



Consumers
for Quality Care

The Medical Loss Ratio Loophole: How Insurers Profit Through Vertical Integration

Medical Loss Ratio (MLR) was designed to protect consumers — a watchdog metric in ensuring that health insurers spend most of patients' premium dollars on their medical care and health care quality improvement and not administrative costs or profits. However, large insurer conglomerates who also own pharmacy benefit managers, provider groups, and others have found a way to turn a consumer protection tool into a profit-maximizing loophole.

What is the Medical Loss Ratio (MLR)?

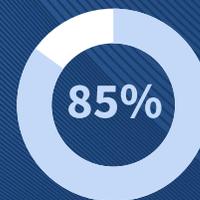
The MLR is the percent of your health care premium that must be spent on medical care and quality improvement activities.

¹This does not apply to self-insured plans. ²Unlike in the commercial market, insurers offering Medicare Advantage plans are not required to pay refunds to policyholders, but can be subject to remittances to CMS and in some cases contract sanctions or termination from Medicare. ³While MLR data must be reported, states do not have to collect rebates and have can apply refunds by population. Refunds paid are shared by the federal government and state governments.

Under the Affordable Care Act (ACA), insurers are required to spend:



IN THE INDIVIDUAL
AND SMALL GROUP MARKETS



IN THE LARGE¹
GROUP MARKET,
MEDICARE ADVANTAGE²,
AND MEDICAID MANAGED
CARE ORGANIZATIONS³

Generally, insurers that have more than 15 or 20 percent of premium dollars remaining after all patient care is paid for must return the additional premium spending back to patients in the form of a rebate or send the remainder to CMS in the case of Part D plans. Sounds fair, right?

How Vertical Integration Took Hold

Before implementation of the ACA, insurers were primarily focused on expanding and diversifying their health insurance operations. Today, three pharmacy benefit managers (PBMs) control 80 percent of all prescriptions dispensed in the US and are vertically integrated with the three largest health insurance companies.

Major insurers have vertically integrated to include not only PBMs, but also physician provider networks, mail-order and retail pharmacies, payment processors, specialty pharmacies, and even private label biosimilar manufacturers.

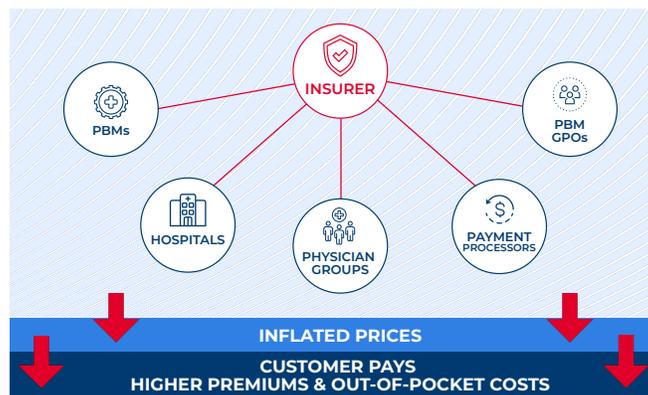
By using tactics like charging inflated prices for services and medications within their own networks, masking the true profitability of the business and boosting the MLR, insurers can claim a higher MLR, potentially avoiding consumer rebates as the inflated charges flow back to the parent company.

What is Vertical Integration?

Vertical integration is a business strategy in which a company takes ownership of two or more steps in the supply chain. In health care, this means an insurer might also own:

- Pharmacy Benefit Managers (PBMs)
- Physician groups
- Pharmacies (mail-order, retail, specialty)
- PBM Group Purchasing Organizations (PBM GPOs)
- Payment processors (e.g., Change Healthcare)

The strategy can streamline operations and reduce costs, but it also allows insurer conglomerates to profit at every step of the supply chain and steer patients toward their own businesses.



How Health Insurers Are Gaming the System



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Here's The Trick

In a vertically integrated organization, the insurer can pay its own PBMs, pharmacies, and providers for care provided to their members – effectively moving funds subject to MLR standards into parts of the company that are not required to meet the same rules. These inflated internal payments count toward the MLR, even though the money never really leaves the insurer's ecosystem. It's like paying yourself and calling it a business expense.

The result? Insurers appear to meet the MLR threshold, avoid issuing rebates to customers or reducing premiums, and keep profits flowing – with no benefit at all to the customer. In fact, due to vertical integration, customers can end up with higher premiums and higher out-of-pocket costs. All while the insurer is *technically* meeting the required spending ratio.

Any practical person can see that this perverts the system and means more money for insurers – less protections for patients.

What This Means for Consumers

Vertical integration has reshaped the health care landscape – and not in patients' favor. Health care costs keep growing as consumers carry the burden of rising premiums, deductibles, and out-of-pocket costs, as well as increasing insurer restrictions on the use of money-saving coupons for prescription medicines. MLR is meant to ensure consumers get the value they are paying so dearly for and that insurers are held accountable for their spending.

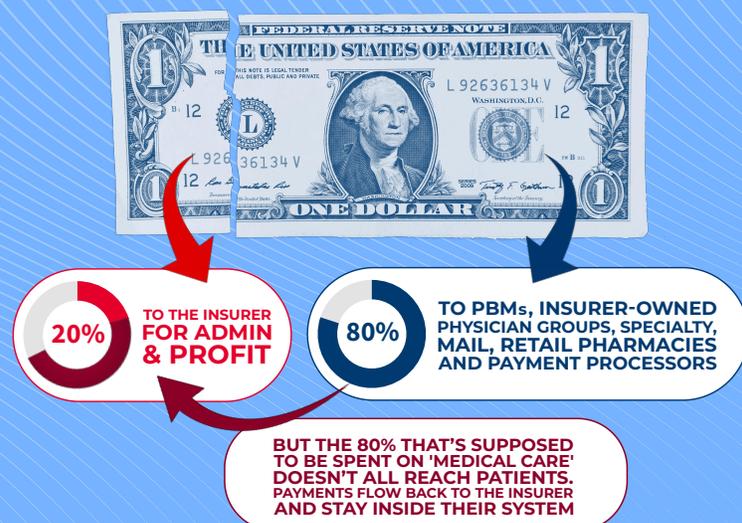
By consolidating services along the health care supply chain, insurers are leaving consumers with higher premiums and deductibles, more restrictions on using cost-saving tools like drug coupons, delays in care due to prior authorization and step therapy, limited choices as independent providers are squeezed out, and more.



THEN VS. NOW: A Tale of Two Dollars

The MLR was meant to ensure that a significant percentage of consumer premium dollars went to patient care. Any remaining premiums not utilized were returned to consumers through rebates or premium reductions. But then vertical integration caught steam as a way to keep the money flowing into insurance companies.

NOW WHERE THE 80% REALLY GOES...



IT LOOKS LIKE CARE SPENDING,
BUT IT'S REALLY PROFIT IN DISGUISE.

The MLR was meant to ensure value. Instead, it has become a shell game – with insurers driving profits by moving money within their own empires while consumers foot the bill.