology.

For More Information

Full text of NAIC letter to HHS concerning medical loss ratio: Letter to HHS

NAIC "Blanks" Form Recommendation: NAIC Blanks Recommendation

NAIC: The Health Reform Solvency Impact (E) Subgroup: NAIC Subgroup

PricewaterhouseCoopers Cost Study: http://www.ahip.org/content/default.aspx?docid=25123

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