"Calculating medical loss ratios correctly will significantly impact the profitability and ultimate solvency of Health insurers"

Managing the Medical Loss Ratio Metric

By Mark S. Fischer

In order to ensure that all health insurance enrollees receive perceived value for their premium dollar, the Patient Protection and Affordable Care Act ("PPACA") established minimum medical loss ratio ("MLR") standards and regulations for health insurers. The standard requires health plans to maintain MLR by state of 80% and 85% for individual/small group plans and large group plans, respectively. Plans failing to meet minimum MLR must rebate the difference to enrollees.

CONCERN

For insurers meeting the MLR targets by state is the greatest challenge of health care reform. MLR requires insurers to rebate excess gains to enrollees. Translated, insurers lose their ability to shore-up reserves during years of high profits. If the future brings greater volatility in claims trends compared to recent years, the challenge then intensifies. The cyclical impacts on insurers' profits and solvency could be serious. Strategically, insurers need to be planning and preparing for such contingencies, while optimizing the MLR inputs.

MLR Theory

Insurers use the medical loss ratio as a basic financial profitability metric which indicates the ratio of medical claims incurred to premiums. PPACA defines MLR differently from the traditional metric as follows:

$$\frac{\text{Incurred medical claims + Expenditures for activities that improve health care quality}}{\text{Premiums - Federal and state taxes and licensing and regulatory fees}}$$

The regulation defines both numerator and denominator. Qualified medical claims and related expenses are delineated. Qualified expenses focus insurers on activities that improve health quality and measurement thereof. Health information technology expense to support the data extraction, analysis, and transmission of quality health information/medical records is also qualified. PPACA's intent is for insurers to focus their efforts on clinical effectiveness, care coordination, chronic disease management, and other patient centered intervention, etc.

Current managed care and insurance models are cost control driven. The focus is on cost negotiations with providers, utilization review, and post claims underwriting. Under PPACA,

these and other cost limiting procedures are not qualified. Marketing expense and general fraud detection activity are not qualified and if pursued, negatively impact profitability.

Strategically, insurers need to review their operations within the definitions of qualified and unqualified expenses. Current health care delivery is fragmented, unorganized, and providers are volume-based compensated. Ineffective or unnecessary care is not being monitored, nor is the quality of medical outcomes. The objective of health care reform is to transform insurers from traditional claims cost managers and premium raters to providers of medical management assistance to enrollees and patients. The insurer becomes responsible for financing the care and the quality control mechanism for the patient and the delivery system.

The new health care paradigm is data driven and hungry for information. The objective is to monitor the patient and flag opportunities for early intervention or prevent medical services that are untried, ineffective, or unnecessary. The objective of evidence-based medicine is to weed out treatments that are less effective and substitute a more effective alternative. Also, the medical delivery system is very inefficient and complex, and insurers are being encouraged to assist with the coordination and the informed consent surrounding care.

MLR Mechanics and Monitoring

MLR becomes the key indicator for monitoring the transformation. Insurers' MLR will be judged both on a competitive and regulatory compliance basis. It is important that your MLR reflects your actual experience. The "Supplemental Health Care Exhibit-Parts 1, 2, and 3" to the statutory Annual Statement has been designed to track and compare health insurers' health care financial results. The Exhibit provides source information by market that will be used in filing the MLR rebate return, but it does not calculate the final amount. The final rebate return contains various state specific provisions and statistical adjustments.

The Exhibit provides detail information in three parts. Part 1 shows the overall MLR calculation. Part 2 details the calculation of premiums and claims. Part 3 shows the allocation of expenses by major categories. Expenses in Part 3 include expense classifications as follows:

1) Improve Health Outcomes
2) Activities to Prevent Readmissions
3) Improve Patient Safety and Reduce Medical Errors
4) Wellness & Health Promotion Activities
5) HIT Expenses
6) Cost Containment Expenses
7) Other Claim Adjustment Expenses
8) General Administrative Expenses

In total, expenses should reconcile to other parts of the Annual Statement and insurers' general ledger.

The exhibit provides sufficient detail to evaluate the level of effort an insurer is expending in quality activities (1-5 above). It provides an analytical roadmap as to where improvement is needed to increase profitability.

A key operating strategy is to maximize the expenses in the qualified category and minimize the non-qualified expenses. This is easier said than done. Most insurers do not have accounting systems that provide sufficient detail to accurately identify actual costs in the categories in Part 3 or the ability to allocate costs by state, by market, or by type of expenses. Formal cost studies need to be performed and allocation methodologies adopted and validated.

Usually, medical management activity is provided on a centralized basis and applied to all markets. It is important to identify an activity measure that provides a reasonable basis for the allocation. This also applies to health information technology expenses. Careful consideration needs to be given to determine the level of internal IT system infrastructure which uniquely supports eligible medical quality activities.

Managed care and other supporting financial systems should be assessed to determine their medical management capabilities. Most managed care systems have modules designed for measuring outcomes, time lags, etc. The past focus on cost metrics had insurers turn off these system capabilities. It is therefore important to understand the clinical capabilities as well as the financial capabilities of your systems. With relatively minor changes your financial systems can assist you with medical quality measurements and be considered a qualified expense. Qualified expense identification and allocation requires considerable judgment, expertise and experience. Documentation for later validation and consistency is a must.

MLR Rebate

The Supplemental Health Care Exhibit provides the initial information to calculate whether a rebate is necessary. It is important to realize that the Exhibit does not contain the final amount. There are possible revisions for claim reserve run-off subsequent to year end, statistical credibility concerns, and other defined adjustments. Be prepared to be able to reconcile the return to the Supplemental Health Care Exhibit and to the Annual Statement as part of the filing process.

Also, note that certain states have requested and received MLR waivers, so the formula or minimum loss ratio may have been modified. In preparation for the reserve estimates, the state analysis needs to be updated for any changes. As of November 15, 2011, seventeen states and Guam have applied for MLR waivers and approximately half have received waivers. The remainders are still pending. The CMS website lists the status and content of waivers.

Accounting Guidance

The accounting guidance in MLR calculation is as follows:

- MLR Rebates are subject to the accounting guidance provided in **Statutory Statement of Accounting Principles ("SSAP") Number 66-Retrospectively Rated Contracts.**

  Rebates should be accrued as part of the change in unearned premium for property casualty entities; as a liability (provision for experience rating refund) with corresponding entry to premiums for life and accident and health entities; and, as part of accident and health reserve with corresponding entry to premiums for managed care/accident and health entities.

- Expense allocations are subject to the accounting guidance provided in **SSAP Number 70-Allocation of Expenses.**

  The statement provides for the allocation of certain expenses of reporting entities into general categories and the apportionment of shared expenses between members of a group of entities.

- Certain health care receivables are subject to the accounting guidance provided in **SSAP Number 84-Certain Health Care Receivables and Receivables Under Government Insured Plans.**

  This statement provides for the accounting treatment of pharmaceutical rebate receivables, claims overpayment receivables, loan and advances to providers (not related), capitation arrangement receivables, risk sharing receivables and amounts receivable under government insured plans.(Impacts claims amounts).

Conclusion

Health care reform is a massive and complex change. MLR is the global positioning system to let insurers, regulators, and consumers know what has been achieved. Health insurers' profitability and ultimate solvency depends on insurers understanding MLR, validating the calculation, and using MLR to monitor strategy implementation.

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