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Medical loss ratios and illustrative rebates:
2010 commercial health insurance

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EXECUTIVE SUMMARY

Section 2718(b) of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act (PPACA), requires health insurance issuers to provide rebates to enrollees when the issuer's medical loss ratio does not exceed 85% for the large group insured market and 80% for the individual and small group insured markets. This requirement is effective beginning in 2011, with rebates first payable in 2012. This report examines the 2010 preliminary medical loss ratios of health insurance issuers, including the allowable adjustments in the medical loss ratio calculation, and presents illustrative rebate estimates based upon 2010 experience.

The preliminary medical loss ratios submitted by health insurance issuers in a new supplemental exhibit to their 2010 annual statements indicate that 83% of premium in the large group insured market, 74% of premium in the small group insured market, and 48% of premium in the individual insured market were associated with 2010 preliminary medical loss ratios in excess of the federal thresholds. The calculation of preliminary medical loss ratios provides for the inclusion of expenses to improve health care quality in the numerator and a reduction to premium for taxes and regulatory fees in the denominator. Preliminary medical loss ratios for 2010 were increased by an average of 2.7% in the large group insured market, 3.5% in the small group insured market, and 3.0% in the individual insured market because of these allowable adjustments. The adjustment for taxes and regulatory fees has a larger impact than the adjustment for expenses to improve health care quality.

Though rebates were not required to be paid based upon 2010 experience, illustrative rebate amounts totaling nearly $2 billion, or 0.8% of premium across the large group, small group, and individual insured markets, were estimated by Milliman using the data in the 2010 annual statement supplemental exhibits. Premium reductions and other changes that health insurance issuers have been making since the PPACA was passed in March 2010, along with state-specific lower minimum medical loss ratios in the individual insured market, make this level of rebate unlikely to be payable based upon 2011 experience. Yet the 2010 estimates are insightful into how much impact the law may have on these three health insurance markets.

The health insurance issuers included in the analyses presented in this report are all health insurance issuers in the United States that submitted Supplemental Health Care Exhibits with their 2010 annual statements and that had positive earned premium (including high risk pools), incurred claims, and member months for 2010.

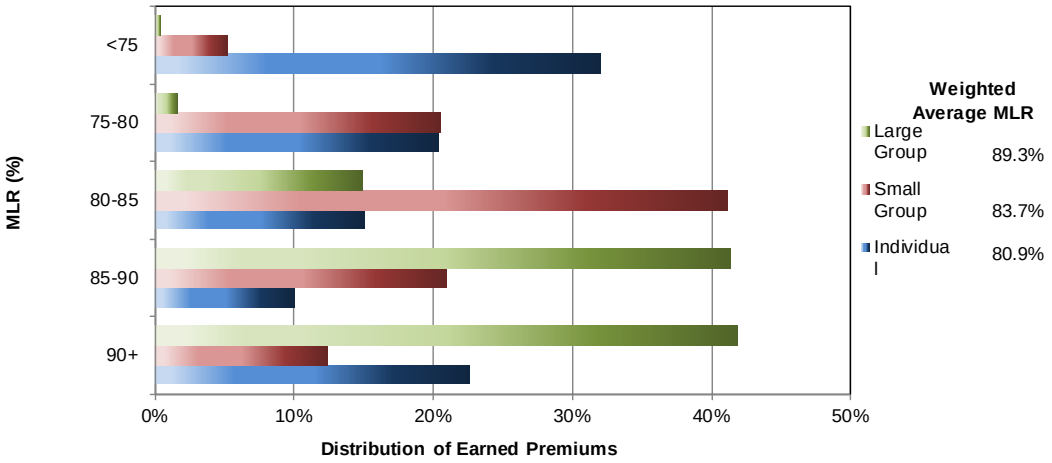
2010 PRELIMINARY MEDICAL LOSS RATIO

The 2010 preliminary medical loss ratios on line 7 of Part 1 of the Supplemental Health Care Exhibit to 2010 annual statements are indicative[1] of the loss ratios, prior to credibility adjustments, that health insurance issuers will be using in the rebate calculations. Figure 1 provides the distribution of premium by 2010 preliminary medical loss ratio for the large group, small group, and individual insured markets.

Figure 1 indicates that in the large group insured market approximately 42% of premium was associated with 2010 preliminary medical loss ratios above 90% and approximately 41% of premium was associated with 2010 preliminary medical loss ratios between 85% and 90%, for a total of approximately 83% of premium above the 85% federal minimum medical loss ratio. A total of approximately 74% of premium in the small group insured market was associated with 2010 preliminary medical loss ratios above the 80% federal minimum medical loss ratio while only approximately 48% of premium in the individual insured market was associated with 2010 preliminary medical loss ratios above the 80% federal minimum medical loss ratio. Though the preliminary medical loss ratios are prior to the credibility adjustments that will ultimately impact the amount of rebates to be paid, the preliminary medical loss ratios are a strong indication that rebates will be lowest in the large group insured market and highest in the individual insured market.

Figure 1 also indicates a strong concentration of preliminary medical loss ratios above 85% for the large group insured market and between 75% and 90% for the small group insured market. The individual insured market shows a greater range of preliminary medical loss ratios, with the largest concentration below 75%.

FIGURE 1: DISTRIBUTION OF EARNED PREMIUMS BY 2010 PRELIMINARY MEDICAL LOSS RATIO (LINE 7)



Note: State-specific information is available upon request.

[1] Health insurance issuers may defer experience related to policies newly issued in a calendar year with less than 12 months of experience in the calendar year to the medical loss ratio calculation of the subsequent calendar year if 50% or more of the total earned premium for the calendar year is attributable to such policies. Few health insurance issuers are expected to be able to defer experience.

MEDICAL LOSS RATIO ADJUSTMENTS

Health insurance issuers usually calculate a medical loss ratio as the ratio of incurred claims to earned premium. The rebate calculations allow two material adjustments[2] to the calculation of the medical loss ratio:

1. Federal and state taxes and licensing or regulatory fees are to be subtracted from earned premiums in the denominator.
2. Expenses to improve health care quality are to be added to incurred claims in the numerator.

Both adjustments have the impact of increasing the medical loss ratio. The 2010 preliminary medical loss ratios were increased by a weighted average of 2.7% in the large group insured market, 3.5% in the small group insured market, and 3.0% in the individual insured market because of the allowable adjustments. The adjustment for taxes and regulatory fees had a larger impact than the adjustment for expenses to improve health care quality.

Taxes and regulatory fees

Health insurance issuers are permitted to adjust for federal and state taxes and licensing or regulatory fees in the medical loss ratio calculation. The 2010 taxes and regulatory fees were reported on lines 1.5 through 1.7 of Part 1 of the Supplemental Health Care Exhibit to 2010 annual statements. The 2010 values are indicative of the taxes and regulatory fees that health insurance issuers will be using in the rebate calculations. Figure 2 presents the impact of excluding 2010 taxes and regulatory fees from the denominator of the medical loss ratio calculation. Separate impacts are shown for the large group, small group, and individual insured markets. The percentiles are based on earned premiums including high risk pools.

Figure 2 indicates that the weighted average impact on the medical loss ratio of the taxes and regulatory fees adjustments is to increase medical loss ratios by 2.0% in the large group insured market, 2.8% in the small group insured market, and 2.3% in the individual insured market. The percentiles in Figure 2 demonstrate a wider variation of the impact in the individual insured market in comparison to the large group and small group insured markets.

FIGURE 2: IMPACT OF TAXES AND REGULATORY FEES ADJUSTMENT ON MEDICAL LOSS RATIO

Insured Market	25th Percentile	50th Percentile	75th Percentile	Weighted Average
Large Group	0.7%	1.8%	3.1%	2.0%
Small Group	1.2%	2.8%	4.1%	2.8%
Individual	0.3%	1.8%	3.8%	2.3%

Note: State-specific information is available upon request.

Expenses to improve health care quality

Health insurance issuers are also permitted to adjust for expenses for activities to improve health care quality in the medical loss ratio calculation in order to not penalize health insurance issuers from investing in these activities, which are expected to lower medical costs and/or improve the quality of life for members. Examples of activities to improve health care quality include those designed to: prevent hospital readmissions, improve patient safety, reduce medical errors, lower infection and mortality rates, and promote health activities. (The definition of expenses for activities

[2] The allowable adjustments for deductible fraud and abuse detection/recovery expenses and certain state assessments were determined to have an estimated weighted average impact of <0.2% on the medical loss ratios.

to improve health care quality can be found in the instructions to the Supplemental Health Care Exhibit.)

The 2010 expenses to improve health care quality on line 6.3 of Part 1 of the Supplemental Health Care Exhibit to 2010 annual statements are indicative of the expenses to improve health care quality that health insurance issuers will be using in the rebate calculations. Figure 3 presents the impact of including 2010 expenses to improve health care quality in the numerator of the medical loss ratio calculation for the large group, small group, and individual insured markets. The percentiles are based on earned premiums including high risk pools.

Figure 3 indicates that the weighted average impact of the expenses to improve health care quality adjustment on the medical loss ratio is to increase them by 0.7% in each of the three insured markets. The percentiles in Figure 3 demonstrate a fairly consistent variation in the impact of the expenses to improve health care quality adjustment across the insured markets.

FIGURE 3: IMPACT OF EXPENSES TO IMPROVE HEALTH CARE QUALITY ADJUSTMENT ON MEDICAL LOSS RATIO

Insured Market	25th Percentile	50th Percentile	75th Percentile	Weighted Average
Large Group	0.4%	0.7%	0.9%	0.7%
Small Group	0.4%	0.7%	1.0%	0.7%
Individual	0.3%	0.4%	1.0%	0.7%

Note: State-specific information is available upon request.

Expenses to improve health care quality were reviewed in another Milliman research paper[3] on a per member per month (PMPM) basis because of the variability of premiums by insured market and state. The analysis showed that average expenses to improve health care quality on a PMPM basis are approximately 40% less in the individual insured market than in the large group and small group insured markets.

[3] Herbold, J. "2010 commercial health insurance: Administrative expenses" Milliman research report.

2010 ILLUSTRATIVE REBATE ESTIMATES

Though rebates were not required to be paid based upon 2010 experience, illustrative rebate amounts totaling nearly $2 billion across the large group, small group, and individual insured markets were estimated by Milliman using data from the Supplemental Health Care Exhibit of 2010 annual statements of health insurance issuers. The estimates reflect the credibility adjustment to the medical loss ratio based upon life years. The estimates are based on one year of data (2010), which is consistent with how the rebates will be calculated for 2011. Rebates in 2012 will be based on two years of data while rebates in 2013 and later years will be based on three years of data. Using more than one year of data will help to minimize the impact of year-to-year fluctuations in experience.

Figure 4 presents the estimated illustrative 2010 rebate amounts assuming an 85% federal minimum medical loss ratio for the large group insured market in all states and an 80% federal minimum medical loss ratio for small group and individual insured markets in all states. Illustrative 2010 rebates are estimated to total nearly $2 billion or 0.8% of total premium across the large group, small group, and individual insured markets. Consistent with the 2010 preliminary medical loss ratio information presented in this report, the large group insured market is expected to have the lowest percentage of enrollees receiving a rebate (15%) and the lowest rebate amounts ($84 per enrollee receiving a rebate). The individual insured market is expected to have the highest percentage of enrollees receiving a rebate (53%) and the highest rebate amounts ($188 per enrollee receiving a rebate). Illustrative 2010 rebates are estimated at 0.3% of total premium for the large group insured market, 0.7% of total premium for the small group insured market, and 3.9% of total premium for the individual insured market.

FIGURE 4: ESTIMATED ILLUSTRATIVE 2010 REBATE AMOUNTS

	INSURED MARKET			
	LARGE GROUP	SMALL GROUP	INDIVIDUAL	TOTAL
Estimated Number of Enrollees Receiving Rebate	6,094,000	4,375,000	5,323,000	15,792,000
Percentage of Enrollees Receiving Rebate	15%	24%	53%	23%
Illustrative 2010 Rebate Amounts	$509,472,000	$489,263,000	$1,000,367,000	$1,999,103,000
Average Illustrative 2010 Annual Rebate per Enrollee Receiving Rebate	$84	$112	$188	$127
Illustrative 2010 Rebates as a Percentage of Total Earned Premium	0.3%	0.7%	3.9%	0.8%

Note: Values have been rounded. State-specific information is available upon request.

Because of regulations and market conditions, the percentage of enrollees receiving rebates and the rebate amounts are expected to vary significantly by state. Figure 5 presents the distribution of states, including the District of Columbia, by the percentage of enrollees that would have received a 2010 rebate had the federal minimum medical loss ratios been applied. In the large group insured market in 41 states and in the small group insured market in 31 states, less than 20% of enrollees would have received a 2010 rebate. The percentage of enrollees that would have received a 2010 rebate is more widely dispersed for the individual insured market.

FIGURE 5: PERCENTAGE OF ENROLLEES THAT WOULD HAVE RECEIVED A 2010 REBATE

PERCENTAGE OF ENROLLEES THAT WOULD HAVE RECEIVED A 2010 REBATE	NUMBER OF STATES		
	LARGE GROUP INSURED MARKET	SMALL GROUP INSURED MARKET	INDIVIDUAL INSURED MARKET
0%	7	11	3
1% - 20%	34	20	12
20% - 40%	7	7	14
40% - 60%	2	8	5
60% - 80%	1	4	4
80% - 98%	0	1	13
National Average	15%	24%	53%

Note: State-specific information is available upon request.

Figure 6 presents the distribution of states, including the District of Columbia, by the average illustrative 2010 annual rebate per enrollee had the federal minimum medical loss ratios been applied. In the large group insured market in 33 states and in the small group insured market in 30 states, the average illustrative 2010 rebate per enrollee is less than $100. This is in contrast to the individual insured markets where the average illustrative 2010 rebate per enrollee is greater than $150 in 37 states.

FIGURE 6: AVERAGE ILLUSTRATIVE 2010 ANNUAL REBATE PER ENROLLEE

AVERAGE ILLUSTRATIVE 2010 ANNUAL REBATE PER ENROLLEE	NUMBER OF STATES		
	LARGE GROUP INSURED MARKET	SMALL GROUP INSURED MARKET	INDIVIDUAL INSURED MARKET
$0	7	11	3
$1 - $50	12	6	1
$50 - $100	14	12	5
$100 - $150	7	7	5
$150 - $200	6	4	11
$200 - $300	3	8	15
$300 - $400	2	1	7
$400 +	0	2	4
National Average	$84	$112	$188

Figure 7 presents the distribution of states, including the District of Columbia, by the illustrative 2010 rebates as a percentage of total earned premium. In the large group insured market in 47 states and in the small group insured market in 39 states, the illustrative 2010 rebates as a percentage of total earned premium is less than 1%. This is in contrast to the individual insured markets where illustrative 2010 rebates as a percentage of total earned premium is greater than 1% in 40 states.

FIGURE 7: ILLUSTRATIVE 2010 REBATES AS A PERCENTAGE OF TOTAL EARNED PREMIUM

ILLUSTRATIVE 2010 REBATES AS A PERCENTAGE OF TOTAL EARNED PREMIUM	NUMBER OF STATES		
	LARGE GROUP INSURED MARKET	SMALL GROUP INSURED MARKET	INDIVIDUAL INSURED MARKET
0%	7	11	3
0.1% - 1%	40	28	7
1% - 3%	4	12	17
3% - 6%	0	0	18
6% +	0	0	6
National Average	0.3%	0.7%	3.9%

STATE-SPECIFIC MINIMUM MEDICAL LOSS RATIOS

State-specific minimum medical loss ratios will ultimately impact the amount of rebates paid to enrollees, resulting in both higher and lower rebate amounts than the 2010 illustrative rebate estimates based on the federal minimum medical loss ratios that are presented in this report. State-specific minimum medical loss ratios can be higher or lower than the federal minimum medical loss ratios.

Section 2718(b) of the Public Health Service Act allows states to require higher minimum medical loss ratios than the 85% federal minimum medical loss ratio for the large group insured market and the 80% federal minimum medical loss ratio for the small group and individual insured markets. Higher minimum medical loss ratios are likely to result in higher rebate amounts. Massachusetts, for example, has a 90% minimum medical loss ratio for its merged small group and individual insured markets.

Section 2718(b) of the Public Health Service Act also allows the Secretary of the U.S. Department of Health & Human Services to adjust the 80% minimum medical loss ratio for the individual insured market in a state if 80% would destabilize the market. Lower minimum medical loss ratios are likely to result in lower rebate amounts. As of January 6, 2012, 17 states have applied for adjustments, of which six states have been approved, eight states have been denied, and three states are still in the application and review phases. Approved adjustments are applicable for no more than 2011 through 2013. Updates regarding the approval and denial of adjusted minimum medical loss ratios for state individual insured markets can be found at http://cciio.cms.gov/programs/marketreforms/mlr/index.html.

As noted previously, the 2010 illustrative rebate estimates presented in this report are based on the federal minimum medical loss ratios. State-specific minimum medical loss ratios were not considered in the calculation of the 2010 illustrative rebate estimates presented in this report.

CONCLUDING REMARKS

The rebates required by section 2718(b) of the Public Health Service Act will first become payable in 2012 based upon the 2011 experience of health insurance issuers in the large group, small group, and individual insured markets. This report, analyzing information in a new supplemental exhibit to 2010 annual statements, has provided insight into the preliminary medical loss ratios that will be used in the rebate calculations and the impact of the allowable adjustments to the medical loss ratio calculation. The report has also presented illustrative rebate estimates to quantify the potential impact that the legislation may ultimately have. Analysis of the information in the supplement exhibit to 2011 and later annual statements will continue to provide insight into changes by health insurance issuers and other market participants as they react to this legislation.

LIMITATIONS

This analysis has relied on data and other information from the Supplemental Health Care Exhibit of 2010 annual statements of health insurance issuers. This information was obtained using Insurance Analyst PRO from Highline Data in June 2011. The data and other information has not been audited or verified but a limited review was performed for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete. Values from Supplemental Health Care Exhibits submitted by health insurance issuers after the data and other information was obtained from the Highline Data in June 2011 are not included in this report.

The views expressed in this report are made by the author of this report and do not represent the opinions of Milliman, Inc. Other Milliman consultants may hold different views.

ACKNOWLEDGEMENT

Jason Howard, ASA, MAAA, created the database of data and other information used to support the analyses in this report. Allen Schmitz, FSA, MAAA, peer reviewed this report. The author appreciates their assistance.

QUALIFICATIONS

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this report, Jill Herbold, is a member of the American Academy of Actuaries, and meets the qualification standards for performing the analyses in this report.

APPENDIX: METHODOLOGY

Values from the Supplemental Health Care Exhibit of 2010 annual statements of health insurance issuers were obtained using Insurance Analyst PRO from Highline Data as of June 2011. Values were collected from health; life, accident & health; and property & casualty 2010 annual statements. Values were stored in a database to support the summaries and analyses presented in this report.

The health insurance issuers included in the analyses presented in this report are all health insurance issuers in the United States that submitted Supplemental Health Care Exhibits with their 2010 annual statements and that had positive earned premium including high risk pools from line 1.4, incurred claims from line 5.0, and member months from Other Indicators line 4 of Part 1 of the Supplemental Health Care Exhibit for 2010. Figure 8 below provides a summary of 2010 earned premiums from line 1.4 of Part 1 of the Supplemental Health Care Exhibit of 2010 annual statements of health insurance issuers used in the analyses in this report.

FIGURE 8: SUMMARY OF 2010 EARNED PREMIUMS (LINE 1.4)

INSURED MARKET	2010 EARNED PREMIUM INCLUDING HIGH RISK POOLS (IN MILLIONS)
Large Group	$159,312
Small Group	72,259
Individual	25,672
Total	$257,243

Note: Values have been rounded. State-specific information is available upon request.

The 2010 illustrative rebate estimates presented in this report were based upon values from the Supplemental Health Care Exhibit of 2010 annual statements of health insurance issuers and the rebate calculation instructions for 2011. The rebate calculation instructions were published in the Federal Register 45 CFR Part 158 Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule. The regulations and related guidance can be found at http://cciio.cms.gov/resources/regulations/index.html#mlr. Though permitted by the rebate calculation instructions, adjustments were not made for policies newly issued in 2010 with less than 12 months of experience in 2010, insurance coverage provided to a single employer at blended rates, or for the credibility adjustment based on average plan deductible. Such adjustments were not made because the data was not available on which to base the adjustments. In 2012 the rebate calculation will be based on the combined experience from 2011 and 2012 and then, beginning in 2013, the rebate calculation will be based on the combined experience of the three most recent years. This multi-year approach may help to mitigate volatility in medical loss ratios from year to year and reduce the use of the permitted credibility adjustments.