



# The Council for Affordable Health Insurance's ISSUES & ANSWERS

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## How High Loss Ratios Undermine Affordable Health Insurance

States across the country have begun unveiling health reform proposals in a variety of forms. Unfortunately, Republican Governor Arnold Schwarzenegger (CA) and Democratic Governor Ed Rendell (PA) have both introduced comprehensive reform proposals that include a controversial health insurance price control scheme requiring health insurers to meet an 85 percent loss ratio — which means that at least 85 percent of collected premiums must be used to pay health care costs. Such legislation is unprecedented.

The governors hope that by squeezing down the carriers' administrative costs to 15 percent of collected premiums, care will become more affordable and more accessible. However, the experience of other states that have tried similar, although less onerous, legislation provides the governors with little hope for success.

**What Is a Loss Ratio?** A loss ratio is the percentage of premiums spent directly on patient care. The 85 percent loss ratio proposed by Governors Rendell and Schwarzenegger would mean that health insurers would be required to spend at least \$85 of every \$100 in premiums on direct patient care. Conversely, health insurers can spend only \$15 of every \$100 on administrative expenses. Thus loss ratios are, in effect, price controls, seeking to limit the cost of insurance by controlling one of its primary components. While these proposals may appear at first glance to be reasonable, it is important to understand what makes up insurance company administrative costs.

**What Is Included in Administrative Expenses?** Administrative expenses include all the costs required to conduct the business of health insurance, and to provide customer services to members. These expenses include, among others:

- Monitoring efforts to ensure patients are getting appropriate care, especially those with chronic medical conditions;
- The cost to process a medical claim accurately, including issuing and sending a check for services and providing an explanation of the payment;
- Customer service staff to answer questions — often 24 hours a day, 7 days a week;

- The cost to collect premiums and credit those premiums to the correct account;
- Agent commissions;
- Costs imposed by state laws, including premium taxes, external review fees (i.e., costs an insurer must pay to an independent provider to review a claim), assessments for high risk pools, timely claims payment requirements, and others; and
- Profit and general overhead costs.

In other words, insurers and health plans incur numerous costs in their efforts to provide good customer service, to process and monitor both claims and care. Unfortunately, while many of those efforts surely reduce claims and therefore reduce upward pressure on premiums, critics see only the “costs,” not the benefits. They are ignorant of the fact that those costs may actually save money.

**Factors Affecting Administrative Expenses.** Loss-ratio laws often treat the individual and group health insurance markets as if they are the same. They aren't. There are numerous factors that may affect the cost of administering a plan, including group size, premium amount, plan design, and others.

For example, in the individual market an agent selling health insurance coverage will need to meet separately with each individual to assess his or her needs, and health insurers collect premiums separately from each individual. It's a very time consuming and expensive process, but necessary for those without access to group coverage.

In the employer market, by contrast, the agent may meet with the employees in groups, and a single check is remitted for numerous employee premiums. Thus, agents selling in the individual market will, in general, need higher commissions to cover their added time and costs than agents selling in the group market.

Finally, some plans (e.g., high deductible plans, limited benefit plans, dental plans) have relatively low premiums, and so there are fewer dollars available to cover administrative expenses (because the loss ratio is a percentage of total premiums). Thus, pushing for very low loss ratios will lead to insurers offering only expensive, comprehensive plans — eliminating lots of less-comprehensive and more-affordable options.

**Do Administrative Costs Add Value?** Forcing health insurers to cut administrative costs would lead to more claims-payment errors, poor customer service, or a delay in timely claims processing. Similar problems exist in processing premium payments and other service areas. Paring costs too much could significantly affect customer service. Insurers try to balance the forces of competition, which encourage companies to trim administrative expenses to keep costs low, with the consumers' right to information and the companies' desire to provide excellent customer service. Onerous loss-ratio demands would undermine that balance.

Customer service and the business of insurance are not the only components of administrative expenses. Some are associated with processes that help to reduce health care costs and improve health outcomes. Proper claims-payment systems, for example, can reduce duplicate payments. Preferred provider networks provide discounts on medical services in exchange for access fees. Managed care departments work with doctors and patients to find the most cost-effective care (sometimes even if it is more expensive in the short run). Health insurers spend hundreds of thousands of dollars on fraud detection and prevention, which saves millions of dollars.

Some health insurers have even spent millions of dollars on information systems to help consumers understand their medical choices, while others have provided direct phone access to nurses to help patients understand their medical conditions. These efforts reduce health care expenditures, and result in lower health insurance premiums. As a result, a loss ratio set too high may actually result in lower-quality care and higher health insurance premiums.

Ironically, the more successful insurers are at reducing unnecessary claims, the worse their loss ratio appears to be (because it is a ratio of costs to claims).

**The Role for Standards.** Some states, like Wisconsin, have decided that rate regulation in a competitive market provides consumers with little value. They correctly believe that companies with loss ratios that are too low (e.g., paying only 40 cents in claims out of every premium dollar taken in) will not be able to compete on price with companies that have higher loss ratios.

Other states regulate rates more extensively by reviewing not only the rates of each individual health plan (using a loss ratio), but also regulate the difference in rates between one plan and another. The purpose of rate review is not just to ensure fair rates to consumers, but also that rates are adequate to meet the insurers' obligations — in other words, they have enough money to pay claims.

Several standards have been suggested by the National Association of Insurance Commissioners (NAIC). The NAIC model recognizes that loss ratios should not be applied uniformly without regard to product or how that

product was issued. As a result, the NAIC model actually includes a table that varies the loss ratio based on the product and its issue rules. Most states have followed this approach, although perhaps deviating from the specified loss-ratio amount.

In most states, individual coverage faces a loss ratio between 55 and 65 percent, while small group health insurance plans face slightly higher loss ratios. Most large groups operate under the federal ERISA law (i.e., self-fund their health insurance), and so their plans are not subject to state rate regulation.

A few states have experimented with increasing loss ratios to artificially lower premiums and cut administrative expenses. Both Kentucky and North Dakota passed higher loss ratios as part of a series of reforms in the 1990s. Kentucky's loss ratio bill was part of a larger health reform legislation that decimated the market. Not until the loss ratio was lowered to a more reasonable 65 percent did the individual market finally begin to recover. North Dakota has faced a similar crisis with carriers abandoning the market, few choices and higher premiums. With the passage of Senate Bill 2154, which lowers the group loss ratio from 75 to 70 percent and individual products from 65 to 55 percent, policymakers in North Dakota expect a resurgence in the market.

No state has successfully implemented an 85 percent loss ratio.

**Conclusion.** Governors Schwarzenegger and Rendell need to tread carefully. High loss-ratio standards have led to less competition, fewer choices, and in the end higher health insurance costs. Those standards also favor high premium plans and undermine Health Savings Accounts, which ironically is one Governor Schwarzenegger's favorite health insurance options.

*For more information on this and other topics, please see CAHI's "State Legislators' Guide to Health Insurance Solutions," available online at [http://www.cahi.org/cahi\\_contents/resources/pdf/2007StateLeg.pdf](http://www.cahi.org/cahi_contents/resources/pdf/2007StateLeg.pdf).*

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