This brief uses data submitted by insurers on medical loss ratios (MLRs) from 2010 to 2014 to assess changes in claims, premiums, and MLRs across and within states’ individual health insurance markets. The Affordable Care Act’s (ACA’s) MLR provisions require that most insurers spend a minimum percentage of premium revenues on health care and quality improvement expenses or provide a rebate. The ACA set these MLR floors because a higher MLR tends to benefit consumers as a greater share of premiums are devoted to the costs of care as opposed to administrative costs and profits, but a very high MLR can mean financial losses for insurers if claims costs exceed premium revenues.

This analysis aims to explore the effect of the ACA’s individual market reforms on MLR and its components. This brief begins by examining insurers’ experiences in the individual, small-group and large-group markets from 2010 to 2014, looking at net claims (claims and health care quality improvement expenses net of commercial reinsurance and federal reinsurance, rebates and expected rebates, and other adjustments), net premiums (premiums net of federal and state taxes and licensing and regulatory fees and other adjustments), and net MLRs (net claims divided by net premiums). We then focus on the individual market, the market most altered by the ACA, comparing average net MLRs by state in 2010 and 2014. Finally, we examine the distribution of net MLRs in the individual market by state in 2014 to show how the measure varies across insurers. Key findings include the following:

- Average net MLRs rose in the individual market between 2010 and 2014 because of rising net claims relative to net premiums, but even in 2014 net claims were far lower in the individual market than in other markets. This suggests that although the typical coverage in the individual market is more comprehensive than pre-ACA, it is still somewhat less comprehensive than typical employer based coverage, and it is also possible that the use of health care services or the health risks of individual market enrollees is lower than in the group market.

- In 2010, average net MLR was below 80 percent in 29 states and above that in 21 states and the District of Columbia, even before the ACA’s market reforms. By 2014, all but three states had average individual-market net MLRs higher than 80 percent.

- Nationally, average net MLRs in the individual market in 2014 varied from 83 percent at the 25th percentile to 99 percent at the 75th percentile, but within some states there was very little variation.

**Background**

The major health insurance reforms of the ACA in 2014 ushered in a dramatic transition in the individual market, including the start of guaranteed issue and adjusted community rating of premiums for all seeking individual-market coverage. These reforms built on earlier provisions of the ACA in 2011 to improve consumer value for those buying health insurance in the individual market, namely the MLR requirements. The MLR provision requires that individual-market insurers and most other insurers spend a minimum percentage of premium revenues on health care and quality improvement expenses. The ACA set these MLR floors because a higher MLR tends to benefit consumers by ensuring that a greater share of premiums are devoted to the costs of care as opposed to administrative costs and operating margins, but a very high MLR can mean financial losses for insurers if expenses for health care and quality improvements exceed premium revenues.

The ACA market reforms were likely to have affected average claims in states’ individual markets in 2014 in ways that were not entirely predictable. Because insurers did not have the full year of 2014 post-ACA claims data when setting 2015 premiums, one key question is what that data look like and how insurers might use them to adjust premiums for 2016. MLRs in 2014 do not directly predict 2016 premiums, because the risk pools could be evolving and because insurers set premiums to compete for enrollees in the future year’s pool rather than the past year’s pool. But MLRs in 2014 are suggestive of how well the insurers had
set premiums originally relative to the 2014 pool of enrollees. If insurers were far off the historical average or target MLRs in 2014 and only recently obtained sufficient data to identify that gap, insurers may consider that new information when setting 2016 premiums.

Indeed, preliminary data from the 2014 benefit year indicate that average individual-market MLRs in 2014 were higher than the required level and higher than historical levels. And though requested rate increases for 2016 vary widely, some individual marketplace insurers have requested significant rate increases, presumably to ensure solvency and sustainable profit margins, not just to return to historical MLR averages.

To shed light on recent individual-market experience and where it may be headed, this brief uses data submitted by insurers on MLR and components of MLR from 2010 to 2014 to assess claims, premiums and MLRs across and within states’ individual markets in 2014. This analysis aims to explore the effect of the minimum MLR provision and other individual-market reforms on MLR and its components, and the potential effect of the phase-out of reinsurance and risk corridor programs and the continuation of the risk adjustment program. This brief first examines insurers’ experiences in the individual, small-group and large-group markets from 2010 to 2014, looking at net claims (claims and health care quality improvement expenses net of commercial reinsurance and federal reinsurance, rebates and expected rebates, and other adjustments), net premiums (premiums net of federal and state taxes and licensing and regulatory fees and other adjustments), net MLRs (net claims divided by net premiums). We then compare average net MLRs in the individual market by state in 2010 and 2014. Finally, we examine the distribution of net MLRs among individual-market insurers within each state in 2014. For a description of the data, methods and measures used in this brief, see the “Methods” section below.

This analysis is not definitive because the effect of the three federal premium stabilization mechanisms, the “three Rs” of reinsurance, risk corridors, and risk adjustment, have not been fully accounted for in the data available thus far. The net effect of these programs will be to decrease average net MLRs and reduce the variation in net MLRs in a state. (See the appendix for more information on the three Rs programs.) But the first two programs are temporary, so it is still useful to examine the data without fully accounting for these programs because insurers’ pricing strategies must account for the phase-out of these programs after 2016.

**Findings**

Average net MLRs rose in the individual market between 2010 and 2014 because of rising net claims relative to net premiums, but even in 2014 net claims were far lower in the individual market than in other markets.

The average net MLR in the individual market rose from 79 percent in 2010 before the ACA’s federal MLR requirement to 84 percent in 2011 after the federal requirement took effect (Table 1). The average net MLR in the individual market then stayed relatively flat until hitting 92 percent in 2014, when the ACA’s major individual-market reforms substantially transformed the market. Underlying the changes in net MLR, net claims growth exceeded net premium growth significantly in the individual market in both 2010 to 2011 and 2013 to 2014. In contrast, because the regulatory reforms had a minimal effect on the small- and large-group markets, changes in net MLR in the small- and large-group markets were minimal between 2010 and 2014. The average net MLR in the small- and large-group markets remained fairly constant between 2010 and 2014, with small increases (1 percentage point) in 2011 to 2012 and 2013 to 2014 because net claims growth exceeded net premiums growth slightly in those two periods.

Net claims, and to a lesser extent net premiums, rose in the individual market at faster rates than in the small group market, particularly in 2013 to 2014. Yet despite the faster growth in net claims and net premiums in the individual market even across a longer time frame between 2010 and 2014, both were far lower in the individual market than the
Table 1. Net Claims and Net Premiums in the Individual, Small-Group, and Large Group Markets, 2010 to 2014

<table>
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<tbody>
<tr>
<td><strong>Individual Market</strong></td>
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<tr>
<td>Avg net incurred claims, PMPY</td>
<td>$1,967</td>
<td>$2,161</td>
<td>$2,267</td>
<td>$2,394</td>
<td>$3,069</td>
<td>10 %</td>
<td>5 %</td>
<td>6 %</td>
<td>28 %</td>
</tr>
<tr>
<td>Avg net health premiums, PMPY</td>
<td>$2,439</td>
<td>$2,558</td>
<td>$2,648</td>
<td>$2,755</td>
<td>$3,341</td>
<td>5 %</td>
<td>4 %</td>
<td>4 %</td>
<td>21 %</td>
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<tr>
<td>Avg net MLR</td>
<td>79 %</td>
<td>84 %</td>
<td>85 %</td>
<td>86 %</td>
<td>92 %</td>
<td>4 %</td>
<td>1 %</td>
<td>2 %</td>
<td>5 %</td>
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<tr>
<td><strong>Small-group Market</strong></td>
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<tr>
<td>Avg net incurred claims, PMPY</td>
<td>$3,147</td>
<td>$3,203</td>
<td>$3,290</td>
<td>$3,408</td>
<td>$3,600</td>
<td>2 %</td>
<td>3 %</td>
<td>4 %</td>
<td>6 %</td>
</tr>
<tr>
<td>Avg net health premiums, PMPY</td>
<td>$3,766</td>
<td>$3,826</td>
<td>$3,901</td>
<td>$4,037</td>
<td>$4,199</td>
<td>2 %</td>
<td>2 %</td>
<td>3 %</td>
<td>4 %</td>
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<tr>
<td>Avg net MLR</td>
<td>83 %</td>
<td>83 %</td>
<td>84 %</td>
<td>84 %</td>
<td>85 %</td>
<td>0 %</td>
<td>1 %</td>
<td>0 %</td>
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<tr>
<td><strong>Large-group Market</strong></td>
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<tr>
<td>Avg net incurred claims, PMPY</td>
<td>$3,442</td>
<td>$3,572</td>
<td>$3,668</td>
<td>$3,652</td>
<td>$3,898</td>
<td>4 %</td>
<td>3 %</td>
<td>0 %</td>
<td>7 %</td>
</tr>
<tr>
<td>Avg net health premiums, PMPY</td>
<td>$3,867</td>
<td>$4,013</td>
<td>$4,082</td>
<td>$4,072</td>
<td>$4,299</td>
<td>4 %</td>
<td>2 %</td>
<td>0 %</td>
<td>6 %</td>
</tr>
<tr>
<td>Avg net MLR</td>
<td>89 %</td>
<td>89 %</td>
<td>90 %</td>
<td>90 %</td>
<td>91 %</td>
<td>0 %</td>
<td>1 %</td>
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<td>1 %</td>
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</table>

Source: 2010 to 2014 Supplemental Health Care Exhibit data by the National Association of Insurance Commissioners.

Notes: MLR = medical loss ratio; PMPY = per member per year. Mean medical claims incurred during the reporting year and mean health premiums earned are both computed PMPY. Measures are computed as a mean for insurers by market segment and year, weighted by member years. See text for a description of the data and sample exclusions. The sample size for individual insurers was 1,126 in 2010; 1,139 in 2011; 979 in 2012; 965 in 2013; and 826 in 2014.

Across the states, average net MLRs were higher in 2014 than in 2010 (Figure 2). In 28 states, average net MLR was below 80 percent in 2010 and above that in 2014. Though nearly all states had average net MLRs higher than 80 percent in 2014, even in 2010 before the ACA’s MLR requirements and individual-market reforms, 21 states and the District of Columbia had average net MLRs higher than 80 percent. Only New Hampshire had an average net MLR below 80 percent in both 2010 and 2014.

But several factors are likely to decrease final average net MLRs significantly across most states compared to 2014 estimates. Although not fully accounted for in the data used to produce our estimates, the full 2014 payments related to the temporary transitional reinsurance program and the federal risk corridor program will decrease average net MLRs significantly in eligible individual-market plans across most states. Transitional reinsurance payments are only partially accounted for in the analysis in this brief. Payments from the federal risk corridor program, when included, will decrease the average net MLRs of small- and large-group markets, even at the end of the period. Thus in 2014, the average net premium per member per year (PMPY) in the individual market ($3,341) was substantially lower than in the small-group ($4,199) and large-group ($4,299) markets. Similarly, average net claims PMPY were lower in the individual market ($3,069) than in the small-group ($3,600) and large-group ($3,898) markets.

Much of the difference in average claims paid likely reflects higher cost-sharing in the individual market relative to the small and large group markets, a difference between the markets which was evident in the pre-ACA period and continues but to a lesser extent today.

In 2010, average net MLR was below 80 percent in 29 states and above that in 21 states and the District of Columbia, even before the ACA’s market reforms. By 2014, all but three states had average individual market net MLRs higher than 80 percent. The two states with the largest increases in average net MLR were Oklahoma with 72.1 percent in 2010 and 111.1 percent in 2014 and Montana with 79.8 percent in 2010 and 114.2 percent in 2014. In contrast, the largest declines in net MLR between 2010 were in North Dakota (97.7 percent to 89.5 percent) and New York (95.8 percent to 88.9 percent).

But several factors are likely to decrease final average net MLRs significantly across most states compared to 2014 estimates. Although not fully accounted for in the data used to produce our estimates, the full 2014 payments related to the temporary transitional reinsurance program and the federal risk corridor program will decrease average net MLRs significantly in eligible individual-market plans across most states. Transitional reinsurance payments are only partially accounted for in the analysis in this brief. Payments from the federal risk corridor program, when included, will decrease the average net MLRs of
eligible individual-market plans, limiting insurers’ profits and losses when costs are 3 percentage points less or more than expected. In addition, in premium pricing for future plan years, insurers consider the predicted costs for the future year. If they overprice for expected future claims, they cannot effectively compete and would lose market share. Several factors could decrease the average health risk and claims experience in the individual market in each state after 2014. First, the individual mandate penalties grow and are likely to encourage more of the remaining uninsured to enroll in coverage even though they may not perceive a substantial need for medical care. Second, those enrolling in the first year are likely to be those most in need of care, and as information about coverage and financial assistance spreads, more healthy individuals are likely to enroll, bringing down average expected claims. Third, if any pent-up demand for care among new enrollees who were previously uninsured exists, this excess demand is likely to be satisfied in the first year after enrollment, and the health care spending profile of those early enrollees will regress toward the population average over time. Finally, if plans with low enrollment grow, this could tend to stabilize average claims because larger enrollment leads to more predictability in average claims.

Despite these factors that are likely to decrease average net MLRs in the individual market over time, in some states, premium increases will likely be necessary if insurers aim to achieve a net MLR near the recent historical average, which is in the 80 percent to 85 percent range. Premiums may also rise as insurers prepare for the expiration of the temporary premium stabilization programs. In addition, as grandfathered plans are phased out and enrollees take up coverage in ACA-compliant plans with essential health benefits, the average claims for these enrollees may increase relative to claims under their grandfathered plans.

The interquartile range of net MLRs varied widely within many states but was zero in some states with concentrated insurer markets.

The average net MLR estimates show very wide interquartile ranges (IQRs) for net MLRs in the individual market in 2014 overall and in most states (Figure 3). Nationally, the 25th percentile was 83 percent and the 75th percentile was 99 percent, leading to a 16 percentage-point IQR. The nine states with an IQR greater than the U.S. average in 2014 are (listed by highest IQR): the District of Columbia (32 percentage-point IQR), New Mexico, California, Pennsylvania, Kentucky, Oregon, New York, Wisconsin and Massachusetts (17 percentage-point IQR). Eleven states (Rhode Island, Iowa, Arkansas, North Carolina, North Dakota, Vermont, Alabama, West Virginia, South Dakota, Illinois and Oklahoma) had an IQR of zero (i.e., no variation in net MLRs between the 25th and 75th percentiles), which in many of these states reflects a highly concentrated market.

The wide interquartile range is consistent with the wide variation in requested rate increases proposed by insurers in some states (e.g., New Mexico and Maryland) for 2016. For example, Oregon had a relatively high and variable net MLR in 2014 compared with other states, with an average net MLR of 103 percent and a 22 percentage-point IQR. The state’s insurance commissioner recently approved 2016 rate increases of 25 percent and 33 percent for two large
Taken together, it is likely that premiums for some insurers will rise in many states’ individual markets if insurers seek to return to the recent historical average net MLR in the 80 percent to 85 percent range.

**Methods**

Insurers began submitting standardized MLR reports to the National Association of Insurance Commissioners (NAIC) in April 2011 based on their 2010 claims experiences (the year before the MLR regulations took effect) and in subsequent years. We use data from the 2010 through 2014 Supplemental Health Care Exhibit (SHCE) files compiled by the NAIC from data submitted by insurers and made available through Mark Farrah Associates. We examine comprehensive health insurance (coverage that provides benefits for a comprehensive set of medical expenses, including doctor and hospital services, and prescription drugs) offered in the individual, small-group and large-group markets for each of the 50 states and the District of Columbia.

In addition to ACA-compliant plans, the 2014 data also include two types of plans that are not ACA-compliant: grandfathered plans (plans that were in existence on March 23, 2010, and have not substantially cut benefits or increased costs for consumers) and transitional or “grandmothered” plans (plans that were effective before 2014 in certain states that allowed these nongrandfathered plans to renew). We use the SHCE data and not the MLR data collected by CMS for federal rebate purposes because the CMS MLR data do not exist for 2010 and have not been released for 2014. Data limitations and exclusion criteria are discussed in a recent paper using previous years of SHCE data.
Changes in Claims, Premiums and Medical Loss Ratios Across and Within States’ Individual Markets Between 2010 and 2014

Estimates are made at the insurer level and weighted by member years. The net MLR has components similar to those in the federal calculation of net MLR used for the purposes of federal MLR rebates to policy holders, plus an approximation of the federal MLR rebate paid to consumers (see endnote for details on the computation of net MLR).¹⁶

In figures 2 and 3, states and the District of Columbia are displayed in increasing order of the average net MLR in the individual market in 2010 and 2014, respectively (the U.S. estimate is also shown). To examine the distribution of net MLRs within a state while reducing the influence of outliers and data inconsistencies, figure 3 shows the interquartile range, a robust measure of statistical dispersion. To calculate the interquartile range, insurers were ranked by net MLR in each state’s market and then divided into quartiles based on member years. However, the average net MLRs in the figure are based on the full range of insurers in each state’s market, not only the insurers with net MLRs in the interquartile ranges.

Our analysis is limited by incomplete SHCE data related to the transitional reinsurance program. Insurers’ estimated reinsurance receipts are underreported relative to actual federal reinsurance payment requests reported by the Department of Health and Human Services (HHS).¹⁷ In addition, the SHCE data do not reflect the HHS’s announcement in June 2015 that the transitional reinsurance would have a coinsurance rate of 100 percent, rather than the originally set 80 percent.¹⁸

Appendix: The Three R Programs

Because of the potential for adverse selection in the newly reformed individual market in 2014, the federal government’s three Rs programs were initiated to help keep premiums affordable and stable by providing payments to health insurers whose enrollees incur higher costs. These payments, the first two of which are temporary, are not fully reflected in the data analyzed in this brief, but would significantly decrease average net MLRs and reduce the variation in net MLRs in a state.

1. The transitional reinsurance program is a temporary premium stabilization program created by the ACA to provide nongrandfathered, nontransitional individual-market plans reimbursement for three benefit years between 2014 and 2016.¹⁹ In June 2015, the HHS increased the national coinsurance rate for the 2014 benefit year for the transitional reinsurance program from 80 percent to 100 percent for covered claims costs (between the attachment point of $45,000 and the reinsurance cap of $250,000) of eligible individual-market plans.²⁰ The transitional reinsurance program was intended to phase down over the three years of operation, with targeted collection of $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016 (not including collections for the U.S. Treasury and administrative expenses). For the 2014 benefit year, HHS reported that collections were expected to be about $9.7 billion (with some of those collections occurring by November 2015). The data totaling these transitional reinsurance payments for 2014 are not yet available and these payments are only partially accounted for in this analysis. Accounting for the full amount of the transitional reinsurance payments would have a positive effect on the financial performance in 2014 of eligible individual-market plans, significantly decreasing average net MLRs.²¹

2. The temporary risk corridor program is a temporary premium stabilization program created by the ACA for nongrandfathered, nontransitional qualified health plans in the individual or small-group markets for benefit years 2014 to 2016. After accounting for reinsurance and risk adjustment payments and charges in each of the three benefit years, the risk corridor program is intended to reduce the effect of a targeted amount of premiums minus allowable administrative expenses that is set low or high relative to actual claims. Insurers’ profits and losses are capped at 3 percent of the ratio of allowable costs to the target amount in most cases.²² In contrast to the risk corridor program, the permanent MLR provisions are intended to limit insurer profits but not losses.

3. The permanent risk adjustment program is a premium stabilization program created by the ACA for nongrandfathered, nontransitional individual and small-group market plans for benefit years 2014 and later. This program is intended to reduce the effects of adverse selection at the state-market level by compensating issuers with higher-risk enrollees compared with other insurers in that state market. In 2014, there was a net payment into the risk adjustment pool, which may not be the case in later years.²³

Conclusion

Overall, consumers are benefiting from a large increase in average net MLRs in the individual market in 2014, driven by an increase in average net claims paid out on individual market insurance policies relative to net premiums paid in to insurers. In contrast, the small- and large-group markets, where regulations and other factors had already achieved high and stable net MLRs even before the ACA, were fairly stable from 2010 to 2014.

The regulatory reforms primarily affected the individual market in terms of premium pricing reforms, changes to benefits and enrollment. And though we expect the individual market to stabilize over time with MLRs and components more similar to the small-group market, the findings related to premium pricing and claims demonstrate that the individual market is still in significant transition. In the short term, there is a substantial amount of uncertainty around federal reinsurance payments and where average net MLRs in the individual market will land after all payments are accounted for. In the
long term when the reinsurance and risk corridor programs have expired, though the permanent risk adjustment program is likely to reduce the variation in MLRs within state individual markets, achieving net MLRs similar to the small-group market is likely to require average individual market premiums to increase relative to claims for some insurers in some states. Yet, as we saw even before implementation of the ACA’s reforms, net MLRs are likely to continue to vary year-to-year across insurers within a state and on average across insurers in different states.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

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Notes

1. Beginning in 2011, the ACA required that insurers have an MLR of at least 80 percent in the individual and small-group markets and 85 percent in the large-group market. MLR considers loss from an insurer’s perspective as the amount an insurer pays out for the covered health care expenses of its enrollees, expressed as a share of the premium revenue it collects from (or on behalf of) enrollees. The provision was intended to limit the share of premium revenue that covers administrative costs (i.e., overhead) and operating margin (i.e., profit). All else equal, insurers balance a higher MLR, which provides higher value to consumers and increases market share, with a moderate MLR, which ensures solvency and sustainable profits.


4. As noted, average net MLR in the individual market for 2014 will be lower when federal reinsurance payments for 2014 are fully taken into account.


8. Though the penalty for not having coverage in 2014 was the greater of $95 per adult or 1 percent of adjusted family income, the penalty grows over time. By 2016, the penalty will be the greater of $695 per adult or 2.5 percent of adjusted family income. See Kaiser Family Foundation. “The Requirement to Buy Coverage Under the Affordable Care Act.” Menlo Park, CA: Kaiser Family Foundation, 2013, [http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/](http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/) (accessed September 2015).


10. Though those in grandfathered plans may be healthier than those in ACA-compliant plans, both groups of enrollees are already aggregated in the data analyzed here. Thus, one factor related to grandfathered plans that could change in the future is the expansion of essential health benefits to those currently in grandfathered plans, which would not change the average risk in the individual market as a whole.


The SHCE data used in this study reflect only health insurance purchased from an insurance company (commonly referred to as “fully insured products”). Thus the small-group data exclude small-employer products that are provided directly to employees through a third-party administrator (commonly referred to as “self-insured products”). For brevity, we refer to the fully insured small-group market as the “small-group market.” Association business is included in the individual and small-group market data. Policies that are not considered comprehensive health insurance (such as “mini-med” plans with limited benefit payments for specific services and overall annual limitations for covered benefits) are excluded from the analysis. In California, SHCE data cover only a fraction of insurers because health maintenance organizations are regulated separately from other insurers in the state and are not required to submit data to the NAIC. For further information on data and methods, see Clemans-Cope L, Garrett B and Wisoker D. “Health Insurer Responses to Medical Loss Ratio Regulation: Increased Efficiency and Value to Consumers.” Washington: Urban Institute, 2015, [http://www.urban.org/research/publication/health-insurer-responses-medical-loss-ratio-regulation](http://www.urban.org/research/publication/health-insurer-responses-medical-loss-ratio-regulation) (accessed September 2015).

Clemans-Cope et al., “Health Insurer Responses to Medical Loss Ratio Regulation.” Exclusion criteria were modified to include MLRs of up to 300 percent to include a large insurer in Massachusetts. We also include a large insurer, Health Care Services Corporation, that was excluded from the earlier analysis because of inconsistent reporting but for which data are now available in each year.

The net MLR computation includes additional categories of expenditures added to claims in the numerator and other categories of expenditures subtracted from premiums in the denominator, either of which would tend to increase net MLR relative to MLR, all else equal. We follow NAIC guidelines in computing the components of net medical claims and net adjusted premiums. The numerator of the net MLR is net medical claims incurred during the reporting year including expenses for reinsurance, including both commercial reinsurance and federal reinsurance related to the ACA, MLR-related rebates and expected rebates other adjustments involved in computing net claims as defined by the NAIC, expenses for improving health care quality incurred during the reporting year, and deductible fraud and abuse detection and recovery expenses. The denominator of the net MLR is net adjusted premiums, defined as premiums minus federal and state taxes, and licensing and regulatory fees plus other adjustments involved in computing net premiums as defined by the NAIC.

Mark Farrah Associates. “A Brief Analysis of the 2014 ACA Reinsurance and Risk Adjustment Results.”


States can set up their own programs; only Massachusetts has done so.

Levitt L et al., “How Have Insurers Fared Under the Affordable Care Act?”


Centers for Medicare and Medicaid Services. “Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2014 Benefit Year.”