A Dynamic Medical Loss Ratio

Dual Indexing to Medical and General Inflation

currant

Introduction

Imagine hiring a contractor to oversee a home renovation and paying him 20% of total project costs. If the price of specialized labor or lumber doubles, the contractor's fee doubles automatically — even if the scope of work, staffing, and effort remain unchanged. Under this arrangement, the contractor has little incentive to negotiate with subcontractors or suppliers; in fact, the contractor is financially rewarded for the cost increases he is expected to manage.

Under the Affordable Care Act (ACA), the medical loss ratio (MLR) limits how much insurers can spend on administration and profit. Insurers are required to spend a fixed percentage of premium dollars on medical care and quality improvement, with the remainder available for the administrative allowance — the portion covering corporate overhead, marketing, and profit. This requirement sets a minimum for medical spending and a maximum for administrative costs — two sides of the same rule.

Health insurance premiums are rising across both the ACA Marketplaces and the employer-sponsored market. In rate filings and actuarial trend projections, insurers largely attribute these increases to higher medical costs — driven by rising provider prices, increasing utilization, and growing specialty drug spending. These explanations have focused attention on the affordability consequences of premium growth. What has received far less attention is how the MLR allocates those increases. When medical costs push premiums up, the MLR automatically increases the dollars available for administration — even if rent, salaries, and IT costs have not changed.

The legislative design of the medical loss ratio

The 80% and 85% thresholds

Market Segment	MLR Requirement	Maximum Administrative Share
Individual / Small Group	80%	20%
Large Group	85%	15%

Design and intent

The thresholds established by Section 2718 of the ACA were designed to promote transparency and value by ensuring that a substantial portion of premium dollars is directed toward clinical care and quality improvement. The goal was consumer protection: ensuring premiums finance care rather than overhead, especially when supported by federal subsidies.

Lawmakers sought to achieve these protections without destabilizing insurance markets or undermining insurer participation and competition. Legislative history indicates that the ACA's 80% and 85% MLR thresholds reflect policymakers' recognition that large-group markets achieve greater economies of scale, resulting in lower per-member administrative costs than those observed in individual and small-group markets. The lower 80% threshold for individual and small-group coverage accommodates higher fixed administrative costs in retail markets.

Why a static percentage creates problems

The application of a static percentage has produced unintended consequences as medical and nonmedical costs increasingly diverge.

- Inflationary "passenger effect": Under a fixed-percentage MLR, the administrative component is defined as a constant share of premium (15% or 20%). As premiums rise, allowable administrative dollars rise mechanically in dollar terms — even if administrative input costs do not increase at the same rate. This creates a structural linkage between medical-cost-driven premium growth and administrative allowance growth, rather than a linkage to the underlying cost dynamics of administration. The result is a mechanical linkage between medical-cost-driven premium growth and administrative allowance growth, rather than a linkage to actual administrative cost dynamics.
- Asymmetric incentives: Because the administrative allowance scales with medical spending, rising medical costs increase the dollar amount available for operations — weakening the insurer's incentive to constrain medical prices. Conversely, reductions in medical spending reduce administrative dollars, creating a disincentive to aggressive cost management.
- Countercyclical squeeze: When general inflation outpaces medical inflation, the problem reverses. Nonmedical costs like wages, technology, and regulatory compliance rise, but the administrative allowance does not increase to match. This can squeeze margins regardless of efficiency, threatening participation in the very markets the MLR was designed to protect.

The proposed fix: the Dynamic MLR

The Dynamic MLR solves this problem by indexing administrative spending to general inflation and medical spending to medical inflation. This decouples the two, eliminating the automatic administrative growth that occurs under current rules.

Mechanics of the formula

The Dynamic MLR replaces a fixed percentage with an efficiency standard that updates annually based on actual spending and inflation. The model begins with the insurer's observed cost structure in the prior year, then adjusts each component forward using the inflation index most closely associated with that cost category.

The Dynamic MLR threshold for year *t* is:

$$MLR_t = \frac{S_{med,t-1} \times (1 + i_{m,t})}{[S_{med,t-1} \times (1 + i_{m,t})] + [S_{admin,t-1} \times (1 + i_{g,t})]}$$

where:

- $S_{med,t-1}$ denotes medical spending in the prior year
- $S_{admin,t-1}$ denotes administrative spending in the prior year
- $i_{m,t}$ denotes the medical inflation rate applied in year *t*
- $i_{g,t}$ denotes the general inflation rate applied in year *t*

The numerator is prior-year medical spending grown by medical inflation. The denominator is total spending: prior-year medical spending grown by medical inflation plus prior-year administrative spending grown by general inflation.

Application of the formula begins with baseline-year spending, which is split into medical and administrative components. In subsequent years, these components are inflated separately using their respective inflation indices, not reallocated based on any fixed-percentage threshold.

Alternatively, this can be expressed as a recursive formula using the prior-year MLR:

$$MLR_t = \frac{m_{t-1}(1 + i_{m,t})}{m_{t-1}(1 + i_{m,t}) + (1 - m_{t-1})(1 + i_{g,t})}$$

This expression is algebraically equivalent to the spending component-based definition above and yields the same result.

Because medical and administrative spending use different inflation measures, the threshold adjusts in both directions. When medical inflation outpaces general inflation, the threshold rises; when general inflation exceeds medical inflation, the threshold falls. In this way, the Dynamic MLR moves up or down based on the relationship between medical and general inflation rather than remaining fixed.

Path dependence and symmetric adjustment

The Dynamic MLR operates as a recursive function in which each year's threshold is calculated from the prior year's cost structure, creating a path-dependent efficiency standard. Unlike reforms that only tighten requirements, this provides symmetric protection across economic conditions. When medical inflation outpaces general inflation, the threshold rises, preventing administrative margins from expanding as a byproduct of rising care costs. Conversely, when general inflation exceeds medical inflation, the threshold relaxes, preventing insurers from being squeezed by rising nonmedical operating costs. In both cases, the outcomes are governed by underlying inflation dynamics rather than by a static percentage cap.

Regulatory precedents for inflation indexing

Inflation indexing is not common in federal health regulation but has been adopted where static thresholds would distort incentives or lose real economic value. These precedents are notable precisely because they rely on explicit, mechanical indexing rather than discretionary or periodic updates.

The Inflation Reduction Act's Medicare prescription-drug inflation rebate is one such precedent. Manufacturers must pay rebates when drug prices rise faster than general inflation (measured by CPI-U all items). By indexing allowable price growth to inflation, the policy ensures manufacturers bear real price increases rather than beneficiaries or taxpayers. This addresses nominal drift by linking financial consequences to an economic benchmark rather than a fixed statutory threshold.

A second precedent appears in the Stark Law's physician self-referral prohibitions, where financial thresholds and penalty amounts are explicitly indexed to CPI-U all items by CMS. This indexing prevents enforcement thresholds and penalty amounts from losing real value over time as prices rise. In this context, inflation indexing serves an administrative and fairness function: preserving the real economic significance of regulatory limits without requiring frequent statutory revision.

These precedents demonstrate that inflation indexing is an established regulatory tool in health policy, used strategically where fixed nominal thresholds would distort incentives or lose real economic value over time. The Dynamic MLR builds on this same principle, extending it to a domain in which static percentage thresholds similarly interact poorly with divergent inflation trends.

Alternative approaches to MLR reform

Policymakers and analysts have proposed various ways to fix how the MLR currently works. These approaches differ in their mechanisms and intended effects, but most operate within the fixed-percentage structure established by the ACA. Most reforms tighten thresholds, refine definitions, or limit accounting practices. None change how administrative spending responds to divergent inflation.

One set of proposals would raise MLR thresholds, either once or incrementally over time. These approaches are intended to deliver immediate or ongoing reductions in allowable administrative spending. However, they retain the same fixed relationship between medical spending and the administrative allowance, leaving the framework insensitive to whether medical and nonmedical costs are rising at different rates.

Other proposals tighten what counts as medical or quality-improvement spending. These reforms aim to improve reporting integrity and reduce reclassification of administrative activities, but they do not alter the underlying mechanics that link administrative allowances to medical-spending growth.

Other reforms would restrict how vertically integrated insurers account for payments to affiliated entities and pharmacy rebates. These approaches are designed to address consolidation-related concerns and prevent insurers from meeting MLR requirements through internal transfers rather than through actual medical spending. While important for governance and transparency, they do not engage with how the administrative allowance responds to broader economic conditions.

Taken together, these approaches illustrate the range of incremental adjustments that have been considered within the existing MLR structure. Table 1 compares the enacted MLR framework with proposed reforms and the Dynamic MLR, showing how each approach responds to divergent inflation trends.

Table 1: Enacted and proposed approaches to medical loss ratio policy

Approach	How it Works	Adjusts for Divergent Inflation?
Currently Enacted MLR (80%/85%)	Requires insurers to spend a fixed minimum percentage of premiums on medical care and quality improvement	No
One-Time Threshold Increase	Raises statutory MLR floors once (e.g., 82%/87%)	No
Fixed Ratchet Increases	Automatically increases MLR thresholds on a set schedule	No
Quality Improvement (QI) Definition Tightening	Prevents reclassification of administrative costs as medical or QI spending	No
Vertical Integration / Rebate Adjustments	Limits how payments to affiliated entities count under the MLR	No
Currant's Dynamic MLR	Indexes medical spending and administrative allowances to distinct inflation rates	Yes

How the Dynamic MLR could have performed

The Dynamic MLR framework is applied retrospectively to observed premiums across three markets: the individual ACA Marketplace, the small-group employer market, and the large-group employer market. For each market, observed premiums are compared to counterfactual premiums implied by the Dynamic MLR, holding medical spending constant, with the difference reported as an annual efficiency dividend.

All calculations follow the methodology described above. Dynamic MLR values are calculated using full precision and displayed to four decimal places. Counterfactual premiums and dividends are rounded to cents for presentation.

Data sources

Premium data come from the KFF.

- ACA Marketplace: National average benchmark premiums (second-lowest-cost silver plan) for a 40-year-old, weighted by county plan offerings
- Employer-sponsored insurance: All-plans average premiums by employer size — small-group premiums reflect employers with 10–199 workers, and large-group premiums reflect employers with 200 or more workers

Medical inflation and general inflation are measured using the CPI-U medical care component and CPI-U all items, respectively, as reported by the U.S. Bureau of Labor Statistics.

Dynamic MLR trajectories

Table 2 reports medical and general inflation values over time.

Table 2: The Dynamic MLR economic index (2011–2025)

Year	Medical Care CPI	General CPI-U	Economic Context
2011	3.5%	3.2%	Anchor year: ACA MLR takes effect
2012	3.2%	2.1%	Divergence: Medical inflation leads
2013	2.0%	1.5%	Stable growth: Low inflation globally
2014	3.0%	1.6%	Widening gap: Medical inflation surges
2015	2.6%	0.1%	Energy deflation: Suppressed general CPI
2016	3.9%	1.3%	Peak spread: Maximum administrative drift
2017	1.8%	2.1%	Convergence: Indices align
2018	2.1%	2.4%	General lead: Business costs rise
2019	4.5%	1.8%	Care spike: Sharp increase in services
2020	1.8%	1.2%	Pandemic: Suppressed service volume
2021	2.2%	4.7%	Recovery: Post-pandemic inflation begins
2022	3.9%	8.0%	Historical reversal: High business costs
2023	0.4%	4.1%	Contractual lag: Medical rate drops
2024	2.8%	2.9%	Normalization: Parity returns
2025	3.2%	2.7%	Stabilization: Parity maintained

Example calculation

Consider a small-group family plan in 2012 with a premium of $15,465. Applying the statutory 80 percent MLR implies medical spending of $12,372. Using the Dynamic MLR for 2012 (0.801709), the counterfactual premium that would generate the same medical spending is $15,432.03. The difference — $32.97 — represents the annual dividend.

1. Split the 2011 premium into spending components:

   $S_{med,2011}$ = 0.80 x $14,460 = $11,568

   $S_{admin,2011}$ = 0.20 x $14,460 = $2,892

2. Inflate each component to 2012 values:

   $S_{med,2011}S_{med,2011}(1 + i_{m,2012})$ = $11,568 x (1 + 0.032) = $11,938.18

   $S_{admin,2011}(1 + i_{g,2012})$ = $2,892 x (1 + 0.021) = $2,952.73

3. Calculate the 2012 Dynamic MLR:

   We apply 2012 indices to the 2011 components to find the new efficiency floor:

$$MLR_{2012} = \frac{\$11{,}568 \cdot (1 + 0.032)}{\$11{,}568 \cdot (1 + 0.032) + \$2{,}892 \cdot (1 + 0.021)} = 0.801709 \ldots \approx 0.8017$$

   Alternatively:

$$MLR_{2012} = \frac{0.80 \cdot (1 + 0.032)}{0.80 \cdot (1 + 0.032) + 0.20 \cdot (1 + 0.021)} = 0.801709 \ldots \approx 0.8017$$

4. Calculate the 2012 counterfactual premium:

   We apply the Dynamic MLR to the actual medical spend of the current year to find what the premium should have been under the efficiency standard:

$$P_{2012}^{cf} = \frac{0.80 \cdot \$15{,}465}{0.801709 \ldots} = \$15{,}432.03$$

5. Identify the savings:

   The difference between the actual premium ($15,465) and the counterfactual premium ($15,432.03) yields the $32.97 per-member saving for 2012.

ACA Marketplace

Table 3 reports observed ACA Marketplace benchmark premiums, counterfactual premiums implied by the Dynamic MLR, and resulting annual dividends for single coverage from 2014 through 2025. From 2014 through 2022, counterfactual premiums are lower than observed premiums in most years, resulting in positive annual dividends. From 2023 through 2025, counterfactual premiums exceed observed premiums, producing small negative annual dividends.

Table 3: ACA Marketplace benchmark (second-lowest-cost silver) premiums, counterfactual premiums, and annual dividends, 2014–2025

Year	Dynamic MLR	Actual Premium	Counterfactual Premium	Dividend
2014	0.800	$ 3,276.00	$ 3,276.00	$ -
2015	0.804	$ 3,312.00	$ 3,295.86	$ 16.14
2016	0.808	$ 3,588.00	$ 3,552.99	$ 35.01
2017	0.807	$ 4,308.00	$ 4,268.39	$ 39.61
2018	0.807	$ 5,772.00	$ 5,722.16	$ 49.84
2019	0.811	$ 5,736.00	$ 5,658.11	$ 77.89
2020	0.812	$ 5,544.00	$ 5,462.63	$ 81.37
2021	0.808	$ 5,424.00	$ 5,368.98	$ 55.02
2022	0.802	$ 5,256.00	$ 5,242.06	$ 13.94
2023	0.796	$ 5,472.00	$ 5,497.28	$ (25.28)
2024	0.796	$ 5,724.00	$ 5,751.58	$ (27.58)
2025	0.797	$ 7,500.00	$ 7,528.70	$ (28.70)

Note: ACA Marketplace analysis uses individual coverage premiums for a 40-year-old purchasing the second-lowest-cost silver plan (the benchmark premium), which KFF tracks as the standardized benchmark from 2014-2025. Family coverage is available through the Marketplace, but a comparable historical family premium series is not published.

Small-group market

Table 4 presents results for the small-group employer market from 2011 through 2025, separately for single and family coverage. For both coverage types, counterfactual premiums are lower than observed premiums in most years, yielding positive annual dividends. Annual dividends are generally larger for family coverage than for single coverage.

Table 4: Small-group market (employers with 10–199 workers) premiums, counterfactual premiums and annual dividends, 2011–2025

		Single			Family		
Year	Dynamic MLR	Actual Premium	Counterfactual Premium	Dividend	Actual Premium	Counterfactual Premium	Dividend
2011	80.00%	$ 5,336.00	$ 5,336.00	$ -	$ 14,460.00	$ 14,460.00	$ -
2012	80.17%	$ 5,602.00	$ 5,590.06	$ 11.94	$ 15,465.00	$ 15,432.03	$ 32.97
2013	80.25%	$ 5,696.00	$ 5,678.33	$ 17.67	$ 15,573.00	$ 15,524.70	$ 48.30
2014	80.46%	$ 5,792.00	$ 5,758.53	$ 33.47	$ 16,159.00	$ 16,065.63	$ 93.37
2015	80.85%	$ 6,178.00	$ 6,113.07	$ 64.93	$ 16,977.00	$ 16,798.56	$ 178.44
2016	81.24%	$ 6,489.00	$ 6,390.03	$ 98.97	$ 17,753.00	$ 17,482.23	$ 270.77
2017	81.19%	$ 6,485.00	$ 6,389.62	$ 95.38	$ 17,883.00	$ 17,619.98	$ 263.02
2018	81.15%	$ 6,812.00	$ 6,715.52	$ 96.48	$ 19,008.00	$ 18,738.78	$ 269.22
2019	81.55%	$ 7,114.00	$ 6,979.08	$ 134.92	$ 20,449.00	$ 20,061.19	$ 387.81
2020	81.64%	$ 7,564.00	$ 7,412.48	$ 151.52	$ 20,616.00	$ 20,203.02	$ 412.98
2021	81.27%	$ 7,699.00	$ 7,578.67	$ 120.33	$ 21,598.00	$ 21,260.43	$ 337.57
2022	80.67%	$ 7,950.00	$ 7,883.58	$ 66.42	$ 21,960.00	$ 21,776.54	$ 183.46
2023	80.10%	$ 8,645.00	$ 8,633.83	$ 11.17	$ 23,481.00	$ 23,450.67	$ 30.33
2024	80.09%	$ 9,003.00	$ 8,993.11	$ 9.89	$ 25,168.00	$ 25,140.36	$ 27.64
2025	80.17%	$ 9,211.00	$ 9,192.01	$ 18.99	$ 26,054.00	$ 26,000.28	$ 53.72

Large-group market

Table 5 reports results for the large-group employer market from 2011 through 2025, distinguishing between single and family coverage. Counterfactual premiums are lower than observed premiums in most years, producing positive annual dividends.

Table 5: Large-group market (employers with 200+ workers) premiums, counterfactual premiums, and annual dividends, 2011–2025

		Single			Family		
Year	Dynamic MLR	Actual Premium	Counterfactual Premium	Dividend	Actual Premium	Counterfactual Premium	Dividend
2011	0.850	$ 5,477.00	$ 5,477.00	$ -	$ 15,520.00	$ 15,520.00	$ -
2012	0.851	$ 5,628.00	$ 5,619.00	$ 9.00	$ 15,980.00	$ 15,954.45	$ 25.55
2013	0.852	$ 5,967.00	$ 5,953.12	$ 13.88	$ 16,715.00	$ 16,676.12	$ 38.88
2014	0.854	$ 6,130.00	$ 6,103.44	$ 26.56	$ 17,265.00	$ 17,190.18	$ 74.82
2015	0.857	$ 6,289.00	$ 6,239.42	$ 49.58	$ 17,938.00	$ 17,796.60	$ 141.40
2016	0.860	$ 6,438.00	$ 6,364.35	$ 73.65	$ 18,395.00	$ 18,184.58	$ 210.42
2017	0.859	$ 6,776.00	$ 6,701.25	$ 74.75	$ 19,235.00	$ 19,022.82	$ 212.18
2018	0.859	$ 6,930.00	$ 6,856.39	$ 73.61	$ 19,972.00	$ 19,759.85	$ 212.15
2019	0.862	$ 7,175.00	$ 7,072.94	$ 102.06	$ 20,717.00	$ 20,422.33	$ 294.67
2020	0.863	$ 7,466.00	$ 7,353.83	$ 112.17	$ 21,691.00	$ 21,365.12	$ 325.88
2021	0.860	$ 7,709.00	$ 7,618.63	$ 90.37	$ 22,389.00	$ 22,126.55	$ 262.45
2022	0.855	$ 7,873.00	$ 7,823.67	$ 49.33	$ 22,564.00	$ 22,422.62	$ 141.38
2023	0.851	$ 8,321.00	$ 8,312.94	$ 8.06	$ 24,104.00	$ 24,080.65	$ 23.35
2024	0.851	$ 8,884.00	$ 8,876.68	$ 7.32	$ 25,719.00	$ 25,697.82	$ 21.18
2025	0.851	$ 9,361.00	$ 9,346.52	$ 14.48	$ 27,280.00	$ 27,237.81	$ 42.19

Adjusting dividends to constant 2025 dollars

Annual dividends are converted to constant 2025 dollars for comparison across years. The time-adjusted dividend is:

$$\overline{D}_t = D_t \times Multiplier_t$$

where:

- $\overline{D}_t$ denotes the dividend from year *t* expressed in 2025 purchasing power
- D_t denotes the nominal dividend in year *t*
- $Multiplier_t$ adjusts for cumulative inflation from year t to 2025

Calculating the inflation multipliers

The multiplier for each year reflects cumulative general inflation (CPI-U all items) from that year through 2025. It is calculated by compounding the annual inflation rates:

$$Multiplier_t = \left(1 + i_{(g,t+1)}\right) \times \left(1 + i_{(g,t+2)}\right) \times \ldots \times \left(1 + i_{(g,2025)}\right)$$

For example, the 2012 multiplier compounds inflation from 2013 through 2025:

(1.015) × (1.016) × (1.001) × (1.013) × (1.021) × (1.024) × (1.018) × (1.012) × (1.047) × (1.080) × (1.041) × (1.029) × (1.027) = 1.401

This means $1.00 in 2012 had the same purchasing power as $1.40 in 2025.

Table 6 reports the inflation adjustment factors used to convert nominal dividends into 2025-equivalent dollars.

Table 6: Inflation adjustment factors (to 2025 dollars)

Year	Multiplier
2012	1.401
2013	1.381
2014	1.359
2015	1.357
2016	1.340
2017	1.313
2018	1.281
2019	1.258
2020	1.243
2021	1.187
2022	1.099
2023	1.056
2024	1.025
2025	1.000

Illustrative example: 2012 small-group family adjustment

The following shows how nominal 2012 savings are adjusted to 2025 purchasing power:

1. Identify the 2012 small-group family dividend: $32.97 (from Table 4)
2. Identify the 2012 multiplier: 1.401 (from Table 6)
3. Calculate the adjusted dividend: $32.97 x 1.401 = $46.19

Cumulative efficiency dividends (adjusted for inflation)

Table 7 aggregates annual dividends across years to report cumulative nominal dividends and cumulative time-adjusted dividends (2025-equivalent dollars) for each market and coverage type. In the individual Marketplace, cumulative values reflect the 2014–2025 period. In the employer market, cumulative values reflect the 2011–2025 period, with dividends computed relative to the 2011 baseline.

Table 7: Cumulative efficiency dividends (nominal and 2025-equivalent), by market and coverage type

Market	Coverage Type	Nominal Dividend Sum	Time-Adjusted Sum
Marketplace	Single	$287.26	$380.76
Small Group	Single	$932.08	$1,170.99
	Family	$2,589.60	$3,252.57
Large Group	Single	$704.82	$886.08
	Family	$2,026.50	$2,546.59

Illustrative examples across market segments

Hypothetical examples illustrate the counterfactual cumulative savings if the Dynamic MLR had been implemented in 2011 using the ACA statutory thresholds as the initial baseline:

- ACA Marketplace individual purchaser: An individual continuously enrolled in benchmark silver coverage from 2014–2025 would have accumulated $918.42 in savings (2025 dollars). This assumes a 40-year-old purchasing the second-lowest-cost silver plan, consistent with the standardized benchmark used in Table 3.
- Cohort A (25-person small group). With 15 single employees and 10 families covered, this company saves $50,091 in 2025 dollars.
- Cohort B (150-person mid-market business). With an enrollment mix of 90 single employees and 60 family enrollments, this company captures $300,543 in 2025 dollars.
- Cohort C (500-person large employer): With an enrollment mix of 300 single employees and 200 family enrollments, this company would have captured $816,922 in cumulative savings (2025 dollars) under the Dynamic MLR framework over the 2011–2025 period.

Discussion

What the results show across markets

The Dynamic MLR would have affected premiums differently across markets. In employer markets, small-group savings consistently exceed large-group savings. The small-group administrative allowance (20%) is 33% larger than the large-group allowance (15%), producing proportionally larger efficiency dividends: $1,254.91 versus $941.52 for single coverage (2025 dollars). This difference reflects the statutory threshold structure, not variation in underlying market dynamics. The Marketplace pattern illustrates the framework's symmetric adjustment mechanism. From 2014 through 2022, positive cumulative dividends totaled $918.42 per individual as medical inflation outpaced general inflation. In 2023–2025, when general inflation surged and outpaced medical inflation, the threshold fell below 80%, producing $81.56 in negative dividends. This symmetry has consumer-protection implications: By permitting larger administrative allowances when operating costs rise, the Dynamic MLR would have reduced pressure on insurer margins during a period when some insurers exited markets due to unfavorable economics.

Gradual adjustment through lagged indexing

The Dynamic MLR's recursive structure creates built-in stability by smoothing year-to-year adjustments. Because each year's threshold is calculated from the prior year's observed cost structure, changes occur gradually rather than immediately in response to current-year shocks. A sudden spike in medical costs or administrative expenses affects the threshold in the following year, not instantly — dampening volatility and reducing the risk of sharp, disruptive swings for insurers and purchasers.

This gradual adjustment is a stabilizing feature with a tradeoff: the formula responds to cost pressures with a one-year lag rather than in real time. Importantly, while the lag slows the magnitude of adjustment, it does not affect the direction. The threshold still responds correctly to current-year inflation differentials — rising when medical inflation exceeds general inflation, falling when the reverse occurs. The recursive structure delays how much the threshold moves, not whether it moves in the right direction.

The recursive design prioritizes predictable, incremental change over immediate responsiveness.

Dependence on the starting threshold

This analysis uses the ACA's statutory thresholds as baseline starting points because they reflect the regulatory framework in place in 2011, though this is not meant to imply that these are the correct or optimal levels. Different starting thresholds would produce different savings estimates.

The Dynamic MLR formula works with any starting threshold. If implemented, policymakers could set initial thresholds based on updated evidence about administrative costs, market conditions, affordability or insurer participation goals, or other policy considerations. This analysis demonstrates how the inflation-indexing mechanism behaves rather than prescribing specific threshold values.

Choice of inflation indices

The Dynamic MLR formula indexes the medical side using medical inflation (price growth) rather than medical spending growth (which combines price, utilization, and case mix). This deliberate choice aligns the medical-side measure with the general inflation benchmark used on the administrative side.

Using medical-spending growth would introduce utilization and case-mix effects into threshold updates, causing the threshold to move not only when prices change, but also when service use changes due to utilization rebounds, coding and intensity shifts, or other claims-cycle dynamics. While that broader response may be a good fit with other policy objectives, it is not the goal here.

A spending-growth variant could be considered in future work, though it would require additional design decisions, including whether the administrative side should also use a measure of administrative cost growth. The inflation-based approach is simpler, more transparent, and more directly addresses the policy goal of correcting inflation-related drift in a fixed-percentage rule.

The Dynamic MLR formula indexes administrative spending to CPI-U all items — a reasonable benchmark because it is public, transparent, and commonly used in public policy. This simplifies implementation and oversight compared to proprietary or insurer-specific measures.

No dedicated price index currently exists for health insurer administrative costs (or health care administrative costs more broadly). Policymakers could refine the administrative index over time as evidence strengthens — for example, using a composite index that weights specific cost drivers such as wages, IT systems, regulatory compliance, and claims processing.

The core contribution of the Dynamic MLR is its indexing design: it treats medical and administrative cost growth as separate trends and updates each with its own index logic. The goal is to reduce drift from a fixed-percentage rule, not to lock in one permanent pair of indices. If better measures become available, the same design can use different indices, as long as they are transparent, reproducible, and clearly aligned with the policy goal.

Implementation pathways across markets

Implementing the Dynamic MLR in commercial markets (individual, small-group, and large-group) would require amending federal law and issuing regulatory updates.

The Dynamic MLR could similarly be applied to Medicare Advantage, Medicare Part D, and Medicaid managed care. In Medicare Advantage and Part D, implementation would require congressional action and regulatory updates. In Medicaid managed care, it would require federal rulemaking and state implementation.

Conclusion

The MLR was designed to ensure premium dollars finance care rather than overhead. But a fixed-percentage threshold creates an unintended consequence: When medical costs rise faster than administrative costs, the dollar allowance for administration grows automatically — even when insurers' actual operating expenses have not changed. This rewards insurers for the cost pressures they're supposed to manage.

The Dynamic MLR eliminates this distortion by indexing each cost category to its appropriate inflation measure. Medical spending adjusts with medical inflation; administrative spending adjusts with general inflation. The threshold moves accordingly — rising when care costs lead, falling when operating costs lead. This ensures fairness across economic conditions rather than locking in advantages that depend on which inflation rate happens to run higher.

The framework is path-dependent and gradual, adjusting through small annual recalibrations rather than sudden shifts. It preserves the core MLR structure — a minimum share for medical spending, a maximum for administration — while making it responsive to cost realities. When static rules increasingly appear misaligned with divergent inflation trends, this approach offers a more balanced and durable alternative.