

Opinion

Medical Loss Ratios: Another Chance to Game the System?

As regular readers of this column know, I like words, as long as there aren't too many of them. I enjoy their sounds, their meanings, their subtle connotations. But not all words. Certain commonly used words and phrases offend me. Like "provider," for example. The government dreamed that one up to cover anybody who bills for medical care services, all the way from hearing aid salesmen to neurosurgeons. That way they can salute (sic) everyone in a single form letter, "Dear Provider." Already I am turned off, and I haven't even read the first sentence.

Another term that rankles me is "medical loss ratio," abbreviated MLR, which refers to the percentage of premium a health insurer actually has to pay on behalf of insureds when they obtain health care. Now I can understand how the term evolved since in other kinds of insurance there is actual irretrievable loss, like in fire, theft, disability and life insurance. You can lose your valuables in a fire, or lose your livelihood from disability or lose a loved one. In these examples, the loss ratio for an insurance company makes sense. But in health insurance, there isn't any loss to pay for, it's just supposed to pay for "provider" charges. However, the term medical loss ratio makes it sound as though the insurance company thinks it deserves to keep the premiums and reluctantly has to pay some of it for medical claims.

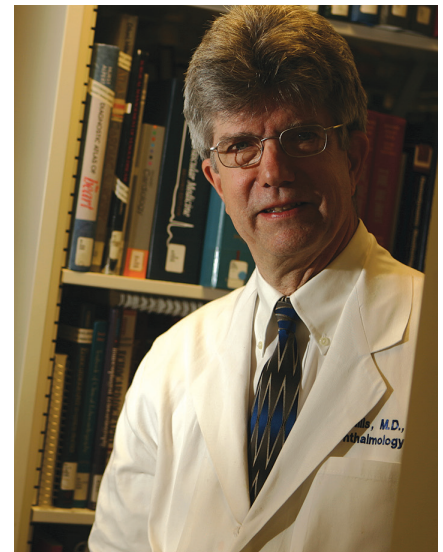
Unfortunately, that is just the attitude exhibited by many health insurance companies.

In 2009, the MLRs of the seven largest for-profit insurers (not counting Medicare and Medicaid) ranged from 68 percent to 92 percent. That means the companies kept between 8 and 32 percent of premiums to pay for items like claims processing, telephone answering systems with on-hold music, and CEO salaries. But that will be changing in 2011. The Patient Protection and Affordable Care Act (the health care insurance reform law) stipulates that MLRs must be at least 80 percent in individual and small group markets, and 85 percent in large group markets, or the companies must issue a rebate to consumers in 2012. Administrative costs cannot be included in the MLR, but quality improvement activities can. So there is quite a scramble going on behind the scenes at insurance companies to redefine costs so they qualify within the MLR. As smart companies, they are going to be trying to game the system. My prediction is that they will all meet the target, and not have to pay rebates.

In the course of this fracas, so-called mini-med plans (offered by fast-food restaurants, big-box retailers, etc.) applied for an exemption to allow a lower MLR, citing increased expenses due to high employee turnover. I guess it costs a lot more money to add and subtract names in the computer than it

does to send claim denial notices. In a typical basic mini-med plan, a worker pays \$13.99 a week for a maximum annual benefit of \$2,000. One visit to an ER or an MRI scan should wipe that out. Babies and hospitalization are way over the limit. Terrible insurance though it is, a spokesman for McDonald's said it would look for other insurance options if it couldn't get the waiver.

Well, I'm sorry I had to drag you through so much detail to explain what's distasteful about "medical loss ratio." By contrast, it doesn't take any explaining to see what's wrong with "provider." It's because the system's already been fully gamed on that one.



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