Medical Loss Ratios and Rebates

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Agenda

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  – The Regulatory Process

➢ Main Concepts
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  – Rebate Calculation
  – MLR Definition
  – Rebate Administration

➢ Interesting Technical Issues
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  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
Background
The Statute

- §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
Background
The Regulatory Process

- 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
Main Concepts
Reporting Requirements

What does “by state” mean here?
- In general, a policy’s experience is allocated to the state in which the contract is sitused, 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
Main Concepts
Rebate Calculation

- 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
\[
\frac{\text{Incurred claims}}{\text{Earned premium}}
\]
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
Consequently, the IFR’s conception of an MLR for rebate calculation purposes looks like this:

\[
\text{Incurred claims} + \text{change in contract reserves} + \text{quality improvement expenses} + \text{Credibility Adjustment} = \frac{\text{Earned premium}}{-\text{State taxes and assessments} - \text{Federal taxes} + \text{Credibility Adjustment}}
\]

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)

Part of favorable A-to-E variance experience now gets transferred to customers via increased rebates

Part of unfavorable A-to-E variance may now get transferred to customers via reduced rebates

UPSIDE RISK

DOWNSIDE RISK
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%)

<table>
<thead>
<tr>
<th>Issuer Block Size (in Life Years)</th>
<th>Level of Credibility Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Adjustment</td>
</tr>
<tr>
<td>1,000</td>
<td>5.0%</td>
</tr>
<tr>
<td>5,000</td>
<td>2.4%</td>
</tr>
<tr>
<td>25,000</td>
<td>1.1%</td>
</tr>
<tr>
<td>50,000</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
Quote from same Academy letter:

What this table suggests is that, even under 50th 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.)
Interesting Technical Issues
3. Income Taxes and the Rebate Calculation

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, $T = \tau U$
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

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

So, under this approach to tax allocation, the rebate amount depends on the insurer’s tax rate & expense allocations.
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.
Consider a fully credible block of individual policies where expected MLR is 65% for 1st 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).
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?