More Bang for the Health Care Buck

How an Efficiency Standard for Health Insurers Can Reduce Overhead and Deliver More Patient Care

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Executive Summary

The high cost of health care in the U.S. imposes an increasing burden on households, businesses, government, and our country's economy – a burden made heavier by the current economic crisis. The money that insurance companies spend on inefficient administration, billing and marketing – instead of medical care for their enrollees – contributes to the high health care costs Americans must endure. To incentive efficiency and get costs under control, the U.S. should require health plans and insurers to spend at least 85 percent of revenue on health care. Almost half of the nation's health plans and insurers we surveyed already meet this efficiency standard, while a similar number could comply with the standard with only moderate effort.

Health care is enormously expensive in the U.S. But a lot of the money Americans spend on health insurance goes toward things that have nothing to do with keeping us healthy, such as inefficient administration and billing practices, marketing, and profits.

- In 2007, insurance companies, the state and federal government, individuals and other payers spent $2.2 trillion on health care, equal to 16 percent of the state's gross domestic product.
- Health plans and insurers have an incentive to keep the percentage of revenue they spend on health care low. For example, Great-West Healthcare of California decreased the percentage of revenue it spent on medical costs every year from 2003 to 2007, from 85.8 percent to 69.1 percent. Over the same period of time the company's profits increased from 0.5 percent to over 10 percent, while the portion spent on administration stayed essentially the same.

Health plans and insurance companies have an incentive to reduce the amount they spend on health care because the stock market favors companies that devote higher portions of their revenue to administration, marketing, and profit-taking.

To get rising health care costs under control, it is critical to encourage greater insurer efficiency and increase the value of coverage by requiring insurers to spend 85 cents of every revenue dollar on health care. Providing incentives for efficiency will reward insurers for finding ways to reduce administrative costs and deliver better value to consumers. Further, data on current practices of American insurers shows that an 85 percent standard is both strong and achievable.

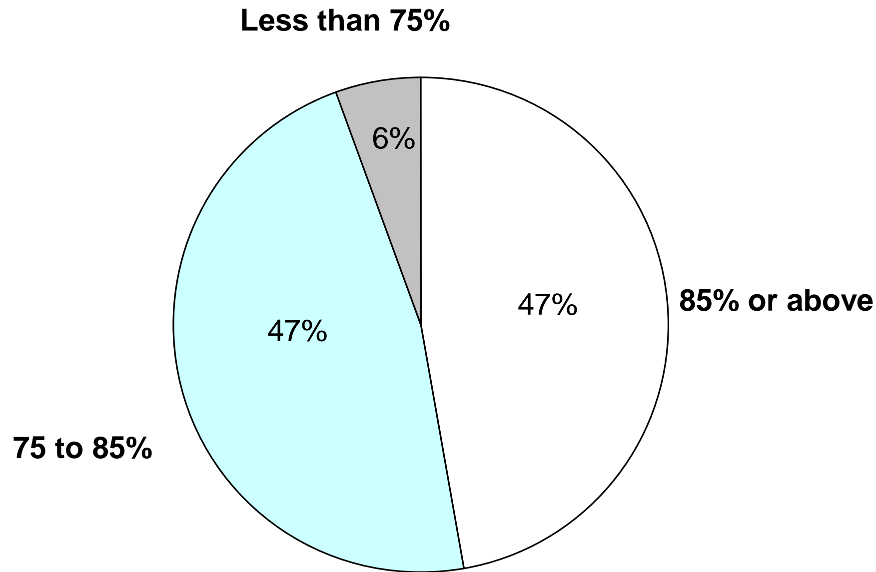
Successful health plans and insurers can, and often do, spend more than 85 percent of revenue on health care.

- While some health insurers spend too small a share of revenue on health care, many major HMOs achieve a proper balance. Nationally, many health insurers – including some of the nation's largest and most respected health plans, such as

Aetna's plans in Washington and Michigan, and Anthem's plan in New York – spend the bulk of revenue on health care.

- Nearly half of 53 health plans surveyed nationwide spend at least 85 percent of their revenues on health care.

Figure 1: The percentage of revenue that selected health insurance companies spend on health care.[1]



Requiring health insurance companies to spend at least 85 percent of their revenue on medical care would ensure that our health care dollars are being spent on health care and could save patients money.

- Enforcing a minimum percentage of health care spending encourages insurance companies to increase their administrative efficiency.

The U.S. should require health plans and insurance companies to spend at least 85 percent of revenue dollars on health care, to encourage efficiency and ensure that the companies are spending health care money on patient health. Furthermore, additional steps should also be taken to help insurance companies increase their efficiency, bring down costs, and ensure that money spent in the health care industry goes to improving our health.

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[1] Data were obtained through the National Association of Insurance Commissioners (NAIC) Consumer Information Source, and can be found at https://eapps.naic.org/cis/.

Introduction

To many Americans, "HMO" is a four-letter word.

Scarred by the managed care experiences of the 1990s and deeply worried about soaring health care costs, most Americans remain deeply skeptical about the motivations and actions of their health insurers. We remember the news stories about patients with medical emergencies whose insurers delayed their care or denied it altogether, leading to long-term health problems and deaths that could have been avoided.

A recent national poll suggests that only 7 percent of Americans view health insurers as generally trustworthy, and only 5 percent trust HMOs.[2] Indeed, Americans are more likely to report that they have personally seen a UFO than that they trust their health insurer.[3]

Among the reasons Americans are skeptical of health insurers is the suspicion that they waste resources on Kafkaesque billing and administrative procedures, and bank large profits by squeezing customers. Consumers worry that the money they spend on health care premiums isn't actually being used to improve their health.

That skepticism is deserved. For-profit health insurers face pressure from investors to maximize profits, creating an incentive to devote fewer resources to health care.

Consumers need a backstop to ensure that the money they spend on health insurance premiums is being used efficiently to improve their health. Many states have assumed a watchdog role by setting a minimum threshold for the share of health plan and insurance companies' revenue dollars – revenue gained almost exclusively through premium payments – that are devoted to health care. These fair rules ensure that when health insurers work to increase their profits, they do it by enrolling new customers or making their operations more efficient – not by short-changing beneficiaries.

Setting a minimum threshold for insurers' spending on health care would protect American consumers and ensure that our health care system is working for us.

Rising Health Care Costs Are Hurting Americans

The high cost of health care in the U.S. imposes an increasing burden on households, businesses, government, and the country's economy. In 2007, insurance companies, the state and federal government, individuals and other payers spent $2.2 trillion on health

[2] Harris Interactive, "The Harris Poll: More Regulation for Banks," 3 December 2008. Available at http://www.harrisinteractive.com/harris_poll/index.asp?PID=979.
[3] Thomas Hargrove and Guido H. Stempel III, "Poll Probes Americans' Belief in UFOs, Life on Other Planets," *Scripps-Howard News Service*, 15 July 2008.

care, equal to 16 percent of the state's gross domestic product.[4] Nationally, health care spending rose 56 percent from 2000 to 2006, versus an inflation rate of just 18 percent and wage increases of 20 percent, forcing employers to choose between reducing benefits, limiting wage increases, and hiring fewer employees.[5]

But while costs are rising, we aren't getting better care for our money. The Business Roundtable recently performed a cost-benefit analysis on the American health care system, comparing the amount we spend on health care to the health of American workers, as measured by indicators such as death rates and sick days. Our leading economic competitors like Canada and the United Kingdom spend 63 cents for every dollar we spend on health care, while our health is 10 percent worse; moreover, the health of American workers is 5 percent worse than workers in Brazil, India and China, who spend 15 cents for every dollar we spend on health care.[6]

One reason that our health care continues to be inferior despite rising costs is that much of the money we spend on health care doesn't actually go towards improving our health. Unproductive spending can be found in many areas of the health care industry -- among them, insurers' spending on excessive administrative expenses and marketing.

These expenses can make up a significant share of health insurers' total spending. While some administrative spending is necessary and even beneficial to health care, much of it could be made more efficient. As an illustration of the variation in administrative spending, California HMOs may spend as little as 4.1 percent of their revenues on such costs, or as much as 16.3 percent.[7] This wide range suggests that the health plans and insurers that spend high percentages of their revenue on administration could make their administrative practices more efficient.

Health plans' and insurers' spending on inefficient administration, marketing, and profits is not the only problem in America's health care system. However, it is one of a number of places where health care money is being spent in a way that does not improve patient health. Improving the efficiency of health insurers is a necessary part of fixing American health care.

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[4] Nolte, Ellen & C. Martin McKee. "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs,* 2008.
[5] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 2006-1990*, no date.
[6] Arnold Milstein and Carrie Hoverman Colla, Mercer Health & Benefits, Prepared for Business Roundtable, *Tracking the Contribution of U.S. Health Care to the Global Competitiveness of American Employers and Workers: 2009 Business Roundtable Health Care Value Comparability Study*, 28 February 2009.
[7] California Medical Association, *15th Annual Knox-Keene Health Plan Expenditures Report*, June 2008 (FY 2006-2007).

Health Plans and Insurance Companies Should Prioritize Health Care

Health Plans and Insurance Companies Have an Incentive to Keep Medical Spending Low

The portion of revenue that health plan and insurance companies spend on actual medical care is known in the insurance world as the "medical loss ratio," or MLR (or, sometimes, the "health benefit ratio"). Perversely, the term derives from the fact that from the insurers' point of view, dollars spent on actual medical care are a "loss" to the company. All other things being equal, consumers get the best value when this number is high, with most of their premium coming back to consumers to pay for health costs such as doctor's visits and surgeries and only the minimum necessary being kept for administration and other non-health costs.

Health plans and insurance companies, however, have an incentive to keep this number low. Stock analysts use the MLR as a rough, inverse indicator of a company's investment potential; since a low ratio can mean higher profits, it often increases an insurance company's stock value.[8]

Because of this incentive, some insurance companies spend extremely low percentages of their revenue on health care, especially in markets where consumers have less bargaining power, such as insurance for individuals or small businesses. Insurers that market healthcare to individuals sometimes spend only 60 percent of premium dollars on health care, devoting the rest to administration, marketing and profit.[9]

The incentive to maximize profits encourages insurance companies to find ways to reduce their spending on medical care in ways that are not always fair to the people to whom they're providing health insurance. For example, an investigation by *BusinessWeek* found that many insurance plans that colleges recommend to their students spend very small portions of their premium money on health care for the students, as little as 10 percent in a semester. Although college students have relatively low medical costs, these insurance companies take advantage of the low competitiveness in this market by offering very limited benefits and keeping the balance of students' premiums.[10] This 10 percent figure does not translate directly into an MLR, since the company presumably would keep another portion of the premium money to build their reserves for health spending. Still, the figure remains shockingly low.

[8] James C. Robinson, "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance," *Health Affairs*, July/August 1997.
[9] "Health Policy Memo: Medical Loss Ratios: Evidence from the States," *Families USA*, June 2008.
[10] Ben Elgin and Jessica Silver-Greenburg, "Is Your Kid Covered?" *BusinessWeek*, 8 May 2008.

The U.S. Can Protect Health Insurance Consumers by Setting an Insurer Efficiency Standard of 85 Percent

To protect consumers, many states require that insurers meet a minimum standard for the percentage of revenue they spend on health benefits. Fourteen states require insurance companies to meet minimum standards ranging from 55 percent for individual health plans in North Dakota, to 82 percent for large group carriers in Minnesota (See Table 1).

Table 1, Floors for the percentage of revenue spent on health care, by state (states without protections are not listed).[11]

State	Individual Market	Small Group Market	Other
California			Managed care plans: Administrative costs not to be "excessive," limited to 15% to 25% based on developmental phase of plan. Administrative costs do not include some factors such as salaries, stock options, etc.
Deleware		75%	
Kentucky	65%	Groups of 2-10: 70% Groups of 11-50: 75%	
Maine	65%	Insurers that file rates annually: 75% Insurers that file rates every three years: 78%	
Maryland	60%	75%	
Minnesota	65%	Groups of 2-9: 71% Groups of 10-50: 75%	Large group carriers: 82%
Nevada			Nonprofit corporations: 75% Individual dental insurance: 75%
New Jersey	75%	75%	
New York	80%	75%	
North Dakota	55%	70%	
Oklahoma		60%	
South Dakota	65%	75%	
Vermont	70%		Safety net market: 80%
Washington	77%		
Wyoming	60%	73%	

[text box]

A floor for health spending: an essential piece of a larger puzzle

Requiring insurers to spend a minimum percentage of revenue on health care can increase the efficiency with which health care is delivered and protect consumers. But it is not a panacea. A medical loss ratio only tells a consumer so much about the efficiency of a

[11] "Health Policy Memo: Medical Loss Ratios: Evidence from the States," *Families USA*, June 2008.

health insurer or quality of the health care coverage they have purchased. For example, a health insurer can boost its MLR by spending *more* on health care, whether those expenditures are warranted or not, rather than by curtailing administrative expenditures or profits. On the other hand, an insurer that invests in quality preventive care – thereby reducing the need for expensive tests and procedures – might have to cut back further on administrative expenditures and profits in order to meet a minimum MLR floor, a perverse result if the overall goal is to reduce wasteful health care spending.

In other words, requiring health insurers to achieve a minimum medical loss ratio is but one piece of the much larger puzzle of health care reform. The important purpose that a minimum medical loss ratio serves is to act as an incentive for insurers to prioritize efficiency and as a backstop protection for consumers to ensure that the money they spend on health care premiums is being spent for their benefit.
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Decision-makers in several states have considered requiring health insurance companies to spend at least 85 percent of their revenue on health care.

Requiring Health Plans and Insurers to Spend 85 Percent of Revenue on Health Care Is Achievable

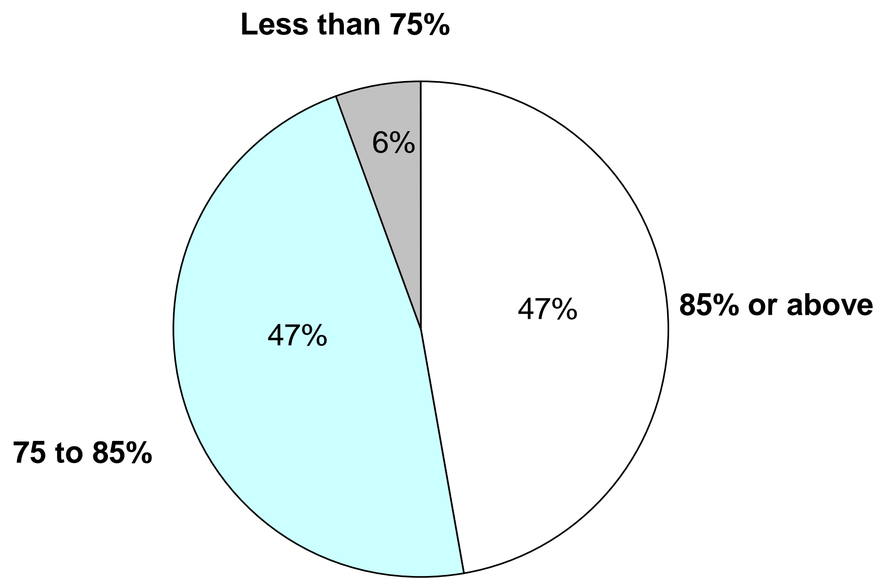
An 85 percent floor for the percentage of revenue health plans and insurers must spend on health care would ensure that health insurance companies are using most of the money they get from premium payments for medical expenses, and incentivize them to be more efficient in their administration and marketing. But these benefits would only be realized if insurers are actually able to meet the standard, which is higher than any other existing requirement. Data on current spending by health plans, however, shows that almost half of insurance providers already achieve this ratio, suggesting that those that do not could change their operations in order to measure up to their more efficient fellows.

To examine the experience in the states, we surveyed the percentage of revenue that health plans spent on medical care using the National Association of Insurance Commissioners consumer information source database. We looked at the six largest national health insurers, and sought their MLRs for their operations in 10 states across the country: Washington, Oregon, Nevada, Colorado, Michigan, Texas, New York, Massachusetts, Georgia, and Florida. In addition we sought out one locally important insurer for each state, identifying these either through the *U.S. World and News Report* lists of best health care plans by state, or, where available, through lists of the health insurance companies with the largest market share in a state.[12]

[12] Best health insurance plans: U.S. News & World Report and the National Committee for Quality Assurance, "America's Best Health Plans: Search By State, *U.S. News & World Report*, 7 November 2008. Available at http://health.usnews.com/sections/health/health-plans/index.html; health plans with the highest market share, by state: United States General Accounting Office, *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market*, 25 March 2002, available at http://www.gao.gov/new.items/d02536r.pdf. Note: six plans were identified through the U.S. News ratings, and only four of these had above average ratings. All six plans had MLRs above 85 percent. Though this

Of the 70 insurers chosen, unique MLRs were listed for 53 in the NAIC database (in some cases, insurers reported the same MLR for their operations in more than one state). Out of these 53 plans, 25 (47 percent) spent 85 percent or more of their revenue on medical care (See Figure 2). The remaining 28 plans (53 percent) spent less than 85 percent of their revenue on medical care. Percentages ranged from 56.1 to 95.2 percent.

Figure 2: The percentage of revenue that selected health insurance companies spend on health care.[13]



The plans spending the highest percentage of revenue on health care were Aetna Health of Washington (95.2 percent), Scott and White Health Plan of Texas (90.3 percent), and Empire Healthchoice Assurance of the Anthem group in New York (89.9 percent). The two plans that spent the lowest percentage of their revenue on health were outliers, with all other plans spending at least 70 percent of their revenue on health care. Those two plans were Humana Employers Health Plan in Georgia (56.1 percent) and Aetna Health Insurance Company in Oregon (57.3 percent). The next lowest-spending plan was Pacificare of Oregon (71.6 percent).

Among those insurers who did not meet the 85 percent threshold for health care spending, the vast majority (25 out of 28) achieved MLRs of between 75 and 85 percent,

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might bias the data in favor of better plans, if this small data set does affect our overall result that successful insurance companies can meet an 85 percent MLR floor, the fact that insurance companies with high-quality and successful plans had high MLRs only emphasizes the point.

[13] Medical Loss Ratios were obtained through the National Association of Insurance Commissioners (NAIC) Consumer Information Source, and can be found at https://eapps.naic.org/cis/.

suggesting that they would be able to comply with an 85 percent standard by taking comparatively modest steps to increase their administrative efficiency.

The data presented above should be viewed with a note of caution. There are a few ways to calculate the ratio, depending on what sources of income are counted as revenue and what expenses are counted as medical care, which may vary state by state. But it is inarguable the data from around the country show that an 85 percent minimum requirement for medical loss ratios is achievable, and in fact, is already met by many leading, profitable health plans and insurers across the country.

A similar study conducted of just California HMOs found that it is not only large, not-for-profit insurers who are able to meet the 85% standard. Three out of five California health insurers with fewer than 20,000 enrollees were also able to spend at least 85 percent of their revenue on health care. Similarly, a majority of both non-profit and for-profit California health insurance companies spent over 85 percent of their revenue on health care.[14]

Clearly, there is such a thing as spending too high of a percentage of revenue on health care – a company that spends its entire revenue on health expenses will not be financially stable. The data shows, however, that 85 percent is not a detrimental percentage of revenue to spend on health care. Many large, profitable companies spend at least that much on patient care.

Health Insurance Companies Should Be Required to Meet a Minimum Standard for Health Care Spending

While many health plans and insurance companies already spend more than 85 percent of their revenue on medical expenses, a number of companies spend less than that, and all private health plans and insurers face consistent pressure to reduce the share of revenue going to care. These companies contribute to the high cost of health insurance through inefficient administrative practices, money spent on marketing, and increasing profits.

A good example of this trend is Great-West Healthcare of California, which had the lowest ratio of any health care plan in that state. Great-West's MLR decreased every year from 2003 to 2007, from 85.8 to 69.1, and over the same period of time its profits increased from 0.5 percent to over 10 percent while the portion spent on administration stayed essentially the same.[15] In effect, Great-West simply decided to pocket a bigger chunk of customers' premiums as profits, reducing spending on care accordingly.

[14] California Medical Association, *15th Annual Knox-Keene Health Plan Expenditures Report*, June 2008 (FY 2006-2007).
[15] California Medical Association, *15th Annual Knox-Keene Health Plan Expenditures Report*, June 2008 (FY 2006-2007).

Health plans and insurers with low spending on health care waste millions of their members' dollars in premium payments that go towards inefficient administration, marketing, and profits.

By enforcing a minimum MLR of 85 percent, most of the money health plan and insurance purchasers spend on premiums would go towards health care, leading to administrative savings and health benefits. This floor would provide an incentive for companies to increase their health plans' efficiency and reduce administrative expenses. Current MLRs for health plans and insurers across the United States show that an 85 percent floor is achievable and is already met by many leading health plans.

Policy Recommendations

The U.S. should require health plans and insurance companies to spend at least 85 percent of their revenue on health care. This will encourage companies to increase the efficiency of their administrative practices. An 85 percent MLR floor is a necessary step towards making sure that more of the money we spend on health care is keeping us healthy.

When setting an 85 percent floor for the amount of money health plans and insurance companies must spend on health care, it will be important to calculate spending and revenue in a way that accurately capture companies' efficiency. The way that the percentage of revenue that an insurer spends on health care is calculated can change the effectiveness of a minimum standard. One of the biggest sources of discrepancy in calculating MLRs is the money health insurers receive from subcontracts with other health plans and insurance companies. Neglecting to count this money as premium revenue usually only increases MLRs by a few percentage points. However, some companies get a large portion of their revenue through subcontracts, and omitting this source of income can make insurers that spend very low percentages of their revenue on health care appear more efficient than they actually are. This sort of revenue source should be included when calculating total revenue for health insurance MLRs.

An efficiency standard will create a universal incentive for health plans and insurers to cut administrative costs and save enrollees money. We can make that incentive even more effective by taking additional steps to help contain these costs:

- Health insurers should develop standardized systems for billing and insurance payment that reduce administrative burdens on both insurers and physicians. State and federal government could incentivize health care providers to participate in a standard system, could make participation a requirement for insurers who provide health care coverage to state employees, or could simply mandate adoption of a system.
- Widespread adoption of electronic medical record systems, especially if they are compatible between different hospitals and physicians' offices, can simplify billing and facilitate information sharing among providers. Easier sharing of information can help doctors to make better-informed diagnoses and recommendations, and reduce duplicative efforts.

The U.S. should move quickly to establish an 85 percent floor for the percentage of revenue health insurance companies spend on keeping Americans healthy, and take other steps to reduce health care costs. Establishing an efficiency standard for health insurers is not a panacea and will not solve all of our health care problems. But it is an important backstop protection for consumers that ensures that they get their money's worth with the hard-earned dollars they spend on health insurance.

Appendix

Health Care Spending For Health Plans

Medical Loss Ratios (MLRs) for Selected Health Plans and Insurance Companies.[16]

Group/Regional	Health Plan or Insurance Company	State operating in	MLR
Aetna	Aetna Health Inc. WA Corp.	WA	95.2
Regional	Scott and White Health Plan	TX	90.3
Anthem	Empire Healthchoice Assurance Inc.	NY	89.9
Aetna	Aetna Health Inc. MI Corp.*	MI	89.7
Regional	Capital Health Plan Inc.*	FL	89.6
Regional	BCBS of MI	MI	89.6
Regional	Group Health Cooperative	WA	89.6
Cigna	Cigna Healthcare of MA Inc.	MA	89.4
Regional	Athens Area Health Plan Select	GA	89.3
Regional	Providence Health Plan	OR and WA	89.1
Cigna	Cigna Healthcare of NY Inc.*	NY	89
Aetna	Aetna Health Inc. CO Corp.	CO	88.9
Anthem	HMO CO Inc.	CO	88.9
Health Net	Health Net Insurance Company of NY Inc.	NY	88.9
Regional	Harvard Pilgrim Health Care Inc.	MA	88.4
Anthem	Anthem Insurance Co.	OR, WA, TX, FL	87.7
Anthem	Empire Healthchoice HMO Inc.	NY	87.6
Anthem	BCBS of GA Inc.	GA	87
Health Net	Health Net Health Plan of OR Inc.	OR, WA	87
UnitedHealth	United Healthcare Insurance Co of NY	NY	86.8
UnitedHealth	United Healthcare of GA	GA	86.5
Humana	Humana Health Plan Inc.	NV, CO	86.4
Regional	Rocky Mountain Healthcare Options Inc.	CO	85.7
UnitedHealth	United Healthcare of NY Inc.*	NY	85.7
Cigna	Cigna Healthcare of FL Inc.*	FL	85.3
Humana	Humana Advantagecare Plan	FL	84.4
Humana	Humana Health Plan of TX Inc.	TX	84.4
Cigna	Cigna Healthcare of TX Inc.	TX	84.1
Regional	Rocky Mountain HMO Inc.	CO	83.7
UnitedHealth	United Healthcare of FL*	FL	83.4
Cigna	Cigna Healthcare of GA Inc.	GA	82.7
Health Net	Health Net of NY Inc.*	NY	82.7
Aetna	Aetna Health Inc. TX Corp.	TX	81.8
Anthem	Rocky Mountain Hospital & Medical Service, Inc.	NV	81.6
UnitedHealth	United Healthcare of New England	MA	81.3
Aetna	Aetna Health Inc. FL Corp.*	FL	80.9
Aetna	Aetna Health Insurance Co. of NY	NY	80.6
Anthem	Blue Cross Blue Shield (BCBS) of GA Inc.	GA	80.5

[16] Medical Loss Ratios were obtained through the National Association of Insurance Commissioners (NAIC) Consumer Information Source, and can be found at https://eapps.naic.org/cis/. All numbers are for the year ending December 31, 2008, except for plan names marked by an asterisk, which are for the year ending December 31, 2007.

Regional	Oxford Health Plans NY Inc.*	NY	80.5
UnitedHealth	Pacificare of CO	CO	80.2
Regional	Oxford Health Insurance Inc.	NY	79.8
UnitedHealth	Pacificare of NV	NV	79.7
Cigna	Cigna Healthcare of CO Inc.	CO	79.3
Aetna	Aetna Health Inc. GA Corp.	GA	79.2
Aetna	Aetna Health Inc. NY Corp.*	NY	78.9
Aetna	Aetna Health Inc. AZ Corp.*	NV	78.4
UnitedHealth	Pacificare of TX	TX	78.1
Humana	Humana Health Insurance Company of FL Inc.	FL	77.7
Regional	Amerigroup TX Inc.	TX	76.4
UnitedHealth	Pacificare of WA	WA	75.9
UnitedHealth	Pacificare of OR	OR	71.6
Aetna	Aetna Health Insurance Company	OR	57.3
Humana	Humana Employers Health Plan GA Inc.	GA	56.1

* MLR is for 2007, as 2008 data was not yet available for these companies.

Plans from the six largest insurance groups, UnitedHealth, Anthem, Aetna, Humana, Cigna, and Health Net were surveyed in 10 states: Nevada, Oregon, Washington, Colorado, Texas, Michigan, Georgia, Massachusetts, New York, and Florida. A number of regionally important plans that were not otherwise represented were also included. Some insurance plans had the same financial data listed for a number of states; in this case, the MLR was only counted once, and the states we surveyed that had the same MLR were all listed together.