

MASSACHUSETTS MEDICAL LOSS RATIOS

CHIA's 2015 Annual Report on the Performance of the Massachusetts Health Care System referenced Medical Loss Ratios (MLRs) within the commercial market. This brief further describes how MLRs are calculated and applied in Massachusetts, and how MLR thresholds vary for different populations. Detail is also provided on the proposed federal MLR for Medicaid Managed Care Organizations.

MEDICAL LOSS RATIOS

MLRs measure the proportion of collected health insurance premiums that payers have used—or expect to use—to pay for their members' medical expenses in a particular market.¹ The higher the MLR, the less of each premium dollar, on average, a health insurance payer has spent—or expects to spend—on administrative services, marketing, broker fees, or surplus.² MLRs are frequently used to assess the “value” of health insurance plans.³ Although MLR minimums were implemented nationally with the Patient Protection and Affordable Care Act, Massachusetts already had MLR standards that exceeded, and continue to preempt, national minimums for individual and small group plans.

In Massachusetts, the Division of Insurance (DOI) collects and monitors insurance payers' commercial MLRs based on standards set by the federal Centers for Medicare and Medicaid Services (CMS), by Massachusetts state law, and by calculation tools and methodologies established by the National Association of Insurance Commissioners (NAIC).^{4,5} Insurance payers are expected to complete MLR calculations as instructed by the DOI according to the formula described in **Figure 1**. Within the MLR numerator,⁶ insurance payers are to include members' health care service expenses during the coverage period (i.e., claims plus capitation and other alternative payment amounts) and expenses related to health care quality improvement and fraud reduction.⁷ Within the MLR denominator, payers are to include premiums earned but may subtract incurred taxes and fees. Resulting MLRs may be further adjusted to account for the size of a payer's membership and its membership's concentration in High Deductible Health Plans (HDHPs), as low membership and/or highly concentrated HDHP membership may contribute to greater claims (MLR numerator) volatility.^{8,9}

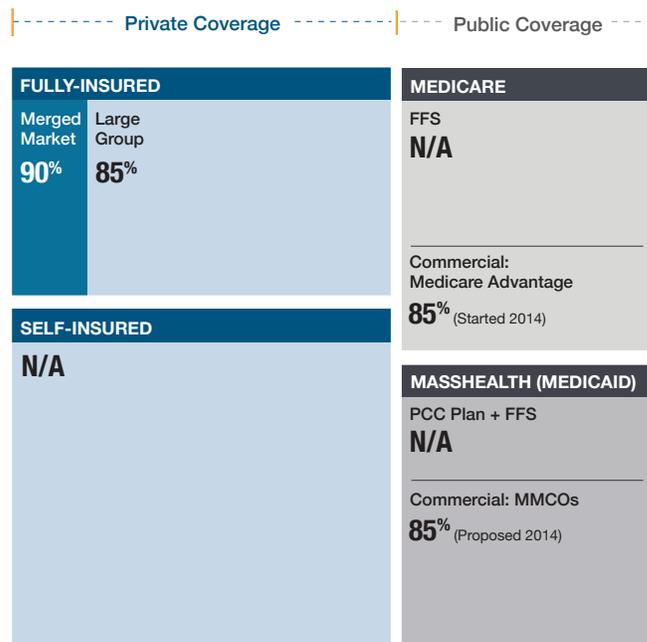
In 2013, Massachusetts minimum MLR standards varied by market and employer group size. (**Figure 2**) For fully-insured coverage available to

1 Medical Loss Ratio Components

$$MLR = \frac{(\text{Medical Claims}) + (\text{Quality Improvement \& Fraud Expenses})}{(\text{Earned Premiums}) - (\text{Taxes, Assessments \& Fees})}$$

Source: General MLR standards from Massachusetts and federal regulations. See [technical appendix](#).

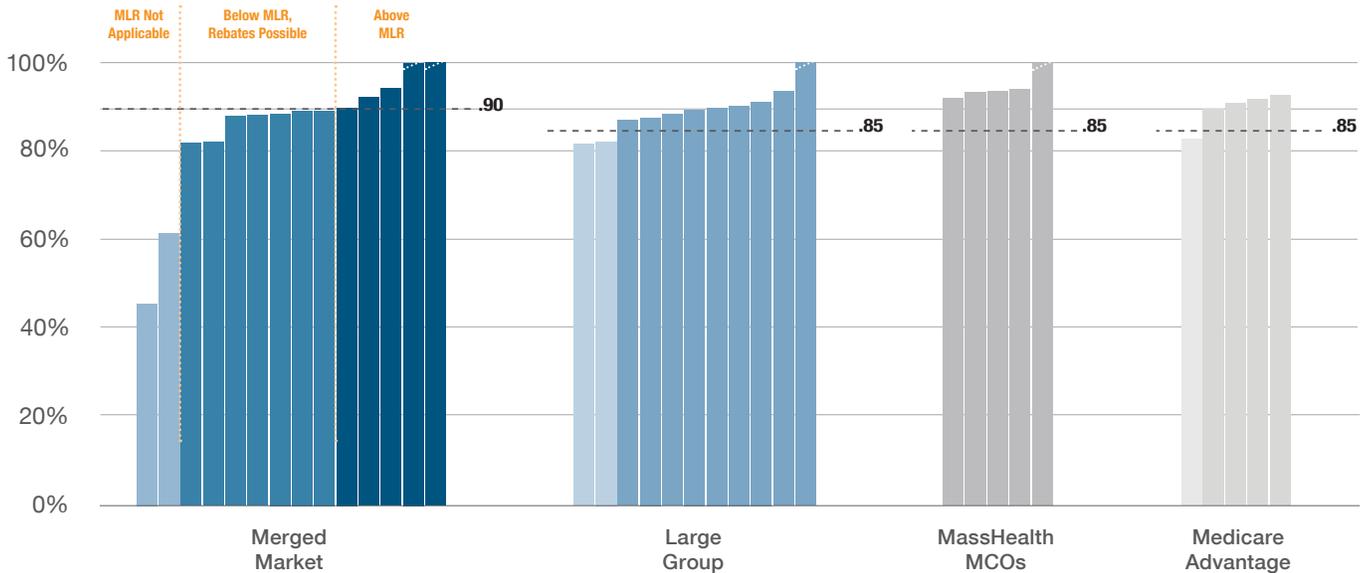
2 Massachusetts Market MLR Thresholds, 2013



Source: MLR standards from Massachusetts and federal regulations

Notes: Figure approximately scaled to Massachusetts membership per [2014 Massachusetts Health Survey](#).

3 Massachusetts Commercial Payer MLRs, 2013



Source: 2013 Massachusetts Annual Comprehensive Financial Statements; CHIA and Oliver Wyman Actuarial Consulting analysis

individuals and small group employers (with 50 or fewer employees) in Massachusetts’ merged market, payers were required to meet a minimum MLR threshold of 90% (i.e., 90% of adjusted premiums must have been spent on qualifying medical expenses);¹⁰ federal law required that payers offering fully-insured plans in the large group market (covering employer groups with more than 50 employees) meet the minimum MLR threshold of 85%. Payers administering self-insured group plans of all sizes, which represent 60% of the commercial market, are not required to meet state or federal minimum MLRs.¹¹ Payers administering Medicare Advantage and/or Medicare Part D plans, starting in 2014, are required to meet a federally-set standard of 85%.¹² A recently proposed CMS rule, discussed in the next section, also proposes a similar 85% threshold for Medicaid/CHIP managed care organizations (MMCOs). When payers do not meet MLR standards, policyholders (and/or the government) provide refunds (“rebates”) totaling the amount needed to otherwise meet the standard.¹³

PROPOSED CMS MEDICAID MANAGED CARE MLR

On June 1, 2015, CMS proposed a rule outlining MLR requirements for Medicaid/CHIP managed care programs.¹⁴ The proposed rule, which is subject to change during the current public comment period, requires Medicaid/CHIP payers to annually calculate and report MLRs, allowing state regulators to conduct retrospective and prospective analyses of payments compared to expenditures to ensure fair and equitable

arrangements are maintained. Per the rule, Medicaid/CHIP payers would also be required to achieve at least an 85% MLR by a calculation similar to that used in the commercial and Medicare Advantage markets.^{15,16,17} Rebate requirements, however, would be at individual state discretion. MLR requirements would commence with managed care contracts with effective dates beginning in 2017, though the first MLR calculations would not begin until late-2018.¹⁸

The proposed rule requires an audited financial statement from payers that supports the MLR calculation. Meeting this requirement may be challenging for MMCOs if they do not have audited financial statements specific to the contract period, or if they are a multi-line MMCO and do not have Medicaid-specific audited statements.

The CMS proposed rule further encourages states to establish a “maximum” MLR, with consideration for the unique circumstances of their Medicaid programs and markets. No proposed threshold is given.¹⁹

MASSACHUSETTS’ MEDICAL LOSS RATIOS IN CONTEXT (2013)²⁰

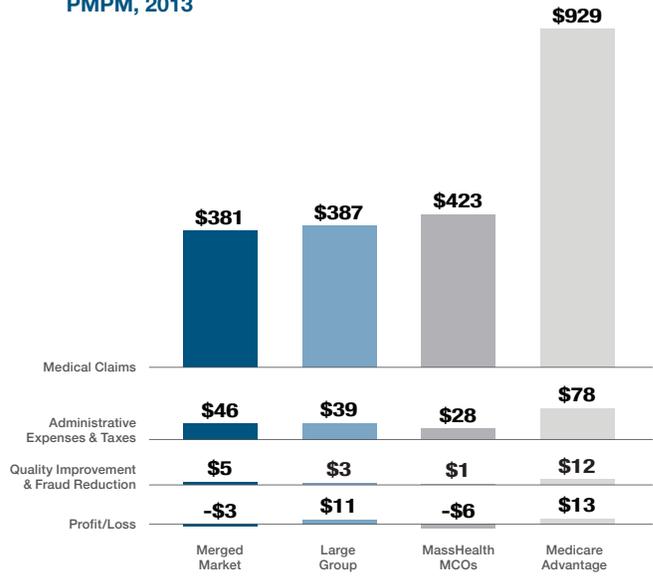
In 2013, the latest year for which complete Massachusetts market data was available,²¹ seven commercial payers operating in the Massachusetts merged market fell below the 90% MLR threshold.²² (Figure 3) Most Massachusetts Large Group payers exceeded an 85% MLR threshold, as did most Massachusetts Medicare Advantage payers.²³ Had the proposed

85% Medicaid minimum-MLR been in effect, all of Massachusetts' MMCOs in 2013 would have exceeded the threshold, with Network Health holding a calculated MLR exceeding 100%.²⁴

Insurance payer spending varied by covered population in 2013. (Figure 4) Medical claims, per member per month (PMPM), ranged from \$381 PMPM to \$929 PMPM among populations and benefit packages. Administrative spending²⁵ was higher within the Medicare Advantage payers (\$78 PMPM) than commercial payers (\$39-\$46 PMPM) or MassHealth Managed Care Organizations (\$28 PMPM). Similarly, MassHealth MCOs spent less on health care quality improvement and fraud detection and recovery efforts than did Medicare Advantage and commercial payers (\$1 PMPM vs. \$3-\$12 PMPM)²⁶ Early 2014 data show similar spending levels.

Technical support provided by Oliver Wyman Actuarial Consulting and Mercer. For questions on this brief, please contact Kevin Meives, Senior Health System Policy Analyst, at (617) 701-8208 or at Kevin.Meives@state.ma.us.

4 Massachusetts Commercial Payer Spending PMPM, 2013



Source: 2013 Massachusetts Annual Comprehensive Financial Statements; CHIA and Oliver Wyman Actuarial Consulting analysis

Notes: MassHealth spending data does not include wrap services.

Notes

- 1 See additional information from the CMS and its Center for Consumer Information and Insurance Oversight (CCIIO), as well as material published by the California Healthcare Foundation.
- 2 While for-profit payers may factor expected profit into their premium development, non-profit payers may factor in an assumed contribution to surplus. The overwhelming majority of Massachusetts insured health coverage is written by non-profit payers.
- 3 See Robert Wood Johnson Foundation's May 2015 brief, *Health Insurer Responses to Medical Loss Ratio Regulation*.
- 4 CMS provides federal MLR rebate report guidance annually. The National Association of Insurance Commissioners (NAIC), separately, provides guidance for MLR calculations in the SHCE (Supplemental Health Care Exhibit). SHCE MLRs and Annual Comprehensive Financial Statements (ACFS) MLRs reported to Massachusetts are calculated on a one-year and statutory financial reporting basis; CMS MLRs, which the Massachusetts DOI uses for its MLR Reports, use restated claims with three months claims run-out and include three year MLR averaging.
- 5 Data used in this brief are from Massachusetts DOI's ACFS, which use NAIC standards per regulation 211 CMR 149.04. ACFS MLRs shown here do not include any credibility adjustments or three year averaging.
- 6 In 2014, payers must subtract Advance Cost Sharing Reduction (CSR) payments and add 3R—risk adjustment, risk corridor, reinsurance—net transfer payments to their MLR numerator.
- 7 The lesser of expenses or reimbursements from such activities.
- 8 If a payer's membership is over 1,000 lives in all three years and has pre-credibility adjusted MLRs lower than the state requirement for each of the three years individually, no credibility adjustment is granted.
- 9 Starting in 2013, CMS MLR calculations are based on the experience incurred during the current and two prior calendar years.
- 10 The federal standard is lower at 80%. In Massachusetts, state law defined that the MLR for the merged individual/small group market declined from 90% in 2012 and 2013 to 89% in 2014 to 88% in 2015.
- 11 All plans, including self-insured plans, are required to maintain a minimum value threshold of 60% (i.e. the plan must cover at least 60% of the total cost of medical services for a standard population, and must include substantial coverage of inpatient hospital and physician services). Minimum values set a threshold of payers' cost sharing of expected claims. MLR ratios, by contrast, calculate payers' actual claims experiences compared to their collected premiums.
- 12 Medicare Supplement plans offered by insurance payers are required to meet a 85% MLR threshold.
- 13 In Massachusetts, in 2014, \$15 million in rebates were issued to approximately 209,000 consumers by insurance payers based on 2013 experiences. See CMS 2013 MLR Rebate report.

- 14 See Proposed Rule here. It is currently unclear how this MLR requirement applies to managed care programs that administer dual-enrollees (Medicare-Medicaid).
- 15 Medicaid/CHIP MLR requirements differ from commercial and Medicare Advantage MLRs in four, notable ways: 1) it is calculated annually with no special start-up modifications (e.g., rolling three year calculation, option to push first year experience into subsequent periods); 2) It will follow the contract year for capitation rates (i.e., does not need to be calculated on calendar year); 3) Stop loss, risk corridor, and retrospective risk payments are to be subtracted from incurred claims, while solvency fund payments are to be included; and 4) Activities related to fraud recovery and prevention are to be included in the numerator of the calculation along with incurred claims, but are limited to 0.5% of premium revenues.
- 16 Many MassHealth MCOs have developed unique payment and service-arrangements (e.g., specialty drugs, behavioral health, and long term care); it is unclear how such arrangements may be handled by the proposed MLR.
- 17 The proposed rule includes a provision for a credibility adjustment when an MCO has membership below a certain level.
- 18 Allowing for claims run-out.
- 19 Note: A maximum MLR coupled with a minimum MLR creates a risk corridor that may introduce risks to a state's budget.
- 20 2013 Annual Financial Comprehensive Statement data used to estimate MLRs. MLRs shown are estimates without potential credibility adjustments and prior years' experience. CHIA analysis with Oliver Wyman Actuarial Consulting with Mercer Consulting providing subject-matter expertise. Estimated MLRs shown may differ from those presented by the Massachusetts DOI due to different data sources used for differing purposes.
- 21 Latest year of ACFS data available with retention decomposition for the full market (Merged Market, Large Group, Medicaid, and Medicare Advantage). CHIA's 2015 *Annual Report on the Performance of the Massachusetts Health Care System* included 2014 SHCE data for the large group market only.
- 22 Shown MLRs without credibility adjustments or three-year averaging. Several of these payers were required to issue rebates based on their three-year MLR averages. See footnote 13.
- 23 Neighborhood Health Plan and United Healthcare fell below the large group threshold without credibility adjustments. United Healthcare fell below the Medicare Advantage threshold.
- 24 BMC HealthNet, Fallon Health, Health New England, Neighborhood.
- 25 Includes taxes, assessments, fees, and fines, and excludes quality improvement and fraud detection expenses and gains/losses.
- 26 MMCO Quality and Fraud Detection expenses PMPM were 32% of that found in the private commercial merged market PMPM, 43% of large group, and 12% of Medicare Advantage.