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How High Loss Ratios Undermine Affordable Health Insurance

States across the country are unveiling various health reform proposals, and chief among those is the regulation of health insurance rates. California, Michigan, New Mexico and Pennsylvania have all introduced a controversial health insurance price-control scheme requiring health insurers to meet a targeted loss ratio of 70 percent or more, which means that at least 70 percent of collected premiums must be used to pay direct health expenditures.

While many states have implemented loss-ratio requirements, few have ever tried loss ratios at or above 70 percent. These states hope that by squeezing down the carriers' administrative costs to less than 30 percent of collected premiums, insurance will become more affordable and more accessible. However, the experience of other states that have tried similar, although less onerous, legislation provides little hope for success.

In rate regulation, it appears that less is more. States that rely on a competitive market have tended to have lower overall health insurance rates.

What Is a Loss Ratio? A loss ratio is the percentage of premiums spent on direct patient care. Thus a 70 percent loss ratio would mean that health insurers would be required to spend at least \$70 on patient care for every \$100 in premiums. Conversely, health insurers may spend no more than \$30 of every \$100 on administrative expenses. Loss ratios are, in effect, price controls, seeking to limit the cost of insurance by controlling one of its primary components. While these proposals appear at first glance to be reasonable, it is important to understand what makes up insurance company administrative expenses.

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 many others:

- The cost to collect premiums and credit those premiums to the correct account;
- The cost to process a medical claim accurately, including issuing and sending a check for services and providing an explanation of the payment;

- Monitoring efforts to ensure patients are getting appropriate care, especially those who suffer from chronic medical conditions;
- Customer service staff — often more than half of an insurer's employees — to answer questions from members and medical providers 24 hours a day, 7 days a week;
- Agent commissions;
- Costs imposed by state and federal 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, or excess revenue (non-profits), and general overhead costs.

In other words, insurers and health plans incur numerous costs in their efforts to process and monitor claims and care, set premiums, and comply with state and federal requirements. Unfortunately, while those efforts surely reduce claims costs and therefore reduce upward pressure on premiums, critics see only the costs, not the benefits. They are ignorant of the fact that some of those costs may actually save money.

Factors Affecting Administrative Expenses. Loss-ratio laws often sound as if the individual and group health insurance markets 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 to individuals 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 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. 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, and 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 high loss ratios will lead to insurers offering only expensive, comprehensive plans — eliminating less-comprehensive but 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. 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 administrative expenses are associated with processes that help to reduce health care costs and improve health outcomes. Health information technology (e.g., electronic personal medical records and other electronic information) can be expensive to implement, but can ensure patients receive appropriate and cost-effective care while limiting medical errors. Proper claims payment systems 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 (which is sometimes even 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 a lower quality of care and higher health insurance premiums.

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. While other states may regulate rates more extensively, 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, in-

surers need to have enough money to pay claims. In most states, individual coverage faces a loss ratio between 55 and 65 percent.

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 undertaken in the 1990s. Kentucky's loss-ratio bill was part of larger health reform legislation that decimated the market. Not until the loss ratio was lowered to a more reasonable 65 percent (which also allowed some administrative expenses to be included in claims costs, thereby lowering the actual loss ratio) 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 market loss ratio from 65 to 55 percent, policymakers in North Dakota expect a similar resurgence in the market.

No state has successfully implemented a 70 percent loss ratio in the individual market. Nor is there any reason to expect the new reformers will be any more successful.

Conclusion. Michigan needs 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 and other more affordable products — products that attract the uninsured.

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/StateLegislatorsGuide2008.pdf.

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