HEALTH POLICY MEMO

June 2008

Medical Loss Ratios: Evidence from the States

A **minimum medical loss ratio** is a requirement that insurers spend, at least, a specified percentage of premium dollars on medical care rather than on administration, marketing, and profit. If an insurer does not spend enough on medical care to meet the minimum medical loss ratio, it must either refund consumers or adjust its premiums accordingly for the following year. Without this requirement, insurers can charge very high premiums to individuals and small businesses, and spend a startlingly low proportion of these premium dollars on health care services. In interviews with insurance regulators in 19 states, Families USA learned that insurers in the individual market sometimes maintain medical loss ratios of only 60 percent, retaining 40 percent of premium dollars for administration, marketing, and profit.

To increase the portion of premiums dollars dedicated to medical services, some states require insurers to meet minimum medical loss ratios in the small group, individual, Medicare supplement, and long-term care markets. Other states require specific insurers (such as HMOs or safety net insurers) to meet a minimum medical loss ratio.

In March and April 2008, Families USA conducted a 50-state survey that determined which states have laws or regulations that establish a minimum medical loss ratio (see table on page 3). Individual market results are reported in *Failing Grades: State Consumer Protections in the Individual Health Insurance Market* (June 2008). This memo supplements the report with additional data.

Families USA's survey asked state regulators if they require a minimum medical loss ratio of 75 percent in the small group and/or individual market. Only a handful of states (see below) require individual and/or small group insurers to maintain a medical loss ratio of 75 percent. This medical loss ratio still leaves room for improvement, but it is preferable to lower standards. Some states volunteered information about other loss ratios they had on the books, while others may not have. For example, Alabama and Virginia reported that they require minimum medical loss ratios in the Medicare supplement market, and Texas and Wisconsin have loss ratios for Medicare supplemental policies and long-term care policies. Our table may not reflect the minimum loss ratios in every market of every state. Please alert us if you identify any errors or omissions.

- **Maine** requires small group insurers to spend at least 75 percent of the premiums they collect on medical claims. Insurance companies are subject to rate review by the Bureau of Insurance (BOI), which can call hearings to evaluate how well insurance companies are complying with the required medical loss ratio. An insurer can avoid the hearing process and file its rates on an informational basis, without further review, if it agrees to spend an even higher proportion of premiums on medical claims: 78 percent over a continuous three-year period. If the insurer fails to meet the 78 percent medical loss ratio, it must refund the excess premium dollars it has collected to policyholders. In contrast to the small group requirements, individual plans are only required to meet a medical loss ratio of 65 percent.
    - As a result of Maine's medical loss ratio requirement, in 2008, one Maine insurance company will refund policyholders $6.6 million and another will refund policyholders $1 million.

- **New Jersey** requires a 75 percent medical loss ratio for all insurers in the small group and individual markets. Insurers must report annually, and if they do not achieve the 75 percent loss ratio, they must automatically issue refunds to policyholders. At the beginning of the year, when insurers set their premiums, they file a certification that medical claims will exceed 75 percent of premiums. At the end of the year, if the amount spent on medical claims is less than 75 percent of collected premiums, they must issue refunds to enrollees in their health plans to make up the difference.

  The New Jersey Insurance Department reports that this is an easy system for the state to administer—insurers know whether they have met the standard, and they process refunds when they do not. What's more, in recent years, the small group market has been competitive, and on average, insurers actually have a higher medical loss ratio than the minimum 75 percent—they spend about 80 percent of premium dollars on medical care. However, not all insurers meet the requirement, and some insurers do issue refunds in the small group market.

  The individual market is less competitive, and the 75 percent medical loss ratio has helped control premiums.

  - Between 1993 (when the state implemented the 75 percent medical loss ratio in the individual market) and 2006, insurers that failed to meet the requirement refunded a total of $11.6 million dollars to consumers.

- **Minnesota** passed regulations in 1993 that initially required insurers in the small group market to meet a 75 percent medical loss ratio and individual market insurers to meet a 65 percent loss ratio. Both medical loss ratios increased by 1 percentage point each year until 2000, when the loss ratios were 82 percent in the small group market and 72 percent in the individual market. The loss ratios have remained at these levels since 2000.

  Each year, when insurers file proposed rate increases, they must include information about the loss ratio they have achieved over the past several years, and the loss ratio they expect to achieve in the following year. If insurers do not achieve the loss ratio they had anticipated the previous year, they are asked to adjust premiums accordingly.

- **New York** approves premium rate increases only if small group insurers are in compliance with a 75 percent medical loss ratio. Individual market insurers must meet an 80 percent loss ratio. Insurers must file annual reports indicating that they are meeting the required loss ratios, and if they are not, they must refund the difference to policyholders. New York has defined the medical loss ratios in such a way that they encourage insurers to undertake cost-containment mechanisms (the costs of which can be counted as medical expenses).

  - In late May 2008, New York's Governor and Department of Insurance announced that Oxford Health Insurance will refund $50 million to 37,000 small businesses in the state because, in 2006, they did not achieve the 75 percent minimum medical loss ratio.[1]

- **Washington** enforces a minimum medical loss ratio in the individual market. Legislation enacted during the 2008 session increased the medical loss ratio from 72 percent to 77 percent.

Table 1.

Medical Loss Ratio Requirements

	Individual Market	Small Group Market	Other	Statutory Reference
California			Managed care plans: Administrative costs not to be "excessive," limited to 15% to 25% based on developmental phase of plan. Administrative costs do no include some factors such as salaries, stock options, etc.	California Health And Safety Code HSC Section 1378, enforced through Cal. Admin. Code tit. 28, § 1300.78
Delaware		75%		Title 18 Chapter 25 § 2506[a]
Kentucky	65%	Groups of 2-10: 70% Groups of 11-50: 75%		KRS 304.17A-095(6)[b]
Maine	65%	Insurers that file rates annually: 75% Insurers that file rates every three years: 78%		Individual: Title 24-A, Chapter 33, §2736-C[c] Small group: Title 24-A Chapter 35 §2808-B 2-C[d]
Maryland	60%	75%		Maryland Code § 15-605[e]
Minnesota	65%	Groups of 2-9: 71% Groups of 10-50: 75%	Large group carriers: 82%	62A.021[f]
Nevada			Nonprofit corporations: 75% Individual dental insurance: 75%	NRS 695B.170 NRS 686B.125
New Jersey	75%	75%		17B:27A-25
New York	80%	75%		§ 3231(3)(2)(A)
North Dakota	55%	70%		26.1-36-37.2
Oklahoma		60%		36 O.S. 6515
South Dakota	65%	75%		Individual: 58-17-64[g] Small group: 58-18-63
Vermont	70%		Safety net market: 80%	Title 8 Chapter 107 4080b(C)(m)[h]
Washington	77%			SB 5261[i]
Wyoming	60%	73%		Individual: Chapter 33 Article 6C §33-6C-1[j] Small Group: §33-16D-5[k]

See table notes on page 4.

Table Notes

[a] Delaware's statute says that it follows the standards of the National Association of Insurance Commissioners (NAIC) to determine medical loss ratios in the individual market (http://delcode.delaware.gov/title18/c025/index.shtml).

[b] http://www.lrc.ky.gov/krs/304-17A/095.PDF

[c] http://janus.state.me.us/legis/statutes/24-A/title24-Asec2736-C.html

[d] http://janus.state.me.us/legis/statutes/24-A/title24-Asec2808-B.html

[e] http://www.michie.com/maryland/lpext.dll/mdcode/162b2/1736e/17557/1756c

[f] https://www.revisor.leg.state.mn.us/bin/getpub.php?type=s&num=62A.021&year=2007

[g] http://legis.state.sd.us/statutes/DisplayStatute.aspx?Type=Statute&Statute=58-17-64

[h] http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04080b

[i] http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Session%20Law%202008/5261-S.SL.pdf

[j] http://www.legis.state.wv.us/wvcode/code.cfm?chap=33&art=6C#06C

[k] http://www.legis.state.wv.us/wvcode/code.cfm?chap=33&art=16D§ion=WVC%2033%20%20-%2016%20D-%20%20%201%20%20.htm#01

Sample Legislation

New Jersey

17B:27A-25

(2) Each calendar year, a carrier shall return, in the form of aggregate benefits for all of the five standard policy forms offered by the carrier pursuant to subsection a. of section 3 of P.L.1992, c.162 (C.17B:27A-19), at least 75% of the aggregate premiums collected for all of the standard policy forms, other than alliance policy forms, and at least 75% of the aggregate premiums collected for all of the non-standard policy forms during that calendar year. A carrier shall return at least 75% of the premiums collected for all of the alliances during that calendar year, which loss ratio may be calculated in the aggregate for all of the alliances or separately for each alliance.

Carriers shall annually report, no later than August 1st of each year, the loss ratio calculated pursuant to this section for all of the standard, other than alliance policy forms, non-standard policy forms and alliance policy forms for the previous calendar year, provided that a carrier may annually report the loss ratio calculated pursuant to this section for all of the alliances in the aggregate or separately for each alliance. In each case where the loss ratio fails to substantially comply with the 75% loss ratio requirement, the carrier shall issue a dividend or credit against future premiums for all policyholders with the standard, other than alliance policy forms, nonstandard policy forms or alliance policy forms, as applicable, in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal 75% of the aggregate premiums collected for the respective policy forms in the previous calendar year. All dividends and credits must be distributed by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied.

The annual report required by this paragraph shall include a carrier's calculation of the dividends and credits applicable to standard, other than alliance policy forms, non-standard policy forms and alliance policy forms, as well as an explanation of the carrier's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the commissioner by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policyholder. For purposes of this paragraph, "alliance policy forms" means policies purchased by small employers who are members of Small Employer Purchasing Alliances.

(3) The loss ratio of a health benefits plan issued pursuant to subsection j. of section 3 of P.L.1992, c.162 (C.17B:27A-19) shall be calculated in accordance with the provisions of section 7 of P.L.1995, c.340 (C.17B:27A-19.3), for the purposes of meeting the requirements of this subsection.

Minnesota

62A.021 Health Care Policy Rates

Subdivision 1. Loss ratio standards

(a) Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, and except as otherwise authorized by section 62A.02, subdivision 3a, for individual policies or certificates, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and all types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1, 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

(b) All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

(c) A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

(d) Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

(e)(1) For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

(e)(2) For purposes of this section, (i) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (ii) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

(f) The loss ratio phase-in as described in paragraph (a) does not apply to individual policies and small employer policies issued by a health plan company that is assessed less than three percent of the total

annual amount assessed by the Minnesota Comprehensive Health Association. These policies must meet a 68 percent loss ratio for individual policies, a 71 percent loss ratio for small employer policies with fewer than ten employees, and a 75 percent loss ratio for all other small employer policies.

(g) Notwithstanding paragraphs (a) and (f), the loss ratio shall be 60 percent for a health plan as defined in section 62A.011, offered by an insurance company licensed under chapter 60A that is assessed less than ten percent of the total annual amount assessed by the Minnesota Comprehensive Health Association. For purposes of the percentage calculation of the association's assessments, an insurance company's assessments include those of its affiliates.

(h) The commissioners of commerce and health shall each annually issue a public report listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in this state by the health plan companies that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than June 1 for loss ratios experienced for the preceding calendar year. Health plan companies shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.

Subdivision 2. Compliance audit

The commissioner has the authority to audit any health carrier to assure compliance with this section. Health carriers shall retain at their principal place of business information necessary for the commissioner to perform compliance audits.

Subdivision 3. Loss ratio disclosure

(a) Each health care policy form or health care certificate form for which subdivision 1 requires compliance with a loss ratio requirement shall prominently display the disclosure provided in paragraph b on its declarations sheet if it has one and, if not, on its front page. The disclosure must also be prominently displayed in any marketing materials used in connection with it.

(b) The disclosure must be in the following format:
Notice: This disclosure is required by Minnesota law. This policy or certificate is expected to return on average (fill in anticipated loss ratio approved by the commissioner) percent of your premium dollar for health care. The lowest percentage permitted by state law for this policy or certificate is (fill in applicable minimum loss ratio).

(c) This subdivision applies to policies and certificates issued on or after January 1, 1998.

History: 1992 c 549 art 3 s 8; 1993 c 345 art 8 s 2; 1997 c 225 art 2 s 2,3; 2002 c 330 s 9; 2003 c 109 s 1; 2006 c 255 s 9

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[1] *Governor Paterson Announces NY Small Businesses to Receive $50 Million in Insurance Refunds* (Press Release from State of New York Executive Chamber, May 29, 2008), available online at http://www.ins.state.ny.us/press/2008/p0805291.htm.

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