

How the ACA's Medical Loss Ratio Rule Protects Consumers and Insurers Against Ongoing Uncertainty

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ABSTRACT

ISSUE: The Affordable Care Act's rule on minimum medical loss ratios (MLRs) protects consumers by capping insurers' profits and overhead. In the early years of the law, these caps were rarely used because most insurers in the individual health insurance market experienced substantial losses. More recently, however, insurers are earning substantial profits while the individual market is rattled by regulatory uncertainty and change.

GOAL: To understand the ongoing role that the medical loss ratio rule plays in the individual health insurance market.

METHODS: Analysis of insurers' financial performance 2015–2017, as reported to the federal government.

KEY FINDINGS AND CONCLUSION: Consumer rebates under the MLR rule increased noticeably in 2017 as insurers raised rates and regained profitability. At the same time, the rule's calculation of MLRs based on a three-year rolling average allowed insurers in 2017 to recoup a portion of their losses from earlier years. As the individual market continues to experience cycles of profits and losses, the MLR rule dampens the severity of these cycles, thus protecting insurers as well as consumers.

TOPLINES

- ▶ Consumer rebates under the ACA's "medical loss ratio" rule increased in 2017, as insurers raised rates and regained profitability.
- ▶ Because the ACA's caps on health plans' profits and overheads are based on a three-year rolling average, they also help insurers recoup recent losses.



BACKGROUND

Regulation of insurers' medical loss ratios (MLRs, or loss ratios) is one of the most notable consumer protections in the Affordable Care Act (ACA). The loss ratio is the percentage of premium dollars that insurers spend on medical claims and quality improvement, rather than dollars retained for administrative overhead and profit.

Under the ACA, insurers that do not incur a loss ratio of at least 80 percent (based on a three-year rolling average) in the individual or small-group market must rebate the difference to consumers.¹ Put another way, insurers with average overhead and profits during the past three years that exceed 20 percent must rebate the excess to members. Large-group insurers must do the same for loss ratios less than 85 percent, or when overhead and profits average more than 15 percent of premium dollars based on a three-year average.²

The ACA's MLR rule took effect in 2011. In its first few years, this rule provided important consumer protection by requiring substantial consumer rebates and inducing insurers to reduce their administrative costs, which likely helped to keep premiums somewhat lower.³ These

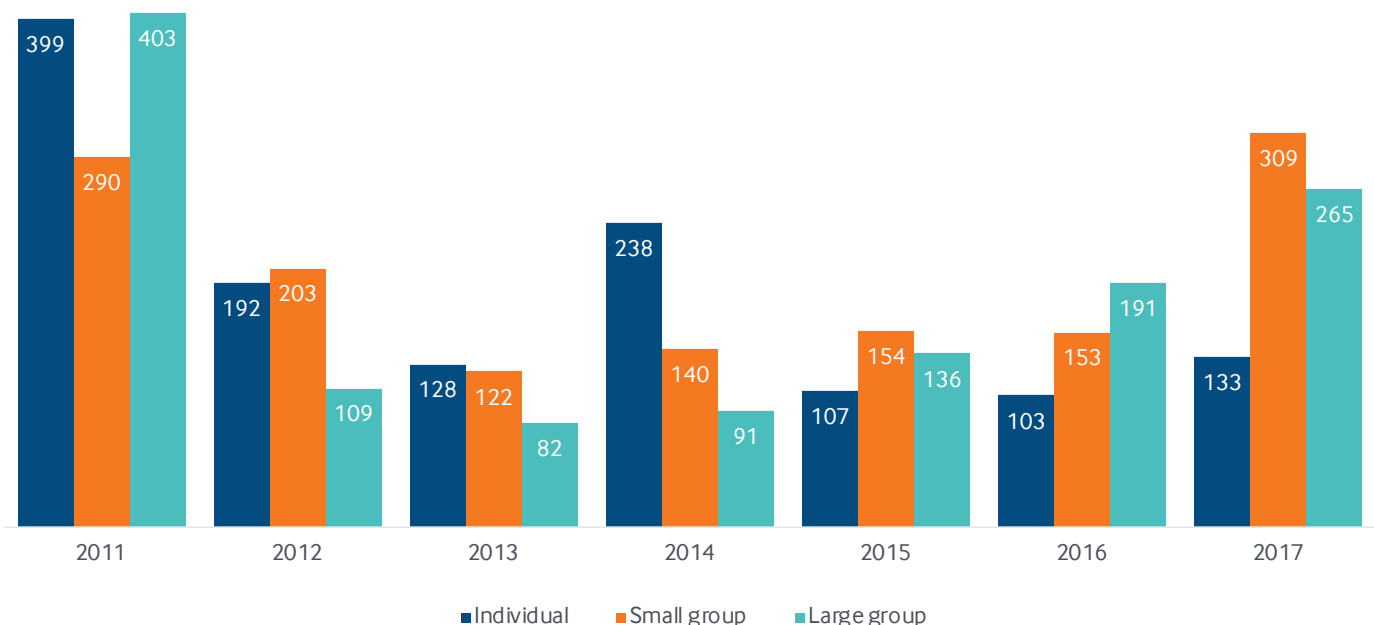
protections became less visible once insurers adjusted their rates to reflect their lower overhead.⁴ Following substantial rate increases for individual health insurance in 2017 and 2018, however, the ACA's loss ratio limits have renewed relevance by helping stabilize a market that has been buffeted by cyclical underpricing and overpricing.

This issue brief explains how the ACA's MLR rule serves an important buffering function in two ways. The rule protects consumers by limiting how much insurers can attempt to recoup previous losses through higher profits in any one year. At the same time, the rule allows insurers to replenish some of their reserves that deplete during lean times by calculating MLR limits based on a three-year rolling average.

THE CHANGING RELEVANCE OF LOSS RATIO LIMITS

As shown in Exhibit 1, rebates in the individual health insurance market declined from almost \$400 million in 2011 to slightly more than \$100 million annually in 2015 and 2016,⁵ accounting in those later years for only about 0.14 percent of insurers' premiums. Rebates also declined in the group markets but less dramatically (in proportionate terms).

Exhibit 1. Rebates by Market 2011 to 2017 (in \$ millions)



Data: Center for Consumer Information and Insurance Oversight, *Summary of 2016 Medical Loss Ratio Results* (CCIIO, Dec. 2017).

To fully understand this pattern, it helps to have a clearer picture of insurance pricing during this period. The individual market had a significant drop in rebates after 2014 because loss ratios in that market increased to an unprofitable level for most insurers in 2015 and 2016. Insurers underpriced those years because of the highly competitive conditions in the newly reformed individual market, coupled with actuarial uncertainty over the full extent of health care needs for the newly insured.⁶

But since 2017, the ACA's MLR limits have once again become more relevant for consumers in the individual market.⁷ To help insurers regain profitability, state regulators allowed them to target the minimum allowable loss ratios, which meant that rates increased more than the anticipated increases in medical claims. As a result, rate increases averaged roughly 25 percent in 2017 and 30 percent in 2018.⁸

For the most part, these increases were caused by changes in federal rules, such as the planned phasing out of the ACA's transitional reinsurance program, as well as the unplanned cessation of cost-sharing reduction payments to insurers.⁹ But these hefty increases were also driven by insurers' aiming to substantially lower their previous loss ratios.

In fact, many insurers overshot their targeted loss ratios in 2017 and 2018, resulting in greater profitability than they may have anticipated. Accordingly, their rate increases were much more subdued in 2019, averaging only about 3 percent.¹⁰

This cyclical pattern of underpricing followed by overpricing (relative to actual medical claims) is driven in large part by insurers' uncertainty about the ACA's evolving market conditions. This uncertainty has two causes: actuarial and political.¹¹

When the newly reformed individual market first opened in 2014, insurers lacked the actuarial experience needed to accurately estimate the newly insured's use of medical services. This actuarial uncertainty carried over into 2016 because insurers must file their rates roughly 18 months prior to the end of the following rating year.¹² Also, in 2015 and 2016, there was substantial turnover among insurers

in the individual market, as some initial players learned that they were not able to compete effectively under the new market rules.¹³

The ACA's drafters anticipated this uncertainty and included several risk-mitigating measures, known as the "three R's:" reinsurance, risk-adjustment, and risk corridors.¹⁴ The first two measures were implemented, but risk corridors were not because of Republican opposition that characterized this market-stabilizing measure as a "bailout for insurers."¹⁵ Risk corridors would have substantially dampened the initial cycling between substantial losses and excessive profits in the ACA's individual market.¹⁶

Despite the absence of the ACA's full complement of stabilizing features, participating insurers began to gain their actuarial footing in 2017. At this point, however, the cause of insurers' uncertainty shifted from typical actuarial factors to more political factors, including dramatic changes in administrative policies and market rules under the Trump administration. These changes are described in more detail elsewhere, but in brief they include abruptly ceasing cost-sharing reduction payments, repealing the individual mandate penalty, and drastically reducing funding for marketing and consumer navigation during open enrollment.¹⁷

This political and regulatory uncertainty continues. Regulators are greatly loosening rules that previously had limited the sale of non-ACA-compliant policies, and the full impact of these changes is still unknown.¹⁸ Moreover, the Justice Department has taken the position in court that the ACA should be struck down as unconstitutional, which could have a catastrophic impact on the individual market. However, the fate and timing of that litigation is highly uncertain.

In short, these roller-coaster conditions would probably have leveled out by 2017 if ongoing changes to market rules had not intensified the uncertainty. Against this backdrop, we now consider the role that the ACA's loss ratio rule might play in stabilizing the market by protecting both consumers and insurers through continuing cycles of losses and excessive profits that result from ongoing market uncertainty.

The following sections examine two key stabilizing features in the ACA's loss ratio rule. Using a three-year rolling average to calculate excess overhead and profits protects insurers by allowing them to recoup at least a portion of their recent losses through somewhat larger rate increases in a current year. At the same time, requiring insurers to rebate excess overhead and profits protects consumers from unjustified price increases.

In effect, the ACA's loss ratio rule serendipitously serves a function similar to the ACA's risk corridor provisions that were undermined by Republican opposition: the MLR rule partially shelters insurers in bad times and keeps them from unduly profiteering in good times.

PROTECTION OF INSURERS

Viewing the individual market as a whole, Exhibit 2 shows that in 2015 and 2016 (averaged together), insurers had poor financial results. Their collective loss of -7.4 percent was because of a high medical loss ratio — 95 percent. Some insurers were more successful and were required to pay a rebate; however, across the entire market, these rebates averaged only \$6 per person per year (50 cents a month), equal to just 0.01 percent of the premium.

Insurers' financial performance improved dramatically in 2017. By increasing premiums by 11 percent more than the increase in claims (14% vs. 3%),¹⁹ insurers reduced their

medical loss ratios by nine percentage points overall, from 95 percent to 86 percent. And, by holding steady their administrative costs, their profit margins improved by 11 points, from -7.4 percent to 3.3 percent.

Because of this financial improvement, rebates increased by almost 50 percent in 2017. But rebates still remained much lower than in the ACA's early years, averaging only \$9 a person for 2017 (\$0.73 a month) marketwide.

Rebates remained low for two reasons. First, although insurers' MLRs dropped quite a bit, they remained above the regulatory minimum on average. Second, for insurers with 2017 loss ratios below 80 percent, their earlier losses in 2015–2016 decreased the rebate amount they owed because the rebate is calculated using a three-year rolling average.

This effect can be seen by examining insurers that were in the individual market all three years, 2015–2017. Out of 303 such insurers with at least 1,000 members, there were 74 insurers with loss ratios below the required 80 percent in 2017. Without the three-year rolling average, these more profitable insurers would have owed rebates averaging \$258 per member in 2017. Instead, the ACA's three-year look-back rule required insurers that were in the market that long to pay a rebate of only \$21.55 per member for the year. This reduction allowed these insurers to recoup \$919 million of prior 2015–2016 losses overall.

Exhibit 2. Financial Performance of the Individual Market, 2015 to 2017

Per member per month	2015–2016	2017	Change 2015–2016 to 2017
Premium	\$367	\$420	14%
Claims and quality expenses	\$349	\$361	3%
Medical loss ratio	95%	86%	-9%
Administrative expenses	\$45	\$45	0%
Profit	-\$27	\$14	152%
Profit margin	-7.4%	3.3%	11%
Rebate	\$0.50	\$0.73	45%

Data: Center for Consumer Information and Insurance Oversight, *Summary of 2016 Medical Loss Ratio Results* (CCIIO, Dec. 2017).

PROTECTION OF CONSUMERS

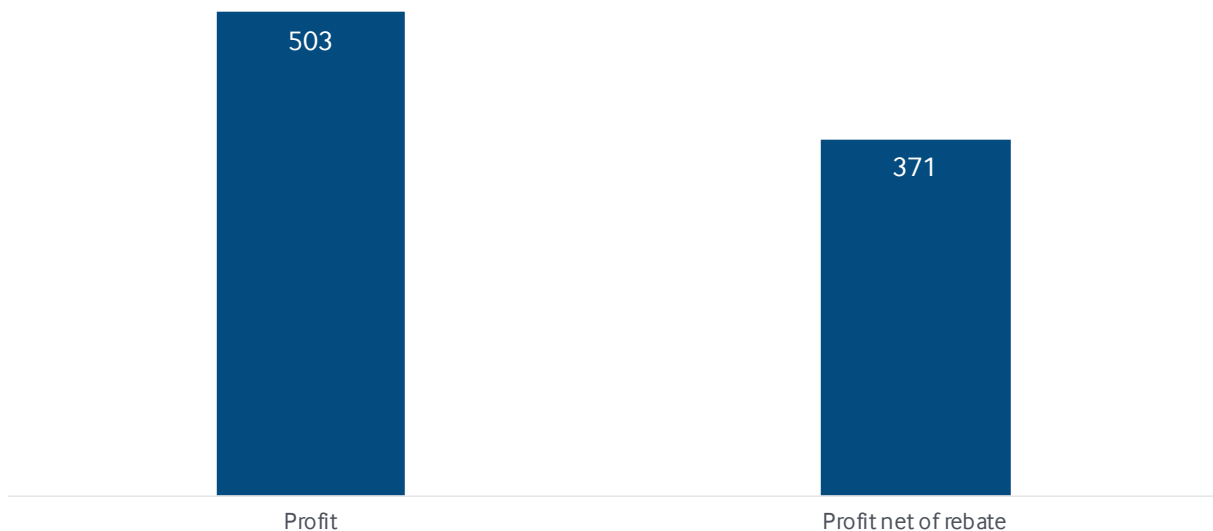
At the same time the ACA's MLR rule helps cushion the extent of insurers' losses over time, it also continues to protect consumers against overpriced health plans. Although most insurers in 2017 owed no rebates, 29 insurers paid a rebate of \$140 per member, amounting to \$132 million, or 3.3 percent of their premiums. Not counting these rebates, these insurers had a handsome overall profit margin of 12.6 percent in 2017. As shown in Exhibit 3, these rebates reduced their profit margins by slightly more than 25 percent.

This backstop against excessive profits is expected to have even more importance once full financial reporting is complete for 2018, which included a second round of substantial rate increases.²⁰ Despite owing rebates for 2017, insurers continued to increase rates for 2018 in part because they had to file their 2018 rates in mid-2017 without their complete 2017 financial performance data in hand. Also, insurers had to anticipate possible disruptions to the market caused by changes to the ACA's market rules.

By building in more cushion than they needed, insurers are expecting substantially lower loss ratios in 2018, which will generate much higher rebates. One recent analysis projects that loss ratios in the individual market will drop to 70 percent for 2018, resulting in close to \$1 billion in rebates.²¹

These consumer protections could have substantially more impact in some states than in others, depending on how much insurers were permitted to increase rates in each state. Across 50 states and the District of Columbia, insurers in 26 jurisdictions had no rebates for 2017 in the individual market, and rebates were less than \$5 a person in 11 states. However, in seven states (Arizona, Massachusetts, Minnesota, Mississippi, Missouri, New Hampshire, and New Mexico), rebates exceeded \$50 per person in the 2017 individual market.²² Notably, in four of these seven states (Minnesota, Missouri, New Hampshire, and New Mexico), a single insurer with profit margins of 15 percent or greater was solely responsible for the rebate (Exhibit 4).

Exhibit 3. Rebate Insurers: Total Profit and Profit Net of Rebate in 2017 (in \$ millions)



Data: Center for Consumer Information and Insurance Oversight, *Summary of 2016 Medical Loss Ratio Results* (CCIIO, Dec. 2017).

Exhibit 4. Rebates in Four Sample States

	Insurer	Profit margin	Members	Rebate	Rebate/Member
Minnesota	HMO Minnesota	26.7%	40,798	\$19,605,596	\$481
	All others	15.6%	93,477	\$0	\$0
Missouri	Healthy Alliance	17.2%	137,694	\$21,764,490	\$158
	All others	4.1%	170,551	\$0	\$0
New Hampshire	Celtic	14.8%	17,331	\$6,673,214	\$385
	All others	5.0%	60,936	\$0	\$0
New Mexico	Molina	15.2%	26,416	\$4,199,476	\$159
	All others	-17.7%	38,860	\$0	\$0

Data: Center for Consumer Information and Insurance Oversight, *Summary of 2016 Medical Loss Ratio Results* (CCIIO, Dec. 2017).

CONCLUSION

When the ACA's medical loss ratio rule first took effect in 2011, its protections were more visible to consumers, who received significant rebates while insurers substantially reduced overhead costs. In subsequent years, these protections became less noticeable, as insurers in the individual market struggled with substantial losses.

Now that the individual market appears to have regained profitability, however, the ACA's MLR rule has renewed relevance, both for consumers and insurers. The rule has resumed its important role of paying rebates to consumers whose health plans enjoy substantial profits. Additionally, the MLR rule affords insurers that suffer substantial losses an opportunity to recoup some of those losses by averaging a low loss ratio against two prior years of high loss ratios.

By smoothing out oscillations in profits and losses, the ACA's MLR rebate rule holds the prospect of not only continuing to protect consumers, but also of helping to counter some of the destabilizing effects of ongoing changes in regulatory policy in the individual market.

NOTES

1. Loss ratios are calculated as the three-year rolling average, meaning that the regulatory standard is applied each year to the insurer's average loss ratio during the prior three years.
2. In most states, large groups are those with more than 50 full-time workers, except in the few states (California, Colorado, and New York) that have opted to extend small-group rules to groups of 100 or less.
3. Michael J. McCue and Mark A. Hall, *The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3* (Commonwealth Fund, Mar. 2015).
4. Center for Consumer Information and Insurance Oversight, *The 80/20 Rule Increases Value for Consumers for Fifth Year in a Row* (CCIIO, Nov. 2016).
5. Center for Consumer Information and Insurance Oversight, *Summary of 2016 Medical Loss Ratio Results* (CCIIO, Dec. 2017).
6. Michael J. McCue and Mark A. Hall, "On the Road to Recovery: Health Insurers' 2016 Financial Performance in the Individual Market," *To the Point* (blog), Commonwealth Fund, Mar. 22, 2018.
7. Louise Norris, "Billions in ACA Rebates Show 80/20 Rule's Impact," *Healthinsurance.org*, May 10, 2019.
8. Charles Gaba, www.ACASignups.net (Rate Hikes menu); and Cynthia Cox, Rachel Fehr, and Larry Levitt, *Individual Insurance Market Performance in 2018* (Henry J. Kaiser Family Foundation, May 2019).
9. American Academy of Actuaries, *Drivers of 2018 Health Insurance Premium Changes* (AAA, July 2017).
10. Chris Sloan, Elizabeth Carpenter, and Chad Booker, *2019 Premium Increases Lowest on Average Since 2015* (Avalere, Sept. 13, 2018).
11. Mark A. Hall, *Stabilizing and Strengthening the Individual Health Insurance Market: A View from Ten States* (Brookings Institution, July 2018).
12. CCIIO, *The 80/20 Rule*, 2016.
13. Ashley Semanskee et al., *Insurer Participation on ACA Marketplaces, 2014–2018* (Henry J. Kaiser Family Foundation, Nov. 2017); and Craig Garthwaite and John A. Graves, "Success and Failure in the Insurance Exchanges," *New England Journal of Medicine* 376, no. 10 (Mar. 9, 2017): 907–10.
14. David Blumenthal, "The Three R's of Health Insurance," *To the Point* (blog), Commonwealth Fund, Mar. 5, 2014.
15. Sarah Goodell, *Risk Corridors* (*Health Affairs*, updated Feb. 2015).
16. Shelby Livingston, "Feds Owe Health Insurers \$12.3 Billion in Unpaid Risk-Corridor Payments," *Modern Healthcare*, Nov. 14, 2017.
17. See note 11.
18. Mark A. Hall and Michael J. McCue, "How Do Noncompliant Health Plans Affect the Market?," *To the Point* (blog), Commonwealth Fund, Nov. 15, 2017; and Kevin Lucia et al., *State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market* (Commonwealth Fund, Mar. 2018).
19. Following the ACA medical loss ratio rules, we include in medical claims the amounts insurers spend on quality improvement, which averaged less than 1 percent of premiums. Premiums are net of taxes and other assessments.
20. Norris, "Billions in ACA Rebates," 2019.
21. Cox, Fehr, and Levitt, "Individual Insurance Market," 2019.
22. These are averages weighted by membership across the entire market, including insurers that paid no rebates in the state.

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