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Issue Brief

Insurers' Responses to Regulation of Medical Loss Ratios

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ABSTRACT: The Affordable Care Act's medical loss ratio (MLR) rule requires health insurers to pay out at least 80 percent of premiums for medical claims and quality improvement, as opposed to administrative costs and profits. This issue brief examines whether insurers have reduced administrative costs and profit margins in response to the new MLR rule. In 2011, the first year under the rule, insurers reduced administrative costs nationally, with the greatest decrease—over $785 million—occurring in the large-group market. Small-group and individual markets decreased their administrative costs by about $200 million each. In the individual market, insurers passed these savings on to consumers by reducing their profits even more than administrative costs. But in the large- and small-group markets, lower administrative costs were offset by increased profits of a similar amount. Stronger measures may be needed if consumers are to benefit from reduced overhead costs in the group insurance markets.

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OVERVIEW

One of the most important consumer protections in the Patient Protection and Affordable Care Act is the regulation of health insurers' medical loss ratios (MLRs). The MLR is a key financial measure that shows the percentage of premium dollars a health insurer pays for medical care and health care quality improvement expenses, as opposed to the portion allocated to overhead in the form of profits, administrative costs, and sales expenses.[1]

The Affordable Care Act sets minimum MLRs for insurers to reduce overhead and thus the ultimate cost of insurance to consumers and the government. As of January 1, 2011, insurers offering comprehensive major medical policies must maintain an MLR of at least 80 percent in the individual and small-group markets and 85 percent in the large-group market.[2] Limiting insurers' medical loss ratio can benefit consumers in two distinct ways:

1. Insurers that pay out less than these percentages on medical care and quality improvement must rebate the difference to their subscribers.

2. To avoid having to pay rebates, insurers may reduce overhead (consisting of administrative costs and profits) and restrain premium increases.

Consumers received their first MLR rebates in August 2012—amounting to over $1 billion—from health insurers that failed to meet the requirements. Other studies have examined the size and distribution of these rebates.[3] This analysis focuses on the second type of consumer benefit: whether insurers reduced their administrative costs without increasing corporate profits, so that administrative savings are passed on to consumers in the form of restraining premium increases, rather than benefitting insurers' bottom lines.

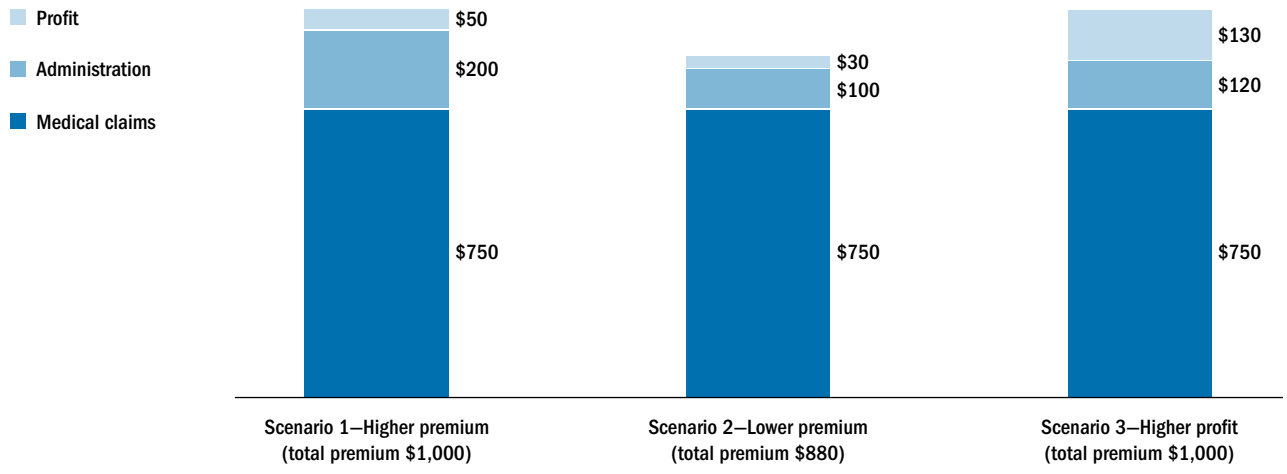
To understand how insurers might respond to MLR limits, it helps to think of insurance premiums being devoted to three possible uses. As shown in Exhibit 1, the major use of premiums is to pay medical claims, but a smaller portion is devoted to overhead, in the form of administrative costs and corporate profits. With the MLR regulation insurers are now required to limit what they devote to overhead. The goal is to encourage insurers to reduce premiums a commensurate amount in order to benefit consumers, as shown in Scenario 2.

Suppose, for instance, that the total premium shown in Scenario 1 is $1,000, with $200 devoted to administration, $50 retained as profit, and the rest ($750) spent on medical claims. With only 75 percent of the premium spent on medical claims, the MLR rule would require this insurer to pay a rebate of $50 if it were in the individual or small-group markets (80% of $1,000 = $800 – $750 = $50) or $100 if it were in the large-group market (85% of 1,000 = $850 – $750 = $100). That rebate either would eliminate the insurer's profit of $50 (in the case of individual/small-group markets) or cause it to take a $50 loss in the large-group market.

To avoid paying a rebate, the insurer might reduce its administrative costs and profits and lower its premium, as shown in Scenario 2. For instance, if the insurer reduces administrative costs from $200 to $100 and lowers profits from $50 to $30, the resulting premium would be $880 ($100 + $30 + $750 = $880). Then, the $750 the insurer spends on medical claims would meet the MLR rule (85% of $880 = $748). With a premium that is $120 lower, consumers would be even better off under this scenario than with the $50 or $100 rebates under Scenario 1.

Alternatively, an insurer might reduce its administrative costs, for example from $200 to $120, but keep premiums at $1,000, as shown in Scenario 3. This means profits would increase to $130 ($1,000 premium – $750 medical claims – $120 admin. costs = $130 profits). Even though this insurer would owe the same rebate as in the first scenario, it would now have more than enough profits from which to pay the same $50 or $100 rebate. Thus, the administrative cost savings would only benefit the insurer, not consumers.

Exhibit 1. Uses of Insurance Premiums—Three Scenarios



Source: Authors' analysis.

Thus, to gauge the consumer benefits of the new MLR rule, it is important not only to track rebates, as others have done, but to look for changes in insurers' administrative costs and profit margins, even when they do not owe rebates. This issue brief does this by comparing how health insurers' administrative costs and profit margins changed from 2010, the year just before the MLR rule took effect, and 2011, the first year under the new rule.

Because this is an uncontrolled "natural experiment," it is likely that other factors also influenced insurers' behavior in addition to the new MLR rule. These may include competitive and state regulatory factors, all of which drive insurers' pricing decisions and operational strategies. However, the 2010–11 time span is a good test case because this is when insurers began to incorporate the new MLR limits into their business strategies. Also, during 2011 the rise in medical costs moderated slightly, to 7.3 percent, down a half point from the trend over the prior four years.[4] If insurers did not anticipate this reduction in their 2011 pricing, then they would be at greater risk of exceeding MLR limits.

Data Sources

Data for this study come from the Supplemental Health Care Exhibit in the annual financial reports that nearly all health insurers file each year with the National Association of Insurance Commissioners. Insurers file this form for each subsidiary in each state in which they sell comprehensive health insurance. In 2010 and 2011, more than 2,000 health or life insurers filed these forms. To observe how plans responded to the new MLR rule, we included only those that reported data in both years. The final two-year sample consisted of 1,219 insurers in the individual market, 804 small-group insurers, and 750 large-group insurers.

Within each state, we aggregated financial and membership data for each market segment (individual, small group, and large group) to provide a statewide picture of insurers' financial performance under each of the three components of the new MLR rule. (See box for more detail on these financial performance measures.)

Measuring Health Insurers' Financial Performance: A Guide to Terminology

Membership is the average number of people a health plan covers over the course of the year.

The Affordable Care Act defines ***small employers*** as those with 100 or fewer employees, but since many states currently define a small employer as having 50 or fewer employees, states are allowed to maintain that definition until 2016. Nongroup insurance constitutes the ***individual market***.

Premiums earned are health premiums net of premium taxes and other regulatory assessments.

Medical expense is net incurred medical claims plus expenses incurred for improving health care quality.

Administrative costs are all nonmedical expenses, including those for sales and claims adjustment, as well as general corporate overhead costs (except for health care quality improvement expenses, which are counted as medical expenses).

Profit margin is also known as the underwriting gain or loss. It is calculated by subtracting medical expense and administrative costs from net premium earned. As such, it does not include profit/loss from investments, and does not account for general corporate taxes. A negative profit margin indicates that medical and administrative costs exceeded premiums.

Total overhead refers to the component of premium that is not spent on medical costs or improving quality of care. It equates simply to the residual of the medical loss ratio, or the sum of administrative costs and profit margin.

Unadjusted medical loss ratio measures the percentage of premium that insurers spend on medical claims and quality improvement. This ratio does not fully account for several adjustments that insurers are permitted to make in calculating whether they comply with the MLR rule or owe a rebate.

IMPACT OF THE MEDICAL LOSS RATIO RULE ACROSS INSURANCE MARKETS

Exhibit 2 presents the overall picture of consumer benefits potentially related to the regulation of insurers' medical loss ratios. The insurers that fell below the MLR minimums in 2011 will pay out $1.1 billion in rebates. In addition, the insurance industry reduced overhead costs by $350 million from 2010 to 2011, which could benefit consumers.[5] Reduced overhead can take the form of lower administrative costs or lower profits or both, as explored below. This produced a combined consumer benefit of $1.45 billion.

As shown in Exhibit 2, the consumer benefits differed across market segments. Also, as shown in Exhibit 3, changes in administrative costs, profits, and medical loss ratios varied considerably across different market segments. The following sections explore these key findings for each market segment in more detail.

The Individual Market: Substantial Gains for Consumers

Consumers in the individual market benefitted substantially under the new MLR rule. According to government reports, insurers that fell below the minimum loss ratio will rebate $394 million to consumers in the individual market (Exhibit 2).[6] In addition, between 2010 and 2011, health insurers reduced both their administrative costs and profits, so that the total amount of premium revenue devoted to overhead, both administrative costs and profits, decreased by $560 million in the individual market (Exhibit 2).

This substantial overhead reduction occurred even though enrollment in the individual market grew by almost a quarter of a million people in 2011. On a per capita basis, reduced overhead amounted to $66 per member ($31 + $35). Of the 35 states with lower overhead per member in the individual market, six had decreases of more than $200 per member (NM, WV, ME, CT, MO, and SC), while only three states (RI, NJ, and NC) had increases this large (Appendix Exhibit 1).

This reduction in overhead included a $209 million reduction in administrative costs, amounting to $31 per member.

Thirty-nine states saw reductions in administrative costs per member, with per-member amounts reduced by $99 or more in five states (DE, OH, LA, SC, and NY), and $50 or more in 10 other states (NV, OK, TX, IL, GA, IN, SD, NC, NM, and CT) (Appendix Exhibit 1). Only in Rhode Island and Massachusetts did administrative expenses increase more than $100 per person.

The other component of reduced overhead was lower profit margins, indicating that overall premium growth was restrained in the individual market. In 2010, individual insurers had an operating profit margin of 0.15 percent overall, but this dropped to an operating loss of –1.2 percent in 2011, amounting to a $351 million reduction in operating profits overall (Exhibit 3). On a per-member basis, individual insurers' operating profits diminished (or losses increased) by $35.

Thirty-four states saw reductions in operating profits per member (Appendix Exhibit 1). Per-member reductions averaged $100 or more in 18 states (NM, WV, ME, AR, CT, MO, MS, WI, VA, AZ, TN, WA, NE, SC, IN, TX, FL, and VT). Per-member profits increased more than this amount in only eight states (RI, NC, NJ, DE, ND, WY, MN, and LA).

Consistent with these patterns, the medical loss ratio in the individual market increased 3.3 percentage points between 2010 and 2011, from 80.8 percent to 84.1 percent (Exhibit 3), based in part on medical costs increasing $159 per member (Appendix Exhibit 1). Thirty-seven states saw increases in the overall MLRs (unadjusted) for their individual market, with increases of 10 percentage points or more in five states (NM, MO, WV, TX, and SC). Only Rhode Island saw MLR reductions this large.

The Small-Group Market: Cost Savings Offset by Higher Profits

Consumers in the small-group market received less benefit than those in the individual market under the new MLR rule. Small-group insurers that fell below the minimum loss ratio rebated a significant amount ($321 million) to consumers (Exhibit 2). Yet, looking at this market segment as a whole, small-group insurers

Exhibit 2. Change in Overhead and Rebate Amounts Owed, 2011

	Individual	Small group	Large group	Total
Change in overhead, 2010–11	–$560 million	$36 million	$174 million	–$350 million
Rebate owed	–$394 million	–$321 million	–$386 million	–$1.1 billion
Total	–$954 million	–$285 million	–$212 million	–$1.45 billion

Note: Rebate values are reported by CMS for all health plans, while the change in overhead is computed from the smaller sample of health insurers selected for this analysis.

did not reduce their nonmedical overhead, as they did in the individual market.

Although small-group insurers reduced their administrative costs by $190 million, this contributed to higher profits of $226 million (Exhibit 3). Therefore, small-group insurers increased by $36 million the amount of premium revenue they devoted to total overhead in 2011 (Exhibit 2). Total overhead remained nearly steady in the small-group market nationwide, despite the fact that administrative costs dropped significantly, because small-group insurers simultaneously increased their profits by a slightly larger amount than their administrative cost savings. This indicates that they failed to pass these cost savings on to consumers in the form of restrained premiums.

Because enrollment also increased in the small-group market, this higher total overhead constituted a small reduction of $5.82 in overhead per

Exhibit 3. Change in Administrative Costs, Profits, and Medical Loss Ratio, 2010 to 2011, by Market Segment

Market segment	2010	2011	Change
Individual market			
Members	9,880,141	10,112,444	232,303
Administrative costs	$4,567,499,331	$4,358,591,410	–$208,907,921
Administrative/member	$462	$431	–$31
Operating profit	$36,869,384	–$313,911,847	–$350,781,231
Profit/member	$4	–$31	–$35
Medical loss ratio	80.8%	84.1%	3.3% points
Small-group market			
Members	16,929,676	17,145,535	215,859
Administrative costs	$8,575,445,177	$8,385,115,996	–$190,329,181
Administrative/member	$507	$489	–$17
Operating profit	$2,042,246,229	$2,268,122,631	$225,876,402
Profit/member	$121	$132	$12
Medical loss ratio	83.6%	83.6%	0.1% point
Large-group market			
Members	37,409,353	37,156,902	–252,451
Administrative costs	$12,759,642,743	$11,974,384,975	–$785,257,768
Administrative/member	$341	$322	–$19
Operating profit	$2,557,131,436	$3,516,388,736	$959,257,300
Profit/member	$68	$95	$26
Medical loss ratio	89.1%	89.2%	0.1% point
Total insured	64,219,170	64,414,881	195,711

Notes: For the individual market, total premiums earned were $23,989,034,449 in 2010 and $25,488,339,831 in 2011, and medical costs were $19,384,665,737 and $21,443,660,265, respectively. For the small-group market, total premiums earned were $64,537,517,787 in 2010 and $65,055,805,260 in 2011, and medical costs were $53,912,749,758 and $54,402,566,483, respectively. For the large-group market, total premiums earned were $140,661,963,437 in 2010 and $143,033,750,738 in 2011, and medical costs were $125,367,094,542 and $127,542,977,497, respectively.
Source: Authors' analysis of Supplemental Health Care Exhibit data, National Association of Insurance Commissioners.

member for the year. Nine states had increases in nonmedical overhead of over $100 per member (RI, AK, NH, ND, MA, AL, VT, MI, and IA) (Appendix Exhibit 2). The six states with the greatest per-member decreases (over $100) were KY, PA, NM, DE, VA, and NE.

Nationally, the reduction in small-group administrative costs amounted to $17 per member in 2011 (Exhibit 3). Thirty states saw reductions in small-group administrative costs per member, with per-member decreases of $99 or more in three states (LA, NE, and NV) and $50 or more in nine other states (WA, DE, NC, TX, KY, WI, PA, WV, and VT) (Appendix Exhibit 2). Administrative expenses increased more than $100 per small-group member in three states (MA, AK, and CT) and by more than $50 in four others (NJ, MD, MN, and MS).

About half of the states (28) saw increases in small-group profits per member (or decreases in losses) in 2011 (Appendix Exhibit 2). Among states with lower profits, the average per-member reduction was more than $100 in only three states (NM, VA, and MD). Twelve states (RI, AK, NH, ND, VT, IA, AL, OH, WY, NC, NV, and MA) had profit increases of $100 or more per member, with Rhode Island topping the list at $897 per member.

The medical loss ratio (unadjusted) in the small-group market was basically constant between 2010 and 2011, moving only from 83.55 percent to 83.62 percent (Exhibit 3). Twenty-eight states saw increases in the overall MLRs (unadjusted) for their small-group market, with increases of two percentage points or more in 12 states (NE, VA, DE, UT, WI, NM, KY, AZ, MO, WV, OK, and MD) (Appendix Exhibit 2). Ten states saw MLR reductions of more than two percentage points (RI, ND, NH, MA, AK, WY, VT, AL, MI, and IA).

The Large-Group Market: Medical Loss Ratios Virtually Unchanged

Large-group insurers that fell below the minimum MLR in 2011 also paid a significant amount in rebates ($386 million), but at the same time the amount of premium revenue that large-group insurers overall devoted to overhead increased by about half this amount, to $174 million (Exhibit 2). Even though large-group insurers reduced their administrative costs by $785 million, they were able to boost profits by $959 million (Exhibit 3).

Seven states (MA, RI, WY, WV, HI, MI, and NH) incurred overhead increases of more than $100 per member in the large-group market (Appendix Exhibit 3). Twenty-one states decreased their total overhead, but only Alaska and Nevada reduced it by more than $100 per member.

On a per-member basis, administrative cost reductions were $19 per member but profit increases were $26 per member (Exhibit 3). Twenty-six states saw reductions in administrative expenses, with per-member amounts of $99 or more in six states (NV, RI, AK, AZ, NJ, and OH), and $50 or more in four other states (KY, MO, LA, and WV) (Appendix Exhibit 3). In no state did administrative expenses rise more than $100 per large-group member. Per-member increases were more the $50 in four states (MD, KS, AR, and TN).

Nineteen states experienced declines in large-group operating profits per member in 2011, with decreases of more than $100 per member in Alaska and $50 or more in five other states (AR, WI, NM, MD, and MS) (Appendix Exhibit 3). In 10 states (RI, WV, NV, MA, NJ, HI, WY, SC, PA, and NH), insurers increased their large-group profits by $99 or more per member, with Rhode Island topping the list at $358 per member.

The medical loss ratio in the large-group market remained virtually unchanged, increasing only from 89.11 percent in 2010 to 89.17 percent in 2011 (Exhibit 3). Large-group insurers were able to increase profits and total overhead without lowering the medical loss ratio market-wide because total medical costs also increased a commensurate amount. Twenty-two states saw increases in the overall MLRs (unadjusted) for their large-group market, with increases of two percentage points or more in five states (AK, NV, KY, IN, and NE). Seven states saw MLR reductions of

this magnitude (HI, RI, MA, WV, WY, MI, and SC) (Appendix Exhibit 3).

CONCLUSION AND IMPLICATIONS

The implementation of the MLR rule in 2011 presents a unique opportunity to observe insurers' initial responses, with a reasonable degree of confidence that the new rule was a substantial factor driving changes in key financial measures. Nationally, administrative costs decreased across all three markets. The greatest dollar-value decrease occurred in the large-group market, which saw a reduction of more than $785 million in administrative costs. Small-group and individual insurers decreased their administrative costs by $190 million and $209 million, respectively.

For the large-group and small-group markets, this reduction in administrative costs coincided with similar increases in profits between 2010 and 2011, of almost $1 billion and $226 million, respectively. A different pattern emerged from the individual market, where profit margins declined even more than administrative costs, by $351 million between 2010 and 2011.

Although the MLR rule, along with other market and regulatory factors, prompted reductions in administrative expenses in all three market segments, in the group markets it appears that insurers were able to retain those cost reductions in the form of increased profits, rather than passing them on to consumers in the form of reduced premiums. By contrast, both administrative costs and profits dropped in the individual market, indicating that consumers benefitted in the form of restrained premium increases. Premiums did increase somewhat, because of the growth in medical costs, but the increases were less than medical cost increases.

One possible explanation for this difference among the three markets is that meeting the minimum MLR in the individual market of 80 percent required insurers to cut profits more in that market than in the group markets. This is because historical pricing patterns had previously supported MLRs lower than 80 percent in the individual market, but not in the group markets.[7] This suggests that, in future years, the MLR rule may need to be coupled with regulatory pressure in order for any further reductions in administrative costs to be reflected in reduced premium rates.[8]

On the other hand, further pressure on premium rates might cause some insurers to leave certain market segments, if they cannot maintain adequate profits. It is possible that some or many insurers responded to the new MLR rule by reducing administrative costs across the board, since many of these costs are shared across all lines of business, and not just the individual market where insurers were most likely to fall below the MLR minimums. In the group markets, where insurers' medical claims were closer to or already in compliance with the MLR rule, insurers may have aimed to set their premium rates at a level that generates more profits in order to offset reduced profits in the individual market. Going forward, if insurers are not able to balance overall profitability in this manner, some might choose to withdraw from less-profitable market segments, which could leave consumers with fewer choices as well as higher premiums.

Regardless of these theoretical concerns, overall changes in financial measures that appear related to the MLR rule benefitted consumers in 2011 by reducing insurers' total overhead—both profit and administrative costs—by $350 million. The individual market contributed the largest component of this decrease in total overhead, with a decline of $560 million. However, the small- and large-group markets offset a third of this decrease by increases in total overhead of $36 million and $174 million, respectively, in 2011.

Changes in total overhead varied widely among states (Appendix Exhibit 4). Thirty states had net reductions of health insurance overhead in 2011, with reductions of more than $100 million in five states (FL, MD, VA, IL, and WI). However, insurers in four states increased their total overhead by more than $100 million (MA, MI, RI, and CA). Changes in profit margins, more than in administrative costs, were the primary drivers of these larger-magnitude increases and decreases (see Appendix tables).

The primary aim of the MLR regulation was to restrain the proportion of premium dollars that insurers apply to profits and administrative expenses, with

the hope that lower overhead will produce lower overall premiums (after taking any rebates into account). Initially, the new minimum loss ratios appear to be producing important consumer benefits in the individual market, but much less so in the group markets. Although insurers have reduced their administrative costs and paid substantial rebates in all three market segments, the rule has not reduced total overhead market-wide in the small- and large-group segments. For that to occur, stronger measures may be needed, either in the form of rate regulation, tighter loss ratio rules, or enhanced competitive pressures.

NOTES

[1] D. A. Austin and T. L. Hungerford, "The Market Structure of the Health Insurance Industry," Congressional Research Service, Sept. 2009.

[2] "Interim Final Rule for the MLR for State Health Plans," *Federal Register,* Dec. 1, 2010 75(230):74864–934, available at http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf; and Centers for Medicare and Medicaid Services, "Medical Loss Ratio: Getting Your Money's Worth on Health Insurance" (Baltimore: CMS, Nov. 22, 2010), available at http://www.healthcare.gov/news/factsheets/2010/11/medical-loss-ratio.html.

[3] Center for Consumer Information and Insurance Oversight, "Medical Loss Ratio List of Health Insurers Owing Rebates in 2012" (Baltimore: CCIIO, July 10, 2012), available at http://cciio.cms.gov/resources/files/mlr-issuer-rebates-20120710.pdf; and Centers for Medicare and Medicaid Services, "The 80/20 Rule: Providing Value and Rebates to Millions of Consumers" (Baltimore: CMS, 2012), available at http://www.healthcare.gov/law/resources/reports/mlr-rebates06212012a.html.

[4] *2011 Milliman Medical Index* (Seattle: Milliman, May 2011), available at http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2011.pdf.

[5] These rebate values are based on all insurers, whereas reduced overhead is based on the smaller sample of insurers selected for this study.

[6] Insurers owed substantial rebates in the individual market even though the overall MLR was above the 80 percent minimum because the rebate is calculated separately for each insurer and market segment in each state, and a number of insurers had loss ratios substantially below the regulated MLR rate of 80 percent. This Web site lists rebates owed by insurers for each state and market segment: http://www.healthcare.gov/law/resources/reports/mlr-rebates06212012a.html.

[7] Austin and Hungerford, "Market Structure," 2009.

[8] The Affordable Care Act requires greater justification by health insurers for rate increases above 10 percent, and states have a variety of rate review processes. Kaiser Family Foundation, "Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable" (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Dec. 2010), available at http://www.kff.org/healthreform/upload/8122.pdf.

Appendix Exhibit 1. State Individual Markets, 2010–11: Change in Overhead and Medical Loss Ratio (Unadjusted)

State	2010 members	2011 members	Change in administrative expenses per member	Change in profit per member	Change in total overhead per member	Change in medical loss ratio
Alabama	175,518	169,350	$7	–$12	–$5	0.8%
Alaska	15,649	15,235	$16	$24	$40	0.3%
Arizona	253,497	253,724	–$13	–$152	–$165	6.9%
Arkansas	111,068	114,044	$51	–$217	–$166	9.2%
California	968,882	1,065,276	–$14	$88	$74	–1.9%
Colorado	298,559	289,229	–$13	–$43	–$56	5.1%
Connecticut	107,325	108,445	–$50	–$193	–$243	8.1%
Delaware	18,441	17,396	–$127	$227	$101	–1.3%
Florida	830,813	831,538	–$27	–$102	–$129	6.1%
Georgia	351,259	362,320	–$62	–$73	–$135	5.1%
Hawaii	30,882	31,416	$43	$69	$112	–3.2%
Idaho	108,611	103,401	–$27	–$79	–$106	6.0%
Illinois	450,648	452,697	–$73	–$61	–$134	5.9%
Indiana	176,740	172,001	–$62	–$112	–$173	9.1%
Iowa	176,146	175,895	–$8	$55	$47	–0.8%
Kansas	125,665	122,039	–$8	–$22	–$30	2.8%
Kentucky	147,776	140,784	–$33	$55	$23	0.2%
Louisiana	166,262	159,987	–$115	$114	–$1	0.6%
Maine	36,803	34,994	–$4	–$282	–$286	9.1%
Maryland	184,093	180,130	–$17	–$91	–$109	5.4%
Massachusetts	88,896	78,725	$109	$41	$151	–3.9%
Michigan	329,063	321,563	$24	–$76	–$52	3.1%
Minnesota	244,447	241,852	–$3	$197	$194	–7.0%
Mississippi	78,065	76,097	$33	–$174	–$141	6.6%
Missouri	225,539	241,111	–$47	–$189	–$236	11.1%
Montana	52,587	50,817	–$24	–$9	–$33	3.1%
Nebraska	107,847	115,576	–$37	–$113	–$150	6.1%
Nevada	86,270	87,750	–$93	–$68	–$161	7.2%
New Hampshire	34,194	34,621	–$15	–$13	–$28	3.4%
New Jersey	121,781	138,577	$37	$314	$351	–8.0%
New Mexico	61,339	60,550	–$53	–$343	–$395	17.6%
New York	117,398	202,260	–$99	$26	–$72	–1.5%
North Carolina	415,183	416,344	–$53	$314	$261	–9.0%
North Dakota	42,352	41,695	–$20	$206	$186	–6.1%
Ohio	199,845	315,407	–$122	–$75	–$197	8.5%
Oklahoma	119,139	118,141	–$83	–$28	–$111	5.6%
Oregon	184,050	174,076	–$35	–$33	–$68	3.4%
Pennsylvania	469,206	465,854	–$38	–$78	–$116	1.7%
Rhode Island	14,814	15,159	$135	$321	$456	–10.2%
South Carolina	132,301	128,228	–$108	–$112	–$220	9.7%
South Dakota	56,558	65,555	–$60	$89	$29	–2.3%
Tennessee	232,206	240,617	–$43	–$143	–$186	8.6%
Texas	725,812	700,592	–$76	–$109	–$185	10.8%
Utah	140,697	137,886	$46	–$39	$7	0.3%
Vermont	17,453	18,229	–$6	–$102	–$107	2.3%
Virginia	315,788	313,030	–$3	–$153	–$156	6.6%
Washington	314,314	296,410	$29	–$114	–$86	4.6%
West Virginia	20,649	20,915	–$15	–$312	–$327	11.1%
Wisconsin	173,385	172,926	–$3	–$163	–$166	7.2%
Wyoming	24,329	21,984	–$12	$201	$189	–4.5%

Source: Authors' analysis of Supplemental Health Care Exhibit data, National Association of Insurance Commissioners.

Appendix Exhibit 2. State Small-Group Markets, 2010–11: Change in Overhead and Medical Loss Ratio (Unadjusted)

State	2010 members	2011 members	Change in administrative expenses per member	Change in profit per member	Change in total overhead per member	Change in medical loss ratio
Alabama	332,412	309,161	$5	$137	$142	–2.6%
Alaska	27,190	33,921	$149	$339	$488	–3.8%
Arizona	305,124	232,276	$13	–$85	–$72	2.6%
Arkansas	124,401	106,979	–$31	$6	–$25	1.3%
California	727,469	710,453	$42	–$50	–$8	0.5%
Colorado	291,540	266,543	–$38	$28	–$10	0.4%
Connecticut	303,179	266,985	$113	–$57	$56	–0.1%
Delaware	54,972	53,838	–$84	–$46	–$131	3.7%
Florida	884,855	856,603	$46	–$89	–$44	1.6%
Georgia	507,948	607,415	–$38	$3	–$36	1.3%
Hawaii	188,455	148,224	–$47	$34	–$14	0.1%
Idaho	99,246	90,401	$16	–$26	–$10	1.2%
Illinois	708,032	605,224	–$43	$21	–$22	1.4%
Indiana	280,751	347,145	–$42	$62	$20	1.1%
Iowa	203,942	175,660	–$29	$141	$112	–2.1%
Kansas	246,865	194,286	$47	$11	$58	1.3%
Kentucky	183,042	194,844	–$63	–$37	–$100	2.6%
Louisiana	309,516	290,308	–$99	$77	–$22	1.4%
Maine	93,616	85,588	$11	–$48	–$37	0.7%
Maryland	415,495	341,518	$85	–$153	–$68	2.1%
Massachusetts	663,965	597,772	$150	$100	$250	–4.2%
Michigan	492,508	488,374	$30	$86	$115	–2.4%
Minnesota	272,651	250,596	$63	–$50	$13	–0.4%
Mississippi	121,942	117,319	$62	$0	$63	–1.5%
Missouri	386,154	333,902	–$11	–$54	–$65	2.5%
Montana	57,292	52,142	–$7	$97	$90	–1.0%
Nebraska	92,257	102,049	–$133	–$88	–$221	6.4%
Nevada	119,740	105,769	–$182	$102	–$80	0.4%
New Hampshire	107,030	94,616	$38	$306	$344	–6.9%
New Jersey	813,777	721,092	$87	–$20	$66	–1.4%
New Mexico	80,242	63,915	$6	–$110	–$104	2.9%
New York	1,767,668	1,587,978	$35	–$53	–$18	0.7%
North Carolina	439,262	367,685	–$64	$107	$42	–0.2%
North Dakota	82,751	64,548	$21	$263	$284	–7.6%
Ohio	720,129	937,425	–$45	$121	$76	–0.8%
Oklahoma	184,925	177,017	–$47	–$30	–$77	2.2%
Oregon	233,830	232,191	–$43	$27	–$17	1.0%
Pennsylvania	908,386	1,201,661	–$58	–$45	–$103	1.2%
Rhode Island	101,552	92,244	$35	$897	$932	–20.4%
South Carolina	194,645	169,886	–$44	$85	$41	–0.2%
South Dakota	54,800	50,647	–$7	$92	$85	–1.5%
Tennessee	419,394	382,530	–$30	$38	$9	–0.2%
Texas	1,144,689	1,343,799	–$63	$81	$18	–0.5%
Utah	209,344	240,604	–$23	–$49	–$72	3.1%
Vermont	66,264	64,256	–$52	$186	$134	–3.0%
Virginia	461,741	412,492	–$9	–$143	–$151	3.9%
Washington	232,193	300,975	–$95	$98	$3	–0.3%
West Virginia	68,938	68,051	–$52	–$44	–$96	2.4%
Wisconsin	333,530	364,504	–$61	–$27	–$88	3.1%
Wyoming	25,885	26,266	–$24	$112	$88	–3.2%

Source: Authors' analysis of Supplemental Health Care Exhibit data, National Association of Insurance Commissioners.

Appendix Exhibit 3. State Large-Group Markets, 2010–11: Change in Overhead and Medical Loss Ratio (Unadjusted)

State	2010 members	2011 members	Change in administrative expenses per member	Change in profit per member	Change in total overhead per member	Change in medical loss ratio
Alabama	512,228	505,606	$0	$9	$9	–0.5%
Alaska	55,687	47,775	–$144	–$118	–$262	3.2%
Arizona	463,743	636,095	–$114	$52	–$62	–0.7%
Arkansas	220,834	236,648	$63	–$50	$13	–0.2%
California	950,761	994,155	$13	–$16	–$2	0.2%
Colorado	719,548	700,315	$31	$15	$46	–0.1%
Connecticut	532,349	458,372	–$2	$53	$51	–0.7%
Delaware	105,987	100,709	$2	$23	$24	0.1%
Florida	1,995,997	1,955,447	–$14	–$6	–$20	0.6%
Georgia	1,037,482	912,580	–$19	$69	$50	–0.8%
Hawaii	456,432	507,338	$13	$136	$148	–4.2%
Idaho	229,887	228,672	$15	$13	$28	–0.9%
Illinois	2,024,382	2,112,604	–$27	$20	–$7	0.1%
Indiana	488,523	378,092	–$38	–$34	–$72	2.2%
Iowa	358,492	371,557	$0	$41	$41	–0.5%
Kansas	482,546	435,484	$67	–$16	$50	–0.2%
Kentucky	409,444	386,609	–$67	–$7	–$74	2.2%
Louisiana	279,031	306,116	–$57	$80	$23	0.0%
Maine	192,210	196,022	–$7	$30	$23	–0.2%
Maryland	1,174,040	1,043,295	$70	–$66	$4	1.3%
Massachusetts	1,035,923	1,039,540	$34	$167	$201	–3.5%
Michigan	1,890,804	1,847,597	$27	$79	$106	–2.6%
Minnesota	688,017	674,328	$31	$3	$34	–0.4%
Mississippi	172,125	183,418	$20	–$71	–$50	1.3%
Missouri	594,334	757,844	–$82	$43	–$38	–0.7%
Montana	95,958	100,311	–$22	$9	–$14	0.6%
Nebraska	217,836	198,405	–$4	–$43	–$47	2.1%
Nevada	357,677	429,515	–$311	$172	–$138	2.9%
New Hampshire	157,108	157,447	$1	$99	$100	-1.6%
New Jersey	1,253,213	1,152,110	–$105	$148	$43	-0.4%
New Mexico	174,100	176,554	$39	–$60	–$21	1.1%
New York	5,560,613	6,400,998	–$25	–$19	–$44	1.6%
North Carolina	536,181	576,318	–$29	–$3	–$31	1.0%
North Dakota	119,677	141,277	$19	–$17	$2	0.1%
Ohio	1,396,134	1,057,022	–$99	$92	–$8	1.2%
Oklahoma	420,989	433,735	–$34	$89	$55	–1.3%
Oregon	723,428	696,862	$13	$56	$68	–1.3%
Pennsylvania	1,799,593	1,591,436	–$33	$103	$70	–0.8%
Rhode Island	186,464	186,395	–$179	$358	$179	–3.8%
South Carolina	345,864	361,047	–$25	$105	$80	–2.0%
South Dakota	111,136	110,234	$13	$45	$58	–0.9%
Tennessee	495,692	480,605	$60	$31	$91	0.0%
Texas	2,124,845	1,826,768	–$8	$12	$5	–0.3%
Utah	511,573	468,431	–$10	–$9	–$19	1.4%
Vermont	74,905	73,717	–$34	–$14	–$48	1.4%
Virginia	1,150,750	1,218,835	$4	–$27	–$23	0.9%
Washington	1,337,594	1,226,963	$10	–$29	–$18	1.0%
West Virginia	138,675	128,484	–$53	$203	$151	–3.4%
Wisconsin	1,014,466	912,087	$13	–$54	–$41	1.3%
Wyoming	34,074	35,127	$36	$121	$157	–3.0%

Source: Authors' analysis of Supplemental Health Care Exhibit data, National Association of Insurance Commissioners.

Appendix Exhibit 4. Change in Total Overhead, 2010 to 2011

State	Individual market	Small-group market	Large-group market	Total
Alabama	–$1,736,364	$34,944,728	$2,448,760	$35,657,124
Alaska	$346,664	$21,381,288	–$17,460,860	$4,267,092
Arizona	–$41,815,000	–$65,270,334	$37,031,681	–$70,053,654
Arkansas	–$17,456,425	–$15,664,502	$8,932,602	–$24,188,325
California	$113,527,355	–$15,085,396	$18,478,378	$116,920,337
Colorado	–$20,040,244	–$18,317,325	$23,972,397	–$14,385,173
Connecticut	–$25,576,960	–$14,802,315	–$19,652,743	–$60,032,018
Delaware	$1,108,575	–$8,032,928	$222,414	–$6,701,938
Florida	–$106,688,662	–$61,600,455	–$61,348,855	–$229,637,971
Georgia	–$43,353,097	$39,618,168	$2,852,940	–$881,989
Hawaii	$3,600,502	–$19,712,613	$80,300,402	$64,188,291
Idaho	–$13,387,370	–$5,568,582	$6,136,809	–$12,819,143
Illinois	–$59,371,936	–$97,268,965	$24,832,103	–$131,808,797
Indiana	–$32,654,220	$56,684,771	–$81,035,260	–$57,004,709
Iowa	$8,125,492	$3,609,325	$20,160,057	$31,894,874
Kansas	–$5,269,383	–$14,166,767	$5,887,870	–$13,548,280
Kentucky	–$572,817	–$10,964,856	–$39,635,681	–$51,173,354
Louisiana	–$3,622,847	–$19,670,384	$17,935,159	–$5,358,073
Maine	–$11,205,945	–$7,138,775	$6,104,518	–$12,240,203
Maryland	–$21,406,187	–$82,441,146	–$51,905,187	–$155,752,520
Massachusetts	$14,998,633	$119,065,046	$210,230,238	$344,293,918
Michigan	–$18,851,531	$53,958,473	$180,465,593	$215,572,535
Minnesota	$46,529,050	–$9,336,336	$18,516,701	$55,709,415
Mississippi	–$11,976,934	$5,579,298	–$5,301,012	–$11,698,648
Missouri	–$46,881,564	–$62,362,996	$63,004,621	–$46,239,939
Montana	–$2,454,316	$1,064,890	–$95,159	–$1,484,585
Nebraska	–$13,581,075	–$13,596,162	–$17,488,257	–$44,665,494
Nevada	–$13,144,251	–$19,375,553	–$25,210,583	–$57,730,387
New Hampshire	–$606,754	$28,170,878	$15,920,910	$43,485,035
New Jersey	$53,342,366	–$13,243,640	–$11,143,934	$28,954,792
New Mexico	–$24,196,622	–$18,787,817	–$2,854,792	–$45,839,231
New York	$17,254,051	–$92,135,902	–$20,363,154	–$95,245,005
North Carolina	$108,848,505	–$30,038,883	$2,578,070	$81,387,693
North Dakota	$7,731,190	$12,614,707	$5,647,323	$25,993,220
Ohio	$8,259,570	$183,018,963	–$155,082,419	$36,196,114
Oklahoma	–$13,716,571	–$20,230,541	$29,162,395	–$4,784,718
Oregon	–$14,588,479	–$4,793,011	$37,778,733	$18,397,244
Pennsylvania	–$55,131,863	$73,908,437	$14,561,295	$33,337,869
Rhode Island	$7,042,816	$83,851,290	$33,404,605	$124,298,711
South Carolina	–$31,300,240	–$9,732,449	$33,457,694	–$7,574,996
South Dakota	$4,837,257	$2,669,923	$6,093,243	$13,600,423
Tennessee	–$40,018,093	–$20,193,092	$38,058,450	–$22,152,735
Texas	–$146,773,991	$158,558,316	–$105,547,218	–$93,762,893
Utah	–$12,090	$829,999	–$22,629,260	–$21,811,351
Vermont	–$1,625,259	$7,893,465	–$4,146,622	$2,121,584
Virginia	–$50,744,050	–$105,425,290	$1,506,713	–$154,662,627
Washington	–$32,828,629	$39,044,524	–$75,249,667	–$69,033,771
West Virginia	–$6,570,826	–$7,332,276	$15,581,781	$1,678,679
Wisconsin	–$29,002,259	–$11,245,815	–$76,879,978	–$117,128,051
Wyoming	$2,921,674	$2,615,838	$5,765,714	$11,303,226
United States	–$559,689,152	$35,547,221	$173,999,532	–$350,142,400

Source: Authors' analysis of Supplemental Health Care Exhibit data, National Association of Insurance Commissioners.

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