



Report of 2018 Loss Ratio
Experience for Insurance
Companies, Nonprofit Health
Service Plan Corporations, and
Health Maintenance Organizations

June 2019

Table of Contents

Introduction 3

Definitions 4

Federal Medical Loss Ratio as Defined by the Affordable Care Act..... 5

Health Insurance Rates Regulation in Minnesota..... 6

Notes on Using the Data 10

Table 1: 2018 Individual Loss Ratio Data 11

Table 2: 2018 Small Employer Group Loss Ratio Data 12

Table 3: 2018 Large Employer Group Loss Ratio Data 13

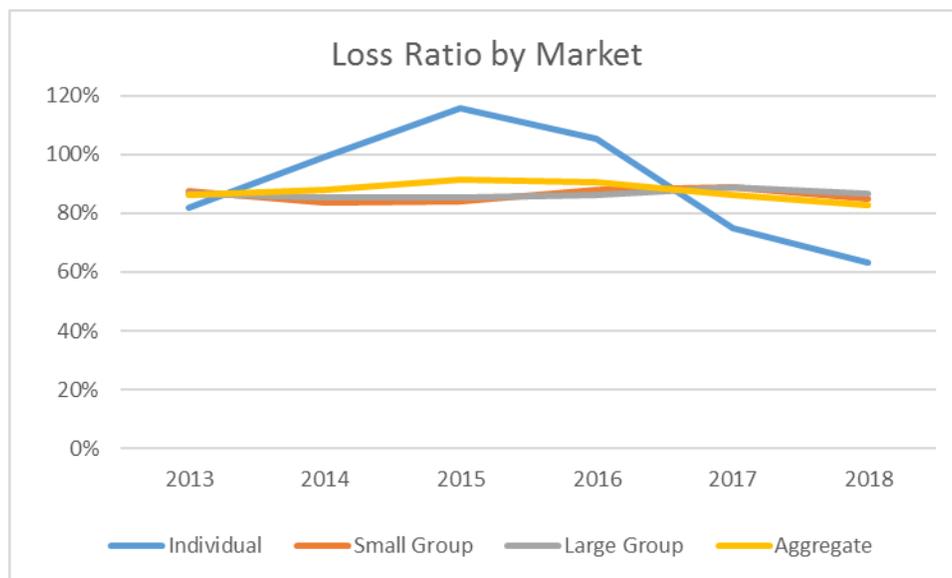
Additional Reference Sources..... 14

Introduction

Minnesota Statutes § 62A.021, subdivision 1(h), requires the Minnesota Departments of Health and Commerce (the Departments) 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 Minnesota. This report includes loss ratios for the calendar year ending December 31, 2018, for health plan companies regulated by the Departments.

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. State law establishes minimum loss ratios for small group and individual plans to ensure a minimum value to the consumer.

Historically, overall loss ratios have been relatively stable, as shown in the chart below. The exception is the experience in the individual market, where in 2014 major reforms were implemented. Individual market enrollment also changed significantly between 2013 and 2018; reaching over 300,000 people at its peak in 2015 and declining by half in 2018. The individual market's enrollment is now fairly stable, which could mean that loss ratios would increase and level off during 2019-2020. The overall aggregate loss ratios have been fairly stable over time, despite the significant reforms that had occurred in all markets starting in 2014.



Definitions

Individual Market

The individual market is where people who do not have access to health insurance through their employer or through public programs such as Medicare, Medicaid, and MinnesotaCare are able to purchase coverage. For purposes of this report, the 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.

Small Employer Group

The small employer group insurance market generally provides coverage to entities actively engaged in business (including political subdivisions of the State) that employed less than 50 workers who worked at least 20 hours per week on business days during the preceding calendar year and employs at least two current employees on the first day of the health plan year. Minnesota laws affecting eligibility for small employer group insurance coverage are actually more nuanced than this description and are summarized in the Small Group Counting guide available on the Minnesota Department of Commerce website.¹

Large Employer Group

The large employer group includes 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.

Uninsured

The uninsured population are those who do not have health plan coverage through the individual market, an employer, Medicare or public programs. According to the 2017 American Community Survey conducted by the U.S. Census, in 2017, the uninsured population in Minnesota was approximately 5.4 percent, with a margin of error of 0.1 percent. Many of those who are uninsured are eligible for public programs but have not enrolled.

Loss Ratio

The loss ratio is the ratio of incurred claims to earned premiums. On the annual Supplemental Health Care Exhibits, health plan companies report total earned premium, incurred claims, and loss ratio for the year ending December 31, 2018, by individual, small employer, and large employer fully-insured health plan markets in Minnesota.

The Affordable Care Act (ACA) created payment streams that affect loss ratios but are not finalized until after financial statements and this report are due. There are often accounting adjustments caused by prior year mis-estimations that

¹ <http://mn.gov/commerce-stat/pdfs/small-group-counting.pdf>

materially affect the accuracy of the loss ratio data presented in this report. The largest items that commonly cause such accounting adjustments are risk adjustment receivables/payables (individual and small group markets), claims that are paid to providers after the year in which services occurred (all markets), state-based reinsurance receivables (individual market only), drug rebate receivables (all markets), and consumer rebate payables (not common, but can occur in all markets). When annual financial statement loss ratio data does not appear to be reasonable, the Minnesota Department of Commerce contacts health plan companies about the financial statement data. When transitions of enrollment between affiliates and prior year adjustments caused unreliable results, affiliate data was aggregated so that the overall market experience was represented. As noted in the tables shown at the end of this report, at times the values are different from the financial statement data in order to provide data that is relevant to the current year under evaluation.

It is also important to keep in mind that the federal website that collects loss ratio information directly from health plan companies will publish more current information than the data presented in this report, though that information will not be published until several months after the statutory deadline for this report.

Federal Medical Loss Ratio as Defined by the Affordable Care Act

The data in this report reflects the Minnesota Medical Loss Ratio. However, the ACA also uses the term Medical Loss Ratio (MLR). The ACA was passed by Congress and signed into law on March 23, 2010. The ACA requirements for MLRs 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 MLR under the ACA is different than the state loss ratio. We describe these differences in detail below.

Starting in calendar year 2011, the federal government required that a health plan company that does not spend enough of its premium dollars on health care must provide a rebate paid the following year to the insured individual or to the policyholder, which may be the employer that purchased the insurance.

Under the ACA, an MLR is the ratio of the health plan company'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 federal MLR is the amount of health insurance premiums that a health plan company spends on health care and activities to improve health care quality, as opposed to profits and administrative costs, including executive salaries, overhead, and marketing. The ACA MLR is expressed as a percentage: a MLR of 90 percent means 9 out of 10 of all premium dollars that the health plan company receives are spent on health care and quality improvement, with the other money spent on overhead, profits, and administrative costs.

Under the ACA requirements, health plan companies 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, generally averaged over three years. This rule does not apply to employers that operate a self-insured plan. In addition, the experience of very small health plan companies with less than 1,000 people enrolled cannot sufficiently confirm that they have or have not met the MLR standard; as a result, those health plan companies are deemed non-credible and are not required to provide rebates. A health plan company with 1,000 to 75,000 people enrolled is considered to have partially-credible

experience and a “credibility adjustment” is applied to its MLR 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 MLR required by ACA and the health plan company’s MLR, subject to the applicable credibility adjustment. Effective January 1, 2011, health plan companies must report MLRs 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 plan year 2011, was filed on June 1, 2012. Health plan companies were required to make the first round of rebates to consumers in 2012. Starting in the summer of 2012, HHS posted health plan companies' reports and MLRs online.²

The Centers for Consumer Information and Insurance Oversight (CCIIO) is responsible for enforcement of the ACA’s MLR reporting and rebate requirements. After working with the National Association of Insurance Commissioners (NAIC) on procedures for the MLR audit program, CCIIO has begun to conduct examinations nationally.

Recent Rebates

HMO Minnesota dba Blue Plus, paid rebates amounting to \$19,605,595 to 33,356 members in 2018 for gains that occurred in 2017, which was an average \$587.77 annual rebate per enrollee for 2017 experience and approximately 6 percent of Blue Plus’ 2017 premiums. Blue Plus was still new to the individual market in 2017 and did not have sizeable losses from 2015 and 2016 to offset 2017 gains, as other health plan companies had.

While final 2018 numbers will not be known until later this year, two health plan companies have reserved for consumer rebates in their 2018 financial statement; UCare has reserved for \$3.5 million (approximately 2 percent of 2018 premiums) and Blue Plus has reserved for \$33.7 million (approximately 19 percent of 2018 premiums). It is possible that other health plan companies may also have to pay a rebate on behalf of 2018 experience if there are material mis-estimates of items such as risk adjustment receivables/payables, claims that are paid to providers after the year in which services occurred, state-based reinsurance receivables, and drug rebate receivables.

Health Insurance 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 becoming final for purchase. 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. 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.

² <http://www.cms.gov/apps/mlr/mlr-search.aspx>

Medical Loss Ratio as Defined by Minnesota Law

A national leader in health policy, Minnesota has had loss ratio requirements for more than 20 years. Individual states may require a higher minimum loss ratios for health plan companies 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 Statute § 62A.021 and the requirements in Minnesota Statute § 62A.02 Subd. 3.

Minnesota’s loss ratio is calculated differently than the ACA Federal MLR shown above. Minnesota’s loss ratio is defined as claims divided by premium:

$$\text{Minnesota MLR} = \text{Incurred Claims} / \text{Earned Premium}$$

The Minnesota MLR is only prospective in nature and Commerce reviews Actuarial Memorandums and past loss ratio experience for demonstrations of compliance. Unlike Minnesota’s state loss ratio standard, which is prospective, the federal MLR standard is retrospective in nature and carries with it rebates to customers if the minimum MLR is not met in each marketplace.

DIFFERENCES BETWEEN MINNESOTA LOSS RATIO AND FEDERAL MINIMUM LOSS RATIO

Loss Ratio Considerations	Minnesota	Federal MLR
Timing Perspective	future / actuarial	hindsight / actual data
Timing Considered	upcoming year	prior three years, weighted
Consequences of Missing Threshold	if future loss ratio believed to be below threshold, rates are disapproved	if past loss ratio is below threshold, rebates are paid to consumers
Claims Adjustments (Numerator)	risk adjustment (+ / -) drug rebates (-) state-based reinsurance (-) federal cost sharing reductions (-)	risk adjustment (+ / -) drug rebates (-) state-based reinsurance (-) federal cost sharing reductions (-) quality improvement expenses (+)
Premium Adjustments (Denominator)		state and federal taxes assessments and licensing fees
Rebate Adjustments	not applicable	past rebates reduce rebate
Small Enrollment Allowance	loss ratio threshold decreased	statistical credibility stops or reduces rebate payment

For Health Maintenance Organizations (HMOs) and nonprofit health service plan corporations, Minnesota law requires that:

- Individual plans have rates that are expected to achieve a minimum MLR of 68 to 72 percent.
- Small employer group plans have rates that are expected to achieve a minimum loss ratio of 71 to 82 percent.

- Large employer group plans are not subject to explicit state minimum thresholds, because this market is generally viewed as competitive with well-informed, discerning customers. That said, rates are expected to be fair, reasonable, justified, and equitable, in line with Minnesota Statute § 62A.02 Subd. 3. Large group loss ratios are relatively high in relation to other insurance markets because of federal minimum loss ratio rebate implications if the actual loss ratio is less than 85 percent.

For insurance companies, Minnesota law requires that individual, small group, and large group plans have rates that are set to achieve a minimum MLR of 60 percent. In practice, the MLRs for health insurance companies are similar to those for health maintenance organizations and nonprofit health service plan corporations.

Loss Ratio is Not the Same as Value

The loss ratio can be a valuable tool in comparing two health plan companies, assuming that they provide similar benefits. In general, the plan with the higher loss ratio may provide better value to consumers; however, this is not always the case. For example, one health plan company may reduce the cost of claims by preventing payment of fraudulent claims, and subrogating claims (Workers Comp and Auto Insurance) to other insurers. While these actions may result in a higher loss ratio, they may not provide additional value to the policyholder. Alternatively, a health plan company may reduce their loss ratio because they have greater expenses related to negotiating and contracting for lower charge levels with doctors and hospitals, which may result in 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 which affect its value, such as availability of particular medical care providers, quality of patient service, and quality of care management.

Recent Changes in State Law

Any change to a health plan company's business environment could affect the loss ratio. Examples include enrollment increases or decreases, federal actions to defund subsidies, specialty drug releases, material rate level changes, benefit coverage changes (whether voluntarily or due to state or federal law changes), and competitor actions. Below is a summary of recent changes in Minnesota law that have a significant effect on loss ratios.

Health Insurance Premium Rebate

In January 2017, a 25 percent insurance premium rebate was provided to Minnesotans purchasing health insurance in the individual market whose income exceeded 400 percent of the federal poverty level. This rebate resulted in health insurance that was more affordable, and more enrollees with incomes over 400 percent than expected remained in the individual market. Unfortunately, 2017 rates were finalized prior to the legislative enactment of the premium rebate. While this fortunately encouraged healthier people to remain in the individual market, it also reduced overall loss ratios from what they would have otherwise been had the program been anticipated in the rate setting process. This program was available only for 2017.

Minnesota Premium Security Plan (Minnesota Reinsurance Program)

In 2017, the Minnesota legislature enacted a law that created the Minnesota Premium Security Plan (MPSP). This state-based reinsurance program is designed to stabilize premiums in Minnesota's individual health insurance market by partially reimbursing health plan companies for high-cost claims. The new state law authorized up to \$271 million per year in 2018 and 2019 for the reinsurance program, and it called for the Minnesota Commerce Department to submit a State Innovation Waiver application to secure partial federal funding. This Section 1332 waiver application was approved by the federal government in September 2017 and the federal government agreed to provide \$130,719,696 for 2018 and \$84,757,861 for 2019. The MPSP was extended to the 2020 and 2021 plan years by legislation passed in May of 2019. No additional state appropriation was provided for this extension as there were funds remaining from the original state appropriation.

The waiver allows Minnesota to use federal funds to cover a significant portion of the annual reinsurance costs and hold down rates for Minnesotans who buy their own health insurance coverage. MPSP covered 80 percent of any individual market enrollee's annual claims that fell between \$50,000 and \$250,000 in 2018. As a result, 2018 premiums for Minnesota consumers in the individual health insurance market are approximately 20 percent lower on average than what they otherwise would have been without reinsurance.

Different Financial Treatment of Minnesota's Premium Rebate (2017) versus MPSP (2018 and 2019)

The 25 percent Premium Rebate program from 2017 did not affect rates that were shown on individual market rate filings, Commerce' rate release document, rates shown on healthcare.gov and MNsure premiums. This was partly due to the timing of the legislation, which occurred at the very end of the open enrollment period and after rates were filed, but also due to the structure of the program. Structurally, health plan companies extended the premium rebate to eligible consumers starting in May 2017, which including any retroactive credits. Health plan companies requested a payment in 2018 after all of the amounts were known. There was no need for a Section 1332 Waiver, as premiums for those people with incomes under 400 percent of the federal poverty level were not affected. Accounting adjustments were needed to address the intermediary administrative role, but were not needed for claims and premiums, since the program focused its financing directly on consumers' premiums.

MPSP's structure was very different. Health plan companies reduced all premiums based on an actuarial analysis of the value of the program. Unlike the 2017 program, for the MPSP program, net premiums (that is, after reinsurance) are shown on rate filings, rate release documents, rates shown on healthcare.gov, and MNsure premiums. This makes it difficult to compare rates between 2017 and 2018. In terms of the loss ratio data provided in this report, premiums for 2018 are lower because they are "net" and already take into account the actuarial value of the reinsurance program. Due to statutory and generally accepted accounting principles, claims reported by health plan companies should be offset for the state-based reinsurance program receivables. In terms of the rebate reporting for the Federal MLR, federal instructions address appropriate accounting³ so that health plan companies cannot overstate claims and thus avoid paying a rebate through taking credit for claims paid by entities such as federal and state governments.

³ See first bullet on deduction instruction for line 2.1, pages 29-30)
<https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2017-MLR-Form-Instructions.pdf>

Notes on Using the Data

Source

The earned premiums, incurred claims, and loss ratios listed in this report were provided by the health plan companies. The loss ratios have not been independently audited and may include unintentional errors.

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. In general, statistical fluctuation in markets decrease with more enrollees. However, it is difficult to predict claims when enrollment changes significantly.

Data Table Descriptions

In the data shown in Tables 1 through 3:

- The column titled Group Number is a unique number assigned by the NAIC in order to identify affiliated groups of companies. The number aids in research of financial data available through the NAIC.
- The column titled State Loss Ratio is based on the Minnesota definition of MLR.
- The column titled Preliminary ACA MLR shows the preliminary estimate of the ACA MLR from the health plan company's annual statement, as shown in the Supplemental Health Care Exhibit.
- The column titled Covered Lives is the number of people insured, including dependents, as reported by the health plan company as of the end of the year.

Table 1: 2018 Individual Loss Ratio Data

Health Plan Company Supplemental Health Care Exhibits for 2018 (except where noted)

Group Code	Name	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR*	Covered Lives
1552	Medica Ins Co (MHPW aggregated)	\$258,126,202	\$167,783,039	65%	94%	34,138
1258	Group Health, Inc.** (HPIC and HPI aggregated)	253,774,890	171,701,986	68%	70%	55,454
461	HMO dba Blue Plus (BCBSMN aggregated)	182,490,831	102,477,259	56%	79%	22,411
4380	UCare MN (UCare Hlth Inc aggregated)	172,250,930	106,848,042	62%	66%	28,761
3492	PreferredOne Ins Co	4,979,646	3,064,460	62%	82%	346
	Total	\$871,622,499	\$551,874,786	63%	78%	141,110

Table 1 lists the loss ratios experienced in the individual health plan market in 2018 by companies that cover individuals in that market. Not all health plan companies with individual health plans in force are shown above. Any health plan company with premium volume lower than \$300,000 is not included.

The Minnesota loss ratios for 2018 ranged from 56 percent to 68 percent. The total Minnesota loss ratio for 2018 is 63 percent, versus 75 percent in 2017.

**Values for the ACA MLR are marked above as preliminary because, due to the late timing of risk adjustment and MPSP processing, health plan companies must estimate financial entries.*

***Relied on Earned Premium and Incurred Claims data provided by company rather than financial statements' Supplemental Health Care Exhibit due to special inquiry.*

Table 2: 2018 Small Employer Group Loss Ratio Data

Health Plan Company Supplemental Health Care Exhibits for 2018 (except where noted)

Group Code	Name	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR*	Covered Lives
1258	HealthPartners Inc	\$606,992,370	\$511,009,319	84%	87%	115,213
461	BCBSM Inc	554,036,939	455,770,093	82%	90%	82,216
1552	Medica Ins Co	285,233,170	257,622,114	90%	95%	62,599
3492	PreferredOne Ins Co	98,973,162	93,748,975	95%	100%	16,242
1258	HealthPartners Ins Co	37,658,962	29,840,486	79%	85%	4,120
461	HMO dba Blue Plus	14,825,212	11,053,954	75%	77%	4,499
4870	Gundersen Hlth Plan MN	1,461,087	1,381,951	95%	97%	273
3492	PreferredOne Comm Hlth Plan	898,504	704,300	78%	111%	169**
1246	Sanford Hlth Plan of MN	497,812	272,596	55%	57%	166
	Total	\$1,600,577,218	\$1,361,403,788	85%	90%	285,497

Table 2 lists the loss ratios experienced in the small employer health plan market in 2018 by health plan companies that cover small employer groups. Not all health plan companies with small employer health plans in force are included. Any health plan company with premium volume lower than \$300,000 is not included. Also excluded are self-funded small employer health plans.

The Minnesota loss ratios for 2018 ranged from 55 percent to 95 percent. The total Minnesota loss ratio for 2018 for health plan companies is 85 percent. The total Minnesota loss ratio for the previous year was 89 percent.

**Values for the ACA MLR are marked above as preliminary because, due to the late timing of processing, health plan companies were forced to estimate financial entries for risk adjustment.*

***Displaying Average Covered Lives for PreferredOne Comm Hlth Plan, as reported separately upon Department inquiry.*

Table 3: 2018 Large Employer Group Loss Ratio Data

Based on Health Plan Company Supplemental Health Care Exhibits for 2018 (except where noted)

Group Code	Name	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR*	Covered Lives
461	BCBSM Inc (Blue Plus aggregated)	\$1,427,750,067	\$1,296,588,643	91%	89%	228,342
1552	Medica Ins Co	774,623,170	640,705,781	83%	85%	134,778
1258	HealthPartners Ins Co	698,510,455	576,980,969	83%	88%	327,872
1258	HealthPartners Inc (Group Health aggregated)	178,562,124	156,191,408	87%	91%	24,395
3492	PreferredOne Ins Co	84,548,145	73,909,408	87%	93%	18,534
1246	Sanford Hlth Plan of MN	3,082,735	3,520,412	114%	110%	645
1	Aetna Life Ins Co	2,261,465	2,082,713	92%	99%	463
3492	PreferredOne Comm Hlth Plan	1,823,222	1,807,840	99%	104%	401
4870	Gundersen Hlth Plan MN	939,650	895,258	95%	98%	150
707	UnitedHealthcare Ins Co**	352,399	245,551	70%	68%	367
	Total	\$3,172,453,432	\$2,752,927,983	87%	88%	735,947

Table 3 lists the loss ratios experienced in the large employer health plan market in 2018 by health plan companies that cover large employer groups. Not all health plan companies with large employer health plans in force are included. Any health plan company with premium volume lower than \$300,000 is not included. Also excluded are large employers with self-funded health plans.

The Minnesota MLRs for 2018 ranged from 70 percent to 114 percent. The total Minnesota loss ratio for 2018 for health plan companies is 87 percent. The total Minnesota MLR for the previous year was 89 percent.

**Values for the ACA MLR are marked above as preliminary due to the late timing of certain claims payments that were unknown at the time when financial statements were filed, in contrast to the time of MLR final reporting.*

***Relied on incurred claims data provided by UnitedHealthcare Ins Co instead of financial statements.*

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 7th Place East, Suite 280

St Paul, MN 55101-2198

651-539-1600; 800-657-3602

<https://mn.gov/commerce/industries/insurance/>

For information about health maintenance organizations, please contact the Health Department at:

Minnesota Department of Health

Managed Care Systems

Section 85

7th Place East

P.O. Box 64882

St. Paul, MN 55164-0882

651-201-5100; 800-657-3916

<http://www.health.state.mn.us/hmo>

HMO Financial Reports as Reported to the Minnesota Department of Health

<https://www.health.state.mn.us/facilities/insurance/managedcare/reports/financial.html>

Health Plan Financial and Statistical Report (HPFSR)

The Minnesota Department of Health (MDH) is required to collect data from HMOs regarding their membership, revenues, and expenditures for Minnesota residents, under Minnesota Statutes, section 62J.38, Minnesota Statutes, section 62J.321, and Minnesota Rules, chapter 4652. As part of this data collection, MDH requires all HMOs to submit aggregated data regarding their business to the department, with filings due April 1 for the prior calendar year. Summary data from health plan companies with over \$3,000,000 in annual healthcare revenue are used to produce the annual report, on Administrative Costs at Minnesota Health Plans. The most recent report is for 2017, and was released in June 2019: <https://www.health.state.mn.us/data/economics/docs/2017admindcosts.pdf>