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Issue Brief

Estimating the Impact of the Medical Loss Ratio Rule: A State-by-State Analysis

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ABSTRACT: One of the most visible consumer protections in the Patient Protection and Affordable Care Act is the requirement that health insurers pay out at least 80 percent to 85 percent of premium dollars for medical care expenses. Insurers that pay out less than this minimum "medical loss ratio" (MLR) must rebate the difference to their policyholders, starting in 2011. Using insurers' MLR data from 2010, this issue brief estimates the rebates expected in each state if the new rules had been in effect a year earlier. Nationally, consumers would have received almost $2 billion of rebates if the new MLR rules had been in effect in 2010. Almost $1 billion would be in the individual market, where rebates would go to 5.3 million people nationally. Another $1 billion would go to policies covering about 10 million people in the small- and large-group markets.

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OVERVIEW

One of the most visible 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 out for medical care expenses, as opposed to the portion kept for profits, overhead, and sales expenses.[1]

The Affordable Care Act sets minimum MLRs for insurers to reduce administrative costs and thus the ultimate cost of insurance to consumers and the government. 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] Insurance companies that pay out less than these percentages on medical care and health care quality improvement must rebate the difference to their policyholders.

The new MLR regulations took effect January 1, 2011, and consumers will receive their first rebates in the summer of 2012 from health insurers that fail to meet the requirements. This issue brief uses insurers' data from 2010 to make rough projections about the impact of the MLR rules by estimating the rebates

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that would have been expected if the new MLR rules had been in effect a year earlier. These "what if" estimates provide a rough prediction of the impact the MLR rules may have in their first year of application—either by way of requiring rebates or by motivating insurers to reduce rates in order to avoid rebates.

This issue brief first describes the sampling process to determine which insurers offering health insurance policies are projected to owe a rebate and discusses how the rebates are estimated. Next, it presents estimated rebates by state, market segment, and insurer characteristics (e.g. publicly traded vs. nonpublicly traded, nonprofit vs. for-profit, and provider-sponsored vs. non–provider-sponsored). Finally, it discusses the implications and limitations of these findings.

HOW THIS STUDY WAS CONDUCTED

Insurer Sample Selection

We included both health and life insurers that offer comprehensive medical coverage and filed their annual financial reports using the National Association of Insurance Commissioners' (NAIC) Supplemental Health Care Exhibit (SHCE).[3] Under the Affordable Care Act, multistate insurers are required to complete the SHCE form for each state in which they have a corporate subsidiary. Thus, our initial sample included 2,633 state insurers that offer comprehensive health insurance as either health or life insurers. The number of members covered by individual, small-group, and large-group policies were 10.1 million, 17.9 million, and 39.6 million, respectively. We excluded property and casualty and fraternal insurers unless they filed as a health insurer.[4,5] Since insurers with enrollment of fewer than 1,000 members have less actuarial "credibility,"—meaning they face greater variability of medical utilization and costs—these insurers are exempted from the MLR rebate regulation.[6] As a result, our reduced sample included the 985 "credible" insurers that covered an average of at least 1,000 members during the calendar year.[7]

Insurers typically have multiple corporate entities within a given state, for different products lines—health maintenance organization (HMO) vs. preferred provider organization (PPO), for example—and for affiliates created or acquired at different times. Therefore, we further aggregated the corporate subsidiaries within each state that belong to a single insurance group.[8] On the basis of corporate affiliation within each state, the total sample size was 648 "credible" insurers who would be subject to the MLR rules (i.e. they averaged at least 1,000 members over the year) if the rules were in effect in 2010. These include 406 insurers offering individual coverage, 396 offering small-group policies, and 421 offering large-group insurance (Exhibit 1). These credible insurers covered about 9.8 million people through individual policies, 17.8 million through small-group policies, and 39.5 million through large-group insurance.

Exhibit 1. Number of Insurers by Market Segment

Types of insurance offered	All individual insurers	Credible* individual insurers	All small-group insurers	Credible* small-group insurers	All large-group insurers	Credible* large-group insurers
Only individual	918	78				
Only small-group			72	8		
Only large-group					70	24
Only individual and small-group	156	72	156	20		
Only individual and large-group	104	10			104	46
Only small- and large-group			77	50	77	48
Individual, small- and large-group	387	246	387	318	387	303
Total	1,565	406	692	396	638	421

* Credible means insurer covers on average at least 1,000 members during the calendar year of 2010 and so would be subject to MLR regulation. Credible insurers operating in more than one market segment may not have credible blocks of business in all market segments. Shown here are insurers with more than 1,000 members in at least one (but not necessarily every) market segment in which they do business.
Source: Authors' analysis.

Measuring Medical Loss Ratios

The Affordable Care Act requires health insurers to pay a rebate to consumers if they do not comply with the minimum medical loss ratio (MLR) of 80 percent for individual and small-group policies and 85 percent for large-group policies. The law 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. Medical loss ratios can be calculated in a variety of ways, depending on how the numerator of medical claims and the denominator of total premiums are defined. The Affordable Care Act's rules differ from standard financial ratios in two important ways. First, the MLR numerator for medical claims includes the cost of quality improvement activities and fraud and abuse detection and recovery expenses. Second, the denominator for total premiums subtracts federal and state taxes and assessments. Both these adjustments result in a higher MLR than a standard financial report, which makes it easier for insurers to meet the minimum MLR requirements.

Full calculation of MLR rebates requires several additional adjustments. The first is a "credibility" adjustment based on average membership, to reflect the fact that insurers with smaller enrollments face greater variability of medical utilization and costs. Insurers with fewer than 75,000 members receive a sliding-scale adjustment ranging from 8.3 percent for 1,000 members to no adjustment for 75,000 or more members. Those with fewer than 1,000 members are exempt from the MLR requirement entirely. We make this adjustment using available data but are not able to make two other allowed adjustments: one for high-deductible insurance,[9] and another for amounts that insurers retain to pay claims filed after year-end for medical care delivered during the current year.[10] Despite the limitations, our aggregate findings are broadly consistent with those from other analysts.[11]

For 2011 through 2013, the MLR regulation also allows states to request a waiver from the Department of Health and Human Services for individual health insurance only. To receive this waiver, states must show that complying with the 80 percent MLR would force too many insurers to exit the individual market and leave members with too few insurance options. Seven states have been granted a waiver out of the 17 that applied, with allowable MLRs ranging from 65 percent to 75 percent (Exhibit 2b below). We use these waivered levels to calculate the expected rebates in those particular states.

ESTIMATING MEDICAL LOSS RATIOS, BY STATE AND MARKET SEGMENT

Rebates for Individual Coverage

Exhibit 2a shows the number and percentage of insurers per state that would owe a rebate for individual coverage if the MLR rules had been in effect in 2010. The exhibit also indicates the total rebate per state (with top five states bolded), and the estimated median rebate per member among insurers that owe any rebate.[12] For states that have received a waiver, Exhibit 2b shows the reduced minimum MLR and what the median rebates would have been without a waiver.

Nationally, we estimate that insurance consumers in the individual market would have received almost a billion dollars in rebates for 2010 if the new MLR rules had been in effect then. Rebates would go out to 5.3 million of the 10.1 million people covered by this type of insurance, which is 53 percent of the individual market nationally.

At a state level, total estimated rebates would be the highest for Texas and Florida, with $172 million and $109 million in rebates, respectively. Fifteen insurers in Texas and 10 in Florida would owe a rebate in the individual market. The next three states with the highest estimated total rebates are: Illinois ($67 million), Virginia ($50 million), and Missouri ($43 million). Eleven states have at least eight insurers that would pay a rebate (Arizona, Florida, Georgia, Illinois, Michigan, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee, and Texas). Among these states, the highest rebate per member is North Carolina with $285 and the lowest is Florida with $145 per member.

Exhibit 2a. Estimated Individual Coverage Rebates and Market Share by State, 2010

State	Number of insurers owing a rebate	Market share of insurers owing a rebate	Estimated total rebate	Annual rebate per member
AK	1	8%	$482,171	$368
AL	5	9%	$4,478,261	$278
AR	5	89%	$8,565,831	$81
AZ	10	95%	$37,263,440	$153
CA**	3	31%	$36,404,709	$123
CO	7	37%	$24,384,475	$219
CT	5	42%	$13,519,939	$296
DC	2	22%	$487,761	$111
DE	2	33%	$1,387,174	$228
FL	**10**	**88%**	**$108,879,716**	**$145**
GA*	11	45%	$37,110,259	$233
HI	0	0%	$0	$0
IA*	5	13%	$4,682,827	$207
ID	4	53%	$3,943,771	$58
IL	**12**	**92%**	**$67,205,184**	**$159**
IN	6	92%	$24,514,821	$148
KS	6	45%	$10,182,059	$180
KY*	4	98%	$8,385,536	$58
LA	5	17%	$9,018,369	$321
MA	2	5%	$3,139,868	$603
MD	5	22%	$14,981,817	$359
ME*	1	34%	$5,436,001	$425
MI	9	31%	$24,425,945	$239
MN	2	12%	$7,906,157	$266
MO	**10**	**88%**	**$42,999,105**	**$203**
MS	6	79%	$8,416,768	$134
MT	4	40%	$6,403,902	$304
NC*	8	15%	$18,144,,817	$285
ND	1	12%	$1,390,628	$283
NE	4	27%	$5,460,006	$185
NH*	4	94%	$7,011,095	$217
NJ	1	4%	$749,781	$151
NM	2	4%	$1,045,584	$439
NV*	6	94%	$11,385,107	$139
NY	1	3%	$2,192,486	$661
OH	6	74%	$39,240,643	$263
OK	6	89%	$16,038,939	$149
OR	3	14%	$7,811,583	$298
PA	10	34%	$31,131,338	$195
RI	0	0%	$0	$0
SC	8	82%	$34,089,117	$311
SD	1	4%	$156,414	$69
TN	8	64%	$25,337,381	$169
TX	**15**	**93%**	**$171,965,247**	**$251**
UT	7	36%	$4,156,869	$81
VA	**7**	**88%**	**$50,525,971**	**$181**
VT	0	0%	$0	$0
WA	3	33%	$6,504,757	$62
WI	5	40%	$10,326,494	$148
WV	4	80%	$4,373,491	$251
WY	2	27%	$1,429,844	$217
US***		53%	$965,073,457	$183

Bolding indicates the five states with the highest total rebate amounts.

* Approved waiver states. ** California data are incomplete. *** Insurers total estimated rebate value is a sum value; rebate per member is total rebates divided by rebate members; market-share percentage is total insured members divided by total insured members receiving a rebate.

Source: Authors' analysis and Center for Consumer Information & Insurance Oversight, Centers for Medicare and Medicaid Services.

Exhibit 2b. Revised Individual Coverage Rebates in Waiver States

Waiver states	Annual rebate per member assuming 80 percent MLR	MLR waiver percentage in 2011	Revised annual rebate per member
GA	$258	70%	$233
IA	$238	67%	$207
KY	$61	75%	$58
ME	$500	65%	$425
NC	$300	75%	$285
NH	$235	72%	$217
NV	$146	75%	$139

Source: Authors' analysis.

No insurers in Hawaii, Rhode Island, or Vermont would have been expected to pay a rebate if the new MLR rules had been in effect in 2010. In Idaho and Kentucky, individual insurers owing a rebate would have had the lowest rebates of $58 per member. It is notable that Maine would have made one of the highest rebate amounts of $425 per member even though it received a waiver to phase in its MLR at a rate of 65 percent in the first year. Without the waiver, the median rebate in Maine would have increased to $500 (Exhibit 2b).[13]

In Kentucky, New Hampshire, and West Virginia, only four insurers offering individual insurance policy would have been expected to pay a rebate. Although these individual insurers represent only 15 percent of Kentucky's insurers, 20 percent of New Hampshire's insurers, and 14 percent of West Virginia's insurers (data not shown), these four insurers control 98 percent, 94 percent, and 80 percent of their respective state's individual market share. It is also important to note that both Kentucky and New Hampshire have received a waiver. Kentucky's revised MLR standard of 75 percent reduces its estimated 2010 rebate per member from $61 to $58. New Hampshire's revised MLR standard of 72 percent reduces its estimated 2010 rebate per member from $235 to $217 (Exhibit 2b).

Rebates for Small-Group Coverage

Exhibit 3 presents estimates of rebates that insurers would be expected to pay for small-group insurance (i.e., employers with 50 or fewer workers), if the new MLR rules had been in effect in 2010. Nationally, small-group insurers would have paid almost a half billion dollars in rebates to 4.3 million small-group members, representing 24 percent of that market segment.

Virginia would have six insurers owing a total of $57 million in rebates and Florida would have four insurers owing $50 million. The next three states with the highest estimated total annual rebates (shown in bold) are: Texas ($43 million), Illinois ($41 million), and Maryland ($38 million). Rebates per member would exceed $300 in California, the District of Columbia, and New Jersey, with the highest rebates estimated for California ($489) and New Jersey ($459). Small-group insurers in 11 states would not have owed any rebate; 17 states would have an estimated rebate per member of less than $100.

In Arizona, Hawaii, and Maryland, at least 40 percent of the small-group insurers would be expected to pay a rebate (data not shown), representing from 18 percent (Hawaii) to 73 percent (Arizona) of the market. Insurers covering at least half of the small-group market share would owe rebates in nine states (Arizona, Florida, Indiana, Maryland, Missouri, Oklahoma, South Carolina, Virginia, and Wisconsin).

Rebates for Large-Group Coverage

Exhibit 4 presents estimated rebates that insurers would pay for large-group insurance if the new MLR rules had been in effect in 2010. In the aggregate, large-group consumers would have received almost a half billion dollars in rebates—to 5.9 million members, or 15 percent of that market segment.[14] Large-group consumers in Maryland, Florida, and Texas would have received estimated annual rebates in excess of $40 million, while California and New York would receive estimated annual rebates of around $38 million. Rebates per member would have exceeded $300 in Michigan and New Hampshire. Large-group

Exhibit 3. Estimated Small-Group Coverage Rebates and Market Share by State, 2010

State	Number of insurers owing a rebate	Market share of insurers owing a rebate	Estimated total rebate	Annual rebate per member
AK	0	0%	$0	$0
AL	0	0%	$0	$0
AR	2	40%	$2,933,712	$57
AZ	8	73%	$21,096,518	$93
CA	2	1%	$2,646,630	$489
CO	2	12%	$10,258,092	$290
CT	2	18%	$4,728,265	$85
DC	3	33%	$14,475,203	$354
DE	2	28%	$2,192,899	$141
FL	**4**	**74%**	**$50,096,511**	**$76**
GA	7	49%	$20,195,670	$77
HI	3	18%	$3,374,091	$100
IA	1	10%	$552,383	$28
ID	0	0%	$0	$0
IL	**9**	**28%**	**$41,330,764**	**$203**
IN	7	61%	$12,797,808	$71
KS	5	15%	$5,963,792	$165
KY	0	0%	$0	$0
LA	1	2%	$297,493	$39
MA	2	3%	$4,172,981	$226
MD	**3**	**62%**	**$38,838,833**	**$151**
ME	1	2%	$40,837	$26
MI	4	5%	$5,475,469	$210
MN	0	0%	$0	$0
MO	7	75%	$31,445,646	$103
MS	1	5%	$919,113	$139
MT	3	17%	$2,087,163	$211
NC	5	9%	$3,502,739	$92
ND	0	0%	$0	$0
NE	5	44%	$9,133,135	$216
NH	1	1%	$286,532	$231
NJ	1	0.3%	$1,398,518	$459
NM	3	11%	$2,058,046	$224
NV	4	45%	$8,933,902	$153
NY	2	2%	$3,763,205	$123
OH	6	20%	$12,333,990	$78
OK	5	63%	$20,852,496	$168
OR	1	4%	$49,342	$5
PA	3	25%	$5,664,244	$21
RI	0	0%	$0	$0
SC	3	57%	$3,911,090	$35
SD	0	0%	$0	$0
TN	4	19%	$8,217,820	$103
TX	**10**	**27%**	**$43,160,221**	**$136**
UT	3	35%	$3,559,213	$48
VA	**6**	**59%**	**$57,251,964**	**$189**
VT	0	0%	$0	$0
WA	0	0%	$0	$0
WI	4	51%	$11,184,352	$63
WV	1	34%	$1,512,451	$64
WY	0	0%	$0	$0
US		24%	$472,693,133	$85

Bolding indicates the five states with the highest total rebate amounts.

* California data are incomplete. ** Insurers total estimated rebate value is a sum value; rebate per member is total rebates divided by rebate members; market-share percentage is total insured members divided by total insured members receiving a rebate.

Source: Authors' analysis.

Exhibit 4. Estimated Large-Group Coverage Rebates and Market Share by State, 2010

State	Number of insurers owing a rebate	Market share of insurers owing a rebate	Estimated total rebate	Annual rebate per member
AK	0	0%	$0	$0
AL	2	5%	$5,466,934	$218
AR	1	8%	$2,971,794	$161
AZ	5	15%	$10,745,893	$154
CA	**6**	**44%**	**$39,135,237**	**$94**
CO	3	2%	$3,448,936	$276
CT	4	28%	$6,221,888	$40
DC	5	26%	$34,711,861	$260
DE	3	13%	$517,190	$37
FL	**4**	**17%**	**$42,789,749**	**$128**
GA	7	18%	$16,981,710	$89
HI	1	2%	$1,205,585	$168
IA	0	0%	$0	$0
ID	1	1%	$164,749	$63
IL	6	2%	$3,584,636	$72
IN	1	3%	$1,818,242	$111
KS	1	1%	$87,899	$19
KY	3	65%	$11,464,698	$43
LA	1	0.40%	$81,048	$81
MA	3	1%	$2,983,405	$152
MD	**6**	**20%**	**$55,509,115**	**$231**
ME	1	4%	$450,857	$58
MI	2	1%	$5,112,485	$315
MN	1	0.40%	$319,334	$124
MO	3	11%	$7,756,319	$112
MS	2	13%	$2,120,132	$0
MT	0	0%	$0	$95
NC	4	12%	$11,136,690	$166
ND	1	2%	$390,156	$131
NE	2	10%	$1,837,553	$82
NH	1	1%	$629,610	$375
NJ	5	19%	$27,427,485	$116
NM	0	0%	$0	$0
NV	2	58%	$21,646,775	$94
NY	**7**	**15%**	**$38,119,610**	**$44**
OH	1	36%	$24,768,128	$48
OK	1	2%	$233,112	$32
OR	0	0%	$0	$0
PA	6	24%	$35,705,528	$57
RI	1	5%	$180,950	$19
SC	1	0%	$176,325	$176
SD	0	0%	$0	$0
TN	4	28%	$9,366,399	$67
TX	**7**	**27%**	**$40,213,023**	**$68**
UT	1	17%	$277,337	$3
VA	6	15%	$20,653,608	$112
VT	1	12%	$395,816	$42
WA	1	1%	$295,954	$20
WI	1	15%	$6,198,204	$38
WV	1	5%	$486,170	$66
WY	0	0%	$0	$0
US**		15%	$495,788,128	$72

Bolding indicates the five states with the highest total rebate amounts.

* California data are incomplete. ** Insurers total estimated rebate value is a sum value; rebate per member is total rebates divided by rebate members; market-share percentage is total insured members divided by total insured members receiving a rebate.

Source: Authors' analysis.

insurers in Alaska, Iowa, Montana, New Mexico, Oregon, South Dakota, and Wyoming would not have incurred any rebate. In Connecticut, the District of Columbia, Maryland, and New Jersey, more than half of the large-group insurers would pay a rebate (data not shown). In Kentucky and Nevada, large-group insurers that would owe rebates have more than 50 percent of the market share; those in eight other states (California, Connecticut, the District of Columbia, Maryland, Ohio, Pennsylvania, Tennessee, and Texas) that would owe rebates cover 20 percent or more of the market.

Rebate Estimates by Insurer Characteristics

Exhibit 5 presents the percentage of credible insurers that would be expected to pay a rebate by various insurer characteristics, as well as their median rebate per member.[15] In this exhibit, we treat each corporate entity within a state as a separate insurer—rather than aggregating affiliated subsidiaries into a single insurer—to generate more observations about how each type of corporate entity is managed.

If the new MLR rules were in effect for 2010, insurers that are privately-owned, nonprofit, and provider-sponsored would be substantially less likely than their corporate counterparts to owe rebates in each of the market segments. For some market segments, there are large differences in the likelihood of owing a rebate. Provider-sponsored health plans show the most pronounced difference, perhaps because they are more inclined to favor provider reimbursement over corporate profits. A consistent pattern did not emerge, however, for median rebate amounts among insurers owing any rebate.[16]

Overall Market in Each State

Exhibit 6 presents estimates for each state across the three market segments combined. In 26 states, at least 20 percent of commercial health insurance consumers would have received rebates for 2010 if the new MLR rules had been in effect that year. Rebates would go to almost half the market or more in Arizona, Florida, Kentucky, Missouri, and Nevada. Overall, in 19 states, nine or more insurers would owe rebates in at least part of the market, with Texas topping the list with 22 rebate insurers.

Exhibit 5. Estimated Annual Rebates by Insurer Characteristics, 2010

	Credible* insurers owing a rebate	Median rebate per member
Individual coverage		
Publicly traded (n=266)	70%**	$217**
Nonpublicly traded (n=263)	48%	$334
For-profit (n=411)	70%**	$237**
Nonprofit (n=118)	20%	$107
Non–provider-sponsored (n=499)	61%**	$230
Provider-sponsored (n=30)	23%	$174
Small-group coverage		
Publicly traded (n=292)	37%**	$108
Nonpublicly traded (n=275)	22%	$138
For-profit (n=379)	39%**	$126
Nonprofit (n=188)	12%	$78
Non–provider-sponsored (n=500)	33%**	$119
Provider-sponsored (n=67)	8%	$92
Large-group coverage		
Publicly traded (n=357)	28%**	$93***
Nonpublicly traded (n=275)	16%	$162
For-profit (n=420)	29%**	$101
Nonprofit (n=212)	10%	$117
Non–provider-sponsored (n=559)	25%**	$101
Provider-sponsored (n=73)	5%	$116

* Credible means insurer covers on average at least 1,000 members during the calendar year of 2010 and so would be subject to MLR regulation.
** = significant at .01 level. ***= significant at .05 level.
Source: Authors' analysis.

Exhibit 6. Estimated Market Share and Total Annual Rebate for Insurers Owing Rebate

State	Number of insurers owing a rebate	Overall % market receiving rebate	Total estimated annual rebate
AK	1	1%	$482,171
AL	6	4%	$9,945,195
AR	5	37%	$14,471,337
AZ	13	52%	$69,105,851
CA*	8	27%	$78,186,576
CO	9	12%	$38,091,504
CT	7	26%	$24,470,092
DC	5	27%	$49,674,824
DE	5	20%	$4,097,263
FL	**11**	**47%**	**$201,765,976**
GA*	15	32%	$74,287,639
HI	3	6%	$4,579,677
IA*	6	6%	$5,235,210
ID	5	15%	$4,108,520
IL	**17**	**21%**	**$112,120,583**
IN	10	37%	$39,130,871
KS	9	11%	$16,233,750
KY*	4	55%	$19,850,234
LA	6	5%	$9,396,910
MA	6	2%	$10,296,254
MD	**9**	**30%**	**$109,329,765**
ME*	2	7%	$5,927,694
MI	12	5%	$35,013,899
MN	3	3%	$8,225,491
MO	13	45%	$82,201,070
MS	7	24%	$11,456,013
MT	6	15%	$8,491,065
NC	12	12%	$ 32,784,247
ND	2	3%	$1,780,784
NE	7	22%	$16,430,694
NH*	5	12%	$7,927,237
NJ	6	11%	$29,575,784
NM	5	4%	$3,103,630
NV*	8	61%	$41,965,783
NY	7	12%	$44,075,301
OH	11	34%	$76,342,761
OK	10	32%	$37,124,548
OR	4	3%	$7,860,925
PA	15	25%	$72,501,110
RI	1	3%	$180,950
SC	11	33%	$38,176,531
SD	1	1%	$156,414
TN	11	32%	$42,921,600
TX	**22**	**39%**	**$255,338,491**
UT	9	24%	$7,993,419
VA	**12**	**37%**	**$128,431,543**
VT	1	6%	$395,816
WA	4	6%	$6,800,711
WI	6	26%	$27,709,050
WV	5	21%	$6,372,111
WY	2	7%	$1,429,844
US		23%	$1,933,072,547

Bolding indicates the five states with the highest total rebate amounts.

* California data are incomplete.

Source: Authors' analysis.

SUMMARY AND IMPLICATIONS

The new limits on insurers' medical loss ratios in the Affordable Care Act are intended to reduce overhead costs and consequently, the overall costs of health insurance. If the new MLR rules had been effect in 2010, we estimate that insurance consumers would have received close to $2 billion in rebates. These would be spread across 53 percent of the members in the individual market, but only 24 percent and 15 percent of the small- and large-group markets, respectively. This indicates that the new rules have been designed in a way that does not place onerous restrictions on the market as a whole. The law's minimum MLRs were keyed to existing market averages. In addition, the definition of MLR in the law is somewhat more forgiving than prevailing reporting practices. Further, seven states (out of the 17 that applied) have been granted waivers that reduce the target MLRs in their individual markets.

As expected, a greater proportion of consumers in the individual market would expect rebates than would those in the group markets. This reflects the fact that the individual market is held to the same minimum loss ratio as is the small-group market, even though loss ratios in the individual market historically are lower,[17] due in part to higher average sales costs. For consumers who receive rebates, the average amounts could be substantial—often in the $100 to $300 range per person, and occasionally more. Insurers in Texas and Florida are expected to pay over $200 million in rebates in each state, across all three policy types.

Also as expected, a significantly greater proportion of for-profit and publicly traded insurers would owe rebates compared with nonprofit insurers, if the MLR rules had applied in 2010. Notably, few provider-sponsored insurers would owe any rebates, perhaps reflecting their institutional incentive to favor medical claims over corporate profits.

Insurers have had advance notice of the new MLR rules for a year and are expected to change in various ways in anticipation of their effect.[18] Some insurers may reduce their overhead and premiums or increase costs related to improving quality of care to be sure they conform to the MLR minimums. However, others may seek to maximize profits by ensuring that their MLRs do not rise higher than the minimums set by the Affordable Care Act. Moreover, profits are affected both by the MLR and by how much insurance a company sells. To attract more subscribers, pressure on the MLR can thus translate into reduced premiums through reduced medical costs. Regardless of which of these speculative possibilities transpire, it is almost certain that the MLR rules will produce different results in future years than are estimated here for 2010. However, even if rebates dwindle, this analysis indicates that millions of consumers stand to benefit from the new rule's reduction of profits and overhead costs incurred by many insurers.

Notes

1 D. A. Austin and T. L. Hungerford, *The Market Structure of the Health Insurance Industry* (Washington, D.C.: Congressional Research Service, Nov. 17, 2009), available at http://www.fas.org/sgp/crs/misc/R40834.pdf.

2 Federal Register, Vol. 75, No. 230, Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, interim final rule for state health plans, Dec. 1, 2010, available at http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf; and healthcare.gov, "Medical Loss Ratio: Getting Your Money's Worth on Health Insurance," fact sheet, Nov. 22, 2010, available at http://www.healthcare.gov/news/factsheets/2010/11/medical-loss-ratio.html.

3 In a few instances, we filled in by hand SHCE information missing from the electronic NAIC data set (specifically, for CareFirst, a Blue Cross plan in the District of Columbia, Maryland, and Virginia markets). Still missing are data from many health insurers operating in California. These insurers do not file NAIC forms since they are regulated only by California's Department of Managed Care and not by its Department of Insurance. California health insurers will have to comply with the MLR regulation but are not required to submit the SHCE data electronically to NAIC. Nevertheless, NAIC data do include 56 California life insurers that filed SHCE data, since they are offering health insurance products regulated by California's Department of Insurance.

4 Under the Affordable Care Act, insurers offering comprehensive medical insurance are required to report their MLR by market segment (individual, small-group and large-group) for each corporate entity in each state in which they are licensed to operate. Nationally, we collected the SHCE form for 2,633 health insurance companies, which do business in different market segments as follows: those offering individual coverage only, 1,342; offering small-group coverage only, 138; offering large-group coverage only, 113; offering individual and small-group coverage only, 226; offering individual and large-group coverage only, 116; offering small- and large-group coverage only, 199; offering coverage in all three markets, 499.

5 The NAIC requires insurers to report annual financial filings using one of four different forms, called "blanks": Health, Life, Property and Casualty, or Fraternal Blanks. If 95 percent of insurer's premium revenue is from health insurance, an insurer files health insurance blanks (forms). If health insurance accounts for less than 95 percent of premium revenue, the insurer submits the financial blanks associated with the type of license it holds in the state, which can be Life, Property and Casualty, or Fraternal. This analysis is limited to insurers that used the health blank in 2010. This includes 19 property/casualty insurers. However, following the federal regulation, we did not sample property/casualty and fraternal insurers that did not submit the health blank. We also excluded insurers from all U.S. territories including Guam, Puerto Rico and Virgin Islands. For details, see Federal Register, Vol. 75, No. 230, on the interim final rule for the MLR for state health plans, Dec. 1, 2010 (note 2 above).

6 Following the above MLR regulation (see note 2 above, Federal Register, Vol. 75, No. 230), member is defined as life years or member months divided by 12.

7 We also dropped one individual insurer that reported a zero value for MLR and another that reported a negative MLR.

8 Accordingly, throughout the remainder of this brief, "insurer" refers to the affiliated group of corporate entities in each state, unless otherwise noted.

9 Insurers that receive a credibility adjustment (those with fewer than 75,000 members) and that also offer a high-deductible plan (greater than $2,500) can receive an additional adjustment depending on the deductible size. For example, having a $10,000 deductible will increase a smaller insurer's credibility adjustment by 173.6 percent. This reflects the fact that "catastrophic" coverage has a much lower premium than comprehensive insurance and therefore bears a greater proportionate share of fixed or average overhead costs.

10 We also are unable to estimate which insurers will use the "dual contract" aggregation rule, which allows them to combine loss experience from two different products that are sold as a bundled product, such as indemnity coverage that "wraps around" an HMO plan to provide out-of-network coverage in "point of service" product.

[11] See, for instance, Memorandum to Kevin McCarty from Sandy Praeger dated June 9, 2011; Consumer Health Insurance Savings under the Medical Loss Ratio Law (U.S. Senate Comm. on Commerce, Science and Transportation, May 2011, http://commerce.senate.gov/public/?a=Files.Serve&File_id=98f51e42-e9ef-441a-a5e3-6bdac44d6a27); U.S. General Accountability Office, Private Health Insurance: Early Indicators Show that Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards (Oct. 21, 2011); Jill Herbold, 2010 Commercial health Insurance: Medical Loss Ratios and Illustrative Rebates (Milliman, Feb. 2012). Our total rebate values for small-group and large-group policies may be higher because we included the SHCE fillings that were missing from NAIC's electronic data, for CareFirst Group within the District of Columbia, Maryland, and Virginia markets.

[12] "Member" refers to each person covered by insurance. However, rebates will not necessarily be distributed to members on a per capita basis. Instead, rebates may be allocated differently for family versus single or adult coverage. Also, for employer-sponsored insurance, rebates will be divided between employers and workers in proportion to the share of the premium paid by each.

[13] Massachusetts and New York also show high estimated median rebates but for only a small fraction of the market. These estimates are likely anomalous since they primarily reflect small-indemnity plans owned by much larger insurers, which are used to cover the out-of-network component of HMO "point of service" products. Therefore, it is likely that their loss experience is eligible to be aggregated with that of the larger plan, under the MLR's "dual contract" rule, explained previously.

[14] Our results generally accord with, but are not identical to, similar analyses done by others. For instance, our total rebate value for large-group insurers was $495 million, compared to $526 million from NAIC's analysis (see Sandy Praeger dated June 9, 2011; Consumer Health Insurance Savings under the Medical Loss Ratio Law (U.S. Senate Comm. on Commerce, Science and Transportation, May 2011)). The major differences occurred in four states (Colorado, Georgia, Ohio, and Virginia) where electronic data were missing or incomplete in the NAIC analysis but we were able to obtain more complete information from hard copies or other sources.

[15] The median test was used to test differences in median rebate per member across the three organizational traits and the chi square test was used for the percentage values of the group traits. Insurer characteristics were initially defined by the traits listed on demographic page of their NAIC electronic filing, but for insurers that are subsidiaries of a larger company, the trait is defined by the parent company. Thus, an insurer is defined as nonprofit if it is a subsidiary of a nonprofit health care system, even if the subsidiary is incorporated as a for-profit entity. "Provider-sponsored" insurers are those owned, governed by, or managed jointly with health care systems, community health centers, or physician groups.

[16] One reason publicly traded insurers would owe lower median rebates is that the nonpublicly traded category includes both nonprofits and private for-profits, and the private for-profits would owe much higher median rebates than the other subgroups (data not shown).

[17] Austin and Hungerford, *Market Structure,* 2009.

[18] C. McDonald, *A Practical Guide to Federal Medical Loss Ratio Requirements,* © 2011 by Atlantic Information Services, http://aishealth.com/marketplace/bmlr-enlad.

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