

HOW ONE GOVERNMENT REGULATION INCENTIVIZES HEALTH INSURANCE COMPANIES TO INCREASE COSTS

Gadai Bulgac, Research Assistant
November 17, 2025

Background

People are struggling because of rising medical costs and health insurance premiums. Lawmakers have attempted to address this with legislation and regulation, including the misnamed “Affordable Care Act” (ACA, “Obamacare”), which made healthcare less affordable. One provision of the ACA, the [Medical Loss Ratio](#) (MLR) rule, has contributed to the inflation of medical costs.

The [MLR rule](#) requires that a minimum of 80% (for individual and small group plans) or 85% (for large group plans) of total collected premium dollars must be spent on medical costs or healthcare quality improvements.

The intent of this policy was to reduce costs and how much insurers can profit off of the government, but it had an unintended side effect: it made prices go up dramatically.

If insurance companies spend less than the MLR on medical costs, they have to issue rebates to consumers in the amount that they “overcharged.” The MLR rule does not include administrative costs, which have to be covered by the remaining 15% or 20% of premium dollars.

MLR also applies to some other federal healthcare programs such as Medicare Advantage and Medicare Part D prescription plans, but does not apply to self-funded plans such as employer-sponsored insurance.

How It Should Work

Before explaining how MLR makes prices go up, we must look at how an actually free market would operate. In a free market, businesses have two ways to increase profits: cut costs or increase their overall revenue. This incentivizes businesses to offer quality products and reduce their expenses in a competitive market.

Under regular free market forces, companies must compete for customers, so cost reductions are often passed onto consumers in the form of price cuts. This can be seen in [less regulated markets](#) such as televisions, computer software, and cellphone service which have seen [prices fall](#) over time alongside decreasing regulation.

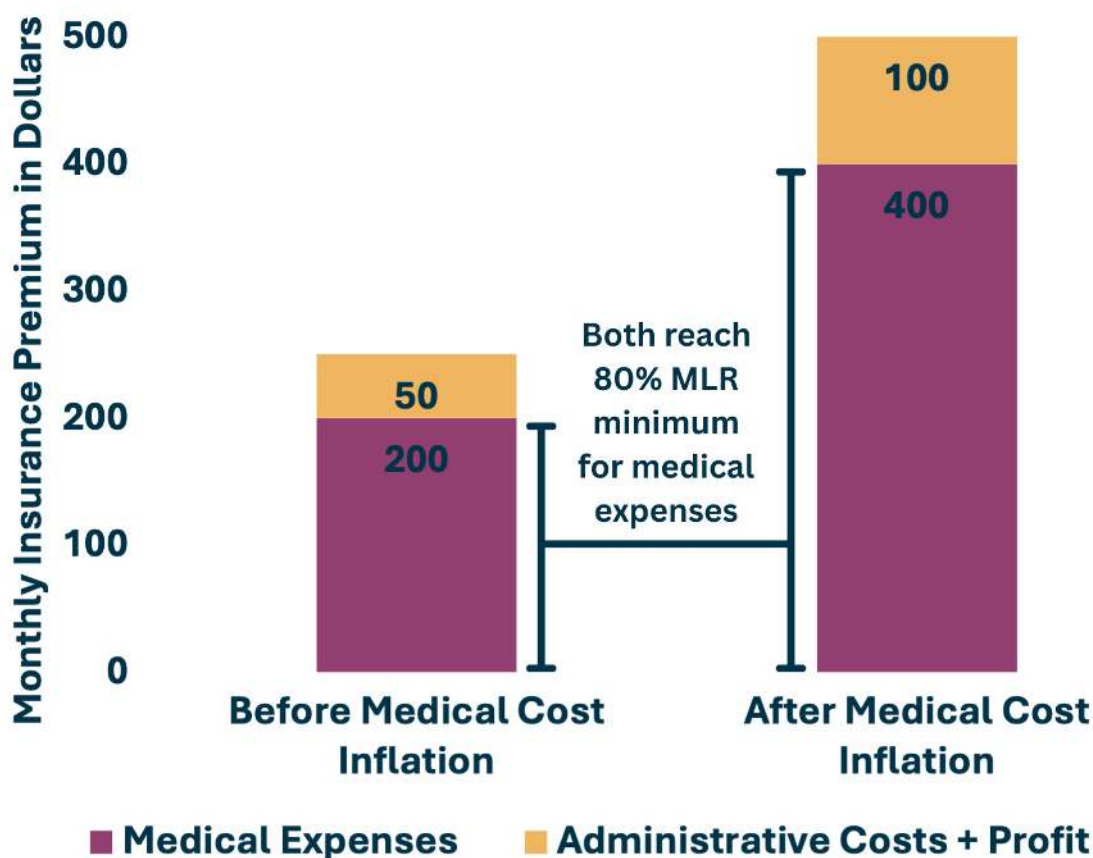
MLR completely removes this incentive to cut costs.

How MLR Incentivizes Medical Cost Increases

If insurers have to provide rebates on the money they save from cutting medical costs below the MLR minimum, then they have no real incentive to control costs. In fact, by establishing a minimum that insurance companies have to spend on medical expenses, the MLR rule actually incentivizes them to increase costs. If medical expenses grow, insurance companies can charge higher premiums and generate more revenue, and therefore profit, on the remaining portion of non-MLR premium dollars.

Say, for example, that a person is paying \$250 a month in premiums for an Obamacare plan. Under MLR, \$200 has to go towards medical expenses, and the remaining \$50 can go towards administrative expenses and profit. If medical costs double to \$400 a month, the company can charge \$500 a month and have \$100 left over for profit and administrative expenses instead of \$50.

How Insurance Companies Profit From Higher Medical Costs



Insurance companies then have less incentive to regulate how many procedures healthcare providers perform, as more procedures and diagnostics drives up medical

costs to the MLR limit to ensure insurers won't have to give rebates. Insurers also don't need to negotiate prices down on pharmaceuticals because higher prices allow them to hit the MLR limit and they make more money if patients have to pay more.

It is no wonder, then, that premiums have historically been increasing at a rapid pace. In many cases, it is the taxpayer that is left holding the bag for medical cost inflation, as the government subsidizes a significant portion of enrollees' premiums and thereby insurance companies' bottom lines.

Insurance Companies Gaming the MLR System

The problem compounds if an insurer owns the healthcare provider location and/or the pharmacy where their patients fill their prescriptions, which would make them "vertically integrated," meaning they control multiple parts of the supply chain. MLR has exacerbated this consolidation of the healthcare market by the big insurance companies.

Insurers can prescribe diagnostics, drugs, and treatments to their patients at the hospitals they own, and then they can set the prices for those prescribed procedures and, as well as the prices for prescribed drugs at the pharmacies that they also own. This allows them to increase prices at will in order to reach their revenue and MLR targets.

UnitedHealth Group, the nation's largest health insurer, is also the largest employer of physicians. More than 90,000 physicians, about 10% of American doctors, are employed by or affiliated with UnitedHealth Group, including through its Optum Health division. One study found that UnitedHealthcare pays Optum providers 17% more than non-Optum providers (and even higher in markets where UnitedHealthcare has larger market share).

CVS Health and Cigna, both vertically integrated insurance companies, charged 24 and 27 times more on average, respectively, for a number of specialty drugs at their pharmacies than their competitors. They could not only claim the higher cost of the drugs as medical expenses but also profit off the large difference in their price versus the actual cost of the drug.

One particularly egregious example was CVS Health and the cancer drug Gleevec. They charged \$17,710 for a 30-day supply of the drug, while competitor Cost Plus Drugs charged \$72 for a 30-day supply of the generic version of the same drug. That \$17,000 difference can be recorded as a medical expense and pocketed as internal revenue, moving money from the insurance side of the corporation to the pharmacy side under the MLR setup.

Another strategy insurers use to game the system to reach MLR targets is "quality improvements," which are considered medical expenses for the purposes of calculating MLR. A broad variety of activities can be considered quality improvements, including

“wellness and health promotion activities,” or “enhanc[ing] health information technology.”

These quality improvements can have a positive effect on patient outcomes, but spending will often surge if a particular company underestimated its projected medical expenses and needs to increase them to hit the MLR minimum for the year.

Steps to Reform

Public policy must not be measured on intentions, but on outcomes. The MLR rule may have been intended to control how much health insurance companies would profit from premiums, but it has instead contributed to rising costs.

To reduce healthcare costs, lawmakers should eliminate the MLR and other burdensome and ill-conceived regulations.

Congress should also reduce the government’s involvement in healthcare as subsidies, mandates, and regulations have only made costs and outcomes worse for patients and taxpayers alike.