Insurance Watchdog COALITION

A BRIEFING FOR POLICYMAKERS

MEDICAL LOSS RATIO

The Medicare Advantage Spending Gap: What Insurers Actually Spend on Health Care

Insurers are spending billions less on health care than what they're reporting. Plans reported an MLR near 90% in 2023. By their own filings, medical and prescription-drug claims were **82.5%** of revenue — below the 85% federal requirement, and **$36 billion** below the figure they reported.

89.8%	82.5%	85%
Reported MLR	Actual claim spending	Federal floor

$36B

Less spent on medical and prescription-drug care than insurers report

THREE FIXES

1. Count only medical and Rx claims
2. Report by plan, not by contract
3. Disclose payments to affiliated providers

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EXECUTIVE SUMMARY

MA Insurers Say 90% Goes to Medical Care. Their Own Filings Say 82.5%.

Medical Loss Ratio (MLR) is intended to measure how much health insurers spend on medical care as a percentage of their overall revenues. Many insurers now call it "medical care ratio," reflecting the common assumption that it measures "how much payers shell out to cover their members' medical expenses."

That's what Congress intended when it required Medicare Advantage (MA) plans to spend at least 85% of revenue on medical care. Today, MLR "medical expenses" include billions of insurer overhead costs, non-health care services, and even portions of prior-authorization systems.

In 2023, Medicare Advantage plans reported an MLR of 89.8%. By their own filings, only 82.5% of revenue paid a medical or prescription-drug claim — 2.5 points below the 85% requirement, and $36 billion less than the reported figure implies.

Current MLR rules let plans count things that are not medical care as if they were. Administrative costs — including portions of prior-authorization systems — count as "quality improvement." Benefits like gym memberships and cash cards for everyday expenses count as medical spending.

Large insurers can also meet the 85% minimum by paying their own providers more than they pay independent ones — every dollar of the markup still counts as "medical."

Three reforms would close the gap.

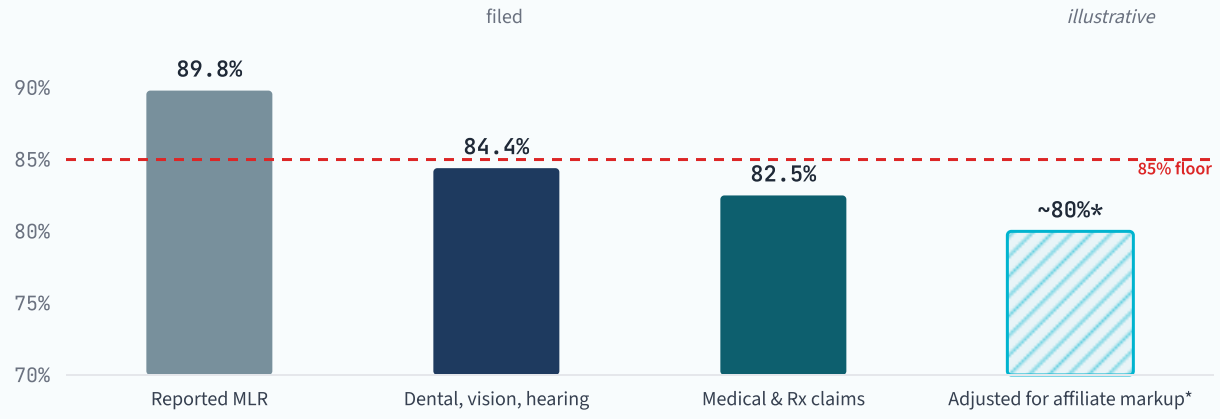
1. CMS should count only medical and prescription-drug claims toward the 85% minimum.
2. Congress should require insurers to report MLR by plan, not by contract.
3. CMS should require insurers to disclose what they pay affiliated providers, in dollars — and benchmark those payments to independent-provider rates.

[1]UnitedHealth Group, Form 10-K (FY2025): "Medical care ratio is calculated as medical costs divided by premium revenue." The term is also used by Molina Healthcare and other publicly traded insurers in SEC filings and earnings releases.

[2]Healthcare Dive, "UnitedHealth reports highest medical costs since COVID-19 pandemic's start," Jan. 12, 2024.

What Medicare Advantage's Reported MLR Counts as Medical Spending

Plans must spend 85% of revenue on medical care · each 1 point ≈ $5 billion · 2023



*Illustrative. Assumes a 17% affiliate-spending share — the UnitedHealthcare figure in Frank & Milhaupt (note 12) — at a 17% markup. Affiliate payments are not measured for Medicare Advantage.

Source: CMS CY2023 Part C/Part D Medical Loss Ratio Public Use File; Arnold & Fulton, Health Affairs (Nov. 2025).

SECTION I

MLR: A Flawed Measure of Medical Spending by Insurers

MLR was created to ensure that large insurers spend at least 85% of revenue on medical care — not overhead, marketing, administrative costs, or profits.

The Origins of a Flawed Rule

MLR was already being gamed before the rule took effect. A 2010 Senate Commerce Committee investigation found insurers were already reclassifying administrative costs as "medical spending" to prepare for it — one insurer alone had moved more than half a billion dollars of overhead onto the medical side of its ledger.[3]

The same investigation found something else: medical-loss ratios varied widely across plans sponsored by the same insurer — an early warning that one blended, contract-level number conceals which plans actually spend on care. MLR is still reported this way today.[4]

Since then, CMS has further expanded what insurers can claim as medical spending in Medicare Advantage. Now MLR includes insurers' administrative costs, non-medical benefits, and tax-funded premium subsidies that CMS doesn't count as medical expenses in Affordable Care Act marketplace plans. Each change has made it easier for insurers to hit the 85% target without spending more on medical care.

[3]Senate Committee on Commerce, Science & Transportation (Chairman Rockefeller), "Rockefeller Releases New Report on Health Insurance Spending for Consumers" (Apr. 15, 2010). Commercial-market data, cited for the reclassification mechanism now operating in Medicare Advantage.

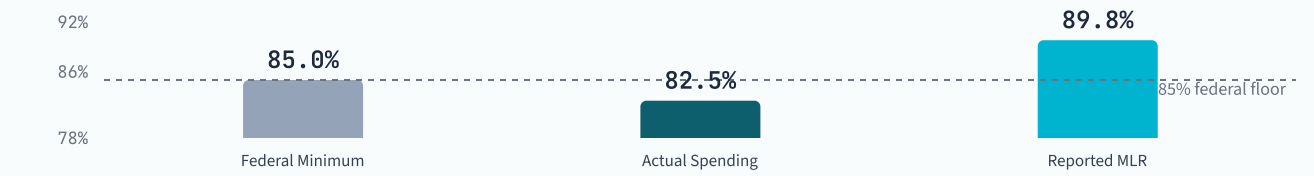
[4]Senate Committee on Commerce, Science & Transportation (Chairman Rockefeller), "Rockefeller Releases New Report on Health Insurance Spending for Consumers" (Apr. 15, 2010) (see note 3): medical-loss ratios varied widely across plans sponsored by the same insurer. CRS R42735; CMS MLR guidance: CMS still calculates the MA MLR at the contract level and does not distinguish the relative efficiency of plans under the same insurer.

SECTION II

Medicare Advantage: The 82.5% Problem

Medicare Advantage plans reported an 89.8% MLR in 2023 — but only 82.5% of revenue went to medical and prescription-drug claims.

Figure 1. Reported MLR vs. Actual Medical & Rx Claim Spending (2023)



BREAKDOWN OF THE $36 BILLION GAP

- Non-medical supplemental benefits $11B — Flex cards, gym memberships, cable TV
- Administrative "quality improvement" $8B — Prior-auth systems classified as medical care
- Part B premium reductions $2.5B — Tax-funded subsidies counted as spending
- Dental, vision & hearing claims $9B — Still leaves ratio at 84.4% — below the floor
- Bonus & incentive payments $5B — Genuine care spending, but not a claim

Source: CMS Contract Year 2023 Part C/Part D Medical Loss Ratio Public Use File.

That $36 billion gap breaks into five pieces:

$8 billion in administrative costs — including portions of prior-authorization systems — classified as "quality improvement" and counted as medical spending.

$2.5 billion in tax-funded Part B premium reductions — yet CMS doesn't count tax-funded premium subsidies in ACA marketplace plans as "medical spending" by insurers.

$5 billion in bonus and incentive payments to providers — genuine spending on care, but not a medical or prescription-drug claim, and excluded here under this report's stricter test.

$9 billion in dental, vision, and hearing claims — counted in full, they still leave the ratio at only 84.4%, short of the 85% floor.

$11 billion in non-medical supplemental benefits, including prepaid "Flex Cards" covering expenses from cable TV bills to golf memberships.

Medicare Advantage Flex Cards: Insurers Can Offer These — But Should MLR Count Them as "Medical Spending"?

97% of MA Flex Card Plans Don't Cover Co-pays

- Cable and WiFi bills
- Cell phone bills
- Groceries
- Golf course fees
- Gym memberships

*Varies by plan. Under current CMS rules, these count toward the 85% medical-spending floor. Sources: CMS, Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F), fact sheet (Apr. 4, 2024); CMS PBP Benefits 2026 (co-pay use); "The Medicare Flex Card 2025 Explained – Facts vs. Myths," LMS Benefits (Aug. 13, 2025); "Medicare Flex Card: What It Is and How to Get One," MedicareFAQ (Apr. 8, 2026). See note 11.

SECTION III

Insurers Can Meet MLR Minimums by Inflating Payments to Affiliated Providers

The 82.5% figure above is drawn entirely from insurers' own CMS filings. What follows shows how affiliate-markup practices documented in the commercial market could inflate MLR "medical spending" if they occur at the same rate in Medicare Advantage.

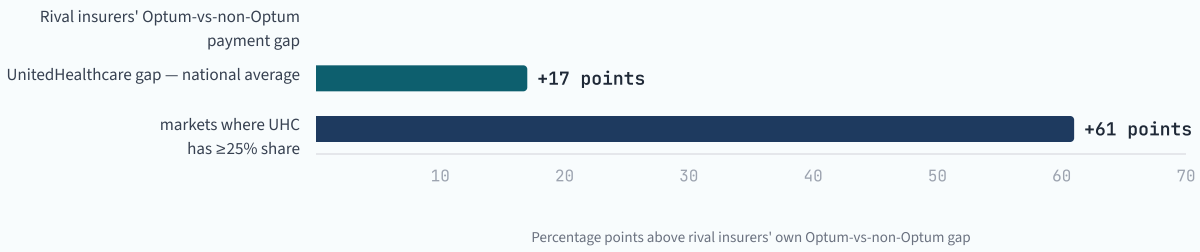
Insurers can raise their reported MLR by paying their own providers and subsidiaries more than they pay independent ones. Under current rules, every dollar of that markup still counts as medical spending. Between 2016 and 2019, the share of spending UnitedHealthcare and CVS/Aetna directed to their own affiliated businesses grew roughly 250% and more than five-fold, respectively, across all lines of business.

A 2025 study of commercial price-transparency data across 28 metropolitan areas found that UnitedHealthcare's payments to its own Optum-affiliated physician practices run 17 percentage points higher than the equivalent gap at rival insurers — widening to 61 points in markets where UnitedHealthcare holds 25% or more of the insurance market. UnitedHealth disputes this finding and states that it pays Optum and non-Optum providers at similar rates; the company has not published data supporting that position.

Assuming insurers inflate payments to affiliated providers in Medicare Advantage at the same rate they do in the commercial market, the markup on every 10% of claims paid to affiliates would be improperly counted as medical spending — overstating the ratio by roughly 1.2 percentage points, about $6 billion. Brookings researchers found related-business spending shares in 2019 ranging from about 13% (CVS/Aetna) to 17% (UnitedHealthcare), and above 60% at Kaiser Permanente; at a 17% affiliate share, the medical share would fall by roughly 2 points, to about 80%.

UnitedHealthcare Pays Optum More Than Rivals Pay Their Affiliates

How much UnitedHealthcare's own Optum-vs-non-Optum payment gap exceeds the equivalent gap at rival insurers



Figures are relative, not raw payment levels: they show how much larger UnitedHealthcare's Optum-vs-non-Optum payment gap is than the equivalent gap at rival insurers, not what UnitedHealthcare pays Optum outright. UnitedHealth disputes this finding; see note 27.

Source: D. Arnold & B. Fulton, "UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers," Health Affairs (Nov. 2025). Commercial-market data; no Medicare Advantage equivalent exists.

[5]Bipartisan Budget Act of 2018 (CHRONIC Care Act), creating Special Supplemental Benefits for the Chronically Ill (SSBCI): benefits with a "reasonable expectation of improving or maintaining the health or overall function" of enrollees, not required to be "primarily health related." Congressional Budget Office, Estimated Direct Spending and Revenue Effects of Division E of Senate Amendment 1930, the Bipartisan Budget Act of 2018 (Feb. 8, 2018), Sec. 50322 ("Expanding supplemental benefits to meet the needs of chronically ill Medicare Advantage enrollees"): $0 in each year 2018–2027. K.B. Watson et al., "Trends in Multiple Chronic Conditions Among US Adults, By Life Stage, Behavioral Risk Factor Surveillance System, 2013–2023," Preventing Chronic Disease 22:240539 (Apr. 17, 2025): 93.0% of adults 65 and older reported one or more chronic conditions in 2023. Per-beneficiary supplemental-benefit spending grew from $960 to $2,520 between 2015 and 2024 — MedPAC, Report to Congress (March 2025).

[6]In Medicare Advantage, CMS counts Part B premium reductions — a tax-funded premium subsidy — as MLR medical spending. Yet in ACA marketplace plans, CMS counts advance premium tax credits as premium revenue, not medical spending. 42 C.F.R. § 422.2420(b)(1)(ii); 45 C.F.R. § 158.130; CRS R42735. Timeline sources: see Methods.

[7]Computed from CMS, Contract Year 2023 Part C/Part D Medical Loss Ratio Public Use File (Medicare Advantage contracts only; 593 contracts, prefixes H, R, and E). See Methods.

[8]Qualifying QIA can include portions of prior authorization, health-IT, wellness programs, and fraud-recovery activities; CMS has permitted ICD-10 conversion costs to qualify. Plans may classify spending as QIA without proving it improved patient medical outcomes. 42 C.F.R. § 422.2430(a)(2) (qualifying categories); § 422.2430(b)(5) (ICD-10 implementation costs up to 0.3% of revenue); § 422.2430(b)(7) (excluding all retrospective and concurrent utilization review); § 422.2430(b)(13) (excluding the portion of prospective utilization review, including prior authorization, that does not meet the QIA definition).

SECTION IV

Conclusion and Reforms

MLR was meant to tell policymakers how much Medicare Advantage plans spend on medical care. It doesn't. Measured as medical and prescription-drug claims, the figure is 82.5%, not the 89.8% plans report. Counting what insurers pay their own affiliated providers at market rates would lower that figure further.

Every number above is the plan's own classification. Plans calculate their MLR, attest to it, and submit it — CMS conducts only "selected review," not an audit. A CMS pilot audit already found what this report describes: non-claims administrative costs sitting in the medical line.

What the Hospitals Say

> *"[The AHA] has become increasingly concerned with how large commercial insurance plans may be gaming Medicare Advantage medical loss ratio (MLR) regulations by directing qualifying payments to entities within the same corporate umbrella."*
>
> — American Hospital Association, July 15, 2026

> *"Insurers that own providers "can inflate reported medical spending by directing care to their affiliates — often paying higher rates — while retaining the funds within the same corporate family.""*
>
> — Federation of American Hospitals, April 21, 2026

Three Reforms

01 Only Count Medical and Rx Claims Toward MLR

The 85% test should count only what plans pay for medical and prescription-drug claims. Everything else — administrative "quality" programs, gym memberships, cash cards, premium subsidies — should be reported separately. CMS can do this by regulation; no new law is needed.

02 Require MA Insurers to Report at the Plan Level

Congress should require the ratio to be disclosed by component and at the plan level, not aggregated by contract. CMS collects some plan-level information in the MLR filing but withholds it from public release; H.R. 9644 would require plan-level disclosure starting in 2029.

03 Benchmark Payments to MA Plans' Affiliated Providers

CMS should require plans to report what they pay providers, PBMs, and other businesses they own — in dollars, by affiliate — as a separate line in the MLR filing, and compare those payments to what independent providers are paid.

[9]About $2.5 billion, roughly 0.5 points of the reported MLR. The funds go directly to the Social Security Administration to reduce a beneficiary's monthly Part B premium; no clinical service is purchased.

[10]DVH claims are about $9 billion. Under CMS rules, this figure includes flat capitated payments to benefit vendors, counted in full whether or not an enrollee used the benefit.

[11]Insurers call these "OTC cards," "flex cards," or "healthy-options allowances." CMS data show 97% of plans offering a card do not allow it to be used for a copay; what the cards cover is general, non-medical expenses, with no PIN and no ID check required at the point of sale. This report does not address whether plans should offer these benefits — only that non-medical expenses should not count as medical spending for MLR purposes. Golf: Clever Care Health Plan (Calif.) covers greens fees at seven Los Angeles-area courses, per C. Pope, "Should Medicare Cover Golf Fees?" City Journal (May 5, 2025). Cable and utility bills: Wellpoint, "What Is a Medicare Flex Card?" (listing cable, along with gas, water, electric, and cell phones, among eligible utility expenses). WiFi and gym memberships: "The Medicare Flex Card 2025 Explained – Facts vs. Myths," LMS Benefits (Aug. 13, 2025); "Medicare Flex Card: What It Is and How to Get One," MedicareFAQ (Apr. 8, 2026). Co-pay figure: computed from CMS PBP Benefits 2026 — about 3% of card-offering plans allow the card toward a medical co-pay.

[12]Between 2016 and 2019, the share of UnitedHealthcare's and CVS/Aetna's spending going to their own affiliated businesses grew roughly 250% and more than five-fold, respectively, across all lines of business. R. Frank & C. Milhaupt (Brookings/USC-Schaeffer), Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation. When a plan pays its own provider group a flat capitated rate, the entire payment counts as a medical claim. A 2026 study found hospital–Medicare Advantage vertical integration is associated with higher measured MLRs. D. Meyers et al., "Hospital–Medicare Advantage Vertical Integration and Medical Loss Ratios," Health Affairs Scholar (2026).

[17]42 C.F.R. § 422.2460 (annual reporting and attestation); § 422.2480 (CMS conducts "selected review" of MLR reports).

[18]CMS, Medicare Plan Payment Group, "Medical Loss Ratio (MLR) Report and Attestation Submission Reminder for Contract Year 2024" (Oct. 31, 2025).

[19]Z. Chen, A. Trivedi, H. Rooke-Ley, J. Marr & D. Meyers, "Federal Enforcement Actions Against Medicare Advantage Plans," JAMA Internal Medicine 186(7): 861–868 (July 2026). Of 844 enforcement actions from 2010 to 2023, 87% were monetary penalties; the highest penalty imposed was $6.50 per enrollee (2019), against gross margins of $1,815 per enrollee that year.

[20]42 C.F.R. §§ 422.2420, 422.2430. The numerator definition is regulatory, not statutory; Section 1857(e)(4) of the Social Security Act sets the 85% threshold and leaves its calculation to the Secretary.

[21]CMS collects some plan-level information in the MLR filing but withholds it from public release. 42 C.F.R. § 422.2490(b)(2). H.R. 9644, introduced July 13, 2026 and ordered reported by the House Ways and Means Committee July 15, 2026 (42–0), would require organizations to submit and publicly report revenue, claims, and non-claims cost data at the plan level.

METHODS

Our Numbers, Their Data

Every MLR figure in this report is computed from a single primary source: CMS's Contract Year 2023 Part C/Part D Medical Loss Ratio Public Use File — the raw reports plans themselves filed.[22]

The $36 billion gap between the reported number and medical and prescription-drug claims breaks into five parts: about $8 billion in administrative spending classified as "quality improvement"; about $11 billion in non-medical supplemental benefits, including prepaid cards; about $2.5 billion in Part B premium reductions; about $5 billion in bonus and incentive payments to providers — genuine spending on care, but not a claim under this report's test; and about $9 billion in dental, vision, and hearing claims.[23]

These figures do not include payments to affiliated providers. CMS does not require Medicare Advantage plans to report what they pay affiliated providers, so no comparable figure exists.[24]

Timeline sources (Section I): NAIC, Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio (Oct. 2010); CMS-4173-F, 78 Fed. Reg. 31284 (May 23, 2013); Bipartisan Budget Act of 2018; CMS-4182-F, 83 Fed. Reg. 16440 (Apr. 16, 2018) (fraud-reduction activities in the numerator from CY2019); CMS-4190-F1, 85 Fed. Reg. 33796 (June 2, 2020) (payments to non-provider entities as incurred claims from CY2021).

Anticipated Objections

This report expects to be challenged. Three objections and one limit on scope are addressed here directly.

First: this is not a partisan complaint, and it is not unique to this report. The American Hospital Association and the Federation of American Hospitals — usually on opposing sides of health policy fights — have both warned that insurers direct payments to their own affiliated providers at above-market rates.[25] A Democrat and a Republican on the House Ways and Means Committee have jointly asked the Government Accountability Office to investigate.[26]

Second: insurers may respond that MLR already accounts for quality, not just claims — and industry groups describe MLR that way, as spending on "medical care and quality improvement activities." That description is accurate: CMS regulations define the numerator to include both. It is also the problem: policymakers and seniors hear "medical care" and reasonably assume something narrower than what the rule actually counts.

Third: UnitedHealth disputes the finding that it pays Optum providers more than independent providers for the same services. The company has not published data of its own showing otherwise.

Fourth — a limit on scope rather than an objection: this report's affiliate-markup argument applies to physician practices, not hospitals. A 2026 study of vertically integrated Medicare Advantage plans found that 66 to 73 percent of hospitals charge similar prices to affiliated and unaffiliated plans, but across all hospital-plan pairs studied, affiliated-plan prices averaged 5.3% higher than unaffiliated-plan prices for the same procedure at the same hospital — a gap concentrated in inpatient care and in concentrated markets. This report does not extend its physician-markup finding to hospital claims generally.

ABOUT THE AUTHOR

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Mark Merritt is Executive Director of the Insurance Watchdog Coalition. He has held senior executive roles at some of the nation's largest health care trade associations, including 15 years as CEO of PCMA, the pharmacy benefit manager trade group; he has since become a public critic of PBM practices. He holds bachelor's and master's degrees from Georgetown University and served as a Fellow at Harvard's Institute of Politics.

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[22]We include Medicare Advantage contracts only (593 contracts; prefixes H, R, and E), excluding 42 standalone prescription-drug plans. Aggregates are dollar-weighted: total numerator ($442.6B) divided by total revenue ($492.8B) yields 89.8%. The regulatory MLR nets taxes and fees from the denominator, yielding 90.3% — the figures in this report use the more conservative, gross-revenue convention. The underlying data is self-reported by plans under attestation and subject only to "selected review" by CMS (42 C.F.R. § 422.2480); to the extent self-reporting biases classification, it favors "medical," meaning the gap shown here is a floor, not a ceiling.

[23]Dental, vision, and hearing claims are about $9.4 billion; provider bonus and incentive payments about $4.9 billion; quality-improvement spending about $8.0 billion; non-medical supplemental benefits about $11.0 billion (line 2.1b); Part B premium reductions about $2.5 billion (line 2.5). Together, $35.8 billion — the $36 billion gap. All components reconcile to the reported numerator to the dollar.

[24]CMS does not require Medicare Advantage plans to report what they pay affiliated providers, so no comparable figure exists. See note 15 for the illustrative estimates used in Section III.

[25]American Hospital Association, Statement for the Record, House Committee on Ways & Means, Markup of Healthcare Legislation (July 15, 2026), supporting H.R. 9644 and stating the association "has become increasingly concerned with how large commercial insurance plans may be gaming Medicare Advantage medical loss ratio (MLR) regulations by directing qualifying payments to entities within the same corporate umbrella." Federation of American Hospitals, Statement for the Record, House Committee on Ways & Means (Apr. 21, 2026), stating that insurers owning providers "can inflate reported medical spending by directing care to their affiliates — often paying higher rates — while retaining the funds within the same corporate family."

[26]Rep. Lloyd Doggett (D-TX), Ranking Member, and Rep. Greg Murphy, M.D. (R-NC), House Ways & Means Health Subcommittee, letter to the Comptroller General requesting a GAO investigation of vertical consolidation among Medicare Advantage organizations and its effect on MLR calculations (Apr. 16, 2025).