United States Government Accountability Office

Report to the Chairman, Committee on Commerce, Science, and Transportation, U.S. Senate

July 2014

PRIVATE HEALTH INSURANCE

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

GAO-14-580

July 2014

PRIVATE HEALTH INSURANCE

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

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.

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.

Contents

Figures

Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
MLR	medical loss ratio
PPACA	Patient Protection and Affordable Care Act
QI	quality improvement

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

July 10, 2014

The Honorable John D. Rockefeller IV
Chairman
Committee on Commerce, Science, and Transportation
United States Senate

Dear Mr. Chairman:

The Patient Protection and Affordable Care Act (PPACA) established federal minimum medical loss ratio (MLR) standards for private insurers.[1] An MLR serves as a basic financial indicator, expressing the percent of premiums that insurers spend on their enrollees' medical claims and quality initiatives, as opposed to administrative expenses or "non-claims" costs.[2] The greater the share of enrollees' premiums spent on medical claims and quality initiatives, the higher the MLR. These minimum MLR standards are intended to help ensure that individuals covered under private health insurance plans (enrollees) receive adequate value for their premiums and to create incentives for insurers to become more efficient in their operations. If minimum PPACA MLR standards are not met, then insurers are required to pay rebates back to their enrollees. Insurers were required to begin paying rebates under PPACA based on their experience in 2011. In that year, approximately 80 million individuals were enrolled in plans sold by insurers that were subject to these PPACA MLR provisions, according to the Centers for Medicare & Medicaid Services (CMS).[3]

PPACA MLR provisions require insurers to calculate separate MLRs for their expenditure of premiums for each market (large group, small group, and individual) in each state in which they do business, and require higher minimum MLR standards for plans sold in the large group market

[1]Pub. L. No. 111-148, §§ 1001(5), 10101(f), 124 Stat. 119, 130, 136, 885 (2010) (adding § 2718 to the Public Health Service Act) (codified at 42 U.S.C. § 300gg-18).

[2]For purposes of this report, the term "medical claims" is synonymous with the term "clinical services" as used in the law. See 42 U.S.C. § 300gg-18(a)(1); 45 C.F.R. § 158.140 (2013).

[3]CMS, *The 80/20 Rule: How Insurers Spend Your Health Insurance Premiums* (Baltimore, Md.: Feb. 15, 2013).

than for plans sold in the small group and individual markets.[4] CMS oversees the MLR standards and issues regulations to identify insurers' expenses that are to be counted as claims and quality improvement activities, as well as non-claims costs.[5] For example, marketing expenses and spending on agents' and brokers' commissions and fees are counted as non-claims costs.[6]

There has been debate among health insurance industry stakeholders about the effects of the PPACA MLR requirements—including the requirement that insurers count agent and broker compensation as a non-claims cost—on consumers, insurers, and agents and brokers. For example, while insurance industry representatives have expressed concern that the requirements could result in insurers leaving certain markets in some states, causing instability in those markets, consumer advocates and others have asserted that the requirements have resulted in greater transparency for enrollees regarding how insurers are using their premiums. In addition, the agent and broker industry and others have raised concerns that counting agent and broker compensation as a non-claims cost in calculating the MLR could cause insurers to decrease that compensation, which could reduce the availability of agents and brokers to assist consumers in choosing a health plan to meet their needs.[7] Some groups advocating for consumers, however, believe that

[4]In general, insurers in the large group market must meet a minimum MLR of 85 percent, and insurers in the small group and individual markets must meet a minimum MLR of 80 percent. This difference reflects the assumption that administrative expenses per enrollee are typically lower in the large group market.

[5]Insurers may implement quality improvement activities such as wellness assessments and care coordination plans that are designed to increase the likelihood of desired health outcomes for their enrollees.

[6]45 C.F.R. §§ 158.150(c)(11), 158.160(b)(2)(iv) (2013) (relating to marketing expenses and fees and commissions, respectively). Agents and brokers—which are also referred to as "producers" in the insurance industry—assist consumers and employers in choosing and enrolling in health insurance plans. They also provide assistance after enrollment with resolving claims issues and making enrollment changes.

[7]Since PPACA established the MLR requirements several bills have been introduced in the Congress to exclude agent and broker compensation from the calculation of the MLR, thereby providing that such compensation no longer be considered a non-claims cost. This change could decrease the incentive to reduce the use of, or compensation to, agents and brokers. See H.R. 1206, 112th Cong. § 3 (2011); S. 2068, 112th Cong. § 3 (2012); S. 2288, 112th Cong. § 3 (2012); S. 650, 113th Cong. § 3 (2013); and H.R. 2328, 113th Cong. § 3 (2013). As of June 2014, none of these bills had been enacted into law.

counting agent and broker compensation as a non-claims cost provides an appropriate incentive for insurers to reduce such costs while not unduly impacting the ability of agents and brokers to assist consumers.

You asked us to review the effects of the PPACA MLR requirements on enrollees and insurers as well as how excluding agents' and brokers' commissions and fees from the MLR would affect the rebates that insurers pay.[8] In this report, we (1) examine the extent to which insurers met the PPACA MLR standards in 2011 and 2012, and how much they spent on the PPACA MLR components of medical claims, quality improvement activities, and non-claims costs; (2) examine the amount of rebates insurers paid in 2011 and 2012 as a result of the PPACA MLR requirements, and how this amount would have changed with agents' and brokers' commissions and fees excluded from the PPACA MLR and rebate calculations; and (3) describe the perspectives of insurers on the effects of the PPACA MLR requirements on their business practices.

To examine the extent to which insurers met the PPACA MLR standards in 2011 and 2012, and how much they spent on the MLR components of medical claims, quality improvement activities, and non-claims costs, we analyzed the 2011 and 2012 MLR data that insurers reported to CMS.[9] We analyzed the 2011 and 2012 MLR data because the PPACA MLR reporting and rebate requirements began in 2011 and the 2012 data were the most recently available data at the time of our analysis. We also used these data to analyze insurers' median MLRs and the percent of insurers who met or exceeded the minimum MLR standards, by insurance market, year, and state. We analyzed how much insurers spent on the MLR components of medical claims, quality improvement activities, and non-claims costs, by insurance market, year, and state. Within the non-claims costs component of the MLR, we analyzed insurers' spending, including on agents' and brokers' fees and commissions as well as general

[8]Throughout this report, references to "excluding" or "subtracting" agents' and brokers' commissions and fees from the MLR calculation or formula means, more specifically, excluding these expenses from the denominator of the MLR formula. The MLR formula is shown in figure 1 later in this report.

[9]Within CMS, the Center for Consumer Information and Insurance Oversight is responsible for collecting the MLR data from insurers and overseeing the PPACA MLR requirements. Insurers reported their 2011 and 2012 MLR data to CMS by June 2012 and June 2013, respectively. The MLR data are based on the insurers' experience for the prior calendar year.

administrative expenses, such as marketing and staff salaries. We also examined the amount remaining after subtracting from premiums (less taxes and fees) the costs associated with medical claims and quality improvement activities as well as non-claims costs. Throughout this report we refer to this amount as insurers' premium surplus.[10] We reviewed the MLR data for reasonableness and consistency, including screening for outliers. We also reviewed documentation about the MLR data and spoke with CMS officials about steps taken to ensure data reliability. Based on this review, we determined that the data used in this report were sufficiently reliable for our purposes.

To examine the amount of rebates insurers paid based on their experience in 2011 and 2012 as a result of the PPACA MLR requirements, and how this amount would have changed with agents' and brokers' commissions and fees excluded from the MLR and rebate calculations, we similarly analyzed the 2011 and 2012 MLR data that insurers reported to CMS. We used these data to analyze the amount of rebates that insurers paid by insurance market, year, and state. We also used these data to calculate the amount of rebates insurers would have owed if the commissions and fees that insurers paid to agents and brokers were not counted as a non-claims cost in calculating the MLR in each year, assuming no other changes in insurers' business practices in response to this different method of calculating the MLR. To perform this calculation, we subtracted the amount of commissions and fees that insurers paid to agents and brokers who are not employed by insurers from the MLR formula and recalculated the amount of rebates that insurers would have owed as a result.[11] We conducted all of these analyses by insurance market, year, and state.

To describe the perspectives of insurers on the effects of the PPACA MLR requirements on their business practices, we interviewed eight

[10]Premium surplus includes profit and other reserved capital.

[11]Because some insurers have employees who sell their plans, we conducted a separate calculation of rebates taking into account this type of compensation. We used the MLR data to subtract from the MLR formula the amount of salaries and benefits that insurers paid to such employees, as well as the commissions and fees that insurers paid to agents and brokers that they do not employ.

insurers.[12] We selected insurers to achieve variation in size, as determined by the number of their enrollees; the concentration of their health insurance business within the individual market; whether they paid rebates based on their experience in 2011 or 2012; the number of states in which they operated; and their not-for-profit status.[13] In 2012, one of the eight insurers we interviewed operated in all 50 states and had about 2 million enrollees, three each operated in between 4 and 13 states and had between approximately 1 and 7 million enrollees, and the remaining four operated in either 1 or 2 states and each had between approximately 70,000 and 675,000 enrollees. We used a structured interview protocol to gather consistent information from insurers about their perspectives on the effects of the PPACA MLR requirements on their business practices, including the payment of agents and brokers, premium rates, quality improvement activities, and decisions to leave any insurance markets.[14] Our findings are limited to those insurers we spoke with and are not representative of the perspectives across all of the insurers reporting MLR data to CMS.

We conducted this performance audit from October 2013 to July 2014 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 based on our audit objectives.

[12]The eight insurers we interviewed included seven insurance groups that each operated two or more insurance companies and one insurance company that was not part of a larger insurance group. Many, but not all, insurance companies are part of a larger insurance group.

[13]While not-for-profit insurers may make profits to help them stay in business, the profits must go back into the organization.

[14]We asked insurers about the effects of the PPACA MLR requirements on their business practices from 2011, the first year they were subject to the PPACA MLR requirements, through 2014.

To obtain further background information on the PPACA MLR requirements, we also interviewed officials from two consumer groups, a trade association representing the health insurance industry, and three trade associations representing the agent and broker industry.

Background

Under the PPACA MLR requirements, private insurers must report annually to CMS their MLRs by each state and insurance market in which they operate, as well as the dollar amounts for the components that make up their MLRs, such as premiums. Insurers must pay rebates when their MLRs do not meet or exceed the minimum applicable PPACA MLR standards. Agents and brokers sell insurers' plans to individuals and employers and assist individuals and employers in various ways.

PPACA MLR Reporting Requirements

PPACA requires that private insurers offering group or individual health insurance coverage report annually on the various components that are used to calculate their PPACA MLRs, and each of these components must be reported by state and by market.[15] Private insurers first reported this information in 2012, based on their 2011 experience. The markets include large group, small group, and individual. Large and small group employers are defined by the number of their employees. Prior to PPACA, a small employer was defined in federal law as having a maximum of 50 employees. From the time PPACA was passed in 2010 until 2016, PPACA gives states the option of continuing to define a small group employer as having 50 or fewer employees, but starting in 2016, they must define small employers as having from 1 to 100 employees.[16] The individual market includes policies sold by insurers directly to individuals. Insurers report their MLR data to CMS by entering information on a standardized form that includes multiple data fields that make up the MLR and rebate formulas.

The MLR data that insurers report to CMS include the following components, as required by law.

[15]The PPACA MLR requirements do not apply to certain plans such as self-funded plans, in which employers assume the risk for paying for medical claims. Medicare Advantage Plans and Medicare Part D prescription drug plans are subject to separate PPACA MLR requirements, beginning in 2014. See Pub. L. No. 111-152, § 1103, 124 Stat. 1029, 1047 (2010) (codified at 42 U.S.C. § 1395w-27(e))(pertaining to MA plans and, by reference through 42 U.S.C. § 1395w-112(b)(3), to Medicare Part D plans).

[16]See Pub. L. No. 111-148, § 1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013).

- **Medical claims**. These include claims paid and incurred for clinical services and supplies provided to enrollees by physicians and other clinical providers.[17]
- **Expenses for quality improvement (QI) activities**. These include expenses for activities that are 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, reduce medical errors, and lower infection and mortality rates; or (4) implement, promote and increase wellness and health activities. Insurers are also allowed to include expenses for health information technology required to accomplish these activities as well as a percentage of their expenses for converting disease classification codes.[18]
- **Premiums**. These include the sum of all funds paid by an enrollee and employer, if applicable, as a condition of receiving coverage from the insurer. These also include any fees or other contributions associated with the health plan.
- **Federal and state taxes and licensing or regulatory fees**. These include federal income taxes, assessments, state insurance, premium and other taxes, and regulatory authority licenses and fees. Federal income taxes on investment income and capital gains are excluded.
- **Non-claims costs**. These include all other insurer expenses—those beyond medical claims, expenses for QI activities, and federal and state taxes and licensing or regulatory fees. CMS defines non-claims costs for the following categories: (1) agents' and brokers' fees and commissions; (2) cost containment expenses, which reduce the number of health services provided or the costs of such services, but are not related to an activity to improve health care quality; (3) claims adjustment expenses, such as office maintenance and supplies costs, not classified as cost containment expenses; (4) salaries and benefits

[17]Insurers include medical claims incurred during the applicable calendar year and paid through March 31 of the following year. Insurers also include unpaid claim reserves for claims incurred during the applicable calendar year.

[18]See 45 C.F.R. §§ 158.150(b), 158.151 (2013). CMS included as QI a portion of those expenses for converting disease classification codes (i.e., ICD-10), starting in 2012.

that insurers pay to their employees who sell their plans;[19] (5) other taxes that may not be excluded from premium revenue; (6) other general and administrative expenses, such as salaries and advertising; and (7) community benefit expenditures, which include expenses for activities such as health educational campaigns that are available broadly to the public.[20]

The remaining amount of premiums that an insurer does not spend on the components of medical claims, QI activities, taxes and fees, and non-claims costs, will be referred to as the insurer's "premium surplus" in this report. Premium surplus includes profit and other reserved capital.

PPACA MLR and Rebate Formulas

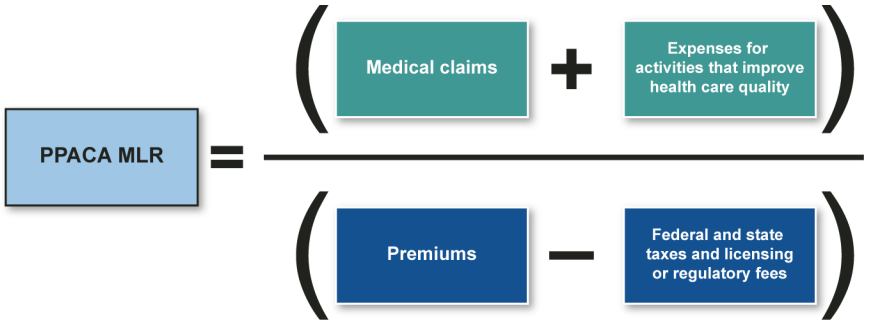
The PPACA MLR is generally calculated by dividing (a) the sum of an insurer's medical claims and expenses for QI activities (the formula numerator) by (b) the insurer's premiums, after excluding from them the amount of insurer's federal and state taxes and licensing or regulatory fees (the formula denominator).[21] (See fig. 1.)

[19]An employee of an insurer who sells health plans would typically only sell those plans the employer offers, while agents and brokers who are not employed by an insurer would generally sell the health plans of various insurers.

[20]See 45 C.F.R. § 158.160(b)(2) (2013). Insurers can exclude from their MLRs certain community benefit expenditures for the objectives of improving access to health services, enhancing public health and relief of government burden, limited to specified amounts. 45 C.F.R. § 158.162(b)(1)(vii), (viii) and (c) (2013). Insurers would include any additional community benefit expenditures as part of the non-claims cost category of other general and administrative expenses.

[21]Premiums in the denominator also include any subsidies the insurer has received as part of federal or state high-risk pools, such as federal funds provided to insurers who participated in PPACA's Pre-Existing Condition Insurance Plan program. This program was designed to extend health insurance to high-risk individuals with pre-existing medical conditions and ended in 2014. Medical claims for high-risk pools are also included in insurers' MLR numerator.

Figure 1: PPACA Medical Loss Ratio (MLR) Formula



Source: GAO. | GAO-14-580

Some insurers, such as those with a small number of enrollees, are permitted certain adjustments to their MLRs. These adjustments are referred to as credibility adjustments, and they are added to, and thus increase, the insurer's MLR.[22] Credibility adjustments are provided to address the unreliability associated with calculating an MLR based on a small number of enrollees.

Insurers with a small number of enrollees calculated their MLRs for 2012 based on their 2011 and 2012 experience combined.[23] All insurers will calculate their MLRs for their experience in 2013 and subsequent years based on data from a 3-year period. That is, insurers will add their data for the year for which the MLR is being calculated to their MLR data for the 2 prior years.

For each insurer, separate MLRs are calculated for each state and market combination in which it does business and each MLR is used to determine whether an insurer must pay rebates. Insurers must meet a minimum PPACA MLR standard, generally 80 percent for the individual and small group markets and 85 percent for the large group market, with

[22]For more information about credibility adjustments, see GAO, *Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements*, GAO-11-711 (Washington, D.C.: July 29, 2011).

[23]Insurers with 1,000 to less than 75,000 enrollees in 2011 and 2012 combined received a credibility adjustment. If these insurers owed rebates in 2011 the rebates were added to their claims in 2012.

some exceptions. Specifically, the applicable PPACA minimum MLR standard is based on one of the following:

- 85 percent in the large group market, 80 percent in the small group market, and 80 percent in the individual market;
- a higher MLR standard if specified by law in the state in which the insurer operates; or
- a Department of Health and Human Services (HHS)-approved, adjusted MLR standard for a particular state's individual market.[24]

When an insurer's PPACA MLR is lower than the applicable PPACA MLR standard, the insurer must pay a rebate. The rebate amount is based on the PPACA MLR rebate formula, as shown in figure 2. The difference between the applicable PPACA MLR standard and the insurer's MLR is calculated and this difference is multiplied by the insurer's premiums, after federal and state taxes and licensing or regulatory fees are removed.

Figure 2: PPACA Medical Loss Ratio (MLR) Rebate Formula

Source: GAO. | GAO-14-580

There are different ways in which rebates can be paid out by insurers that depend, in part, on whether rebates are associated with individual or group market plans. In general, insurers can choose to provide rebates in the form of a lump-sum payment or as a premium credit for the following MLR year. Insurers in the individual market must provide rebates to their enrollees while insurers in the small and large group markets may meet this obligation by providing rebates to group policyholders, for example,

[24]PPACA provides HHS with authority to adjust the 80 percent MLR standard for the individual market if the Secretary of HHS determines that the standard could destabilize the individual market in a given state. Pub. L. No. 111-148, §§ 10001(5). 10101(f), 124 Stat. 136, 885 (codified at 42 U.S.C. § 300gg-18(b)(1)(A)(ii)). To date, seven states have been granted such adjustments: Georgia, Iowa, Kentucky, Maine, Nevada, New Hampshire, and North Carolina. Each state's adjustment allows for a lower MLR standard and is temporary.

employers. In turn, group policyholders are responsible for allocating the amount of rebate that is proportionate to the total amount of premium paid by enrollees and may retain part of the rebate based on the amount of premium that they contributed.

The Role of, and Insurer Payments to, Agents and Brokers

Agents and brokers sell plans for insurers and perform a variety of functions on behalf of individuals and employers. According to the Bureau of Labor Statistics, in 2012 there were approximately 337,000 jobs held by insurance sales agents, which include agents and brokers working independently as well as those who are employed by an insurer.[25] Agents and brokers provide assistance to individuals and employers in choosing and enrolling in plans. For example, they may assess an individual's insurance needs and describe the characteristics of different plans that best meet those needs. Agents and brokers may also provide assistance after an individual or employee has enrolled in a plan, for example, by helping enrollees communicate with health plans in trying to resolve disputed medical claims or adding a new family member to a current plan. Insurers who use agents and brokers to sell their plans typically pay them based on a percentage of the plan's premium or as a flat fee, for example, determined by the number of enrollees in the plan.[26]

[25]This figure also includes sales agents in types of insurance other than health, such as life and property. Agents may have licensure in more than one type of insurance.

[26]In 2014, agents and brokers who completed applicable training may provide assistance to consumers with the PPACA-mandated state-based and federally facilitated health care exchanges, for example, by helping consumers enroll in a qualified health plan. The exchanges are marketplaces where individuals can compare and select among qualified health plans offered by participating private issuers of health coverage.

Most Insurers Met or Exceeded the PPACA MLR Standards in 2011 and in 2012, and Insurers' Spending on the MLR Components Varied by Market

More than three quarters of insurers met or exceeded the minimum PPACA MLR standards in 2011 and in 2012, the median PPACA MLRs for all insurers were about 88 percent in each year, and there was variation across insurance markets. Insurers' spending on enrollees' medical claims and non-claims costs as a percentage of premiums varied across insurance markets in 2011 and 2012.

Most Insurers Met or Exceeded the PPACA MLR Standards in 2011 and in 2012 and Median PPACA MLRs among All Insurers Were 88 Percent

Most insurers met or exceeded the PPACA MLR standards established for the markets and state in which they operated, but group market insurers were more likely to meet or exceed the standards than individual market insurers.[27] In 2011, about 76 percent of insurers met or exceeded the minimum PPACA MLR standards and, in 2012, 79 percent of insurers met or exceeded the standards. As an example of variation across the markets, in 2012 about 86 percent of insurers in the large group market and 81 percent of insurers in the small group market met or exceeded the MLR standards, compared to 70 percent of individual market insurers.

The median PPACA MLRs in 2011 and in 2012 among all insurers were about 88 percent, and the median for the large group market was higher than that of the small group and individual markets. For example, in 2012 the median PPACA MLR for insurers in the large group market was about 91 percent compared to 86 percent in the individual market and 85 percent in the small group market. (See table 1.) We observed that insurers' median PPACA MLRs slightly increased from 2011 to 2012 and the percent of all insurers meeting or exceeding the standards increased by about 3 percentage points. However, these 2 years of data may not reflect future patterns in MLRs. (See app. I for a listing of the PPACA MLRs in each state for 2011 and 2012.)

[27]Because our analyses are based on separate MLRs that each insurer reports for each market (i.e., individual, small group, or large group) and state combination, "insurers" refer to these different MLR reporting combinations.

Table 1: The Percent of Insurers that Met or Exceeded the PPACA Medical Loss Ratio (MLR) Standards and Insurers' Median PPACA MLRs in 2011 and in 2012, by Insurance Market

	2011		2012	
	Percent of insurers that met or exceeded the MLR standard	Median MLR (%)	Percent of insurers that met or exceeded the MLR standard	Median MLR (%)
Individual market	65.1	84.0	69.7	85.8
Small group market	79.7	84.5	81.2	85.1
Large group market	83.7	90.3	86.2	90.7
All markets	**76.4**	**87.5**	**79.1**	**88.0**

Source: GAO analysis of CMS data. | GAO-14-580

Notes: Some insurers operate in multiple markets and multiple states. A separate MLR is reported for each insurer, market, and state combination.

The Percentage of Premiums Insurers Spent on Medical Claims and Non-Claims Costs in 2011 and 2012 Varied by Market

In 2011 and 2012, the percentage of net premiums that insurers spent on their enrollees' medical claims varied across insurance markets.[28] Specifically, insurers in the large group market spent a higher percent of their net premiums on medical claims in both years compared to insurers in the small group and individual markets. For example, in 2012 insurers in the large group market spent about 89 percent of their net premiums on medical claims compared to the 85 percent that individual market insurers spent and the 84 percent that small group market insurers spent.

Our analysis of the data showed that for the other components of the MLR formula—non-claims costs, premium surplus and QI expenses—there was more of a mix in variation across markets. We found that insurers' spending on non-claims costs as a percent of their net premiums varied by insurance market, with insurers in the individual and small group markets spending more than insurers in the large group market on non-claims costs in 2011 and in 2012. For example, in 2012 insurers in the individual market spent about 16 percent of their net premiums on non-claims costs compared to the 7 percent that large group insurers spent. With regard to premium surplus, our analysis showed that there

[28]Net premiums is the amount of insurers' premiums after subtracting the insurer's federal and state taxes and licensing or regulatory fees. Net premiums is the denominator in the PPACA MLR formula.

was also variation across the insurance markets in 2011 and in 2012, with insurers in the individual market having less premium surplus than insurers in both the small and large group markets.[29] An insurer's premium surplus includes profit and other reserved capital but does not account for any PPACA MLR rebates the insurer may have to pay to enrollees.[30] Insurers' spending on QI expenses did not vary across markets as insurers in each market spent about 1 percent of net premiums on QI expenses in 2011 and in 2012. (See table 2.) While our analysis showed that from 2011 to 2012 there were some shifts in the percentage of spending on these different components among the different markets and among all insurers, these two years of data may not reflect future patterns in spending. (See app. II for a listing of insurers' spending on the MLR components by state for 2011 and 2012.)

[29]Premium surplus is the amount remaining after subtracting from net premiums the costs associated with medical claims, quality improvement activities, as well as non-claims costs.

[30]Because state regulators require insurers to maintain specific levels of capital to conduct business, insurers may maintain some of their profits for this purpose. Insurers that operate in more than one market within a state may have had profits in some markets within a state and not others.

Table 2: Insurers' Spending as a Percent of Net Premiums[a] in 2011 and 2012, by Insurance Market

	Medical claims (%)	Non-claims costs (%)	Premium surplus[b] (%)	Quality improvement expenses (%)	Total (%)
2011					
Individual	82.5	16.1	0.7	0.8	**100**
Small group	82.8	12.4	3.9	0.8	**100**
Large group	88.8	7.6	2.9	0.7	**100**
All markets	**86.7**	**9.6**	**3.0**	**0.7**	**100**
2012					
Individual	84.7	15.5	-1.1	0.9	**100**
Small group	83.5	11.9	3.7	0.9	**100**
Large group	89.1	7.4	2.7	0.8	**100**
All markets	**87.3**	**9.3**	**2.6**	**0.8**	**100**

Source: GAO analysis of CMS data. | GAO-14-580

Note: For each market, we calculated sums for insurers' spending on medical claims, non-claims costs, premium surplus, as well as quality improvement expenses. We then divided each by the sum of insurers' net premiums in each market. Rows may not sum to 100 due to rounding.

[a]Net premiums is the amount of insurers' earned premiums after subtracting the insurer's federal and state taxes and licensing or regulatory fees. Net premiums is the denominator in the PPACA medical loss ratio formula.

[b]The insurer's premium surplus is the amount remaining after subtracting from net premiums the costs associated with medical claims and quality improvement activities as well as non-claims costs.

Three of the six non-claims cost categories generally comprised the largest share of insurers' spending, and there was some variation across the markets in spending on each of these three categories.[31] The three categories that made up the largest share of insurers' spending on non-claims costs were agents' and brokers' fees and commissions, other general expenses, and other claims adjustment expenses. We found that insurers' spending on these three categories of non-claims costs varied by market. Insurers in the small group market spent a higher share on agents' and brokers' fees and commissions than insurers in the individual and large group markets. For example, in 2012 small group insurers

[31]We did not analyze community expenditures as a separate category of non-claims costs. Insurers may have excluded a certain amount of such expenses from the denominator of their MLRs, and any additional amounts would be included in the non-claims cost category of other general and administrative expenses.

spent about 42 percent of their total non-claims costs on agents' and brokers' fees and commissions compared to the 23 percent that large group insurers spent. In comparison, insurers in the individual and large group markets spent a higher share of non-claims costs than insurers in the small market on other general expenses, such as salaries, rent, and travel; and on other claims adjustment expenses including office and computer maintenance. (See table 3.)

Table 3: Insurers' Spending on Agents' and Brokers' Fees and Commissions and Other Categories of Non-Claims Costs as a Percent of Total Non-Claims Costs in 2011 and 2012, by Insurance Market

	Agents' and brokers' fees and commissions[a] (%)	Other general expenses[b] (%)	Other claims adjustment expenses[c] (%)	Cost containment expenses[d] (%)	Direct sales' salaries and benefits[e] (%)	Other Taxes[f] (%)	Total (%)
2011							
Individual	29.8	43.2	14.0	6.8	6.1	0.1	**100**
Small group	40.9	34.2	12.1	6.6	6.0	0.2	**100**
Large group	23.0	43.9	17.3	8.4	6.9	0.5	**100**
All markets	**29.8**	**40.7**	**15.1**	**7.6**	**6.5**	**0.3**	**100**
2012							
Individual	28.1	45.1	13.8	7.2	5.7	0.1	**100**
Small group	42.2	31.8	11.8	7.2	6.5	0.4	**100**
Large group	23.1	42.9	16.6	9.5	7.2	0.8	**100**
All markets	**29.9**	**39.8**	**14.6**	**8.4**	**6.8**	**0.5**	**100**

Source: GAO analysis of CMS data. | GAO-14-580

[a]Agents' and brokers' fees and commissions include all expenses paid to agents and brokers, who are not employees of the insurer, for the sale and solicitation of the insurer's policies.

[b]Insurers' other general and administrative expenses include salaries, accreditation and certification fees, rent, legal fees and expenses, travel, advertising and utilities.

[c]Insurers' other claims adjustment expenses include costs such as office maintenance, computer maintenance, maintenance of records, and general clerical and secretarial costs.

[d]Cost containment expenses includes expenses that reduce the number of health services provided or the cost of such services.

[e]Direct sales' salaries and benefits include compensation to employees of insurers who sell their plans.

[f]Other taxes include state sales taxes and any other taxes that have not been removed from the medical loss ratio denominator.

Insurers Paid $1.1 Billion in Rebates in 2011 and $520 Million in 2012, and Would Have Paid About 75 Percent Less with Agents' and Brokers' Fees and Commissions Excluded, Absent Other Changes in Business Practices

Insurers paid about $1.1 billion in total rebates to enrollees and policyholders who paid premiums in 2011, the first year that insurers were subject to the PPACA MLR requirements, and about $520 million in rebates in 2012. These amounts would each have decreased by about 75 percent had agents' and brokers' fees and commissions been excluded from the MLR and rebate calculations, assuming insurers made no other changes that could affect their MLRs. Of the $1.1 billion in total rebates that insurers paid in 2011, insurers in the large group market paid 37 percent of this total, or $405 million in rebates, the largest amount across the three insurance markets.[32] Of the $520 million in total rebates that insurers paid in 2012, insurers in the small group market paid the largest amount in rebates (about $207 million). (See app. III for a listing of the rebate amounts that insurers paid in each state for 2011 and 2012.)

We found that the average rebate amounts insurers paid per enrollee and the likelihood that insurers paid rebates varied by insurance market.[33] Insurers across the three markets paid an average rebate of $83.60 per enrollee in 2011 and $58.50 per enrollee in 2012. Rebate amounts varied by insurance market each year, and individual and small group insurers paid higher per-enrollee rebates compared to insurers in the large group market. To illustrate, individual market insurers paid an average rebate of $68.30 per enrollee in 2012 compared to the average rebate of $39.20 that insurers in the large group market paid. In both 2011 and 2012, insurers in the individual market were more likely to pay rebates than insurers in the small and large group markets. For example, in 2012 about 30 percent of individual market insurers paid rebates and about 14 percent of large group insurers did so. The total and average rebate amounts that insurers paid decreased from 2011 to 2012 overall and within each market, with the greatest decrease occurring in the large

[32]The total rebate amounts for 2011 and 2012 are somewhat higher than those CMS reported. According to CMS officials, the rebate amounts CMS reported for 2011 and 2012 did not include the rebates that insurers paid for plans that had annual coverage limits of $250,000 or less. See CMS, *2012 MLR Rebates by State,* accessed April 23, 2014, http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2012-mlr-rebates-by-state-08-01-2013.pdf, and CMS, *The 80/20 Rule: How Insurers Spend Your Health Insurance Premiums*, accessed April 23, 2014, http://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr-report-02-15-2013.pdf.

[33]We calculated the average rebate amount by dividing the total amount of rebates insurers paid by the total number of individuals (including dependents) enrolled in their plans.

group market. (See table 4.) However, these two years of data may not reflect future rebate patterns.[34]

Table 4: Amount of PPACA Medical Loss Ratio (MLR) Rebates Insurers Paid to Enrollees and Policyholders and Percent of Insurers That Paid Rebates in 2011 and 2012, by Insurance Market

	Total amount of rebates (dollars in millions)	Average rebate amount per enrollee[a] (in dollars)	Percent of insurers who paid rebates
2011			
Individual	**400.8**	95.3	34.9
Small group	**296.1**	90.6	20.3
Large group	**405.0**	71.0	16.3
Total	**1,101.9**	**83.6**	**23.6**
2012			
Individual	**201.1**	68.3	30.1
Small group	**206.9**	67.0	18.6
Large group	**112.1**	39.2	13.7
Total	**520.1**	**58.5**	**20.8**

Source: GAO analysis of CMS data. | GAO-14-580

Note: Some insurers operate in multiple markets and states. A separate MLR and rebate amount, if applicable, is reported for each insurer, market, and state combination.

[a]The average rebate amount is the total amount of rebates insurers paid divided by the total number of individuals (including dependents) enrolled in their plans.

Our analysis of the data showed that rebates would have been reduced by about 75 percent if agents' and brokers' fees and commissions were excluded from the MLR and rebate calculations.[35] Specifically, we found that the rebates paid by insurers to enrollees and policyholders who paid premiums in 2011 would have fallen from $1.1 billion to about

[34]Insurers will calculate their MLRs based on data from a 3-year period, beginning in 2013. This may affect the amount of rebates that insurers must pay.

[35]To perform our calculations, we subtracted from the MLR denominator agents' and brokers' fees and commissions for each year and recalculated the MLR with the new denominator. We determined whether the insurer would have met or exceeded the applicable PPACA MLR standard, based on the recalculated MLR, and if an insurer would not have met or exceeded the standard, we calculated a rebate amount. To determine the rebate amount, we multiplied the difference between the recalculated MLR and the applicable standard by the amount of premium, after subtracting taxes and agents' and brokers' fees and commissions.

$272 million, and in 2012 would have fallen from $520 million to about $135 million.[36] There was variation in the impact of the recalculated MLRs across the three markets. For example, in both years, the differences between the actual and recalculated rebate amounts were greater, on a percentage basis, in the small group market compared to the individual market. (See table 5.) These rebate calculations are based on the assumption that insurers did not make other changes during this time that would have affected their MLRs. However, if the formula had been different, insurers might have made different business decisions in those years.[37] (See app. IV for a listing of the rebate amounts that insurers would have paid with agents' and brokers' commissions and fees excluded from the MLRs in each state for 2011 and 2012.)

[36]We also performed a calculation that excluded the salaries and benefits that insurers pay their employees who sell their plans, in addition to the fees and commissions that insurers pay agents and brokers whom they do not employ, and found further reductions in the recalculated rebate amounts. Total rebate amounts would have been further reduced to about $213 million in 2011 and about $115 million in 2012.

[37]For example, if insurers had increased the fees and commissions that they pay agents and brokers because the fees and commissions were excluded from the MLR formula (without increasing their premiums by the same amount), then rebates would have decreased more than our estimates. This is because insurers' MLRs would have increased more than the increases we calculated.

Table 5: Amount of Rebates Insurers Would Have Paid to Enrollees and Policyholders with Agents' and Brokers' Commissions and Fees Excluded from PPACA Medical Loss Ratio and Rebate Calculations in 2011 and 2012

	Total amount of rebates (dollars in millions)	Amount of rebates with agent and broker compensation excluded (dollars in millions)	Difference (percent change)
2011			
Individual	**400.8**	119.1	-70.3
Small group	**296.1**	26.6	-91.0
Large group	**405.0**	126.0	-68.9
Total	**1,101.9**	**271.7**	**-75.3**
2012			
Individual	**201.1**	64.2	-68.1
Small group	**206.9**	45.0	-78.3
Large group	**112.1**	26.1	-76.7
Total	**520.1**	**135.3**	**-74.0**

Source: GAO analysis of CMS data. | GAO-14-580

Most Insurers We Interviewed Reported Factors Other than PPACA MLR Requirements as Affecting their Business Practices

All eight insurers that we interviewed reported that they increased their premium rates since 2011 due to a variety of factors, and most (five of the eight) reported that the factors were largely unrelated to PPACA MLR requirements. Key factors cited for making premium changes included: trends in medical claims, competition with other insurers, the PPACA requirements that insurers offer their plans on a guaranteed-issue basis as well as provide essential health benefits in their plans,[38] and the per-capita fees associated with PPACA's reinsurance program.[39] For example, one insurer that has increased premiums in the individual market since 2011 stated that its increased premiums were due in part to the increased costs that the insurer told us was associated with it

[38]See Pub. L. No. 111-148, §§ 1201, 1563(c), 10103, 10107, 124 Stat. 154, 264, 892, 911 (codified at 42 §§ 300gg-1 et seq.).

[39]The purpose of this reinsurance program is to stabilize premiums by partially offsetting claims for high-risk individuals in the individual market. All insurers must make contributions, beginning in January 2014, and those in the individual markets are eligible for payments. This program is temporary and will operate from 2014 to 2016. See Pub. L. No. 111-148, §§ 1341, 10104(r), 124 Stat. 208, 906 (codified at 42 U.S.C. § 18061).

providing coverage on a guaranteed-issue basis, as mandated under PPACA.[40] Three of the eight insurers reported that the PPACA MLR requirements were one factor among a variety of factors that influenced their decisions regarding premium rates, and two of these insurers told us that the MLR requirements have generally moderated their premium increases. For example, one insurer that has increased its premium rates in the individual market since 2011 stated that without the PPACA MLR requirements in place the insurer would have likely increased rates further. Another insurer explained that if it does not meet the PPACA MLR standards in its planning, it will adjust its premium rate increases to avoid the associated expense and administrative work required to issue rebates to enrollees.

Four of the eight insurers we interviewed reported they did not make any recent changes to their agents' and brokers' fees and commissions, and of the four that did make changes, one reported that the MLR requirements were a primary driver behind that decision. All four of the insurers who did make changes told us that they have reduced fees and commissions in certain markets since 2011 either by changing their payment method from a percent of premiums to a flat fee, or by reducing the set percentage of premiums that they pay to agents and brokers.[41] According to one insurer, paying agents and brokers on a flat fee basis will help the insurer reduce the fees and commissions it pays over time because otherwise the insurer would increase such payments every time it increases its premium rates. While one of the four insurers stated that the PPACA MLR requirements were the primary driver of its decision to reduce agent and broker compensation, the other three insurers that also reduced their agent and broker compensation cited other influencing factors. For example, insurers told us that they reduced such compensation since 2011 because of the general trend preceding enactment of PPACA to pay agents and brokers a flat fee rather than a percentage of premiums. According to insurers, this reduction in compensation allows them to operate more efficiently by lowering their

[40]PPACA requires that certain health plans be offered on a guaranteed-issue basis, that is, that an insurer accept every applicant and meet coverage requirements such as providing women's preventative services (e.g., well-women visits), without cost sharing for the enrollee.

[41]We asked insurers about their business practices from 2011, when the PPACA MLR requirements took effect, to the present. This time period is broader than the period for which we analyzed MLR data.

non-claims costs as well as offer more competitive premium rates for their plans.

All eight insurers we interviewed told us that the PPACA MLR requirements have not affected where they do business and have had no effect, or a very limited effect, on their spending on QI activities since 2011. Two of the eight insurers we interviewed stated that they exited certain insurance markets since the PPACA MLR requirements began, but they did not attribute those decisions to the MLR requirements. For example, one insurer who operated in all 50 states told us that it left the individual market in three states in 2014, in part because of its concerns in each market over maintaining a sufficient network of providers and being able to provide affordable coverage. The insurer further explained that a low number of enrollees in each market contributed to its decisions to no longer operate in the three states. None of the insurers we interviewed reported that the PPACA MLR requirements have generally influenced their spending on QI activities since 2011, and all eight insurers reported other influencing factors, such as customer and employer demand for QI programs, competition among insurers, and the goal of improving enrollees' health outcomes, which in turn could lower the use and costs of health care services.

Five of the eight insurers we interviewed also commented that the 2013 PPACA MLR calculation, which is based on a 3-year period including 2013 and the prior 2 years, will likely reduce some of the effects in the MLR formula of year-to-year variability in enrollees' medical claims. Variability in medical claims occurs when actual and expected medical claims differ, and one source of such variability is the effect of large claims. One insurer, who paid rebates in 2011, noted that it would not have owed rebates had the MLR formula been based on 3 years of insurers' experience. In comparison, another insurer told us that it will likely owe rebates for 2013 because the MLR data it reported in 2011 and 2012 will be averaged into 2013. The insurer added that over time, however, it believes the 3-year MLR formula should be beneficial for the insurer by reducing the likelihood of owing rebates.

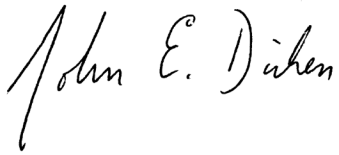
Agency Comments

We provided a draft of this product to HHS for comment. HHS responded that it had no general or technical comments.

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or 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 V.

Sincerely yours,



John E. Dicken
Director, Health Care

Appendix I: PPACA Medical Loss Ratios by State in 2011 and 2012

This appendix presents information on insurers' median PPACA medical loss ratios by state and insurance market for 2011 (see table 6) and for 2012 (see table7).

Table 6: Insurers' Median PPACA Medical Loss Ratios (MLRs) in 2011, by State and Insurance Market

	Median MLR (%)			
State	Individual market[a]	Small group market[b]	Large group market[c]	All Markets
Alabama	76.9	87.2	101.8	**92.2**
Alaska	83.9	88.4	93.1	**91.6**
Arizona	83.9	80.3	91.2	**84.0**
Arkansas	81.2	84.4	88.6	**85.9**
California	81.6	84.2	90.5	**87.6**
Colorado	90.1	83.5	88.1	**87.0**
Connecticut	80.7	84.5	87.6	**86.6**
Delaware	80.6	85.3	90.0	**88.6**
District of Columbia	102.5	78.1	82.7	**82.4**
Florida	80.4	85.1	88.1	**85.6**
Georgia	84.2	83.6	91.1	**85.1**
Hawaii	94.2	87.5	90.5	**89.9**
Idaho	89.9	85.5	93.1	**90.4**
Illinois	82.3	84.1	88.9	**86.9**
Indiana	83.2	85.6	95.2	**87.6**
Iowa	84.6	83.8	93.3	**87.3**
Kansas	79.1	83.5	90.6	**87.0**
Kentucky	81.5	89.1	91.0	**88.1**
Louisiana	81.1	82.0	89.9	**84.1**
Maine	90.3	89.2	88.1	**89.0**
Maryland	81.8	81.5	85.8	**83.9**
Massachusetts	90.8	89.1	88.5	**89.1**
Michigan	82.1	83.6	92.1	**86.1**
Minnesota	92.0	87.2	92.7	**91.3**
Mississippi	84.2	87.4	91.2	**87.6**
Missouri	79.6	82.0	90.1	**86.1**
Montana	79.0	78.1	94.5	**82.0**
Nebraska	82.4	81.7	91.9	**87.5**
Nevada	80.9	81.7	91.1	**83.9**

State	Median MLR (%)			All Markets
	Individual market[a]	Small group market[b]	Large group market[c]	
New Hampshire	83.5	89.8	91.0	**90.6**
New Jersey	95.3	85.6	87.0	**86.7**
New Mexico	87.8	88.3	93.8	**92.5**
New York	99.2	94.3	87.8	**91.0**
North Carolina	79.4	82.6	89.5	**83.8**
North Dakota	85.4	84.5	89.8	**87.6**
Ohio	95.2	87.7	92.8	**90.8**
Oklahoma	77.8	81.3	88.4	**85.4**
Oregon	85.7	85.9	91.9	**88.4**
Pennsylvania	87.6	86.1	88.4	**87.8**
Rhode Island	87.0	86.9	92.9	**88.0**
South Carolina	79.9	78.6	88.7	**86.0**
South Dakota	86.6	89.5	95.0	**89.5**
Tennessee	79.7	82.1	89.9	**85.5**
Texas	84.1	83.4	90.6	**88.1**
Utah	79.5	84.4	92.3	**85.6**
Vermont	105.0	89.4	92.8	**92.6**
Virginia	79.6	81.2	90.7	**83.5**
Washington	87.4	87.4	90.4	**88.0**
West Virginia	75.0	83.7	97.5	**86.8**
Wisconsin	93.8	94.6	94.7	**94.6**
Wyoming	83.2	87.4	94.8	**89.4**

Source: GAO analysis of CMS data. | GAO-14-580

Notes: The PPACA MLR is calculated by dividing (a) the sum of an insurer's medical claims and expenses for quality improvement (QI) activities by (b) the insurer's premiums, after excluding from them the amount of insurer's federal and state taxes and licensing or regulatory fees. PPACA MLRs over 100 percent indicate that the insurer's claims and QI expenses for a particular market were greater than the premiums it collected for that year after excluding the applicable taxes and fees. Insurers operating in the insular areas of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and United States Virgin Islands were also subject to the PPACA MLR requirements. In 2011 HHS granted seven states temporary adjustments to the 80 percent MLR standard for the individual market, and each state's adjustment allowed for a lower MLR standard. The states were Georgia, Iowa, Kentucky, Maine, Nevada, New Hampshire, and North Carolina.

[a]The individual market includes plans sold by insurers directly to individuals.

[b]The small group market includes plans sold by insurers to small employers. Prior to PPACA, a small employer was defined in federal law as having a maximum of 50 employees. Under PPACA, a small employer is defined as having from 1 to 100 employees. In 2011, states had the option of continuing to define a small employer as having 50 or fewer employees. Starting in 2016, states must define a small employer as having from 1 to 100 employees. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013).

[c]The large group market includes plans sold by insurers to large employers. Prior to PPACA, a large employer was defined in federal law as having a minimum of 51 employers. Under PPACA, a large

employer is defined as having 101 or more employees. In 2011, states had the option of continuing to define a large employer as having 51 or more employees. Starting in 2016, states must define a large employer as those having 101 or more employees. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013).

Table 7: Insurers' Median PPACA Medical Loss Ratios (MLRs) in 2012, by State and Insurance Market

	Median MLR (%)			
State	Individual market[a]	Small group market[b]	Large group market[c]	All Markets
Alabama	85.5	86.8	92.2	**91.2**
Alaska	83.4	82.3	94.0	**84.4**
Arizona	85.4	79.7	89.6	**85.4**
Arkansas	82.0	80.9	86.7	**83.3**
California	83.2	84.2	91.4	**89.1**
Colorado	89.2	85.4	89.9	**88.2**
Connecticut	84.9	84.2	88.4	**87.3**
Delaware	81.4	84.1	89.8	**84.1**
District of Columbia	106.1	81.3	85.5	**84.9**
Florida	82.9	85.6	89.2	**87.1**
Georgia	85.5	83.4	93.0	**87.0**
Hawaii	95.0	89.1	88.3	**90.3**
Idaho	86.2	83.5	92.4	**89.6**
Illinois	81.6	83.5	90.0	**85.2**
Indiana	91.8	85.7	92.7	**88.4**
Iowa	83.6	84.8	92.8	**88.2**
Kansas	85.1	82.2	91.4	**89.2**
Kentucky	85.6	88.3	96.4	**89.4**
Louisiana	81.9	81.9	89.8	**85.7**
Maine	100.8	85.5	86.3	**85.7**
Maryland	79.5	83.7	87.0	**85.1**
Massachusetts	91.5	88.2	89.1	**89.7**
Michigan	78.7	83.0	91.2	**85.9**
Minnesota	93.0	90.2	95.3	**93.7**
Mississippi	86.0	88.4	94.5	**89.9**
Missouri	82.7	83.0	90.9	**88.8**
Montana	89.7	82.8	93.8	**85.4**
Nebraska	85.5	84.8	89.8	**86.2**
Nevada	85.3	80.8	89.7	**85.9**

State	Median MLR (%)			All Markets
	Individual market[a]	Small group market[b]	Large group market[c]	
New Hampshire	78.3	88.8	91.0	**88.0**
New Jersey	109.5	86.8	87.0	**87.7**
New Mexico	89.3	86.5	93.0	**91.5**
New York	95.1	93.0	86.9	**91.6**
North Carolina	81.9	82.2	92.5	**84.5**
North Dakota	87.5	89.3	93.5	**89.3**
Ohio	87.9	89.3	94.2	**92.2**
Oklahoma	78.4	83.8	90.2	**86.3**
Oregon	90.2	84.7	90.0	**88.9**
Pennsylvania	94.1	87.8	91.9	**89.8**
Rhode Island	101.9	86.8	93.7	**90.5**
South Carolina	84.1	80.5	94.1	**86.8**
South Dakota	98.5	91.8	92.4	**92.2**
Tennessee	83.6	82.4	94.4	**85.8**
Texas	81.7	84.7	89.7	**87.0**
Utah	82.0	82.5	91.1	**86.5**
Vermont	108.6	89.7	91.8	**92.9**
Virginia	83.7	81.1	91.1	**86.4**
Washington	89.9	86.5	90.9	**90.2**
West Virginia	77.8	82.8	95.5	**86.3**
Wisconsin	86.7	92.5	95.4	**92.8**
Wyoming	84.1	82.4	87.2	**83.1**

Source: GAO analysis of CMS data. | GAO-14-580

Notes: The PPACA MLR is calculated by dividing (a) the sum of an insurer's medical claims and expenses for quality improvement (QI) activities by (b) the insurer's premiums, after excluding from them the amount of insurer's federal and state taxes and licensing or regulatory fees. PPACA MLRs over 100 percent indicate that the insurer's claims and QI expenses for a particular market were greater than the premiums it collected for that year after excluding the applicable taxes and fees. Insurers operating in the insular areas of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and United States Virgin Islands were also subject to the PPACA MLR requirements. In 2012 HHS granted four states temporary adjustments to the 80 percent MLR standard for the individual market and each state's adjustment allowed for a lower MLR standard. The states were Georgia, Iowa, Maine, and New Hampshire.

[a]The individual market includes plans sold by insurers directly to individuals.

[b]The small group market includes plans sold by insurers to small employers. Prior to PPACA, a small employer was defined in federal law as having a maximum of 50 employees. Under PPACA, a small employer is defined as having from 1 to 100 employees. In 2012, states had the option of continuing to define a small employer as having 50 or fewer employees. Starting in 2016, states must define a small employer as having from 1 to 100 employees. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013).

[c]The large group market includes plans sold by insurers to large employers. Prior to PPACA, a large employer was defined in federal law as having a minimum of 51 employers. Under PPACA, a large

employer is defined as having 101 or more employees. In 2012, states had the option of continuing to define a large employer as having 51 or more employees. Starting in 2016, states must define a large employer as those having 101 or more employees. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013).

Appendix II: Insurers' Spending of Net Premiums by State for 2011 and 2012

This appendix presents information on insurers' spending as a percent of their net premiums, by state for all markets combined for 2011 (see table 8) and for 2012 (see table 9).

Table 8: Insurers' Spending as Percent of Net Premiums[a] in 2011 by State, for all Markets Combined

State	Medical claims (%)	Non-claims costs[b] (%)	Premium surplus[c] (%)	Quality improvement activities (%)	Total (%)
Alabama	90.0	5.4	4.3	0.3	**100**
Alaska	86.0	8.5	4.6	1.0	**100**
Arizona	83.4	12.9	2.8	1.0	**100**
Arkansas	83.6	13.1	2.5	0.9	**100**
California	89.1	7.9	2.6	0.5	**100**
Colorado	86.4	10.4	2.5	0.7	**100**
Connecticut	84.0	9.0	6.1	0.9	**100**
Delaware	84.2	10.0	5.3	0.5	**100**
District of Columbia	83.7	8.9	6.7	0.8	**100**
Florida	83.1	11.5	4.6	0.8	**100**
Georgia	84.8	11.3	2.9	1.0	**100**
Hawaii	89.7	7.0	2.6	0.7	**100**
Idaho	86.9	12.1	0.3	0.6	**100**
Illinois	86.7	9.3	3.4	0.6	**100**
Indiana	84.9	9.3	4.9	0.8	**100**
Iowa	85.8	10.8	2.5	0.9	**100**
Kansas	87.1	11.2	1.2	0.6	**100**
Kentucky	83.6	10.4	4.9	1.1	**100**
Louisiana	84.0	10.8	4.8	0.4	**100**
Maine	88.1	7.4	3.6	0.8	**100**
Maryland	86.2	10.7	2.0	1.0	**100**
Massachusetts	87.6	9.7	1.9	0.8	**100**
Michigan	87.2	10.4	1.7	0.8	**100**
Minnesota	86.9	9.1	3.4	0.7	**100**
Mississippi	86.9	11.7	0.9	0.4	**100**
Missouri	83.2	11.2	4.6	1.0	**100**
Montana	87.3	11.9	0.3	0.5	**100**
Nebraska	87.3	10.7	1.6	0.4	**100**
Nevada	83.4	12.3	3.0	1.3	**100**

State	Medical claims (%)	Non-claims costs[b] (%)	Premium surplus[c] (%)	Quality improvement activities (%)	Total (%)
New Hampshire	87.1	9.3	2.7	0.9	**100**
New Jersey	86.0	11.8	1.4	0.7	**100**
New Mexico	88.7	10.9	-0.8	1.2	**100**
New York	89.3	7.0	3.0	0.7	**100**
North Carolina	84.5	12.6	2.2	0.7	**100**
North Dakota	90.1	6.0	3.4	0.6	**100**
Ohio	85.3	10.7	3.0	0.9	**100**
Oklahoma	84.4	10.7	4.4	0.6	**100**
Oregon	88.2	9.4	1.9	0.6	**100**
Pennsylvania	86.3	9.8	3.1	0.8	**100**
Rhode Island	85.4	11.6	2.2	0.8	**100**
South Carolina	83.0	12.0	4.3	0.7	**100**
South Dakota	89.0	8.9	1.1	1.0	**100**
Tennessee	81.7	12.2	4.5	1.5	**100**
Texas	83.5	11.6	4.1	0.8	**100**
Utah	86.1	10.9	2.3	0.8	**100**
Vermont	88.0	10.7	0.4	0.9	**100**
Virginia	85.5	8.6	5.0	0.9	**100**
Washington	86.9	9.8	2.2	1.1	**100**
West Virginia	86.8	8.7	3.6	1.0	**100**
Wisconsin	90.4	9.0	-0.2	0.8	**100**
Wyoming	87.2	9.9	2.7	0.2	**100**

Source: GAO analysis of CMS data. | GAO-14-580

Notes: The markets include large group, small group, and individual. Under PPACA, a small employer is defined as having from 1 to 100 employees and a large employer is defined as having 101 or more employees. However, in 2011 states had the option of continuing to define small and large employers with definitions established in federal law prior to PPACA (small group as having a maximum of 50 and large group as having 51 or more employees). Starting in 2016, states must define small and large employers under the PPACA definition. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013). The individual market includes plans sold by insurers directly to individuals. Insurers operating in the insular areas of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and United States Virgin Islands were also subject to the PPACA medical loss ratio (MLR) requirements. Rows may not sum to 100 due to rounding.

[a]Net premiums is the amount of insurers' earned premiums after subtracting the insurer's federal and state taxes and licensing or regulatory fees. Net premiums is the denominator in the PPACA MLR formula.

[b]Non-claims costs include cost containment expenses, all other claims adjustment expenses, direct sales' salaries and benefits, agents' and brokers' fees and commissions, other taxes and other general and administrative expenses.

[c]The insurer's premium surplus is the amount remaining after subtracting from net premiums the costs associated with medical claims and quality improvement activities as well as non-claims costs.

An insurer's premium surplus includes profit and other reserved capital but does not account for any PPACA MLR rebates the insurer may have to pay.

Table 9: Insurers' Spending as Percent of Net Premiums[a] in 2012 by State, for all Markets Combined

State	Medical claims (%)	Non-claims costs[b] (%)	Premium surplus[c] (%)	Quality improvement activities (%)	Total (%)
Alabama	92.2	10.0	-2.6	0.4	**100**
Alaska	87.0	8.0	4.2	0.9	**100**
Arizona	84.3	12.3	2.2	1.2	**100**
Arkansas	84.7	13.1	1.2	1.0	**100**
California	88.7	7.8	2.9	0.6	**100**
Colorado	87.6	10.0	1.7	0.7	**100**
Connecticut	86.1	9.5	3.5	0.9	**100**
Delaware	84.8	10.2	4.4	0.7	**100**
District of Columbia	87.0	8.3	3.8	1.0	**100**
Florida	85.4	11.5	2.2	0.9	**100**
Georgia	87.3	10.9	0.8	1.0	**100**
Hawaii	90.5	7.4	1.4	0.7	**100**
Idaho	88.8	13.6	-3.0	0.7	**100**
Illinois	86.6	9.1	3.6	0.6	**100**
Indiana	84.2	9.6	5.3	0.8	**100**
Iowa	86.2	10.9	2.1	0.8	**100**
Kansas	87.4	11.6	0.5	0.6	**100**
Kentucky	83.9	10.4	4.6	1.2	**100**
Louisiana	84.8	10.7	4.0	0.6	**100**
Maine	88.7	7.9	2.5	0.9	**100**
Maryland	87.1	10.2	1.4	1.3	**100**
Massachusetts	88.3	8.8	1.9	1.0	**100**
Michigan	86.2	11.0	1.9	0.9	**100**
Minnesota	89.7	9.2	0.4	0.8	**100**
Mississippi	90.1	11.8	-2.4	0.5	**100**
Missouri	85.4	10.4	3.3	1.0	**100**
Montana	89.3	10.7	-0.6	0.6	**100**
Nebraska	87.6	10.8	1.2	0.4	**100**
Nevada	83.3	10.9	4.4	1.5	**100**
New Hampshire	86.2	9.2	3.7	0.9	**100**

State	Medical claims (%)	Non-claims costs[b] (%)	Premium surplus[c] (%)	Quality improvement activities (%)	Total (%)
New Jersey	85.4	11.2	2.5	0.9	**100**
New Mexico	91.9	10.9	-4.4	1.6	**100**
New York	88.7	6.2	4.3	0.7	**100**
North Carolina	81.2	11.7	6.2	0.8	**100**
North Dakota	91.5	6.7	1.2	0.6	**100**
Ohio	86.8	9.9	2.4	0.9	**100**
Oklahoma	85.5	9.7	4.1	0.7	**100**
Oregon	88.3	9.5	1.5	0.7	**100**
Pennsylvania	88.4	9.9	0.9	0.8	**100**
Rhode Island	87.1	11.3	0.9	0.7	**100**
South Carolina	85.5	11.9	1.7	0.9	**100**
South Dakota	89.7	8.6	0.7	1.0	**100**
Tennessee	83.1	12.1	3.2	1.6	**100**
Texas	85.2	11.0	2.9	1.0	**100**
Utah	87.5	10.7	1.0	0.8	**100**
Vermont	90.3	9.4	-0.6	0.9	**100**
Virginia	86.9	8.5	3.7	0.9	**100**
Washington	88.2	9.9	0.8	1.1	**100**
West Virginia	87.9	8.1	3.4	0.6	**100**
Wisconsin	89.5	8.8	0.9	0.9	**100**
Wyoming	82.8	10.1	6.7	0.3	**100**

Source: GAO analysis of CMS data. | GAO-14-580

Notes: The markets include large group, small group, and individual. Under PPACA, a small employer is defined as having from 1 to 100 employees and a large employer is defined as having 101 or more employees. However, in 2011 states had the option of continuing to define small and large employers with definitions established in federal law prior to PPACA (small group as having a maximum of 50 and large group as having 51 or more employees). Starting in 2016, states must define small and large employers under the PPACA definition. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013). The individual market includes plans sold by insurers directly to individuals. Insurers operating in the insular areas of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and United States Virgin Islands were also subject to the PPACA medical loss ratio (MLR) requirements. Rows may not sum to 100 due to rounding.

[a]Net premiums is the amount of insurers' earned premiums after subtracting the insurer's federal and state taxes and licensing or regulatory fees. Net premiums is the denominator in the PPACA MLR formula.

[b]Non-claims costs include cost containment expenses, all other claims adjustment expenses, direct sales' salaries and benefits, agents' and brokers' fees and commissions, other taxes and other general and administrative expenses.

[c]The insurer's premium surplus is the amount remaining after subtracting from net premiums the costs associated with medical claims and quality improvement activities as well as non-claims costs. An insurer's premium surplus includes profit and other reserved capital but does not account for any PPACA MLR rebates the insurer may have to pay.

Appendix III: PPACA Medical Loss Ratio Rebates by State for 2011 and 2012

This appendix presents information on the total amount of PPACA medical loss ratio rebates that insurers paid to enrollees and policyholders who paid premiums, by state and insurance market for 2011 (see table 10) and for 2012 (see table 11).

Table 10: Total Amount of PPACA Medical Loss Ratio Rebates Insurers Paid to Enrollees and Policyholders in 2011, by State and Insurance Market

		Rebate amounts (in dollars)		
State	**Total**	**Individual market[a]**	**Small group market[b]**	**Large group market[c]**
Alabama	**4,220,331**	3,189,860	1,030,471	0
Alaska	**1,280,908**	0	1,280,908	0
Arizona	**29,617,637**	12,931,977	8,852,429	7,833,231
Arkansas	**7,976,578**	533,645	5,856,324	1,586,610
California	**77,405,460**	20,644,294	42,633,080	14,128,086
Colorado	**26,171,887**	3,063,156	653,254	22,455,477
Connecticut	**13,176,140**	4,216,883	459,952	8,499,305
Delaware	**2,563,523**	1,062,076	0	1,501,447
District of Columbia	**55,183,584**	199,633	9,337,321	45,646,630
Florida	**123,625,660**	47,257,109	50,713,189	25,655,361
Georgia	**19,764,771**	2,889,653	1,754,466	15,120,652
Hawaii	**195,053**	0	0	195,053
Idaho	**1,124,918**	144,303	980,615	0
Illinois	**26,611,126**	7,794,746	12,200,294	6,616,086
Indiana	**14,305,969**	2,894,670	9,243,360	2,167,939
Iowa	**1,469,276**	0	1,469,276	0
Kansas	**4,177,418**	3,573,859	603,559	0
Kentucky	**15,326,103**	232,937	4,119,316	10,973,850
Louisiana	**4,272,659**	3,018,598	0	1,254,060
Maine	**2,579,922**	0	0	2,579,922
Maryland	**29,368,794**	12,892,466	2,281,663	14,194,665
Massachusetts	**13,492,100**	750,600	10,292,374	2,449,125
Michigan	**14,034,163**	11,998,544	2,035,619	0
Minnesota	**8,956,885**	494,492	0	8,462,393
Mississippi	**6,235,077**	6,133,419	101,658	0
Missouri	**61,468,647**	16,348,539	38,984,778	6,135,330
Montana	**2,567,493**	1,685,051	882,442	0
Nebraska	**4,832,049**	3,704,559	1,127,491	0

State	Total	Rebate amounts (in dollars)		
		Individual market[a]	Small group market[b]	Large group market[c]
Nevada	**5,184,115**	828,521	3,973,839	381,755
New Hampshire	**77,507**	0	0	77,507
New Jersey	**8,847,312**	1,291,536	0	7,555,776
New Mexico	**3,874,411**	0	3,874,411	0
New York	**96,075,052**	6,048,297	3,663,077	86,363,678
North Carolina	**19,461,110**	3,192,881	894,587	15,373,642
North Dakota	**10,160**	10,160	0	0
Ohio	**11,331,726**	8,195,193	3,136,533	0
Oklahoma	**20,641,441**	6,947,424	13,282,727	411,290
Oregon	**4,645,593**	2,630,847	1,209,614	805,132
Pennsylvania	**52,294,403**	21,383,386	345,698	30,565,319
Rhode Island	**0**	0	0	0
South Carolina	**19,630,152**	15,277,769	4,297,790	54,594
South Dakota	**47,948**	47,948	0	0
Tennessee	**30,631,189**	18,569,459	3,251,333	8,810,396
Texas	**168,534,316**	136,040,527	14,307,687	18,186,102
Utah	**4,963,580**	2,741,795	1,364,193	857,591
Vermont	**2,679,964**	333,946	0	2,346,018
Virginia	**44,066,000**	5,010,247	23,183,222	15,872,530
Washington	**594,031**	432,333	0	161,698
West Virginia	**2,703,790**	2,268,826	434,964	0
Wisconsin	**10,167,510**	649,028	4,854,402	4,664,080
Wyoming	**1,112,043**	932,840	179,203	0

Source: GAO analysis of CMS data. | GAO-14-580

Note: Insurers operating in the insular areas of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and United States Virgin Islands were also subject to the PPACA medical loss ratio requirements.

[a]The individual market includes plans sold by insurers directly to individuals.

[b]The small group market includes plans sold by insurers to small employers. Prior to PPACA, a small employer was defined in federal law as having a maximum of 50 employees. Under PPACA, a small employer is defined as having from 1 to 100 employees. In 2011, states had the option of continuing to define a small employer as having 50 or fewer employees. Starting in 2016, states must define a small employer as having from 1 to 100 employees. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013).

[c]The large group market includes plans sold by insurers to large employers. Prior to PPACA, a large employer was defined in federal law as having a minimum of 51 employers. Under PPACA, a large employer is defined as having 101 or more employees. In 2011, states had the option of continuing to define a large employer as having 51 or more employees. Starting in 2016, states must define a large employer as those having 101 or more employees. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013).

Table 11: Total Amount of PPACA Medical Loss Ratio Rebates Insurers Paid to Enrollees and Policyholders in 2012, by State and Insurance Market

		Rebate amounts (in dollars)		
State	Total	Individual market[a]	Small group market[b]	Large group market[c]
Alabama	**314,374**	314,374	0	0
Alaska	**1,645,701**	937,064	708,637	0
Arizona	**18,711,068**	2,531,582	5,644,562	10,534,924
Arkansas	**4,171,735**	864,644	2,115,463	1,191,628
California	**65,666,231**	18,739,344	41,973,768	4,953,120
Colorado	**11,486,675**	1,296,964	403,311	9,786,401
Connecticut	**5,530,448**	1,408,528	4,121,920	0
Delaware	**1,361,054**	633,103	0	727,951
District of Columbia	**5,149,792**	85,582	2,003,528	3,060,682
Florida	**54,560,916**	39,766,048	13,345,485	1,449,383
Georgia	**17,817,736**	7,208,571	10,329,073	280,093
Hawaii	**1,551,371**	0	0	1,551,371
Idaho	**2,300,265**	214,330	2,085,935	0
Illinois	**6,240,594**	2,998,021	1,506,688	1,735,886
Indiana	**22,656,341**	890,422	20,564,825	1,201,094
Iowa	**264,438**	125,524	0	138,914
Kansas	**4,043,320**	2,748,348	1,294,972	0
Kentucky	**14,405,533**	10,966,162	2,444,800	994,572
Louisiana	**2,473,246**	1,215,914	487,347	769,985
Maine	**501,240**	0	0	501,240
Maryland	**13,143,978**	6,899,337	0	6,244,641
Massachusetts	**40,126,759**	3,140,949	35,699,941	1,285,870
Michigan	**18,810,417**	10,542,615	7,059,979	1,207,824
Minnesota	**1,435,260**	983,686	0	451,574
Mississippi	**5,851,556**	3,550,203	881,517	1,419,837
Missouri	**19,186,416**	3,059,896	11,073,463	5,053,056
Montana	**1,537,571**	1,395,689	0	141,882
Nebraska	**2,000,151**	1,345,830	544,744	109,577
Nevada	**4,159,345**	969,396	2,516,061	673,888
New Hampshire	**1,171,335**	497,882	0	673,453
New Jersey	**10,768,382**	0	6,631,571	4,136,811
New Mexico	**239,567**	80,853	158,714	0
New York	**35,290,183**	3,932,003	3,454,360	27,903,820

State	Total	Rebate amounts (in dollars)		
		Individual market[a]	Small group market[b]	Large group market[c]
North Carolina	**10,478,768**	2,800,469	2,665,508	5,012,791
North Dakota	**19,792**	19,792	0	0
Ohio	**486,681**	360,491	126,190	0
Oklahoma	**16,009,195**	5,927,336	6,075,797	4,006,061
Oregon	**3,327,997**	863,555	585,236	1,879,206
Pennsylvania	**6,877,987**	6,056,538	159,066	662,383
Rhode Island	**18,053**	0	0	18,053
South Carolina	**6,169,507**	6,015,932	153,575	0
South Dakota	**41,240**	0	0	41,240
Tennessee	**5,676,201**	3,707,437	1,263,676	705,088
Texas	**46,695,311**	40,904,426	2,034,381	3,756,504
Utah	**4,665,982**	815,854	3,262,953	587,175
Vermont	**126,810**	0	0	126,810
Virginia	**11,874,030**	1,601,343	7,065,955	3,206,732
Washington	**806,496**	785,946	0	20,550
West Virginia	**1,120,757**	848,779	271,978	0
Wisconsin	**3,567,932**	765,370	0	2,802,562
Wyoming	**1,477,087**	201,532	542,820	732,735

Source: GAO analysis of CMS data. | GAO-14-580

Note: Insurers operating in the insular areas of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and United States Virgin Islands were also subject to the PPACA medical loss ratio requirements.

[a]The individual market includes plans sold by insurers directly to individuals.

[b]The small group market includes plans sold by insurers to small employers. Prior to PPACA, a small employer was defined in federal law as having a maximum of 50 employees. Under PPACA, a small employer is defined as having from 1 to 100 employees. In 2012, states had the option of continuing to define a small employer as having 50 or fewer employees. Starting in 2016, states must define a small employer as having from 1 to 100 employees. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013).

[c]The large group market includes plans sold by insurers to large employers. Prior to PPACA, a large employer was defined in federal law as having a minimum of 51 employers. Under PPACA, a large employer is defined as having 101 or more employees. In 2012, states had the option of continuing to define a large employer as having 51 or more employees. Starting in 2016, states must define a large employer as those having 101 or more employees. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013).

Appendix IV: Rebates Insurers Would Have Paid with Agent and Broker Payments Excluded from 2011 and 2012 Calculations

This appendix presents information on the amount of rebates that insurers would have paid to enrollees and policyholders who paid premiums with agents' and brokers' commissions and fees excluded from the PPACA medical loss ratio and rebate calculations (absent other changes in business practices), compared to the actual amounts that insurers paid, by state for 2011 (see table 12) and for 2012 (see table 13).

Table 12: Amount of Rebates Insurers Would Have Paid to Enrollees and Policyholders with Agents' and Brokers' Commissions and Fees Excluded from PPACA Medical Loss Ratio and Rebate Calculations Compared to Actual Amount of Rebates Insurers Paid in 2011 by State, for all Markets Combined

	Rebate amounts (in dollars)		
State	Actual amount insurers paid	Without agents' and brokers' commissions and fees	Difference (% change)
Alabama	4,220,331	2,717,619	-36
Alaska	1,280,908	412,957	-68
Arizona	29,617,637	2,935,154	-90
Arkansas	7,976,578	382,738	-95
California	77,405,460	10,933,330	-86
Colorado	26,171,887	13,204,301	-50
Connecticut	13,176,140	657,733	-95
Delaware	2,563,523	2,024,723	-21
District of Columbia	55,183,584	37,751,449	-32
Florida	123,625,660	18,863,983	-85
Georgia	19,764,771	4,205,820	-79
Hawaii	195,053	59,391	-70
Idaho	1,124,918	106,461	-91
Illinois	26,611,126	4,396,035	-83
Indiana	14,305,969	1,445,408	-90
Iowa	1,469,276	0	-100
Kansas	4,177,418	999,233	-76
Kentucky	15,326,103	211,106	-99
Louisiana	4,272,659	683,325	-84
Maine	2,579,922	1,311,783	-49
Maryland	29,368,794	16,018,019	-45
Massachusetts	13,492,100	6,082,374	-55
Michigan	14,034,163	2,992,204	-79
Minnesota	8,956,885	5,050,162	-44

State	Rebate amounts (in dollars)		
	Actual amount insurers paid	Without agents' and brokers' commissions and fees	Difference (% change)
Mississippi	6,235,077	4,050,093	-35
Missouri	61,468,647	7,872,733	-87
Montana	2,567,493	422,145	-84
Nebraska	4,832,049	861,853	-82
Nevada	5,184,115	68,494	-99
New Hampshire	77,507	0	-100
New Jersey	8,847,312	3,737,623	-58
New Mexico	3,874,411	0	-100
New York	96,075,052	9,376,682	-90
North Carolina	19,461,110	2,840,313	-85
North Dakota	10,160	0	-100
Ohio	11,331,726	1,203,396	-89
Oklahoma	20,641,441	2,747,220	-87
Oregon	4,645,593	1,699,414	-63
Pennsylvania	52,294,403	31,057,232	-41
Rhode Island	0	0	0
South Carolina	19,630,152	1,707,491	-91
South Dakota	47,948	0	-100
Tennessee	30,631,189	9,309,181	-70
Texas	168,534,316	42,209,454	-75
Utah	4,963,580	486,863	-90
Vermont	2,679,964	1,883,498	-30
Virginia	44,066,000	4,722,362	-89
Washington	594,031	58,584	-90
West Virginia	2,703,790	1,306,546	-52
Wisconsin	10,167,510	204,151	-98
Wyoming	1,112,043	542,092	-51

Source: GAO analysis of CMS data. | GAO-14-580

Notes: The markets include large group, small group, and individual. Under PPACA, a small employer is defined as having from 1 to 100 employees and a large employer is defined as having 101 or more employees. However, in 2011 states had the option of continuing to define small and large employers with definitions established in federal law prior to PPACA (small group as having a maximum of 50 and large group as having 51 or more employees). Starting in 2016, states must define small and large employers under the PPACA definition. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013). The individual market includes plans sold by insurers directly to individuals. Insurers operating in the insular areas of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and United States Virgin Islands were also subject to the PPACA medical loss ratio requirements.

Table 13: Amount of Rebates Insurers Would Have Paid to Enrollees and Policyholders with Agents' and Brokers' Commissions and Fees Excluded from PPACA Medical Loss Ratio and Rebate Calculations Compared to Actual Amount of Rebates Insurers Paid in 2012 by State, for all Markets Combined

	Rebate amounts (in dollars)		
State	Actual amount insurers paid	Without agents' and brokers' commissions and fees	Difference (% change)
Alabama	314,374	240,188	-24
Alaska	1,645,701	427,816	-74
Arizona	18,711,068	2,327,960	-88
Arkansas	4,171,735	1,160,162	-72
California	65,666,231	6,818,746	-90
Colorado	11,486,675	686,892	-94
Connecticut	5,530,448	1,103,280	-80
Delaware	1,361,054	1,203,270	-12
District of Columbia	5,149,792	2,454,703	-52
Florida	54,560,916	15,232,312	-72
Georgia	17,817,736	2,920,457	-84
Hawaii	1,551,371	1,394,767	-10
Idaho	2,300,265	301,454	-87
Illinois	6,240,594	2,187,437	-65
Indiana	22,656,341	1,763,988	-92
Iowa	264,438	149,567	-43
Kansas	4,043,320	1,000,904	-75
Kentucky	14,405,533	3,468,822	-76
Louisiana	2,473,246	1,079,876	-56
Maine	501,240	0	-100
Maryland	13,143,978	7,579,820	-42
Massachusetts	40,126,759	28,483,017	-29
Michigan	18,810,417	6,413,173	-66
Minnesota	1,435,260	842,951	-41
Mississippi	5,851,556	2,523,128	-57
Missouri	19,186,416	2,629,432	-86
Montana	1,537,571	893,756	-42
Nebraska	2,000,151	1,049,561	-48
Nevada	4,159,345	1,280,956	-69
New Hampshire	1,171,335	342,650	-71
New Jersey	10,768,382	651,598	-94

State	Rebate amounts (in dollars)		
	Actual amount insurers paid	Without agents' and brokers' commissions and fees	Difference (% change)
New Mexico	239,567	63,448	-74
New York	35,290,183	6,989,447	-80
North Carolina	10,478,768	1,736,726	-83
North Dakota	19,792	16,419	-17
Ohio	486,681	328,436	-33
Oklahoma	16,009,195	2,931,977	-82
Oregon	3,327,997	2,085,421	-37
Pennsylvania	6,877,987	2,525,182	-63
Rhode Island	18,053	0	-100
South Carolina	6,169,507	415,006	-93
South Dakota	41,240	30,962	-25
Tennessee	5,676,201	1,224,962	-78
Texas	46,695,311	8,049,784	-83
Utah	4,665,982	277,430	-94
Vermont	126,810	0	-100
Virginia	11,874,030	3,557,241	-70
Washington	806,496	746,827	-7
West Virginia	1,120,757	487,604	-56
Wisconsin	3,567,932	227,232	-94
Wyoming	1,477,087	858,543	-42

Source: GAO analysis of CMS data. | GAO-14-580

Notes: The markets include large group, small group, and individual. Under PPACA, a small employer is defined as having from 1 to 100 employees and a large employer is defined as having 101 or more employees. However, in 2012 states had the option of continuing to define small and large employers with definitions established in federal law prior to PPACA (small group as having a maximum of 50 and large group as having 51 or more employees). Starting in 2016, states must define small and large employers under the PPACA definition. See Pub. L. No. 111-148, §1304(b), 124 Stat. 172 (codified at 42 U.S.C. § 18024(b)); 45 C.F.R. § 158.103 (2013). The individual market includes plans sold by insurers directly to individuals. Insurers operating in the insular areas of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and United States Virgin Islands were also subject to the PPACA medical loss ratio requirements.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or DickenJ@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan, Assistant Director; George Bogart; Romonda McKinney Bumpus; Pamela Dooley; Julianne Flowers; and Laurie Pachter made key contributions to this report.