2013 Rate Review Forum

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An Overview of Medical Loss Ratio and the Rate Review Process in New Jersey

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How Regulators Use Loss Ratios

"To a hammer, every problem looks like a nail."*

*[Abraham Maslow (1908-1970) American psychologist]

- Loss Ratios have limited usefulness
- The primary purpose is to put an upper *limit* on the *total relative* cost of insurance coverage.
- Loss Ratios also play a role in monitoring financial condition and fairness of pricing between policyholders.
- Loss Ratio is defined as benefits divided by premiums.
  - Loss ratio can be calculated for any carrier, product or period of time as long as these three are the same for both the benefits and premiums.
- Benefits are payments to medical providers; could *include* quality payments; could *exclude* administrative costs of providers.
- Premiums may be before or after some or all taxes.

Rate Regulation

- A generic rate regulation law requires that rates be adequate, not excessive, and not unfairly discriminatory.

- New Jersey's law for the small employer (N.J.S.A. 17B:27A-17 et seq.) and individual (N.J.S.A. 17B:27A-2 et seq.) markets requires that rates be adequate and not unfairly discriminatory.

- Rather than using the language 'not excessive', rates are required to meet the 80% minimum loss ratio (MLR) standard.

- Rates for a carrier must be set so that the expected aggregate benefits are at least 80% of expected aggregate premiums. A refund is payable if, for a calendar year, the MLR is not met.

Loss Ratios and Medical Costs

- Loss ratio requirements do not force or incent carriers to control medical costs.
- Medical costs are driven by the frequency with which people become ill or injured and choose to seek medical service, as well as the types of service they choose and the unit costs.
- Note: When rates are regulated by loss ratios, escalating medical costs increase the *maximum* amount available for expenses and profits.
  - However, competition should limit the ability of carriers to charge the maximum amount permitted by loss ratios.
- Recent pricing loss ratios [Refer to Slide 8]

Retrospective Loss Ratio

- Calculated based on actual benefits and premiums for a past calendar period.
- Primary purpose: To determine refund liability.
  - NJ: 80% Loss Ratio for Individual and Small Group; none for Large Group
  - Federal: 80% Loss Ratio for Individual and Small Group, 85% Large Group
- Secondary purposes:
  i. Monitor Financial Condition
  ii. Monitor Market Viability
  iii. Monitor Pricing Accuracy (Actual to Expected)

Prospective Loss Ratio

- A carrier (actuarial) estimate of loss ratio in a future period, which is based on projections of benefits and premiums for that future period.
- Primary purpose: Projected loss ratio must exceed a minimum of 80%
- Secondary purpose: Projected loss ratios for different products and plans must have a reasonable relationship (they don't all need to exceed 80%)
- NJ: Individual and small group rates are required meet the prospective minimum of 80%
- Federal: This is not an explicit requirement, but it may be an implicit or indirect one.

Actual Target (Pricing) Loss Ratios 2012 – 2013

Loss Ratio Range	SEH #	SEH %	IHC #	IHC %
Equal to 80%	5	15%	6	22%
Between 80% – 85%	19	58%	9	33%
Greater than 85%	9	27%	12	44%
Total	33		27	

Suggests that competition or other factors may keep carriers from increasing rates to the maximum permitted by the minimum loss ratio. [Refer to attached exhibit for more detail.]

Exhibit

Actual Target (Pricing) Loss Ratios 2012– 2013

Small Employer (SEH)		Individual (IHC)	
Effective Date	Projected Loss Ratio	Effective Date	Projected Loss Ratio
4/1/2013	80.0%	2/1/2013	80.0%
8/1/2012	80.0%	2/1/2013	80.0%
8/1/2012	80.0%	5/1/2013	80.0%
11/1/2012	80.0%	5/1/2012	80.0%
1/1/2013	80.0%	8/1/2012	80.0%
7/1/2013	80.1%	8/1/2012	80.0%
8/1/2012	80.3%	11/1/2012	80.0%
2/1/2013	80.6%	11/1/2012	80.0%
2/1/2013	80.6%	11/1/2012	80.4%
10/1/2012	80.8%	5/1/2013	81.2%
7/1/2012	81.1%	8/1/2012	81.3%
11/1/2012	81.2%	2/1/2013	81.3%
4/1/2012	81.3%	5/1/2013	81.8%
4/1/2012	81.3%	2/1/2013	82.1%
2/1/2013	82.0%	11/1/2012	82.9%
8/1/2012	82.0%	3/1/2013	87.4%
7/1/2012	82.2%	10/1/2012	88.1%
5/1/2013	82.2%	3/1/2012	91.9%
5/1/2013	82.2%	3/1/2013	94.0%
7/1/2013	82.4%	5/1/2013	97.4%
2/1/2013	83.0%	7/1/2012	97.4%
2/1/2013	83.0%	1/1/2013	98.9%
1/1/2013	84.2%	1/1/2013	100.3%
5/1/2013	84.4%	2/1/2013	103.9%
8/1/2012	85.1%	5/1/2012	104.6%
2/1/2013	85.6%	7/1/2012	206.6%
11/1/2012	85.6%	7/1/2012	211.9%
4/1/2013	85.7%		
1/1/2013	86.4%		
10/1/2012	86.6%		
8/1/2012	95.4%		
5/1/2013	113.1%		
1/1/2013	115.3%		

Definitions I

- Carrier: A legal entity that is licensed to provide coverage.
- Affiliated Group: One or more carriers under common ownership. Think of it as a brand name. In NJ the brands “Aetna”, “AmeriHealth”, “Cigna”, “Horizon”, and “Oxford/United” all refer to two or more carriers.
- Market: Individual, Small Group, Large Group

Definitions II

- Submarket: Standard and Pre-Standard (or Pre-Reform), and Purchasing Alliances (We will ignore pre-standard, pre-reform and purchasing alliances for this discussion.)

- Product: For example: HMO, POS, PPO, EPO

- Plan: A particular benefit or cost sharing structure within a product, such as 70% or 90% coinsurance.

Loss Ratios at the Carrier Level – I

- The legal loss ratio minimum (retrospective or prospective) is generally calculated at the carrier/market level.

- For example: NJHealth (a made up name) would need to satisfy four loss ratio tests:
  - NJH Insurance Small Employer
  - NJH HMO Small Employer
  - NJH Insurance Individual
  - NJH HMO Individual

Loss Ratios at the Carrier Level – II

Exceptions:

NJ

- Individual MLR (retrospective, not prospective) is calculated at the affiliated group level, not the carrier level;
- The individual Basic & Essential (B&E) product must meet a prospective 80% MLR standard on its own;
- Separate loss ratio calculations are done for pre-reform plans and purchasing alliances.

Federal

- Small and large employer products are calculated at the carrier level, but there is some aggregation within the affiliated group if an HMO product and an insurance product are part of a benefit plan for one employer.

Additional Analysis (Combining)

This analysis is largely retrospective.

- For each market (individual or small employer), calculate the loss ratio for the affiliated group. If this is high (>85% e.g.), especially in multiple years, it indicates that the affiliated group is not profitable in this market. If the carriers are adequately capitalized and have other profitable lines of business, the concern is not financial failure. The concern is that the carrier will choose to reduce participation in, or leave, the market.

Further analysis:

- For an affiliated group, calculate the loss ratios for individual and small employer combined;
- Evaluate the overall profitability of the carrier, or affiliated group, to see if there is a financial solvency concern;
- Other lines of business include Medicare Advantage and Medicaid;
- Compare loss ratios to profitability measures such as profit margin.

Combining – Example

	Premiums	Claims	Loss Ratio
Midway HMO			
Small Employer	$1,000,000	$790,000	79.0%
Individual	$150,000	$125,000	83.3%
Midway Insurance			
Small Employer	$500,000	$450,000	90.0%
Individual	$100,000	$95,000	95.0%
Midway (combined)			
Small Employer	$1,500,000	$1,240,000	82.7%
Individual	$250,000	$220,000	88.0%
Total	$1,750,000	$1,460,000	83.4%

Combining – Example continued

1. The Small Employer HMO did not meet the loss ratio requirement. But, overall, the small employer had a loss ratio of 82.7%, so small employers are probably not being overcharged.

2. The Individual Insurance had a loss ratio of 95%. This would be unacceptable if this was a stand-alone line of business. However, the affiliated group overall book of business was 83.4%.

3. The Insurance loss ratios being much higher than the HMO loss ratios might indicate a problem to be investigated, such as payment to non-network providers.

Combining – Numerical Example

We looked at statistics of 8 carriers (in 4 affiliated groups) in 2 markets (SEH to IHC) from 2008 to 2011 (4 years). There 64 loss ratios, plus combinations.

Refunds

- There were 32 possible refund cases in SEH.
  - There were 4 SEH refunds (12.5%)
- There were16 possible refund cases in IHC.
  - There was 1 IHC refund (6.25%)

Affiliated Group Analysis

- SEH – Out of 16 cases, 0 cases less than 80% (minimum 80.6%)
- IHC – Out of 16 cases, 1 case less than 80% (refund situation)

Reform (SEH and IHC combined)

- Out of 16 cases, there were 9 cases with loss ratio greater than 85%. (max 93.5%)

[Refer to attached exhibit for more detail.]

Exhibit

Combining

Numerical Example

Carrier	Market	2008	2009	2010	2011
Horizon BCBS	SEH	91.4%	90.5%	85.3%	87.8%
Horizon BCBS	IHC	74.5%	79.2%	79.9%	74.3%
Horizon HC	SEH	85.4%	82.8%	77.6%	78.4%
Horizon HC	IHC	86.5%	86.9%	86.6%	80.9%
Horizon Total	SEH	89.2%	87.5%	81.9%	82.9%
Horizon Total	IHC	81.4%	82.7%	82.1%	75.8%
Horizon Total	Total	88.1%	86.8%	81.9%	81.5%
Aetna Life	SEH	89.8%	79.9%	66.5%	108.90%
Aetna Life	IHC	118.2%	159.7%	75.6%	100.40%
Aetna Health	SEH	84.3%	92.4%	88.4%	84.0%
Aetna Health	IHC	133.2%	138.6%	164.6%	195.6%
Aetna Total	SEH	84.3%	92.2%	88.1%	85.10%
Aetna Total	IHC	133.2%	140.6%	150.3%	163.30%
Aetna Total	Total	85.7%	93.5%	89.6%	87.4%
Oxford Health Ins	SEH	80.9%	83.6%	81.5%	81.4%
Oxford Health Ins	IHC	70.8%	81.0%	93.6%	112.2%
Oxford Health NJ	SEH	80.3%	82.5%	81.3%	81.1%
Oxford Health NJ	IHC	98.8%	100.5%	114.1%	98.0%
Oxford Total	SEH	80.6%	83.0%	81.4%	81.1%
Oxford Total	IHC	79.0%	85.9%	98.1%	109.5%
Oxford Total	Total	80.4%	83.5%	84.5%	86.3%
AmeriHealth Ins	SEH	86.7%	86.3%	82.0%	84.6%
AmeriHealth Ins	IHC		114.2%	83.0%	89.8%
AmeriHealth HMO	SEH	89.8%	90.2%	82.0%	78.9%
AmeriHealth HMO	IHC	93.8%	90.6%	83.3%	88.2%
AmeriHealth Total	SEH	88.5%	88.5%	82.0%	81.0%
AmeriHealth Total	IHC	93.8%	90.8%	83.3%	88.7%
AmeriHealth Total	Total	89.1%	88.8%	82.2%	81.9%

NJ Refund Situation
Reform LR > 85%
Not in Market

Additional Analysis (Breaking Down)

This analysis is both retrospective and prospective.

- Loss Ratios at the product level – underpriced, overpriced, subsidies between plans.
- Loss Ratios at the plan level – unfair discrimination; adverse selection.

At some level, the numbers become less useful due to credibility concerns, such as a very small number of enrollees in a plan.

Comparing Loss Ratios Among Products

Carrier "Ajax"		
	2012 Actual	2012 Expected*
HMO Product	79.0%	80.0%
POS Product	84.0%	82.0%
Average**	81.5%	81.0%
*From the rate filing		
**Assuming equal weighting for each plan		

- The HMO policyholders do not get a refund, because the MLR calculation is at the carrier level, not the product level.
- What is the justification for the POS product having a higher than expected MLR?
  - Higher average premium, fixed expenses.
  - Different taxes
- Is there an acceptable subsidy of high cost plans by low cost plans?

Comparing Loss Ratios Among Products

Carrier "Zephyr"			
PPO Product	Actual AV*	Premium	Projected MLR
60% AV Plan	61%	$50	74%
70% AV Plan	71%	$80	80%
90% AV Plan	91%	$140	88%
Average**		$90	83%
*Actuarial Value (AV)			
**Assuming equal weighting for each plan			

Is this unfair discrimination? No, Yes and Yes!

I. No. The carrier can justify different loss ratios based on expenses and an intended subsidy

Comparing Loss Ratios Among Products

II. Yes. The MLR standard should apply at the plan level. All plans should have the same MLR. This determines the rate relativity. (Ignore the AV for purposes of the example.)

Carrier "Zephyr"			
PPO Product	Actual AV	Premium	Projected MLR
60% AV Plan	61%	$44.56	83%
70% AV Plan	71%	$77.07	83%
90% AV Plan	91%	$148.37	83%
Average*		$90.00	83%

*Assuming equal weighting for each plan.

Comparing Loss Ratios Among Products

III. Yes. Rate relativities should be based on Actuarial Value (AV). (ACA Single Risk Pool concept). Loss ratios will vary widely.

Carrier "Zephyr"			
PPO Product	Actual AV	Premium	Projected MLR
60% AV Plan	61%	$73.86	50%
70% AV Plan	71%	$85.96	74%
90% AV Plan	91%	$110.18	112%
Average*		$90.00	83%

*Assuming equal weighting for each plan.

The 3Rs and Loss Ratio

Risk Adjustment – Permanent Modification program

Risk Corridors – Temporary Catastrophic Program

Transitional Reinsurance – Temporary Subsidy for the Individual market

These programs (in NJ, all are administered by HHS) are expected to contribute to premium stabilization through risk spreading.

Risk Spreading: Reinsurance, Risk Adjustment, and Risk Corridors

Program:	Reinsurance	Risk Adjustment	Risk Corridors
What:	Provides funding to plans that cover the highest cost individuals	Transfers funds from the lowest risk plans to the highest risk plans	Limit issuer loss (and gains)
Who Participates:	All issuers and TPAs contribute; non-grandfathered individual market plans (in and out of the Exchange) are eligible for payments	Non-grandfathered individual and small group market plans, in and out of the Exchange	Qualified Health Plans (QHPs)
When:	Throughout years 2014-2016	After end of benefit year 2014 and subsequent years	After reinsurance and risk adjustment 2014-2016

Risk Adjustment

Built on a system that already exists in Medicare Advantage, Risk Adjustment is a permanent program which transfers funds from plans with relatively low risk enrollees to plans with relatively high risk enrollees to protect against adverse selection. It reduces the need for refunds and the variance among the plans.

- If a carrier (sets rates to) expect a loss ratio > 80%, it is more likely that there will be no refund.
- If a carrier (sets rates to) expect a loss ratio = 80%, the expected refund is smaller.

Risk Adjustment also reflects demographics (age, gender) that are not reflected in rating.

The Risk Adjustment will be small if each carrier gets the same percentage of people with expensive health conditions.

Reinsurance

Reinsurance will be funded with collections from all health insurance issuers and third-party administrators for self-insured plans. HHS states that Reinsurance contributions will total $10 billion in 2014.

A 3-year program (2014-2016).

Only individual market plans are eligible to receive payments, based on medical cost experience.

It is likely that every individual carrier will receive Reinsurance payments.

Reduces both expected claims and the riskiness of claims. (This was discussed earlier … large claims introduce the most variance into the equation.)

The impact on loss ratios is to "pull actual closer to expected", a restatement of what was said about Risk Adjustment.

Risk Corridors

- HHS will pay a Qualified Health Plan (QHP) issuer when its claims costs are greater than 103% of its cost projections
- HHS will receive payments from a QHP issuer when its claims costs are less than 97% of its cost projections

Simplified example: Assume (counter to fact) that Risk Corridors limit a carrier's financial results to a loss ratio between 75% and 85%.

- If the loss ratio is <75% (for example, 72%) the carrier puts 3% (75 – 72) into the Risk Corridor "pool".
- If the loss ratio is >85%, (for example 87%) the carrier receives 2% (87 – 85) from the Risk Corridor "pool".

Expected Risk Corridor adjustments could be small, because actual results need to deviate from expected by a great deal.

Risk Corridor payments, when a carrier is in a favorable (low loss ratio) situation, have to interact with the refund.

Simplified Risk Corridor – Example

- Premium = 100, with expected claims =82, expected administrative expenses = 15, and expected gain = 3. (Taxes are ignored to keep this simple.)
- The pricing loss ratio is 82/100 = 82% > 80% minimum
- The risk corridor is the pricing loss ratio (not the minimum) plus/minus 5% so from 77% to 87%.
- If claims are actually 72 (loss ratio of 72%), the carrier will pay 5% of premium to the risk corridor program, and 3% as a refund to policyholders. The carrier also gets to keep an extra 2% as gain, so the total gain is 3+2=5. (The order of payment will vary for Federal and State.)

Medical Loss Ratio and Rate Review in New Jersey

Questions?

Resources

Health Insurance Education: Rate Review Process and Consumer Resources (State)
http://www.state.nj.us/dobi/lifehealthactuarial/rateinfo/index.html

New Jersey Commercial Health Market Information (State)
http://www.state.nj.us/dobi/division_insurance/lhactuar.htm

Individual Health Coverage (IHC) Program Data (State)
http://www.state.nj.us/dobi/division_insurance/ihcseh/data_ihc.htm

Small Employer Health Benefits (SEH) Program Data (State)
http://www.state.nj.us/dobi/division_insurance/ihcseh/data_seh.htm

Your Insurance Company and Costs of Coverage (Federal)
http://www.healthcare.gov/

Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (Federal)
http://www.healthcare.gov/news/factsheets/2012/03/risk-adjustment03162012a.html

The Affordable Care Act and Medical Loss Ratios: Federal and State Methodologies
http://www.cshp.rutgers.edu/Downloads/9340.pdf

The ACA's Risk Adjustment and Other Risk Spreading Mechanisms
http://law.shu.edu/ProgramsCenters/HealthTechIP/HealthCenter/upload/affordable-care-act-risk-adjustment-9520.pdf