
Report of 2017 Loss Ratio Experience for
Insurance Companies, Nonprofit Health
Service Plan Corporations, and
Health Maintenance Organizations

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Introduction

Under Minnesota Statutes § 62A.021, subdivision 1(h), the Minnesota Departments of Health and Commerce (the Departments) are required 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, 2017, 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.

According to the 2017 Minnesota Health Access Survey conducted by Minnesota Department of Health (Health), approximately 53 percent of Minnesota's population received coverage through an employer, while 4 percent of the population purchased individual coverage, and approximately 37 percent of Minnesota's population received coverage through public programs. The 2017 uninsured population in Minnesota was 6 percent.

Definitions

Loss Ratio

Loss ratio is the ratio of incurred claims to earned premiums. On their annual Supplemental Health Care Exhibits, health plan companies reported total earned premium, incurred claims, and loss ratio for the year ending December 31, 2017, by individual, small employer, and large employer fully-insured health plan markets in Minnesota. Loss ratio is often referred to as the medical loss ratio, or "MLR."

Individual Market

The individual market is available to people who wish to purchase health insurance but do not have access through their employer or through public programs such as Medicare, Medicaid, and MinnesotaCare.

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 includes entities actively engaged in business (including political subdivisions of the State) that meet the following criteria:

- employed 2-50 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.

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.

Federal Medical Loss Ratio as Defined by the Affordable Care Act

The data in this Report reflects the Minnesota Medical Loss Ratio. However, the federal Affordable Care Act (ACA) also uses the term Medical Loss Ratio.

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 slightly different than the state loss ratio described below.

Starting in calendar year 2011, the federal government required that an insurer 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 insurer'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 an insurer 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 insurer receives are spent on health care and quality improvement, with the other money spent on overhead, profits, and administrative costs.

Under the ACA requirements, insurers 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 insurers with less than 1,000 people enrolled cannot sufficiently confirm that they have or have not met the MLR standard; as a result, those insurers are deemed non-credible and are not required to provide rebates. An insurer 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 insurer'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. Insurers were required to make the first round of rebates to consumers in 2012. Starting in the summer of 2012, HHS posted insurers' reports and MLRs online at <http://www.cms.gov/apps/mlr/mlr-search.aspx>.

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.

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.

Medical Loss Ratio as Defined by Minnesota Law

A national leader in health policy, Minnesota has had MLR requirements for more than 20 years. Individual states may require a higher minimum MLR for insurers operating within their state and may calculate the MLR differently from the ACA definition. Minnesota law requires that individual, small employer, and large employer health plan rates meet the specific minimum MLR 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:

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

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

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 MLR standard, which is prospective, the federal MLR standard is retrospective in nature and carries with it rebates to customers if the minimum MLRs are not met in each marketplace.

Recent Changes in State Law

Any change that has been made in a health plan company's business since the beginning of the reporting period also affects the loss ratio. For example, rate levels or benefits offered may have changed significantly due to legislative requirements, newly-effective Affordable Care Act (ACA) plan design and coverage requirements, or plan changes made voluntarily by the health plan company.

Health Insurance Premium Rebate

In 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 of these enrollees than expected remained in the individual market.

2017 health insurance rates were finalized prior to the enactment of the premium rebate. This encouraged healthier people to remain in the individual market, which reduced overall loss ratios.

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 verified and may include unintentional errors.

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.

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 NAIC Number is a five-digit identifier assigned to all companies filing financial data with the NAIC. It is also known as Company Code. The number aids in research of financial and market conduct data available through the NAIC for the specific company.
- The column titled Domicile refers to the state in which the health plan company was first licensed and the state that has the primary regulatory responsibility over that health plan company.
- 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: 2017 Individual Loss Ratio Data

Health Plan Company Supplemental Health Care Exhibits for 2017

Group Code	NAIC Number	Name	Domicile	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR*	Covered Lives
461	95649	HMO dba Blue Plus	MN	\$ 328,003,142	\$ 233,977,916	71%	65%	37,344
1552	95232	Medica Hlth Plans of WI	WI	\$ 224,336,728	\$ 181,190,316	81%	85%	28,674
1258	44547	HealthPartners Ins Co	MN	\$ 142,102,558	\$ 102,479,434	72%	78%	34,527
4380	52629	UCare MN **	MN	\$ 136,845,196	\$ 101,790,176	74%	81%	22,567
1258	52628	Group Hlth Plan Inc	MN	\$ 116,414,670	\$ 87,720,593	75%	77%	22,611
1552	12459	Medica Ins Co	MN	\$ 19,529,573	\$ 17,691,557	91%	93%	3,065
3492	11817	PreferredOne Ins Co	MN	\$ 5,693,816	\$ 2,629,573	46%	39%	243
1258	95766	HealthPartners Inc	MN	\$ 2,941,891	\$ 2,629,573	103%	105%	337
		Total		\$975,867,574	\$730,495,137	75%	NA	149,368

Table 1 lists the MLRs experienced in the individual health plan market in 2017 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. Health plan companies vary in their inclusion and treatment of risk adjustment, reinsurance and risk corridor (3Rs) program revenues and payments, affecting premiums and/or claims entries in terms of 2017 incurred values as well as 2016 accounting reconciliations.

The Minnesota MLRs for 2017 ranged from 46% to 103%. The total Minnesota MLR for 2017 is 75% which was an improvement from 105% in the previous year. Aside from high premium increases, a key driver influencing the loss ratio reduction between 2016 and 2017 was the 25% premium rebate program that was financed by the State of Minnesota. This program encouraged healthier individuals to remain in the individual market. Carriers' premiums had been approved months before this program had been proposed and enacted, such that carriers and regulators were unaware of this support when premiums had been approved.

**Values for the ACA MLR are marked above as preliminary because, due to the late timing of the 3Rs processing, health plan companies must estimate financial entries for each of the 3R programs.*

***The Supplemental Health Care Exhibit entries for UCare MN and UCare Health Inc. have been combined since UCare Health Inc. does not offer commercial coverage, but handles out-of-network processing on behalf of UCare MN.*

Table 2: 2017 Small Employer Group Loss Ratio Data

Health Plan Company Supplemental Health Care Exhibits for 2017

Group Code	NAIC Number	Name	Domicile	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR*	Covered Lives
461	55026	BCBSM Inc	MN	\$ 578,511,660	\$ 487,359,938	84%	86%	93,595
1258	95766	HealthPartners Inc	MN	\$ 550,733,154	\$ 516,206,009	94%	96%	129,259
1552	12459	Medica Ins Co	MN	\$ 153,640,159	\$ 133,993,582	87%	90%	32,851
3492	11817	PreferredOne Ins Co	MN	\$ 131,803,111	\$ 125,094,288	95%	100%	32,500
1258	44547	HealthPartners Ins Co	MN	\$ 47,444,179	\$ 42,616,414	90%	93%	7,378
7	13935	Federated Mut Ins Co	MN	\$ 34,014,896	\$ 24,956,094	73%	85%	4,723
461	95649	HMO dba Blue Plus	MN	\$ 6,892,098	\$ 4,849,213	70%	73%	1,947
3492	95724	PreferredOne Comm Hlth Plan	MN	\$ 2,786,868	\$ 2,527,089	91%	142%	261
4870	14202	Gundersen Hlth Plan MN	MN	\$ 1,826,229	\$ 1,607,414	88%	91%	321
		Total		\$1,507,652,354	\$1,339,210,041	89%	NA	302,835

Table 2 lists the MLRs experienced in the small employer health plan market in 2017 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 health plans. Sanford is missing from this 2017 exhibit altogether because of premium entries below \$300,000.

The Minnesota MLRs for 2017 ranged from 70% to 95%. The total Minnesota MLR for 2017 for health plan companies is 89%. The total Minnesota MLR for the previous year was 88%.

**Values for the ACA MLR are marked above as preliminary because, due to the late timing of the 3Rs processing, carriers were forced to estimate financial entries for each of the 3R programs.*

Table 3: 2017 Large Employer Group Loss Ratio Data

Based on Health Plan Company Supplemental Health Care Exhibits for 2017

Group Code	NAIC Number	Name	Domicile	Earned Premium	Incurred Claims	State Loss Ratio	Preliminary ACA MLR*	Covered Lives
461	55026	BCBSM Inc	MN	\$1,295,015,889	\$1,195,623,145	92%	92%	227,457
1552	12459	Medica Ins Co	MN	\$ 767,968,750	\$ 649,923,585	85%	89%	142,836
1258	44547	HealthPartners Ins Co	MN	\$ 673,561,885	\$ 595,665,209	88%	92%	298,347
1258	95766	HealthPartners Inc	MN	\$ 220,858,325	\$ 187,615,655	85%	87%	33,247
3492	11817	PreferredOne Ins Co	MN	\$ 83,841,832	\$ 70,973,754	85%	87%	18,559
7	13935	Federated Mut Ins Co	MN	\$ 14,872,884	\$ 14,024,580	94%	100%	2,854
461	95649	HMO dba Blue Plus	MN	\$ 3,318,895	\$ 5,293,319	159%	163%	552
1	60054	Aetna Life Ins Co	CT	\$ 2,100,566	\$ 1,091,203	52%	66%	497
1246	95725	Sanford Hlth Plan of MN	MN	\$ 1,371,662	\$ 1,167,838	85%	94%	363
901	67369	Cigna Hlth & Life Ins Co	CT	\$ 1,271,944	\$ 689,578	54%	66%	0
3492	95724	PreferredOne Comm Hlth Plan	MN	\$ 901,925	\$ 551,302	61%	82%	382
4870	14202	Gundersen Hlth Plan MN	MN	\$ 657,708	\$ 599,412	91%	94%	153
		Total		\$3,065,742,265	\$2,723,218,580	89%	NA	725,247

Table 3 lists the MLRs experienced in the large employer health plan market in 2017 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 2017 ranged from 52% to 159%. The total Minnesota MLR for 2017 for health plan companies is 89%. The total Minnesota MLR for the previous year was 86%.

Group Health Plan Inc. large group premium and claims data will be revised.

**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.*

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>