

# Medical Loss Ratios and Rebates

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## ➤ Background

- The Statute
- The Regulatory Process

## ➤ Main Concepts

- Reporting Requirements
- Rebate Calculation
- MLR Definition
- Rebate Administration

## ➤ Interesting Technical Issues

1. The insurer's risk/return profile
2. Credibility adjustment
3. Income taxes and the rebate calculation
4. Accounting for rebates at interim periods

- One year ago today: H.R. 3590, the Patient Protection and Affordable Care Act (ACA), was enacted
- Medical loss ratios mentioned in ACA in two places:
  - Creation of §2718 of Public Health Service Act (PHSA)
    - Relates to MLR reporting & MLR-based rebates
    - Applies to all issuers
  - Creation of §833(c)(5) of Internal Revenue Code
    - Relates to use of MLR in determining tax status
    - Applies only to certain BCBS organizations
- This talk focuses strictly on §2718 and its accompanying regulation

- §2718: “Bringing Down The Cost of Health Care Coverage”
- §2718(a): “Clear Accounting for Costs”
  - Creates new federal expense reporting requirements for health insurers
- §2718(b): “Ensuring That Customers Receive Value for their Premium Payments”
  - Creates new federal requirements to rebate a portion of premiums to customers if medical loss ratio (MLR) thresholds are not met
- §2718(c) creates a specific role for the National Association of Insurance Commissioners (NAIC) to play in crafting regulation to implement §2718

- §2718 uses the terms “health insurance issuer”, “individual health insurance”, “group health insurance” without explicitly defining them
- Those terms already had specific meanings under the PHSA (as amended by HIPAA)
- As such, scope of §2718 is generally believed to exclude:
  - Self-funded employee benefit plans, and/or stop-loss insurance issued to such plans
  - Governmental programs (Medicaid, Medicare Parts C & D)
  - *Excepted benefits* under HIPAA
    - Dental
    - Medicare Supplement
    - Disability, LTC, critical illness, etc.

- NAIC process to craft input to HHS on §2718 commenced within days of ACA's enactment
  - Open process with significant input from industry, consumer representatives, professional bodies
- Two main outcomes of NAIC process
  - August 2010: Adoption of the Supplemental Health Care Exhibit (SHCE)
    - A new annual financial reporting requirement, with first filing due 4/1/11 for year-end 2010
    - This is not the same as the new reporting required by §2718(a)!
  - October 2010: Adoption and transmittal to HHS of the PPACA MLR Regulation

- HHS process started with a Request For Information from stakeholders, with comments due in May 2010
- November 2010: HHS issued an Interim Final Rule (IFR) implementing §2718
  - Apparent intent was to certify, rather than modify, the input received from NAIC
  - As an IFR, rather than a NPRM (Notice of Proposed Rulemaking), this regulation became effective on 1/1/2011, even though the comment period was open until 1/31/2011
- Technical corrections issued in late December
  - Further sub-regulatory guidance (e.g., FAQ) seems likely

- Reports due to HHS (in addition to the SHCE, due to NAIC), although format not yet specified
- Each annual report covers an “MLR Reporting Year”, defined as being the calendar year
  - First report will be due 6/1/2012, for 2011
- Reports are at health insurance issuer level (i.e., legal entity level, not holding company level)
- Each issuer submits separate reports for:
  - Each state in which issuer is licensed; and
  - Within each state, by market:
    - Individual
    - Small employer
    - Larger employer

- What does “by state” mean here?
  - In general, a policy’s experience is allocated to the state in which the contract is situated, i.e., issued and delivered
  - This allocation approach need not, and often will not, align with methods used for Schedule T reporting (e.g., based in some fashion on member state of residence)
- What does “small employer” mean here?
  - As defined elsewhere in the PHSA; not necessarily aligned with existing state approach for how to count employees
  - ACA amends PHSA definition to be 1-100, instead of 2-50; however, a state can use 1-50 up until 2016
  - Is using 50 instead of 100 an “opt-in”, or a “negative opt-out”?

- With a few specified exceptions, rebates are calculated at the same aggregation level as in the reporting, namely
  - By legal entity;
  - By state; and
  - By market (individual, small group, large group)
- A medical loss ratio (MLR) is calculated based on the information in the report, rounded to nearest 0.1%
  - Report uses three months' runout for incurred claims
- If that MLR is less than the established threshold applicable to that state & market, then the issuer owes rebates to customers

- Rebate thresholds, in general, are:
  - Individual market = 80%
  - Small employer market = 80%
  - Large employer market = 85%
- §2718 permits states to raise these thresholds
- §2718 also gives HHS the flexibility, on a state-by-state basis, to reduce the individual market threshold in order to avoid “destabilization” of market
  - IFR establishes the process by which a state can seek such an adjustment to MLR rules
  - As of 3/22/11, one state (ME) has received an adjustment, seven other states’ applications are in process

- In historical usage, “medical loss ratio” usually meant simply

Incurred claims

Earned premium

- However, §2718 specifically indicated that, for rebate calculation purposes, certain adjustments would be made to both the numerator (claims) and denominator (premium) of the MLR

- Numerator adjustments from §2718 :
  - Include, as part of incurred claims, the issuer's *change in contract reserves*
  - Include *quality improvement* expenses
- Denominator adjustments from §2718:
  - Remove *state taxes and assessments* from premiums
  - Remove *federal taxes* from premiums
- In addition, the IFR's MLR computation includes an extra additive component, known as a *credibility adjustment*

# Main Concepts

## MLR Definition



- Consequently, the IFR's conception of an MLR for rebate calculation purposes looks like this:

$$\frac{\begin{array}{l} \text{Incurred claims} \\ + \text{ change in contract reserves} \\ + \text{ quality improvement expenses} \end{array}}{\begin{array}{l} \text{Earned premium} \\ - \text{ State taxes and assessments} \\ - \text{ Federal taxes} \end{array}} + \text{Credibility Adjustment}$$

- These adjustments generally produce higher MLRs than the traditional claims-to-premium definition

Policy justifications for these MLR adjustments:

➤ *Change in contract reserves*

- Relevant to individual policies in a non-GI market
- Due to pricing & underwriting practices, loss ratios are typically lower in earlier durations, and higher later
- Contract reserves reflect portions of premiums that are designed to cover claim costs in later years
- Annual change likely to be positive for growing blocks, negative for contracting blocks
- Including this creates a more level playing field across issuers whose blocks are at different stages of maturity

Policy justifications for these MLR adjustments:

➤ *Activities to improve health care quality*

- §2717 of PHSA creates new quality reporting requirements, oriented around 4 categories:
  - Improving health outcomes
  - Preventing hospital readmissions
  - Improving patient safety & reducing medical errors
  - Wellness and health promotion
- IFR follows suit and tracks these 4 categories
- Conceptually, allowing issuers to count these expenses in MLR numerator creates an incentive for issuers to pursue/expand these activities

Policy justifications for these MLR adjustments:

➤ *State taxes and assessments*

- Insurers are charged premium taxes and other state regulatory assessments (e.g., to fund state high risk pools), which are not discretionary expenses for insurers
- The level of these taxes/assessments varies by state (and possibly by type of company), and costs are typically passed through from insurers to customers
- In order to fairly apply a uniform MLR threshold across entire industry, it's appropriate to adjust premiums to remove these expenses

Policy justifications for these MLR adjustments:

➤ *Federal taxes*

- Excluding income taxes from premiums creates a fairer comparison across insurers (e.g., tax-exempt vs. taxed at AMT rates vs. taxed at corporate rates)
- Exclusion is broader than just FIT
  - e.g., payroll taxes
- Note that ACA creates new types of federal taxes that will take effect in future and, presumably, be passed through to customers via increased premiums
  - e.g., §9010 health insurance provider excise tax

Policy justifications for these MLR adjustments:

➤ *Credibility adjustment*

- Small blocks of business are more vulnerable to statistical fluctuations in experience than larger blocks
- Rebates introduce an asymmetry: bad experience is borne by insurer, good experience returned via rebates
- Potential for “false positive” rebates: Block was priced at or above the rebate MLR threshold but, due simply to statistical fluctuation, experience was better and rebates are owed
- Credibility adjustment reduces likelihood of false positives, keeping market attractive for smaller blocks
- However, introduction of credibility adjustment also increases likelihood of “false negatives”

Adjustments not made to the MLR, despite potential policy arguments in their favor:

- Brokerage commissions
  - NAIC task force will hold hearing later this week
  - Possibility of legislative action (e.g., H.R. 1206)
- Cost containment expenses (other than those that happen to qualify as quality improvement expenses)
- Loss adjustment expenses
  - Language of §2718(a) specifically mentions LAE
  - Despite this, regulators never seemed to seriously consider including LAE in numerator

- Rebates due annually by August 1 for previous year
- Rebates made on pro rata basis, as the additional amount that needs to be *added to the numerator* in order to bring the actual MLR up to the threshold
  - Example: if threshold is 80% and actual MLR is 77%, then all customers receive a 3%-of-premium rebate
  - Insurer cannot give higher rebates to customers with better experience and lower (or no) rebates to customers with poorer experience
- Rebates need to be made to all customers who paid premiums in MLR reporting year, even if they are no longer customers (but with a *de minimus* exception)

- Who needs to receive rebates?
  - Individual market — the policyholder (even if the policy covers more than one person)
  - Group market — situation is more complex (next slide)
- How do rebates need to be made?
  - Former customers: by check, or by issuing a credit to the credit card or debit card that had previously been used to pay premiums
  - Current customers: above options, or also by a premium credit to a single future bill (or successive bills, if rebate exceeds one month's premium)

- Rebate distribution in group market
  - §2718 states “enrollees” are to receive rebates
  - IFR interprets this as requiring rebates to be paid “on a pro rata basis to the person or entity that paid the premium on behalf of the enrollee”
  - So: If both the employer and employees contribute portions of the premium for a group product, the IFR requires that they share any rebate proportionally
  - Information problem for insurers!
  - IFR allows insurer to outsource rebate distribution to the employer; but even then insurer remains liable for ensuring that subscribers receive appropriate rebate

# Interesting Technical Issues

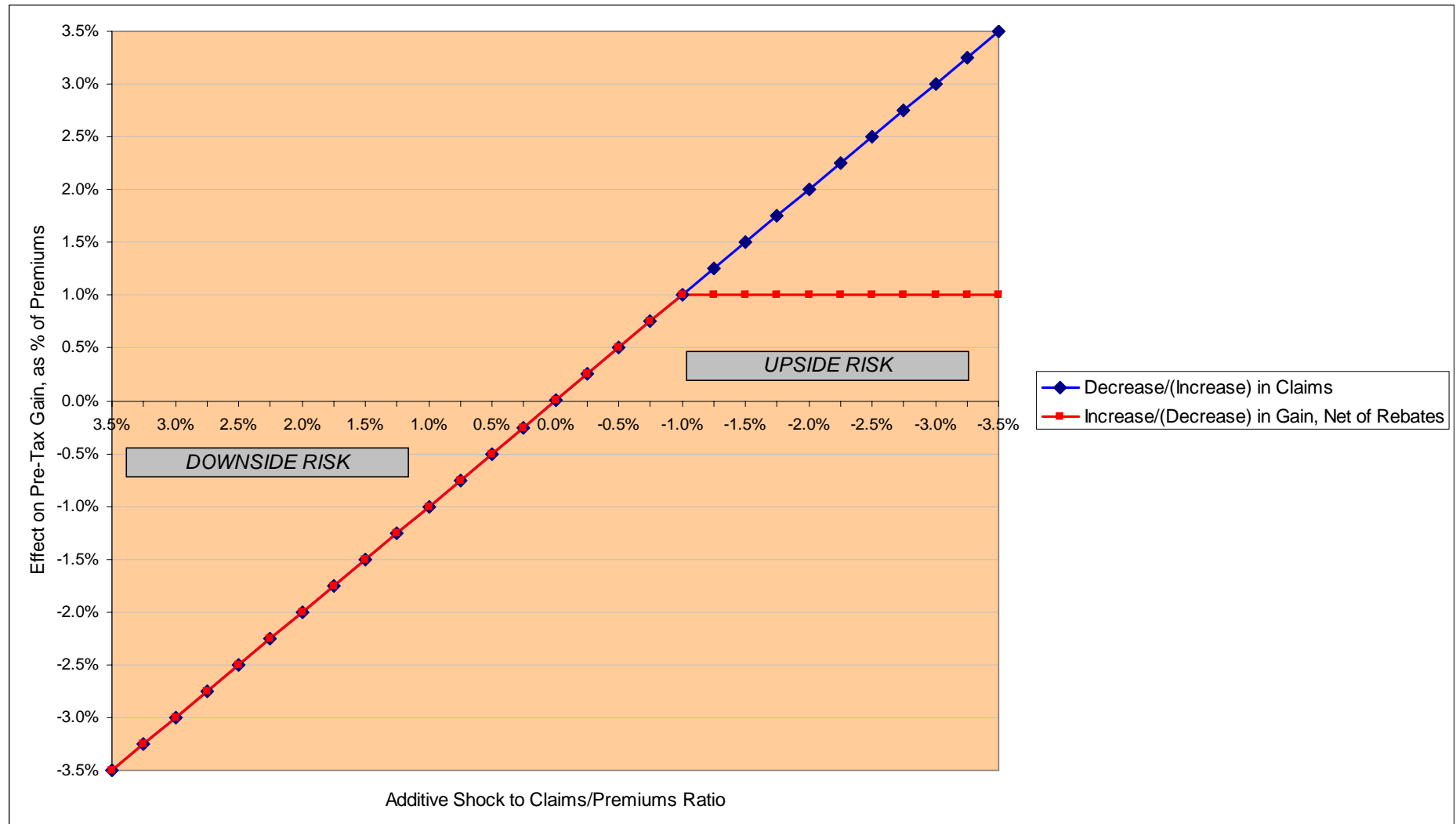
## 1. The Insurer's Risk/Return Profile

- Insurer is a portfolio of separately priced blocks
- Historically, there were diversification benefits: Favorable A-to-E variances in one block's pricing have been available to offset unfavorable A-to-E variances in another block's pricing
  - Two-way street: Insurer bears upside and downside risk
  - Analogous to owning a stock
- Rebate requirements introduce an asymmetry, reduce the diversification benefit in the portfolio
  - One-way street: Gains returned to consumers via rebates, losses borne by insurer
  - Analogous to writing a put option on a stock

# Interesting Technical Issues

## 1. The Insurer's Risk/Return Profile

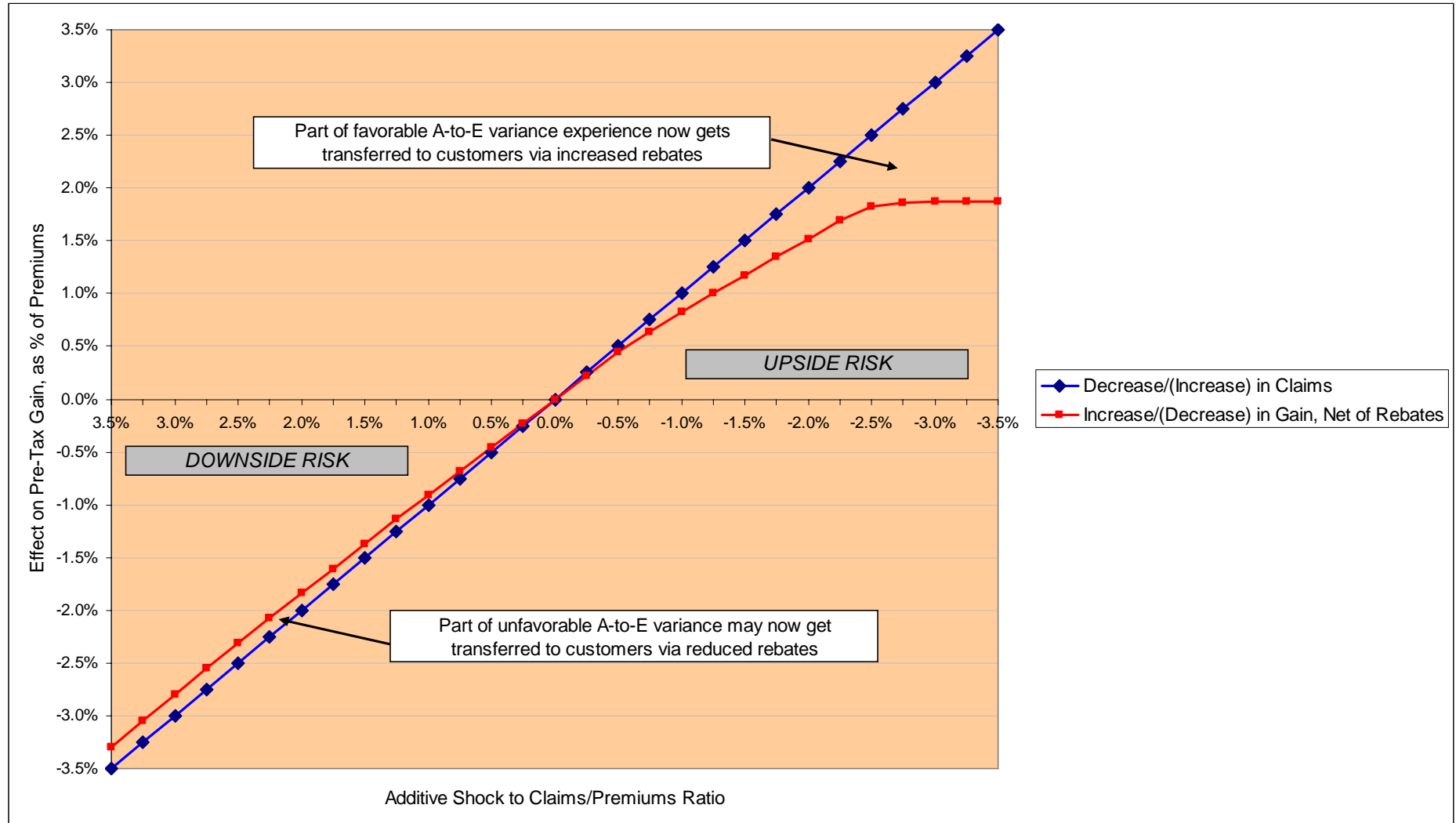
For a single block, with pricing MLR = 1% above rebate threshold



# Interesting Technical Issues

## 1. The Insurer's Risk/Return Profile

For a hypothetical portfolio (multiple blocks, different pricing MLRs)



# Interesting Technical Issues

## 2. Credibility Adjustment

- Only applies to a partially credible block
  - In 2011, this means between 1,000 and 75,000 lifeyears
- Adjustment is product of Table 1 factor (based on size) and Table 2 factor (based on deductible mix)
  - Use of Table 2 factor is optional; it can only help the insurer, but might be cumbersome to compute
- These tables were proposed by NAIC based off of modeling performed by Milliman
- Conceptual basis was to reduce chance of a “false positive” rebate payment to 25%
  - i.e., if insurer prices to hit MLR threshold, statistical fluctuation alone would result in rebates being paid one year in four

# Interesting Technical Issues

## 2. Credibility Adjustment

- Even when the insurer's pricing MLR is at or above the rebate threshold, in principle product pricing now needs to include a (non-zero) *expected cost of rebates*
  - Mathematical consequence of the asymmetric risk profile
- Table below is excerpted from a letter sent by an Academy work group to HHS in November 2010

**Contribution of Statistical Fluctuation to Issuer's  
Expected Cost of Policyholder Rebates, as % of Premium  
(Assuming Issuer's Pricing Loss Ratio = 80%)**

Issuer Block Size (in Life Years)	Level of Credibility Adjustment		
	No Adjustment	50th Percentile	80th Percentile
1,000	5.0%	1.3%	0.1%
5,000	2.4%	0.7%	0.1%
25,000	1.1%	0.4%	0.1%
50,000	0.8%	0.3%	0.1%

### ➤ Quote from same Academy letter:

What this table suggests is that, even under 50<sup>th</sup> percentile credibility adjustments like those adopted by the NAIC, issuers with larger blocks of business will have a competitive advantage of about 0.5% to 1.0% of premium over issuers with smaller blocks of business, as a result of the mechanics of the policyholder rebates.

(This is in addition to any other reasons why issuers with larger blocks may have a competitive advantage over issuers with smaller blocks, such as economies of scale or improved pricing data.)

### ➤ Notation:

- P = premiums, less non-income taxes (e.g., premium taxes)
  - C = claims, plus quality improvement expenses
  - E = allocated expenses, excluding items incorporated in P or C
  - R = rebates
  - U = post-rebate underwriting gain =  $P - C - E - R$
  - $\tau$  = income tax rate
  - T = allocated income taxes
- No explicit guidance in the IFR about how one is supposed to allocate income taxes back to lines of business
- Seems reasonable to assume that allocated income taxes would be proportional to post-rebate underwriting gain; that is,  $T = \tau U$

# Interesting Technical Issues

## 3. Income Taxes and the Rebate Calculation

➤ With this notation, and ignoring the credibility adjustment, the MLR for calculating rebates is equal to  $C \div (P - T)$

➤ So, if  $\rho$  is the rebate threshold (e.g., 80%), then

$$R = \max\{0, \rho(P - T) - C\}$$

➤ However: We assumed that  $T$  is a function of  $U$ ; but  $U$  is itself a function of  $R$ , so  $R$  appears on both sides of equation

➤ Solving for  $R$ , after a bunch of algebra we arrive at

$$R = \max\left\{0, \frac{\rho(1-\tau)}{1-\rho\tau} P - C + \frac{\rho\tau}{1-\rho\tau} E\right\}$$

➤ So, under this approach to tax allocation, the rebate amount depends on the insurer's tax rate & expense allocations

## 4. Accounting for Rebates at Interim Periods

- At year-end, carriers will need to estimate, and record a liability for, the rebates it expects to ultimately pay for the current MLR reporting year
- What about interim reporting periods prior to year-end?
- In theory, two types of accounting policies could be used:
  - Pro rata method. Estimate the ultimate year-end rebate, based on actual experience plus a forecast of the remainder of the year; record a pro rata share of that estimate
  - YTD method. Look solely at year-to-date experience, as if all contracts were to terminate at the reporting date; apply the rebate formula to the YTD experience, and record the result
- Because of claims seasonality, these policies may produce radically different financial statement results

## 4. Accounting for Rebates at Interim Periods

- Consider a fully credible block of individual policies where expected MLR is 65% for 1<sup>st</sup> quarter but 80% for full year
- Under pro rata method:
  - Expected year-end rebate liability is zero; therefore, rebate liability at end of first quarter is also zero
  - Underwriting margin for first quarter is much higher than expected underwriting margin for full year
- Under YTD method:
  - Rebate liability at end of first-quarter is non-zero, based on experience to date, even though company does not actually expect to ultimately pay rebates
  - First quarter underwriting margin is lower than under pro rata method (and, closer to full-year underwriting margin)

## 4. Accounting for Rebates at Interim Periods

- This is reminiscent of accounting policy issues arising from Medicare Part D, where many companies chose to apply the YTD method
- But note that this time around the situation is reversed:
  - With Part D, applying the YTD method involves recording a larger interim asset, thus deferring the recognition of losses from early quarters to later quarters
  - Here, applying the YTD method involves recording a larger interim liability, thus deferring the recognition of profits from early quarters to later quarters
- What will companies want to do?
- How will auditors and regulators view the situation?