

Report of 2014 Loss Ratio Experience in
the Individual and Small Employer
Markets for:
Insurance Companies
Nonprofit Health Service Plan
Corporations and
Health Maintenance Organizations

September, 2015



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Introduction

Under Minnesota Statutes § 62A.021, subdivision 1(h), the Minnesota Departments of Health and Commerce 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, 2014, for health plan companies regulated by the Minnesota Departments of Health and Commerce. 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 pages six through eight for a description of the requirements.

According to the 2013 Minnesota Health Access Survey conducted by the Health Department, approximately 56 percent of Minnesota's population received coverage through an employer, while 5 percent of the population purchased individual coverage, and approximately 31 percent of Minnesota's population received coverage through public programs. The 2013 uninsured population in Minnesota was 8 percent.

Definitions

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, 2014, by individual, small employer, and large employer 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 Commerce Department 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
- 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 good measure of relative value if two health plan companies are very similar in the benefits they provide and other factors. 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 a value to the honest policyholders. 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 typically 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 affecting 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. 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. The individual market's recent high loss ratios, as shown in Attachment 1, are primarily a result of this new ACA-guaranteed coverage rule.

Transfers from MCHA

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). At the start of the ACA in 2014, approximately 70 percent of MCHA policyholders transitioned their coverage to the individual market. Most health care companies assumed that only 30 to 40 percent of policyholders would transfer from MCHA to the individual market during the year. The high loss ratios shown in Attachment 1 are partially attributable to the higher claims costs of individuals who unexpectedly transferred more quickly than anticipated from MCHA to the individual market in 2014. This factor is closely connected to the guaranteed coverage topic discussed above.

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, on and after of January 1, 2014, health plan companies may no longer deny coverage or charge higher premiums based on the health of the policyholder. This core tenant of the ACA allows consumers to purchase health care coverage, even with pre-existing conditions. Programs and regulations enforced by Commerce 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 in 2014. To protect consumers, the ACA established three programs: risk adjustment, reinsurance, and risk corridors (3Rs). The overall goal of these three programs is 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 new 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, similar to the basic premise of insurance of pooling risk. 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 is to stabilize individual market premiums during the early years of new market reforms. This program will be 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 also runs from 2014 through 2016 and is 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 is intended to reduce extreme gains and losses for the health plan companies. The risk corridors program sets a target of approximately 80 percent of premium dollars for exchange health plan companies to spend 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 will be used to reimburse health plan companies with claims that exceed 3 percent of the target amount.

Rates Regulation in Minnesota

Minnesota Statutes § 62A.02, requires all health plan rates to be approved by the Commissioner of Commerce or the Commissioner of Health before being used. 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. The Department of Commerce reviews all rates to verify reasonableness and compliance with state and federal law. Rate restrictions for individual plans are specified in Minnesota Statutes § 62A.65 and small employer plans are specified in Minnesota Statutes § 62L.08.

Federal Medical Loss Ratio as defined by the Patient Protection and Affordable Care Act

The ACA was passed by Congress and signed into law on March 23, 2010. The ACA requirements for medical loss ratios 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 medical loss ratio is slightly different than the state loss ratio described below.

A national leader, Minnesota has had Medical Loss Ratio 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 in 2012 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 medical loss ratio 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, it is expressed as a percentage: A medical loss ratio of 90 percent means nine out of 10 of all premium dollars that the insurer receives are spent on health care and quality improvement, with the other dollar 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 medical loss ratio 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 medical loss ratio 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 medical loss ratio required by ACA and the issuer's medical loss ratio, subject to the applicable credibility adjustment.

Effective January 1, 2011, health plan companies must report medical loss ratios 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 calendar 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 medical loss ratios 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 Medical Loss Ratio 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 loss ratio for insurers operating within their state and may calculate the loss ratio differently from the ACA definition. Minnesota law requires that individual, small employer, and large employer health plan rates meet the specific minimum loss ratio standards in Minnesota Statutes § 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 loss ratio of 68 percent to 72 percent for health maintenance organizations and nonprofit health service plan corporations (HMOs).

HMOs and nonprofit health service plan corporations have different minimum loss ratios based on whether they are assessed less than three percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. Companies assessed at less than three percent of the total annual MCHA assessment must only reach a 68 percent minimum loss ratio because the smaller an entity is, the less reliable their data is and the more financial risk they are taking on due to random statistical variations in claims. The state ratio is only actuarial in nature (that is, only prospective) and Commerce reviews Actuarial Memorandums and past loss ratio experience for demonstrations of compliance.

The federal minimum loss ratio standard has a similar safeguard. Specifically, the new ACA rules have "credibility adjustments" to take into account that carriers with lower enrollment are far more at risk for the effect of random statistical variation.

Unlike Minnesota's pre-existing state loss ratio standard, which is prospective, the federal loss ratio standard is retrospective in nature and carries with it rebates to customers if the

minimum loss ratios are not met in each marketplace.

Individual coverage:

- 72 percent for companies assessed three percent or more of the total annual MCHA assessment
- 68 percent for companies assessed less than three percent of the total annual MCHA assessment

Small employer coverage:

- 82 percent for companies assessed three percent or more of the total annual MCHA assessment
- 71 percent for companies assessed less than three percent of the total annual MCHA assessment, on their policies with fewer than 10 employees
- 75 percent for companies assessed less than three percent of the total annual MCHA assessment, on their policies with 10 or more employees

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 loss ratio of 60 percent. For insurance companies (including affiliates) that are assessed 10 percent or more of the total annual MCHA assessment, the loss ratio standards used are the same as those used for health maintenance organizations and nonprofit health service plan corporations.

Individual, Small Group and Large Group Loss Ratios

The loss ratios shown on Attachments 1 through 3 under the column titled State Loss Ratio are based on the state definition of loss ratio. The column titled Preliminary ACA MLR gives the preliminary estimate of the ACA loss ratio 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 Seventh Place East, Suite 500

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 Seventh 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 (not including health plan companies offering only Association or Conversion Policies) Supplemental Health Care Exhibit for 2014

Group Code	NAIC Number	Name	Domicile	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR♦	Covered Lives
461	55026	BCBSM Inc	MN	555,513,106	580,843,644	105%	123%	154,881
3492	11817	PreferredOne Ins Co	MN	269,311,391	253,583,929	94%	111%	77,464
1552	12459	Medica Ins Co	MN	50,531,905	60,604,746	120%	129%	20,213
1258	44547	HealthPartners Ins Co	MN	46,430,000	44,536,000	96%	107%	20,229
19	69477	Time Ins Co	WI	36,552,897	24,093,371	66%	94%	9,783
1258	52628	Group Health Plan Inc	MN	12,753,000	14,026,000	110%	117%	4,548
1552	95232	Medica Health Plans of WI	WI	10,935,291	9,133,605	84%	108%	3,081
1258	95766	HealthPartners Inc	MN	9,449,000	11,189,000	118%	126%	1,676
4380	52629	UCare MN	MN	2,464,136	3,893,947	158%	106%	557
1552	52626	Medica Health Plans	MN	2,453,132	4,134,359	169%	176%	196
19	65080	John Alden Life Ins Co	WI	1,856,041	1,479,391	80%	97%	567
707	62286	Golden Rule Ins Co	IN	1,025,705	1,186,087	116%	112%	186
Total				\$999,275,604	\$1,008,704,079	101%	N/A	\$293,381

***Attachment 1** lists the loss ratios experienced in the individual health plan market in 2014 by companies that cover individuals in that market. Not all health plan companies with individual health plans in force are included, as some had premium volume lower than \$300,000, which were not included.

The state loss ratios for 2014 ranged from 66% to 169%. The total state loss ratio for 2014 is 101%. The total state loss ratio for the previous year was 82%.

♦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 2**

Small Employer Group Supplemental Health Care Exhibit for 2014

Group Code	NAIC Number	Name	Domicile	Premium Earned	Incurred Claims	State Loss Ratio	Preliminary ACA MLR♦	Covered Lives
461	55026	BCBSM Inc	MN	506,489,479	406,054,732	80%	86%	97,551
1258	95766	Healthpartners Inc	MN	345,634,000	298,410,000	86%	93%	99,618
1552	12459	Medica Ins Co	MN	205,535,267	171,496,997	83%	90%	23,249
1258	44547	Healthpartners Ins Co	MN	80,231,000	70,962,000	88%	96%	18,196
3492	11817	PreferredOne Ins Co	MN	55,514,574	52,238,085	94%	98%	17,657
7	13935	Federated Mut Ins Co	MN	35,069,221	22,114,173	63%	74%	6,826
3492	95724	PreferredOne Comm Hlth Plan	MN	33,666,623	31,975,379	95%	102%	4,545
19	69477	Time Ins Co	WI	650,634	295,222	45%	59%	80
4751	14202	Gundersen Health Plan MN	MN	459,812	303,857	66%	69%	193
19	65080	John Alden Life Ins Co	WI	404,516	243,656	60%	71%	35
1246	95725	Sanford Health Plan of MN	MN	393,171	304,919	78%	89%	102
Total				\$1,264,048,297	\$1,054,399,020	83%	N/A	\$268,052

**Attachment 2 lists the loss ratios experienced in the small employer health plan market in 2014 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 large employers with self-funded health plans.

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 state loss ratios for 2014 ranged from 45% to 95%. The total state loss ratio for 2014 for health plan companies is 83%. The total state loss ratio for the previous year was 87%.

♦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 excluding self-insured employers Supplemental Health Care Exhibit for 2014

Group Code	NAIC Number	Name	Domicile	Premium Earned	Incurred Claims	State Loss Ratio	Preliminary ACA MLR♦	Covered Lives
461	55026	BCBSM Inc	MN	1,075,087,108	938,661,281	87%	91%	199,765
1552	12459	Medica Ins Co	MN	656,309,682	573,602,271	87%	94%	141,723
1258	44547	Healthpartners Ins Co	MN	610,651,000	493,332,000	81%	89%	284,981
1258	95766	Healthpartners Inc	MN	287,804,000	235,487,000	82%	87%	44,132
3492	11817	PreferredOne Ins Co	MN	86,108,980	75,651,539	88%	94%	22,232
1258	52628	Group Health Plan Inc	MN	44,364,000	43,686,000	98%	102%	8,126
3492	95724	PreferredOne Comm Hlth Plan	MN	23,634,951	20,340,642	86%	91%	6,375
461	95649	HMO dba Blue Plus	MN	16,910,035	12,939,166	77%	83%	2,501
7	13935	Federated Mut Ins Co	MN	15,645,173	11,972,472	77%	90%	4,337
901	67369	Cigna Health & Life Ins Co	CT	5,664,318	5,000,089	88%	96%	2,057
1552	52626	Medica Health Plans	MN	2,323,448	3,702,818	159%	229%	428
1246	95725	Sanford Health Plan of MN	MN	1,396,532	1,054,209	75%	89%	195
Total				\$2,825,899,227	\$2,415,429,487	85%	N/A	\$716852

***Attachment 3 lists the loss ratios experienced in the large employer health plan market in 2014 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.

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 state loss ratios for 2014 ranged from 77% to 159%. The total state loss ratio for 2014 for health plan companies is 85%. The total state loss ratio for the previous year was 86%.

♦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.