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The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3

Michael J. McCue and Mark A. Hall

Abstract For the past three years, the Affordable Care Act has required health insurers to pay out a minimum percentage of premiums in medical claims or quality improvement expenses—known as a medical loss ratio (MLR). Insurers with MLRs below the minimum must rebate the difference to consumers. This issue brief finds that total rebates for 2013 were \$325 million, less than one-third the amount paid out in 2011, indicating much greater compliance with the MLR rule. Insurers' spending on quality improvement remained low, at less than 1 percent of premiums. Insurers' administrative and sales costs, such as brokers' fees, and profit margins have reduced slightly but remain fairly steady. In the first three years under this regulation, total consumer benefits related to the medical loss ratio—both rebates and reduced overhead—amounted to over \$5 billion. This was achieved without a great exodus of insurers from the market.

OVERVIEW

One of the consumer protections granted by the Affordable Care Act (ACA) is the regulation of health insurers' medical loss ratios, or MLRs. A key financial measure, an MLR shows the percentage of premium dollars a health insurer pays out for medical care and quality improvement expenses compared with the portion allocated to profits, administrative costs, and sales expenses. For instance, if an insurer uses 80 cents of every premium dollar to pay its customers' medical claims and carry out activities to improve the quality of care, it has a medical loss ratio of 80 percent.

To reduce overhead and ultimately lower the cost of insurance to consumers and the government, in 2011, the ACA set minimum MLRs of at least 80 percent in the individual and small-group markets and of at least 85 percent in the large-group market.¹ Insurers that pay out less than these percentages on medical care and quality improvement must rebate the difference to their members.

Previously, we reported that health insurers that failed to meet MLR requirements paid out more than \$1 billion in rebates to consumers

for insurance sold in 2011,² and \$513 million in 2012.³ In addition, insurers reduced overhead (i.e., administrative costs and profits) by over \$350 million in 2011, and by more than \$1 billion in 2012, in part to reduce the rebates they might owe. In both years, insurers reported spending less than 1 percent of their premium revenues on improving the quality of care.

This issue brief revisits these measures in year 3 of the new law to determine the continued impact of the MLR regulation. In 2013, rebates continued to drop, falling to \$325 million, which indicates even greater compliance with the MLR standard. Insurer spending on quality improvement remained low, at less than 1 percent of premiums. In year 3 insurers increased overhead by \$1.6 billion, but still this was \$0.9 billion less than the amount allocated to overhead in 2011. Summing the savings achieved in each year we find that insurers showed a cumulative savings in overhead costs of over \$3 billion over these first three years. While it is not known exactly how much of the reduced overhead can be attributed to the new MLR regulation rather than market competition, it is fair to conclude that total consumer benefits related to the MLR amount to more than \$5 billion in the first three years due to savings of over \$3 billion and almost \$2 billion in rebates.

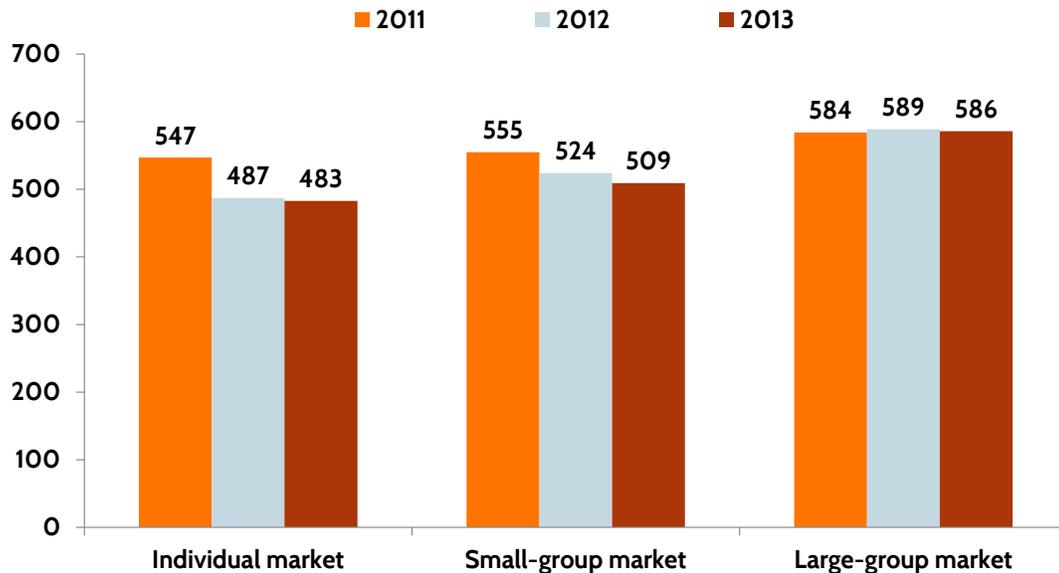
NUMBER OF INSURERS

When the Affordable Care Act was enacted, some critics predicted it would cause an exodus of insurers from the market.⁴ To assess this concern, we measured changes in the number of active insurers, either inside or outside the new marketplaces. In this analysis, we only included insurers with 1,000 or more members in a market segment.

From 2011 to 2013, there was a modest contraction but still a substantial number of insurers actively competing (Exhibit 1). Throughout the country in 2013, there were still roughly 500 insurers in each of the individual, small-group, and large-group markets. These numbers reflect modest

Exhibit 1. Number of Credible Health Plans, by Market Segment

Insurers with 1,000 or more members, by market



ABOUT THIS STUDY

Medical loss ratio data were collected from the Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) for 2011 through 2013. In computing 2010, we used 2010 National Association of Insurance Commissioners (NAIC) filings since CMS did not collect MLR data in 2010. Data were collected from health insurers in 50 states and Washington, D.C., but not from the territories. The key financial measures were calculated consistent with the NAIC Supplemental Health Care Exhibit.

CMS requires only insurers with “credible” actuarial experience to calculate MLRs and pay rebates. For MLR and rebate analysis, we followed the approach used by CMS, which bases credibility on a three-year aggregate. For simply counting the number of active insurers, however, we included only insurers that had 1,000 members in the particular market segment in order to have a more consistent study sample across multiple years. In calculating financial measures, we included insurers with 100 members or more, in order to capture the experience of insurers that were less active and possibly exiting these markets. We excluded plans with negative or zero values for net premiums earned or net medical claims. Exhibit 3 shows the resulting study sample for the MLR and rebate analysis. For financial measures, we had the following study sample: 1,827 insurers in 2011, 1,589 in 2012 and 1,496 in 2013 (individual market); 1,030 insurers in 2011, 932 in 2012, and 894 in 2013 (small-group market); and 930 insurers in 2011, 846 in 2012, and 854 in 2013 (large-group market).

decreases from 2011 in the individual and small-group markets, where the number of insurers with at least 1,000 members declined 13 percent and 9 percent, respectively.⁵

Some degree of market consolidation is to be expected. The number of insurers has declined steadily for more than a decade as the industry consolidates either through acquisition and merger or because smaller insurers have difficulty competing.⁶ Therefore, a modest reduction in the number of insurers does not appear to be strongly related to the Affordable Care Act. Indeed, the ACA’s subsidized insurance marketplaces are credited with bringing a significant number of new insurers into the individual market.⁷

CONSUMER REBATES

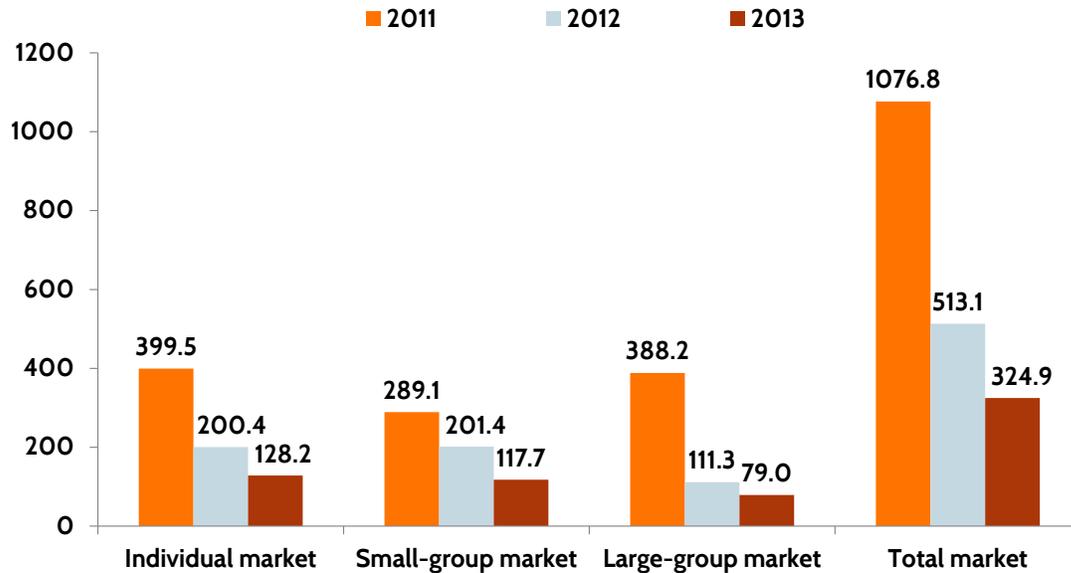
Overall, the amount of total rebates that insurers paid to consumers dropped by more than two-thirds from 2011 to 2013—from \$1.1 billion to \$325 million dollars (Exhibit 2). The reduction is attributable primarily to a decline in the average size of rebates owed in the group markets, rather than a reduced total number of insurers owing rebates (Exhibit 3). In 2011, median rebates ranged from \$99 to \$116 per member across the three market segments. By 2013, median rebates remained at \$100 in the individual market, but dropped to \$29 and \$61 in the small- and large-group markets, respectively. There was only a modest reduction of between 2 and 7 percentage points in the number of insurers owing rebates (Exhibit 3).

In the individual market, insurers paid \$128 million in rebates in 2013, amounting to less than one-half of 1 percent of collected premiums. This is a decline of more than two-thirds from 2011, when they paid out \$400 million. Between 2011 and 2013, the median adjusted MLR increased 2.4 percentage points from 82.5 percent to 84.9 percent, indicating that insurers in the individual market are paying out a greater portion of their premiums for medical claims and quality improvement.⁸

In the group markets, the median adjusted MLR has held steady since 2011. Despite this stability in the middle, we see a substantial decline in the amount of rebates owed by insurers that fell below the minimum loss ratios. Total small-group rebates dropped 60 percent from 2011 to 2013,

Exhibit 2. Rebates by Market Segments, 2011–2013

Dollars in millions



Source: Authors' analysis of Centers for Medicare and Medicaid Services rebate data.

Exhibit 3. Medical Loss Ratios and Rebates by Insurance Market Segment, 2011–2013

	Individual market				Small-group market				Large-group market			
	2011	2012	2013	Change	2011	2012	2013	Change	2011	2012	2013	Change
	n=548	n=655	n=747	2013-2011	n=562	n=622	n=667	2013-2011	n=587	n=663	n=697	2013-2011
Median adjusted MLR	82.5%	84.5%	84.9%	2.4%	84.6%	85.3%	85.0%	0.4%	89.2%	89.6%	89.3%	0.1%
Percent of credible insurers owing rebate	38%	35%	31%	-7%	20%	18%	18%	-2%	18%	15%	13%	-5%
Median rebate per member	\$108	\$95	\$100	-\$8	\$116	\$86	\$29	-\$87	\$99	\$57	\$61	-\$38
Total rebate paid (in millions)	\$399.5	\$200.4	\$128.2	-\$271.3	\$289.1	\$201.4	\$117.7	-\$171.4	\$388.2	\$111.3	\$79.0	-\$309.2

Note: Insurers with actuarial "credibility" are those with enough enrollment to be subject to the MLR rule. Adjusted MLRs are defined in note 8 on page 10.

Source: Authors' analysis of Centers for Medicare and Medicaid Services medical loss ratio and rebate data.

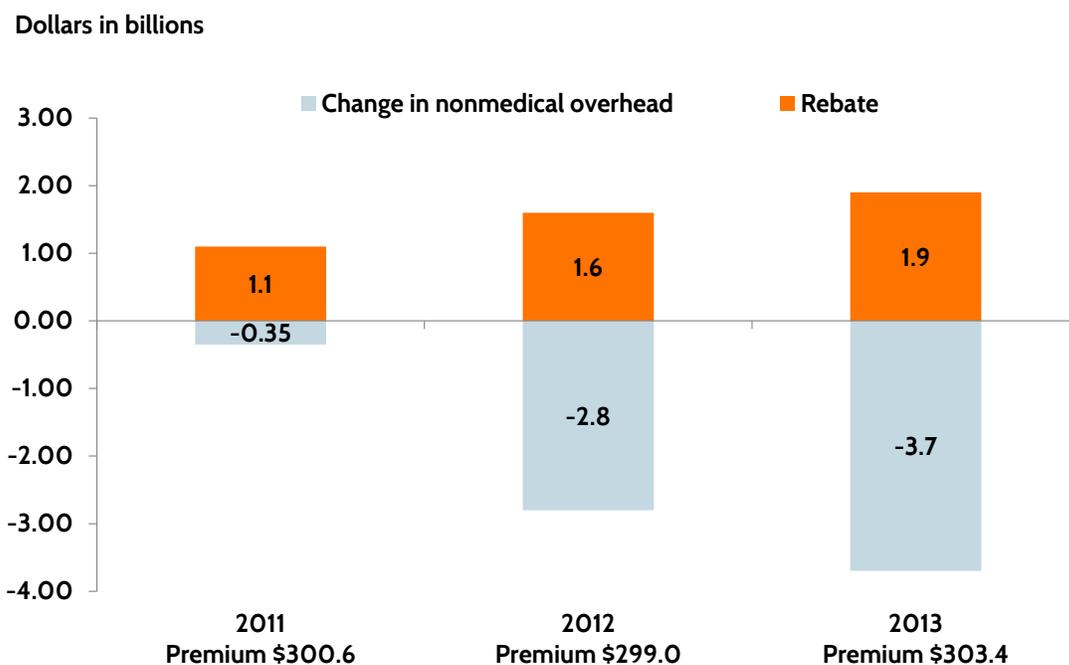
from \$289 million to \$118 million. Total large-group rebates dropped 80 percent, from \$388 million to \$79 million. In the small-group market, the proportion of insurers owing rebates has remained steady but the rebate amounts have dropped, indicating that insurers below the MLR minimums are coming closer to being in compliance. In the large-group market, we see declines in both the size of rebates and the number of insurers owing rebates (Exhibit 3).

Insurers' Financial Performance

We next analyzed how key financial performance measures for insurers changed from 2011 to 2013. Previously, we reported that between 2010 and 2011, the first year of the MLR rule, insurers' non-medical overhead dropped by about \$350 million, owing to reduced administrative costs and reduced profits, mainly in the individual market.⁹ As shown in Exhibit 4, this initial gain in consumer benefits was retained in the second and third years of the MLR rule. Overall, the amount of premium devoted to medical claims and quality improvement has remained at about 88 percent, meaning nonmedical overhead has been at about 12 percent each of the past three years.

Small percentage changes in nonmedical overhead produced substantial benefits for consumers. The drop in nonmedical overhead of half a percentage point between 2011 and 2012 amounted to a consumer gain of about \$2 billion in reduced profits and administrative spending. This is in addition to the consumer gain already achieved in 2011. In 2013, nonmedical overhead increased \$1.6 billion. Still, administrative expenses remained \$500 million below the 2011 level. The total reduction in overhead reported for 2011, 2012, and 2013 amount to \$3.7 billion cumulatively over the three years the MLR rules have been in effect (Exhibit 4). It is impossible to know how much of this reduced overhead is attributable strictly to the new regulation. Nevertheless, the consumer gains related to medical loss ratios amount to over \$5 billion dollars, including rebates of almost \$2 billion and reduced overhead of over \$3 billion.

Exhibit 4. Cumulative Rebate and Nonmedical Overhead Reduction, 2011–2013



Quality Expense and Overhead Components

The MLR rule regards expenses for quality improvement as being part of medical claims rather than part of administrative expenses. In 2013, these quality improvement expenses (see [Glossary](#) for definition) remained at just under 1 percent of premiums.

We also looked at insurers' expenses for brokers as a component of administrative costs. This issue is significant because some industry observers expect that increasing MLRs will cause insurers to reduce the role of—or compensation for—-independent brokers. But broker expenses, which generally amount to about 3 percent of premiums, have dropped only slightly—by 0.2 percentage points overall since 2011 (Exhibits 5 and 6).

Exhibit 5. Components of Insurance Premiums, 2011–2013

	All markets			
				2013–2011
(in \$ billions and % of premium)	2011	2012	2013	% pt. change
Net premium	\$300.6	\$299.0	\$303.4	
Net medical claims	\$261.3	\$261.5	\$264.4	
	86.9%	87.5%	87.1%	0.2%
Quality improvement	\$2.2	\$2.4	\$2.4	
	0.7%	0.8%	0.8%	0.1%
Nonmedical overhead*:	\$37.1	\$35.0	\$36.6	
	12.3%	11.7%	12.1%	–0.2%
Broker expense	\$8.7	\$8.4	\$8.3	
	2.9%	2.8%	2.7%	–0.2%
Other admin. expense	\$21.0	\$19.9	\$21.3	
	7.0%	6.7%	7.0%	0.0%
Underwriting gain/loss	\$7.4	\$6.8	\$7.0	
	2.5%	2.2%	2.3%	–0.2%

* Nonmedical overhead percentage equals sum of broker expense, other admin. expense, and underwriting gain/loss percentages.

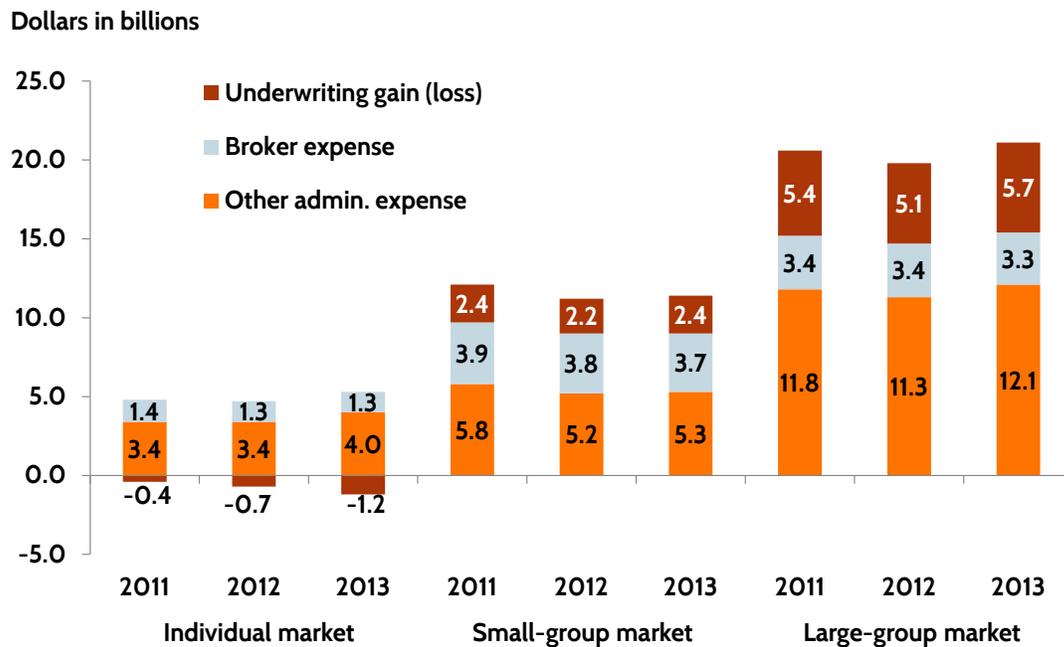
Note: Overhead consists of profits plus administrative and sales costs.

See the appendix on page 9 for analysis by markets.

Source: Authors' analysis of National Association of Insurance Commissioners and Centers for Medicare and Medicaid Services medical loss ratio and rebate data.

Finally, insurers' operating profit margins (also known as underwriting gains) have declined only slightly overall—by 0.2 percentage points since 2011 (Exhibits 5 and 6). Modest profit margin decreases in the individual market, where underwriting losses increased from 1.4 percent to 3.8 percent, have been partially offset by modest increases in the small- and large-group markets, where profit margins have risen modestly but remain at about 3 percent (see [Appendix](#)).

Exhibit 6. Overhead Components, 2011–2013, by Market



Note: The appendix on page 9 provides total premium and overhead for each column. Overhead consists of profits plus administrative and sales costs.
 Source: Authors' analysis of National Association of Insurance Commissioners and Centers for Medicare and Medicaid Services medical loss ratio and rebate data.

CONCLUSION

The new federal regulation of health insurers' medical loss ratios continues to provide substantial consumer benefits in the third year of operation. Total rebates to consumers dropped by two-thirds, from over \$1 billion in 2011 to \$325 million in 2013, reflecting greater compliance with the MLR rule and meaning that insurers are spending a larger percentage of premium dollars on medical claims. To meet the legal minimums, insurers also reduced their administrative costs without substantially increasing their profits, producing a net reduction in overhead that cumulatively amounted to more than \$3 billion over three years. Combined with the total of almost \$2 billion in rebates, consumer benefits related to the MLR rule were more than \$5 billion in the first three years. Insurers' spending on quality improvement has remained low, at less than 1 percent of premiums, even though the new law allows insurers to count these expenses toward meeting their required minimums.

These consumer gains have not come at the cost of substantially reduced competition or choice among insurers. Although there has been a modest reduction in the number of insurers in the market, this appears to continue a decade-long trend of consolidation. Roughly 500 insurers appear to remain active in both the individual and the group markets across all states. Federal regulation of MLRs appears to be producing significant consumer benefits without causing any substantial harm to the insurance markets.

GLOSSARY

Quality improvement costs are all expenses related to improving the quality of care and include activities in the following categories: improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, increasing wellness and promotion, and implementing health information technology. Quality improvement expenses are included along with medical expenses in the numerator of the MLR for purposes of calculating rebates owed under the federal regulation.

Overhead refers to the component of premium that is not spent on medical claims or improving quality. It equates simply to the sum of administrative and sales costs plus profit margin.

- **Agent and broker expenses** are usually reported as part of administrative expenses. In this brief we separate out this element.
- **Other administrative costs** are all administrative expenses other than those for agent and broker fees. Included are internal sales expenses, claims adjustment costs, and salary and benefit expenses, as well as all other general corporate overhead costs.
- **Profit margin** is also known as the underwriting gain or loss. It is calculated by subtracting all medical and administrative costs from net premium earned. As such, it does not include profit or loss from investments or taxes on investments. A negative profit margin indicates that medical and administrative costs exceeded premiums.

Appendix: Components of Insurance Premiums, by Markets, 2011–2013

	Individual market				Small-group market				Large-group market			
	2011	2012	2013	2013–2011 % Pt Chg	2011	2012	2013	2013–2011 % Pt Chg	2011	2012	2013	2013–2011 % Pt Chg
(in \$ billions)												
Net premium	\$29.1	\$29.8	\$31.3		\$74.9	\$73.4	\$73.0		\$196.6	\$195.7	\$199.1	
Net medical claims	\$24.5	\$25.5	\$26.9		\$62.2	\$61.6	\$61.0		\$174.6	\$174.4	\$176.5	
	84.2%	85.6%	85.9%	1.7%	83.0%	83.9%	83.6%	0.6%	88.8%	89.1%	88.6%	-0.2%
Quality improvement	\$0.2	\$0.3	\$0.3		\$0.6	\$0.6	\$0.6		\$1.4	\$1.5	\$1.5	
	0.7%	1.0%	1.0%	0.3%	0.8%	0.8%	0.8%	0.0%	0.7%	0.8%	0.8%	0.1%
Nonmedical overhead*:	\$4.4	\$4.1	\$4.1		\$12.1	\$11.2	\$11.3		\$20.6	\$19.8	\$21.2	
	15.1%	13.8%	13.1%	-2.0%	16.1%	15.3%	15.5%	-0.6%	10.5%	10.1%	10.6%	0.1%
Broker expense	\$1.4	\$1.3	\$1.3		\$3.9	\$3.8	\$3.7		\$3.4	\$3.4	\$3.3	
	4.8%	4.4%	4.2%	-0.6%	5.2%	5.2%	5.1%	-0.1%	1.7%	1.7%	1.7%	0.0%
Other admin. expense	\$3.4	\$3.4	\$4.0		\$5.8	\$5.2	\$5.3		\$11.8	\$11.3	\$12.1	
	11.7%	11.4%	12.8%	1.1%	7.7%	7.1%	7.3%	-0.4%	6.0%	5.8%	6.1%	0.1%
Underwriting gain (loss)	(\$0.4)	(\$0.7)	(\$1.2)		\$2.4	\$2.2	\$2.4		\$5.4	\$5.1	\$5.7	
	-1.4%	-2.0%	-3.8%	-2.4%	3.2%	3.0%	3.3%	0.1%	2.7%	2.6%	2.9%	0.2%

* Nonmedical overhead percentage equals sum of broker expense, other admin. expense, and underwriting gain/loss percentages.

Source: Authors' analysis of National Association of Insurance Commissioners and Centers for Medicare and Medicaid medical loss ratio and rebate data.

NOTES

- ¹ The small-group market currently consists of employers with 50 or fewer workers, but in 2016, this market segment will expand to include groups of up to 100 workers.
- ² M. J. McCue and M. A. Hall, *Insurers' Responses to Regulation of Medical Loss Ratios* (New York: The Commonwealth Fund, Dec. 2012).
- ³ M. J. McCue and M. A. Hall, *The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 2* (New York: The Commonwealth Fund, May 2014). In this study, we report an even greater reduction in nonmedical overhead for 2012, based on a more consistent measure of premium revenue.
- ⁴ For instance, R. Epstein, "Unmanageable Competition," *Forbes*, Nov. 24, 2009.
- ⁵ In this snapshot, we did not investigate whether these enrollment drops were large or miniscule for each insurer or whether these insurers remained somewhat active in the market or withdrew entirely. Also, note that some changes in insurer counts, both increases and decreases, can occur simply because an insurance holding company with various subsidiaries either consolidates or increases the number of subsidiaries. Also, since 2012, new insurers have entered the individual market in several states as part of their new insurance exchanges. See C. Cox G. Claxton, L. Levitt et al., *An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014* (Menlo Park, Calif.: Kaiser Family Foundation, Sept. 2013). Therefore, our coarse measure does not perfectly reflect the level of effective competition in a state. Nevertheless, it gives a rough indicator of any major changes nationally.
- ⁶ J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, Nov. 2004 25(6):11–24; U.S. Government Accountability Office, *Concentration of Enrollees Among Individual, Small-Group, and Large-Group Insurers from 2010 through 2013* (Dec. 2014); and D. Andrew Austin and T. L. Hungerford, *The Market Structure of the Health Insurance Industry* (Washington, D.C.: Congressional Research Service, 2009).
- ⁷ U.S. Department of Health and Human Services, *Health Plan Choice, Premiums and Affordability in the 2015 Health Insurance Marketplace* (Washington, D.C.: DHHS, Dec. 2014); McKinsey Center for U.S. Health System Reform, *Emerging Exchange Dynamics: Temporary Turbulence or Sustainable Market Disruption?* (New York: McKinsey and Company, 2013); and J. Holahan, R. Peters, K. Lucia et al., *Cross-Cutting Issues: Insurer Participation and Competition in Health Insurance Exchanges: Early Indications from Selected States* (Washington, D.C.: Urban Institute, July 2013).
- ⁸ In calculating the MLR for rebate purposes, the federal rule allows insurers to make various adjustments. Insurers with fewer than 75,000 members and those that have high deductibles (i.e., greater than \$2,500) may increase their calculated MLR under a formula that takes into account greater actuarial predictability for smaller pools and lower claims for high-deductible plans. In addition, we only included rebates from insurers within 50 states but not U.S. Territories, so there may be slight underreporting of rebates.
- ⁹ McCue and Hall, *Insurers' Responses to Regulation of Medical Loss Ratios*, 2012.

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