Healthcare reform's minimum medical loss ratios

How to manage the increased risk?

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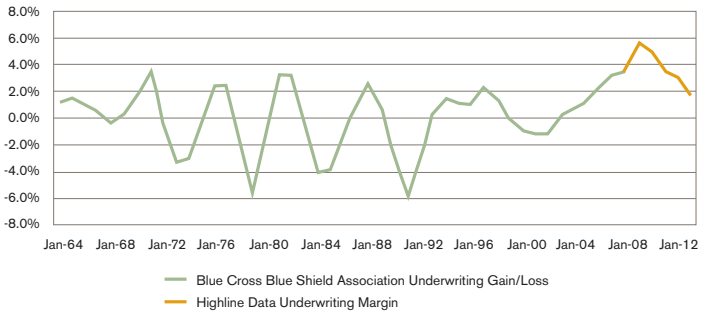
One of the most important changes contained in the 2010 Patient Protection and Affordable Care Act (PPACA) requires health insurance carriers to meet minimum medical loss ratio (MLR) targets of 80% for small group and individual plans and 85% for large group plans. Insurers who do not meet these targets must refund the excess to plans and individual insureds. These requirements change the risk for all insurers, because the chief cause of deviations from targeted or expected profit margins in health insurance is the effect of unexpected fluctuations in health claim cost trends. Historically, trends have been volatile and subject to the so-called underwriting cycle. Relatively stable trends, such as we've seen during the past two decades, are no guarantee of stability in the future. The big question is: How can insurers adjust to major upward shifts in future claim costs, given the MLR requirements?

WHAT IF HISTORY REPEATS ITSELF?

In the past, sudden inflationary jumps in healthcare costs drove strong underwriting cycles; insurers would lose money for two or three years until they adjusted their trends and premium rates upward. The trends then moderated, and insurers would make large profits, replenishing their reserves. These replenished reserves helped prepare insurers for the next upswing in claim costs, which in time triggered another rise in trends and rates.

From the 1960s to the early 1990s, these cycles were regularly characterized by three successive years of gain followed by three successive years of loss. Figure 1 illustrates this.

FIGURE 1: BLUE CROSS BLUE SHIELD UNDERWRITING RESULTS



Results from Highline Data for 2005-2009 obtained from adding the separate companies as reported. These represent an overwhelming majority of Blue Cross and Blue Shield results.
Highline Data results for Wellpoint Inc Group differ from other published sources for Wellpoint, Inc.

Stability. Since 1989, the pattern has been less regular and much more muted. In particular, the years of underwriting loss have been less frequent, and the losses less severe, compared with the preceding 30 years. The volatility of the 1960s-1980s period was due in part to the growth in healthcare following the introduction of Medicare and Medicaid, and the subsequent expansion of Medicare to cover disabled populations; and in part to less sophisticated operations among healthcare insurance carriers. In fact, the cycle is still apparent from the more recent data, but instead of varying around 0% it is now generally fluctuating in positive territory.

Several factors produced the relative stability of the 1990s-2000s period:

- Inflation rates became steadier, and the occasionally severe inflation of the 1970s and 1980s has not reappeared.
- Large carriers such as Blue Cross and Blue Shield became for-profit companies, or at least began operating on a more sophisticated actuarial basis.
- The average lag time between the occurrence and payment of claims dropped dramatically. This means that insurers could project financial results and take measures to mitigate problems more quickly.
- During the 1990s, the National Association of Insurance Commissioners (NAIC) and the BlueCross BlueShield Association implemented surplus, or risk-based capital (RBC), requirements for healthcare. The new standards clarified targets for surplus and contingency reserves, as well as the minimums needed to avoid

regulatory takeover. The result for insurers was greater solvency and less-severe fluctuations in the underwriting cycle.

No certainty moving forward. The fact that we've been in a prolonged period of moderate inflation, with similarly moderating effects on claim trends, does not guarantee that cost trends in the future will be limited and predictable. For example, the impact of a severe pandemic in one year can have a significant impact on insurers' financial results.

And this is where the new MLR requirements imposed by healthcare reform pose a challenge. Because insurers are required to refund excess gains to insurance plans and individual insureds, insurers will lose their ability to shore up reserves during years of high profits. The effect on insurers' profits–and even their solvency–could be very serious.

PROTECTING INSURERS

Insurers need to develop strategies for protecting themselves from these potentially increasing risks. Three possible ways are:

- Hedging the trend risk using a swap on a published index, for example the S&P Healthcare Economic Commercial Index
- Adding additional rating margins
- Getting providers to take on more risk through greater capitation, or holdback and bonus payments

Swaps. One possible strategy would allow an insurer to hedge some of its risk by engaging in a swap with an investment bank or other financial institution. Let's suppose that an insurer builds a 7% trend into its rates, and the company's analysis indicates that it can withstand a trend of up to 2% above that without significant damage to its balance sheet and capital. In this case, the insurer feels it can weather any trend up to 9% in the following year with no harm to the company's finances, but the company will need protection against any rise beyond that level. To protect against higher trends, the insurer might set up a high-yield bond similar to a catastrophe (CAT) bond. The insurer would pay interest to counterparties (e.g., investment banks or hedge funds) at a rate commensurate with the risk, but the bond would carry a condition exempting the insurer from paying interest and/or repaying the principal in a specified proportion to the amount by which the healthcare trend exceeds 9%, as measured by the S&P Healthcare Economic Commercial Indices or some other index. In this way, the trend risk becomes a financial risk, sold within the financial markets. Insurers pursuing such a strategy would likely look at making multi-year swaps because a single-year swap would likely not provide sufficient protection over the course of multi-year cycles.

Additional rating margins. If insurers set premium rates at a level aimed at hitting the exact MLR target and then have a year of unexpectedly high claims, they will lose money; if they set rates using a target below the MLR and have a bad year, they will also lose money (but much less). The MLR regulation permits some deviation below the minimum MLR to account for a portion of the anticipated statistical fluctuation in results (depending on the size and composition of the business), and after an initial phase-in period rebates will be based on a rolling three-year window. However, these accommodations will not fully mitigate the impact of statistical fluctuation, nor are they designed to compensate for the kinds of misses that result from the broader underwriting cycle. Insurers will likely attempt to set rates at levels that will enable them to do better than the MLR requirements, in the expectation of giving refunds if they meet their targets. If an insurer has a good year, it just refunds more money back to the plans. To further increase their margins, insurers have to lower their target MLR even further, which means even larger refunds. They also face the challenge of getting the additional rate increases through the regulatory process at a time of heightened scrutiny over premium rates. It is clear that this strategy is a tricky one.

Passing risk to providers. For obvious reasons, providers are not eager to assume risk. However, current trends in contracting are pushing in the direction of requiring providers to take on some of the risk. One way to make it more palatable to both sides might be to tie reimbursement increases to an S&P index in order to offset the risk between providers and insurers. Providers would give up some upside risk to protect insurers, and insurers would give up some downside risk to protect providers. The result would be a much more predictable environment.

Another way of sharing risk would be to negotiate contracts in terms of capitated payments. This is the traditional approach of health maintenance organizations (HMOs), and it is gaining strength now in the movement toward accountable care organizations (ACOs).

Greater use of indices could also facilitate the use of holdbacks and bonuses on insurance payments. In a holdback situation, the insurer's liability for a certain type of surgery might be agreed to at $1,000. However, the contract between the insurers and providers holds back a part of the payment, e.g., $200, and if the index trend relative to the specified trend is as expected, the insurer pays the $200 later. If the trend is higher (e.g., 9% instead of 7%), the provider gives up a portion of the holdback; if the trend is lower (e.g., 5%), the provider receives a bonus.

CONCLUSION

Meeting MLR targets will be one of the biggest challenges of healthcare reform, and the challenge will intensify if the future brings greater volatility in claim trends than recently experienced. There are ways of preparing for such contingencies, and insurers should begin planning their strategies now.

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