MLR Regulation Creates Challenges for Future of Affordable Coverage

Bronze plans may be scarce in state insurance exchanges

The final medical loss ratio (MLR) regulations will likely create a vacuum for affordable coverage that cannot be filled by Bronze plans under the state insurance exchanges. If the "essential benefits" and "actuarial value" requirements are equally as discriminatory, there will be no affordable options available and the cost of subsidies will skyrocket. As a result, millions of Americans that have policies today that could have qualified as Bronze plans will be forced to change their coverage or drop coverage because they can no longer afford it.

Background

On December 7, 2011, the U.S. Department of Health & Human Services (HHS) published in the *Federal Register* the final regulation governing how it will implement the minimum medical loss ratio (MLR) requirements for insurance plans sold in the private market.[1] These regulations have been in effect on an "interim final" basis for all of 2011 and will continue to apply in future years. Although these regulations are "final," the Department provided a 30-day comment period that ends January 6, 2012.

It is important to understand that the new MLR requirements only apply to policies sold by insurance companies, also known as "fully insured" policies. That means individuals purchasing coverage on their own, small businesses, and some larger businesses will be the most affected by the regulations. But the regulations will not apply to a large number of people, mostly employees of companies that "self-insure" their employee benefits. The requirements likewise do not apply to third-party administrators (TPAs), including the portion of an insurance company's business involved in administering a self-insured employer's health benefits for its employees.

What Is a "Medical Loss Ratio"?

A medical loss ratio measures, in percentage terms, the amount of premiums collected by an insurance company that are spent on direct patient care through payment of medical claims. Some adjustments may be made for taxes paid and other items, but the basic concept remains the percentage of premiums spent on medical claims. The health reform law requires that insurance companies spend at least 80 percent of the premiums they collect, on average, as medical claims for policies sold to individuals and to small businesses (less than 50 employees). The law requires a higher MLR – 85 percent – for policies sold to larger companies.

A minimum medical loss ratio sounds good on its face. The intent is to ensure that consumers get good value from their insurance policy, not unlike determining what percentage of funds given to a charity actually benefit the people it purports to help rather than fundraising and other expenses. But while charities are "non-profit" organizations, insurance companies are in the business of making a profit – whether they pay taxes on that profit or not – so they can stay in business providing coverage to

[1] Federal Register, Vol. 76, No. 235, Wednesday, December 7, 2011, p. 76574 – 76594.

Americans who buy their policies. Some insurance companies sell shares of stock in their company to investors and are also interested in providing a valuable return on shareholders' investments.

Some politicians, insurance regulators, and consumer advocates do not like the fact that insurance companies are in business to make a profit. These individuals and groups frequently criticize insurance companies for making excessive profits and paying their executives exorbitant compensation. Therefore, the minimum loss ratio standards act as price controls, seeking to limit the cost of insurance by controlling the portion of the premium that is available to be spent on administrative expenses and profit (i.e., the remaining 15 or 20 percent of the premium collected). For example, a 70 percent MLR standard would require insurance companies to pay at least $70 of every $100 in premiums collected on medical claims. As a result, the company would be required to spend no more than $30 of every $100 in premiums collected on administrative expenses (including profits).

Only a few states imposed minimum MLR standards on certain segments of their insurance markets before the health reform law was enacted, but most did not. Only one state (New York) imposed any MLR standards as high as those called for in the health reform law. For example, Minnesota imposed an 82 percent MLR in the large group market, compared to the new law's 85 percent minimum. In the small group market, several states imposed a 75 percent MLR requirement, but that is well below the new 80 percent MLR in the new law, and most states either had lower MLR requirements or did not impose any. In the individual market, only New York and California imposed an 80 percent MLR, but California just raised their minimum MLR to 80 percent earlier in 2011, after the federal law was enacted. With the bar being raised higher than any state had previously, it will be interesting to see how the new higher standards impact insurance companies.

Some states have clearly been concerned about the new higher standards. But states must seek a waiver if they want to use a lower standard to prevent destabilization of their insurance markets. As of December 22, 2011, six states have approved waivers – Georgia, Iowa, Kentucky, Maine, Nevada, and New Hampshire. Six states' waiver requests have been rejected – Delaware, Florida, Indiana, Louisiana, Michigan, and North Dakota. Five additional states – Kansas, North Carolina, Oklahoma, Texas, and Wisconsin -- have applied for waivers but are still waiting for approval from federal officials.

It is important to understand that each insurance carrier must calculate separate MLRs for each market segment (e.g., individual, small group, large group) within each state where they sell products. MLRs are not calculated separately for each product (e.g., HMO, PPO, HDHP) but are aggregated within each market segment in each state. For example, an insurance company that sells products in each market segment in all 50 states plus the District of Columbia would need to calculate 153 separate MLRs. These calculations will then be used to determine whether the insurance company must issue any rebates (partial refund of premium) to particular policyholders.

How Is an MLR Calculated Under the HHS Regulation?

The formula for calculating MLRs under the HHS regulation is a modified version of the ratio of paid medical claims to premiums collected, as follows:

$$\text{MLR} = \frac{\text{Claims} + \text{Quality}}{\text{Premiums} - [\text{Taxes, Fees}]}$$

The insurance industry sought a variety of adjustments to the MLR formula but most were not adopted. The adjustments for taxes, fees, and "quality" (e.g., cost of claims audits, wellness, etc.) were adopted but are not significant to this discussion.

The regulation does include two important adjustments in the MLR calculation, but the adjustments are only valid through 2013. The adjustment factors were an attempt to reduce market volatility for new plans and plans with small enrollment (a credibility adjustment) and for plans with high deductibles (a cost-sharing adjustment). These adjustments may reduce or, in some cases, eliminate the need for some carriers to pay rebates for some market segments in some states.

Credibility Adjustment

Some insurers may have a small market share in certain market segments in any given state, making their claims experience more volatile because they have a smaller pool of policy holders over which to spread risk (i.e., one large claim could skew the experience of the entire block of business). The credibility adjustment is intended to help "smooth" the volatile experience of small blocks of business.

Life-Years Base Credibility	Factor
< 1,000	Not credible
1,000	8.3%
2,500	5.2%
5,000	3.7%
10,000	2.6%
25,000	1.6%
50,000	1.2%
75,000	0.0%

Here's how the credibility adjustment works (see chart at right): If a block of business for an insurance company in a state has less than 1,000 life years,[2] it is considered "not credible" and no rebate is required. On the other end of the spectrum, if a carrier's block of business in a state has more than 75,000 life years, it is considered "fully credible" and no credibility adjustment is applied. In between the two extremes, there is a positive adjustment to the MLR for small blocks of business, but the adjustment gets smaller as carriers' enrollment in blocks of business increase.

The adjustment is applied as a "credit" to the initial MLR calculated by the carrier for the block of business. For example, if a carrier calculates an initial MLR of 78% for a block of business with 5,000 enrollees, it would then add a credibility adjustment of 3.7 percentage points, raising the MLR for the block of business to 81.7% for purposes of determining whether it complies with the minimum MLR standard for the block of business and whether it must pay rebates.

[2] "Life years" is similar to but not the same as "covered lives." The term "life years" adjusts the number of "covered lives" when some individuals are not covered by the plan for an entire 12-month period.

Cost-sharing Adjustment

Insurers that sell plans with high deductibles will also have more volatile claims experience because the plan doesn't pay for claims costs below the deductible and the plan collects less in premiums. The cost-sharing adjustment is intended to help "smooth" the experience of high deductible plans. The way this is done under the regulation is that the insurance company computes the weighted-average deductible for the policies it sells within the block of business in the state. If the weighted average deductible is less than $2,500, there is no adjustment for cost-sharing (see chart at right). If the weighted average deductible is greater than $2,500 but less than $10,000, then an adjustment factor is applied. There is no additional adjustment applied when the weighted average deductible exceeds $10,000.

Health Plan Deductible	Deductible Factor
<$2,500	1.000
$2,500	1.164
$5,000	1.402
≥$10,000	1.736

The cost-sharing adjustment factor is a mathematical constant that is determined by linear interpolation. The example below illustrates how this is done.

Example

ABC Insurance Company sells 10,000 policies in the small group market in Idaho with the following enrollment distribution, by policy deductible:

Policy Deductible	Enrollment (Life Years)	Adjustment Factor
$250	500	
$500	1,250	
$1,500	2,000	
$3,000	3,500	
$7,500	1,750	
$10,000	1,000	
Weighted Avg:	**Total:**	
$3,378	**10,000**	**1.282**

Where's the Problem?

After reading an analysis of the MLR requirements by Citigroup[3] in October, 2010, I was concerned that the National Association of Insurance Commissioners (NAIC) would not realize that high deductible plans would need special consideration when determining MLRs. So I was delighted to see the cost-sharing adjustment factor and that it appeared helpful to high deductible plans (i.e., the adjustment factor increases as deductibles increase). But then I discovered a potentially serious problem when I learned that the credibility and cost-sharing adjustment factors are not applied independently as I thought they

[3] "Nobody's Right if Everybody's Wrong: A More Detailed Look At The Impact Of Minimum MLRs," Citigroup Global Markets, Inc., October 21, 2010

should be. Instead, the two factors are multiplied together before being applied thereby reducing the impact that the cost-sharing adjustment factor has on the MLR for a block of business, even if they plan has very high deductibles. Here's how the formula looks after applying the two adjustment factors to the initial MLR:

Adjusted MLR = [Initial MLR] + [Cost-sharing Factor x Credibility Factor]

Applying the formula to the example above, where an insurance carrier has a block of business with 10,000 life years and weighted average deductible of $3,378, the carrier would receive a positive adjustment of 3.3 percentage points. If the carrier's initial MLR was 73.1 percent, the adjustments would increase the MLR to 76.4 percent for purposes of calculating rebates, as follows:

Adjusted MLR = 73.1% + [1.282 x 2.6%] = 76.4%

In this case, the credibility and cost-sharing adjustment factors reduce but do not eliminate the need to pay rebates for this block of business.

Upon closer inspection, the most adjustment a carrier's block of business could receive would be 14.41 percentage points (1.736 x 8.3%), so it is not mathematically possible for any plan with an initial MLR below 65 percent to reach the minimum MLR of 80 percent. Keep in mind that this is only possible if a carrier's block of business has 1,000 enrollees and a weighted average deductible of $10,000 or more.

Most carriers' blocks of business will likely receive much lower adjustments and the adjustments will approach zero as enrollment grows. If an insurance company grows its enrollment in a block by selling high deductible health plans, the cost-sharing adjustment factor will continue to be reduced by the credibility adjustment factor (which ultimately becomes zero), meaning carriers will receive no adjustment after their enrollment exceeds 75,000 members in the block of business even if they are selling plans with average deductibles above $10,000. I worry that this will discourage insurance companies from selling more high deductible plans in the future, especially in the state insurance exchanges of the future.

Related Issues

Why do high deductible plans have more challenges meeting the MLR standards? There are several reasons.

First, high deductible plans naturally pay fewer claims because of the up-front deductibles. Plans with higher deductibles end up being disadvantaged by the MLR formula because they cannot count claims incurred below the deductible. Since high deductible plans are designed not to pay claims below the deductible, a high MLR arbitrarily discriminates against these plans by requiring them to meet a standard they were not designed to meet. For example, if a "Bronze" plan is only designed to pay 60 percent of the cost of benefits on average, it does not seem appropriate to force it to pay 80 percent of its premiums as medical claims.

Second, high deductible plans still incur expenses associated with processing claims below the deductible even though the claims are not paid by the plan. High deductible plans must process all claims to ensure that they are properly credited towards satisfying deductibles and limits on out-of-pocket expenses. Although the MLR rule does not allow insurance carriers to count claims paid by patients as "paid claims," the carrier must still incur the cost of processing them.

A potential fix to these first two problems would be to modify the MLR regulation to allow all insurance plans to include claims incurred for benefits covered by the plan below the deductible. This should be permitted for all plans – low deductible and high deductible plans alike. This would remove the bias against high deductible plans.

Third, fixed costs represent a higher share of expenses for high deductible plans because of their lower premiums. Every plan has fixed costs for things such as property rent/lease/mortgage, utilities, liability insurance, telephones, computers, software, etc. All things being equal, $100 of fixed costs represent a higher share of premiums for a plan with a premium of $2,000 compared to a plan with a premium of $5,000. The lower the premium, the higher the percentage of premium fixed costs represent.

Actuaries typically allocate non-claims costs across their company's product portfolio using an allocation formula. For example, if an insurance company sells a zero-deductible plan with a $10,000 premium, it must allocate $8,000 for medical claims to meet the minimum 80 percent MLR, leaving $2,000 for "administrative costs" and contingencies other than claims (i.e., the remaining 20 percent).

Some portion of the $2,000 "administrative expenses" would be allocated for fixed costs (examples described above) and the rest to variable costs that fluctuate with the amount of premium collected (i.e., commissions, premium tax, profit). The allocation for variable and fixed costs can vary somewhat from company to company, but variable costs typically are given a higher allocation (e.g., 60 percent for variable costs and 40 percent for fixed costs). So in this case, variable expenses would be $1,200 (60 percent of $2,000) and fixed expenses would be $800 (40 percent of $2,000).

If these amounts are applied to a high deductible plan with an actuarial value of 60 percent (i.e., a "Bronze plan"), the premium needed to cover all expenses (claims and administrative expenses) would be determined as follows:

$4,800 for claims ($8,000 x 60%)

$720 for variable expenses ($1,200 x 60%)

$800 for fixed expenses (pre-determined)

$6,320 total premium needed

Interestingly, if the plan actually pays out $4,800 in medical claims per member (on average) as intended, its MLR will be only 76 percent, four percentage points below the 80 percent minimum MLR. In fact, this plan would need to incur claims of $5,056 per member (on average) to achieve an 80

percent MLR. But since the carrier only set aside an average of $4,800 per member for medical claims, it will lose money unless it raises its premium. But if it raises its premium, then the plan will be less affordable.

Fourth, the MLR "cost-sharing adjustment factor" is only based on the policy deductible, not the limit on out-of-pocket expenses. This means that plans with different deductibles but identical limits on out-of-pocket expenses would have different cost-sharing adjustment factors applied. For example, a plan with a $2,000 deductible and an out of pocket limit of $5,000 receives no cost-sharing adjustment (factor = 1.000) because its deductible is less than $2,500. However, a plan with a $5,000 deductible and a $5,000 out-of-pocket limit (i.e., 100 percent coverage after the deductible is met) receives a cost-sharing adjustment factor of 1.402 because of its higher deductible. Note that HSA-qualified "high deductible" plans can have deductibles as low as $1,200 (for 2011 and 2012) for self-only coverage, so none of these plans will have any cost-sharing adjustment applied.

Conclusions

Clearly, the MLR adjustment factors for cost-sharing and credibility help companies offering high deductible plans but only if they have low enrollment. Most companies will likely see little benefit because the adjustments end up being minimal and ultimately disappear because of the way the MLR formula is constructed. In the short-term, this could limit future growth of HSAs in the fully-insured markets (individual, small group, large group) and put extra pressure on premium pricing to minimize potential rebates. Insurance companies (especially the current market leaders) may be encouraged to sell more expensive plan designs with more first-dollar coverage (e.g., HMOs and traditional PPOs) because it will be easier to meet the MLR requirements. The result could be a future market dominated by more expensive plans, dramatically reducing affordability of coverage and adding significantly to the costs of income-based subsidies provided under the law, since the subsidies are based on the weighted average premiums for Silver plans in the "market area."

The good news is that most of the growth in enrollment in high deductible plans is coming from the large employer market which is largely self-insured and thus exempt from these regulations. The MLR regulations may even encourage more fully insured businesses to become self-insured just to avoid these regulations.

While it is easy to take comfort in the tremendous growth opportunity for high deductible plans in the self-funded employer market, it is also important to keep in mind the uncertainty that remains after the employer and individual mandate requirements become effective in 2014. A relatively low penalty ($2,000 or $3,000) could encourage employers to drop self-funded coverage and overnight lead to a mass exodus of workers into the state insurance exchanges where fully insured plans subject to these MLR requirements will be sold.

Unanswered Questions

This leaves several unanswered questions. Will insurance companies still be selling high deductible plans in 2014? Will consumers demand high deductible plans with low premiums to comply with the

individual mandate? Will the income-based subsidies available through the exchanges stimulate demand for "Bronze" and "Silver" plans?

Can the regulation be fixed? Yes, and the 30-day comment period provides an opportunity to do so, **but the comment period closes January 6, 2012**.

How could the regulation be fixed? One option would be to exempt high deductible plans from the MLR standard altogether. Such an exemption was requested in comment letters submitted by the American Bankers Association HSA Council, America's Health Insurance Plans, and the Council for Affordable Health Insurance.

Another option would be to set a more appropriate MLR for high deductible plans, one that might mirror the actuarial value standard for the plan. For example, a "Bronze" plan with a 60 percent actuarial value would have a 60 percent minimum MLR requirement applied.

A third option would be to allow all insurance companies to count claims paid below the deductible (by the members, not the plan) for covered benefits as "claims paid by insurance" solely for purposes of calculating whether the plan meets the MLR.

A fourth option would be to change the formula for calculating the MLR so that the credibility adjustment factor and cost-sharing adjustment factors are applied independently. This would eliminate the possibility of having zero adjustment applied to high deductible plans.

This regulation cannot be fixed by adjusting the essential health benefits, as some have suggested.

What You Can Do to Help

Changing the final regulation will require political will. Letting your elected representatives know that the regulation needs to be fixed will help federal regulators make the right decision. You can find out how to contact your representatives online at www.house.gov and www.senate.gov.

You can also submit comments to the U.S. Department of Health and Human Services. The best way to ensure your comments are received is to submit them electronically via the following link http://www.regulations.gov/#!documentDetail;D=CMS-2011-0179-0001 then clicking on the button "Submit a Comment."

Comments cannot be accepted via email or facsimile. If you choose to send a written letter, be sure to reference file code CMS–9998–FC. However, letters must be received (not just postmarked) by 5:00 p.m. ET on January 6, 2012.

I urge you to comment on this regulation.

Roy Ramthun

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