

Application of an 80% Medical Loss Ratio

What is the affect on the individual medical insurance market in Kentucky?

I've been asked to express an opinion with respect to implementation of the 80% Medical Loss Ratio (MLR) and rebate provisions added to Section 2718 of the Public Health Service Act (PHSA) by the Patient Protection and Affordable Care Act (PPACA) as specified in Section 2718(b) (1) (A) with respect to its effect on the stabilization and volatility of the individual medical insurance market in the Commonwealth of Kentucky.

I am familiar with the new health reform law (PPACA) and its requirement that insurers in the individual market maintain a MLR of at least 80 percent – i.e. for policies in the individual market, at least 80 percent of the premium must to go directly to coverage of medical costs or quality improvement activities. Otherwise, if an insurer spends less than 80 percent on medical costs and quality improvement activities in any year, then the insurer will be required (subject to credibility provisions) to provide a rebate to all such policyholders. I am also familiar with the Interim Final Regulations which were produced as a guide for defining medical costs, quality improvement activities and other insurance expenses with respect to the calculation of the MLR.

In forming my opinion I reviewed, among other things, the documents listed in Exhibit 1. [For your convenience some of these documents have been copied and included as Exhibits.] Moreover, my opinion is based on more than 45 years of actuarial and insurance management experience and more than 25 years as a health actuarial consultant to the Kentucky Department of Insurance and other insurance regulators. My curriculum vitae is attached as Exhibit 2.

Opinion

Based on my review of the current state of the individual market in Kentucky, and its positive and adverse development over the past two decades, it is my opinion that:

1. The immediate application of the 80 percent minimum standard MLR will likely destabilize an already volatile individual market in the Commonwealth of Kentucky, and
2. Adjusting the minimum standard percentage to 65 percent for calendar year 2011 and gradually increasing the percentage to 80 percent in calendar year 2014 will not act to destabilize the individual market in the Commonwealth of Kentucky.

Brief Statement of Rationale:

Kentucky is in the unique position of having concrete evidence on which to base expectations relative to the potential disruption to its individual medical insurance market if the 80 percent MLR requirement is imposed beginning in 2001. In the mid 1990s Kentucky underwent a massive disruption of this market resulting from the implementation of state imposed health insurance reform. The history surrounding this period and the effects of insurance reform on the marketplace is well documented and attached to the application submitted by Commissioner Clark. There are many similarities between the Affordable Care Act and the reform efforts undertaken by Kentucky. Therefore, I have based my opinion upon this history and the fact that

scenarios exist in this market that have been specifically referenced by the Academy of Actuaries as problematical in the successful implementation of the MLR.

Basis for Expressing Opinion

1. The PHSA provides for a downward adjustment in the minimum standard MLR and gives the Secretary authority to make an adjustment without limitation as to the amount of the adjustment.

Section 2718(b)(1)(A) of the PHSA provides that, beginning not later than January 1, 2011, health insurance issuers offering group or individual health insurance coverage must with respect to each plan year, provide an annual rebate to each enrollee under such coverage if the ratio of: (1) the amount of premium revenue the issuer spends on reimbursement for clinical services provided to enrollees and activities that improve health care quality to (2) the total amount of premium revenue for the plan year (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of PPACA) is less than 80 percent for coverage offered in the small group market or in the individual market (or a higher percentage that a given State may have determined by regulation), *except that the Secretary may adjust this percentage for a State if the Secretary determines that the application of the 80 percent minimum standard may destabilize the individual market in that State.*¹

2. The PHSA clearly recognizes that the immediate implementation of an 80% minimum standard MLR has the potential to destabilize the individual market and/or exacerbate the volatility of the individual market due to the establishment of State Exchanges.

Section 2718(b)(2) requires that in determining these minimum percentages, States shall seek to ensure **adequate participation** by health insurance issuers, **competition** in the State's health insurance market, and **value for consumers** so that premiums are used for clinical services and quality improvements. Additionally, Section 2718(d) *provides that the Secretary may adjust the rates described in Section 2718(b) if the Secretary determines that it is appropriate to do so, on account of the volatility of the individual market due to the establishment of State Exchanges.* (In this context, the terms "State Exchange" and "Exchange" refer to the State health insurance exchanges established under PPACA).²

3. The individual market in Kentucky is currently dominated by one insurer and lacks adequate participation by health insurance issuers and competition in the State's individual health insurance market as required by Section 2718(b) (2) in determining minimum MLR percentages.

In the 1990s Kentucky engaged in health insurance reform efforts that had drastic repercussions on its marketplace. One consequence of these reforms was the domination of the marketplace by one insurer. The history of these efforts and their effect on the individual market are well

¹ Wording of this paragraph is substantially the same as that of FR Doc. 2010-8599 Filed 04/12/2010. (Emphasis added)

² Wording of this paragraph is substantially the same as that of FR Doc. 2010-8599 Filed 04/12/2010. (Emphasis added)

documented and form the basis of many of my assumptions underlying my opinion. Exhibit 3 is a brief summary of this history.

4. The establishment of state exchanges by 2014 in and of itself is not expected to reverse Kentucky's efforts toward building stabilization and reducing volatility in its individual market. However, along with the establishment of state exchanges, if the 80% minimum MLR standard is imposed in 2011 without allowing reasonable time for individual market insurers to reach that standard, Kentucky's already unstable and volatile individual market will be put in extreme jeopardy.

In an April 2010 letter to the NAIC, Rowen Bell, Chairman of the American Academy of Actuaries Medical Loss Ratio Regulation Work Group, raised a concern over "the potential disruptive impact that the implementation of §2718 could have on the individual health insurance market..."³ (Exhibit 4) This letter describes three different but related perspectives 1) the 80% MLR requirement is inconsistent with current pricing assumptions, 2) underwritten policies issued prior to the 'guaranteed issue' requirements will have lower current loss ratios, making it difficult to achieve the 80% MLR in the early years, but loss ratios will increase by policy duration as the business matures, and 3) the first two perspectives will have a disproportionate impact on companies which can lead to additional volatility in premium and rate change levels in the individual market. In a newly developing individual medical insurance market, such as Kentucky, these three disruptive influences will have an even greater impact, making it more likely to result in destabilization of Kentucky's individual market.

Because of the disruptive influences just described, most companies in the individual market need time to adjust their business practices to meet the 80% minimum MLR standard. In February 2010 the American Academy of Actuaries published a paper titled *Critical Issues in Health Care Reform - Minimum Loss Ratios*. (Exhibit 5) Page 4 of this paper devoted a complete section specifying that the implementation of new medical loss ratio requirements must allow for adequate lag time and described three key 'time' issues:

A. Time to file new rates

Rates for 2011 have already been filed and approved based on current regulatory requirements and may not have allowed for an 80% MLR. Note: rates are filed in advance of their implementation and are guaranteed to the individual for 12 months. In many cases, implementing the 80% MLR requirement on policies already priced to have a lower MLR, forces the insurer to write the business at a loss.

For example, assuming policies are written with the expectation of a 65% MLR and 5% of premium was expected to go toward profit as a means of strengthening the company's assets for the future protection of consumers in the event claims costs exceed expectations. If pricing expectations are met, the immediate implementation of the 80% requirement forces the company to lose 10% of premium on these policies.

Losses diminish, rather than contribute to, the protection of consumers, jeopardize a company's financial position, and reduce a company's desire to stay in the market.

B. Time to modify agent and broker compensation structures, and

Not only do agent and broker commission contracts need to be re-written, but many existing commission contracts have long-term, legally enforceable agreements requiring insurers to

³ PPACA Medical Loss Ratio Provision and Potential Disruption to Individual Market, Rowen Bell, AAA, 4/28/2010

pay commissions for many years in the future. Companies are working to reduce costs through lower commission rates, but the process requires time to be fully implemented.

- C. Time between the enactment of the requirement and its implementation to allow the regulatory process to clarify the medical loss ratio definition before pricing decisions need to be made and filed.

The Interim Final Regulation for calculating MLRs was not submitted by the Office of Consumer Information and Insurance Oversight, Department of Health and Human Services for comment until November of 2010. As noted above, the medical loss ratio definition must be clarified before pricing decisions are made and corresponding rates can be filed.

In addition to these three key 'time' issues, there other issues affecting an insurance company's ability to remain in the individual market. It is also important that insurers are given reasonable time to address, the following five issues.

- D. Management of risks: Insurance is a 'risk' business. For the payment of premiums, specific risks are transferred to the insurer. For a long time, survival of insurers has been tied to their ability to manage insurance risks. One aspect of this management is the insurer's ability to measure risks through underwriting procedures and establish premiums based on these measured risks.
- E. Value of underwriting: Insurers and policyholders both gain as a result of the underwriting process. Not only does the process allow the insurer to manage risks, but policyholders gain by having the costs for the transfer of their risks to the insurer to be commensurate with the value of that transfer.
- F. Business development costs: Underwriting savings do not last forever. As time goes on, individual health circumstances change and claim cost savings diminish. However, earlier savings are a big asset in helping to offset business development cost and the higher first-year costs of delivering the insurance policy.
- G. Value of agents and brokers: One aspect of higher first-year costs is the cost for paying agents and brokers to find potential customers and assist them in selection of suitable products. The NAIC expressed their concern to Secretary Sebelius for "the impact the medical loss ratio requirement could have on the ability of insurance agents and brokers to continue assisting health insurance consumers at a time of rapid changes that makes their role even more essential."⁴
- H. Diminished services: Not only are the necessary services of agents and brokers in jeopardy, but also in jeopardy are other customer services which are provided directly by insurers. When loss ratio requirements increase, the funds remaining for administration and profit must be reduced. To accomplish this reduction, insurers are forced to cut other customer services.

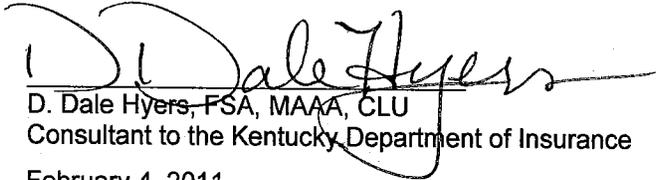
Summary Statement

The wisdom of the authors of the PHSA to include authority for the Secretary to adjust the 80% MLR requirement demonstrates that disruption of the individual market was recognized as a likely possibility.

⁴ Letter to Secretary Sebelius, NAIC, 10/27/2010

Deliberately ignoring the wisdom of the authors of the PHSA and denying operation of its provisions is contrary its specific intent. Kentucky needs the protections allowed through a waiver to encourage stability of its individual market, to assist in the continued development of adequate participation by health insurance issuers, and to foster competition in the State's health insurance market.

The expected loss of insurers in the individual market resulting from failure to accept the Commissioner's request to adjust the MLR minimum percentage runs contrary to the requirements Section 2718 of the PHSA to ensure adequate participation by health insurance issuers, competition in the State's health insurance market, and value for consumers.



D. Dale Hyers, FSA, MAAA, CLU
Consultant to the Kentucky Department of Insurance

February 4, 2011

Documents Reviewed
in the Formation of Opinion

1. Patient Protection and Affordable Care Act (PPACA)
2. Public Health Service (PHS) Act, Section 2718
3. Interim Final Regulations (IFR)
4. PPACA Medical American Academy of Actuaries April 28, 2010 letter to NAIC (Exhibit 4)
5. Critical Issues in Healthcare Reform, Minimum Loss Ratios, American Academy of Actuaries, February 2010 (Exhibit 5)
6. Health Insurance Reform in the 1990s: A Kentucky Historical Perspective, George Nichols III
7. Market Report on Health Insurance, revised addition, George Nichols III

D. Dale Hyers, Managing Director, Wakely Consulting Group, Louisville Kentucky**Experience**

Prior to joining Wakely Consulting Group, Dale was the President and co-founder of Hyers & Levy an actuarial, insurance management and health care management consulting firm. His actuarial training and experience began in 1964 at Aetna Life & Casualty Insurance Company in Hartford, Connecticut. It continued at Integon Life Insurance Corporation in Winston-Salem, North Carolina, and Capital Holding Corporation in Louisville, Kentucky. While at each of the latter two companies he was the senior Group Insurance and Credit Life and Health Insurance Actuary. He left Capital Holding to start Hyers & Levy in 1983.

Dale has written a chapter on pricing of health care benefits that appears in a book published by the American Hospital Association. This book is titled HOSPITAL-SPONSORED HEALTH MAINTENANCE ORGANIZATIONS: Issues for Decision-Makers. His chapter is titled "Understanding the Rate Making Process." He is also the editor of a study Hospital Cost Analysis by DRG to provide a "standard" for measuring the effectiveness of hospital medical cost management programs.

Dale has been a consultant to insurance companies, HMOs and Blue Cross Blue Shield Corporations as well as employers and health care providers on a wide variety of actuarial, insurance management and health care management issues.

Dale has been a consulting actuary for the Kentucky Department of Insurance, the Georgia Department of Insurance, the Hawaii Division of Insurance, the Indiana Department of Insurance, the Maine Attorney General's Office, the Maryland Insurance Administration, the Michigan Insurance Bureau, the Michigan Attorney General's office, the Pennsylvania Department of Insurance, the Tennessee Department of Commerce and Insurance, and the Vermont Department of Banking Insurance Securities & Health Care Administration.

Professional Credentials

- Fellow, Society of Actuaries (F.S.A.)
- Member, American Academy of Actuaries (M.A.A.A.)
- Member, American Society of Chartered Life Underwriters (C.L.U.)

Areas of Specialization

- Product Development
- Pricing
- Valuation
- Provider Capitations
- Managed Care Contracting
- Insurance Management
- Expert Witness & Testimony

Education

- M.A. Mathematics, University of Kentucky
- B.S. Carson-Newman College

History of the Individual Medical Insurance Market in Kentucky

The individual market in Kentucky is currently dominated by one insurer and lacks adequate participation by health insurance issuers and competition in the State's individual health insurance market as required by Section 2718(b) (2) in determining minimum MLR percentages.

For many years Kentucky's individual market has been dominated by a single insurer. This dominance was exacerbated in the mid 1990s due to health insurance reform legislation that was implemented in our individual market. As a result of the damage done during the reform effort, this insurer essentially monopolized the individual market. Kentucky legislators and insurance commissioners recognized the potential harm to consumers resulting from this situation, and for more than a decade, have taken steady steps to ensure adequate participation by health insurance issuers, competition in Kentucky's health insurance market, and value for Kentucky consumers.

The 1994 Kentucky General Assembly passed HB 250 containing broad-sweeping efforts to reform Kentucky's health insurance market, including guaranteed access to insurance regardless of the health status of the individual, modified community rating (MCR),⁵ mandates requiring coverage for certain medical conditions, and a more stringent review of rate filings by the Department of Insurance. In the words of former insurance commissioner George Nichols III, "Kentucky became a national leader, but an unforeseen consequence was the state also became an island where **more than 60 health insurance companies abandoned this market.**"

(emphasis added)⁶ Naturally, requiring acceptance of individuals with known high medical costs and mandating coverage for previously uncovered medical conditions put more costs into the 'insurance' system resulting in increased premium charges. Along with higher premiums and fewer insurers, came fewer consumer choices. Younger members, unable or unwilling to assume the costs of older members, dropped their insurance coverage, increasing the number of uninsured in Kentucky.

The Health Purchasing Alliance was also created by HB 250. This alliance was to provide an 'affordable' pool of insurance coverage by creating a combined public/private market. Former Governor Brereton Jones issued a mandate that all public employees (state, local, county, school, university, and public retirees) join the alliance. Private sector individuals and employer groups with less than 100 employees could volunteer to join. According to Commissioner Nichols, "The alliance also had unreasonable timelines, including an unreasonably short period of time to prepare to enroll 300,000 people by the first day of implementation."⁷ He further stated, "Regulations tied to implementation of the law were in chaos as well."⁸

⁵ MCR disallowed premium rating not only by health status but also by gender, and occupation, and required younger members to pay relatively more than their share of medical costs.

⁶ Health Insurance Reform in the 1990s: A Kentucky Historical Perspective, George Nichols III, p3

⁷ Ibid p24

⁸ Ibid p27

The alliance began operations and enrollment in July 1995. By September only 300 people were enrolled⁹ and 45 carriers had notified the Department of Insurance that they were going to leave Kentucky.¹⁰

During this time Kentucky Kare (a previously self-insured health plan for State employees) was opened by the alliance to accept other mandated public employees.

By November 1995, just months after beginning operations, the Health Policy Board (which was created and given its authority by HB 250) “discovered that alliance rates were higher than non-alliance rates” and issued new rates effective January 1, 1996.¹¹

In 1995, “for the first time, Kentucky Kare began losing money, paying \$1.04 in claims for every \$1.00 in premiums.” Its \$90 million reserve fund at the end of 1994 had begun to dissipate,¹² and in 1996 requested a 28% rate increase to stop the drain on reserves.¹³

SB 343 was enacted by the General Assembly in 1996 abolishing the Health Policy Board, and local governments, universities and small association groups were no longer required to be in the alliance. However, “Once SB 343 was in effect, only two carriers were left in the individual market, Anthem and Kentucky Kare, and the latter was in serious financial trouble.”¹⁴

Then in 1998 the Health Purchasing Alliance was abolished. The alliance was closed for business on June 30, 1999 with many lawsuits pending. During this time Kentucky Kare had collapsed and state employees were back under the authority of the Personnel Cabinet.¹⁵

From this low point, Kentucky legislators, the Kentucky Department of Insurance and others began the slow, sometimes agonizing, task of redeveloping Kentucky’s individual market.

Letters went out and meetings were held with prior individual market insurers, with a single question to be answered, “What will it take for your company to decide to return to the Kentucky individual medical insurance market?” A simple paraphrase of the answers is, ‘Allow us to manage our risks and conduct our operations in a manner that does not force us to operate at a financial loss in Kentucky.’ What went unsaid was, ‘We also must have assurance or at least a reasonable expectation that future legislation and regulation changes will not again put us in financial jeopardy.’

Success has been hard-fought and admittedly slow. Insurers who exited, discontinuing all of their Kentucky business, were not allowed to return for five years. Others, while not prohibited from returning, remained cautious. However, based on covered lives, the non-Anthem market share of private individual medical insurance in Kentucky grew from nearly 0% in 1996 to over 10% during 2008. Early reports indicate the non-Anthem market share to be approximately 15% in 2010. When based on premiums, the non-Anthem market share is even lower due to the fact that Anthem sells higher benefit products and its more mature block of business has proportionately less underwriting savings.

⁹ Ibid p29

¹⁰ Ibid p30

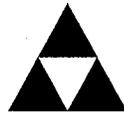
¹¹ Ibid p31

¹² Ibid pp 81 and 82

¹³ Ibid p32

¹⁴ Ibid p34

¹⁵ Ibid p54

AMERICAN ACADEMY of ACTUARIES

April 28, 2010

To: Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC

Steven Ostlund
Chair, Accident & Health Working Group, NAIC

From: Rowen Bell
Chair, Medical Loss Ratio Regulation Work Group

Re: PPACA Medical Loss Ratio Provisions and Potential Disruption to Individual Market

Dear Lou and Steve:

The American Academy of Actuaries¹ (Academy) Medical Loss Ratio Regulation Work Group recently sent you an initial letter outlining several technical issues germane to your groups' work regarding implementation of the medical loss ratio (MLR) and rebate provisions added to §2718 of the Public Health Service Act (PHSA) by the Patient Protection and Affordable Care Act (PPACA). In this second comment letter, we would like to raise a broader policy concern—namely, the potential disruptive impact that the implementation of §2718 could have on the individual health insurance market prior to (and potentially beyond) the effective date of the guaranteed issue requirements, due in large part to historical pricing practices employed in the individual market. This concern is primarily relevant in those states that permit medical underwriting of individual insurance. We are continuing to evaluate potential approaches to mitigating this concern and look forward to further discussions on this subject.

This potential disruption to consumers in the individual market would likely occur from three different, albeit related, perspectives:

1. Applying an 80 percent MLR requirement to existing individual business that had originally been priced under different (lower) MLR expectations may require a company to reduce the premiums it ultimately retains (i.e., collected premiums less rebates) to levels that create losses, with little to no ability to recover those losses. Materially reducing the non-claims costs associated with existing business in order to reduce financial losses is unlikely to be feasible. Such a situation might lead some companies currently active in the individual market to terminate the existing blocks of business and leave the market, in an effort to avoid those future losses and the potential solvency concerns associated with those future losses. If some companies do exit the individual market, then those companies' former policyholders may find themselves unable to find new coverage in the individual market for a period of years (noting that guaranteed issue requirements do not take effect until 2014), and would not be eligible for the new high risk pools created by PPACA §1101 during the first six months after cessation of coverage.

¹ The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

2. Individual policies underwritten and issued prior to the introduction of guaranteed issue requirements in 2014 will continue to exhibit traditional patterns of having loss ratios that increase by policy duration. Issuing new underwritten policies over the next few years would therefore tend to make it more difficult for an insurer to achieve an 80 percent annual MLR across its entire block of individual medical business. This could serve as an incentive for carriers who remain in the individual market to minimize their marketing activity prior to 2014, creating a potential lack of product availability in the individual market over the next few years.
3. Since the MLR for underwritten individual products typically increases with policy duration, a company whose individual book of business has a higher proportion of recently-sold business may find it more difficult to achieve an 80 percent annual MLR in the near future than a company having a more mature book of business (and a correspondingly higher MLR). As such, the application of uniform annual MLR requirements could have a disproportionate impact across companies, which could lead to additional volatility in premium and rate change levels in the individual market.

In order to mitigate these potential disruptive factors in the individual market, the NAIC may wish to explore alternatives to a straight-forward application of an annual MLR threshold to the individual market, at least in a transition period over the next few years. For example, it may be desirable to take a carrier's durational mix of business into account when assessing its individual market MLR for §2718 rebate purposes.

Moreover, any such alternative applications of MLR requirements for the individual market will be most effective if they are developed in the very near future. As noted above, some carriers may seek to exit the individual market out of concern about the impact that rebate requirements in 2011 may have on their existing book of business and potentially on their solvency. Carriers will likely need to reach decisions on this point in the next several weeks; in order for a carrier to effect its exit from the market as of January 1, 2011, an announcement may need to be made in June 2010 to satisfy the six-month advance notice requirements of the Health Insurance Portability and Accountability Act (HIPAA). Consequently, any transitional alternatives will be more effective, in terms of minimizing potential individual market disruption, if they are announced in the next several weeks.

In analyzing this issue, it is important to note that the individual market has several unique characteristics that are typically not seen in either the small group or large group markets. Due to the selection of risks through underwriting in a voluntary market, historically the expected MLR of individual business has been significantly lower in the early policy durations, increasing over time as new illnesses covered by the policy but not present at the time of policy issuance manifest themselves (often referred to as the "wear off" of initial underwriting). In the individual market, pricing has traditionally been done using a lifetime target MLR, built up from a target MLR at each policy duration and the expected amount of business in force at each duration. By contrast, group insurance pricing is typically performed on an annual rather than lifetime basis. As PPACA's guaranteed issue requirements take effect, companies will likely revisit their approaches to pricing new business in the individual market in order to adapt to changes in the underwriting and the expected MLR pattern vis-à-vis the annual MLR requirements. However, business issued prior to that time—including not only grandfathered individual coverage, but also new business written after the adoption of PPACA but before the imposition of guaranteed issue requirements—will in most cases have been priced on a lifetime rather than annual basis.

Moreover, the lifetime MLR at which these existing blocks of individual medical insurance were priced has frequently been less than the 80 percent threshold discussed in §2718. We note two particular reasons why historically the lifetime pricing MLR in the individual market may have been lower than 80 percent.

First, product designs popular in the individual market have typically had lower “actuarial values” (i.e., higher policyholder cost-sharing features and lower medical costs) than product designs popular in the group market. At the same time, the per-enrollee costs of claims administration and policy administration are generally not any lower, and may actually be higher, for individual policies relative to group policies. The combination of these observations generally results in higher claims administration and policy administration costs, when expressed as a percentage of premium, in the individual market than in group markets. Second, the individual market has historically relied heavily on agents and brokers, which generate high distribution expenses, particularly in the first policy year. These agent and broker expenses are established by contracts and cannot be adjusted easily, if at all, on policies issued prior to the enactment of PPACA.

In summary, we have concerns regarding the application of the required annual MLR calculation to individual business priced to a lifetime MLR target. Due to the inherent inconsistency between the lifetime pricing methodology used for individual underwritten medical business, including the expected pattern of durational loss ratios, and an annual MLR computation, it may be prudent for the NAIC to swiftly consider options for adjusting the MLR computation for individual medical products.

We hope that our discussion of this issue is helpful to you as the NAIC continues its work on MLR implementation issues. If you have any immediate questions regarding this letter, please contact Heather Jerbi, the Academy’s senior federal health policy analyst, at ierbi@actuary.org or 202.785.7869.

Sincerely yours,

Rowen B. Bell, FSA, MAAA
Chairperson, Medical Loss Ratio Regulation Work Group
American Academy of Actuaries

Cc: Jay Angoff, Director, Office of Consumer Information and Insurance Oversight, HHS
Richard Kronick, Deputy Assistant Secretary, Health Policy, HHS

CRITICAL ISSUES IN HEALTH REFORM

Minimum Loss Ratios

February 2010

AMERICAN ACADEMY of ACTUARIES



Policymakers are considering implementing federal minimum loss ratio requirements as part of broader health reform efforts. Loss ratios measure the benefits received by policyholders divided by the premiums paid, and are put forth as one dimension to measure value to consumers in the aggregate.

Although loss ratio minimums currently play a role in state health insurance regulation, the minimums suggested as part of federal health reform efforts are typically more stringent and broadly applicable and would impose stiffer penalties than those existing within the current regulatory framework. Whether such stricter loss ratio requirements can enhance value to policyholders depends on the implementation details. This paper highlights relevant issues that policymakers should consider when contemplating the inclusion of minimum loss ratio requirements as part of federal health reform.

Most states currently impose minimum loss ratio requirements.

Setting a minimum loss ratio requirement is one aspect of determining whether premiums are reasonable in relation to the policy benefits. Most states have minimum loss ratio requirements for health insurance plans in the individual market, but such requirements are rare in the group market. The National Association of Insurance Commissioners (NAIC) Model Regulation for Filing of Rates includes minimum loss ratio requirements, which are enforced through the state rate filing processes. Under the model regulation, all insurers must file prospective rates with the state insurance regulator for their individual market plans. Most states also require an actuarial certification that the rates for small group market plans comply with small group rating laws. The penalty in most states for not meeting the loss ratio minimums is that the insurance department will disapprove the rate filing.

Loss ratios vary by market segment.

Loss ratios vary across the different market segments. In particular, loss ratios for plans in the individual market will typically fall below those in the small group market, which in turn will fall below those in the large group market. Several factors contribute to these differences, including:

- **Compensation for bearing risk.** Due in part to relatively lower customer participation rates, the individual and small group markets have higher claims volatility risk than the large group market. As a result, insurers subject to this increased risk often require higher risk margins, leading to lower loss ratios.
- **Administrative expenses.** Administrative expenses are typically higher relative to premiums for individual and small group health insurance products than for large group products. One of the reasons for this is that, on average, benefit levels are lowest for customers in the individual market and highest for those in the large group market. These benefit differences are reflected in the premium levels. For example, the premium for an individual policy with a \$2,500 deductible will be lower than for the same policy with a \$500 deductible. Therefore, any expenses that are largely independent of the benefit design, such as benefit adjudication expenses, will be a higher share of premiums for plans in the individual market than in the large group market. Another reason for the loss ratio differences is that the individual and

ADDITIONAL RESOURCES

Market Reform Principles
http://www.actuary.org/pdf/health/market_reform_may09.pdf

Risk Pooling
http://www.actuary.org/pdf/health/pool_july09.pdf

Health Reform Now
http://www.actuary.org/issues/health_reform.asp



AMERICAN ACADEMY of ACTUARIES

small group markets also incur expenses not typically incurred in the large group market. For instance, agent and broker expenses included in the premiums for individual and small group market plans are typically undertaken by consultants and human resources staff for large group plans, and therefore not included in premiums. In addition, underwriting expenses related to risk assessment and risk classification are incurred to a greater extent in the individual market. Finally, any per-policy administrative expenses, such as the initial policy entry into the insurer's administrative systems, can be spread over more insureds in a large group policy than in a small group or individual policy. Because individuals exhibit greater turnover (lower persistency) than groups, expenses associated with issuance of a policy must be spread over a shorter timeframe.

Current health reform proposals include insurance market reforms and other provisions that could impact not only loss ratios, but also how they vary across market segments. For example, the establishment of health insurance exchanges for the individual and/or small group markets could lead to a reduced role for agents and brokers, leading to lower expenses and higher loss ratios for those market segments depending on the magnitude of the cost allocation for the exchange. A reduced role of underwriting in a reformed insurance market may also reduce administrative expenses, especially in the individual market, thereby increasing loss ratios. In addition, the use of risk adjusters or reinsur-

ance to spread risks across insurers would increase administrative expenses and reduce loss ratios.

Even if health reform provisions reduce some variation in loss ratios by market segment, some differences will remain (e.g., billing expenses). Therefore, it would be appropriate to vary any federal loss ratio requirements by market segment. Otherwise, significant market distortions could arise. For instance, insurers whose business is comprised mostly of large groups rather than individuals and small groups would find it easier to meet minimum loss ratio requirements. As a result, insurers that could not attract significant amounts of large group business could find it difficult to satisfy the loss ratio requirement and exit the market.

Many definitional issues arise when calculating loss ratios.

To calculate loss ratios, the value of benefits received by policyholders is divided by the premiums paid. However, there are myriad technical issues around how to define the benefits and premiums; different definitions may be appropriate for different purposes such as rate regulation or insurer solvency. When using loss ratios to ensure that insurance policies provide value to customers in the aggregate, the following issues should be considered in the calculation:

- **Incurred-basis versus paid-basis.** Premiums received from customers are intended to cover all valid claims incurred in a particular month or year, regardless of when the claim payments are actually made. In

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order to ensure consistency, the benefits value used in a loss ratio calculation should reflect claims on an incurred-basis, rather than a paid-basis. Allowing several months to pass between the end of the premium payment period and the calculation of the loss ratio would reduce inaccuracies caused by reporting lags and the claims adjudication process.

- **Cost containment expenses.** An NAIC regulation defines the concept of cost containment expenses, which are amounts that the insurer spends in order to manage the cost of medical claims.¹ These expenses include case management, disease management, 24-hour nurse hotlines, wellness programs, provider network development, as well as fraud detection and prevention programs. As these expenditures are more akin to benefits than administrative expenses or provisions for risk, it would be appropriate to include cost containment expenses as part of the value of benefits in the loss ratio calculation. Including these expenses in the loss ratio calculation encourages insurers to effectively manage the quality, efficiency, and cost of care for policyholders.
- **Capitation payments.** Provider capitation arrangements may include the provider assuming the responsibility of paying the claims (and other member services). It would be difficult to segment administrative services out of the capitation for the purposes of meeting a minimum loss ratio, but an insurer could manipulate the loss ratio if segmentation is not performed. For example, instead of paying \$85 for health care claims and \$4 to settle those claims, an insurer pays a capitation payment of \$89 to a provider group and it settles the claims. Both transactions are essentially the same but the loss ratio could be very different.
- **Premium taxes.** The actual premium rates charged reflect any premium taxes levied by the state. Premium tax rates vary by state, and in some states by insurer (e.g., insurers domiciled in that state pay one rate while out-of-state insurers pay a higher rate). To make the loss ratio calculation comparable across insurers, it would be appropriate to subtract premium taxes from the value of premiums used in the loss ratio calculation.
- **Income taxes.** Health insurers, excluding some HMOs, are subject to federal income taxes, which are passed through to premiums. To make the loss ratio calculation comparable across all insurers, it would be appropriate to subtract federal income taxes paid from the premiums used in the loss ratio calculation.
- **Reinsurance and risk adjustment payments.** Both the benefits and the premium values in the loss ratio calculation should reflect any reinsurance programs and risk adjustment payments. Additional regulatory scrutiny may be required to ensure that reinsurance mechanisms are not used merely to avoid falling below the minimum required loss ratio.
- **Policy reserves.** With some health insurance policies, a portion of the premiums collected in the current year are intended to pre-fund claims incurred in future years. In these situations, the insurer records a liability, known as a policy reserve, on its balance sheet to reflect amounts collected from past premiums that are designed to pay claims in future periods. For products where policy reserves exist, the change in the policy reserve during the year needs to be added to the value of benefits in the loss ratio calculation.
- **Time period.** There is often significant seasonality in the manner in which medi-

¹The Statutory Statement of Accounting Principles (SSAP) No. 85, promulgated by the NAIC, stipulates that an insurer is not entitled to classify expenditures as being cost containment expenses unless it can support the contention that claims would have been higher if those expenditures had not been made.

cal claims emerge within a coverage year, due in large part to benefit design issues. Therefore, loss ratio calculations should be based on an annual timeframe, rather than more frequently.

- **Geographic variances.** The current cost of health care has much greater geographic variation than the cost of providing administrative services--as such, it should be expected that loss ratios would vary by geography, such as higher loss ratios in metropolitan areas with high costs of health care and lower loss ratios in areas where the cost of health care is lower. Using a level minimum loss ratio across all regions could result in carriers focusing on markets where the cost of health care (and associated premiums) is higher and a loss ratio target is easier to achieve.

Unless a minimum loss ratio is specific with respect to risk levels, market segments, benefit designs, and geography, it will either be set at a level that is too high for many well-functioning insurers which will cause unnecessary disruption to the market, or be set at a level that is too low to achieve its goals.

Implementation of new medical loss ratio requirements must allow for adequate lag time.

From a practical standpoint, it would be difficult to impose a new minimum medical loss ratio requirement immediately after the enactment of such a policy change. Appropriate time would be necessary for plans to file new rates. Plans typically file their premiums six to 12 months before they become effective, and also need time prior to rate filing in order to develop the rates.

The agent and broker compensation structure would also make immediate implementation of a new medical loss ratio requirement difficult. As noted above, individual and small group market premiums include expenses to cover agent and broker compensation (e.g., fees and commissions), which contribute to the lower loss ratios in these markets. Under

typical agent and broker contracts, insurers agree to pay fees and commissions not only the initial year a policy is sold, but also each year that a policy is renewed. Achieving new higher medical loss ratio requirements for existing business will often depend on reducing agent and broker compensation, which is specified by contract. Re-negotiating these contracts for existing business would be very difficult, and would depend on the willingness of agents and brokers to accept lower compensation for business that has already been sold. New compensation rates would also need to be set for policies sold after the new requirements go into affect, which also would take time to negotiate.

In addition, much of the detailed calculation of the medical loss ratio will be left to regulatory development. Therefore, it is important that enough time be left between the enactment of the requirement and its implementation to allow the regulatory process to clarify the medical loss ratio definition before pricing decisions need to be made and filed.

The consequences of non-compliance may be difficult to implement.

Enforcing compliance of minimum loss ratios is fairly straightforward on the state level. In general, the penalty for falling below minimum loss ratio requirements is that the state insurance department will disapprove a rate filing. Federal minimum loss ratio requirements under consideration may require insurers to pay policyholder refunds if their loss ratios fall below the minimum. However, the optimal method of transferring the deficiency to policyholders is unclear, given the likelihood of turnover in the insurer's customer base between the period covered by the loss ratio calculation and the point in time at which the deficiency has been computed.

Minimum loss ratios will not address many public policy concerns.

In and of itself, imposing a minimum loss ratio requirement would not address many of

the public policy concerns surrounding the health system. Minimum loss ratios do not help contain health care spending growth, ensure that health care services are appropriate and accurately billed, or address directly the quality and efficiency of health care services. Therefore, while a well-designed minimum loss ratio requirement may be an appropriate component of a federal health reform package, such requirements should not be viewed as a panacea. Moreover, monitoring compliance with loss ratio requirements may create additional costs for insurers and regulators and, depending on how the requirement is designed, could create insurance market disruptions or distortions that could affect consumers.