

GAO Highlights

Highlights of [GAO-14-580](#), a report to the Chairman, Committee on Commerce, Science, and Transportation, U.S. Senate

Why GAO Did This Study

Private insurers are required to meet minimum PPACA MLR standards—expressed as the percent of premium dollars spent on patient care and related activities—and beginning in 2011 they must pay rebates back to enrollees and policyholders who paid premiums if they do not meet these standards. GAO was asked to review the effects of the PPACA MLR requirements on insurers and enrollees and how rebates would change if agent and broker payments were excluded from the MLR formula. This report examines (1) the extent to which insurers met the PPACA MLR standards, and how much they spent on the MLR components of claims, quality improvement activities, and non-claims costs; (2) the amount of rebates insurers paid and how this amount would have changed with agents' and brokers' commissions and fees excluded from the MLR; and (3) the perspectives of insurers on the effects of the MLR requirements on their business practices.

To do this work, GAO analyzed the MLR data that insurers reported to CMS for 2011 and 2012 (the most recent data available) at the national level for each insurance market—large group, small group, and individual. GAO also interviewed eight insurers, selected based on variation in their size, concentration of business in the individual market, geography, whether they paid rebates, and profit status. In 2012 the number of enrollees covered by these insurers ranged from about 70,000 to 7 million. GAO's finding on insurers' perspectives is limited to those insurers interviewed and is not representative of the perspectives across all insurers reporting MLR data.

View [GAO-14-580](#). For more information, contact John E. Dicken, 202-512-7114, DickenJ@gao.gov.

July 2014

PRIVATE HEALTH INSURANCE

Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees

What GAO Found

The Patient Protection and Affordable Care Act (PPACA) established federal minimum medical loss ratio (MLR) standards for the percentage of premiums private insurers must spend on their enrollees' medical care claims and activities to improve health care quality, as opposed to what they spend on administrative ("non-claims") costs. Insurers report to the Centers for Medicare & Medicaid Services (CMS) annually on their PPACA MLRs. More than three quarters of insurers met or exceeded the standards in 2011 and in 2012, and the median MLRs among all insurers were 88 percent. Insurers' MLRs and their spending on claims and non-claims costs varied across different insurance markets. Specifically, insurers in the large group market had higher median MLRs and spent a higher share of their premiums on enrollees' claims and less on non-claims costs, compared to insurers in the individual and small group markets.

Insurers that did not meet or exceed the PPACA MLR standards in 2011 and 2012 paid rebates in the amounts of \$1.1 billion and \$520 million (respectively) back to enrollees and policyholders who paid premiums in those years. These amounts would have decreased by about 75 percent had the commissions and fees insurers paid to agents and brokers been excluded from the MLRs. Agents and brokers sell insurance products and provide various services to consumers and groups related to their insurance needs and the commissions and fees charged for these services are included in the MLRs. Insurers in the large group market paid the highest rebate amount (\$405 million) across insurance markets in 2011 and insurers in the small group market paid the highest amount (\$207 million) in 2012. Insurers in the individual market were more likely to pay rebates than insurers in the small and large group markets. GAO found that rebates would have fallen from \$1.1 billion to \$272 million in 2011 if the commissions and fees insurers paid to agents and brokers had been excluded from the MLRs, and rebates would have similarly fallen from \$520 million to \$135 million in 2012. GAO's calculations assumed that insurers did not make other changes in their business practices in response to a different method for calculating MLRs.

GAO found that most of the eight insurers it interviewed reported that factors other than the PPACA MLR requirements affected their business practices since 2011. All eight insurers reported that they increased their premium rates since 2011 and that they based these decisions on a variety of factors, such as trends in medical care claims, competition with other insurers, and other requirements. Three of the eight insurers stated that the MLR requirements were one among several factors that influenced their decisions about premium rates. Four of the eight insurers stated they had recently made changes to their payments to agents and brokers, and one reported the MLR requirements were a primary driver behind its business decision. All eight insurers GAO interviewed stated that the MLR requirements did not affect their decisions to stop offering health plans in certain markets and have had no effect or a very limited effect on their spending on quality improvement activities.

GAO provided a draft of this product to the Department of Health and Human Services (HHS) for comment. HHS responded that it had no general or technical comments.