

ObamaCare Will Dramatically Reduce Choice in Private Insurance

By John R. Graham

One of the ways in which ObamaCare will reduce individuals' and businesses' choices of health insurance is through regulating the Medical Loss Ratio (MLR), a relatively simple concept: Take the amount of dollars an insurer spends on medical care and divide it by the total premiums. For example, if an insurer earns \$10 million in premiums and spends \$8.5 million on medical claims, its MLR would be 85 percent. Under ObamaCare, policies that cover large businesses will have to achieve an MLR of 85 percent, while those for small businesses and individuals will have to achieve an MLR of 80 percent. That shouldn't be too hard, should it?

Actually, the MLR can be quite complicated – especially when the government gets involved. Suppose, for example, an insurer invests in information technology that it gives to providers in its network in order to improve co-ordination of care. Is that a medical cost? Also, health insurers pay taxes. Although these taxes are obviously not medical costs, is it appropriate for the government to punish an insurer that pays higher taxes, which are revenue to the government?

Suppose two insurers of the same size compete in a region's large-group market. They earn premiums of \$1 million each. They each spend \$850,000 on medical claims, thereby achieving an MLR of 85 percent. Suppose, however, that one insurer is non-profit and the other is for-profit that earns a profit of 4 percent (\$40,000) and pays combined federal and state corporate income tax of 45 percent (\$18,000). Its MLR automatically shrinks to 83.5 percent and ObamaCare shuts it down. It should be blindingly obvious to anyone that this makes no sense, except to the sponsors of the poorly worded ObamaCare legislation.

KEY POINTS:

- **The National Association of Insurance Commissioners (NAIC) has just issued regulations that will reduce choice in health insurance for individuals and businesses.**
- **These regulations focus on the Medical Loss Ratio (MLR), a misleading bookkeeping concept irrelevant to peoples' choice of health insurance.**
- **To succeed in reducing choice, ObamaCare relies on states to establish "exchanges" that will reduce the choice of policies that individuals and businesses can buy.**
- **To prevent this harm, states should follow the example of Minnesota and not apply for federal grants to establish exchanges.**

The example cited above addresses only income taxes, not premium taxes, because ObamaCare clearly states that the MLR's denominator as "the total amount of premium revenue (excluding federal and state taxes and licensing or regulatory fees..."

Consider Senator Max Baucus, who recently denied ever having read the legislation he sponsored, blaming the fiasco on unnamed "experts" who wrote the bill. Senator Baucus recently wrote a letter to Kathleen Sebelius, U.S. Secretary of Health and Human Services, in which he and his colleagues attempted to re-write the legislation to include corporate income taxes in the denominator, thus discriminating against for-profit insurers.¹

This makes no sense, except to the sponsors of the poorly worded ObamaCare legislation.

"The Medical Loss Ratio is an accounting monstrosity that enralls the unsophisticated observer and distorts the health policy discourse,"² explains professor James C. Robinson of the University of California, Berkeley. This "monstrosity" emerges for a number of reasons, according to the professor.

Many health insurers compete in markets across the country, allocating overheads across state lines, which makes accounting conventions even more arbitrary. For example, Blue Cross of California is now owned by WellPoint, Inc., headquartered in Indianapolis. Blue Cross of California does *not* uniformly implement a single loss ratio or profit margin for all of its lines of business.³ Narrow networks obviously have fewer administrative costs than broader networks, but patients appear to value broader networks nevertheless. Health plans with rich benefits or which operate in areas where providers are expensive will incur high MLRs. Further, integrated managed-care organizations, such as Kaiser Permanente, can have much higher MLRs because they move administrative costs to the provider side of their organizations. PPOs have higher administrative costs because they cannot do this.⁴

Regulating the MLR is also deadly for consumer-directed plans, which are becoming increasingly popular. Let's assume a scenario where a consumer-directed health policy incurs exactly the same costs as a traditional policy. In fact, this is unlikely because total costs of consumer-directed plans are significantly lower than for traditional ones, as patients have better incentives to control costs.⁵ The traditional policy costs \$4,000 and spends \$3,400 on patient care, for an MLR of 85.00. With the consumer-directed policy, the patient controls \$800 more of the medical spending than with the traditional policy (through a higher deductible), and his premium goes down by \$800. In this case the MLR goes down to 81.25 (\$2,600/\$3,200). There is no *real* difference, but the accounting looks worse.

In any case, MLRs are irrelevant to the insured and their employers, who actually choose health plans based on other criteria—likely invisible to politicians and regulators. Let's look at the example of California: Table 1 shows the top 10 health plans, by enrollment, as well as their MLRs as reported for the period from December 2006 to December 2007. The average MLR for all plans is 89.6, but there is significant variance.⁶

Table 1: California's Top Ten Health-Service Plans by Enrollment, December 2007

Health Plan Name	Medical Loss Ratio, 2007	Share of Total Patients Covered	Medical Loss Ratio, 1994/5	Change, 1994/5 to 2007
Kaiser Foundation Health Plan, Inc.	94.8	32%	96.8	(2.0)
Blue Cross of California	81.5	21%	93.5	(12.0)
California Physicians' Service (Blue Shield of California)	85.7	12%		
Health Net of California, Inc.	85.7	10%		
PacifiCare of California	86.2	8%		
Orange County Health Authority	90.5	2%		
Inland Empire Health Plan	93.3	2%		
Aetna Health of California, Inc.	83.3	1%	77.4	5.9
Cigna HealthCare of California, Inc.	95.2	1%	83.2	12.0
Molina Healthcare of California	167.3	1%		

Source: California Department of Managed Health Care; Robinson.⁷
The top 10 plans account for 90 percent of all patients covered by California health-service plans.

Table 1 also shows MLRs for some plans in 1994/5, and changes in the MLR from 1994/5 to the present (where the data are available).⁸ Kaiser's loss ratio is very stable over the period. On the other hand, Blue Cross of California experienced a significant deterioration of its MLR over the period, while Cigna experienced an improvement of the same magnitude.

Nevertheless, Blue Cross of California sits in the second spot in the rankings, covering one-fifth of all California patients enrolled in health-service plans, while Cigna is in the ninth spot, with just 1 percent of patients. Clearly, when people choose health plans they are looking at things other than the MLR. Under ObamaCare, Blue Cross of California and Aetna would have to either withdraw from the market or waste resources re-inventing their accounting in order to satisfy the regulation concerning MLR.

The National Association of Insurance Commissioners has just issued its proposed draft of MLR regulations.⁹ Many issues, including the treatment of corporate income taxes, remain unsettled. Unfortunately, the irresponsible behavior of legislators who voted for ObamaCare suggests that the final regulations will severely limit Americans' choice of health plan by January 2014.

In anticipation of repealing ObamaCare before 2014, states should adopt a policy of resistance by any legal means.

Facing this threat, states should remember that ObamaCare relies on states' collaboration to impose its anti-choice regulations, through state-based "exchanges" that would choose health insurance for their citizens. In anticipation of repealing ObamaCare before 2014, states should adopt a policy of resistance by any legal means. For example, Tim Pawlenty, governor of Minnesota, has signed an executive order forbidding state bureaucrats from even applying for federal grants to set up an exchange.¹⁰ Other governors would serve the public interest by following his lead.

ENDNOTES

- 1 Max Baucus et al., *Letter to The Hon. Kathleen Sebelius* (Washington, DC: Congress of the United States, August 20, 2010). Available at http://www.politico.com/static/PPM170_100811_taxes.html.
- 2 James C. Robinson, "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance," *Health Affairs*, vol. 16, no. 4 (July/August 1997), pp. 176–187.
- 3 Leif Associates Inc., "Actuarial Rate Setting Review of Blue Cross of California: 2005 Individual and Small Group Rate Change, Pursuant to Undertakings Provided as Part of Blue Cross of California Notice of Material Modification Regarding Proposed Change in Control of Ultimate Parent Company," report to the California Department of Managed Health Care Leif Associates, Inc., (Denver, CO: November 22, 2005), p. 6.
- 4 Robinson, "Use and Abuse."
- 5 John R. Graham, "Bulletproof? Health Savings Accounts in 2007 and 2008," *Health Policy Prescriptions*, vol. 5, no. 1 (January 2007).
- 6 Author's calculations from California Department of Managed Health Care, "Health Plan Financial Summary Report." See also Robinson, "Use and Abuse."
- 7 Ibid.
- 8 Robinson, "Use and Abuse."
- 9 National Association of Insurance Commissioners, Blanks Agenda Item Submission Form (Kansas City, MO: National Association of Insurance Commissioners, June 18, 2010).
- 10 Gov. Tim Pawlenty, *Executive Order 10-12* (St. Paul, MN: Office of Governor Tim Pawlenty, August 31, 2010).