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# Realizing Health Reform's Potential

## The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 2

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**Abstract:** For the past two years, the Affordable Care Act has required health insurers to pay out a minimum percentage of premiums in the form of 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 2012 were \$513 million, half the amount paid out in 2011, indicating greater compliance with the MLR rule. Spending on quality improvement remained low, at less than 1 percent of premiums. Insurers continued to reduce their administrative and sales costs, such as brokers' fees, without increasing profit margins, for a total reduction in overhead of \$1.4 billion. In the first two years under this regulation, total consumer benefits related to the medical loss ratio—both rebates and reduced overhead—amounted to more than \$3 billion.



### OVERVIEW

One of the consumer protections afforded by the Affordable Care Act (ACA) is the regulation of health insurers' "medical loss ratios," or MLRs. An MLR is a key financial measure that shows the percentage of premium dollars a health insurer pays out for medical care and quality improvement expenses, as opposed to the portion allocated to overhead in the form of 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, the cost of insurance to consumers and the government, the ACA sets minimum MLRs for insurers. Starting January 1, 2011, insurers offering comprehensive major medical policies were required to maintain an MLR of at least 80 percent in the individual and small-group markets and at least 85 percent in the large-group market.<sup>1</sup> Insurers that pay out less than these percentages on medical care and quality improvement must rebate the difference to their members.

Any major new regulation of an industry requires a period of adjustment, and often some measure of disruption or dislocation can be expected. A year ago, we reported that health insurers that failed to meet the MLR requirements paid out over \$1 billion in rebates to consumers in 2012.<sup>2</sup> In addition, insurers reduced administrative costs and profits by over \$350 million, in part to reduce the rebates they might owe. Insurers reported spending less than 1 percent of their premium revenues on improving the quality of care.<sup>3</sup>

This issue brief revisits these measures a year later to determine whether there has been an impact of similar magnitude in the MLR regulation's second year. We find that rebates in year 2 dropped by half, to \$513 million, indicating greater compliance with the minimum MLR standard. Insurer spending on quality improvement remained low, at less than 1 percent of premiums. However, insurers continued to reduce their administrative and sales costs, such as brokers' fees, without increasing profit margins, for a total reduction in overhead of \$1.4 billion. This is on top of the \$350 million of reduced overhead seen in 2011. It is not known exactly how much of the reduced overhead can be attributed to the new MLR regulation rather than to market competition, but it seems fair to conclude

that total consumer benefits related to the MLR have amounted to more than \$3 billion in the first two years (consisting of \$1.5 billion in rebates and \$1.75 billion in reduced overhead).

Data for this brief come mainly from insurers' MLR filings with the Centers for Medicare and Medicaid Services (CMS) for 2011 and 2012. Using these data, each section of this report draws on a different sample of insurers: all reporting insurers, or insurers with "credible" actuarial experience (defined as having at least 1,000 members in each market segment). (For more, see "About This Study," below.)

## CONSUMER REBATES

Overall, the amount that insurers paid in consumer rebates dropped by half from 2011 to 2012, from \$1.1 billion to \$513 million dollars (Exhibit 1). This total reflects both a reduction in the percentage of insurers owing rebates and in the size of rebates they owed. The pattern varied somewhat by market segment, but in general, there was a greater drop in the size of rebates than in the percentage of insurers that paid rebates (Exhibit 2).

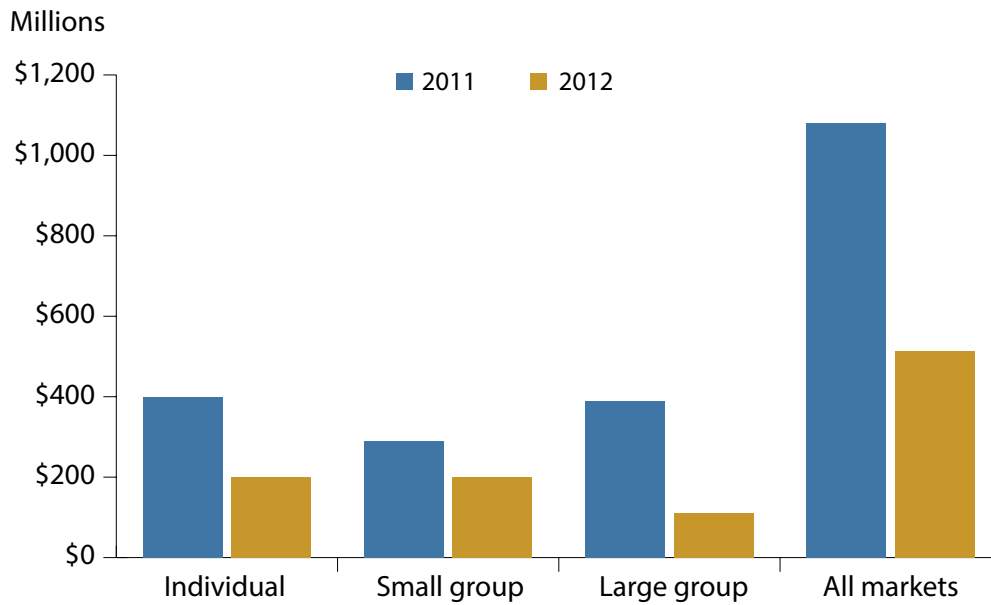
In the individual market, the median adjusted MLR<sup>4</sup> among insurers increased 2 percentage points,

### ABOUT THIS STUDY

Study data were collected from the Centers for Medicare and Medicaid Services (CMS) as of August 1, 2013, for 2012 data and November 26, 2012, for 2011 data. Data were collected from health insurers in 50 states and the District of Columbia, but not from the territories. The key financial measures are referenced from insurers' National Association of Insurance Commissioners Supplemental Health Care Exhibit. In calculating financial measures, we included all insurers regardless of size, but we excluded those with negative or zero values for premium earned or medical claims. For the individual market, this produced a sample of 1,904 insurers in 2011 and 1,635 in 2012; for the small-group market, there were 1,030 insurers in 2011 and 950 in 2012; and for large-group insurers, 907 in 2011 and 852 in 2012.

CMS requires only insurers with "credible" actuarial experience to calculate MLRs and pay rebates. Actuarial credibility for this purpose requires at least 1,000 members in the particular market segment in a state. In 2011, this number was based on only a year of experience. In 2012, however, insurers were required to determine credibility based on two years' of experience combined, so more insurers became credible and thus subject to the MLR rule in 2012 than in 2011. Because of this change in measuring credibility, when we counted the number of active insurers, we did not use the CMS credibility rule. Instead, we counted insurers that had at least 1,000 members in a single year.

### Exhibit 1. Consumer Rebates in the Individual, Small-Group, and Large-Group Markets



Source: Authors' analysis of CMS rebate data.

from 82.5 percent to 84.5 percent, between 2011 and 2012. Overall, individual market insurers paid \$200 million in rebates in 2012, about half the amount they rebated the year before and less than 1 percent of their premium.

In the group markets, the median adjusted MLR increased less than 1 percentage point for both small- and large-group insurance. For the small-group market, this resulted in a smaller decline in rebates than for large groups. Total small-group rebates dropped 30

percent from 2011 to 2012, from \$289 million to \$201 million, whereas total large-group rebates dropped 71 percent, from \$388 million to \$111 million.

We also observed whether MLRs and the percentage and size of rebates differed among insurers according to their corporate characteristics. In 2012, as in 2011, insurers had lower median MLRs in most market segments, and thus were more likely to owe rebates, if they were for-profit, publicly traded, or not sponsored by health care providers (Exhibit 3).

### Exhibit 2. Medical Loss Ratios and Rebates by Market Segment, 2012 and 2011

	Individual		Small Group		Large Group	
	2011 n=548	2012 n=655	2011 n=562	2012 n=622	2011 n=587	2012 n=663
Median adjusted MLR	82.5%	84.5%	84.6%	85.3%	89.2%	89.6%
Percentage of credible insurers owing rebate	38%	32%	20%	18%	18%	15%
Median rebate per member	\$108	\$95	\$116	\$86	\$99	\$57
Total rebate paid (in millions)	\$399.5	\$200.4	\$289.1	\$201.4	\$388.2	\$111.3
Rebate as a percentage of premium	1.39%	0.72%	0.38%	0.28%	0.192%	0.06%

Insurers with actuarial “credibility” are those with enough enrollment to be subject to the MLR rule. Adjusted MLRs are defined in [note 4](#) on page 8. Source: Authors' analysis of CMS medical loss ratio and rebate data.

### Exhibit 3. 2012 MLR and Rebate by Corporate Type

Individual Market	Median Adjusted MLR	Percentage Owing Rebate
Non-publicly traded n=325	88%	28%
Publicly traded n=330	82%	36%
Not-for-profit n=117	93%	10%
For-profit n=538	83%	37%
Provider-sponsored n=40	98%	10%
Non-provider-sponsored n=615	84%	34%
Small-Group Market		
Non-publicly traded n=325	87%	14%
Publicly traded n=297	84%	22%
Not-for-profit n=156	87%	10%
For-profit n=466	85%	21%
Provider-sponsored n=60	92%	3%
Non-provider-sponsored n=562	85%	19%
Large-Group Market		
Non-publicly traded n=314	92%	10%
Publicly traded n=349	88%	20%
Not-for-profit n=171	92%	2%
For-profit n=492	89%	20%
Provider-sponsored n=68	93%	2%
Non-provider-sponsored n=595	89%	17%

Source: Authors' analysis of CMS medical loss ratio and rebate data.

### Insurers' Financial Performance

We next analyzed how key financial performance measures for insurers changed from 2011 to 2012. Last year, we reported that between 2010 and 2011, the first year of the MLR rule, administrative costs decreased nationally in each fully insured market segment. The biggest decrease—more than \$785 million—occurred in the large-group (fully insured) market, with reductions of about \$200 million in both the small-group and individual markets.<sup>5</sup> For the large-group and small-group markets, this \$975 million combined reduction in administrative costs coincided with increases in profits of more than \$1 billion. In the individual market, profit margins declined by \$351 million, which was more than administrative costs.

As shown in Exhibits 4 and 5, similar trends continued and increased in the MLR rule's second year. The overall MLR for the industry (unadjusted for quality expenses or other factors) increased by half a percentage point, which means that premium amounts

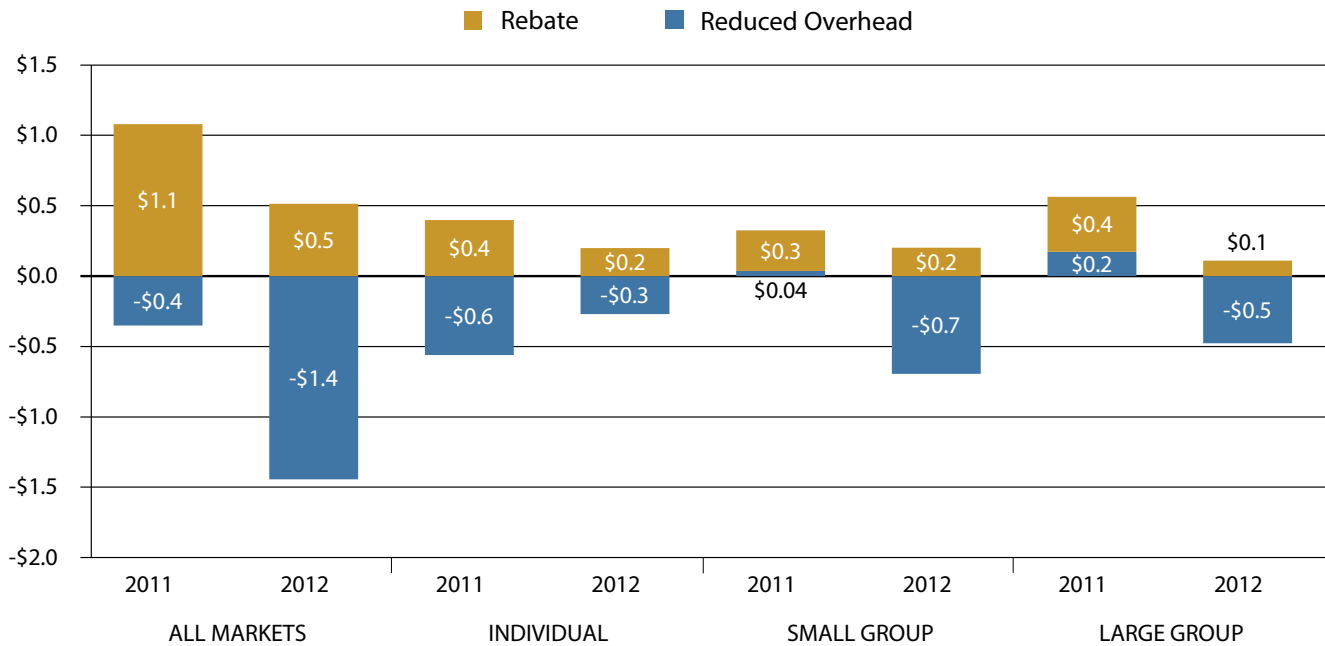
devoted to overhead (profits plus administrative and sales costs) decreased by \$1.4 billion. The lowered overhead—while not entirely attributable to the MLR rule—represents a significant benefit for consumers.

### Quality Expense and Overhead Components

Exhibit 5 presents components of insurers' expenses that are of particular interest for public policy. The Affordable Care Act's MLR rule regards expenses for quality improvement (for definition, see glossary on page 7) as being part of medical claims rather than part of administrative expenses. In 2012, these quality improvement expenses remained just under 1 percent of premiums.<sup>6</sup>

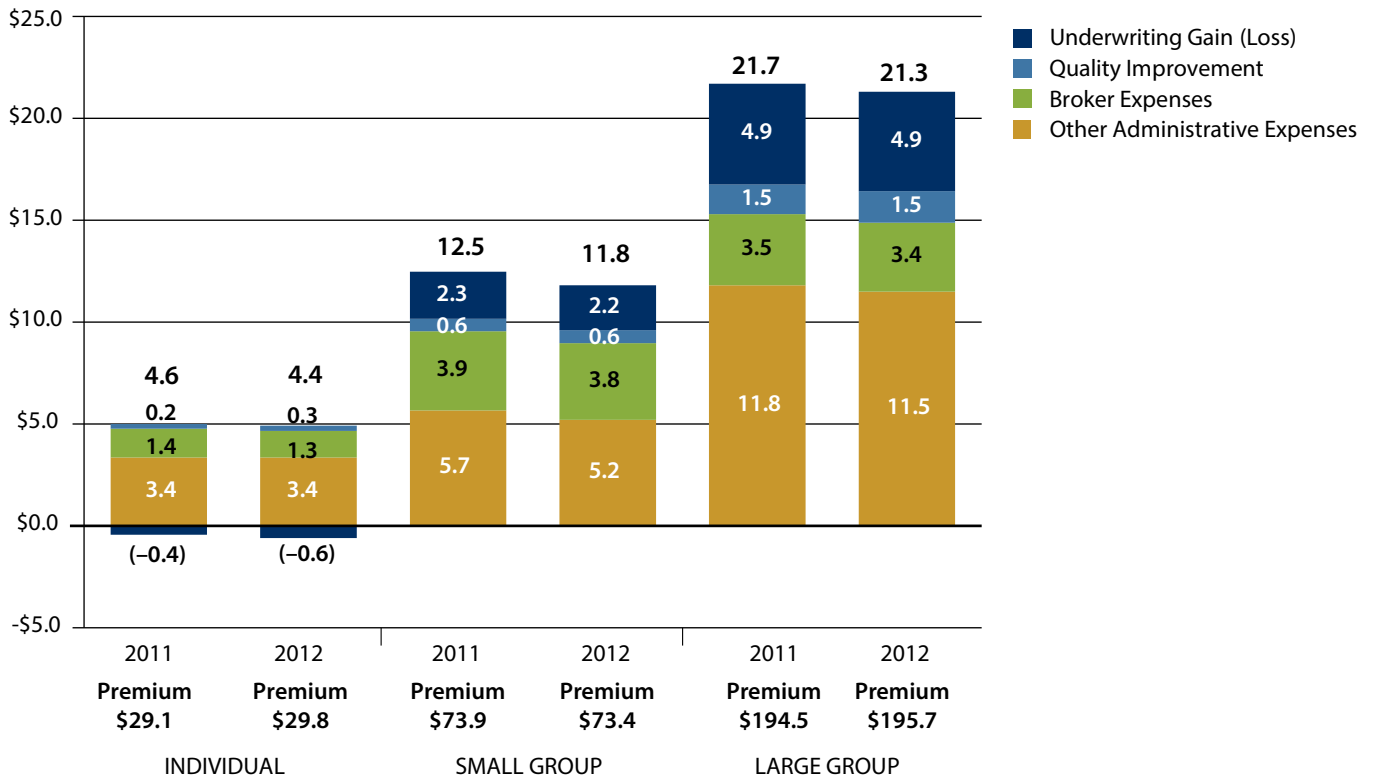
We also focus on insurers' expenses for brokers as a component of administrative costs. This issue is significant because of the concern that increasing MLRs will cause insurers to reduce the role of—or compensation for—independent brokers. Broker expenses, which amount to about 3 percent of

**Exhibit 4. Insurance Rebates and Overhead Reductions, 2011 and 2012, by Market (in billions)**



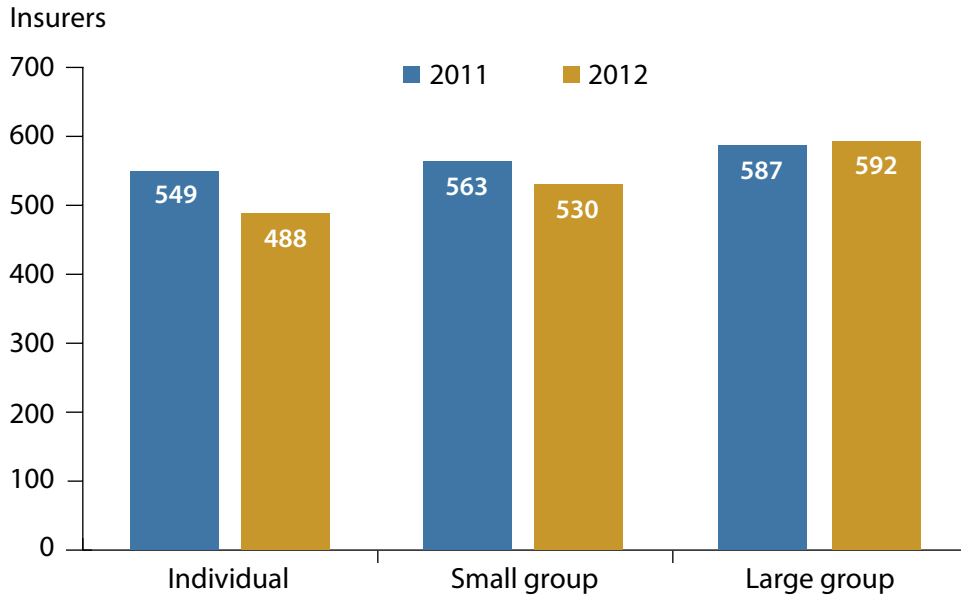
Note: Overhead consists of profits plus administrative and sales costs.  
 Source: Authors' analysis of NAIC and CMS medical loss ratio and rebate data.

**Exhibit 5. Components of Insurance Overhead and Quality Improvement Spending, by Market (in billions)**



Source: Authors' analysis of CMS medical loss ratio data.

### Exhibit 6. Number of Credible Insurers with 1,000 or More Members, by Market



Source: Authors' analysis of CMS medical loss ratio and rebate data.

premiums, dropped by almost \$300 million across all three markets in 2012. However, that amounts to only 3.5 percent of total broker expense.

Finally, insurers' total profits (also known as underwriting gain) for all markets declined by over \$300 million, which is only 0.1 percent of premiums. Individual insurance continued to show a small loss, while group insurance had underwriting gains of 2.5 percent to 3 percent.

#### Number of Insurers

When the Affordable Care Act was enacted, some critics predicted it would cause an exodus of insurers from the market.<sup>7</sup> 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.

In 2012, there was a modest contraction but still a substantial number of insurers actively competing (Exhibit 6). Throughout the country, there were roughly 500 insurers in each market segment (individual, small-group, and large-group). These numbers reflect modest decreases from 2011 in the individual and small-group markets, where the number of insurers

with at least 1,000 members declined 11 percent and 6 percent, respectively.<sup>8</sup>

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.<sup>9</sup> Therefore, a modest reduction in the number of insurers does not appear to be strongly related to the Affordable Care Act. Perhaps some insurers have left because their business model depended on the type of close medical underwriting that the ACA now prohibits. However, the ACA's subsidized insurance marketplaces are credited with bringing a significant number of new insurers into the individual market.<sup>10</sup>

#### CONCLUSION

The new federal regulation of health insurers' medical loss ratios continues to provide substantial consumer benefits in its second year of operation. Although total rebates to consumers dropped by half, from over \$1 billion to \$513 million for 2012, this results from insurers' greater compliance with the MLR rule. To meet the new minimums, insurers also reduced their administrative costs without substantially increasing profits,

producing a net reduction in overhead of \$350 million in 2011 and \$1.4 billion in 2012. The combined effect of both \$1.5 billion in rebates and \$1.75 billion in reduced overhead amounts to more than \$3 billion of consumer benefit related to the MLR rule in the first two years. However, insurer spending on quality improvement has remained low, at less than 1 percent of premium, 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 was a modest reduction in the number of insurers with 1,000 or more members, this appears to continue a decade-long trend of consolidation. Despite this reduction, roughly 500 insurers appear to remain active in both the individual and the group markets across all states. On balance, federal regulation of MLRs appears to be producing significant consumer benefits without causing any substantial harm to the insurance markets.

### GLOSSARY OF FINANCIAL MEASURES

**Premium earned** is net adjusted premium earned after accounting for reinsurance.

**Medical expense** is net incurred medical claims after accounting for reinsurance. This is a gross measure that 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.

**Quality improvement costs** are all expenses related to improving quality of care activities and include the following activities: improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, increasing wellness and promotion, and incurring health information technology expenses for improving quality of care. Total quality of care is 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 costs or improving quality of care. 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, but here 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 medical and quality improvement expenses and administrative and sales 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.

## NOTES

- <sup>1</sup> The small-group market consists of employers with 50 or fewer workers.
- <sup>2</sup> M. J. McCue and M. A. Hall, *Insurers' Responses to Regulation of Medical Loss Ratios* (New York: The Commonwealth Fund, Dec. 2012).
- <sup>3</sup> M. A. Hall and M. J. McCue, *Insurers' Medical Loss Ratios and Quality Improvement Spending in 2011* (New York: The Commonwealth Fund, Mar. 2013).
- <sup>4</sup> 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.
- <sup>5</sup> McCue and Hall, *Insurers' Responses*, 2012. In data not shown, insurers reported a somewhat lower proportion of quality expense being devoted to health outcomes (44% in 2012 vs. 51% in 2011) but a somewhat increased proportion being devoted to wellness and health promotion (17% in 2012 vs. 13% in 2011). It is difficult to interpret how meaningful these changes are in how insurers allocate quality expenses.
- <sup>6</sup> Ibid.
- <sup>7</sup> For instance, R. Epstein, "Unmanageable Competition," *Forbes*, Nov. 24, 2009.
- <sup>8</sup> 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.
- <sup>9</sup> J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, Nov. 2004 25(6):11–24; American Medical Association, *Competition in Health Insurance* (various years); D. Andrew Austin and T. L. Hungerford, *The Market Structure of the Health Insurance Industry* (Washington, D.C.: Congressional Research Service, 2009).
- <sup>10</sup> McKinsey Center for U.S. Health System Reform, *Emerging Exchange Dynamics: Temporary Turbulence or Sustainable Market Disruption?* (New York: McKinsey and Company, 2013); J. Holahan et al., *Insurer Participation and Competition in Health Insurance Exchanges* (Urban Institute, 2013), [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf406939](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf406939).



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