*Pros and Cons of Obamacare:*
*Is It What the United States Needs?*

# THE AFFORDABLE CARE ACT AND MEDICAL LOSS RATIOS: NO IMPACT IN FIRST THREE YEARS

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The Patient Protection and Affordable Care Act (ACA) set limits on insurers' overhead, mandating a medical loss ratio (MLR) of at least 80 percent in the individual and small-group markets and 85 percent in the large-group market starting in 2011. In implementing the law, the Obama administration introduced new rules that changed (and inflated) how insurers calculate MLRs, distorting time trends. We used insurers' filings with the U.S. Securities and Exchange Commission to calculate the largest insurers' MLRs before and after the ACA regulations took effect, using a constant definition of MLR. MLRs averaged 83.04 percent in the three years before reform and 83.05 percent in the three years after reform. We conclude that the ACA had no impact on insurance industry overhead spending.

The Patient Protection and Affordable Care Act (ACA) set a minimum level for health insurers' Medical Loss Ratios (MLRs), or the share of premiums devoted to medical payments (i.e., actual payments to doctors, hospitals, pharmacies, etc.). It mandated an MLR of at least 80 percent in the individual and small-group markets and 85 percent in the large-group market commencing in 2011. Insurers falling short of required MLRs are required to rebate the difference to enrollees (1). This provision was expected to reduce insurers' overhead. We evaluated its

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impact by examining large insurance firms' MLRs before and after the implementation of this provision.

## METHODS

Traditionally, financial analysts and insurance firms have calculated MLR by dividing total medical payments by total premium income. However, in its final rule, the U.S. Department of Health and Human Services mandated a novel, less stringent MLR calculation for purposes of ACA compliance. Insurers are allowed to raise the numerator (medical payments) by including most expenditures on quality improvement initiatives and some expenditures for updating claims coding systems. Additionally, they are allowed to lower the denominator (premium income) by subtracting most taxes, regulatory fees, and "community benefit" spending.

These changes inflate MLRs, making filings for the ACA incomparable with MLR estimates from previous years. To assess temporal trends, we calculated MLRs using the pre-2011 definition based on insurers' official Form 10-K filings with the U.S. Securities and Exchange Commission. We analyzed data for risk-bearing insurance plans (i.e., excluded self-insured employer plans) for every health insurer listed in the Fortune 500 for three years before and after the implementation of the MLR regulation. We excluded one firm (Cigna) because a 2010 change in its accounting practices prohibited accurate assessment of temporal trends.

## RESULTS

Table 1 displays MLRs for the nine firms before and after the new regulations. The weighted average MLR of the nine firms did not change appreciably (83.04% for 2009–2010 and 83.05% for 2011–2013). MLRs fell at four firms (including three of the nation's four largest insurers); they increased slightly at four and markedly at one (Centene, a major managed Medicaid contractor).

## DISCUSSION

The ACA appears to have had little or no impact on insurance industry overhead. Although overhead was reduced at some insurers, with one exception these reductions were within the range of year-to-year fluctuations commonly seen in the past. While the MLR requirements forced insurers to pay rebates of US$1.1 billion in 2011 and US$504 million in 2012, these rebates constituted less than 0.1 percent of private insurance revenues and appear to have had no overall impact on MLRs.

Table 1

Medical loss ratios (in percent) of health insurance firms listed in the Fortune 500, 2008–2013

| Insurer (6) | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2008–2010 average | 2011–2013 average | Change |
|---|---|---|---|---|---|---|---|---|---|
| UnitedHealth | 82.0 | 82.3 | 80.6 | 80.8 | 80.4 | 81.5 | 81.6 | 80.9 | –0.7 |
| Humana | 84.5 | 82.8 | 82.9 | 82.1 | 83.7 | 83.9 | 83.4 | 83.2 | –0.2 |
| WellPoint | 84.5 | 83.6 | 83.2 | 85.1 | 85.3 | 85.1 | 83.8 | 85.2 | 1.4 |
| Aetna | 81.5 | 85.2 | 82.3 | 79.6 | 82.2 | 82.9 | 83.0 | 81.6 | –1.4 |
| Coventry H.C.* | 84.0 | 85.4 | 79.4 | 82.1 | 84.0 | N/A | 82.9 | 83.0 | 0.1 |
| Health Net | 86.9 | 86.3 | 86.6 | 86.4 | 89.1 | 85.6 | 86.6 | 87.1 | 0.5 |
| WellCare H.P. | 85.3 | 85.4 | 84.6 | 81.1 | 85.2 | 86.8 | 85.1 | 84.4 | –0.7 |
| Centene | 82.5 | 83.5 | 83.8 | 85.2 | 91.6 | 88.6 | 83.3 | 88.5 | 5.2 |
| Molina H.C. | 84.8 | 86.8 | 84.5 | 83.9 | 87.5 | 87.1 | 85.4 | 86.1 | 0.8 |
| Weighted average of 9 firms | 83.42 | 83.59 | 82.14 | 82.28 | 83.26 | 83.51 | 83.04 | 83.05 | 0.01 |

*Coventry H.C. was acquired by Aetna in 2012, effective as of its FY2013 annual financial report. The "2011–2013 average" for Coventry includes only the years 2011–2012.

Our findings are consistent with trends in the National Health Expenditure Accounts, which report slightly falling medical spending as a proportion of private insurance premiums two years into reform (from 88.0% in 2009–2010 to 87.8% in 2011–2012) (2). These national figures differ from the MLRs that we report because they include nonprofit insurers and self-insured plans (which generally have lower overhead than for-profit insurers).

A study using provisional data from the National Association of Insurance Commissioners found that the unweighted, median MLR for the individual market increased in 2011 (which accounts for 15% of enrollment), but did not change in the small- and large-group markets (3).

Why hasn't the ACA raised MLRs? First, most plans already met the MLR requirements from 2007–2009, even without the MLR redefinition allowing a number of deductions (4). Moreover, self-insured employer plans, which accounted for 60 percent of all covered workers in 2011 (5), were entirely exempt from the MLR requirements. Second, exemptions and adjustments were granted to the plans most likely to trigger rebates—small insurers, those offering high deductible plans, mini-med plans, and expatriate plans. Additionally, the Obama administration gave several states permission to allow insurers in their state to temporarily increase their MLR thresholds for the individual and small-group markets.

In sum, the ACA has not decreased private insurers' overhead, which remains six-fold higher than traditional Medicare's.

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