Milliman Research Report

Prepared by:

Paul R. Houchens
FSA, MAAA

October 2011

Milliman

2010 Commercial Health Insurance Market:

New Financial and Enrollment Data Available from the Supplemental Exhibit

Milliman is among the world's largest independent actuarial and consulting firms. Founded in 1947 as Milliman & Robertson, the company currently has 54 offices in key locations worldwide. Milliman employs more than 2,500 people. The firm has consulting practices in healthcare, employee benefits, property & casualty insurance, life insurance and financial services. Milliman serves the full spectrum of business, financial, government, union, education and nonprofit organizations. For further information, visit milliman.com.

TABLE OF CONTENTS

INTRODUCTION

What level of market competition exists in the current health insurance marketplace? Are administrative costs and underwriting margins in the individual and small group markets significantly higher than in the large group market? How does claim cost experience vary between the individual and small group markets?

In the past, these questions have been difficult to answer because insurance carrier financial experience was generally only reported on an aggregate basis rather than at the state level or for a specific segment of the commercial insurance market. Because of the introduction of a new financial exhibit that must be completed with each carrier's year-end statutory filing, many of these questions can now be answered with greater clarity. This paper uses data reported in the Supplemental Health Exhibit for calendar year 2010 to focus on key premium, claim cost, and administrative statistics within each insurance market and discusses observed differences among them.

SUPPLEMENTAL HEALTH EXHIBIT OVERVIEW

Section 2718 of the Patient Protection and Accountable Care Act (PPACA) institutes minimum medical loss ratio requirements for health insurance carriers in the individual, small group, and large group markets. In response to the minimum medical loss ratio requirements, the National Association of Insurance Commissioners (NAIC) developed the Supplemental Health Exhibit form to track key expenditure components for a carrier's medical loss ratio calculation. The Supplemental Health Exhibit (Exhibit) requires each carrier to report financial and enrollment experience at the state level into seven business categories and must be completed with the year-end statutory filing. Links to the Exhibit form are provided in the Methodology section of this report.

Representing three of the seven business categories, the Exhibit requires carriers to report experience separately for the comprehensive individual, small group, and large group health insurance markets. Individual market values exclude limited benefit plans, dread-disease policies, accident-only coverage, and other policies that are not considered comprehensive health insurance. The small group and large group categories exclude self-funded employers that typically purchase stop-loss insurance. Business written through an association is included in the Exhibit based on the insured entity's individual, small group, or large group status.

Reported Exhibit information (as of June 2011) from the December 31, 2010, annual statements was compiled for the comprehensive insurance markets using Insurance Analyst PRO® from Highline Data. Figure 1 provides a summary of the number of companies, covered lives, and aggregate premium amounts reported for calendar year 2010 on a national basis. Subsidiary companies were grouped with parent corporations for the purposes of determining the number of companies and assessing market share concentration. Experience from companies that are not required to complete the Exhibit or did not complete the Exhibit as of June 2011 is not included in this report. The inclusion of missing data could alter the results presented in this report. A limited review of the data used in this analysis was performed to assess the data's reasonableness and consistency. However, individual company results have not been audited. To the extent that individual company data was not correctly reported, the values presented in this report will not be representative of actual financial results.

FIGURE 1: AGGREGATE VALUES BY INSURANCE MARKET

DECEMBER 31, 2010, SUPPLEMENTAL HEALTH EXHIBIT

MARKET	AGGREGATE COMPANIES	AGGREGATE LIVES	AGGREGATE PREMIUM (US MILLIONS)
INDIVIDUAL	196	10,300,000	$25,818.7
SMALL GROUP	171	18,000,000	$72,506.9
LARGE GROUP	177	39,200,000	$159,530.2
TOTAL	238	67,500,000	$257,855.8

Note:
1. Values have been rounded.
2. Subsidiary companies have been grouped.
3. Aggregate premium values taken from Page 1, Line 1.1 of the Supplemental Health Exhibit.

REPORTED REVENUE AND EXPENSES BY MARKET

To establish an understanding of the relative cost differences among the individual, small group, and large group health insurance markets, composite reported expenses in the three markets were summarized on a per-member-per-month (PMPM) basis.

FIGURE 2: COMPOSITE REPORTED INSURANCE MARKET EXPENSES AND REVENUE (PMPM BASIS)

DECEMBER 31, 2010, SUPPLEMENTAL HEALTH EXHIBIT

	MEASURE	INDIVIDUAL	SMALL GROUP	LARGE GROUP
A	EARNED PREMIUM	$211.67	$333.25	$333.74
B	REGULATORY FEES AND TAXES	6.46	12.00	7.99
C	PREMIUM REINSURANCE ADJUSTMENTS	2.36	2.97	8.89
D = A - B - C	NET ADJUSTED EARNED PREMIUMS	$202.85	$318.28	$316.86
E	INCURRED MEDICAL CLAIMS	$164.45	$266.58	$288.64
F	REINSURANCE AND REBATE CLAIM ADJUSTMENTS	1.67	2.97	8.63
G = E - F	NET INCURRED CLAIMS AFTER REINSURANCE	$162.78	$263.61	$280.01
H	QUALITY IMPROVEMENT	$1.40	$2.35	$2.36
I	CLAIM ADJUSTMENT EXPENSES	8.28	8.75	7.88
J	DISTRIBUTION COSTS	14.28	17.46	7.83
K	OTHER ADMINISTRATIVE	16.53	15.26	13.22
L = H + I + J + K	TOTAL ADMINISTRATIVE	$40.49	$43.82	$31.29
M = D - G - L	UNDERWRITING GAIN (LOSS)	($0.42)	$10.85	$5.56
L / A	ADMINISTRATIVE EXPENSE RATIO*	19.1%	13.1%	9.4%
M / A	UNDERWRITING GAIN (LOSS)*	(0.2%)	3.3%	1.7%

*As a percentage of earned premium.

DEFINITIONS

Note: All line references are from page 1 of the Supplemental Health Exhibit.

Claim Adjustment Expense: The carriers' reported expenses related directly to paying claims (Line 8.3).

Distribution Costs: The carriers' reported expenses related to selling insurance coverage. These expenses include direct sales salaries, agent and broker fees, and commissions (Lines 10.1 and 10.2).

Earned Premium: The direct written premium plus the change in unearned premium reserves (Line 1.1).

Incurred Medical Claims: The benefit plan costs incurred by the carriers' covered members for medical and prescription drug expenses (Line 5).

Net Adjusted Earned Premium: The premium revenue earned by the carrier, less high-risk pool assessments, state and federal taxes, and other licenses and fees, and net ceded reinsurance premiums (Line 1.12).

Net Incurred Claims After Reinsurance: Incurred claims adjusted for reinsurance and rebate amounts (Line 5.7).

Other Administration Expenses: Administrative expenses not associated with claim payment or distribution expenses (Lines 10.3 and 10.4).

Premium Reinsurance Adjustments: Net assumed less ceded reinsurance premiums and other premium adjustments (Line 1.9, 1.10, and 1.11).

Quality Improvement Expenses: Carrier administrative expenses associated with quality improvement (Lines 6.3).

Regulatory Fees and Taxes: High-risk pool assessments, state and federal taxes, and other regulatory fees that are deducted from earned premium (Lines 1.2, 1.3, 1.5, 1.6, and 1.7).

Reinsurance and Rebate Claim Adjustments: Adjustments to incurred claims for reinsurance, rebates, and other revenue (Lines 5.1, 5.2, 5.3, 5.4, 5.5, and 5.6).

Underwriting Gain (Loss): The carriers' remaining premium income after payment for medical claims and administrative expenses. A negative amount indicates that the carriers' expenses exceeded premium revenue (Line 11).

As shown in Figure 2, premium and medical expenses are more than 35% lower in the individual market than they are in the group health insurance markets ($212 versus $333 earned premium PMPM). This is attributable to individual markets generally having leaner covered benefits than the small and large group markets. Most individual policies currently do not cover maternity costs and may have deductible levels that are substantially higher than the average employer plan. Many states also allow medical underwriting in the individual market. This may prohibit individuals with preexisting conditions or chronic illness from entering the health insurance market or result in these individuals being directed to a state's high-risk pool. The absence of a high-risk population helps make the underlying morbidity of the individual risk pool lower than for the small group and large group risk pool populations. It should be noted that we have observed premium rates that are comparable between the individual and small group markets in states with community rating in the individual market. This is discussed in further detail later in this report.

Administrative expenses on a PMPM basis are relatively similar among the three markets with the exception of distribution costs. The large group market's distribution costs are approximately 50% lower than for the individual and small group insurance markets. Economies of scale are created for large employers relative to the other health insurance markets, which may explain the lower distribution costs. However, large employers may pay an insurance broker or consultant fees directly rather than through the commission structure, and these fees would not appear in the carrier's financial experience. Additionally, large employers generally employ human resources or benefits staff to carry out many of the functions that brokers perform for a small employer. The additional tasks that brokers perform in the small group market may be an explanation of why distribution costs are higher in the small group market relative to the individual and large group markets.

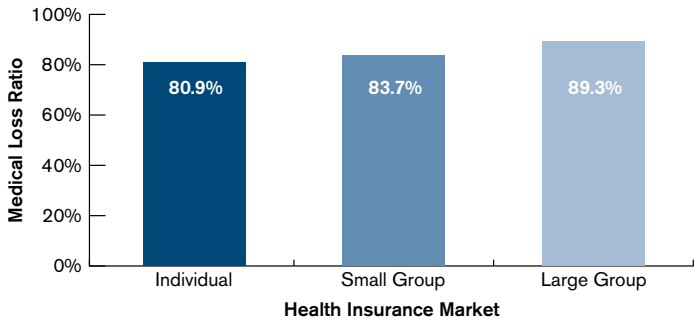
Underwriting results indicate that the small group market was the most profitable for carriers in 2010. On an aggregate basis, carriers' underwriting gain in the small group market was nearly $11 PMPM or 3.3% of earned premium. The underwriting gain in the large group market was approximately half of the gain in the small group market, which was $5.56 PMPM or 1.7% of earned premium. The individual market was the least profitable market, as carriers reported an aggregate underwriting loss.

Figure 3 illustrates the preliminary medical loss ratio for the three health insurance markets. The preliminary medical loss ratio is illustrated on page 1, Line 7, of the Exhibit, and is calculated as

(Line 4 + Line 5.0 + Line 6.3) ÷ Line 1.8.

FIGURE 3: PRELIMINARY MEDICAL LOSS RATIO BY INSURANCE MARKET

DECEMBER 31, 2010, SUPPLEMENTAL HEALTH EXHIBIT



The individual market's medical loss ratio is the lowest of the three health insurance markets because of the lower insured medical expenses and lower premium costs. Even though the small group's combined administrative and underwriting gain PMPM was $15 greater than the individual market's, the higher medical claim cost in the small group market gives the small group market a medical loss ratio that is 2.8% higher than the individual market. The large group market has a higher medical loss ratio than the small group market, which is driven by a higher medical cost PMPM and lower distribution costs.

MARKET SHARE BY COVERED LIVES

As an initial measure of market competitiveness, this analysis summarizes the percent of total insured market lives covered by the carrier with the largest market share within the individual, small group, and large group for each state. This measure illustrates the relative concentration of market share for the leading carrier in each state.

Figure 4 illustrates the distribution of market share for the leading carrier in each of the three markets for all 50 states and Washington, D.C. This measure indicates that the average state market share in each market category for leading carriers is between 50% and 60%. However, Figure 4 indicates a significant percentage of states with leading carriers having market share exceeding 70% of total market lives. In the large group market, 14 states have a carrier with greater than 70% market share.

FIGURE 4: STATE DISTRIBUTION OF COVERED LIVES INSURED BY MARKET LEADER

DECEMBER 31, 2010, SUPPLEMENTAL HEALTH EXHIBIT

MARKET LEADER MARKET SHARE	NUMBER OF STATES		
	INDIVIDUAL	SMALL GROUP	LARGE GROUP
<40%	9	11	9
40% - 50%	12	17	8
50% - 60%	15	5	13
60% - 70%	4	12	7
70% - 80%	7	3	8
80% - 90%	4	1	3
90% - 100%	0	2	3
AVERAGE MARKET SHARE	54.4%	52.0%	57.9%

Note: Individual state data is available upon request.

A summary of the number of companies that represent 90% cumulative market share in each insurance market provides another measure of market competitiveness. This measure was chosen to represent a proxy for the number of insurance carriers with minimal market share available to consumers in each state. In the individual market, the average number of companies that represent 90% cumulative market share was 4.9. This value decreased to 4.5 for the small group market, and further reduced to 4.0 for the large group market. Market share appears to be most heavily concentrated in the large group market, with 44 states having five or fewer companies that represent at least 90% market share.

FIGURE 5: STATE DISTRIBUTION OF NUMBER OF COMPANIES TO ACHIEVE 90% MARKET SHARE

DECEMBER 31, 2010, SUPPLEMENTAL HEALTH EXHIBIT

COMPANIES TO ACHIEVE 90% CUMULATIVE MARKET SHARE	NUMBER OF STATES		
	INDIVIDUAL	SMALL GROUP	LARGE GROUP
1	0	2	3
2-3	14	18	20
4-5	18	19	21
6-7	15	9	5
8+	4	3	2
AVERAGE NUMBER OF CARRIERS	4.9	4.5	4.0

Note: Individual state data is available upon request.

INDIVIDUAL VERSUS SMALL GROUP PREMIUMS: INFLUENCE OF RATING RULES

As illustrated in Figure 2 on page 4, the aggregate small group market reported claim expense PMPM is significantly higher than the individual insurance markets, by approximately 60%. Again, this is attributable to insurance policies in the individual market having a lower actuarial value and a population with more favorable morbidity relative to the group insurance markets. However, this relationship between the individual and group insurance markets is not true for every state. The differences are attributable to rating allowances prescribed by current state law for the individual and small group insurance markets.

Current state insurance rating allowances in the commercial insurance markets were summarized using information gathered from statehealthfacts.org. Forty-three out of 50 states, plus Washington, D.C., allow medical underwriting in the individual market, either unrestricted or with required rate bands. The remaining seven states do not allow premium rating by health status in the individual market and instead require a form of community rating.

Community rating only allows premiums to vary by specified characteristics of the insureds (adjusted community rating) or must be the same for every insurance applicant (pure community rating). The PPACA requires adjusted community rating in the individual and small group health insurance markets in 2014, allowing premiums to vary only by age (limited to a 3:1 ratio), family composition, tobacco usage (limited to a 1.5 rating adjustment), and geographic region. States may impose additional restrictions on rating methodology, but may not allow less restrictive rating approaches than are currently prevalent in most states.

In states that currently allow medical underwriting in the individual market, insurance carriers are generally not required to issue policies to an applicant. Insurance carriers may decline applicants with preexisting medical conditions. Of the 43 states that allow health status rating in the individual market, plus Washington, D.C., 33 have a high-risk pool for insurance applicants who are rejected by health insurance carriers from standard policies. A portion of these individuals are now eligible for the Pre-Existing Condition Insurance Plan (PCIP) instituted by the PPACA. For the 11 states that do not have a high-risk pool (other than the PCIP), the state may designate an *insurer of last resort*, have a specified product that is issued on a guaranteed basis, or require that each market participant insure a quota of high-risk individuals.

For the seven states that allow only adjusted community rating in the individual market, policies must be guaranteed issue, either continuously or during an open enrollment period. The guaranteed issue requirement means that an applicant cannot be rejected for insurance coverage for reasons other than fraud or failure to pay premiums. However, two states, Oregon and Washington, are unique in allowing insurance carriers to cede high-risk individuals to a high-risk pool managed by the state. This results in the high-risk (and high-cost) individuals being removed from the community-rated risk pool.

Washington individual health insurance rating laws allows insurance carriers to administer a Standard Health Questionnaire (SHQ) to every applicant. If the applicant is credited with more than 325 debit points based on identified medical conditions, the applicant becomes eligible for the Washington State Health Insurance Pool (WSHIP). Premiums in WSHIP are limited to 110% to 150% of the premium charged for a standard commercial policy with similar benefits. WSHIP is funded primarily by health insurance carrier assessments and member premiums.

The Oregon Medical Insurance Pool (OMIP) is open to qualifying individuals that have been treated or have a specified medical condition, have been rejected by an insurer for health reasons, been offered only an insurance plan that excluded coverage for specified conditions, or been offered only select benefit plans. Premiums in the OMIP cannot exceed 125% of the premium cost for a similar plan offered in the commercial market. Funding for the OMIP is provided by member premiums and assessments of the commercial health insurance market.

The operation of these two high-risk pools is similar to other states that operate high-risk pools, but allow medical rating in the commericial individual market. States rely on insurance carrier assessments, general fund revenue, grants, and member premiums to operate high-risk pool programs.

Community rating in the small group market is more prevalent than in the individual market. Eleven states currently have either adjusted community rating or pure community rating in the small group market. Although the PPACA only allows premiums to vary by age, family composition, tobacco usage, and geographic region, current small group adjusted community rating laws may also allow for premium variance by gender, group size, or industry. Current community rating does not allow for premiums to differ by health status or group claim experience.

To illustrate the impact that rating rules have on relative claim expenses between the individual and small group insurance markets, each state and Washington, D.C., was stratified into one of the six cohorts listed in Figure 6. Note that for states requiring community rating in the individual market, community rating is also required in the small group market. Of insured member months in the individual market during 2010, 91% were in states that currently allow health status rating. In the small group market, 72% of insured member months were enrolled in states with health status rating.

FIGURE 6: INSURANCE MARKET RATING COHORTS

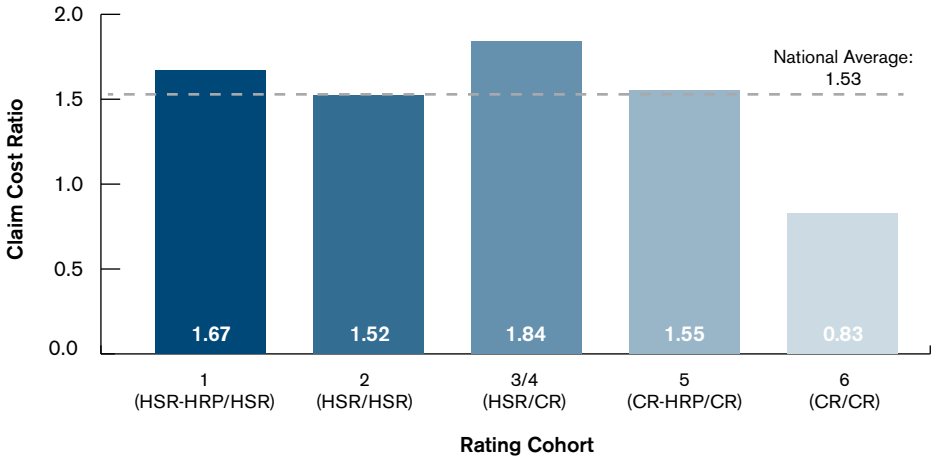
STATE MARKET RATING COHORT	INDIVIDUAL MARKET RATING LAWS	SMALL GROUP MARKET RATING LAWS	STATES
1	HEALTH STATUS RATING / HIGH-RISK POOL	HEALTH STATUS RATING	30
2	HEALTH STATUS RATING / NO HIGH-RISK POOL	HEALTH STATUS RATING	10
3	HEALTH STATUS RATING / HIGH-RISK POOL	COMMUNITY RATING	3
4	HEALTH STATUS RATING / NO HIGH-RISK POOL	COMMUNITY RATING	1
5	COMMUNITY RATING / HIGH-RISK POOL	COMMUNITY RATING	2
6	COMMUNITY RATING / NO HIGH-RISK POOL	COMMUNITY RATING	5

Note: 1. Health status rating includes both restricted (*bands*) and unrestricted.
2. Community rating includes both *pure* and *adjusted*.

Figure 7 provides the reported 2010 medical claim expense PMPM ratio between the small group and individual markets by the defined market cohorts and on a national level. Because of low enrollment values in cohort 4, results for cohorts 3 and 4 have been combined.

FIGURE 7: SMALL GROUP TO INDIVIDUAL MARKET CLAIM EXPENSE RATIO BY STATE INSURANCE RATING RULES

DECEMBER 31, 2010, SUPPLEMENTAL HEALTH EXHIBIT



Note: Rating cohort labels indicate the individual/small group rating rules.
- HSR: Health status rating
- HSR-HRP: Health status rating with high-risk pool
- CR-HRP: Community rating with high-risk pool
- CR: Community rating

Figure 7 illustrates a clear difference in the claim expense ratios between the individual and small group insurance markets based on current state health insurance rating laws. Although the national average, weighted by combined individual and small group member months in each state, is 1.53, the ratio varies from a low of 0.83 in states that require community rating in both the individual and small group markets (without an individual high-risk pool) to 1.84 in states that allow medical underwriting in the individual risk pool, but only community rating in the small group market.

Although the number of member months in rating cohorts 3 and 4 (health status rating individual, community rating small group) is too low to make any definitive conclusions, the higher ratio may suggest that the small group insured populations in these states have a higher claim morbidity relative to markets that allow medical underwriting in the small group market. For small employers with relatively healthy populations in states that require community rating, self-funding may allow the employer to avoid subsidizing the higher-cost insured population. The PPACA mandates adjusted community rating in the small group market, which may increase the prevalence of small employers self-funding versus remaining in the community rated risk pool.

Perhaps the most interesting observation from Figure 7 is the impact of the high-risk pool in Washington and Oregon (cohort 5). In this cohort, the ratio between the small group and individual markets is similar to states that allow medical underwriting in the individual market. Although the high-risk pool populations are relatively small in each state, the average claim cost of the participants can be five to 10 times higher than the average commercially insured individual. By segmenting the high-risk population out of the commercial individual market, the individual commercial per-member claim cost (and premium) is lower.

CONCLUSION

With the implementation of the Supplemental Health Exhibit, the NAIC has created a resource that simplifies the analysis of insurance carrier experience in the individual and group health insurance markets. The analysis in this report provides further insight into key characteristics of the current commercial health insurance markets.

The values reported in the Exhibit for the three markets indicate unique cost structures within each market. The individual market has substantially lower underlying per-member claim costs than the group insurance markets. Administrative cost differences among the three markets are primarily driven by distribution expenses, with the large group market having lower costs than the individual and small group markets.

Reported covered lives and member months allow the size of each market to be assessed relative to publicly available surveys on both a national and state-by-state basis. A review of insured lives within each state market indicates relatively high market share concentration within one or a few insurance carriers.

A review of per-member insured benefit expenses between the individual and small group markets indicates substantial variation in claim expense ratios based on current state health insurance market rating laws. These relativities, along with the estimated actuarial value of health insurance policies within each market, can be used to assess the relative morbidity between the individual and small group markets in each state. Insurance carriers can use this information to more accurately price their products with the implementation of the state health insurance exchanges and adjusted community rating in 2014.

Analysis and aggregation of carrier data can provide policymakers, regulatory authorities, and the health insurance industry with new insights into the operational efficiency, claim experience, and enrollment data in the commercial health insurance markets. In future years, the data reported in the Exhibit can support the evaluation of industry experience and trends. Multi-year Exhibit information can be used to evaluate the impact of the PPACA on carrier administrative expenses, carrier market competition, and premium costs.

METHODOLOGY

December 31, 2010, Supplemental Health Exhibit filings were collected during June 2011 using Insurance Analyst PRO® from Highline Data. The filings were collected from the Health; Life, Accident & Health; and Property & Casualty statements. The filings were aggregated into a database to support the summarization and analysis of the reported information. The December 31, 2010, Supplemental Health Exhibit template may be found at:

PART 1
http://www.naic.org/documents/committees_e_app_blanks_10_blanks_revisions_101026_supp_hc_ex_1_health.pdf

PART 2
http://www.naic.org/documents/committees_e_app_blanks_10_blanks_revisions_101026_supp_hc_ex_2_health.pdf

PART 3
http://www.naic.org/documents/committees_e_app_blanks_10_blanks_revisions_101109_supp_hc_ex_3_health.pdf

Instructions for completing the template may be found at:
http://www.naic.org/documents/committees_e_app_blanks_filing_issues_supp_hc_ex_guidance_101221.pdf

Reported lives and member months were reviewed for inconsistencies. For example, in a few cases carriers reported covered lives, but did not report any member months (or vice versa). For these carriers, implied covered lives or member months were estimated using the average member months per covered life ratio for other reporting carriers in the respective state and insurance markets.

Current state health insurance rating rules were obtained from statehealthfacts.org, operated by the Kaiser Family Foundation. Rating rule information from this website has not been audited.

LIMITATIONS

In developing the results presented in this report, I have relied on data and other information from the December 31, 2010, Supplemental Health Exhibit filings. The exhibit information was aggregated using Insurance Analyst PRO from Highline Data as of June 2011. I have not audited or verified this data and other information. I performed a limited review of the data used directly in this analysis for reasonableness and consistency. To the extent a carrier submitted its Supplemental Health Exhibit after the data was aggregated, it will not be contained in these values. There may be a number of such carriers that have not been included in the Highline data. If the underlying data or information is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete. It should also be noted that the data has not been adjusted for differences in age, gender, and other demographic and plan benefit differences. The use of benefit ratios minimizes the impact such differences might have, but this assumes that carriers have reasonably priced for the demographic and benefit differences of their plans.

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

ACKNOWLEDGEMENT

I would like to thank Jason Howard, ASA, MAAA, for his work in creating the database that contains the data used to support the analysis performed in this report. I would also like to thank Jim O'Connor, FSA, MAAA, who peer reviewed this report.

QUALIFICATIONS

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Chase Tower/Circle
111 Monument Circle, Suite 601
Indianapolis, IN 46204-5128
USA
+1 317 639-1000 tel

milliman.com