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Report of 2016 Loss Ratio Experience in the Individual and Small Employer Markets for: Insurance Companies Nonprofit Health Service Plan Corporations and Health Maintenance Organizations

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Introduction

Under Minnesota Statutes Section 62A.021, subdivision 1(h), the Minnesota Departments of Health and Commerce (the Departments) are required to issue a public report each year listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in the State of Minnesota. This report includes loss ratios for the calendar year ending December 31, 2016, for health plan companies regulated by the Departments. There is a public interest in dissemination of information that may help consumers choose from among available health plan companies.

The loss ratio is a measure of how much premium revenue collected by a health plan company was spent on medical care. Revenue not used to pay medical expenses is used for health plan administration, marketing, taxes, other expenses, and net income. However, due to many reasons related to operation and measurement, loss ratios are not necessarily an indicator of value for a specific health plan company in any one year.

State law establishes minimum loss ratios for small group and individual plans to ensure a minimum value to the consumer. See page six for a description of the requirements.

The small employer group includes entities actively engaged in business (including political subdivisions of the state) that meet the following criteria:

- employed 2-50 workers who worked at least 20 hours per week on business days during the preceding calendar year; and
- employs at least 2 current employees on the first day of the health plan year.

According to the 2015 Minnesota Health Access Survey conducted by the Minnesota Department of Health (Health), approximately 56 percent of Minnesota's population received coverage through an employer, while 6 percent of the population purchased individual coverage, and approximately 34 percent of Minnesota's population received coverage through public programs. The 2015 uninsured population in Minnesota was 4 percent.

Definition

Loss Ratio is the ratio of incurred claims to earned premiums. On their annual Supplemental Health Care Exhibits, health plan companies reported total earned premium, incurred claims, and loss ratio for the year ending December 31, 2016, by individual, small employer, and large employer fully insured health plan markets in Minnesota.[1] Loss ratio is often referred to as the medical loss ratio, or "MLR."

Notes on Using the Results

How to Use the Data

In order to use the loss ratio data for a specific purpose, it is important to find out additional information relevant to that purpose.

For example, when the Minnesota Department of Commerce (Commerce) reviews health plan rates for compliance with statutory requirements, we ask for additional information to evaluate the rates, including:

- how the loss ratio has been calculated
- the benefits that will be offered
- any recent changes in rates or benefits
- national experience when Minnesota experience is not credible (i.e. small sample size)
- an analysis of the relative newness of the experience
- any other information that will help evaluate whether rates will meet the statutory requirements

Unintentional Errors

The earned premiums, incurred claims, and loss ratios listed in this report have been provided by the health plan companies. The loss ratios have not been independently verified and may include unintentional errors.

[1] Individual market includes individual policies that converted from group coverage and individual certificates issued to members of associations; however, health plan companies offering only those policies are not included in this report, because state loss ratio requirements do not apply to them.

Loss Ratio is not the Same as Value

The loss ratio can be a valuable tool in comparing two health plan companies, assuming that they provide similar benefits. In that case, the plan with the higher loss ratio may provide better value to consumers.

Health plan companies differ in a variety of ways, however, and therefore the relative loss ratio is not always indicative of relative value. For example, one health plan company may not spend much effort preventing payment of fraudulent claims, while another may spend much effort resulting in non-payment of many fraudulent claims. The first company would have a higher loss ratio due to the fraudulent claims it paid but that would not be indicative of value. Similarly, one health plan company may pay doctors and hospitals at a higher charge level than another, due to different contractual arrangements, but those higher payments do not necessarily represent greater value to the policyholder.

Also, every prospective policyholder is different, with different health care needs. In order to compare health plan companies, it is necessary to review other aspects of the company which affect its value, such as availability of particular medical care providers, quality of patient service, and quality of care management.

Statistical Fluctuation

Loss ratios are subject to statistical fluctuation at a given point in time. Each individual's health care costs and the total incurred claims of a health plan company are more or less unpredictable. Having a high or low loss ratio may be due to fluctuations and may not be repeated in a future time period.

Recent Changes

Any change that has been made in a health plan company's business since the beginning of the reporting period also affects the loss ratio. For example, rate levels or benefits offered may have changed significantly due to legislative requirements, newly effective Affordable Care Act (ACA) plan design and coverage requirements, or plan changes made voluntarily by the health plan company.

Guaranteed Coverage

Prior to 2014, newer policies typically had lower levels of claims than policies that had been in force for more time due to health plan companies' ability to refuse to cover prospective policyholders who had a high expectation of claims. Effective January 1, 2014, the ACA required health plan companies to offer coverage to all individual and group applicants within the open enrollment period.

Transfers from the Minnesota Comprehensive Health Association

Prior to 2014, Minnesotans with pre-existing conditions could be refused coverage by a health care company. Those individuals could access health coverage through the Minnesota Comprehensive Health Association (MCHA). With the enactment of the ACA in 2014, MCHA policyholders transitioned their coverage to the individual market.

New Benefits

Starting in 2014, the ACA required additional mandatory benefits for individual health care policies for the first time. While the small group market had to adopt these additional benefits as well, those policies generally already provided comprehensive coverage and were largely unaffected. Some of these newly required benefits include maternity, pharmacy, mental health, and substance abuse coverage. These additional benefits increased health plan companies' incurred claims. These additions may have increased the loss ratio, because these benefits were previously available to fewer policyholders.

Federal Risk Mitigation Programs

Due to ACA requirements beginning on January 1, 2014, health plan companies may no longer deny coverage or charge higher premiums based on the health status of the policyholder. This core tenet of the ACA allows consumers to purchase health care coverage, even with pre-existing conditions. Programs and regulations exist to prevent health plan companies from discriminating against sicker enrollees. Because of the new health care laws, health plan companies faced uncertainty about how to price new coverages for new purchasers. To protect consumers, the ACA established three risk-mitigation programs known as the "3 R's": risk adjustment, reinsurance, and risk corridors. The overall goal of these three programs has been to provide more certainty, to promote competition, and to stabilize premiums. These three programs affect the earned premium and incurred claims amounts shown on Attachment 1. The loss ratio on Attachment 1 may be affected by additional income and expense items due to these three programs. These programs are described in further detail below.

Risk Adjustment Program

The risk adjustment program is the only permanent federal health care risk mitigation program. Prior to 2014, health plan companies in the individual and small group markets were concerned with the overall claims levels of only their own risk pool. The risk adjustment program provides payments to health plan companies that disproportionately attract higher-risk policyholders (such as individuals with chronic conditions). The program transfers funds from health plan companies with relatively lower risk enrollees to health plan companies with relatively higher risk enrollees. The goal of the risk adjustment program is to encourage health plan companies to compete based on the value and efficiency of their plans, rather than by attracting healthier enrollees. This also helps protect certain health plan companies from adverse selection.

Temporary Reinsurance Program

The goal of the ACA's temporary reinsurance program has been to stabilize individual market premiums during the early years of new market reforms. This program was in place from 2014 through 2016. The program transfers funds from nearly all the health insurance markets to the individual market. Health plan companies in the individual market receive highly-subsidized reinsurance support for their highest cost policyholders.

Temporary Risk Corridors Program

The ACA's temporary risk corridors program intended to discourage health plan companies from setting high premiums in response to uncertainty about who will enroll and what they will cost. The program was intended to reduce extreme gains and losses for health plan companies operating on the health insurance exchange. The risk corridors program sets a target of approximately 80 percent of premium dollars to be spent on health care claims and quality improvement. Health plan companies with claims less than 3 percent of the target amount must pay into the risk corridors program. The funds collected are used to reimburse health plan companies with claims that exceed 3 percent of the target amount. The latest transfer resulted in only 3.3 percent of the expected program reimbursements for plan year 2015, though the program's 2015 program receipts were directed to companies with 2014 plan year losses. Future payments into the program will continue to be prioritized to the health plan company losses that accrued in 2014. The proportion being reimbursed for 2016 is still unknown at the time of this writing.

Rates Regulation in Minnesota

Minnesota Statutes Section 62A.02 requires all health plan rates to be approved by the Commissioner of Commerce or the Commissioner of Health before becoming final for purchase. Minnesota has an effective rate review process, which means a health plan company must supply actuarial justification and data demonstrating that the benefits are reasonable in relation to the premiums. Commerce reviews all rates to verify reasonableness and compliance with state and federal law. Rate restrictions for individual plans are specified in Minnesota Statutes Section 62A.65, and small employer plans are specified in Minnesota Statutes Section 62L.08.

Federal Medical Loss Ratio as defined by the Affordable Care Act

The ACA was passed by Congress and signed into law on March 23, 2010. The ACA requirements for MLRs are provided under Section 2718 of the ACA. More detailed information regarding these requirements may be found in the Code of Federal Regulations Title 45, Part 158. Note that the calculation of the MLR is slightly different than the state loss ratio described below.

As national leader, Minnesota has had MLR requirements for more than 20 years. Starting in calendar year 2011, the federal government required that an insurer that does not spend enough of its premium dollars on health care must provide a rebate paid the following year to the insured individual or to the policyholder, which may be the employer that purchased the insurance.

Under the ACA, an insurer's MLR is the ratio of the issuer's payments for medical services and activities that improve health care quality to premium revenue (minus the issuer's federal and state taxes, licensing, and regulatory fees). In other words, a MLR is the amount of health insurance premiums that an insurer spends on health care and activities to improve health care quality, as opposed to profits and administrative costs, including executive salaries, overhead, and marketing. Like Minnesota's loss ratio, the ACA MLR is expressed as a percentage: a MLR of 90 percent means 9 out of 10 of all premium dollars that the insurer receives are spent on health care and quality improvement, with the other money spent on overhead, profits, and administrative costs.

Under the ACA requirements, insurers must provide a rebate to consumers if the MLR is less than 85 percent in the large group market and 80 percent in the small group and individual markets. This rule does not apply to employers who operate a self-insured plan. In addition, the experience of very small insurers with less than 1,000 people enrolled cannot sufficiently confirm that they have or have not met the MLR standard, and as a result those insurers are deemed non-credible and are not required to provide rebates. An insurer with 1,000 to 75,000 people enrolled is considered to have partially-credible experience and a "credibility adjustment" is applied to its MLR under the ACA.

The amount of rebate to each enrollee is the total amount of premium revenue received by the issuer from the enrollee (after subtracting Federal and State taxes, licensing, and regulatory fees), multiplied by the difference between the MLR required by ACA and the issuer's MLR, subject to the applicable credibility adjustment.

Begining January 1, 2011, health plan companies reported MLRs for all fully insured plans to the Secretary of the U.S. Department of Health and Human Services (HHS). A "Plan Year" is defined as the calendar year. The first report, covering plan year 2011, was filed on June 1, 2012. Insurers were required to make the first round of rebates to consumers in 2012. Starting in the summer of 2012, HHS posted insurers' reports and MLRs online at http://www.cms.gov/apps/mlr/mlr-search.aspx.

The Centers for Consumer Information and Insurance Oversight (CCIIO) is responsible for enforcement of the ACA's MLR reporting and rebate requirements. After working with the National Association of Insurance Commissioners (NAIC) on procedures for the MLR audit program, CCIIO has begun examinations nationally.

Medical Loss Ratio as Defined by Minnesota Law

Individual states may require a higher minimum MLR for insurers operating within their state and may calculate the MLR differently from the ACA definition. Minnesota law requires that individual, small employer, and large employer health plan rates meet the specific minimum MLR standards in Minnesota Statutes Section 62A.021.

Minnesota's loss ratio is defined as incurred claims divided by earned premium, which is different from the ACA MLR calculation. Minnesota law requires that small employer group plans have rates that are expected to achieve a minimum loss ratio of 71 percent to 82 percent, and that individual plans have rates that are expected to achieve a minimum MLR of 68 percent to 72 percent for health maintenance organizations and nonprofit health service plan corporations.

For insurance companies, Minnesota law requires that large group plans, small employer group plans, and individual plans have rates that are set to achieve a minimum MLR of 60 percent. However, in practice the MLR standards used are similar to those used for health maintenance organizations and nonprofit health service plan corporations, since the premiums must be reasonable in relation to benefits per Minnesota Statute Section 62A.02. Moreover, the insurers attest to expected MLRs that are in line with the competitive environment of Minnesota.

The Minnesota MLR is only prospective in nature and Commerce reviews Actuarial Memorandums and past loss ratio experience for demonstrations of compliance.

Unlike Minnesota's state MLR standard, which is prospective, the federal MLR standard is retrospective in nature and carries with it rebates to customers if the minimum MLRs are not met in each marketplace.

Individual, Small Group and Large Group Loss Ratios

The MLRs shown on Attachments 1 through 3 under the column titled State Loss Ratio are based on the Minnesota definition of MLR. The column titled Preliminary ACA MLR gives the preliminary estimate of the ACA MLR from the health plan company's annual statement, as shown in the Supplemental Health Care Exhibit. Domicile as shown on Attachments 1 through 3 refers to the state in which the health plan company was first licensed and the state that has the primary regulatory responsibility.

Additional Reference Sources

For information about insurance companies and nonprofit health service plan corporations, please contact the Commerce Department at:

Minnesota Department of Commerce
Insurance Division
85 7th Place East, Suite 280
St Paul, MN 55101-2198
(651) 539-1600; (800) 657-3602
mn.gov/commerce/insurance

For information about health maintenance organizations, please contact the Health Department at:

Minnesota Department of Health
Managed Care Systems Section
85 7th Place East
P.O. Box 64882
St. Paul, MN 55164-0882
(651) 201-5100; (800) 657-3916
www.health.state.mn.us/hmo

Attachment 1
Individual Market
Supplemental Health Care Exhibit for 2016

Group Code	NAIC Number	Name	Domicile	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR*	Covered Lives
461	55026	BCBSM Inc	MN	648,723,630	691,772,997	107%	108%	90,357
1552	95232	Medica Hlth Plans of WI	WI	171,809,789	179,661,941	105%	118%	40,514
1258	44547	Healthpartners Ins Co	MN	133,534,000	143,157,000	107%	109%	51,523
461	95649	HMO dba Blue Plus	MN	52,559,407	47,624,803	91%	94%	12,077
1258	52628	Group Hlth Plan Inc	MN	52,346,000	58,905,000	113%	112%	18,212
4380	52629	UCare MN**	MN	36,394,087	26,892,987	74%	104%	15,425
1552	12459	Medica Ins Co	MN	26,883,960	23,891,539	89%	94%	7,150
1258	95766	Healthpartners Inc	MN	3,064,000	4,739,000	155%	164%	441
3492	11817	PreferredOne Ins Co	MN	2,316,656	10,621,651	458%	143%	1,494
1552	52626	Medica Hlth Plans ***	MN	348,546	840,690	241%	1445%	9
		Total		**$1,127,980,075**	**$1,188,107,608**	**105%**	**NA**	**237,202**

Attachment 1 lists the MLRs experienced in the individual health plan market in 2016 by companies that cover individuals in that market. Not all health plan companies with individual health plans in force are shown above, as some had premium volume lower than $300,000, which were not included. Health plan companies vary in their inclusion and treatment of risk adjustment, reinsurance and risk corridor program revenues and payments, affecting premiums and/or claims entries in terms of 2016 incurred values as well as 2014 accounting reconciliations.

The Minnesota MLRs for 2016 ranged from 94% to 1445%. The total Minnesota MLR for 2016 is 105%. The total Minnesota MLR for the previous year was 116%.

*Values for the ACA MLR are marked above as preliminary because, due to the late timing of the 3Rs processing, health plan companies must estimate financial entries for each of the 3R programs.

**The Supplemental Health Care Exhibit entries for UCare MN and UCare Health Inc. have been combined since UCare Health Inc. does not offer commercial coverage, but handles out of network processing on behalf of UCare MN.

***Carrier does not offer individual coverage; these policies are legacy conversion/portability continuation policies from the group insurance market.

Attachment 2
Small Employer Group
Supplemental Health Care Exhibit for 2016

Group Code	NAIC Number	Name	Domicile	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR*	Covered Lives
461	55026	BCBSM Inc	MN	540,864,397	470,883,560	87%	91%	108,943
1258	95766	Healthpartners Inc	MN	453,965,000	409,743,000	90%	94%	104,427
1552	12459	Medica Ins Co	MN	81,158,601	64,311,906	79%	86%	13,501
1258	44547	Healthpartners Ins Co	MN	68,685,000	57,199,000	83%	88%	9,773
3492	11817	PreferredOne Ins Co	MN	59,387,210	57,233,090	96%	95%	16,832
7	13935	Federated Mut Ins Co	MN	31,749,923	25,701,406	81%	91%	7,789
3492	95724	PreferredOne Comm Hlth Plan	MN	9,999,960	8,114,853	81%	88%	958
461	95649	HMO dba Blue Plus	MN	3,456,296	2,898,390	84%	86%	1,073
4870	14202	Gundersen Hlth Plan MN	MN	1,174,006	1,049,434	89%	90%	254
		Total		**$1,250,440,393**	**$1,097,134,639**	**88%**	**NA**	**263,550**

Attachment 2 lists the MLRs experienced in the small employer health plan market in 2016 by health plan companies that cover small employer groups. Not all health plan companies with small employer health plans in force are included, as some had premium volume lower than $300,000, which were not included. Also excluded are self-funded health plans. Sanford is missing from this 2016 exhibit altogether because of premium entries below $300,000.

An entity actively engaged in business (including political subdivisions of the state) that meets the following criteria is considered a small employer group:

- employed 2-50 workers who worked at least 20 hours per week on business days during the preceding calendar year; and
- employs at least 2 current employees on the first day of the health plan year.

The Minnesota MLRs for 2016 ranged from 79% to 96%. The total Minnesota MLR for 2016 for health plan companies is 88%. The total Minnesota MLR for the previous year was 84%.

*Values for the ACA MLR are marked above as preliminary because, due to the late timing of the 3Rs processing, carriers were forced to estimate financial entries for each of the 3R programs.

Attachment 3
Large Employer Group
Supplemental Health Care Exhibit for 2016

Group Code	NAIC Number	Name	Domicile	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR*	Covered Lives
461	55026	BCBSM Inc	MN	1,256,681,810	1,085,321,500	86%	91%	224,513
1552	12459	Medica Ins Co	MN	708,824,012	593,665,949	84%	89%	133,389
1258	44547	Healthpartners Ins Co	MN	652,127,000	561,352,000	86%	91%	276,930
1258	95766	Healthpartners Inc	MN	229,059,000	199,686,000	87%	91%	34,288
3492	11817	PreferredOne Ins Co	MN	88,365,785	76,901,774	87%	91%	21,248
1258	52628	Group Hlth Plan Inc	MN	50,967,000	51,561,000	101%	103%	8,055
7	13935	Federated Mut Ins Co	MN	14,806,349	10,010,530	68%	81%	3,123
461	95649	HMO dba Blue Plus	MN	5,591,227	5,657,755	101%	109%	675
901	67369	Cigna Hlth & Life Ins Co	CT	4,158,034	3,679,620	88%	95%	955
1246	95725	Sanford Hlth Plan of MN	MN	2,226,896	1,914,948	86%	127%	430
3492	95724	PreferredOne Comm Hlth Plan	MN	674,603	556,367	82%	86%	101
1	60054	Aetna Life Ins Co	CT	632,514	621,601	98%	103%	232
4870	14202	Gundersen Hlth Plan MN	MN	428,207	376,753	88%	92%	83
		Total		**$3,014,542,437**	**$2,591,305,797**	**86%**	**NA**	**704,022**

Attachment 3 lists the MLRs experienced in the large employer health plan market in 2016 by health plan companies that cover large employer groups. Not all health plan companies with large employer health plans in force are included, as some had premium volume lower than $300,000, which were not included. Also excluded are large employers with self-funded health plans.

Large Employer Group means a person, firm, corporation, partnership, association, or other entity actively engaged in business in Minnesota, including a political subdivision of the state, that employs more than 50 employees.

The Minnesota MLRs for 2016 ranged from 68% to 101%. The total Minnesota MLR for 2015 for health plan companies is 86%. The total Minnesota MLR for the previous year was 85%.

*Values for the ACA MLR are marked above as preliminary due to the late timing of certain claims payments that were unknown at the time when financial statements were filed, in contrast to the time of MLR final reporting.