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A Summary of the Updated Medical Loss Ratio Methodology and Historical Results

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A Summary of the Latest Updated Medical Loss Ratio Methodology and Historical Results

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The Center for Medicare and Medicaid Services (CMS) recently released its annual Medical Loss Ratio (MLR) data form along with filing instructions for Contract Year 2018[1].

Introduction to MLR Rules:

The CMS Loss Ratio methodology was developed in conjunction with a requirement from the Patient Protection and Affordable Care Act (PPACA) of 2010. As part of this legislation new rules were introduced which required medical insurance carriers to spend a minimum amount of their premiums on medical care. This minimum amount varies by the type of product being sold or administered. On the commercial side, Individual and Small Group policies have a minimum Medical Loss Ratio of 80%, while Large Group policies have a requirement to spend at least 85% of their premiums on medical care. These requirements took effect in 2011 and have been in place since. They apply to each calendar year separately with annual MLR filings being required for all carriers in each State where they operate.

In government programs, Medicare Advantage and Managed Medicaid carriers must spend at least 85% of their revenue on claims. While commercial insurance requirements took effect in 2011, the criteria for government programs were developed later on and Medicare Advantage requirements took effect in 2014[2]. Like the commercial MLR requirements, these rules apply on a calendar year basis with annual filings in each state that a carrier operates. For Managed Medicaid, the 85% requirement went into effect in 2017 for all contracts that started on or after July 1, 2017. For the Children's Health Insurance Program (CHIP), the MLR requirement applies to any contracts beginning on July 1, 2018 and later.[3] It is worth noting that prior to the implementation of this rule, many states already had minimum MLR requirements as shown in Figure 1 from the Kaiser Family Foundation below.[4]

Figure 1
MEDICAID MLR REQUIREMENTS IN THE STATES, OCTOBER 2010

State	Minimum MLR for Medicaid MCOs	Includes direct care management as medical expense
AZ	84%	
DC	85%	x
HI	91.5% for QUEST plans; 93% for QExA plans for aged and disabled	x
IL	80%	
IN	85%	
MD	85%	x
NJ	80%	x
NM	85%	x
OH	85%	
VA	92%	x
WA	80%	

Figure 1 also demonstrates that states have often implemented higher MLR requirements on some or all of their Managed Medicaid blocks. Generally, Medicaid blocks with greater average costs, such as disabled and nursing home populations are more likely to have higher MLR requirements than just traditional Medicaid and CHIP programs. Finally, Medicaid contracts typically run during State fiscal periods or other non-calendar year periods, such as July 1, 2019 – June 30, 2020.

Minimum MLR Methodologies

The Medical Loss Ratio methodologies are generally consistent across the different types of insurance products mentioned above. The differences between commercial, Medicare Advantage, and Managed Medicaid MLR methodologies are relatively minor. In the section below, this report will focus on the basic components of the MLR formula which are common to most MLR calculations. The main differences are related to what specific items might be kept in or taken out of the calculations.

The main MLR calculation consists of a numerator that represents acceptable claims expenses and a denominator that represents acceptable earned revenue components. If the ratio of the numerator to the denominator exceeds the required MLR percentage, then the carrier does not owe any rebate. If the ratio is less than the required MLR percentage, then the carrier owes a rebate back to its members. Finally, for blocks of business that lack full credibility, there are specific adjustments to the MLR formula which allow carriers to pay back less than the full unadjusted rebate or no rebate at all. Overall, the generic MLR formula is as follows[5]:

Adjusted MLR = MLR (Claims) Numerator / MLR (Premium) Denominator + Credibility Adjustment

If the Adjusted MLR is less than the Minimum MLR, then:

*MLR Payback = (Minimum MLR – Adjusted MLR) * MLR Denominator*

Components of the Numerator: Claims Related Expenses[6]

The numerator of the MLR Calculation includes the following basic components:

1. Adjusted incurred claims for the reporting year
    a. Includes claims paid and incurred in the reporting year plus runout period
    b. Includes reserves for claims incurred in the reporting period but not paid yet through the runout period
    c. Includes reserves for provider risk sharing payments
    d. Includes claims recoverable through coordination of benefits or other recovery methodologies
    e. May Include changes in deferred incurred claims
    f. May include restatements of runout for prior reporting periods
2. Expenses related to Improving health care quality
    a. Includes costs related to improving health outcomes
    b. Includes activities to prevent hospital readmission
    c. Includes improving patient safety and reducing medical error
    d. Includes wellness and health promotion activities
    e. Includes health information technology expenses related to health improvement.
3. Reconciliations and changes in any estimated federal adjustment payments such as
    a. Cost Sharing Reduction payments
    b. Federal Transitional Reinsurance Program payments
    c. Federal Risk Adjustment Program payments or charges
    d. Federal Risk Corridor Program payments or charges

   e. Any changes in Part D Reconciliations
   f. This amount may be positive or negative
4. Final MLR Numerator = Section 1 + Section 2 + Section 3

Components of the Numerator: Earned Premium Revenue[7]

The denominator of the MLR Calculation includes the following basic components:

1. Premium Earned for the reporting year
   a. Includes collected premiums for the reporting year
   b. Includes receivable premium for the reporting year
   c. Includes premiums from Federal and State High Risk Programs
   d. Includes reserves for claims incurred in the reporting period but not paid yet through the runout period
   e. Includes Federal Risk Adjustment Program changes
   f. Includes Part D Federal Reinsurance
   g. Includes reductions for prior year experience rating refunds
2. Federal and State Taxes and Licensing or Regulatory Fees
   a. Includes State Premium Taxes
   b. Includes the Health Insurance Provider's Fee (which returned in 2018)
   c. Includes any other pass through taxes
3. Final MLR Denominator = Section 1 - Section 2

The final MLR calculation may be adjusted for credibility. The credibility adjustments are a function of annual enrollment and average deductible. In order to determine the extent of the enrollment adjustment, the insurer must submit enrollment statistics which are then used to calculate any potential MLR calculation adjustments. If the insurer falls below the credibility threshold (typically 1000 member-years or 12,000 member-months), then their block of business is considered to have no credibility and will not be subject to an MLR calculation. If the block of business has partial credibility, then the insurer is instructed to increase the calculated MLR by an amount based on how credible their block of business is. The more credible their block is (i.e. more member lives), the smaller the adjustment. The deductible adjustment is based on the average deductible of the line of business in question. Plans with lower average deductibles do not receive the benefit of any adjustment. For plans with average deductibles high enough to meet a threshold, a multiplicative deductible factor may be applied to the membership-based credibility factor. The table below shows the current enrollment and deductible based factors being used for commercial health insurance plans by CMS.

Table 1

COMMERCIAL MLR BASE CREDIBILITY FACTORS[8]

Life Years	Credibility Factor
<1,000	No Credibility.
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% (Full Credibility).

Table 2
COMMERCIAL MLR DEDUCTIBLE FACTOR[9]

Life Years	Credibility Factor
<$2,500	1
$2,500	1.164
$5,000	1.402
≥$10,000	1.736

If an insured block of large group policies had a calculated raw MLR of 81% along with 10,000-member lives and an average deductible of $5,000, their adjusted MLR would be calculated as follows:

*Adjusted MLR = Base MLR (81.0%) + 2.6%*1.402 = 84.6%*

It should also be noted that any factors that lie between established credibility parameters should be linearly interpolated and not rounded.

Thus, the combination of the two credibility factors has the potential for significantly reducing or eliminating MLR Rebate liabilities for any insured plans with high factors of variability (low enrollment + high deductibles). In the case of the example above, the credibility adjustment added 3.6% to the raw MLR and thus reduces the insurer's rebate liability by 3.6%

Overall, the main differences in MLR methodologies relate to the type of adjustments that may be applied to the numerator, denominator, and credibility factors as well as to the factors themselves. Over time, CMS has been working on streamlining the MLR process and making it as consistent as possible between different lines of business.

Recent Changes to MLR Methodologies

In addition to the new rules filed for the Medicaid MLR calculations, there are some new rules within the more established commercial and Medicare Part C & D methodologies that were recently made. The MLR requirements for Medicare Advantage (Part C) and Part D changed significantly in 2018. In April of 2018, CMS issued a final rule (CMS-4182-F) which significantly reduce the extent of MLR data that needed to be annually filed. These changes apply to CY2018 and beyond[10]. The main impact of the CMS-4182-F reporting is that the old MLR data form is no longer required for Medicare Advantage and Part D lines of business. Instead, there is a more simplified MLR for was created which only includes seven entries[11]:

1. Contract Year
2. Contract Number
3. Organization Name
4. Date MLR Form Finalized
5. Contact Information
6. Adjusted MLR
7. MLR Rebate Amount owed.

This process has significantly streamlined MLR reporting for Medicare and will continue to do so in future years.

There were also some minor tweaks to the forms and methodologies in the commercial MLR methodologies and documentation for 2018. The 2018 MLR instructions included clarification on determining group size and State for

association coverage, group conversion policy experience, risk adjustment data validation amounts, average deductibles for issuers in States with merged markets, and the use of standardized Quality Improving Activities (QIA) reporting option. In addition, due to the discontinuation of the Cost Sharing Reduction Payments, cost sharing is no longer a part of current year reporting for the CY 2018 MLR calculation. Also, the resumption of the Health Insurer Provider fee in 2018 will result in the renewed removal of those amounts from the MLR denominator. [12]

Overall, the MLR process has been relatively stable over time from a methodology standpoint although several changes have been made to accommodate and differentiate between certain emerging marketplaces.

Comparison of Commercial Insurance Characteristics With and Without MLR Rebates

The characteristics of commercial blocks of business that owe Rebates has gone through some significant variation since the program's inception. By using Medical Loss Ratio data from public use files and other annual published summaries by the Center for Consumer Information & Insurance Oversight (CCIIO), we can observe some of these emerging patterns and changes over time. The main data elements that were extracted were related to annual membership, MLR Premium (which consist of Earned Premium less any premium taxes and provider fees), MLR Claims (which consist of incurred claims plus expenses related to health care quality costs), and MLR Rebates. Both MLR Premiums and claims have also been adjusted to take into account federal reinsurance, risk corridor settlements, and risk adjustment. The data was also divided between marketplace totals and totals for carriers owing MLR rebates.

The data in many of the figures below show some distinct patterns emerging as the MLR requirement was implemented and as major policy changes made their way through the insurance markets, particularly in the individual Health Insurance Exchange market. It is worth noting, that the minimum MLR requirement is 80% for the individual and small group markets, and 85% for the large group markets. Also, the MLR requirement does not apply to self-insured groups, hence the smaller volume of large group business relative to any total industry statistics that are generally observed.

Figure 2 below shows the volume of total commercial membership subject to the MLR requirement. Only fully insured policies are included here. With the implementation of the individual Exchanges, the individual marketplace saw a significant increase in participation in 2014 and 2015 before leveling off in 2016 and beginning to decline in 2017. Some of the 2017 and 2018 declines may be attributable to large rate increases in the individual market and insurers exiting many markets which over time resulted in lower enrollment due to less affordability and choice.

Figure 2

COMMERCIAL MEMBERSHIP SUBJECT TO MLR CALCUATION CALENDAR YEAR AND MARKET SUBGROUP[13]

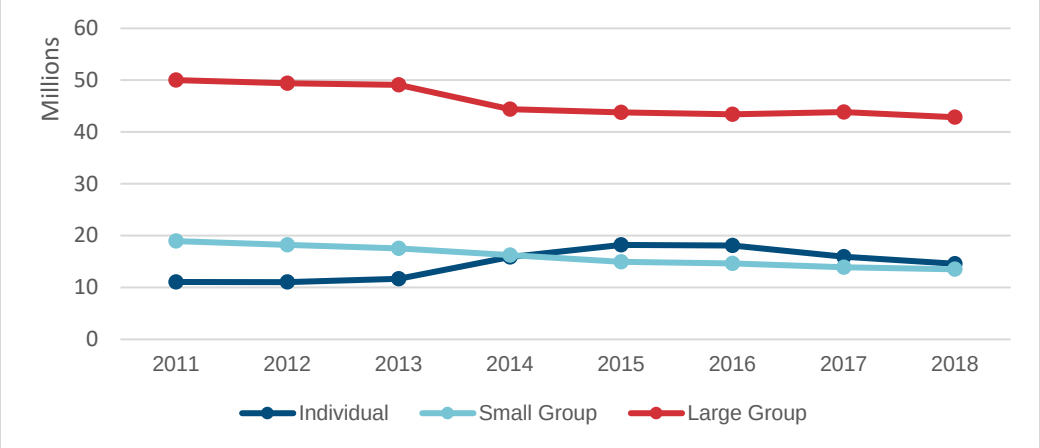


Figure 3 below shows the total rebate dollars returned to insured individuals by marketplace and by year. One can see that following the implementation of the MLR program beginning in 2011, there was a sharp decline in payouts as insurance companies that did not meet the threshold adjusted their premiums to reduce future rebate payments. Excluding the anomaly observed in 2011, the large group market has been the most stable with the smallest amount of year over year change observed. The small group market had some small disruptions but remained relatively stable over the years while also following some of the same industry wide patterns. The individual market saw the greatest amount of variability. Initial pre-Exchange rebates were considerably higher, but then dropped off when the exchanges went live before significant increases were observed in 2018.

Figure 3

MLR REBATES PAID OUT BY CALENDAR YEAR AND COMMERCIAL MARKET SUBGROUP[14]

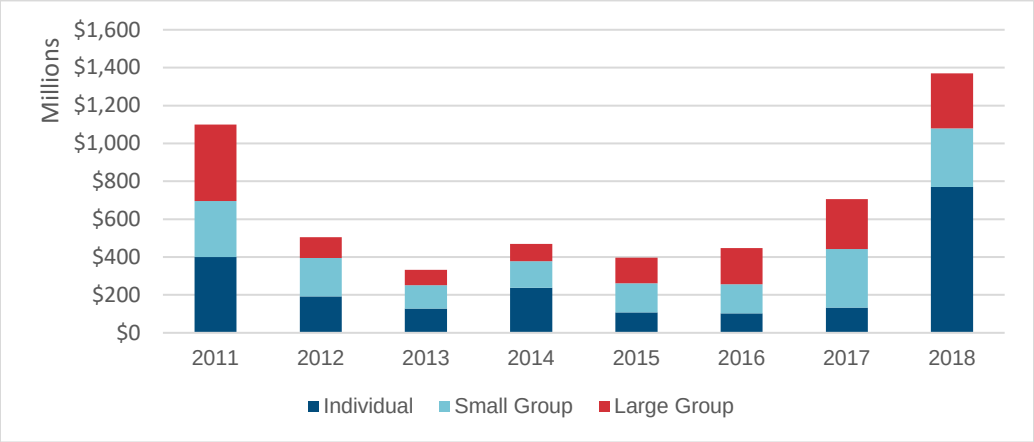
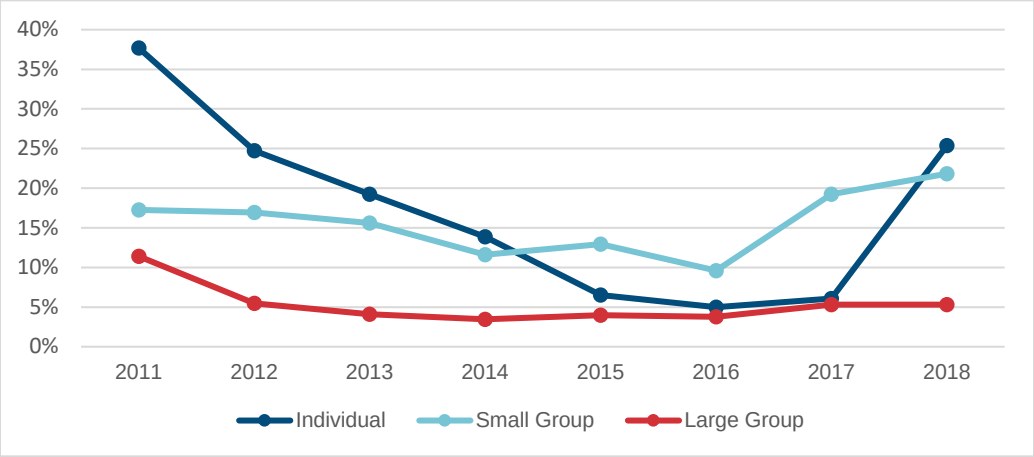


Figure 4 below emphasizes the point of greater stability in the Large and Small Group markets as the percentage of members receiving rebates stayed relatively flat.

Prior to the exchanges, there was a large percent of individual market membership receiving rebates as many of these pre-ACA policies were priced with higher Loss ratios. In 2018, there was a very large total rebate paid out in the individual market as the total share of individuals with rebates rose dramatically from ~5% to over 25%. This correlates with some market disruptions in 2017 including the end of the Cost Sharing Reduction payments, the cap on Risk Corridor Payments along with their phase-out and the end of the Reinsurance Program.

Figure 4

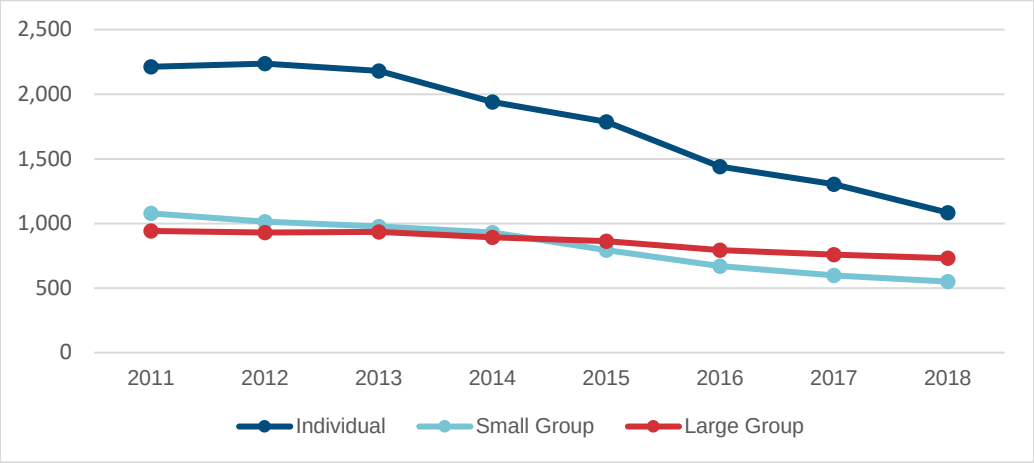
PERCENTAGE OF TOTAL MEMBERSHIP RECEIVING MLR REBATES BY MARKETPLACE[15]



In addition, Figure 5 below demonstrates a clear pattern of industry consolidation in all three marketplaces. Large Group, Small Group, and Individual Market unique MLR submissions in total have decreased from 2011 – 2018 with the Individual and Small Group Submissions each dropping by roughly 50%. Large Group Submissions only decreased by roughly 22% over the same period. It appears that the impacts of consolidation and carrier withdrawals in the ACA market drove more conservative pricing of policies with some of them overestimating the potential financial impacts of these different events. The result of these changes was a large increase in rebates in 2018 with a large portion of the resulting Individual rate increases being passed back to consumers in the form of rebates.

Figure 5

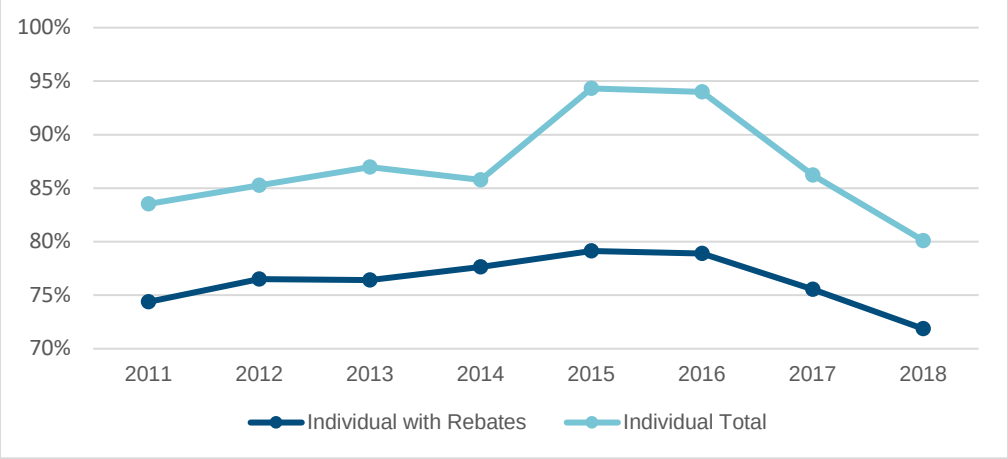
COUNT OF TOTAL NUMBER OF CARRIERS FILING MLR REPORTS BY YEAR AND MARKETPLACE[16]



Figures 6-8 below are another indication of some correlated market statistics. Figure 6 shows that the overall Raw MLR for the individual market rose significantly in 2015 and 2016 reaching an MLR of almost 95%. This corresponds to periods of very low individual MLR paybacks and was likely a large contributor to fewer carriers remaining in the market. Furthermore, the average MLR for groups with rebates from 2015-2016 was close to 79% - an indication that very few rebate dollars were distributed in those years. Because of these adverse financial results, many carriers left the exchanges in filed for large rate increases in subsequent years. When the market experience turned around in 2017 and 2018, there were significant drops in total MLRs for as well as a drop in MLRs of groups receiving rebates. In fact, the overall individual MLR was right around 80% - the minimum MLR threshold.

Figure 6

RAW MLR FOR INDIVIDUAL BLOCK WITH REBATES AND TOTAL INDIVIDUAL BLOCK[17]



On the Small Group and Large Group in Figures 6 & 7, the MLRs are very stable from year to year. In addition to this overall stability, the MLRs for groups with rebates followed similar up and down patterns to those of the overall group. The marketplace consolidation that was taking place at the latter part of the period showed some correlations with the subsequent MLR improvements, particularly in the small group marketplace.

Figure 7

RAW MLR FOR SMALL GROUPS WITH MRLREBATES AND TOTAL SMALL GROUP[18]

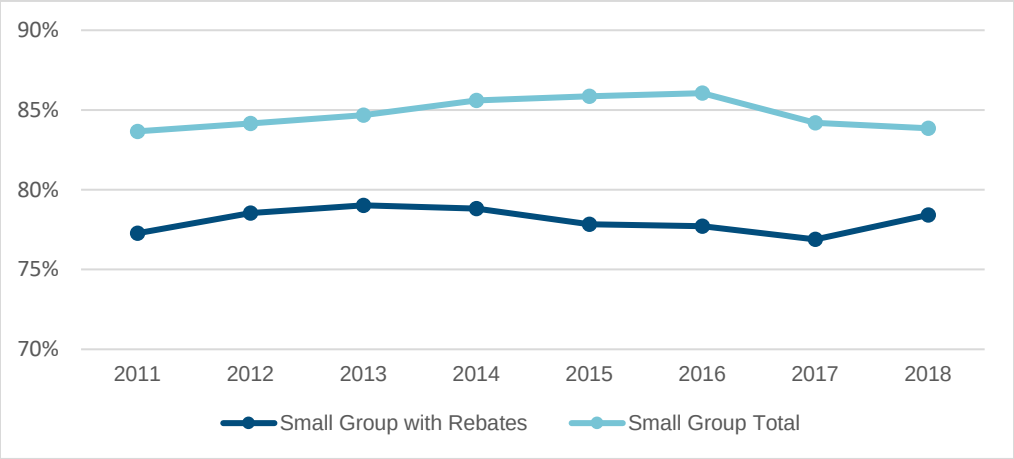
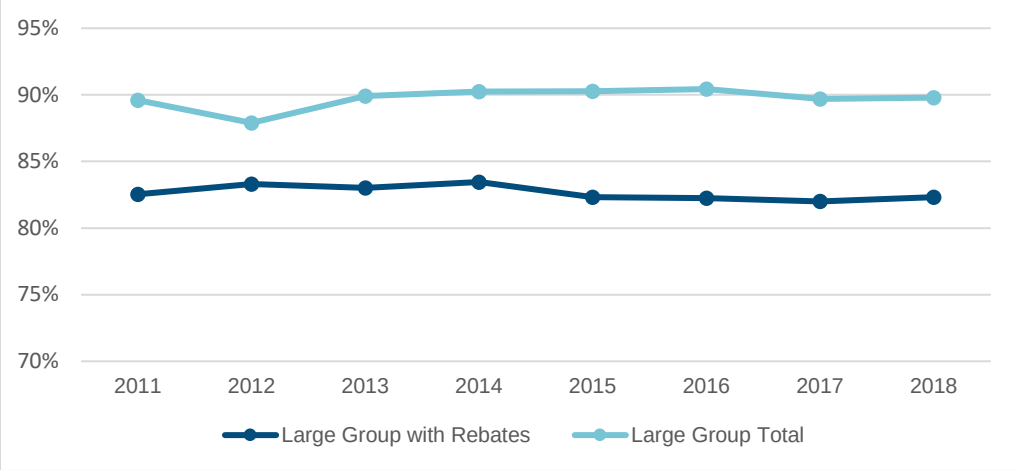


Figure 8

RAW MLR FOR LARGE GROUPS WITH MLR REBATES AND TOTAL. TOTAL LARGE GROUP[19]



Another interesting pattern that can be observed is the change in average premium and claims per member per month (PMPM) costs over time – which is shown in Figures 9 – 14. The typical pattern is for the MLR payback groups to have lower claims PMPMs than the overall average. This makes sense intuitively, since their average MLRs range from 5-15% below the overall category averages. In general, there is also a pattern of premium PMPMs being lower for MLR Rebate groups than for the overall average. This pattern generally holds true with some interesting exceptions. From 2016 – 2018, large group carriers with an MLR Rebate had higher PMPM premiums than the overall average. Small group had very little differentiation in Premium PMPMs between groups with and without MLR rebates for the first five years. Individual Premium PMPMs were roughly the same for groups with and without rebates in 2014 as the new membership and benefits caused a reset in the way risks were distributed in that population. In 2018, Individual carriers with MLR paybacks had higher Premium PMPMs than the overall Individual average. This could be due to large rate increases filed during prior periods that included substantial carrier losses.

Figure 9

INDIVIDUAL MARKET PREMIUM PMPMS FOR MEMBERS WITH MLR REBATES AND TOTAL[20]

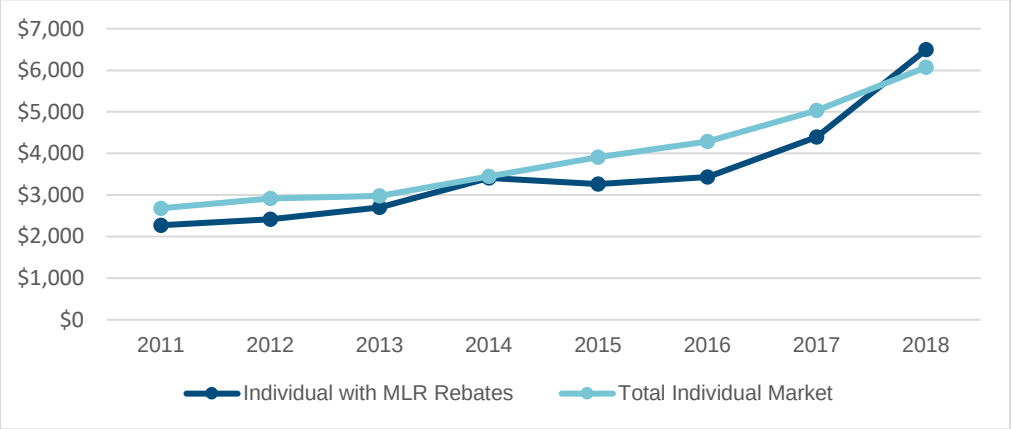


Figure 10

INDIVIDUAL MARKET CLAIMS PMPMS FOR MEMBERS WITH MLR REBATES AND TOTAL[21]

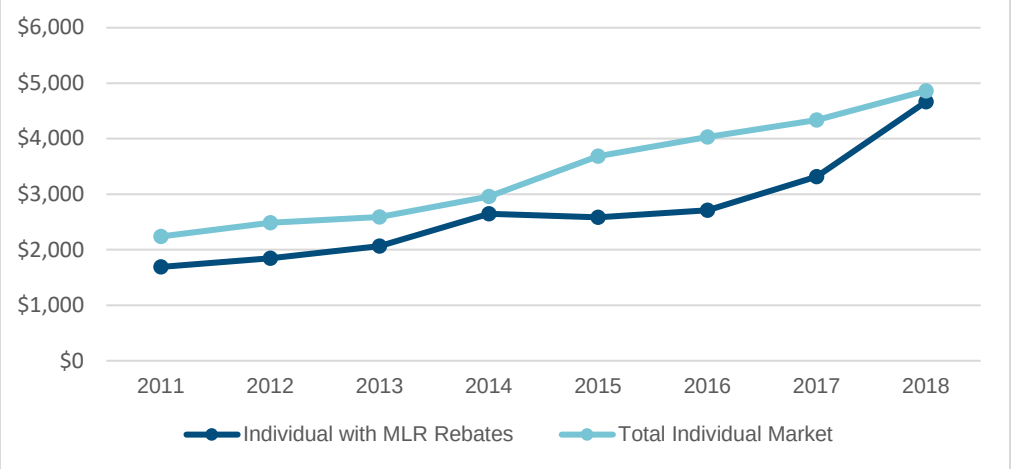


Figure 11

SMALL GROUP MARKET PREMIUM PMPMS FOR GROUPS WITH MLR REBATES AND TOTAL[22]

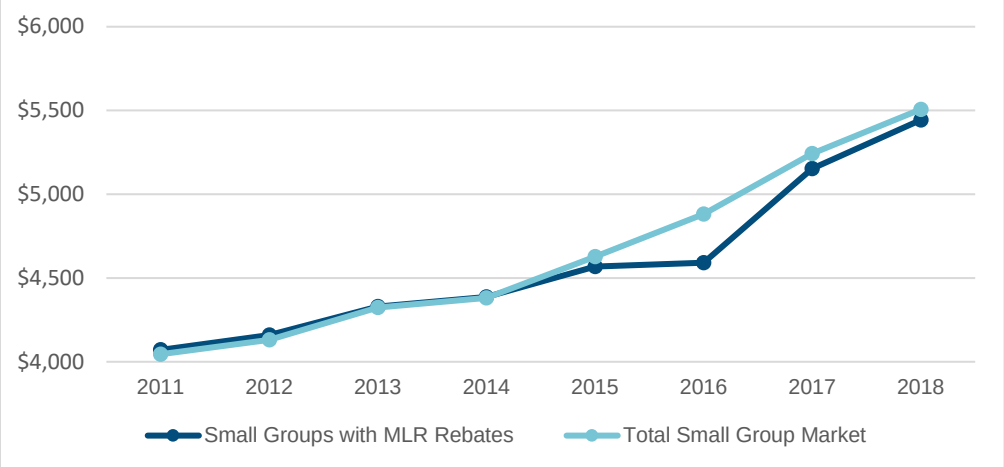


Figure 12

SMALL GROUP MARKET CLAIMS PMPMS FOR GROUPS WITH MLR REBATES AND TOTAL[23]

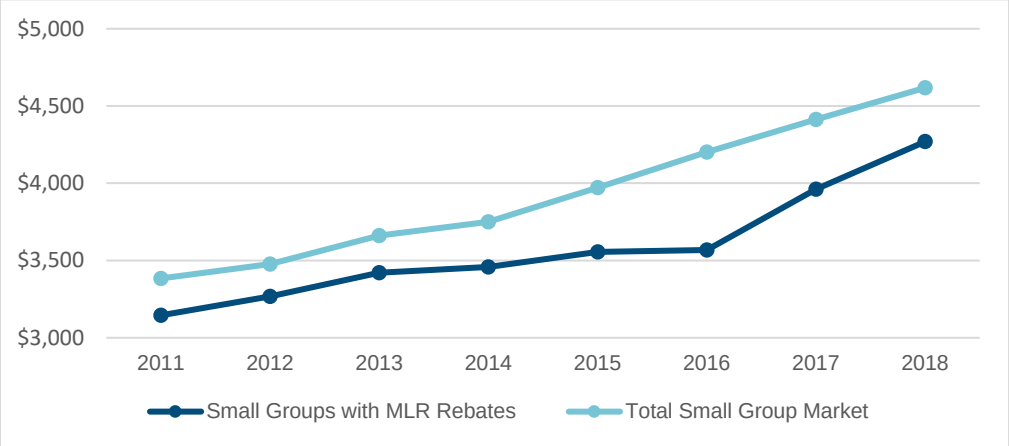


Figure 13

LARGE GROUP MARKET PREMIUM PMPMS FOR GROUPS WITH MLR REBATES AND TOTAL[24]

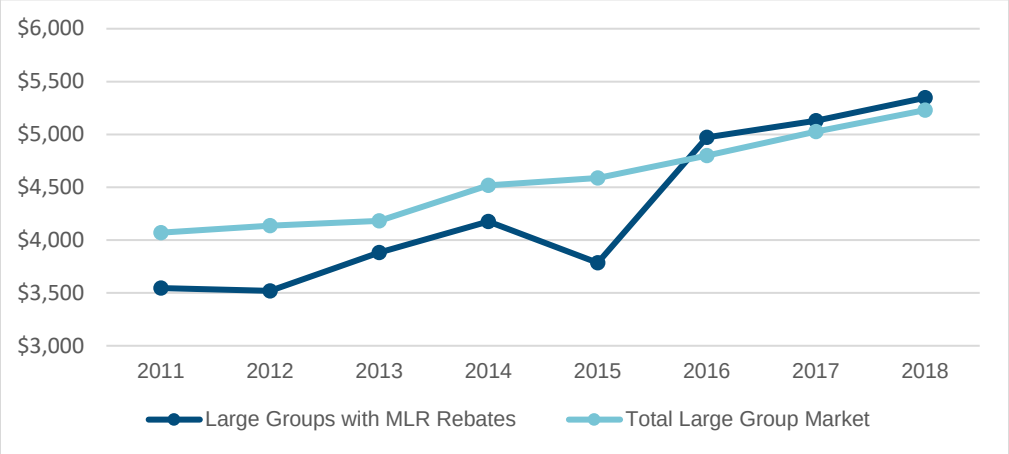
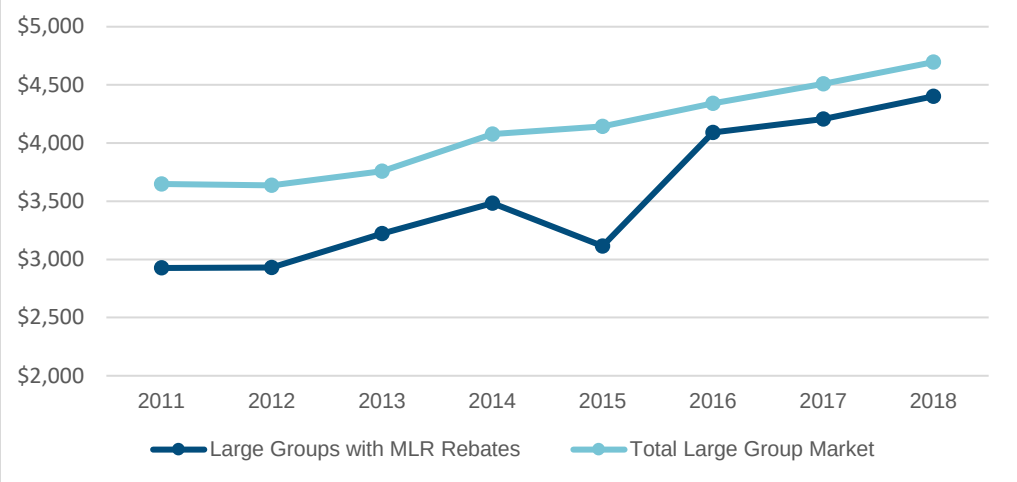


Figure 14

LARGE GROUP MARKET CLAIMS PMPMS FOR GROUPS WITH MLR REBATES AND TOTAL[25]



Overall, there are some key takeaways and conclusions that can be determined through the examination of the MLR reporting data which extends even beyond what is shown in this report. First, regulatory and policy changes in the marketplace coincided with changes in member enrollment, decisions by insurance carriers whether to remain in the marketplace, and the extant of rate increases that were filed. In general, there was a larger gap in MLRs of groups with rebates vs. the overall group during periods when carrier experience was unfavorable. When carrier experience improved, during periods of greater consolidation and higher premium rate increases, there was a smaller gap between MLRs of groups with rebates and the overall MLR. Groups with MLR rebates tended to have lower PMPM premiums during the initial measurement period. At the end of the period, we saw some MLR rebate groups with higher Premium PMPMs than the overall average. In conclusion, MLR rebate submissions are a reasonably good proxy for the overall health and profitability of the markets that they serve. While they do tend reduce insurance carrier profits, they also help provide more value to the consumers that purchase health insurance projects both through the exchange as well as in larger group marketplaces.

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