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STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Using Insurer Filings to Monitor the Private Health Insurance Market

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Authors:
Lynn Blewett, PhD
Pinar Karaca-Mandic, PhD
Jennifer Ricards, MS
Sung Choi, BA
Tsan-Yao Huang, MA

Other Contributors:
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INTRODUCTION

The Affordable Care Act (ACA) includes several provisions related to private health insurance designed to improve access to affordable coverage; the value of the insurance product; and accountability and transparency of premium pricing.[1] A key component of these regulations was the new medical loss ratio (MLR) requirement. The MLR refers to the proportion of a health plan's premium dollar collected that is spent on health care services and quality improvement activities.[2] As of January 1, 2011, all health insurers must now meet a standard MLR of 80 percent in the individual and small group market, and 85 percent in the large group market. In other words, for every dollar an insurer collects in health insurance premiums in the individual or small group markets, 80 cents must be spent on medical care services or activities to improve health care quality (85 cents in the large group market).

On an annual basis, insurers are required to submit reports to the Department of Health and Human Services (HHS) documenting the amount of premiums collected as well as expense detail in several major categories: claims, health care quality improvement activities, taxes and fees, and other non-claims costs (including general and administrative costs). Insurers that fail to meet the new MLR requirement must return the excess premium amounts to plan enrollees in the form of consumer rebates. These reports, available by state (including the District of Columbia and five U.S. Territories), are freely available to the public and can be found on the website of the Center for Consumer Information and Insurance Oversight (CCIIO, part of the Centers of Medicare and Medicaid Services) approximately six to eight months after the June 1 report submission due date.[3] For additional background information and detail on the ACA's MLR requirements, please see CCIIO's summary of the final rule, which is included as Appendix I.

Prior to the ACA, state insurance departments were in charge of setting state-level MLR requirements, which ranged from 50 percent in Pennsylvania to 80 percent in New Jersey in the individual market.[4] The objective in moving to a national standard for MLR thresholds was to increase affordability, value, and accountability of health insurance products across the U.S.[2] Some states identified difficulties in shifting to an 80 percent MLR immediately due to the structures of their individual markets; the ACA granted the HHS Secretary with the authority to approve temporary adjustments (up the three years at a time) of the MLR requirement on a state-by-state basis if, because of their existing markets, a shift to 80 percent

would reduce the choices available to consumers. HHS received 18 applications for MLR adjustments (from 17 states and Guam); these requests ranged from a 60 percent MLR (Iowa) to 72 percent (Nevada and North Carolina) for 2011.[5] Though HHS retains the authority to grant future adjustments should they be necessary, as of 2013 no state had an approved adjustment exempting it from the 80 percent level. Appendix II provides detail on state-requested adjustments and HHS decisions to the 80 percent MLR requirement.

Prior to the release of the CCIIO data, most of the information available on private health insurance, such as premiums, MLRs, and covered lives came from the National Association of Insurance Commissioners (NAIC). The NAIC is a non-profit organization created and governed by insurance regulators from the 50 states, the District of Columbia, and five U.S. Territories. NAIC's data represent a compilation of health insurer filings of Annual Statements to the Insurance Departments of each state in which the health insurers sell products. The data are publicly available for a fee, and are organized in a spreadsheet by exhibit; exhibits of particular interest, described in detail in this paper, is the Supplemental Health Care Exhibit (SHCE). The NAIC also produces reports on the U.S. private health insurance market using information submitted through this process;[6] as well as a series of white papers on various topics related to health insurance and the ACA (e.g., health insurance exchange governance options, tools that states can use to minimize adverse selection).[7–9]

The purpose of this paper is to provide states with information on ways in which they can monitor the private health insurance market over time. This includes key analytic questions of interest, examples and recommendations of state-level analyses of the regulated health insurance market, as well as a comparison of two data sources states can use for monitoring and reporting purposes. More specifically, we compare the data collected by CCIIO for the purposes of regulating private health insurers' MLRs to the data collected by the NAIC. While the data elements collected are similar, there are also distinct differences. We highlight these differences and identify key analytic questions that can be best answered by each data source.

BACKGROUND

For state-level monitoring of the private health insurance market, two sources of administrative data are available: (1) The National Association of Insurance Commissioners' (NAIC's) Supplemental Health Care Exhibit (SHCE) and (2) the Department of Health and Human Services (HHS), Center for Consumer Information and Oversight's (CCIIO's) MLR regulatory filings. The data elements included in each source are similar, with some distinct differences which are described below.

NAIC Health Insurance Data Background

The NAIC is a membership organization that assists state member insurance regulators in developing standards and best practices and provides a forum for state members to coordinate regulatory oversight of private health and other insurance markets. In 1980, the NAIC created guidelines for states to reference in developing their own MLR standards for individual policies; the NAIC guidelines varied by renewability status of the insurance product and ranged from 50% for a non-cancelable product up to 60% for an optionally renewable one. Prior to the ACA, a total of 34 states had some MLR-related policy, requirement, or law, with 10 states using the NAIC guidelines directly. Given the NAIC's long history as a resource in this area, the ACA included a provision that HHS consult with NAIC in the development of standard definitions and provisions for MLR calculation under the law.[4] The final federal MLR regulation was based on recommendations submitted to the HHS Secretary on October 27, 2010, by the NAIC and included recommendations outlining data elements to include in the public reporting requirements that show spending categories used to calculate MLRs.

Prior to 2010, the NAIC collected state insurance filings and aggregated data for research and reporting purposes. While useful for some purposes, there were several limitations with the NAIC data that made it difficult to accurately monitor the individual, small, and large group health insurance markets.[10] For example, these earlier data did not distinguish between the small and large group markets (insurers operating in these markets were filed under the "group market"). Additionally, insurers that had 95 percent or less of their business in health insurance were not required to submit the same information as insurers with more than 95 percent of their business in health insurance. For instance, companies that primarily sold life, fraternal, and property insurance, but also sold health insurance policies, were not required to submit information on covered lives and premiums.

Beginning in 2011, the NAIC began collecting detailed state level health insurance information through its SHCE. The SHCE was designed to align with federal reporting requirements of the ACA,[11] and to assist state and federal regulators in analyzing health insurance revenues and expenses related to MLRs. The SHCE includes detailed information on the number of covered lives, number of policies, member months, health premiums earned and estimated MLRs that can be summarized and reported at the state level. The SHCE contains information from life, fraternal, property/casualty insurers, and health insurers that offer comprehensive individual and group health insurance. With one exception, all states and District of Columbia require health insurers to submit annual financial filings using the NAIC forms. California's two insurance regulatory bodies, the Department of Managed Health Care and the Department of Insurance, do not require insurers to file with NAIC, and thus California data are not included in the SHCE unless insurers voluntarily report to NAIC.

Although states use the SHCE filings to inform regulatory activities, the information has also been used for policy and research purposes. For example, researchers have used the data to evaluate regulations designed to reduce costs and improve market functioning,[12,13] as well as to monitor insurer behavior and overall market functioning.[10,14,15] In addition to the SHCE, the NAIC collects other exhibits that can be used to report on health insurers. For example, the Premiums, Enrollment, and Utilization Exhibit (also known as the "State Page"), as well as the Annual and Quarterly Statements, may be of particular interest to state analysts and policymakers. For an example of health insurance market reporting using the Annual and Quarterly Statement Filings, please see the Robert Wood Johnson Foundation's report on the individual market.[16]

ACA and CCIIO Medical Loss Ratio Data Background

The MLR represents the proportion of total premium revenues spent on health care services and quality improvement activities by a health insurer.[17] It was implemented as part of the ACA in an attempt to improve the value of insurance products by requiring insurers to spend more of their revenues on health care services rather than on administrative costs, and to help regulate premium increases. The Affordable Care Act (ACA) requires insurers to achieve a MLR of 80 percent in the individual and small group markets, and 85 percent in the large group market. Insurers who do not meet this requirement must provide a rebate to their customers starting in 2012.[18]

The MLR reports submitted to HHS/CMS/CCIIO are currently available for the 2011 and 2012 reporting years, and consist of data that health insurers submit in the MLR Annual Reporting Forms (e.g., premiums, claims, expenses, MLR calculations, and rebate amounts).[19] Although the data have been available only since 2011, preliminary investigations suggest that CCIIO collects similar information as the NAIC, and that the CCIIO data will be useful for monitoring state-specific insurer performance.

The U.S. Government Accountability Office (GAO) recently released a report titled "Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees."[20] The purpose of this report was to assess the effects of the new MLR requirements by analyzing the 2011 and 2012 data submitted to HHS/CMS/CCIIO. For both reporting years, the majority of insurers met or exceeded the MLR thresholds. However, the percentage of insurers meeting the MLR thresholds varied by year, and by market segment. For example, 76 percent of insurers met the MLR requirements in 2011, and 79 percent met the MLR requirements in 2012. This resulted in rebates of $1.1 billion paid to enrollees in 2011, and $520 million paid to enrollees in 2012. Regarding the percentage of insurers meeting the MLR threshold by market segment, the individual market generally had fewer insurers meeting the threshold. For example, in 2012, 70 percent of insurers operating in the individual market met the MLR thresholds, while 86 percent in the large group and 81 percent in the small group markets met the MLR thresholds.

Currently, agent and broker compensation is included in the MLR formula as a non-claims expense. In response to industry debate about this compensation as a non-claims expense, the GAO conducted an analysis to determine if more insurers would have met the MLR thresholds if this compensation had been excluded from the MLR calculations. The results demonstrated that the amount of rebates paid to enrollees would have decreased by approximately 75 percent if agent and broker compensation were excluded from the MLR requirements. State policymakers may be particularly interested in Appendix IV within the report, which list the amount of rebates that would have been paid, by state, if the agent and broker compensation had been excluded from the MLR calculations. Additionally, the tables compare the actual rebate amounts paid, the amount that would have been paid had the compensation been excluded, and the percent difference between the two. Excluding states that did not pay any rebates, all states would have seen a decrease in the rebates paid had the compensation been excluded, both in 2011 and 2012.

CCIIO and NAIC DATASET COMPARISONS

Both the CCIIO and NAIC insurance data have similar information on premiums, medical claims, administrative costs, and covered lives. Aggregate data can be used to measure and monitor the private health insurers that operate in each state, by plan and year for the individual, small group, and large group markets. Table 1 provides background information on the CCIIO and NAIC datasets, and contrasts similarities and differences between the two data sources.

In this section, we present the results of CCIIO and NAIC comparisons. For this portion of the analysis, we set out to answer the question: do the CCIIO and NAIC data sources vary on key variables of interest to state analysts and policymakers? If yes, where are these differences? Our analyses demonstrated that the two datasets did not have any significant differences on key variables of interest for credible insurers in the individual, small group, and large group markets. For example, there were no differences in the premiums, incurred claims, expenses, and MLRs (for the NAIC data, the "preliminary" MLR was estimated).

In carrying out these analyses, we conducted tests of significance by comparing the proportion of a particular variable in NAIC data, to the proportion of the same variable in both the CCIIO and NAIC data combined. For example, the proportion of non-credible insurers (those with less than 1,000 covered life years annually) included in the NAIC data to the proportion of non-credible insurers included in both datasets combined. Detailed analytic output on the comparisons between the two datasets are available for download from SHADAC's State Health Reform Data Analytics website.

Although there were no differences in key variables of interest, there were differences in the composition of insurers between the datasets. For example, in both 2011 and 2012, there were significant differences between the number of non-credible insurers included in the CCIIO and NAIC datasets for the individual market. More specifically, there were more non-credible insurers included in the NAIC SHCE data. In the 2011 individual market, there were an additional 158 non-credible insurers in the NAIC data compared to the CCIIO data. In the 2012 individual market, there were an additional 143 non-credible insurers found in the NAIC data. Appendix III includes key dataset terminology.

Table 1. CCIIO and NAIC Dataset Comparisons

Overview

	NAIC Supplemental Health Care Exhibit	CCIIO Medical Loss Ratio Data
Universe	Filed by health, life, fraternal, and property/casualty insurers that sell health insurance policies within the individual and fully-insured small and large group markets. This includes non-credible, partially credible, and fully credible insurers.	Includes health insures offering coverage subject to Section 2718 of the PHS Act and the MLR implementing regulations. This includes non-credible, partially credible, and fully credible insurers.
Availability	Available for purchase from NAIC[1] (approximately $7,000; approximately $700 with qualifying academic discount).	Free public use file available from CCIIO[2].
Years	2012, 2011, 2012, 2013	2012, 2011
Timeframe	12 months (data collected up to December 31 of the reporting year).	15 months (data up to December 31 of the reporting year, as well as first quarter following the reporting year).
Release	Approximately four months after the reporting year (April).	Has varied from eight to eleven months after the reporting period. 2011 data were released November 2012; 2012 data were released August 2013.
Reporting form	NAIC Supplemental Health Care Exhibit	Centers for Medicare and Medicaid (CMS) MLR Annual Reporting Form
Statistical package import – Degree of difficulty	Difficult - Requires advanced programming abilities to import data from Microsoft Excel (e.g., data must be reshaped for each year, then years must be appropriately combined into one file).	Difficult - Requires advanced programming abilities to import data from Microsoft Excel (e.g., data must be reshaped for each year, then years must be appropriately combined into one file). Additionally, the CCIIO 2011 and 2012 Forms differ from one another (e.g., variable name changes and new variables), making it necessary to write new code to import a new year of data into software packages.

Data Contents

	NAIC Supplemental Health Care Exhibit	CCIIO Medical Loss Ratio Data
Covered lives	Yes	Yes
Policies	Yes	Yes
Member months	Yes	Yes

[1] http://www.naic.org/store_pub_statistical.htm#sup_health_exhibit
[2] http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html

	NAIC Supplemental Health Care Exhibit	CCIIO Medical Loss Ratio Data
Health premiums earned	Yes, available by combining several data elements	Yes, available by combining several data elements
Federal taxes	Yes, available by combining several data elements	Yes, available by combining several data elements
State taxes	Yes, available by combining several data elements	Yes, available by combining several data elements
Premium and other taxes	Yes, available by combining several data elements	Yes, available by combining several data elements
Incurred claims	Yes, available by combining several data elements	Yes, available by combining several data elements
Medical loss ratio (MLR)	No, but can be approximated (see below)	Yes, actual MLR (see below)
MLR data in reporting year or aggregated?	Data are included for the reporting year only. Researchers need to calculate their own aggregated variables in order to arrive at the approximated MLR.	Both reporting year and aggregated data are available, but aggregated data are more reliable since some variables can be missing when using the reporting year only.
Credibility adjustment directly available?	No	Yes
Credibility status	Can be determined with aggregated member-years	Can be determined with aggregated member-years
Base credibility factor	Yes, but requires calculation	Yes, reported in Part 5
Deductible factor	No, average deductible not available	Yes, reported in Part 5
Rebates	No, but can be approximated	Yes, actual total and per member rebate

There are key differences between the CCIIO and NAIC data in the context of monitoring changes in the private health insurance market over time. Highlighted below are situations in which one dataset offers an advantage over the other, as well as circumstances in which only one of the datasets can be used for a particular analysis.

- ***CCIIO data are used to determine whether health plans are meeting MLR standards and represent the official MLR record for regulatory purposes.*** Because the data reported to CCIIO are used for regulatory purposes, these data represent the official MLR for each regulated health insurance company. Reporting requirements are uniform across states and this information can be used to monitor changes in the private market within and across states. For within state comparisons, states could analyze changes in the market structure and composition over time, and could compare across market segments within and across years.

- ***CCIIO data include a full 15 months of reporting, allowing for additional months of claims run out, while NAIC data include a 12 month reporting period.*** The NAIC data can be used to estimate medical insurer's MLR, but because the NAIC dataset includes a 12 month reporting period, an official MLR cannot be calculated. The full 15 months of data are required for the federal MLR calculation. In addition to the official MLR and rebate amounts for health plans, the 15 months of data included in the CCIIO dataset allows for a claims run out period to capture claims for services and payments that occurred within the reporting period.

- ***CCIIO data lack information on smaller insurers not subject to MLR regulation.*** For analyses that are not specific to MLR regulation, researchers might consider the NAIC data. CCIIO reporting was created to collect information on and regulate the new MLR threshold requirements. However, some medical insurers are not subject to MLR requirements because they are non-credible (i.e., covering less than 1,000 member life-years). Our analyses of the two datasets suggest that there may be reporting inconsistencies for smaller insurers. For example, using the 2012 individual market data, both the CCIIO and NAIC shows the same 1,080 non-credible insurers, but the NAIC data includes an additional 143 non-credible insurers that are not in the CCIIO dataset. Given these findings, analysts interested in monitoring the premiums of small firms over time might consider using the NAIC data. Additionally, there were some credible insurers (covering more than 1,000 life-years) that were found in the NAIC data, but not

in the CCIIO data. Specific information about these insurers is included as a technical note in Appendix IV.

- ***NAIC data lack information on health insurers within the state of California.*** With one exception, the NAIC collects data from annual financial filings submitted by insurers to the insurance department of each state in which they sell their products. In California, the health insurance market is regulated by two separate agencies, the Department of Managed Health Care (DMHC) and the California Department of Insurance.[21] Most insurers are regulated by the DMHC, and are not required to file information with NAIC, which means that analyses for the state of California cannot be carried out using NAIC data. The CCIIO data include detailed information on California health insurers. Analysts interested in information across all states or in producing national estimates will want to use the CCIIO data.

- ***An advantage of the NAIC data is that they are released one quarter earlier than the CCIIO data.*** For analysts who want to get a start on reviewing trends in the fully insured market, the NAIC data are released approximately three months earlier than the CCIIO data. The NAIC data include similar variables and a "preliminary MLR" can be estimated from the NAIC data.

- ***The NAIC does not include deductible information.*** Measurement of MLR in the NAIC data does not exactly match the MLR used by the HHS to determine rebates and reported by CCIIO. The MLR reported by the NAIC is labeled as a "preliminary MLR." Several adjustments are needed to properly calculate MLR rebates. For example, one of the MLR adjustments allows insurers that sell high deductible policies to increase their MLR. The rationale for this adjustment is that the administrative cost associated with high-deductible plans is generally higher and these high costs are taken into account when calculating the MLR for each insurer.[10,14] The adjustment for insurers that offer high-deductible plans is referred to as the deductible factor. The deductible factor is takes into account the health insurer's average deductible across products. Most importantly, CCIIO data includes the precise adjustment on MLR based on the deductible for each insurer. For reference, the Table 2 displays a list of deductible factors for various average health plan deductibles. Because the NAIC does not collect information on health plan benefit design, it is not possible to calculate an adjustment for the higher administrative costs associated with high deductible plans.

Table 2. Deductible Factors for Average Health Plan Deductibles

Average Health Plan Deductible	Deductible Factor
< $2,500	1.000
$2,500	1.164
$5,000	1.402
>= $10,000	1.736

Source: CMS MLR Annual Reporting Form Filing Instructions

ANALYTIC QUESTIONS

Data included in both the CCIIO and NAIC data can be used for the purposes of monitoring and evaluating the impact of the ACA on the health insurance markets within the state. Where appropriate, we point out where one of the datasets has advantages over the other (the strengths and weaknesses of each dataset are described in the following section). The administrative data collected by CCIIO and NAIC will be critical to monitoring health insurance markets including premiums, covered lives and shifts between the individual, small and large group insured products. Key questions that can be answered using this data include the following.

- What are the trends in premiums of medical insurers in the individual, small, and large group markets, by year and state? How do premiums vary by health insurer and by health insurer characteristics? For example, what is the market concentration and covered lives by Aetna, Anthem, and Blue Cross? Or, what is the market concentration by size of health insurer?

- What are the patterns in the characteristics of health insurers that meet the medical loss ratio thresholds, and what does this look like over time? For example, what are the characteristics of health insurers that meet the MLR thresholds year after year, compared to those who don't and are required to pay consumer rebates?

- In addition to the above, analysts might look at MLR compliance and rebate amounts to assess the impact of different strategies on consumer premiums over time, as well as to assess whether the MLR regulation is an efficient and well-targeted policy.

- How do non-claims expenses influence insurers' ability to meet the MLR thresholds? For example, if agent and broker compensation were excluded from the MLR calculations, how would this change the number of insurers meeting the MLR thresholds, as well as rebates paid to enrollees over time? Is the amount of agent and broker compensation increasing or decreasing over time, and does the compensation amount vary by market segment?

- What types of strategic adjustments do health plans make in order to meet the MLR thresholds? Since the federal rebate calculations allow for claims paid through the first quarter of the

following year to be included in the numerator of the MLR, the CCIIO data could capture strategic behavior made by health plans in order to meet the MLR thresholds. Again, this type of information may provide insight into the strategic behavior of health plans and the type of adjustments made in order to comply with the MLR regulation.

- Using the NAIC data, analysts can compare credible and non-credible health insurers in terms of premiums, covered lives, and high-deductible product offerings. While neither dataset has information on plan design, one can investigate the number and characteristics of credible and non-credible health plans, as well as changes over time. For example, monitoring the entries and exits of non-credible insurers by state and insurer characteristics may provide information on the level of competition in the area as well as whether health plans are decreasing their size to avoid MLR regulation. As mentioned above, the NAIC data may have more complete information on non-credible insurers.

- Similarly, analysts may be interested in monitoring mini-med plans that were slowly phased out under the ACA, as well as subsequent changes in the market. The ACA prohibited upper limits on the annual amounts that mini-med plans paid for enrollee health benefits.[22] For example, plans issued or renewed after September 2010 could not have annual limits of less than $750,000. In 2011, plans could not have annual limits of less than $1.25 million, and annual caps of any amount were eliminated in 2014. Within the NAIC, mini-med plans are defined as those with annual limits of $250,000 per person per year.

CCIIO PRIVATE HEALTH INSURANCE MARKET OVERVIEW

Since the NAIC SHCE data have been used extensively for regulatory and research purposes, the following sections focus on the recently available CCIIO MLR data. More specifically, we provide background and summary information about the CCIIO data contents (detailed variable descriptions are included in Appendices IV and V). Because the CCIIO data are publically available, we also include information on the methods involved in securing and preparing the data for analysis. This detail is provided in hopes that it reduces the amount of time and labor needed to get started with analyses using the CCIIO data.

We acquired the 2011 and 2012 pubic use *MLR Data and System Resources* datasets (CCIIO data), and constructed a database in which the unit of observation was the insurer-state-year combination (e.g., Medica-Minnesota-2011). To assess the potential of the CCIIO data to monitor MLRs, insurer stability, and market trends, we examined the insurer-state-year variables available in the CCIIO data and then merged the CCIIO data with the NAIC's data to compare information across datasets.

CCIIO Data Contents

The CCIIO data can be downloaded in a zip file that contains several Microsoft Excel spreadsheets. Table 3 lists health insurer identifiers available in the CCIIO data. These identifiers can be used to link to other datasets of interest for researchers. For example, the "NAIC_COMPANY_CODE" in combination with the "BUSINESS_STATE," were used to merge CCIIO data to the NAIC data.

Table 3. CCIIO Health Insurer Identification Variables

CCIIO Variable Name	Description
MR_SUBMISSION_TEMPLATE_ID	Unique identifier for each MLR template file within the submission package
BUSINESS_STATE	State, District, or Territory
GROUP_AFFILIATION	Name of the holding company
COMPANY_PK	Unique ID for the Company established by HIOS Proper
INSURER_CODE	Unique ID for the Insurer established by HIOS Proper

CCIIO Variable Name	Description
COMPANY_NAME	Name of the Issuing Insurance Company
COMPANY_ADDRESS	Address of Issuing Insurance Company
DOMICILIARY_STATE	State in which the Company is operating
NAIC_GROUP_CODE	A unique code for a Holding Company assigned by NAIC
NAIC_COMPANY_CODE	A unique code for a Company assigned by NAIC
FEDERAL_EIN	9 digit EIN for an Insurer
AM_BEST_NUMBER	A unique code for a Company assigned by the A.M. Best
DBA_MARKETING_NAME	Marketing name of the Company
NOT_FOR_PROFIT	Control field to identify non-profit Company
CREATED_DATE	Date this record was created
MERGE_MARKETS_IND_SMALL_GRP	Control field to identify that merge markets has been used

Source: CCIIO Medical Loss Ratio Data and System Resources[3]

Insurers are required to prepare and submit an MLR Form for each state in which they write direct health insurance coverage. The MLR Form consists of six separate sections:

- Part 1: Summary
- Part 2: Premium and Claims
- Part 3: Expense Allocation Report
- Part 4: Expense allocation Methodology Report
- Part 5: MLR and Rebate Calculation
- Part 6: Rebate Report

All insurers are required to file Parts 1 and 2, even if they earned zero dollars in premiums for a given state-insurance market segment. If insurers have non-zero premiums in Parts 1 and 2, they must complete Parts 3 through 6. As insurers complete the form, relevant input is copied to subsequent Parts to avoid duplicate data entry.

For those interested in the MLR, the most important component of the Form is Part 5 (MLR and Rebate Calculation). Based on inputs entered into previous sections, Part 5 includes an automatically-calculated MLR and rebate for each relevant insurer, state, and market combination. Appendix V includes a table of variables related to MLR and rebates in Part 5. Similar to the NAIC data, the CCIIO data includes information on key components of the MLR numerator (incurred claims and quality improving expenses) and denominator (e.g., adjusted earned premiums, federal and state taxes). Information on the adjustments used in calculating the MLR rebates is provided, including adjustments for the credibility of the insurer as well as adjustments based on the number of high-deductible products offered. The NAIC does not include these adjustments, which limits that dataset's ability to predict whether an insurer will meet the MLR threshold, as well as the ability to estimate the amount of rebates owed.

Part 6 further summarizes the rebate information, so that both Parts 5 and 6 represent the final outputs of the MLR and rebate calculations. Appendix VI provides more detailed information on the variables included in Part 6, such as the number of policy holders that were paid rebates, and the total amount of rebates.

CCIIO Dataset Preparation

To facilitate quicker and more sophisticated analyses, we imported the data into Stata, a data analysis and statistical software package. From there, the dataset was transformed so that each row in the dataset represented a single health insurer-state observation (e.g., Medica-Minnesota) and each column was a line item (e.g., MLR numerator, average deductible). The dataset was constructed so that there were separate columns and line items for each of the market segments (individual, small group, and large group). We also created a "longitudinal" dataset where the unit of observation was insurer-state-year (e.g., Medica-Minnesota-2011) so that we could have several years of data contained in one dataset.

CCIIO DATA ANALYSIS RESULTS

This section includes descriptive findings from the CCIIO data analysis, such as changes in the health insurance market size, structure, and composition from 2011 to 2012. Additionally, we provide concrete examples of the types of analytics and reports that can be generated at the national and state levels using the CCIIO data.

While both the CCIIO and NAIC data provide information about market size and composition, the CCIIO data also include the official MLR reported and rebates paid to enrollees. Additionally, the CCIIO data includes some plan benefit design information that is not included in the NAIC, such as average deductible. Table 4 shows the health insurance market size, structure, and composition for non-credible and credible insurers in the CCIIO data for 2011 and 2012. Our analysis divides insurers according to their credibility because non-credible insurers are assumed to be in compliance with the MLR threshold.[23] More specifically, federal regulations state that, "If an issuer's MLR is non-credible, it is presumed to meet or exceed the minimum percentage required" (CFR §158.230).[24] Additionally, because the non-credible insurers cover so few lives, they have less predictable claims expenses.

Table 4. Health Insurance Market size, Structure, and Composition for Credible and Non-Credible Insurers in the CCIIO data for 2011 and 2012

CCIIO CREDIBLE INSURERS (≥1,000 Life-Years) 2011

	Individual	Small Group	Large Group
Insurers (N)	549	565	593
Life-Years	10,828,088	18,830,146	49,919,060
Average Premium per Life-Year	2,763	4,169	4,223
Average Deductible	4,858	2,270	1,451
Deductible Factor	1.21	1.02	1.00
Preliminary MLR	0.80	0.83	0.88
Credibility-Adjusted MLR	0.85	0.87	0.90
Rebate Amount	1,913,215	2,530,402	3,633,561
Rebate Amount per Life-Year	158.44	158.91	167.63
Met MLR (did not pay rebates)	340	449	482

CCIIO CREDIBLE INSURERS (≥1,000 Life-Years) 2012

	Individual	Small Group	Large Group
Insurers (N)	654	623	658
Life-Years	16,213,324	25,359,538	59,794,821
Average Premium per Life-Year	2,954	4,205	4,256
Average Deductible	5,142	2,310	1,664
Deductible Factor	1.24	1.03	1.01
Preliminary MLR	0.83	0.86	0.88
Credibility-Adjusted MLR	0.88	0.89	0.91
Rebate Amount	946,099	1,783,369	1,074,412
Rebate Amount per Life-Year	52.10	59.80	79.53
Met MLR (did not pay rebates)	428	489	528

Table 4 (continued). Health Insurance Market size, Structure, and Composition for Credible and Non-Credible Insurers in the CCIIO data for 2011 and 2012

CCIIO NON-CREDIBLE INSURERS (<1,000 Life-Years) 2011

	Individual	Small Group	Large Group
Insurers (N)	1,614	448	289
Life-Years	227,503	126,477	93,226
Average Premium per Life-Year	3,791	5,609	47,174
Average Deductible	4,962	2,666	3,115
Deductible Factor	1.05	1.01	1.01
Preliminary MLR	0.80	0.80	0.80
Credibility-Adjusted MLR	0.80	0.80	0.80
Rebate Amount	--	--	--
Rebate Amount per Life-Year	--	--	--
Met MLR (did not pay rebates)	1,614	448	289

-- Indicates an N/A value (e.g., in 2011, zero non-credible insurers paid rebates in the individual market).
Source: CCIIO Medical Loss Ratio Data and System Resources[3]

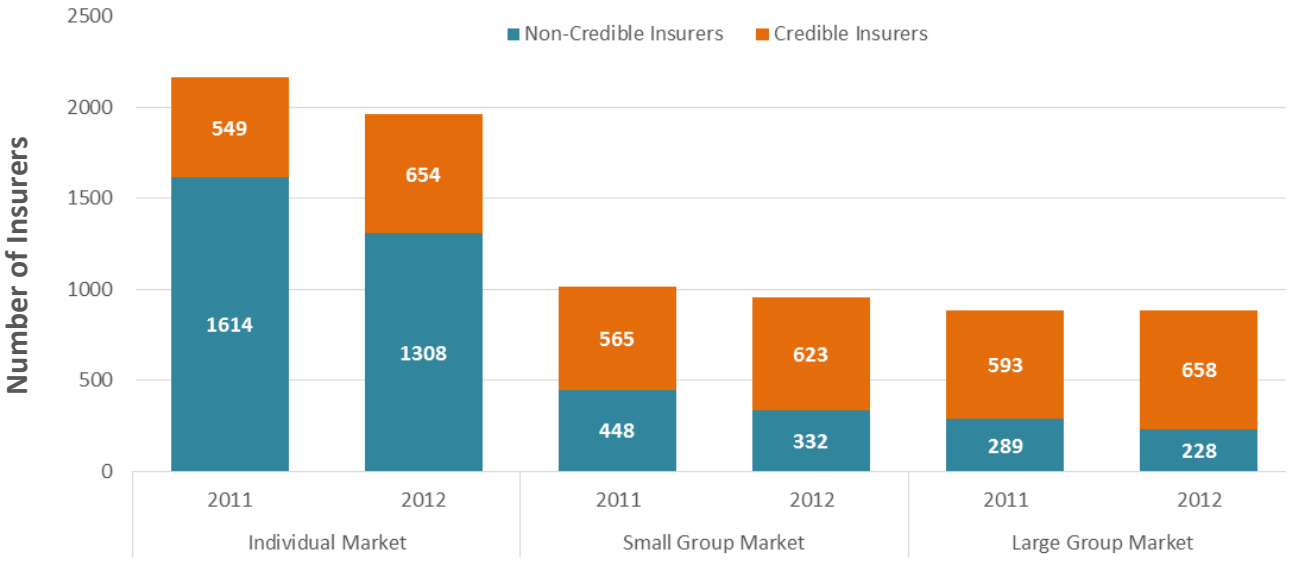
CCIIO NON-CREDIBLE INSURERS (<1,000 Life-Years) 2012

	Individual	Small Group	Large Group
Insurers (N)	1,308	332	228
Life-Years	231,380	110,003	77,927
Average Premium per Life-Year	3,671	5,687	8,425
Average Deductible	4,918	2,669	3,285
Deductible Factor	1.07	1.02	1.01
Preliminary MLR	2.11	0.90	0≥.91
Credibility-Adjusted MLR	2.04	0.91	0.91
Rebate Amount	--	130,298	--
Rebate Amount per Life-Year	--	130	--
Met MLR (did not pay rebates)	1,138	316	223

Figure 1 shows the number of non-credible and credible insurers across each of the market segments using CCIIO 2011 and 2012 data. For both 2011 and 2012, the number of non-credible insurers decreased in each market segment (e.g., from 1,614 to 1,308 in the individual market), while the number of credible insurers increased in each market segment (e.g., from 549 to 654 in the individual market). While there are a larger proportion of insurers in the individual market, and representation in the small and large group markets, non-credible insurers cover 2 percent or less of the life-years in all market segments, and in both 2011 and 2012.

Table 5 shows the percent of total life-years (by market segment) covered by non-credible and credible insurers. Although there are approximately three times the number of non-credible insurers (1,614) compared to credible insurers (549) in the 2011 individual market, the number of life-years those non-credible insurers cover is again only 2.1 percent of the total life-years in the 2011 individual market. In 2012, the percent of total life-years covered drops to only 1.4 percent, the highest percentage in any market segment for the non-credible insurers.

Figure 1. Number of Non-Credible and Credible Insurers by Market Segment, 2011 and 2012 (CCIIO)



Source: [CCIIO Medical Loss Ratio Data and System Resources](#)[3]

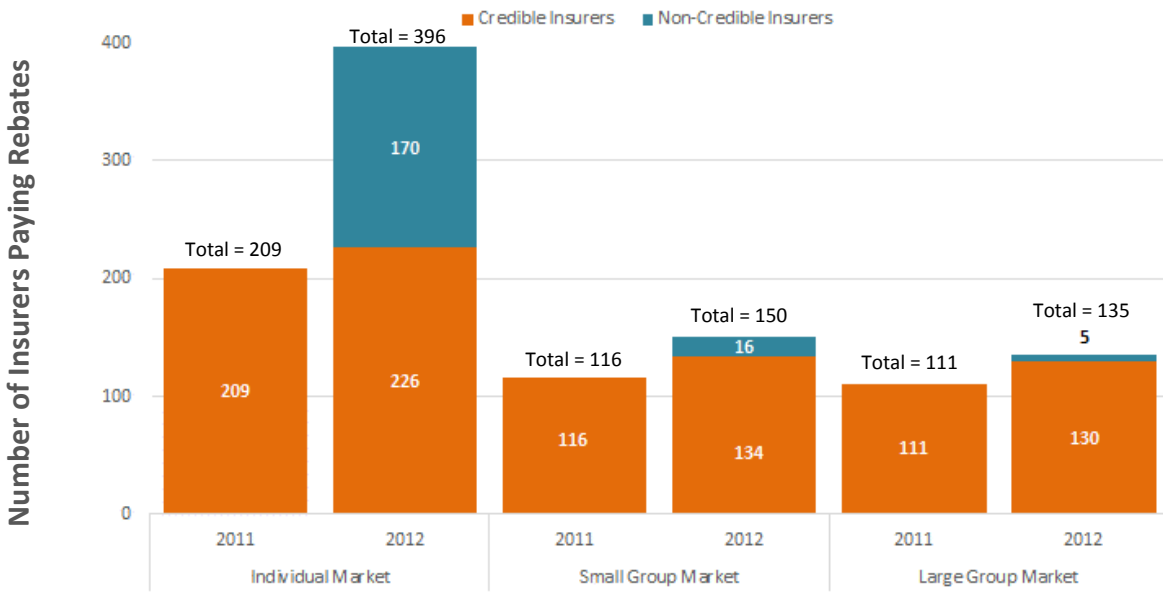
Table 5. Percent of Total Life-Years (By Market Segment) Covered by Non-Credible and Credible Insures

	2011			2012		
	Individual	Small Group	Large Group	Individual	Small Group	Large Group
Non-Credible	2.1%	0.7%	0.2%	1.4%	0.4%	0.1%
Credible	97.9%	99.3%	99.8%	98.6%	99.6%	99.9%

Source: CCIIO Medical Loss Ratio Data and System Resources[3]

The number of insurers that were required to pay rebates as a result of not meeting the MLR thresholds increased from 2011 to 2012 in all market segments. Figure 2 displays the number of insurers that paid rebates as a result of not meeting the required MLR threshold by year and market segment. In 2011 and in 2012, there were at least 100 credible insurers in each market segment that had to pay rebates. The number of non-credible insurers paying rebates changes from 2011 to 2012, because in 2012 credibility was determined in a cumulative manner (i.e., based on more than one year of data). As such, an insurer may be classified as non-credible based on one reporting year alone, but may be eligible to meet MLR thresholds and pay rebates when multiple years are included in the calculation.[10] Since the MLR requirement became effective in January 2011, data for 2013 and later will be essential for assessing trends in the health insurance markets.

Figure 2. Number of Non-Credible and Credible Insurers Paying Rebates by Market Segment, 2011 and 2012 (CCIIO)*



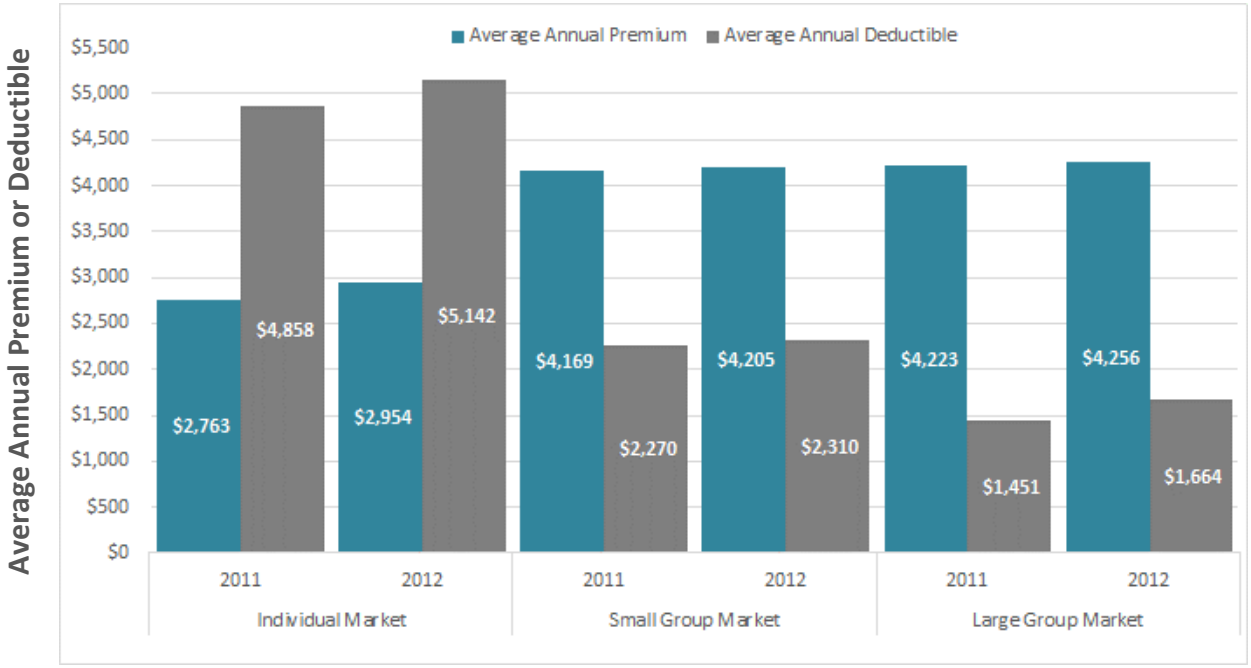
* Beginning in 2012, credibility was determined in a cumulative manner (i.e., based on more than one year of data). As such, an insurer may be classified as non-credible based on one reporting year alone, but may be eligible to meet MLR thresholds and pay rebates when multiple years are included in the calculation.[10]

Source: CCIIO Medical Loss Ratio Data and System Resources[3]

To gain a better understanding of health plan costs, analysts will want to consider both the premiums and deductibles (rather than just the premium or deductible alone). For example, as shown in Figure 2, when the average annual premiums are lower, the average annual deductibles are typically higher (both the average annual premiums and deductibles reported are per life-year). This is true for the individual market in both 2011 and 2012, compared to the small and large group markets in the same years. More specifically, the individual market is the only market segment in which the average annual premium is lower than the average annual deductible.

In 2012, the individual market average annual premium was approximately $3,000 and the average annual deductible was just over $5,000. Comparatively, the small group market had an average annual premium of approximately $4,200 and an average annual deductible of approximately $2,300 in 2012. In the large group market, the average annual premium was similar to the small group market ($4,256), but the average annual deductible was lower ($1,664). Overall, the highest average annual premium was reported in the 2012 large group market ($4,256), and the largest average annual deductible was reported in the 2012 individual group market ($5,142).

Figure 3. Average Annual Premiums and Deductibles for Credible Insurers, 2011 and 2012 (CCIIO)*



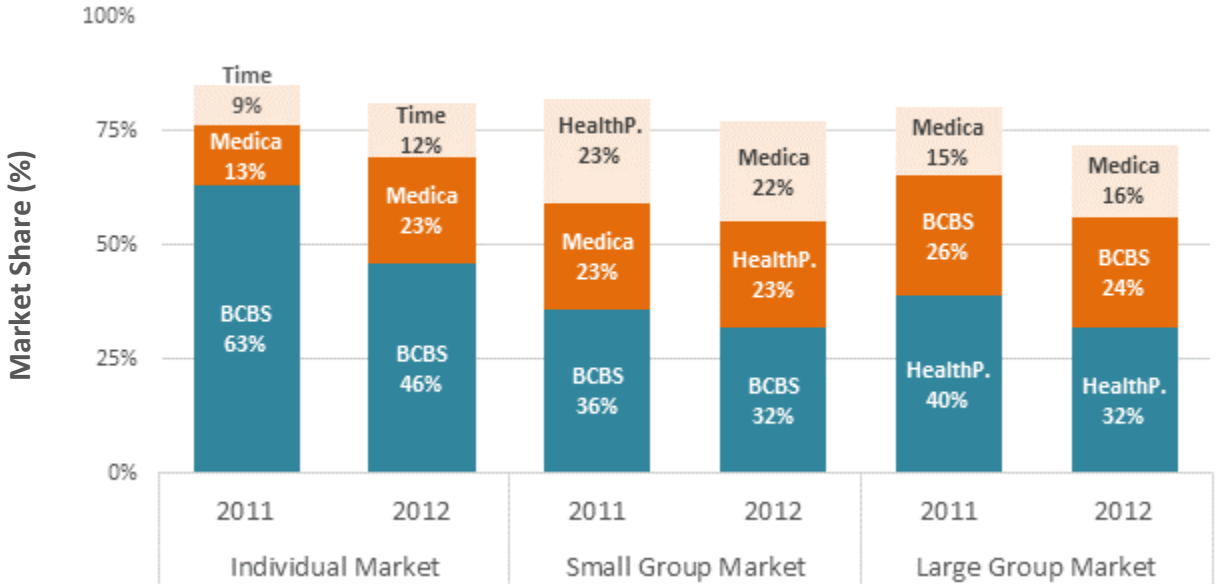
* Average annual premiums and deductibles reported per life-year.

Source: CCIIO Medical Loss Ratio Data and System Resources[3]

Appendix VII provides an example of a state health insurance market profile that could be generated using the CCIIO data (using data from Minnesota). The profile includes a graphic depiction of the market concentration among the top insurers within the state, as well as median premium and rebate amounts for the individual market. The profile could easily be edited to include additional or different information, such as the median premium and rebate amounts for other market segments.

Figure 4 presents data on market concentration by health insurer for the state of Minnesota. This depiction allows the reader to easily summarize information across market segments, and over time. For example, Blue Cross Blue Shield (BCBS) of Minnesota had the largest market share in the individual and small group markets in 2011. Health Partners had the largest market share in the large group market for both 2011 and 2012. Overall, the most dramatic change from 2011 to 2012 was BCBS' drop in market share from 63 percent to 46 percent in the individual market.

Figure 4. Minnesota State Health Insurance Profile, Health Insurance Market Concentration by Market Segment (CCIIO)



Source: [CCIIO Medical Loss Ratio Data and System Resources](#)[3]

The health insurance market profile can also "drill down" to display information on market shares by health insurers across the different markets (see Appendix VII). This detailed page includes rankings and key information for the top five insurers within the state (again, Minnesota in this case in Table 6). In this example, the top five insures in the individual market made up more than 90 percent of the total market share in both 2011 and 2012. Additionally, only two of these insurers did not meet the MLR requirements (Time Insurance in 2011 and PerferredOne in 2011 and 2012) and therefore paid rebates. The "ranking" tables could be easily updated by states to include additional insurers, or other variables of interest (e.g., total life-years covered, average deductibles, etc.).

Table 6. Minnesota State Health Insurance Profile, Top 5 Insurer Ranking Table (from Appendix VII)

	Market Share		Average Premium		Medical Loss Ratio		Rebate Paid	
Individual Group Market	2011	2012	2011	2012	2011	2012	2011	2012
BCBS Minnesota	63%	46%	$2,826	$2,923	0.92	0.93	--	--
Medica	13%	23%	$2,153	$2,122	0.92	0.98	--	--
Time Insurance	9%	12%	$2,258	$2,387	0.80	0.80	$6.61	--
HealthPartners	8%	7%	$2,096	$2,022	0.81	0.94	--	--
PreferredOne	2%	4%	$1,586	$1,633	0.78	0.72	$23.33	$68.17
Total Market Share (Top 5)	*95%*	*92%*						

Source: [CCIIO Medical Loss Ratio Data and System Resources](#)[3]

Key Market Figures 2012 (Minnesota)

Premiums (Median)

Individual	$2,070
Small	$4,242
Large	$5,219

Medical Loss Ratios (Median)

Individual	0.82
Small	0.89
Large	0.92

Rebates Paid (Median)

Individual	$67
Small	$0
Large	$132

The state insurance market profile included in Appendix VII also includes a side bar with key health insurance market figures. For example, in Minnesota, the average premium varies significantly across market segments (from $2,070 in the individual to $5,219 in the large group). Despite the fact that MLRs are highest in the large group market (which means a greater amount of the dollar is spent on health care and quality improvement activities), the median rebate paid to enrollees was only $132.

CCIIO DATA LINKAGES

Because the CCIIO data is designed to capture information related to health insurer performance and market regulation, they are not always ideal or complete data sources for health care reform reporting and evaluation. For example, the CCIIO data lack information related to plan benefit design that could be useful for health care reform analyses, such as product types offered and cost sharing metrics. In order to conduct enhanced state-level analyses, states could consider linking or combining the CCIIO data with other data sources. We outline three examples below:

- **NAIC** - The dataset preparation described in white paper included a merge of the NAIC and CCIIO data. Although this represents an advanced programming endeavor, combining the two datasets maximizes the number of insurers included in the final dataset, thus resulting in a more accurate representation of the true private health insurance market, especially for those interested in analyzing non-credible insurers.

- **State-Level Health Insurance Filings** - Many states collect detailed information from insurance carriers that operate within the state. For example, Oregon requires health insurers to submit data to its Insurance Division on a quarterly basis. Oregon insurers submit information that is not included in the CCIIO data, such the percentage of covered lives by age category and rejection rates (number of lives that were declined coverage divided by the sum of declined and accepted lives).[25] As another example, Minnesota's Health Department collects more detailed cost sharing information than what is included in the CCIIO data. For example, family level annual deductibles, annual out of pocket maximum, and office visit cost sharing requirements (e.g., co-payments, co-insurance).[26] States could consider linking state-level data with the CCIIO data in order to maximize the variables included in the analytic dataset, without having to gather the information directly from the insurers.

- **Health Insurance Oversight System (HIOS)** - The federal government is currently gathering information from private health insurers thorough the Health Insurance Oversight System (HIOS). Under the ACA requirements, data submitted via HIOS will be used for health premium rate review justification, health plan reporting for healthcare.gov, and qualified health plan accreditation, among others.[27] During the data submission process, insures submit some information that is not included in the current CCIIO public use files. Of particular interest to

state policymakers is information on the types of products offered by insurers, such as the number of fee-for-service (FFS), health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), point of service (POS), and other products offered by the insurer within the state. Using the HIOS ID number, data on health insurers could be easily aggregated to present more detailed information on plan design. Currently, it is unclear whether the data submitted via HIOS will be made available to the public or researchers, and what format they will be presented in if they are made available (e.g., consumer-facing website versus analytic files). Nonetheless, HIOS captures a broad range of information on health insurers and could be a promising future resource for both researchers and states.

CONCLUSION

The CCIIO MLR data are a publicly available data source that state analysts and policymakers can use to monitor and evaluate trends in the private health insurance market. Comparisons with the NAIC data showed no significant differences in MLR estimates or average direct premiums.

However, there are distinct differences between the two datasets that researchers should be aware of when deciding which data set will be best for their specific analysis. We identified the key differences which include the reporting periods (15 months for CCIIO versus 12 months for NAIC); the missing values for California in the NAIC supplemental filings; and the lack of small insurers (non-credible plans) in the CCIIO database. In order to maximize the number of insurers included in the analysis dataset, researchers could consider combining the CCIIO and NAIC data. This approach would be especially beneficial for those interested in non-credible insurers, and would also provide a more accurate picture of the entire health insurance market.

Having background information on the two datasets can enhance the ability to effectively use each data resource to effectively monitor and evaluate changes in the private health insurance market over time.

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Appendix I

Affordable Care Act and Medical Loss Ratio

Final Rule Summary

As background, this Appendix includes detail about the Medical Loss Ratio Final Rule, from the Center for Consumer Information and Insurance Oversight (CCIIO). The source document can be downloaded from CCIIO here. The Department of Health and Human Services Final Rule on the Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act, issued in December 2011, can be downloaded here.

Medical Loss Ratio Final Rule Fact Sheet (from CCIIO)

Under the Affordable Care Act, consumers will receive more value for their premium dollar because insurance companies are required to spend 80 percent (individual and small group markets) or 85 percent (large group markets) of premium dollars on medical care and health care quality improvement, rather than on administrative costs, starting in 2011. If they don't, the insurance companies must provide a rebate to their customers starting in 2012. In December 2010, the Department of Health and Human Services (HHS) issued a regulation implementing this provision of the Affordable Care Act, known as the medical loss ratio (MLR). The MLR will make the insurance marketplace more transparent and make it easier for consumers to purchase plans that provide better value for their money. In the 2010 rule, HHS requested comments on a number of the MLR provisions. HHS is now issuing a final rule amending these provisions of the regulation to provide certainty going forward.

The fundamental structure of the MLR policy is not changing. Beginning in 2011, the law requires insurance companies in the individual and small group markets to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities. Insurance companies in the large group market must spend at least 85 percent of premium dollars on medical care and quality improvement activities. Insurance companies must report their MLR data to HHS on an annual basis so that residents of every State will have information on the value of health plans offered by different insurance companies in their State. Insurance companies that do not meet the MLR standard will be required to provide rebates to their consumers. Insurers will make the first round of rebates to consumers in 2012. Rebates must be paid by August 1st each year.

- *Rebates* - The changes in this final rule largely address technical issues involved in the way issuers calculate and report their MLR and the mechanism for distributing rebates to enrollees in group health plans. Rebates. In the previous rule, rebates in the group market would have been subject to tax. The final rule streamlines the rebate process for those enrolled in group policies. In particular, the final rule directs issuers to provide rebates to the group policyholder (usually the employer) through lower premiums or in other ways that are not taxable. This process will vary by plan type. Policyholders must ensure that the rebate is used for the benefit of subscribers. The final rule also requires that issuers provide notice of rebates to enrollees and the group policyholder. All enrollees must be given information about the MLR and its purpose, the MLR standard, the issuer's MLR, and the rebate provided. Insurers will be required to make the first round of rebates to consumers in 2012. Rebates must be paid by August 1st each year.

- *Provide MLR information to more consumers* - Provide MLR information to more consumers. Consistent with comments from consumer groups, the new regulation proposed a new notice requirement that will ensure all consumers receive information on either the amount of their rebate or their insurer's MLR, regardless of whether there is a rebate, as well as how the insurer's MLR has improved under the new law.

- *Special Circumstances Adjustments*. Last year's rule required accelerated reporting by issuers of mini-med and expatriate plans. This allowed HHS to receive and review data on their unique structures and determine how best to address the special circumstances of these plans in the context of the general MLR calculation. The first two quarters of the data have informed the final rule. The final rule continues the application of a methodological adjustment to the way the medical loss ratio is calculated for these plans to ensure that consumers do not lose coverage. Issuers of mini-med and expatriate policies must continue to report this experience separately, on an annual basis. Specifically:

    - *Expatriate Policies* - This final rule maintains for 2012 and future years the special circumstances adjustment of a multiplier of 2.0 to the MLR numerator for expatriate policies. This adjustment acknowledges the higher administrative costs and volatility of experience in these plans when compared to typical insurance plans, which primarily cover care in all parts of the world in a wide variety of health care systems.

    - *Mini-Med Policies*. This final rule reduces the special circumstances adjustment from a multiplier of 2.0 to 1.75 for 2012, 1.5 for 2013, and 1.25 for 2014 for mini-med policies. In 2014, the use of annual dollar limits on coverage will be banned and we expect that these mini-med policies will cease to exist, as plans offered in the Affordable Insurance Exchanges will offer affordable coverage options to all Americans without annual coverage limits. This adjustment should minimize market withdrawal while incentivizing issuers to reduce their administrative expenses and operate more efficiently.

- *Other Changes in the MLR Calculation* - The final rule makes other changes to the calculation of the MLR in areas where HHS requested comment in the interim final rule. Specifically, the final rule allows ICD-10 conversion costs of up to 0.3 percent of an issuer's earned premium in the relevant State market to be considered quality improvement activities, for each of the 2012 and 2013 MLR reporting years. This final rule also levels the playing field within States by allowing an issuer to deduct from earned premiums the higher of either the amount paid in State premium tax or actual community benefit expenditures up to the highest premium tax rate in the State.

The MLR rule provides unprecedented accountability of health insurance companies. It will provide protection and value to approximately 74.8 million insured Americans. Estimates from last year indicate that, starting in 2012, up to 9 million Americans could receive rebates worth from $0.6 to $1.4 billion. However, the existence of the MLR requirement may have improved the pricing patterns of plans; some reports indicate that premium increases were tempered by the prospect of having to pay rebates. The rule, unchanged from the earlier publication, also allows insurers to include payments recovered through fraud reduction efforts in their calculation of incurred claims (up to the amount of fraudulent claims recovered), thereby encouraging plans to fight fraud. The final rule streamlines reporting and rebate requirements, and reduces the administrative burden on issuers and employers, while continuing to ensure that consumers receive maximum value for their health care dollar.

Appendix II

State Medical Loss Ratio Adjustment Requests and Department of Health and Human Services (HHS) Determinations

This appendix provides detail on the 18 applications for MLR adjustments that were received by HHS (from 17 states and Guam). As shown in the table below, these requests ranged from a 60% MLR (Iowa) to 72% (Nevada and North Carolina) for 2011. Though HHS retains the authority to grant future adjustments should they be necessary, as of 2013 no state had an approved adjustment exempting it from the 80% level.

State MLR Adjustment Requests

State/Territory	Requested MLR		
	2011	**2012**	**2013**
Iowa	60	70	75
Georgia	65	70	75
Kentucky	65	70	75
Maine	65	65	65
New Hampshire	70	70	70
Nevada	72	-	-
North Carolina	72	74	76
Delaware	65	70	75
Guam	65	70	75
Indiana	65	68.75	72.5
Michigan	65	70	75
North Dakota	65	70	75
Oklahoma	65	70	75
Florida	68	72	76
Kansas	70	73	76
Louisiana	70	75	-
Texas	71	74	77
Wisconsin	71	74	77

HHS Determinations*

State/Territory	HHS Determination		
	2011	**2012**	**2013**
Iowa	67	75	80
Georgia	70	75	80
Kentucky	75	80	80
Maine	65	65	80**
New Hampshire	72	75	80
Nevada	75	-	-
North Carolina	75	80	80

* HHS made no adjustments to the requests for the following states: Delaware, Guam, Indiana, Michigan, North Dakota, Oklahoma, Florida, Kansas, Louisiana, Texas, and Wisconsin.

** Maine's determination for 2013 (made in 2011) was initially 65 but this was conditioned on new data becoming available at end of 2012. In January 2013, HHS reached a determination that adjustment was no longer necessary for Maine.

Appendix III

Dataset Terminology

Dataset Terminology

This appendix defines key terms used throughout the paper. Where appropriate, we note differences between NAIC's and CMS/CCIIO's definitions as they relate do the datasets and Medical Loss Ratio calculations.

Aggregated life-years: Aggregated life years are the sum of the life-years in the reporting period (e.g., 2012) and previous year (e.g., 2011).

Covered lives: The total number of lives insured, including dependents, under individual policies and under group certificates as of the last day of the reporting period. Reasonable approximations are allowed when exact information is not available to the issuer.

Credibility: Credibility relates to the number of life years covered by an insurer (see "Life Years" below for details). Credibility is categorized as follows:

- **Fully Credible Insurer:** More than 75,000 life-years reported
- **Partially Credible Insurer:** Between 1,000 to 75,000 life-years reported
- **Non-Credible Insurer**: Less than 1,000 life-years as reported

Credibility-Adjusted Medical Loss Ratio (MLR): The MLR is adjusted based on credibility (life years covered by insurer) and deductible factor (average deductible for a policy).

Expenses to Improve Patient Safety: This item includes expenses for activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates. For example: 1) The appropriate identification and use of best clinical practices to avoid harm; 2) Activities to identify and encourage evidence based medicine; 3) Activities to lower the risk of facility-acquired infections; 4) Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions; 5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and 6) Health information technology expenses to support the above activities.

Health Insurance Coverage (as defined by CMS/CCIIO): Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. The definition includes any insurance product, such as drug, chiropractic, or mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, unless specifically identified as "excepted benefits" by the PHS Act.

Health Insurance Market Segments

- **Individual:** Health insurance where the policy is issued to an individual covering the individual and his or her dependents in the individual market.

- **Small Group:** All policies issued in the small group market (including fully insured State and local government policies)

- **Large Group:** All policies issued in the large group market (including the Federal Employees Health Benefit Program and fully insured State and local government policies)

- **Mini Med (Individual, Small Group, Large Group):** All policies that have a total annual limit of $250,000 or less for individual, small group and large group markets, in their respective columns.

- **Expatriate (Small Group, Large Group):** All group policies written in the United States that provide coverage for employees working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country. These policies are to be reported on a nationwide, aggregated basis, separately for the small group and the large group markets, in their respective columns for the MLR reporting year, as of March 31 of the subsequent year, on the Grand Total page of the MLR Form.

Incurred Claims: Includes direct claims paid to or received by physicians and other non-physician clinical providers, including under capitation contracts with those providers, whose services are covered by the policy for clinical services or supplies covered by the policy. For the CMS/CCIIO definition of incurred claims, non-physician clinical providers must be licensed, accredited, or certified to perform clinical health services, consistent with State law, and engaged in the delivery of medical services to enrollees. Reimbursement for clinical services to enrollees is also referred to as incurred claims.

Life-years: The total number of lives insured on a pre-specified day of each month of the reporting period divided by twelve. Also equivalent to **member months** divided by twelve. Reasonable approximations are allowed when exact information is not available to the issuer.

Medical Loss Ratio (MLR): The proportion of premium revenues spent on clinical services and quality improvement. Affordable Care Act provisions require insurance companies to spend at least 80% or 85% of premium dollars on medical care (see "Medical Loss Ratio Standard" below). If insurance companies fail to meet these standards, they are required to provide a rebate to their customers starting in 2012.

$$\text{MLR} = \frac{(\text{Claims} + \text{Quality Improvement})}{(\text{Premiums} - \text{Taxes, Licensing and Regulatory Fees})}$$

Medical Loss Ratio (MLR) Standard: The statutory MLR standard for the relevant market (i.e., 80% for the individual market and small group market; and 85% for the large group market). Rebate is paid to enrollees if the MLR standard is not met.

Member months: The total number of lives insured on a pre-specified day of each month of the reporting period. Reasonable approximations are allowed when exact information is not available to the issuer.

Premiums: All monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan and reported on a direct basis.

Rebates: Rebates are a portion of the premium paid by policyholder or subscriber that is returned to the policyholder or subscriber when the insurer does not meet the MLR standard.

Appendix IV

Technical Note: Credible Insurer Discrepancy

This technical note provides detail on credible insurers (those covering more than 1,000 life-years annually) that were found in the NAIC data, but not in the CCIIO data. These instances were observed in the individual and small group markets only, and in both 2011 and 2012.

Individual Market

In the individual market, there were five credible insurer-state observations in 2011, and one in 2012 that filed the Supplemental Health Care Exhibit with the NAIC, but did not report a filing to the CCIIO.

In 2011, these included:

- Companion Life Insurance Company (AL, PA)
- Consumers Life Insurance Company (IN)
- Virginia Premier Health Plan, Inc. (VA)
- Puritan Life Insurance Company of America (IN)

In 2012, the only insurer found in the NAIC data and not in the CCIIO data was:

- Puritan Life Insurance Company (IN)

Small Group Market

In the small group market, substantially more credible insurer-state observations were found in the NAIC data, but not in CCIIO data. More specifically, there were a total of four credible insurers representing 13 insurer-state observations found in the NAIC data, but not in the CCIIO data in 2011; and six insurers representing 15 insurer-state observations in 2012.

In 2011, these included:

- Aetna Health Insurance Company (NV, GA, VA, TX, PA, NJ, AZ, DE, OH, NY)
- Consumers Life Insurance Company (IN)
- National Benefit Life Insurance Company (NY)
- Network Health Insurance Corporation (WI)

In 2012, the following insurers

- Aetna Health Insurance Company (PA, TX, GA, NV, DE, VA, AZ, OH, NJ, NY),
- Assurity Life Insurance Company (MI)
- Graphic Arts Benefit Corporation (MD)
- McLaren Health Plan Inc. (MI)
- National Benefit Life Insurance Company (NY)
- Network Health Insurance Corporation (WI)

Appendix V

CCIIO Medical Loss Ratio and Rebate Variables (Part 5)

CCIIO Medical Loss Ratio and Rebate Variables (Part 5)

Medical Loss Ratio Numerator:

Location	CCIIO Description
Section 1 Line 1.1	Adjusted incurred claims (report the amount listed on the MLR Form, Part 1 Line 2.1)
Section 1 Line 1.2	Adjusted incurred claims for the prior MLR reporting years, restated as of March 31 of the year following the MLR reporting year (Not applicable to the 2011 MLR Reporting Year)
Section 1 Line 1.3	Quality improving expenses (report the amount listed on the MLR Form, Part 1 Line 4.6)
Section 1 Line 1.4	MLR rebates paid based on experience for the two immediately preceding MLR reporting years. (Not applicable to the 2011 MLR Reporting Year)
Section 1 Line 1.5	MLR numerator (MLR Form, Part 5, Lines 1.2 + 1.3 + 1.4)
Section 1 Line 1.6	Mini-Med / Expatriate numerator after adjustment factor (Line 1.5 x adjustment factor)

Medical Loss Ratio Denominator:

Location	CCIIO Description
Section 2 Line 2.1	Adjusted earned premium (report the amount listed on the MLR Form, Part 1 Line 1.4)
Section 2 Line 2.2	Federal and State taxes and licensing or regulatory fees (report the amount listed on the MLR Form, Part 1 Line 3.4)
Section 2 Line 2.3	MLR denominator (MLR Form, Part 5, Lines 2.1 – 2.2) 52

Credibility Adjustment (Not applicable to the Grand Total page):

Location	CCIIO Description
Section 3 Line 3.1	Life years to determine credibility (report the amount listed on the MLR Form, Part 1 Line 11.5)
Section 3 Line 3.2	Base credibility factor
Section 3 Line 3.3	Average deductible
Section 3 Line 3.4	Deductible factor
Section 3 Line 3.5	Credibility adjustment (MLR Form, Part 5, Lines 3.2 x 3.4)

Medical Loss Ratio Calculation (Not applicable to Grand Total page):

Location	CCIIO Description
Section 4 Line 4.1	Is the experience considered partially or fully credible?
Section 4 Line 4.2	Preliminary Medical Loss Ratio
Section 4 Line 4.2a	Preliminary MLR (MLR Form for the applicable MLR reporting year, Part 5, Lines 1.5 / 2.3)
Section 4 Line 4.2b	Preliminary MLR: Mini-Med / Expatriate (MLR Form for the applicable MLR reporting year, Part 5, Lines 1.6/ 2.3)
Section 4 Line 4.3	Credibility adjustment (MLR Form, Part 5, Line 3.5)
Section 4 Line 4.4	MLR including credibility adjustment if applicable (Lines 4.2a or 4.2b + 4.3) 54

MLR Rebate Calculation:

Location	CCIIO Description
Section 5 Line 5.1	MLR Standard (Not applicable to Grand Total page)
Section 5 Line 5.2	Credibility-adjusted MLR (MLR Form, Part 5, Line 4.4)
Section 5 Line 5.3	Adjusted earned premium, less Federal and State taxes and licensing or regulatory fees (MLR Form, Part 5, Line 2.3, Column CY) (not applicable to Grand Total page)
Section 5 Line 5.4	Rebate amount if credibility-adjusted MLR is less than the MLR standard (MLR Form, Part 5, Lines (5.1 – 5.2) x 5.3))

Number of Policies/Certificates:

Location	CCIIO Description
Section 1 Line 1	Number of policies/certificates

Number of Policyholders/Subscribers Owed Rebates:

Location	CCIIO Description
Section 2 Line 2.a	Number of group policyholders who are being paid a rebate
Section 2 Line 2.b	Number of subscribers being paid a rebate
Section 2 Line 2.c	Number of group policyholders whose calculated rebate is de minimis
Section 2 Line 2.d	Number of subscribers whose calculated rebate is de minimis

Total Amount of Rebates:

Location	CCIIO Description
Section 3 Line 3.a	Total amount of rebates (from Part 4, Line 5.4)
Section 3 Line 3.b	Total amount of de minimis rebates
Section 3 Line 3.c	Amount of rebates being paid by premium credit
Section 3 Line 3.d	Amount of rebates being paid by lump-sum reimbursement

Prior MLR Reporting Year Rebates:

Location	CCIIO Description
Section 4 Line 4.a	Amount of rebates paid based on the prior MLR reporting year
Section 4 Line 4.b	Percentage of rebate notices timely sent to individual policy subscribers or group policyholders owed a rebate

Source: 2012 MLR Annual Reporting Form Instructions[28]

Appendix VI

CCIIO Rebate Report Variables (Part 6)

CCIIO Rebate Report Variables (Part 6)

Rebate Being Paid:

Location	CCIIO Description
Section1 Line 1	Is a rebate being paid?

Number of Policies/Certificates:

Location	CCIIO Description
Section2 Line 2	Number of policies / certificates (from Part 1 Line 11.1)

Number of Policyholders/Subscribers Owed Rebates:

Location	CCIIO Description
Section 3 Line 3.a	Number of group policyholders who are being paid a rebate
Section 3 Line 3.b	Number of subscribers who are being paid a rebate.
Section 3 Line 3.c	Number of group policyholders whose calculated rebate is de minimis
Section 3 Line 3.d	Number of subscribers whose calculated rebate is de minimis

Total Amount of Rebates:

Location	CCIIO Description
Section 4 Line 4.a	Total amount of rebates (from Part 5, Line 5.4)
Section 4 Line 4.b	Total amount of de minimis rebates
Section 4 Line 4.c	Amount of rebates being paid by premium credit
Section 4 Line 4.d	Amount of rebates being paid by lump-sum reimbursement

Amount of Unclaimed Rebates from Prior MLR Reporting Year:

Location	CCIIO Description
Section 5 Line 5.a	Methods used to locate enrollees for unclaimed rebates
Section 5 Line 5.b	Disbursement method of prior MLR reporting year's unclaimed rebates

Source: 2011 MLR Annual Reporting Form Instructions [29]

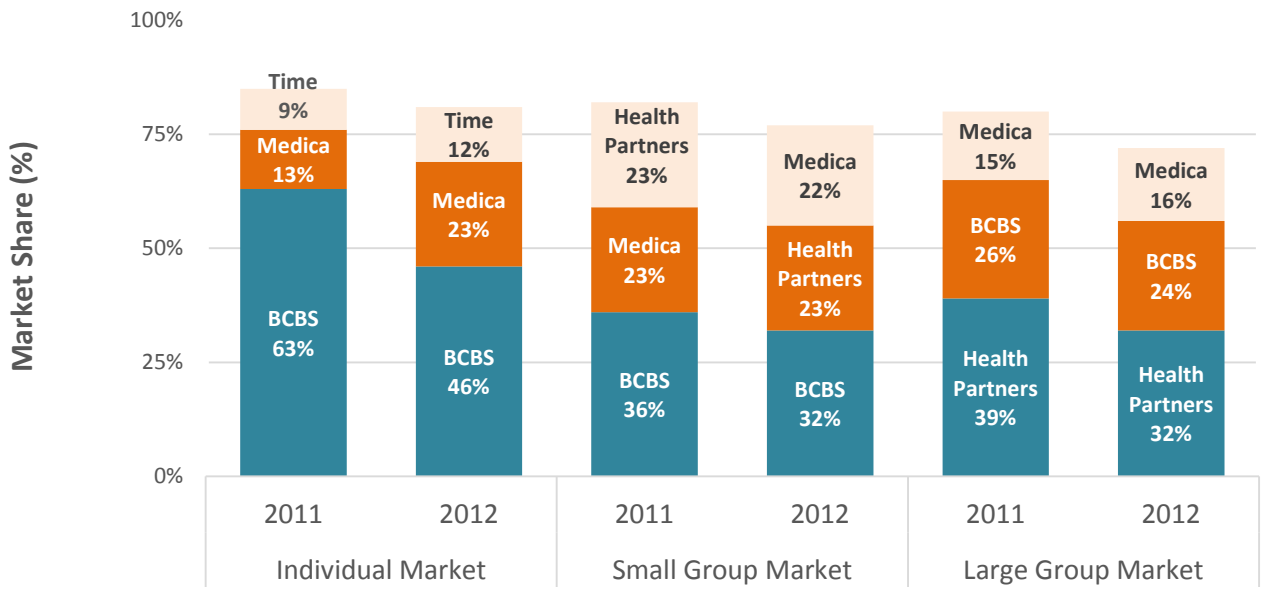
Appendix VII

State Health Insurance Market Profile (Sample)

2012 State Health Insurance Market Profile:
MINNESOTA

This profile is designed to provide a broad overview of your state's commercial health insurance market using publicly available data from the Department of Health and Human Services' Center for Consumer Information and Oversight's medical loss ratio (MLR) regulatory filings for 2011 and 2012. These data include information on premiums, claims, expenses, as well as MLR thresholds and rebates.

Figure 1. Health Insurance Market Concentration by Market Segment



Key Market Figures 2012

Premiums (Median)

Individual	$2,070
Small	$4,242
Large	$5,219

Medical Loss Ratios (Median)

Individual	0.82
Small	0.89
Large	0.92

Rebates Paid (Median)

Individual	$67
Small	$0
Large	$132

Table 1. Top 5 Insurer Ranking Table

	Market Share		Average Premium		Medical Loss Ratio		Rebate Paid	
Individual Group Market	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
BCBS Minnesota	63%	46%	$2,826	$2,923	0.92	0.93	--	--
Medica	13%	23%	$2,153	$2,122	0.92	0.98	--	--
Time Insurance	9%	12%	$2,258	$2,387	0.80	0.80	$6.61	--
HealthPartners	8%	7%	$2,096	$2,022	0.81	0.94	--	--
PreferredOne	2%	4%	$1,586	$1,633	0.78	0.72	$23.33	$68.17
Total Market Share (Top 5)	***95%***	***92%***						
Small Group Market	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
BCBS Minnesota	36%	32%	$4,562	$4,532	0.86	0.89	--	--
Medica	23%	22%	$3,992	$4,070	0.87	0.91	--	--
HealthPartners, Inc.	23%	23%	$3,911	$3,872	0.83	0.83	--	--
HealthPartners Ins. Co.	7%	5%	$4,299	$4,300	0.89	0.92	--	--
PreferredOne	4%	7%	$3,474	$3,127	0.94	0.97	--	--
Total Market Share (Top 5)	***93%***	***89%***						
Large Group Market	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
HealthPartners Ins. Co.	39%	32%	$1,931	$2,005	0.88	0.89	--	--
BCBS Minnesota	26%	24%	$4,944	$4,911	0.90	0.92	--	--
Medica	15%	16%	$4,177	$4,274	0.87	0.92	--	--
HealthPartners, Inc.	12%	18%	$6,045	$6,129	0.84	0.85	$75.29	--
PreferredOne	3%	5%	$3,472	$7,645	0.95	0.93	--	--
Total Market Share (Top 5)	***95%***	***95%***						

-- Indicates an N/A value