Research

Medical Loss Ratio Under the ACA

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The Medical Loss Ratio

A Medical Loss Ratio (MLR) is a calculation used to loosely gauge the efficiency and profitability of a health insurance plan. The measurement determines what portion of the money consumers pay in premiums is spent on providing health care services or improving the quality of care delivery. A higher MLR is thought to indicate a higher quality insurer because a larger portion of the company's funds are spent on providing care. However, this is not necessarily the case if an insurer succeeds in keeping a healthier-than-expected risk pool.

The Affordable Care Act (ACA) defines the MLR as the share of adjusted premium dollars spent on medical claims and quality improvement activities. Insurers are also required by law to report their annual MLR, and any insurer that falls below the mandated minimum will be required to rebate the difference to payers or deduct the difference from the subsequent year's premiums.[1]

The ACA imposed an MLR of 80 percent on individual and small group health insurance plans, and 85 percent on large group plans. The purpose of this rule was ostensibly to control premiums by regulating profits rather than prices by limiting insurers' allowable revenue and administrative costs.

Calculating MLR

An MLR is calculated as claims (payments made by or on behalf of policyholders for provision of medical treatment) plus quality improvement (activities designed to increase the likelihood of desirable health outcomes in ways that can be objectively measured), divided by premiums less taxes and fees.

$$\text{Medical Loss Ratio} = \frac{(\text{claims} + \text{quality improvement expenditures})}{[\text{premiums} - (\text{tax} + \text{fees})]}$$

The MLR does not include loading costs such as administrative expenses or profit. This means that insurers' profits are limited to 20 percent (or less) of total premiums, minus administrative expenses and overhead such as staff, offices, supplies, etc. While most insurers are capable of operating on these thin margins, the profit cap minimizes the incentive for insurers to offer innovative products covering new benefits or geographic regions, and may squeeze out insurers that have difficulty minimizing administrative costs.

Effects

Prior to the passage of the ACA, the majority of insurers were within the 80 percent MLR range. However, roughly one-third of insurers in the individual market were required to make some changes in order comply with the new rule. Between 2011, when the rule went into effect, and 2013, the median MLR in the individual market increased by 2.4 percent, while in the small and large group markets the median MLRs increased by 0.4 percent and 0.1 percent, respectively. This shows a moderate shift in spending away from administrative expenses and profit, and towards provision of care in the individual market to comply with the rule, but less of an impact in the small and large group markets which were largely already in compliance. This could be an indication that individual market plans previously offered insurers exceptionally high profits, that these insurers found ways of limiting administrative expenses, or that the insurers who were unable to adapt to the rule left markets where their profit margins would be substantially impacted by the rule.

The MLR rule puts pressure on insurers to limit administrative overhead in order to preserve profit without running afoul of the MLR minimum. Insurers may achieve this new goal by reducing expenditures on fraud protection measures, limiting "quality improvement" activities to those that satisfy the ACA requirements, limiting networks to reduce administrative burden, or shifting to more managed care-style plans which require care providers to take on responsibility for more administrative duties.

The inherent limitation on corporate revenues could also contribute to consolidation in the insurance market by discouraging investors and new entrants. Without the ability to rapidly recoup start-up costs, competition with already-established players in a market is less likely to prove financially worthwhile. The reduced number of insurance carriers entering new markets since 2011 may, in part, be attributed to this market restriction.

Conclusion

The MLR is an attempt by Congress to cap revenue for insurance providers by mandating how each dollar of income is spent. However, the rule creates unintended incentives that can have deleterious market impacts. As one economist put it, "The Medical Loss Ratio is an accounting monstrosity, a convolution of data from myriad products, distribution channels, and geographical regions that enthralls the unsophisticated observer and distorts policy discourse."[2]

[1] Tom Baker, Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act, 159 U. Pa. L. Rev. 1577, 1612-1614 (section on the MLR requirements, including a brief example of how the rules work).