Underwriting Health Insurance & Medical Loss Ratio in Accountable Care Organizations

The Affordable Care Act (ACA) has redefined how an entire industry does business, and it remains to be seen if the healthcare insurance industry can survive the change. Key to the Affordable Care Act was the dissolution of underwriting practices and the institution of a more restrictive medical loss ratio for the industry. While supporter and detractors of the ACA regulations are battling it out in courtrooms and the media over the constitutionality of the act; the reality is that the health care industry has to deal with the changes immediately. The Affordable Care Act calls for private health care companies to reconfigure themselves into Accountable Care Organizations, forgo underwriting practices and to adopt a medical loss ratio that reduces revenue. This is creating a need for the industry to completely redefine itself in order to stay viable. While critics of the healthcare insurance industry may say it is a good thing to cut their profits and make them more accountable for care, the reality is that the new model of government regulated healthcare is dependent on private companies in order to be successful.

What is happening to the way things were

The Healthcare reform law has created quite a stir in the health insurance industry by putting in place regulations that change the way business is done. Prior to the new law, the core of the health insurance industry lay upon two practices – underwriting and negotiated rates. Both of these long standing operations are now disallowed by the new healthcare reform rules. Underwriting was a process in which consumers were accessed via a formula that took into account risk, cost, history and various demographic markers to determine the extent of coverage that would be offered to them under a health plan. It was the underwriting process that led to the adoption of the "pre-existing condition" clause which closed many people out of affordable health plan options. For companies that were contracting with a health insurance provider, the use of underwriting was essential in being able to formulate a context for allowable negotiations of rates. If companies could agree to certain preset clauses, their overall group rates could be significantly reduced. On a case by case basis, underwriters than approved care for members that helped to keep the group rates as low as possible. Often called a predatory and discriminatory practice, the practice of underwriting makes sound business sense. With the implementation of the health care reform laws however, health insurance companies are now faced with becoming a hybrid of a private business and a socialized service. The health care reform laws created a new grouping for health insurers requiring them to form Accountable Care Organizations in order to be in compliance with the new regulations.

What an Accountable Care Organization looks like

The easiest way to explain what an Accountable Care Organization (ACO) will look like is to look backward to the HMO (Health Maintenance Organization). HMOs consisted of a group of providers – such as doctors, clinics and hospitals – that all signed on as members underneath one insurer to provide for care for the insurer's members. With the ACO, the insurance companies are signing on as members of groups that are agreeing to provide care for members of a national group. The Accountable Care Organization is designed to allow Health Insurers to minimize profit loss while increasing their ability to provide affordable care by being able to pool networks of providers. It has been pronounced as the

“death knell” for the private insurance company as the ACO structure also accompanies a new federal definition of the allowable Medical Loss Ratio. The Medical Loss Ratio (MLR) is the ratio of dollars paid to provide care versus profit allowed.

The new Medical Loss Ratio (MLR)

Under the new regulations the Medical Loss Ratio is set at 85%. This means that the revenue earned by insurers must be reinvested into care provision up to 15%. This represents a radical reconfiguration of costs, revenues and loss for the industry. Prior to the new regulations, the MLR was 81% with an allowable 19% revenue margin. This 4% fall in allowance represents a serious hit to the potential profit of the industry. While it would be easy to jump and say that it will put most insurers out of business, it won’t. There are few insurance companies that make more than 15% of their earnings from providing care. These are corporations that have a broad investment and product scheme. What it does mean is that their investment and products schemes have to shift and be redesigned or the companies will face a fall in overall profits that can damage their credibility and credit rating. Companies that have avoided providing coverage through underwriting to persons with chronic and pre-existing conditions are now going to have to face losing that percentage savings in order to be on the right side of the new regulations for coverage. While this may seem like a rebalance in the favor of the health consumer, it creates a complicate issue when you begin to examine how insurers will regain those profit points.

How profit will be created

The core of the re-profiting for insurers is going to lie in overhauling care coordination and discarding the discounted point of service model of health plans. Key to this is the effective adoption and implementation of electronic health records (EHR) across the industry. The EHR is the only way in which Accountable Care Organizations are going to be able to function in a profitable manner. Currently, insurers maintain isolated databases and the majority of health records is maintained and transmitted in paper form. This is not a practical means for updating or transmitting information in a timely manner which can maximize care coordination. As the process moves forward, the speed at which Accountable Care Organizations can interact with each other to coordinate care will be the single greatest source of lowering health management costs. By allowing for fast coordination, consumers will be placed into an active system of preventative and treatment care faster than ever before. The EHR is also making use of the new ISD 10, required to go into effect in October of 2014, which serves to standardize further the CPT codes and other code formats for diagnosis, treatment and medical supplies across providers. For insurers, profit is going to be sustained based upon their ability to move consumers into and through a system as fast as possible to negate the need for advanced care because of developed conditions. Another revenue stream that will be developing for them is to provide the systems administration for EHR coordination between insurers, providers, hospitals and consumer organizations.

The hidden impact on consumers

The initial implementation of the regulations governing underwriting and medical loss ratio is creating an impact on consumers that has not been noticed by many as yet, but reveals a core problem with the structure of the regulations. The reduction in the MLR is leading insurers and Accountable Care

Organizations to seek to streamline their care provision costs and the first demographic that is feeling this effect are those who have mental illness. Long a group that is underserved by the insurance industry due to the chronic nature of their illness and the lack of consistent diagnosis and treatment by the medical profession, the first test of the regulatory system is coming from a challenge to Medicare D prescription coverage. Several bills are being introduced to effectively gut the range of psychiatric medicine that would be provided for under the Affordable Health Care act that represents the first step towards controlling costs and maximizing profit by reducing the range of treatments available. There has already been an unheralded reduction in the types of medications and antibiotics covered by Medicare and free medicine programs in anticipation of the new regulations. ACOs are now moving forward to reduce the amount of expensive treatments that are not statistically supported as a necessary and required course of care from the eligible lists of treatments they must provide. It remains to be seen how far this initiative will get, and how its level of success will then allow for further reduction in potential treatments, as well as affect the coverage potential for experimental treatments as well.

Managing care service while maintaining business profit

The application of a socialized medical care model to a system that is powered by privatized care providers and insurers is going to require a new hybrid business model in order to keep both systems operating in the black. While Accountable Care Organizations face a restriction of only being allowed 15% of their profit to come from care provision, there is ample opportunity to develop new, compatible revenue streams that can take advantage of the broad based care model. Investing in the development of prevention programs and the creation of wellness oriented service businesses, as well as providing EHR management technology and service remains the best choice for expanding revenue for insurers without running afoul of the new regulations. Given time, the private companies will evolve to redefine the care provider industry in ways that can only be imagined now.