

July 2011

# PRIVATE HEALTH INSURANCE

## Early Experiences Implementing New Medical Loss Ratio Requirements

U.S. Government Accountability Office

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ACCOUNTABILITY ★ INTEGRITY ★ RELIABILITY

## Why GAO Did This Study

To help ensure that Americans receive value for their premium dollars, the Patient Protection and Affordable Care Act (PPACA) established minimum “medical loss ratio” (MLR) standards for health insurers. The MLR is a basic financial indicator, traditionally referring to the percentage of premiums spent on medical claims. The PPACA MLR is defined differently from the traditional MLR (see fig.). Beginning in 2011, insurers must meet minimum MLR requirements or pay rebates to enrollees. While insurers’ first set of data subject to the MLR requirements will be for 2011, and is not due until June 2012, insurers prepared preliminary PPACA MLR data for 2010. GAO examined: (1) what can be learned from the traditional MLR data reported by health insurers prior to PPACA; (2) what factors might affect the MLRs that insurers will report under PPACA; and (3) what changes in business practices, if any, have insurers made or planned to make in response to the PPACA MLR requirements. GAO analyzed premiums, claims, and traditional MLR data for nearly all insurers for 2006–2009 and interviewed a judgmental sample of seven insurers—selected to provide a range based on their size, profit status, and the number of states in which they operated—about their experiences using the PPACA MLR definition.

In commenting on a draft of this report, the Department of Health and Human Services (HHS) said that the MLR provision will increase transparency in the insurance market and value for consumers’ premiums.

View [GAO-11-711](#) or key components. For more information, contact John E. Dicken at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

## PRIVATE HEALTH INSURANCE

### Early Experiences Implementing New Medical Loss Ratio Requirements

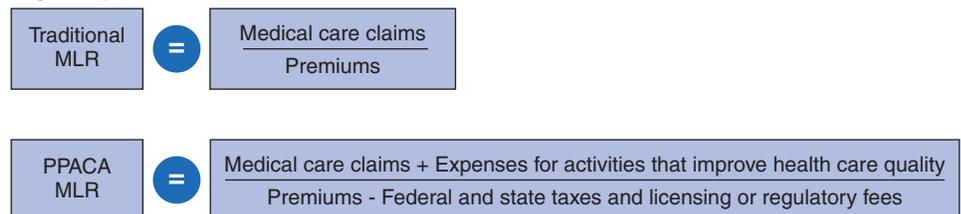
## What GAO Found

From 2006 through 2009, traditional MLRs on average generally exceeded PPACA MLR standards. This is even without the additional components in the new PPACA MLR that will generally increase MLRs. However, traditional MLRs also varied among insurers. Traditional MLRs within the individual market varied more than those within the small and large group markets, and a larger proportion of individual market insurers generally had lower MLRs. Additionally, traditional MLRs varied more among smaller insurers than among larger insurers in all three markets. Some components of the PPACA MLR requirements may mitigate the implications of some of these variations.

The insurers GAO interviewed said their PPACA MLRs will be affected by changes in the MLR formula and their ability to provide more precise data in 2011 and beyond. Most of these insurers reported that the deduction of taxes and fees in the PPACA MLR formula would contribute to the largest change in their 2010 MLRs. Including expenses for activities to improve health care quality was also cited as a factor affecting insurers’ MLRs but to a lesser extent. In addition, because insurers had limited time to respond to HHS’s interim final rule on PPACA MLRs, which was published in late 2010, they said that their 2010 MLRs were based in part on best estimates. Insurers said they expect their ability to provide more precise PPACA MLR data will improve in 2011 and beyond.

Most of the insurers GAO interviewed were reducing brokers’ commissions and making adjustments to premiums, as well as making changes to other business practices, in response to the PPACA MLR requirements. Almost all of the insurers said they had decreased or planned to decrease commissions to brokers in an effort to increase their MLRs. Insurers varied on how the PPACA MLR requirements might affect their decisions to implement activities to improve health care quality. While one insurer said that their decision to implement new activities would be affected by whether or not an activity could be included as a quality improvement activity in the PPACA MLR formula, other insurers said that the PPACA MLR requirements are not a factor in such decisions. Insurers also differed on how the PPACA MLR requirement may affect where they do business. One insurer said that they have considered exiting the individual market in some states in which they did not expect to meet the PPACA MLR requirements, while several other insurers said that the PPACA MLR requirements will not affect where they do business.

#### Key Components of Traditional and PPACA MLR Formulas



Source: GAO.

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## Abbreviations

HHS	Department of Health and Human Services
IT	information technology
MLR	medical loss ratio
NAIC	National Association of Insurance Commissioners
PHSA	Public Health Service Act
PPACA	Patient Protection and Affordable Care Act

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G A O

Accountability \* Integrity \* Reliability

United States Government Accountability Office  
Washington, DC 20548

July 29, 2011

The Honorable Robert E. Andrews  
Ranking Member  
Subcommittee on Health, Employment, Labor,  
and Pensions  
Committee on Education and the Workforce  
House of Representatives

The Honorable John F. Tierney  
House of Representatives

To help ensure that millions of Americans who rely on private insurance for health care coverage receive value for their premium dollars, the Patient Protection and Affordable Care Act (PPACA) established minimum “medical loss ratio” (MLR) standards for insurers.<sup>1</sup> The MLR is a basic financial indicator, traditionally referring to the percentage of insurance premium revenues health insurers spent on their enrollees’ medical claims. The MLR definition specified in the PPACA provision—referred to as the PPACA MLR in this report—differs from the traditional MLR definition. Key differences are that it allows insurers to include in their expenses spending on activities to improve health care quality and to deduct from their revenues certain tax payments and fees. PPACA requires insurers offering coverage in the large group market to meet minimum PPACA MLRs of 85 percent, and in the small group and individual markets to meet minimum PPACA MLRs of 80 percent, or pay rebates to their enrollees.<sup>2,3</sup> The Department of Health and Human

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<sup>1</sup>Pub. L. No. 111-148, §§ 1001(5), 10101(f), 124 Stat. 119, 130, 885 (2010) (inserting and amending a new section 2718 in the Public Health Service Act (PHSA)).

<sup>2</sup>Generally, small and large group markets refer to coverage sold to a “small employer” or a “large employer.” PPACA generally defines a small employer as having employed an average of 1 to 100 employees and a large employer as having employed an average of 101 or more employees during the preceding calendar year. Until 2016, a state has the option to define small employers as having employed an average of 1 to 50 employees during the preceding calendar year and a large employer as having employed an average of at least 51 employees during the preceding calendar year. See Pub. L. No. 111-148, § 1304(b), 124 Stat. 172.

<sup>3</sup>Rebates are refunds issued by the insurer to the individual or entity that paid the premium either in the form of a lump sum payment or credit towards current premiums.

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Services (HHS) estimated that in 2011, the PPACA MLR requirements will apply to health insurance plans covering about 75 million insured Americans.

HHS is responsible for implementing the PPACA MLR provision, including certifying the definitions and methodologies used for calculating MLRs developed by the National Association of Insurance Commissioners (NAIC).<sup>4</sup> The first set of data subject to the requirements will be for insurers' expenditures for calendar year 2011, which are to be submitted to HHS in June 2012. In the interim, in April 2011, insurers submitted preliminary MLR data to NAIC based on their 2010 expenditures using the PPACA MLR definition.<sup>5</sup>

There has been much debate among Congress and other stakeholders on the potential impact of the PPACA MLR requirements. For example, consumer advocates have asserted that the requirements will help ensure that consumers receive value for their premium dollars, and have cited what they believe are excessive industry profits as evidence that minimum MLR requirements are needed. Insurance industry representatives have expressed concern about the potential for the requirements to affect the stability of certain insurance markets, and ultimately consumer choice in those markets.

You asked us to examine issues related to the MLR requirements in PPACA. This report addresses: (1) what can be learned from traditional MLR data reported by health insurers prior to the PPACA MLR requirements; (2) what factors might affect the MLRs that insurers will report under the PPACA MLR requirements; and (3) what changes in business practices, if any, insurers have made or plan to make in response to the PPACA MLR requirements.

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<sup>4</sup>NAIC is the organization of insurance commissioners from the 50 states, the District of Columbia, and the five U.S. territories who regulate the conduct of insurance companies in their respective state or territory.

<sup>5</sup>This study does not include an analysis of insurers' 2010 MLR data. At the time of our study, NAIC was in the process of validating insurers' reported data and the data were not fully complete.

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To determine what can be learned from traditional MLR data reported prior to PPACA, we analyzed premiums, claims, and MLR data insurers reported to NAIC on their annual statements for 2006 through 2009.<sup>6</sup> We used these data to analyze the averages and ranges of traditional MLRs by year, and by insurance market and insurer size. To assess the reliability of these data, we reviewed relevant documentation, conducted interviews with NAIC officials knowledgeable about the data, and conducted electronic testing of the data to identify obvious errors or outliers. We determined that the data were sufficiently reliable for the purposes of this report. To determine what factors might affect the MLRs that insurers will report under the PPACA MLR requirements, and what changes in business practices, if any, insurers have made or plan to make in response to the PPACA MLR requirements, we interviewed a judgmental sample of seven insurers to learn about their experiences reporting 2010 MLRs using the PPACA MLR definition, as well as their expectations related to future reporting of data that will be subject to the PPACA MLR requirements.<sup>7</sup> We selected our sample to reflect a variety of insurers based on certain characteristics, including insurer size as determined by the number of enrollees; the number of insurance companies within the insurance groups; profit status; whether the insurer was publicly traded or privately held; and the number of states in which the insurer operated. We also interviewed a group of officials from seven state insurance commissioners' offices and NAIC officials, which was convened by NAIC at our request, to obtain their perspectives on issues related to the transition of the new PPACA MLR requirements for 2011 and beyond.

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<sup>6</sup>All insurers, with some exceptions, report annual financial statements to NAIC that include data for all health insurance markets offered by an insurer, including individual, small group, and large group markets. The largest exceptions to the NAIC reporting requirements are insurers that are regulated by the California Department of Managed Health Care which report directly to that department. HHS estimates that 9 percent of health insurers subject to the PPACA MLR requirements do not report to NAIC. Our analysis was based on data filed on NAIC's annual Accident and Health Policy Experience Exhibit, which is the form on which the MLR was reported for the years 2006 through 2009.

<sup>7</sup>Our sample of insurers included six insurance groups that operated one or more insurance companies and one insurance company that was not part of a larger insurance group. Many, but not all, insurance companies are a part of larger insurance groups.

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We conducted this performance audit from December 2010 through July 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

PPACA established minimum MLR standards for insurers offering group or individual health insurance coverage using a new MLR formula that differs from the way MLRs have traditionally been calculated. To implement the PPACA MLR provisions, HHS issued an interim final rule that provided specific definitions and methodologies to be used in calculating the new MLRs, and that addressed other areas, including adjustments to the MLRs to address the circumstances of certain types of plans, and oversight and enforcement.<sup>8</sup> Insurers will begin reporting PPACA MLRs to HHS in June 2012.

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## Traditional and PPACA MLR Formulas

In the private health insurance industry, the MLR is a commonly used indicator, measuring the proportion of premium dollars an insurer used for medical claims, as opposed to other functions, such as marketing, actuarial activities, or profit. While many states have minimum MLR standards or MLR reporting requirements, PPACA established federally required minimum MLRs for insurers operating in the individual and group insurance markets.<sup>9</sup>

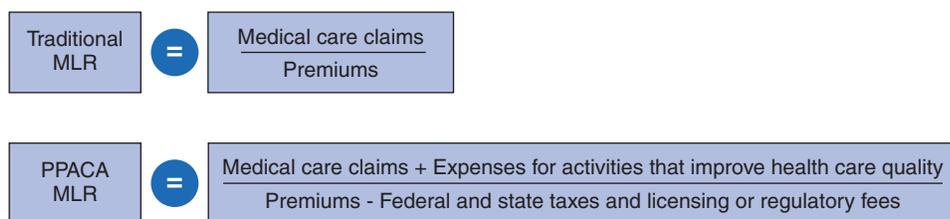
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<sup>8</sup>75 Fed. Reg. 74864, 74921 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158); 75 Fed. Reg. 82277, 82278 (Dec. 30, 2010) (to be codified at 45 C.F.R. pt. 158) (providing corrections for technical and typographical errors in the Dec. 1, 2010 interim final rule).

<sup>9</sup>An analysis prepared by one insurance industry trade group identified 34 states that, as of April 2010, had established MLR guidelines or requirements for certain markets, required the submission of MLR information in rate filings to state regulators, or imposed limitations on administrative expenses. Many of these states used their MLR guidelines to determine whether the benefits of a policy were reasonable relative to premiums. A small number of states required insurers to issue a dividend, credit, or refund to policyholders if the MLR standard was not met. See America's Health Insurance Plans, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations* (Apr. 15, 2010).

The MLR formula specified in PPACA differs from the way MLRs have traditionally been defined. The traditional MLR is generally calculated by dividing an insurer's medical care claims by premiums.<sup>10</sup> In the PPACA MLR formula, the numerator includes insurers' expenses for activities that improve health care quality—such as patient-centered education and counseling, care coordination, and wellness assessments—in addition to claims. Further, the denominator of the PPACA MLR subtracts from insurers' premiums all federal taxes and state taxes and licensing or regulatory fees (see fig. 1).

**Figure 1: Key Components of Traditional and PPACA MLR Formulas**



Source: GAO.

## Implementation of PPACA MLR Requirements

In addition to establishing the new MLR formula, PPACA directed NAIC to establish recommended definitions and methodologies for calculating MLRs, subject to certification by the Secretary of HHS.<sup>11</sup> NAIC submitted its recommendations to HHS on October 27, 2010, and HHS issued its interim final rule implementing the PPACA MLR requirements in PPACA on December 1, 2010, with an effective date of January 1, 2011. According to HHS, the interim final rule adopted NAIC's recommendations in full, and included the following key areas.

<sup>10</sup>For the purposes of this report, medical care claims is broadly defined as payments made or anticipated to be made for medical care expenses. For example, medical care claims would include medical care expenses paid, medical care expenses incurred but not yet paid, as well as changes in an insurer's contract reserves. Contract reserves are funds set aside to pay certain claims expected to be incurred in the future.

<sup>11</sup>Pub. L. No. 111-148, § 10101(f), 124 Stat. 885, 887 (inserting a new § 2718(c) in the PHSA). HHS is responsible for implementing the MLR provisions in PPACA. The department has delegated this responsibility to the Center for Consumer Information and Insurance Oversight, a new office within the Centers for Medicare & Medicaid Services.

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- Activities that improve health care quality. These include activities designed to increase the likelihood of desired health outcomes in ways that can be objectively measured. The activities must be primarily designed to: (1) improve health outcomes; (2) prevent hospital readmissions; (3) improve patient safety; (4) implement, promote, and increase wellness and health activities; and (5) enhance the use of health care data to improve quality, transparency, and outcomes. Insurers are also allowed to include health information technology (IT) expenses needed to accomplish activities that improve health care quality. Also specified were certain activities that do not qualify as those that improve health care quality, such as provider credentialing.
  - Federal and state taxes and licensing or regulatory fees. These include all federal taxes and assessments, excluding taxes on investment income and capital gains.
  - Levels of aggregation for MLR reporting. Insurance companies are required to report MLRs separately for their individual, small group, and large group markets for each state in which they are licensed to operate.<sup>12</sup>
  - Credibility adjustments. All insurers experience some random variability in their claims, where actual claims experience varies from expected experience. The impact of these deviations is less for health plans with a larger customer base. To help address the disproportionate impact of claims variability on small health plans, adjustments to MLRs are permitted for these plans. Specifically, MLRs for plans with
    - less than 1,000 life years will be considered “noncredible” and will be presumed to meet the MLR requirements;<sup>13</sup>
    - 1,000 to less than 75,000 life years will be considered “partially credible” and may receive an upward adjustment ranging from

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<sup>12</sup>Prior to PPACA, insurers did not report traditional MLRs to NAIC by state.

<sup>13</sup>Life years refers to the total number of months of coverage for all enrollees divided by 12.

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1.2 to 8.3 percentage points, depending on size, and a further adjustment if they have high deductibles;<sup>14</sup> and

- 75,000 life years or more will be considered “fully credible” and will not receive an adjustment.

HHS estimates show that for 2011 a small fraction of insurers that offer plans in the individual, small group, or large group markets would be considered fully credible, but these insurers account for the majority of the total life years covered by these types of plans.<sup>15</sup> About half of insurers that offer plans in the small and large group markets and a little less than a third of insurers that offer plans in the individual market would be partially credible and could apply a credibility adjustment.

- Years of data to include in calculating the MLR. Beginning in 2013, insurers’ MLRs will be calculated based on a 3-year period of the accumulated experience for the current reporting year and the 2 preceding years. Because insurers will not have 3 years of MLR data for 2011 and 2012, MLRs for these years will be calculated as follows: (1) MLRs for 2011 will be calculated on their experience for 2011, (2) MLRs for plans that are fully credible in 2012 will be calculated based on their experience for 2012, and (3) MLRs for plans that are partially or noncredible in 2012 will be calculated based on accumulated experience from 2011 and 2012.

HHS’s interim final rule also addressed areas that NAIC did not specifically include in its recommendations, which focused primarily on the definitions and methodologies used for calculating the MLR. Some key areas are summarized below.

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<sup>14</sup>NAIC concluded, based on analysis conducted by an independent consulting firm, that claims experience tends to be more variable for health insurance plans with high deductibles compared with policies with lower deductibles. To address this, the interim final rule specifies that for partially credible plans, the adjustment for the number of life years—referred to as the base credibility factor—can be further multiplied by a deductible factor ranging from 1.0 to 1.736, depending on the average deductible of all policies whose experience is included in the reported MLR.

<sup>15</sup>HHS’s estimates were based on insurance companies’ experience disaggregated by state.

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- Treatment of agents' and brokers' commissions and fees. HHS explicitly listed agents' and brokers' commissions and fees as nonclaims expenses. NAIC did not include any special treatment of these expenses in its recommendation to HHS, but raised concerns about the potential impact of the MLR requirements on the ability of these professionals to continue assisting consumers. HHS officials have continued to discuss this issue with NAIC. Legislation has also since been introduced to deduct agents' and brokers' fees from premiums in the MLR calculation.<sup>16</sup>
  - Adjustment to the standard for a state's individual market. In addition to providing for credibility adjustments, PPACA provided HHS with the authority to adjust the MLR standard for the individual market in a state if it determines that the application of the standard may destabilize the individual market in that state.<sup>17</sup> Although NAIC's recommendations to HHS did not specifically address adjustments to the MLR standard for the individual market, NAIC did raise concerns about the ability of many insurers to readily achieve an MLR of 80 percent. In the interim final rule, HHS established a process for states to apply for an adjustment to the MLR standard for the individual market in that state that included the information states must provide in their applications and the criteria HHS would use to assess the applications.<sup>18</sup> As of July 25, 2011, 12 states and 1 territory had applied to HHS for an adjustment; HHS had granted an adjustment of the MLR in 5 states, did not grant an adjustment in

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<sup>16</sup>H.R. 1206. The bill was introduced in the House of Representatives and referred to the Subcommittee on Health in the Committee on Energy and Commerce.

<sup>17</sup>Pub. L. No. 111-148, § 10101(f), 124 Stat. 885, 886 (inserting a new § 2718(b)(1)(A)(ii) in the PHSA).

<sup>18</sup>States requesting an adjustment to the MLR standard for the individual market must provide information about how the individual market is organized and functions, including the state's current MLR standard for this market, if any; any requirements placed on insurers seeking to withdraw from the individual market; and operational and financial information about each insurer offering coverage in the individual market in the state. The state must also include its proposal for an alternative MLR standard. HHS specified several criteria it may consider in assessing state applications, including: the number of insurers reasonably likely to exit the market without an adjustment to the 80 percent MLR standard; the number of enrollees covered by these insurers; alternate coverage options available for these enrollees; whether consumers may be unable to access insurance agents or brokers absent an adjustment to the MLR standard; and the impact on premiums, benefits, and cost-sharing provided to consumers by insurers remaining in the market if one or more insurers withdraw.

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1 state, and was in the process of reviewing the remaining applications.<sup>19</sup>

- *Oversight.* HHS is responsible for direct enforcement of the reporting and rebate provisions of the MLR requirements, including that the reports are submitted timely, that the data comply with the definitions in the regulations, and that rebates are paid timely and accurately. The interim final rule provides a framework through which HHS may conduct audits to determine insurers' compliance with the provisions and provides that HHS may, in its discretion, accept the findings of audits that state regulators may conduct of an insurer's MLR reporting and rebate obligations, as long as specified conditions are met. The interim final rule also provides for the imposition of civil monetary penalties if insurers fail to comply with the requirements.

HHS received public comments on the interim final rule from representatives of the insurance industry, consumers, state regulators, and others, covering a wide range of topics, such as the treatment of agents' and brokers' fees, the methodology for determining credibility adjustments, and the treatment of taxes. According to HHS officials, HHS has not determined when it will issue a final rule.

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## MLR Reporting

PPACA MLRs will be reported to HHS every June and will reflect insurers' experiences from the previous calendar year. The first set of these data will be submitted to HHS in June 2012, reflecting insurers' experiences from 2011.<sup>20</sup> In April 2011, insurers reported MLRs to NAIC using the PPACA MLR definition based on their 2010 experience. These data are not subject to the PPACA MLR provisions and will not be adjusted to account for credibility or other issues addressed in the provisions.

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<sup>19</sup>HHS adjusted the MLR standard for the individual market for 2011 in Maine, Nevada, New Hampshire, Kentucky, and Iowa. It did not grant North Dakota's request for an adjustment of the MLR standard and was in the process of reviewing applications submitted by Florida, Georgia, Louisiana, Kansas, Delaware, Indiana, and Guam.

<sup>20</sup>In June 2011, HHS also began collecting quarterly MLR data on certain plans—specifically, limited benefit plans that have a total annual limit of \$250,000 or less and expatriate plans—to inform what adjustments to the MLR standards may be appropriate to address the special circumstances of these plans. Limited benefit plans cover the same types of medical services as comprehensive major medical plans but have unusually low annual benefit limits. Expatriate plans generally cover employees working outside their country of citizenship, employees working outside their country of citizenship and their employer's country of domicile, and non-U.S. citizens working in their home country.

## Traditional MLRs on Average Generally Exceeded PPACA MLR Standards, but Varied, Particularly among Individual Market and Smaller Insurers

Traditional MLR averages generally exceeded the PPACA MLR standards in each market, even without the changes in the new PPACA MLR formula that will generally further increase MLRs. However, traditional MLRs also varied among insurers, particularly among those in the individual market and smaller insurers. Since traditional MLRs were calculated differently than they will be under the PPACA requirements, it is difficult to predict, based on these data, what insurers' MLRs would have been using the PPACA formula, or to predict the MLRs that insurers' will report in the future.

### Traditional MLR Averages

From 2006 through 2009, insurers' traditional MLR averages generally exceeded the PPACA MLR standards—80 percent for the individual and small group markets and 85 percent for the large group market. This is even without the new PPACA MLR formula definitions or credibility adjustments that will generally further increase MLRs reported under the PPACA requirements. The average traditional MLRs reported for 2006 through 2009 were also relatively stable for all markets (see table 1). Since traditional MLRs were calculated differently than they will be under the PPACA requirements, it is difficult to predict, based on these data, what insurers' MLRs would have been using the PPACA formula, or to predict the MLRs that insurers' will report in the future.

**Table 1: Average Traditional MLRs by Market for Insurers, 2006–2009**

Year	Individual market		Small group market		Large group market	
	(N)	Mean	(N)	Mean	(N)	Mean
2006	180	84.3	281	79.5	316	84.9
2007	186	83.3	290	81	319	87.3
2008	194	81.2	287	80.6	311	87.3
2009	197	84.7	312	83.1	340	88.8

Source: GAO analysis of NAIC data.

Notes: Excludes insurers with less than 1,000 life years in a market or where life years could not be determined, and insurers that reported negative values for premiums, claims, or number of covered lives. Life years refers to the total number of months of coverage for enrollees divided by 12. Large group market includes plans participating in the Federal Employees Health Benefits Program.

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## Variation in Traditional MLRs

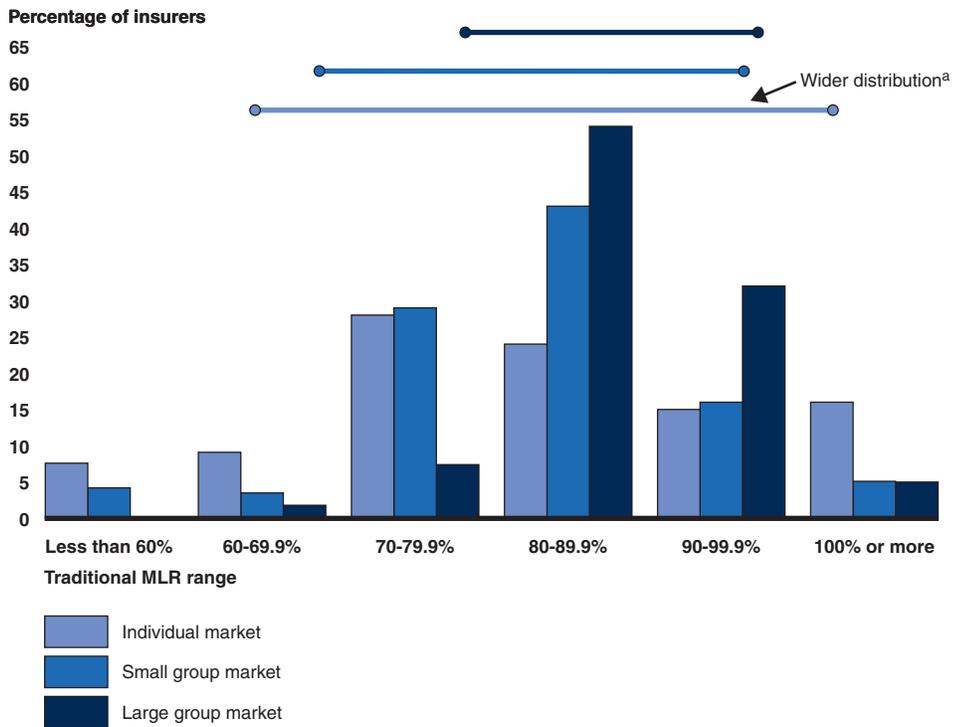
While traditional MLRs on average generally exceeded the PPACA MLR standards from 2006 through 2009, they varied, particularly in the individual market. For example, figure 2 shows that in 2009 traditional MLRs in the individual market were more widely distributed than those in the small and large group markets.<sup>21</sup> Within this variation in the individual market, a larger proportion of insurers generally had lower MLRs; that is, they spent a lower percentage of their premiums on medical claims, as compared to insurers in the small and large group markets.<sup>22</sup> Under PPACA, states may request adjustments to the MLR standard for the individual market if application of the standard may destabilize that market, for example, by causing insurers to exit the market, such that insurance options are limited in the state.

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<sup>21</sup>Our analysis was based on data insurers reported that were an aggregate across all states they operated in. Under PPACA, insurers will have to meet minimum MLR standards within each state in which they operate.

<sup>22</sup>Also, some insurers reported traditional MLRs above 100 percent indicating that the insurer's claims were greater than the premiums it collected for that year. For example, if an insurer had a small number of enrollees and one enrollee had an extremely large claim then the result could be an MLR over 100 percent.

**Figure 2: Range of Traditional MLRs Reported in the Individual, Small Group, and Large Group Markets, 2009**



Source: GAO analysis of NAIC data.

Notes: Excludes insurers with less than 1,000 life years in a market or where life years could not be determined, and insurers that reported negative values for premiums, claims, or number of covered lives. Life years refer to the total number of months of coverage for enrollees divided by 12. Large group includes plans participating in the Federal Employees Health Benefits Program.

<sup>a</sup>The traditional MLRs in the individual market were more widely distributed than those in the small and large group markets. MLRs within one standard deviation above and below the mean ranged from 64.4–105 percent in the individual market, compared to 69.4–96.8 percent in the small group market, and 79–97.9 percent in the large group market. The standard deviation is a measure of the amount of variation in the data from the mean—a larger standard deviation indicates more variability.

Annual fluctuations in insurers’ traditional MLRs were also greater for insurers in the individual market. For example, 70 percent of insurers in the individual market experienced an average annual change in their traditional MLRs of more than 5 percentage points from 2006 through 2009, compared to 46 percent in the small group market and 39 percent in the large group market. Almost 12 percent of insurers in the individual market averaged annual changes greater than 20 percentage points, compared with about 4 percent of insurers in both the small group and large group markets. Beginning in 2013, insurers will calculate their

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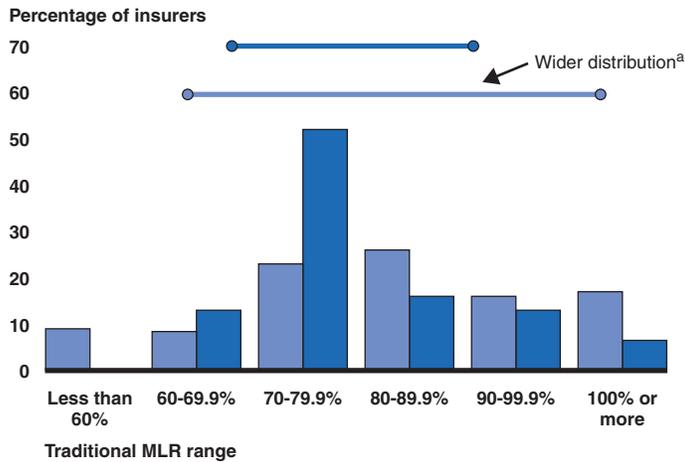
PPACA MLRs based on 3 years of data, which could partially mitigate the impact of variations often experienced by insurers from year to year.

Traditional MLRs were also more varied for smaller insurers in all three markets from 2006 through 2009. For example, figure 3 shows that in 2009 traditional MLRs for smaller insurers were more widely distributed than those for larger insurers, with a higher percentage of smaller insurers generally reporting lower MLRs. The credibility adjustments in PPACA allow smaller insurers to upwardly adjust their MLRs. Data for figure 3 are aggregated across all states that an insurer operates in. However, since insurers are required to report their PPACA MLRs at the state level, it is likely that in 2011 and beyond, more insurers will have less than 75,000 life years in a market at the state level and will be eligible for a credibility adjustment.

**Figure 3: Range of Traditional MLRs Reported in the Individual, Small Group, and Large Group Markets, by Insurer Size, 2009**

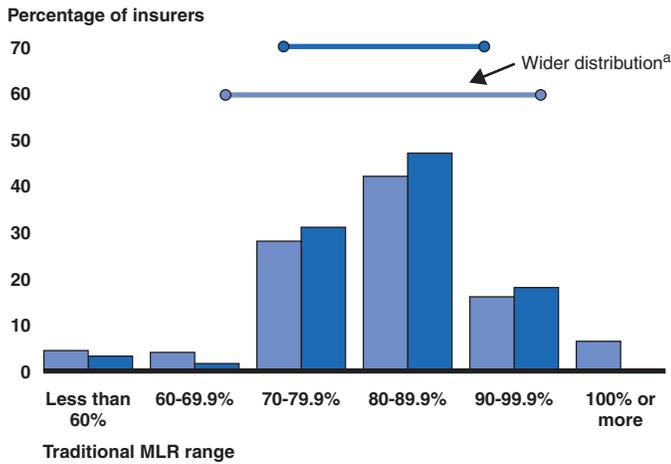
**Individual market:**

Range of traditional MLRs reported by insurer size, 2009



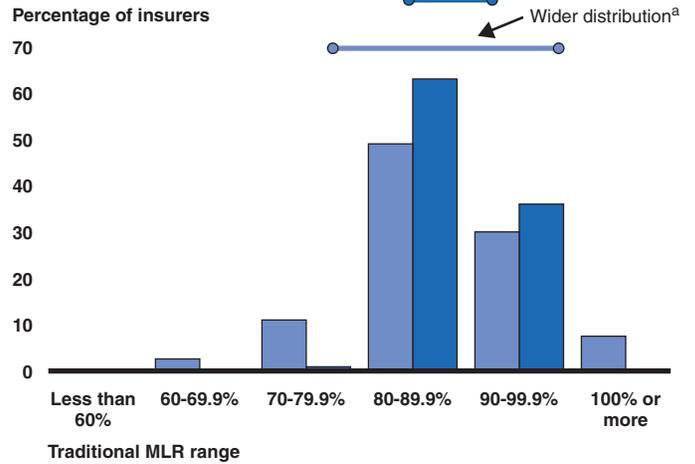
**Small group market:**

Range of traditional MLRs reported by insurer size, 2009



**Large group market:**

Range of traditional MLRs reported by insurer size, 2009



Less than 75,000 life years  
75,000 or more life years

Source: GAO analysis of NAIC data.

Notes: Excludes insurers with less than 1,000 life years in a market or where life years could not be determined, and insurers that reported negative values for premiums, claims, or number of covered lives. Life years refers to the total number of months of coverage for enrollees divided by 12. Large group includes plans participating in the Federal Employees Health Benefits Program.

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<sup>a</sup>The traditional MLRs among smaller insurers were more widely distributed than larger insurers in all markets. In the individual market, MLRs within one standard deviation above and below the mean ranged from 64–107.2 percent for smaller insurers, and 69.2–90.2 percent for larger insurers. In the small group market, the range was 68.5–97.9 percent for smaller insurers and 73.9–91.5 percent for larger insurers. In the large group market the range was 78.1–99.5 percent for smaller insurers and 84.7–92.9 percent for larger insurers. The standard deviation is a measure of the amount of variation from the average—a larger standard deviation indicates more variability.

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## PPACA MLRs Will Be Affected by Changes in the MLR Calculation and Insurers' Ability to Provide More Precise Data in 2011 and Beyond

The insurers we interviewed said their PPACA MLRs will be affected by changes in the MLR formula, primarily due to the deduction of taxes and fees in the denominator, and to a lesser extent, the addition of expenses for activities to improve health care quality in the numerator. Insurers also said that the PPACA MLR requirement to report MLRs by state will affect their PPACA MLRs. Insurers said they expect the precision of their PPACA MLR data to improve in 2011 and beyond, in part because their 2010 MLRs were based on best estimates.

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## Insurers Reported That Changes in the Way MLRs Are Calculated Will Affect Their PPACA MLRs

Most of the insurers we interviewed reported that the deduction of taxes and fees in the denominator of the PPACA MLR formula would contribute to the largest change in 2010 MLRs compared to the traditional MLR formula, but some insurers said the effect of the deductions vary by state and may vary in 2011 and beyond. One insurer told us that the effect of deducting taxes and fees for their 2010 MLRs was more than double the effect of including their expenses for activities to improve health care quality in the numerator. Another insurer told us that the effect of taxes and fees would vary by state because state taxes, such as premium taxes and other state assessments, can vary. Further, one insurer said that while the deduction of taxes and fees was the largest component that affected their 2010 MLRs, and resulted in increased MLRs, if the insurer were to experience a loss in profits in a future year, and therefore a reduction in its income taxes, the effect of this deduction could result in a decrease in MLRs. Regulators from several state insurance commissioners' offices also told us that they believed the deduction of taxes and fees in the PPACA MLR formula would likely have the largest impact on MLRs reported by insurers in 2010.

Most of the insurers we interviewed also said including expenses in the numerator of the PPACA formula for activities to improve health care quality contributed to changes in the 2010 MLRs compared to what they would have been under the traditional formula. However, including these

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expenses had less of an effect on their MLRs than the deduction of taxes and fees. One insurer estimated that the inclusion of these expenses in the PPACA MLR formula would increase their MLRs by 0.5 percentage points, but this was a fraction of the total estimated 2.0–2.5 percentage point increase in their MLR overall, which the insurer said was primarily due to the deduction of taxes and fees. Another insurer estimated that the impact of including their expenses for quality improvement activities would be less than 2 percentage points, but the deduction of taxes represented the largest component driving the increase in their 2010 MLRs. In addition, two insurers said that including quality improvement expenses would have very little impact on their PPACA MLRs. Examples of activities that improve health care quality that insurers included in their PPACA MLR were disease management programs, wellness activities, 24-hour nurse phone lines, and care coordination.

Insurers that issue insurance plans in more than one state said that disaggregating MLRs by state will likely result in some variation in their MLRs across states. For example, one insurer said that a higher proportion of their premium dollars are spent on administrative expenses in one of their states because they tend to sell lower benefit plans, which they said have high administrative costs relative to premiums, in this state. While this insurer historically reported a single MLR combining data across two states, they said the disaggregation by state required for the PPACA MLR resulted in lower MLRs in the state with lower benefit plans compared to the other state. For example, MLRs in this state were 1.5 percentage points lower in the individual market and 4.5 percentage points lower in the small group market than the MLRs in the other state. Another insurer said that prior to the PPACA MLR requirements they priced insurance plans for the small group market to employers located in two states as a single market. When they calculated the PPACA MLRs separately for each state they noted variations between the two MLRs because medical costs were different in each state.

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### Insurers' Ability to Provide More Precise Data Will Affect PPACA MLRs Reported in 2011 and Beyond

All of the insurers we spoke with said that their PPACA MLRs for 2011 and beyond will be more precise than the 2010 MLRs reported to NAIC for several reasons. Because HHS's interim final rule on PPACA MLRs was published in late 2010, insurers told us that they used their best estimates to apply the PPACA definition to experiences incurred earlier in the year. They said their PPACA MLRs for 2011 and beyond will be more precise because they will not be based on estimates and they will have a full year of data that they collected according to the new PPACA MLR categories. A regulator from one state insurance commissioner's office

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described 2010 as a “test” year and said it will help insurers better prepare to report their 2011 MLRs. The regulators also agreed that the 2010 MLR data would not be a clear indicator of insurers’ expenses for quality improvement activities because insurers’ may vary in how precisely they report these expenses. In addition, some insurers told us they had never reported MLRs both by state and by insurance market prior to the PPACA MLR requirements, and were having challenges developing reasonable bases for allocating expenses across states and insurance markets for their 2010 reporting. However, they expected these issues to be resolved for 2011. For example, one insurer told us that their medical quality activities are centralized and apply to all markets, but they must now apportion their expenses for these activities by market, then to each of their insurance companies, and then by state. This insurer said that they implemented a new timekeeping system late in 2010 to better account for the time that their staff spend on these activities to address these allocation issues and expect to produce more precise data for their 2011 MLRs and beyond.

Most of the insurers we interviewed also told us that their 2010 MLR data may be less precise than data reported in future years because of challenges they had in identifying and allocating health IT expenses. For example, one insurer told us that their health IT is a centralized function that is also used for other lines of insurance business, such as Medicare and Medicaid, which they said are not subject to PPACA MLR requirements. Another insurer said that determining their health IT expenses was less clear relative to the other subcategories of activities to improve health care quality in that it was hard to identify how much of their internal IT system infrastructure uniquely supported the other eligible quality activities. In addition, one insurer that only operates in a single state said that identifying expenses for health IT was challenging when factors such as facilities and employees’ salaries had to be considered. However, all of these insurers anticipated that these issues would be largely resolved when they report their 2011 PPACA MLRs.

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## Insurers Reported That They Are Making or Considering Changes to Brokers' Commissions and Premiums, and to Other Business Practices

Almost all of the insurers we interviewed were reducing brokers' commissions and making adjustments to premiums in response to the PPACA MLR requirements. These insurers said that they have decreased or plan to decrease commissions to brokers in an effort to increase their MLRs. One insurer said they started making reductions to their brokers' commissions in the fourth quarter of 2010 for their individual and small group plans to increase their 2011 PPACA MLRs in these markets and, as a result, premiums were not as high as they otherwise would have been. This insurer said these reductions will take effect gradually because they are only being applied to new sales or when groups renew annually. Another insurer lowered commissions to their brokers in the individual market in the first quarter of 2011, such that premiums were increased less than they otherwise would have been, which they expect to result in an increase in their PPACA MLRs for 2011. In addition, one insurer said they are considering reducing premiums in 2012 partly in response to the PPACA MLR requirements and also in conjunction with a reduction in the number of in-network physicians—the combined strategy would help to lower enrollee premiums and increase their MLRs. A regulator from one state insurance commissioner's office said that some insurers in that state have not applied for premium increases and are making adjustments to lower premiums as a strategy to increase their MLRs, and commented that reducing premiums is the best strategy for insurers to improve value for consumers.

Insurers we interviewed varied on how the PPACA MLR requirements might affect their decisions on activities to improve health care quality. One insurer said that they may reduce their expenses on activities that HHS does not consider quality improvement activities in the PPACA MLR formula, such as retrospective utilization review (a review of a patient's records after the medical treatment has occurred) and increase expenses for activities that qualify, such as prospective utilization review. Another insurer said that they are no longer focusing as much on preauthorization for inpatient admissions because this is not an eligible quality improvement activity in the PPACA MLR formula. This insurer also said the PPACA MLR requirements provide an incentive to spend more money on quality improvement activities, which will affect their decisions on implementing new activities in the future. Conversely, five other insurers told us that the PPACA MLR requirements are not a factor in decisions about their activities to improve health care quality.

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Insurers we interviewed also varied on how the PPACA MLR requirements may affect where they do business. For example, one large insurer that operates in multiple states said that they have exited the individual market in one state where they did not have a large market share, in part, because of the MLR requirements, and they are evaluating whether to exit this market in other states where it might be difficult to meet the PPACA MLR requirements. One for-profit insurer told us that they plan to exit or stop issuing new business in the individual market in multiple states as well as consolidating some of their insurance companies in some states in which they did not think they would meet PPACA MLR requirements. Several other insurers said that the PPACA MLR requirements will not affect decisions on where they do business. For example, one not-for-profit insurer said that serving the communities where they operate is part of their mission and, therefore, they will not be exiting any markets in the states they serve. Another insurer is considering eliminating some of their high and mid-level deductible plans, but not exiting any markets.

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## Agency and Third-Party Comments

We obtained written comments from HHS which are reprinted in appendix I. HHS commented that the PPACA MLR provision will increase transparency in the health insurance marketplace and the value consumers receive for their premium dollar. HHS also provided technical comments, which we incorporated as appropriate.

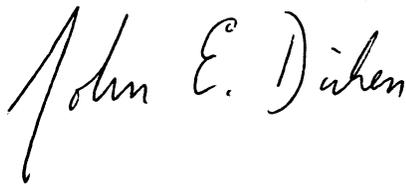
Additionally, we provided a draft of this report to NAIC for comment. NAIC responded that the report was fair, factual, and helpful and provided technical comments, which we incorporated as appropriate.

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As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and appropriate congressional committees. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

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If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at [dickenj@gao.gov](mailto:dickenj@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large initial 'J' and 'D'.

John E. Dicken  
Director, Health Care

# Appendix I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

John Dicken  
Director , Health Care  
U.S. Government Accountability Office  
441 G Street N.W.  
Washington, DC 20548

JUL 15 2011

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "PRIVATE HEALTH INSURANCE: Early Experiences Implementing New Medical Loss Ratio Requirements" (GAO 11-711).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "PRIVATE HEALTH INSURANCE: EARLY EXPERIENCES IMPLEMENTING NEW MEDICAL LOSS RATIO REQUIREMENTS" (GAO-11-711)**

The Department appreciates the opportunity to review and comment on this draft report.

The "Medical Loss Ratio" provision of the Affordable Care Act requires insurers to spend most of consumers' premiums on direct care for patients and efforts to improve care quality. This will make the insurance marketplace more transparent and make it easier for consumers to purchase plans that provide better value for their money. Before the Affordable Care Act was passed, many insurance companies spent a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing. Thanks to the Affordable Care Act, consumers will receive more value for their premium dollar because insurance companies are required to spend a substantial portion of each premium dollar on medical care and health care quality improvement, rather than on administrative costs. If they don't, the insurance companies are required to provide a rebate to their customers starting in 2012. This year, the new rules will protect up to 74.8 million insured Americans and estimates indicate that up to 9 million Americans could be eligible for rebates starting in 2012 worth up to \$1.4 billion. This provision, combined with the many consumer protections in the Affordable Care Act, will help build a consumer-centric health insurance marketplace for the American people.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

John E. Dicken, (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan, Assistant Director; George Bogart; Julianne Flowers; Drew Long; Lisa A. Lusk; Linda McIver; Jessica C. Smith; and Janet L. Sparks made key contributions to this report.

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