



Changes in Health Care Financing & Organization (HCFO)

findings brief

Regulating the Medical Loss Ratio: Implications for the Individual Market

key findings

- In nine states, at least 50 percent of health insurers would likely fail to meet the 80 percent minimum MLR.
- In 12 states, at least 50 percent of total member-years of enrollment are with insurers that do not meet the minimum MLR.
- Beneficiaries in poor health could be vulnerable to coverage disruption if insurers not meeting the threshold decide to exit the market.

Overview

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) contains several provisions to improve the functioning of the individual and small group markets for health insurance. One key regulation is the establishment of minimum medical loss ratios (MLRs). The MLR is the percentage of a health insurer's premium revenues that are spent on medical services for plan members. The ACA mandates a minimum MLR of 80 percent in the small group and individual markets and 85 percent in the large group market. Insurers that fall below those thresholds will have to provide policyholders with a rebate corresponding to the difference between the mandated and actual MLR. These standards went into effect January 1, 2011.

The motivation behind the minimum MLR regulation is for premiums to reflect the actual cost of care enrollees receive, rather than excess profitability or administrative costs for the

insurer. Though the spirit of the regulation is one of consumer protection, multiple stakeholders fear that the measure could have adverse consequences for some individuals' access to coverage. A major concern is that the individual market will become less stable. The individual market currently serves 7 percent of non-elderly individuals and the new MLR regulation could cause disruptions if insurers decide to close blocks of business or leave the market.

In a HCFO-funded study,¹ Jean Abraham, Ph.D., and Pinar Karaca-Mandic, Ph.D., of the University of Minnesota, sought to provide state-level estimates of the size and structure of the individual market for health insurance and to investigate the impact of the new MLR regulation. "Medical loss ratio regulation is creating a lot of stir in the insurance industry," said Dr. Abraham. "As we began studying this issue, we discovered that there was almost no research evidence to understand what effect this new regulation might have on the industry



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and consumer well-being. Our objective was to generate baseline estimates that could be used by policymakers and other stakeholders to understand the importance of this policy.”

Methods

The primary study data was the National Association of Insurance Commissioner’s (NAIC) Annual Statement of Information for Health Insurance Companies for 2002 to 2009. These data are a compilation of health insurers’ annual statements to state insurance departments. The unit of analysis was the company-state observation. For example, the same insurance company operating in two different states would be two distinct observations. Other measures included individual market member-years (total member months of coverage provided by an insurer during the calendar year, divided by 12), incurred claims, change in contract reserves, earned premiums, and the MLR.

The analysis included three steps. First, Dr. Abraham and Dr. Karaca-Mandic studied the individual market across states and over time. They estimated the number of health insurers operating in each state for years 2002, 2005, and 2009, and estimated enrollment in member-years. They also calculated the average MLRs within states over time and estimated the amount of variation over the 2002 to 2009 period.

Secondly, they estimated the number of insurers that would have MLRs below the 80 percent minimum. The researchers used both the historical MLR definition and an “adjusted” measure to reflect changes specified in the interim final rule published by the U.S. Department of Health and Human Services (HHS). Two proposed changes to the historical MLR include characterizing quality improvement measures as clinical expenditures, and removing state and federal taxes, as well as licensing and regulatory fees, from the premium calculation. Because there is uncertainty as to the effect of those modifications, the researchers “adjusted” the historical MLR by 5 percent, based on anecdotal evidence.

Finally, they calculated an estimate of the number of individuals likely to experience major coverage disruption due to their insurer falling below the MLR. These are individuals with high medical expenses or chronic conditions who are “medically uninsurable.” To identify those individuals, the researchers used a similar population—those in high-risk pools across the United States—and found their average claims to be \$9,437 in 2008. They used data from the Medical Expenditure Panel Survey (MEPS) to estimate the proportion of the non-elderly population with individual market insurance coverage with spending in excess of this figure.

Results

The researchers observed enrollment of 6.7 million member-years within 371 health insurance company-state observations. They found wide variation in the number of health insurers operating across states. Generally, more populous states had a larger number of insurers. During the study time period of 2002 to 2009, most states experienced a growth in the number of insurers and individual market enrollees.

The researchers also found extensive variation in the MLR across states. New Hampshire was the state with the lowest MLR at .629, but four states had enrollment-weighted MLRs in excess of one. This can occur if one or more large insurers incur claims that exceed premiums for the year. Their results indicated that 146 of the 371 company-state observations were below the 80 percent minimum MLR requirement. In 21 states, at least half of insurers would not meet the threshold. Using the adjusted MLR, the number of company-state observations declines to 106, and nine of the 21 states would still have at least half of insurers not meeting the threshold.

Translating these numbers to member-years, the researchers documented 3.3 million member-years associated with insurers with MLRs below the mandated minimum. Using the adjusted MLR reduced the member-years to 2.18 million. Of total reported enrollment, 28 percent was associated with

insurers with MLRs below the threshold both before and after adjustment.

Populations vulnerable to coverage disruption due to poor health status ranged from 104,624 to 158,736 member-years. The states with the largest levels of vulnerable enrollment in absolute terms included Arizona, Florida, South Carolina, Texas, and Virginia.

Study Limitations

The researchers acknowledge two important limitations to their study. First, most insurers in California do not file with the NAIC because they are regulated by the California Department of Managed Care; accordingly, California was excluded from the analyses. Secondly, the data from the NAIC does not include individual market policies issued by life insurers. These products account for approximately 20 percent of premiums in the individual market. The researchers conducted supplemental analyses using alternative NAIC filing data sources to estimate the presence of life insurers in this market. Their results suggested that in certain states, life insurers have a large market presence. Finally, the NAIC data did not allow the researchers to make a precise accounting of the number of unique individuals in each state; rather, they observed only total member-years of coverage.

Implications for Policy and Practice

The introduction of the MLR regulation has the potential to significantly change the individual market. Though it is not possible to predict insurer responses, certain populations may be vulnerable to coverage disruption, at least between now and 2014 when guaranteed issue provisions go into effect. State regulators will need to monitor insurers’ responses to the MLR regulation as they achieve compliance through multiple avenues including administrative reductions, premium reductions, or market exit.

The analysis revealed that the market for individual health insurance is highly concentrated, and market exit could have disruptive short-run consequences for

some individuals. State insurance commissioners might consider seeking transitional relief from HHS in the event of market de-stabilization. “As of March 31, 2011, nine states have applied for an adjustment to the regulatory standard,” said Dr. Abraham. “One of them, Maine, has been granted an adjustment out of concern that the 80 percent minimum could de-stabilize the market.”²

For federal policymakers, the analysis suggests that the impact of the MLR regulation will vary significantly across states. This work also illustrates the challenges ahead in evaluating how markets will be affected. There is not a comprehensive, consistent data source across all types of health insurers in the United States. Additional investments will need to be

made in the collection of data for the individual and group markets to enable better monitoring by state and federal officials.

Conclusion

The MLR provision of the ACA will have varying impacts on different state insurance markets, including unintended consequences. The work of Dr. Abraham and Dr. Karaca-Mandic shows the variation in the size and scope of this market across states and the potential for a wide array of responses from insurers to this regulation. “We hope that the findings are useful to policymakers and state insurance regulators, as well as to researchers interested in understanding the effects of ACA provisions on the market for health insurance,” said Dr. Abraham.

For More Information

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Endnotes

- 1 Abraham, J.M. and Karaca-Mandic, P. “Regulating the Medical Loss Ratio: Implications for the Individual Market,” *The American Journal of Managed Care*, Vol. 17, No. 3, 2010, pp. 91-102.
- 2 Centers for Medicare & Medicaid Services. “Medical Loss Ratios: Background.” See also: <http://ccio.cms.gov/programs/marketreforms/mlr/index.html>