AMERICAN ACTION FORUM

How the Medical Loss Ratio Requirement Could Increase Health Insurance Premiums And Insurer Profits at Taxpayer Expense

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Introduction

One of the most highly-touted features of the health reform law is a section requiring health insurers to maintain a minimum Medical Loss Ratio (MLR) – the dollar value of medical payments as a percentage of premium revenue, the difference going to administrative costs and profit. The goal of this provision is to encourage insurers to restrain administrative costs, and also to limit their profit. In effect, it seeks to limit premiums to a "fair" level, and enforce this limit *ex post* with rebates in the case of premiums that turned out to be "too high" compared to the past year's claims.

However, the ill-designed structure of the MLR provision may actually have the opposite effect, for two reasons: First, it is likely to require higher average annual premiums (averaged over several years) for insurers to meet state solvency requirements. Second, it might end up rewarding who raise premiums. Those insurers with higher premiums will have to pay higher rebates to consumers, but the MLR formula (probably inadvertently) allows them to retain higher profits if they do so. Furthermore, since a majority of the population will be eligible for subsidies that insulate them from the cost of higher premiums (but still allow them to benefit from rebates), rebates might be used to "pay" customers to enroll in high-premium plans, in effect transferring to insurers large – and potentially unbounded – sums from taxpayers in the form of subsidies unrelated to medical costs. The result could turn out to be free, or even better-than-free, insurance for some individuals and families, and huge profits for insurers – all at the expense of taxpayers.

Rather than restraining insurance profits, the MLR rebates could become a vehicle for funneling taxpayer dollars from the federal government to subsidized consumers and to insurance company profits. In addition, the MLR formula allows insurers who know they will be paying a rebate to increase their medical spending without reducing their profits, thus bending the "cost curve" upward rather than downward.

Background

The MLR provision of the Affordable Care Act (ACA)[1] requires insurers to spend a specified percentage of total premiums on medical costs, or rebate the difference to their customers. The specified percentage is 80 percent for the individual and small-group markets, and 85 percent for the large-group market. The remaining

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[1] The Patient Protection and Affordable Care Act (PPACA; Public Law 111–148) was enacted on March 23, 2010, and was almost immediately amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; Public Law 111–152), enacted on March 30. For convenience, most authors refer to the two Acts collectively as the "Affordable Care Act" (ACA), even though Congress did not actually pass a law by that name. The relevant second of the ACA adds Section 2718 to the Public Health Service Act.

20 percent or 15 percent represents the maximum proportion of premiums that can be put towards administrative costs and profit, combined.

For example, suppose an insurer in the individual or small-group market spends an average of $8,000 on medical claims[2] per family. If they charge a premium of $10,000 they will meet the 80 percent medical loss ratio requirement, will not have to pay any rebate, and will have $2,000 for administrative costs and profit. However, if they charge a premium of $11,000 their required medical loss under the MLR rule would be $8,800. Since they incur an average of only $8,000 in medical claims, they will have to pay each customer a rebate of $800. They will then be left with a total of $2,200 for administrative costs and profit.

Why the MLR Rule Requires Higher Average Premiums

In order to remain solvent, insurers must charge premiums that, over many years, are high enough to pay both claims and administrative costs. Because of the possibility that claims might be unusually high in some years – higher than that year's premiums – insurers generally accumulate reserves in low-claim years in order to meet their claim obligations in high-claim years.

In most states, state-level regulations require that premiums be "sufficient" – that is, high enough – for insurers to meet claims obligations and remain solvent. The concern is that competitive pressure between insurers might tempt them to set lower premiums to attract customers in the short term, and the expense of their long-run ability to pay claims in high- claim years.

The MLR rule will make it necessary for state regulators to require higher premiums. Why? Before the MLR rule came into effect, insurers could use reserves built up in low-claim years to pay claims in high-claim years, thus reducing premiums (averaged over multiple years) from what they would have been otherwise. Now, with the MLR rule in effect, in low-claim years insurers will have to pay higher rebates rather than accumulate more reserves. This means that premiums will, on average, have to be higher than they would have been otherwise – because insurers will have to pay more claims in high-claim years, without being able to accumulate as much reserve funding in low-claim years. Now, when a specific insurer has a low -claim year, they will end up paying rebates – including federal subsidy dollars – to their customers.

How Higher Rebates Could Benefit Insurers

Note that by increasing their premium and keeping medical expenses constant, their profit is higher even after paying the required rebate. The reason for this is that the required medical costs, and by implication the amount left over for administrative costs and profit, are expressed as a percentage of the nominal premium, not as a percentage of medical costs. This means that a higher premium allows for higher profits, even holding medical

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[2] "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," 75 FR 74864—74934, as corrected in 75 FR 82277—82279. Technically, the amount of medical loss include not only medical claims (amounts paid to providers), but also medical costs incurred directly by the insurer. For example, some insurers offer disease management programs, on-call nursing consultations, and the like. These are paid for by the insurance company, but not as a result of a claim filed directly by a patient or a provider. For purposes of the MLR rule, these expenses are treated as medical loss, just as claims are. For simplicity, we refer to all medical losses as "claims."

costs constant and increasing rebates to attain the required MLR. In principle, there is no limit to how far this could go. In our hypothetical example above, the insurer could increase profits even further by increasing the premium to $20,000 and paying a rebate of $8,000. At a premium of $20,000, the required medical loss would be $16,000. With $8,000 in average medical claims, this would require a rebate of $8,000 – and leave the insurer with $4,000 for administrative costs and profit. The net cost for the consumer would be the nominal premium minus the expected rebate, or $12,000. (See Figure 1 for an illustration.)
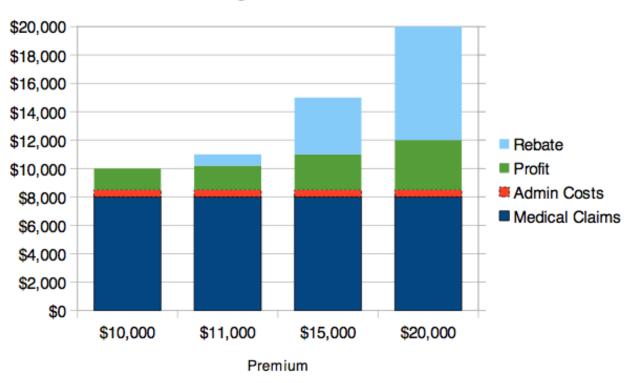
Figure 1: Distribution of Premium Dollars Assuming $8,000 in Medical Loss

One might ask how a consumer would react to the offer of the higher premium coupled with a higher rebate. After all, the rebate amount is not guaranteed, and even after netting out the large rebate, the consumer still ends up paying more than before. So, why should a health insurance consumer accept such a deal?

MLR Rebates and Premium Subsidies

The answer is quite different for a consumer purchasing individual coverage for the period after, rather than before, January 1, 2014. Prior to 2014, someone enrolling in the individual market pays the full cost of the premium, and receives the full benefit of the rebate, if any. Therefore, consumers would prefer a lower premium and no rebate, as that would result in a lower net cost than a higher premium with a rebate.

However, for 2014 and subsequent years, it is expected that a majority of consumers[3] in the individual market will be eligible for income- based premium subsidies.[4] This means that for these households, much of the premium will be paid for by the federal government in the form of a refundable tax credit paid directly to the insurer on the enrollee's behalf. If the household chooses the benchmark "second lowest cost silver plan," then the amount paid by the household is solely a function of its income and
the number of family members. However, the HHS regulation on MLR rebates appears to require the rebates to be paid to the consumer, not the federal government.[5] The result could be that insurers set high premiums, collect premium subsidies from the federal government, then rebate 80 percent of the excess to enrollees, keeping 20 percent as additional profit.

For example, consider a family of four with an income of $46,100, or 2.5 times the federal poverty level. If this family does not have access to employer-sponsored insurance that is "affordable" as defined by ACA, the family will be expected to pay 6.3 percent of its income, or $2,904, for health coverage. They will receive a premium subsidy (in the form of a tax credit paid directly to their insurer) for the difference between that amount and the "second lowest cost silver plan" available. The CBO projects this premium to be $14,100; this means that the credit will be $11,196. Given that the CBO projection included the MLR rule, it is reasonable to assume that the average medical expenditures will be approximately 80 percent of this amount, or $11,280, leaving $2,820 for administrative costs and profit.

However, suppose insurers offering silver plans instead raise their premiums to $17,730. In this case, the required 80 percent MLR would correspond to $14,184. If medical expenditures remained at $11,280, the insurers would be required to pay a rebate of $2,904 – or exactly the amount our example family paid for the coverage, net of their premium subsidy. And, the amount available for administrative costs and profit would increase from $2,820 to $3,546.

In other words, a higher premium would allow this family to, in effect, receive its health coverage for free. If the premium were higher – say, $20,000 – then the family would essentially be paid to take the health plan, since their rebate would exceed the portion of the premium they paid. (See Figure 2.)
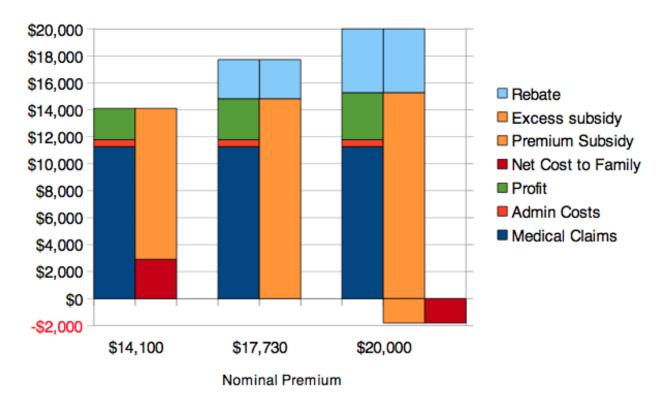
Of course, this is just an example; the premium (before subsidies) would be the same for families at different income levels, yet the amount each family would be expected to pay would vary. Some families would pay an income-based premium amount higher than their rebate; some might turn out to receive a rebate of more than the share of the premium they paid. In general, however, the structure of the subsidies and the MLR rule implies that *higher* nominal premiums could turn out to be associated with *lower* effective premiums for the subsidized population.

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[3] According to the Kaiser Family Foundation, 67 percent of all households will be eligible for income based subsidies. This may not be precisely the percentage for the individual market. http://www.statehealthfacts.org/comparebar.jsp? ind=861&cat=
[4] These subsidies are available to families with incomes less than four times the federal poverty level. The threshold varies by family size; for example, it is $44,680 for a single individual and $92,200 for a family of four, based on the 2012 federal poverty guidelines.
[5] 75 FR 74883-4.

In effect, rather than restraining insurance profits, the MLR rebates could turn out to be a vehicle for funneling taxpayer dollars from the federal government to subsidized consumers (80 percent) and to insurance company profits (20 percent).

Figure 2: Distribution of Premium Costs and Payment
For a family of four with income 2.5 times FPL

Could This Really Happen?

One might ask how likely this scenario is to occur. For one thing, the premium subsidies depend not on the particular coverage selected by a given household, but on the "second lowest cost silver plan" available to that household based on its family size, age of the oldest member, and possibly its tobacco use status. If the household chooses a plan with a higher premium, the household would be required to pay the difference. It would thus not be possible for plans to compete with each other on the basis of higher premiums and thus higher rebates, as the household would pay 100 percent of the difference in premium, but would receive only 80 percent of the difference in the form of a higher rebate.

However, if all – or all but one – of the insurers offering silver plans in a particular region realize the potential benefits to policyholders of higher premiums (not to mention higher profits for themselves), it is possible that this feature of the law could encourage higher premiums and that might appeal to the subsidized population.

From the standpoint of insurers, one problem remains – how to appeal to the sizable minority of the population not eligible for premium subsidies. All other things being equal, this group unambiguously prefers lower premiums even with the MLR rule in effect. The solution from the insurers standpoint could, theoretically, be to price their bronze, gold, and platinum plans with the non-subsidized population in mind. In this vein, it is worth noting that while the ACA specifies the actuarial value for each plan level, it does not specify any restriction on the relative premiums for the different plan levels. In particular, it does not even require that, for example, gold premiums be higher than silver premiums.

It is reasonable to ask, what, if anything, could regulators do to respond to this outcome? The ACA grants the HHS the authority to conduct a "rate review" to make sure insurers selling in exchanges are not charging "too much." It is possible that they might try to use their rate review authority to limit
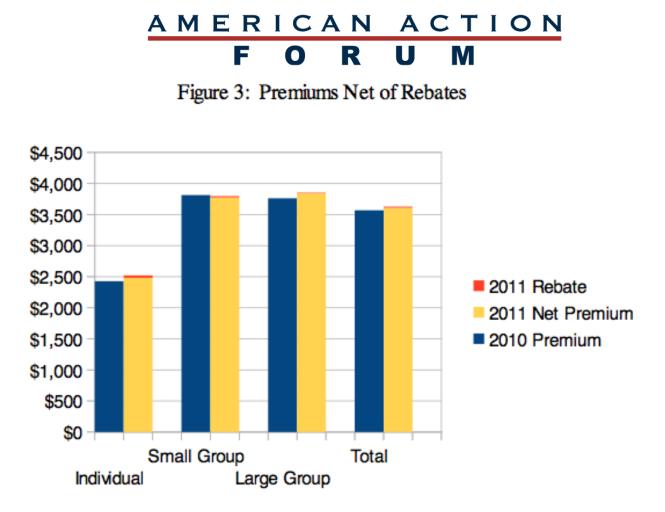premiums even with the MLR rule serving as a "backstop" on excessive premiums. However, their power to do so might be limited by two factors. First, as explained above, state-level regulations similar to rate review require that premiums be "sufficient" for insurers to meet claims obligations and remain solvent. This means, in effect, that while HHS is trying to prevent premiums from being too high, state regulators are trying to prevent them from being too low.

Unless HHS chooses to squeeze insurers out of existence by requiring premiums lower than what state regulators require to ensure solvency, they are going to have to allow higher premiums because of the MLR rule. Without significant actuarial experience with the MLR regime – and with the psychological "backstop" against excess profits provided by the MLR rule itself – it is quite likely that HHS will end up approving higher premiums.

The Pre-Subsidy MLR Experience

Although the premium subsidies will not begin until 2014, the MLR rule came unto effect starting in 2011. The Commonwealth Fund recently published a white paper by Michael J. McCue and Mark A. Hall[6] examining insurer's response to the MLR rule and touting the purported success of the rule in benefiting the insured by restraining insurer's profits. Their measure of "success" comes primarily from the fact that approximately $1.1 billion in rebates were paid to consumers, and average insurer profits were reduced relative to the previous year. In doing so, however, they gloss over the fact that average premiums actually increased in the year the MLR rule took effect – by more than the amount of the average rebate. This represents a net increase in premiums. Figure 3 shows the 2010 premiums, compared to the 2011 premiums net of rebates. The individual and large group markets experienced a net increase in premiums, even after taking rebates into account. The small group market experienced a slight decrease, but the overall average across all three markets was an increase in premiums net of rebates.

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[6] Michael J. McCue and Mark A. Hall, "Insurers' Responses to Regulation of Medical Loss Ratios," The Commonwealth Fund, Pub. 1634, December 2012.

Figure 3: Premiums Net of Rebates

Source: Author's calculations based on McCue & Hall, "Insurers' Responses to
Regulation of Medical Loss Ratios," December 2012.

They also completely ignore the fact that the way the MLR rule is constructed may actually encourage insurers to increase premiums. While profits were reduced relative to the previous year, numerous other statutory and regulatory changes also went into effect, and it is impossible to say what profits would have been in the absence of those other changes.

McCue and Hall hypothesize that an insurer might respond to the new rule by reducing administrative costs, which would allow them to charge a lower premium avoid having to pay a rebate. Alternatively, they hypothesize, an insurer might reduce administrative costs and keep the premium the same to increase pre-rebate profit, and have some profit left over after they pay the rebate. This of course begs the question of how the insurers can reduce administrative costs so easily. Assuming that the insurers are in business to make a profit both before and after the MLR rule came into effect, one has to believe that they had a substantial incentive to reduce administrative cost before the MLR rule came into effect, since every dollar saved on administrative cost went straight to profit. In other words, if they were able to reduce administrative costs, they would already have done so.

One possible answer to this is that the MLR regulations allow certain non -claim costs that affect the health of customers (e.g., operating disease management programs) to be counted as medical costs. Previously, these were counted as administrative costs. Thus, the fact that measured administrative costs were reduced may not

indicate any actual change in costs, but merely a re-allocation of some costs from the "administrative" category to the "medical" category.

Despite the rosy picture presented by the Commonwealth Fund's report, the success and impact of the MLR rule is not directly associated with the aggregate quantity of rebates paid, even in the pre-2014, no-subsidy regime.

Can the MLR Rule Be Fixed?

The MLR rule encourages higher premiums by linking the allowable profit to a percentage of the premium charged. Even after paying the rebate, the allowable profit is still higher by $20 (or in the case of the large-group market, $15) for each $100 increase in the premium.

Would it be possible to "fix" the MLR rule by linking allowable profit to medical costs, rather than to a premium set by the insurer? Holding medical costs constant and setting the maximum allowable profit plus administrative costs to 25 percent of medical costs would produce the same dollar value as 20 percent of the premium. For example, if average medical costs were $8,000, then 25 percent of medical costs would be $2,000 – the same amount as 20 percent of the $10,000 premium. However, with allowable profit no longer linked directly to the premium, there wouldn't be an incentive to raise the premium to increase the allowable amount.

However, it has to be recognized that medical costs are, to some extent, under the control of the insurer as well, even if not as directly as the premium. Faced with an increase of $25 in profit for every $100 of medical costs, an insurer could increase payments to providers, increase covered services, encourage increased utilization. This would, of course, "bend the cost curve" – upward, not downward. Total health expenditures would increase, and premiums – and by implication, premium subsidies – would increase even more. It should be noted, of course, that both consumers and health care providers would feel they benefit from such an increase. Providers would see their revenue increase, and consumers would likely find they have better access to care as a results. The only "loser" in this scenario would be the taxpayers, whose subsidy payments are used to simultaneously increase provider revenue, increase insurer profit, and decrease net premiums for consumers.

Conclusion

It is possible that the MLR rule will have the opposite of its intended effect. Instead of limiting profit and reducing premiums, the MLR rule may prevent insurers from accumulating reserved in low -claim years, and thus require higher premiums to allow them to pay claims in high-claim years. The interaction between the MLR rule, insurer reserves, and state sufficiency requirements could limit HHS's ability to restrain premiums through rate review while allowing insurers to stay in business.

Furthermore, the MLR's associated rebate system may encourage insurers to increase premiums, and allow them to profit from doing so. Starting in 2014, income-based premium subsidies will insulate a majority of the individual market population from higher premiums, but still allow them to collect the MLR rebates. The structure of the subsidies and the MLR rule implies that *higher* nominal premiums would be associated with *lower* effective premiums for the subsidized population. For some consumers, the rebate might meet, or even exceed, the unsubsidized portion of the premium. In all cases, a higher premium would, due to the structure of the MLR rule, allow insurers to keep a higher profit. And in all cases, higher premiums will be met dollar-for-dollar by higher premium subsidies at taxpayer expense for a majority of consumers. In effect, the MLR rebates

could be become a vehicle for funneling taxpayer dollars from the federal government to subsidized consumers and to insurance company profits.