HEALTH ACCESS
California's Health Consumer Advocacy Coalition

FACT SHEET

AB 2499 (Arambula): Improving Medical Loss Ratios

AB 2499 will ensure more of your premium dollars go towards actual health care and less on insurance companies' administrative costs and profits. The medical loss ratio (MLR) is the percent of the premium dollar that health insurers spend on medical care and quality improvement activities as opposed to overhead costs (administrative costs, sales expenses, and profits). Plans and insurers that do not meet the MLR standards must provide rebates to consumers and employers. AB 2499 would improve upon existing medical loss ratio standards as follows: for the individual market from 80/20 to 85/15 and for the large group market from 85/15 to 90/10. The bill would also codify Obama-era regulations on MLR calculations that capture medical expenses, quality improvement activities, and administrative costs.

Trump Administration Plans to Lower MLR Standards

The Affordable Care Act (ACA) established minimum MLR standards for commercial health care plans and insurers: 80/20 for the individual market; 80/20 for the small group market; and 85/15 for the large group market. On November 2, 2017, the Centers for Medicare and Medicaid Services (CMS) published a proposed new rule[i] that would make it easier for states to apply to lower their MLR standards below current standards. The rule would also make changes to the calculation of MLRs and rebates by allowing more exceptions to the standard and by giving states the option on how to report or not report quality improvement activities. The proposed rule further gives states the discretion to decide how they want to set and calculate their MLR standards. Twenty-two states are expected to apply to lower their MLRs below the current threshold. Instead of offering a solution that stabilizes the market, the Trump Administration is reducing the value of coverage to consumers. California should do the exact opposite and instead improve upon our MLR standards.

Existing California law (SB 51, 2011) was adopted shortly after the ACA was enacted and before the federal MLR regulations finalized. As a result, state law defers entirely on federal regulations. Any future federal changes on MLRs, and as recently proposed by the Trump Administration, will automatically change California's MLR calculations. Due to this, California needs to codify our current MLR calculations in statute.

More Money for Health Care, Less for Insurers

Rising health care costs, especially health insurance premiums, continue to be a concern for consumers. The MLR standards have helped to curb excessive health insurer profits and administrative costs by capping these expenses, while at the same time guaranteeing that at least 80% or 85% of premiums go towards actual medical care and quality improvement activities.

The MLR standard provides a floor for how much insurers must spend on actual medical care. The vast majority of insurance companies meet this floor and most have actually well-surpassed these thresholds every year after ACA implementation. Insurers that do not meet the standard are required to refund the difference back to consumers. CMS has reported that insurers paid nearly $447 million in customer rebates for 2016 because they did not meet the MLR standard. Nationally in 2016, the average MLR was 92.9% in the individual market, 86.1% in the small group market, and 90.3% in the large group market.[ii]

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The California Solution: AB 2499 (Arambula) Improves the MLR Floor

The current MLR requirements have been in place since 2014, when the federal regulations were adopted. Similar to national data, most California health plans have exceeded the standards for most health insurance products in both the individual and employer markets. According to the Department of Managed Health Care and health plan data in 2016, all plans that offered coverage in the individual market met and exceeded the 80/20 MLR. Out of all plans that offered coverage in the small employer market, only one plan did not meet the 80/20 MLR. Similarly, only one plan in the large employer market did not meet the 85/15 MLR. The data shows that insurers have become more efficient by exceeding the MLR floor by far. At the same time, insurers have also continued to make billions in profits.

California Medical Loss Ratio Summary 2016[iii]

PLAN NAME	INDIVIDUAL	SMALL GROUP	LARGE GROUP
Aetna of California	n/a	89%	86.10%
Alameda Alliance for Health	n/a	n/a	80.80%
Blue Cross of California	85.10%	80.30%	89.30%
Blue Shield of California	82.70%	80%	90.2%
Chinese Community Health Plan	81.60%	87.40%	89.40%
Cigna of California	n/a	85.10%	96.10%
Community Care Health Plan	n/a	n/a	85.30%
County of Ventura	n/a	52.90%	98.80%
Health Net of California	82.90%	83.90%	92%
Kaiser Permanente	89.60%	92.20%	89.90%
LA Care/Joint Power Authority	106.70%	n/a	100.10%
Molina of California	85.50%	n/a	n/a
San Francisco Health Plan	n/a	n/a	100.20%
San Mateo Health Plan	n/a	n/a	115.20%
Santa Clara County Health Plan	93.70%	n/a	93.20%
Santa Cruz, Monterey Merced Managed Medicare Care Community Plan	n/a	n/a	108.20%
Sharp Health Plan	86.10%	95.60%	88.10%
Sutter Health Plan	n/a	96.50%	90.70%
United Health Care of California	113.30%	83.10%	89.40%
Western Health Advantage	94.70%	94.40%	94.40%

The MLR data demonstrates that California can and should raise the MLR requirements so that more money is spent on care and less on insurance company profits and overhead. Due to federal uncertainty, California should also codify existing MLR formula rules because it would ensure consumers are protected even when federal rules change. **AB 2499 (Arambula)** would change and improve existing standards from **80% to 85% in the individual market and from 85% to 90% in the large group market**. The bill would also preserve federal regulations that dictate what counts as medical expenses, losses, or quality improvement activities, and what counts as insurance company overhead and profit.

[i] Centers for Medicare and Medicaid Services, Health and Human Services Notice of Benefit and Payment Parameters for 2019.
[ii] Centers for Medicare and Medicaid Services, CCIIO, Summary of 2016 Medical Loss Ratio Results.
[iii] Department of Managed Health Care Services, HMO/Health Plan's Financial Statements.