THE FEASIBILITY OF MEDICAL LOSS RATIO FOR DENTAL INSURANCE PATIENTS AND CONSUMERS

HIGH-LEVEL SUMMARY

State-level medical-loss-ratio requirements for dental insurers, legislators could ensure that consumers and patients profit from a competitive and affordable market. This would serve the following benefits:

- Keep dental insurance accountable
- Unlock benefit spending for patients
- Promote competition among insurers

INTRODUCTION

In the current paradigm of American healthcare, there is an inordinate amount of focus, resources, and legislation relating to insurance. And for good reason.

Beginning with various legislative efforts over the years and culminating in the Affordable Care Act (ACA), signed by President Obama in 2010, there are incentives and penalties that consumers face which nudge them toward acquiring health insurance.

The ACA set up state-based public exchanges where private health insurers would offer plans to potential consumers on a rolling basis. Until 2018, when a GOP-controlled Congress repealed it, those who did not have health insurance were subject to a yearly penalty by the IRS.

Though the federal government itself spends over $1.8 trillion directly on healthcare (largely on Medicare and Medicaid), a majority of Americans — over 66% — have insurance plans with private insurers, overwhelmingly through their employers. In 2021, private health insurers paid out over $1.2 trillion in benefits on behalf of their customers.

The price inflation that comes with the amping up of health insurance plans in our entire system — not to mention the role of government subsidies — is a well-known phenomenon. Insurance becomes involved in every rudimentary doctor visit or procedure, leading to bad incentives for health providers, employers, and insurance companies. This process involves a middleman in what should be a simple medical contract between patient and practitioner. Regardless of that fact, our existing laws mandate health coverage.

For most Americans, that means our healthcare experience is reliant upon an insurer to cover procedures and emergency costs, as well as the hope of reimbursement for large chunks of health spending with providers.

As a compromise for opening the public exchanges, the ACA also stipulated a medical-loss-ratio requirement as a condition for health insurers who wish to offer plans to consumers.

MEDICAL-LOSS-RATIO

A medical-loss-ratio is the percent of premium income that insurers pay out in the form of medical claims. Traditionally, this measurement is used by the insurance industry to gauge the solvency and financial health of a firm.

Under the ACA, all health insurers are required to meet a threshold of benefits paid out to consumers, usually around 80% depending on the size of the plan. If an insurer does not meet this threshold, they must offer rebates to customers.

Though traditional health insurance firms are subject to medical-loss-ratios, the same does not apply to dental insurance. States like California require annual accounting of medical-loss-ratios for dental insurers, but only one state, Massachusetts, enforces a certain threshold.

Similar to traditional healthcare, over 59% of American adults have private dental benefits, through their employers. Unlike traditional health insurance, however, dental insurance offers much less in terms of benefits and cost coverage. Traditional plans are capped near $1,500, leaving patients meeting the cap responsible for the remaining dental care costs for the year. While dental care is a vital component of an American's overall health, the market for insurance has not proven as innovative nor flexible as traditional health insurance, which in turn limits choice for consumers.

MLR IN DENTAL INSURANCE

To ensure adequate patient access to their dental benefits, various proposals in state legislatures and on ballot referenda have attempted to apply similar medical-loss-ratio requirements on dental insurers that currently apply to traditional health insurers.

The purpose of the medical-loss-ratio requirements, specifically in the United States, is to ensure that insurance premiums collected are used for the purpose of care provision, rather than administration or bureaucracy.

Rather than limiting or capping profits or administration, medical-loss-ratio requirements only stipulate that the proportionality of claims versus benefit spending remain above a certain level. If that level is not achieved, then patients have the right to a rebate.

It is a small measure of accountability and transparency in an industry that is notably opaque.

They also serve as a countermeasure to insurer efforts to deny claims by patients seeking reimbursement, a scenario many consumers are all too familiar with.

And while medical-loss-ratios have now become standard in overall health coverage, the same scrutiny is not applied to dental plans, which operate on the same model and also benefit from the same gatekeeping effect of state and federal laws.

The reason loss-ratios exist in health insurance relates not just to the expense in question — paying for your care — but also because insurers are uniquely protected by governments.

Insurers are highly regulated entities and usually benefit from a limited number of competitors due to strict federal and state laws that narrow the field of who can offer health insurance products. Dental insurance products are mainly purchased through employers, meaning that competition between dental plans is largely restricted to price rather than the true value the plan offers to patients. These two factors

ensure minimal competition that would otherwise greatly benefit consumers and patients.

This ensures minimal competition that would otherwise greatly benefit consumers and patients.

In the absence of larger reforms that would open the market and expose dental insurers to more competition, thus lowering prices, it is worth considering whether medical-loss-ratios may play a part in providing more value to patients and consumers.

IMPLICATIONS

In 2022, voters in the Commonwealth of Massachusetts overwhelmingly passed a ballot measure requiring medical-loss-ratios for dental health insurers.

The measure applies the same reporting and rebate scrutiny for dental insurers as health insurers, requiring that any dental insurer spend at least 83% of their premiums collected on patient care.

Though the provision will not apply until January 2024, early analysis indicates that the law is creating much-needed debate about better claims payouts and affordability for dental patients.

At its core, the effort aims to unlock more funds for dental patients and grant them more consumer choice. By setting a target goal for benefit spending, it orients benefits paid to patients more in proportion to the premiums they pay — either individually or through their employer.

By passing state-level medical-loss-ratio requirements for dental insurers, legislators could ensure that consumers and patients profit from a competitive and affordable market. This would serve the following benefits:

- Keep dental insurance accountable
- Unlock benefit spending for patients
- Promote competition among insurers

Opponents of medical-loss-ratio requirements for dental insurance, notably dental insurers, believe such thresholds limit their investment and profit potential for the long term. Other critics maintain that mandating such high levels will cause insurers to be less risk averse when paying out claims, perhaps facilitating fraud.

However, the use of medical-loss-ratio requirements in traditional health insurance has overall been a boon to insurers, creating a more competitive market and increasing profitability on the whole. Insurers have been incentivized to cut costs, expand offerings, and create more flexible plans for consumers who want them. The main purpose of the medical-loss-ratio is the dual measure of accountability and rebates to increase benefits to insured consumers.

INTERNATIONAL COMPARISONS

In an international comparison, health insurance administrative costs of 15-20 percent are relatively high. Health systems such as Switzerland, Germany, and the Netherlands generally deliver around 90-94 percent, a much higher solvency than what is required by the 80% medical-loss-ratio in the United States, where it is mandated for traditional health insurance. Full indemnity private health insurance firms in Germany, for example, maintain a medical-loss-ratio of over 90 percent, despite no mandated minimum.

This is likely due to two factors: increased competition

between insurers, who can compete nationwide in a freer market on a larger scale, and the independence of most health insurance from employment, providing more flexibility for plan construction and pooling to benefit consumers. There is a myriad of other factors that lend to a more competitive and affordable insurance market for traditional healthcare in European countries, which may provide a blueprint for future American reforms.

TOWARDS A MORE OPEN AND COMPETITIVE MARKET

While medical-loss-ratio requirements are a helpful first step in unlocking savings for patients and consumers, as well as promoting transparency and competition, there is much more that could be done to radically improve our approach to insurance and patient care.

Encouraging competition to traditional dental insurance, while promoting simple regulations to promote financial transparency, will serve to empower consumers and lower the costs of care. As would decoupling dental insurance from employment.

At present, 93% of privately insured dental patients receive coverage from their employers, meaning there is little incentive to innovate with direct-to-consumer options that would offer competition.

State legislatures should first look to encourage patients to consider membership programs as dental plans, rather than traditional insurance, or to promote the expansion of membership plans altogether. This would give patients more choices in coverage options rather than a limited pool of traditional insurance plans. Using Health Savings Accounts to buy these memberships, as well as pay for care, would also be a huge improvement empowering patients to contract their own care.

This would be similar to the movement of direct primary care doctors, who offer direct monthly subscriptions to patients and do not accept insurance. Removing the insurance middleman means less bureaucracy, less red tape and more time spent serving patients. As a plus, prices are transparent and fair. That alone would provide better competition and prices for patients in need.

The result would be a broad decoupling of health and dental insurance from employers, allowing patients and consumers to choose the plan that works best for them and their families.

CONCLUSION

To achieve a more open, transparent, and competitive market for dental insurance, a medical-loss-ratio requirement is a good first step to improve the system for patients and consumers. By keeping insurers accountable and promoting competition, these provisions would unlock new benefits for patients and help to improve the wellbeing and affordability for dental patients across the country.

Since enacted in the Affordable Care Act, medical-loss-ratio requirements have not contained the rising cost of health expenditures overall, as was claimed by initial proponents, but they have made marginal improvements that are a welcome first step to a more competitive industry. Yet more should be done to contain costs, open markets, and subject healthcare and health insurance to real competition.

Large scale reforms aimed at decoupling insurance from employers, providing more direct-to-consumer options that eschew insurance, and removing red tape at both the state and federal level would be long overdue reforms to empower consumers within a competitive and thriving market for dental care.

ABOUT THE AUTHOR

YAËL OSSOWSKI

Deputy Director

Yaël Ossowski is a writer, radio host, and deputy director at the Consumer Choice Center.

Since 2010, he has worked as a journalist and grassroots organizer in Europe and North America. He was previously Watchdog.org's Florida Bureau Chief, chief Spanish translator, and national investigative reporter from 2012-2015.

He is a contributor to Metropole Magazine in Vienna and has contributed to The Chicago Tribune, Washington Examiner, Le Journal de Montréal, Les Affaires, Charlotte Observer, Miami Herald, and more. He has had over 600 articles published in newspapers, magazines, and online outlets.

Yaël is co-host of the internationally-syndicated Consumer Choice Radio on WFBT Big Talker 106.7FM in Wilmington, North Carolina and Sauga 960AM in the Peel Region of Ontario, Canada.

He studied at Concordia University in Montréal and the University of Vienna, and received an MA in Philosophy, Politics, Economics (PPE) at the CEVRO Institute in Prague.

CONSUMER
CHOICE
CENTER

info@consumerchoicecenter.org
www.consumerchoicecenter.org

700 12th St N.W Suite 700 PMB 94982
Washington, DC 20005