Testimony of

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on

Delivering Better Health Care Value to Consumers: The First Three Years of the Medical Loss Ratio

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Chairman Rockefeller, Ranking Member Thune, and distinguished Members of the Committee, thank you for the opportunity to testify today about the federal regulation of health insurers' medical loss ratios (MLRs). This is a topic that my colleague, Dr. Michael McCue at Virginia Commonwealth, and I have studied in depth for the past two years as reported in a series of publications with the Commonwealth Fund.[1]

I will divide my remarks into three parts: 1) the primary consumer benefits from the Affordable Care Act's (ACA's) MLR rule; 2) secondary benefits or harms from this rule; and 3) opportunities for expanding or improving the rule.

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[1] M. J. McCue and M. A. Hall, The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 2, The Commonwealth Fund, May 2014

M. McCue, M. Hall, and X. Liu, "Impact of Medical Loss Regulation on the Financial Performance of Health Insurers," Health Affairs, Sept. 2013 32(9):1546–51.

Mark A. Hall and Michael J. McCue, Insurers' Medical Loss Ratios and Quality Improvement Spending in 2011, The Commonwealth Fund, March 2013.

M. J. McCue and M. A. Hall, Insurers' Responses to Regulation of Medical Loss Ratios, The Commonwealth Fund, December 2012.

Direct Consumer Benefits

Traditionally, the MLR has been used mainly as an indicator of financial strength. For investors or lenders, a lower MLR is more favorable because it signals the potential for higher profits. The ACA's MLR rule has reversed this directional field – focusing on the MLR as a measure of consumer value. For consumers, a higher MLR is more favorable because this means that a greater portion of the premium dollar is going to pay for medical treatment and quality improvement activities rather than for sales expenses, administrative overhead, or profits. The MLR is not a perfect measure for consumer value; some portion of administrative expense is used to reduce medical costs, which can bring consumer value by reducing total premium costs. No performance measure is perfect. But, despite its limitations, the MLR is a very useful measure of efficiency and consumer value.

Under the ACA, the most direct consumer benefit from a minimum medical loss ratio is to require health insurers to rebate to consumer any amounts by which they fall short of the minimum. Thus, in the individual or small group markets, where the minimum MLR is 80 percent, if an individual insurer spends only 75 percent of its premium dollars on medical claims and quality improvement expenses in a year, it must rebate five percent of its premiums to subscribers after year-end accounting. The minimum MLR for large groups is 85 percent, reflecting the greater economies of scale in that market segment.

The ACA's MLR rule took effect in 2011. For that year, health insurers rebated $1.1 billion to consumers. In 2012, rebates dropped in half, to $513 million, indicating greater compliance with the minimum MLRs. Rebates for 2013 will be determined by August of this year.

Consumer benefits from MLR regulation are not restricted to rebates, however. To avoid having to pay rebates, insurers can increase their MLRs by reducing overhead expenses and profits. Doing that makes insurance a better value for consumers. In fact, insurers have done just this in the first two years under the ACA's MLR rule. [2] In 2011, the first year under the MLR rule, health insurers reduced overall profits and administrative costs by $350 million. Changes in financial performance were most apparent in the individual market, where the median medical loss ratio increased by 5.5 percentage points from 2010 to 2011. The median administrative cost ratio declined by 2.6 percentage points, and the median operating margin declined by 1.3 percentage points. Within the individual market, such changes were most notable among for-profit insurers. These insurers raised their median medical loss ratio from 72 percent in 2010 to 79 percent in 2011—much closer to the required minimum level. In 2012, insurers continued to reduce their administrative and sales costs and their profit margins, by $1.4 billion overall.

It is not known exactly how much of the reduced overhead these two years can be attributed to the new MLR regulation rather than market competition. But, it seems reasonable to estimate that, in

[2] It is not accurate to attribute all such changes to the MLR rule, but the closer in time that overhead reductions are to the new MLR rule, the more likely the rule played a major role in encouraging any increase in health insurers' efficiency.

the first two years under this regulation, total consumer benefits related to the MLR regulation—both in rebates and reduced overhead—amounted to over $3 billion. It is also important to note that, unlike rebates that are paid in a single year, a one-year reduction in overhead pays consumer dividends year after year, as long as the reduction is maintained. Therefore, even if MLR rebates diminish even further, consumers will still continue to receive the benefits of reduced overhead year after year, relative to what it would have been without the improvement in the MLR.

Secondary Benefits or Harms

Another important benefit of the federal MLR rule is simply the transparency and standardization it provides for those who study or observe health insurers' financial performance and consumer value. Prior to the ACA, insurers did not consistently report their MLRs in all states, and the MLR was reported as a fairly coarse measure. As a result of the ACA's new federal rule, MLRs are now adjusted for relevant factors such as insurers' size and types of products. Also, all health insurers now must consistently report their MLR and rebate data to CMS' Center for Consumer Information & Insurance Oversight (CCIIO). This agency releases to the public a detailed data base about insurers' medical and non-medical expenses, and its personnel have been extremely responsive in providing information to assist our research.

The federal MLR data source provides more transparency to consumers and permits more comprehensive and fine-grained analyses by public policy researchers. For instance, we now know for the first time how much insurers report spending on five types of quality improvement activities. And, we can analyze how different types of insurers (nonprofit, investor-owned, provider-sponsored) differ in their various financial measures.

Some analysts initially predicted that federal regulation of MRLs would cause financial distress, perhaps severe, in the health insurance industry. To the contrary, there is no convincing evidence so far that the MLR rule has weakened the insurance industry. The individual market has become somewhat less profitable, operating at a 1 to 2 percent loss, but the group markets continue to generate operating profits in the range of 3 to 4 percent of premiums (before taxes and not considering earnings from investments and other lines of business). The industry's financial strength is confirmed by the stock market, where health insurers' stock prices have increased substantially more than marketwide averages since the ACA was enacted.[3]

Also, the MLR regulation has not caused anything like the exodus of insurers that was prophesized by some. Between 2011 and 2012, there was been a small reduction in the number of active insurers, consistent with the marketwide consolidation that was ongoing prior to the ACA. But

[3] Pradip Sigdyal & Giovanny Moreano, Surging Health Care Index Sets Another Record, CNBC (Apr. 2, 2013), www.cnbc.com/id/100538665; Anna Bernasek, The Dawn Of Obamacare Hasn't Hurt Insurers' Stocks, N.Y. TIMES, Oct. 27, 2013, at BU7, http://www.nytimes.com/2013/10/27/business/insurers-stocks-unhurt-by-the-dawn-of-obamacare.html.

still, throughout the country there were roughly 500 insurers with at least 1,000 members in each market segment (individual, small-group, and large-group).

Future Considerations

The ACA's MLR rule applies to commercial health insurance. A separate provision in the ACA also sets a minimum of 85 percent for private plans sold through Medicare (Medicare Advantage and Medicare Part D). There is no federal rule, however, for the MLRs of private managed care organizations (MCOs) that provide coverage under Medicaid. About a dozen states set their own Medicaid standards, however, and others consider MLRs when they negotiate Medicaid payment rates with private managed care plans.[4]

In view of the substantial expansion of Medicaid that the federal government is funding through the ACA, this Committee might want to consider whether the current state-based system of MLR oversight for Medicaid plans is functioning optimally. Dr. McCue and I have not done an extensive analysis of MLRs for Medicaid MCOs. However, our initial review of NAIC and other state data from 2011 indicates that, nationwide, the median MLR among Medicaid MCOs is about 87 percent. Of 211 such plans, 75 of them (35%) reported MLRs below 85 percent, and 30 (or 14%) reported MLRs below 80 percent.

In addition to bringing the bottom of this distribution up to a level considered acceptable, another potential benefit of a federal MLR rule for Medicaid could be greater uniformity in how Medicaid MCOs measure and report their MLRs. One issue on which states vary is the extent to which Medicaid MCOs may count care management/coordination expenses as medical costs vs. administrative overhead. Also, it is not clear how states do (or should) account for Medicaid MCOs that subcontract with other organizations or provider groups on a capitated basis. Subcapitation occurs with some frequency, but when it does, it is not clear to us whether the entire capitated amount should count as a medical expense, or instead wither the sub-contractor's own administrative expenses and profits count toward the "parent" MCO's non-medical overhead (by reducing how much of its capitation payment counts as "medical").

A federal rule would standardize these accounting and reporting conventions. A uniform rule would also provide the opportunity for collective deliberation over which of various accounting approaches is superior. On the other hand, states vary in the extent to which their Medicaid MCO programs cover different populations with diverse health care needs, such as children, disabled adults and the elderly. Also, states differ in how they develop capitation rates for these different populations. This variation may make it more difficult to adopt a single metric that applies nationally.

Thank you for this opportunity to testify. I will be happy to answer any questions.

[4] Kaiser Family Foundation, Medicaid MCOs and Medical Loss Ratio (MLR) Requirements (April 2012), http://kff.org/medicaid/fact-sheet/medicaid-mcos-and-medical-loss-ratio-mlr/.