Could 2019 be the year of MLR rebates for ACA issuers in the individual market?

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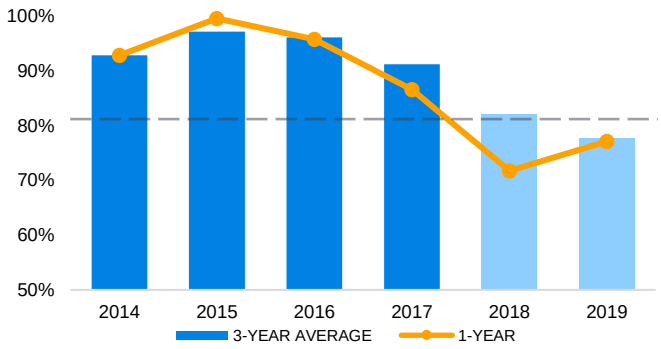
Many issuers faced financial challenges in the individual market in the first few years of the Patient Protection and Affordable Care Act (ACA) after its inception in 2014. Headlines reported large losses forcing issuers like UnitedHealth[1], Aetna[2], and Humana[3] to leave or reduce their presence in the ACA market. The continually changing landscape made it difficult to keep up even after significant rate increases, and issuers repeatedly reported medical loss ratios (MLRs) well above sustainable targets.[4]

Now, as experience emerges for plan year 2018, the tides are changing. A number of issuers filed rate decreases across the marketplace for plan year 2019 and new market entrants are appearing once again, a sign of a more stable market with potential for profitability.[5] As shown in Figure 1, MLRs are dropping. They are projected to approach, and potentially to drop below, the 80% federal threshold for the individual market, on average. As the average MLR (based on a three-year average) continues to decrease, the portion of ACA issuers below the MLR threshold continues to increase.

As MLRs decrease, individual ACA issuers need to start thinking about something that has been mostly irrelevant for them until now—MLR rebates. Although MLR rebate requirements have applied in several markets since 2011, the individual ACA market is unique in that high MLRs have prevented rebates from entering the equation for the majority of issuers since the ACA's inception.

MLR rebates were introduced in the ACA market with the goals of stabilizing the market and providing consumer protection by returning money back to policyholders when an issuer's MLR reflects high profitability, administrative inefficiencies, or low claim levels not otherwise reflected in premium.[6] While rebates are an indication of financial stability and are beneficial to policyholders, they can introduce complicated reporting and distribution challenges.

FIGURE 1: FEDERAL LOSS RATIOS FOR INDIVIDUAL MARKET ACA CARRIERS[7]



Estimating an MLR mid-year can be challenging

The incorporation of risk adjustment, quality improvement expenses, and taxes in the MLR calculation differentiates the ACA MLR from a traditional MLR.[8]

$$Traditional\ MLR = \frac{Claims}{Earned\ Premium}$$

$$ACA\ MLR = \frac{Claims - Risk\ Adjustment + Quality\ Improvement\ Expenses}{Earned\ Premium - Taxes\ \&\ Fees} + Credibility\ Adjustment$$

With new unknown pieces come new challenges for tracking and reporting meaningful estimates throughout the year. Each of the following components of the MLR formula requires special consideration:

- **Claims:** Claim patterns can be difficult to pin down in a market with a regularly changing population and evolving regulations. When estimating incurred claims for the year, issuers should consider the impact of enrollment growth on seasonal fluctuations and evaluate how market changes, such as emerging state reinsurance programs, 1332 waiver programs, or Medicaid expansions, may affect ACA claim liabilities.
- **Risk adjustment:** Incurred claim estimates carry little meaning without understanding how risk adjustment transfers will offset or amplify an issuer's costs. Risk adjustment can be a substantial portion of premium—averaging 10% of individual premium and 5% of small group premium in 2017[9]—and is susceptible to volatility, especially for issuers experiencing significant changes in enrollment year over year. Issuers should be equipped to estimate risk scores throughout the year and understand the implications of annual changes to the U.S. Department of Health and Human Services (HHS) risk score calculation logic. Statewide simulation studies can provide timely insight to help issuers understand where they sit relative to the state average and how estimated risk transfers are likely to influence their MLRs.
- **Quality improvement expenses:** Issuers should have clear processes in place to distinguish and allocate quality improvement (QI) expenses. These processes should be consistent year over year and may require clinical expertise.
- **Earned premium:** Issuers should consider the impact of the ACA's rules on grace periods for unpaid premiums—in particular, issuers may experience reduced earned premiums for members who passively drop coverage in December. It is important to summarize earned premium accurately for MLR reporting periods as well as on a policyholder basis in order to allocate rebates correctly.
- **Taxes and fees:** This includes federal taxes, state taxes, and local taxes, as well as regulatory licenses and fees, but excludes federal income taxes on investment income and capital gains and federal employment taxes.
- **Credibility adjustment:** MLRs are adjusted upward if total enrollment over the three-year aggregation period is low. Issuers should know early in the year how enrollment is tracking, so this adjustment should be incorporated as loss ratios are estimated throughout the year.

Considerations for the 2018 reporting year

Given the significant losses many ACA issuers experienced in 2016 and 2017, even a very profitable 2018 will only partially affect the MLR because experience is aggregated over a three-year period. Unless 2018 experience is sufficient to offset 2016 and 2017 experience in total, a rebate may not be triggered for the 2018 reporting year. For issuers approaching rebate territory, here are some things to consider:

Take credit where credit is due: Utilize all permitted adjustments within the prescribed MLR calculation. These adjustments could push an issuer's aggregate MLR over the 80% threshold.

- *Credibility:* Issuers with fewer than 75,000 life-years in a given market over the three-year period may apply an additive credibility adjustment, up to 8.3%, to the MLR for that market. This adjustment can be further increased using factors prescribed by the Centers for Medicare and Medicaid Services (CMS) if the weighted average deductible of the enrollees is greater than $2,500.[10] This adjustment should not be overlooked, particularly for the intended target, low-enrollment issuers whose experience is susceptible to volatility.
- *Quality improvement:* Issuers should increase the MLR numerator for approved QI expenses as long as these expenses are appropriately segmented. Starting with plan year 2017, issuers have the option to report a default QI expense amount of 0.8% of earned premium in lieu of actual expenditures.[11] If this option is selected, it must be applied for at least three consecutive MLR reporting years across all commercial lines in all states and for all affiliates. Issuers should contemplate this default adjustment with a broad, long-term view, as QI efforts in the pipeline might make the three-year commitment disadvantageous.
- *Taxes:* Issuers can consider reporting community benefit expenditures instead of state premium and policy reserve taxes. Community benefit expenditures are expenditures related to achieving "the objectives of improving access to health services, enhancing public health and relief of government burden."[12] Issuers are not allowed to include employee taxes as part of the MLR calculation—special care should be given to ensuring taxes are reported accurately to avoid any issues resulting from a CMS audit.

- *Blended rate adjustment:* Affiliated issuers may make an adjustment to the MLR if they jointly offer group coverage at a blended rate.[13] It is applied as an adjustment to each affiliate's claims and QI expenses as a reflection of the affiliate's experience of the group as a whole. The adjustment is determined by an objective formula, resulting in each affiliate having the same ratio of claims to premium for the group as the ratio of claims to premium for the aggregate group, defined by the issuer prior to the start of the reporting year.
- *Look at each year separately:* Issuers who owe rebates can take advantage of yearly caps when determining their rebate liability. Under this optional process, issuers can look at each individual year's stand-alone rebate using the current year's credibility adjustment, cap the total rebate at the three-year aggregate amount, and then take credit for rebates paid in prior years to determine an outstanding rebate liability. This flexibility was added by HHS for plan year 2018 in order to avoid excessive penalties for rapidly growing issuers who may see lower loss ratios (and corresponding higher rebates) that otherwise would be reflected in multiple years of reporting, but may benefit other issuers as well.[14]

Defer new business reporting: New issuers or issuers with rapid enrollment growth may benefit from deferring new business reporting. The MLR rules allow for a one-year deferral of new business for issuers with at least half of their premium attributable to newly issued policies,[15] whereby the deferred experience is reported as part of the subsequent year. This flexibility is intended to level the field between established issuers and new market entrants.

Measure twice, report once: MLR forms are subject to audits from CMS. Additionally, policyholders rely on the accuracy of MLR reporting once potential rebates enter the equation. Rebates incorrectly paid to policyholders cannot be taken back, so it is imperative to get it right the first time around. Conversely, issuers create the potential for legal and reputational risk if reporting errors result in a required rebate not being distributed accurately.

In addition to the actual form filing requirements in the second half of the year, issuers should also have a process in place to establish reserves for any projected rebates in year-end financial reporting. Designate an expert to establish a strong understanding of the details and nuances of the MLR reporting instructions. Consider having an external firm review the rebate estimates and audit the MLR form to verify accuracy.

Establish MLR rebate operations now: Even if an issuer's 2016 and 2017 experience is unfavorable enough to prevent an MLR rebate for plan year 2018, issuers should keep in mind that 2018 experience will affect the MLR calculation through plan year 2020.

For an issuer in an MLR rebate position for the first time, handling the logistics of distributing rebate checks can be a daunting task. MLR reporting is due in July following the plan year, but it is helpful to be prepared ahead of time and understand the costs and staffing needs associated with these procedures.

If an issuer does find itself in a rebate position, there are a few options for how to distribute the rebate:[16]

- A premium credit to current enrollees
- A check to each individual member
- A refund to the credit card or direct debit account (if either was used to pay premiums)

Refunds do not need to be issued if the rebate is less than $5 per subscriber, and payments can be made to the subscriber if a policy covers multiple individuals. Amounts not spent must be used to evenly increase rebates for those receiving them. Issuers must make a good faith effort to find enrollees to distribute checks and must defer to state law if that effort fails. Rebates not distributed to policyholders by September 30 following the reporting year face a late penalty.

Current CMS guidance for the individual market requires the issuer to refund the entire rebate to the policyholder regardless of whether the policyholder's premium was subsidized by an Advance Premium Tax Credit (APTC).[17] One notable exception applies in states that elected to expand Medicaid through ACA marketplaces (e.g., Arkansas) where rebates are payable to the state Medicaid agency, which then ultimately shares savings with the federal government.

Issuers must have staff in place to determine the appropriate methods for distributing refunds. Regardless of which option is selected, the issuer will need staff to determine who legally gets a rebate, how it is calculated, and how to find people who are no longer members. The issuer will need to make sure it has a process in place to keep accurate mailing addresses of members if distributing checks by mail.

How to plan for 2019 and beyond?

For issuers projecting a favorable 2018 loss ratio, now is the time to consider the implications and strategies for 2019 and beyond.

- **Track and optimize QI expenses.** Understand the direct impact of the QI expense credit on the MLR formula as well as potential indirect impacts of QI efforts on claims.
- **Set 2020 premium rates with a potential MLR rebate in mind.** An issuer's pricing strategy should holistically consider the net impact of rebates over the three-year window. If 2018 and emerging 2019 experience are favorable, there may be an opportunity to adjust rates in 2020 and increase membership.
- **Consider how the MLR is affected by long-term investments.** For example, there may be a new QI program under consideration that it is time to invest in. Consider how to best book that expense within the MLR calculation, keeping in mind the three-year commitment when electing the 0.8% default QI option.

- **Consider offering a "premium holiday" to reduce member premiums while avoiding some of the tedious logistics of distributing MLR rebate checks.** A premium holiday also puts money back in consumers' pockets much earlier than a rebate check. By timing a premium holiday prior to open enrollment, the issuer can demonstrate the return of value sooner and potentially improve member retention for the following plan year. Credits must be distributed equitably across all members. Note the risk involved because these decisions will need to be made before full claim runout and risk adjustment transfers are known, so there could be surprises after the fact that would result in an unnecessary loss. State insurance regulators should be consulted to better understand what actions are allowed.[18]
- **Ensure an expert is familiar with the details of the federal and state MLR guidelines so that reporting forms are appropriately and accurately filled out.** While this paper focuses on the federal MLR form, some states have their own unique rules for state MLR forms. Designated MLR experts should stay up-to-date with both sets of guidelines as they are always subject to change.
- **Revisit risk contracts with the MLR in mind.** A profitable year is a good time to reopen discussions with providers that may have previously been unwilling to take on risk. Risk contracts that have two-sided risk can moderate swings in experience from year to year, encourage providers to help with medical management, and reduce the frequency of MLR rebates.

Because the MLR formula is a three-year average, scenario testing several years into the future will help develop optimization strategies. As business becomes more profitable in the ACA market, MLR rebates will become an increasingly larger focus for issuers. While important in its own right, the MLR rebate is only one piece of the financial puzzle and will likely be offset in part by risk adjustment transfer payments. Issuers should consider the options presented here and elsewhere and make financial decisions with a holistic view of their business in mind.

Caveats and limitations

This paper should not be interpreted as an endorsement of any particular legislation by Milliman or the authors. The paper reflects a current understanding of the guidance for completing MLR forms from a combination of sources including, but not limited to, the ACA, instructions included with the MLR calculator, and bulletins released by the U.S. Department of Health and Human Services (HHS). Nothing in this paper should be interpreted as legal advice; MLR forms are subject to federal and state reviews. As legislation develops, regulations change, and guidance evolves, issues may emerge that prompt new questions and considerations.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications on all actuarial communications. Esther Blount, Alison Fasching, and Michelle Klein are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis in this paper and rendering the actuarial analysis contained herein.

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Endnotes

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[7] Loss ratios for 2014 through 2017 are calculated from National Association of Insurance Commissioners (NAIC) annual statements filed by companies with reported ACA business and include all commercial business. Loss ratios for 2014 through 2016 are net of federal transitional reinsurance. Loss ratios for 2018 are projected using a premium increase of 34% and an 11% claim trend. Loss ratios for 2019 are projected using a premium increase of 3.1% and a 10.8% claim trend. MLR forms are filed with CMS and are publicly available (see https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html). The loss ratios reported in this paper do not represent values from actual MLR forms filed with CMS but show similar results. Sources for assumptions are as follows: 2018 premium increase: https://www.businessinsider.com/avalere-study-2018-obamacare-premiums-trump-2017-10. 2018 claim trend: 6% medical trend plus 5% additional trend for removal of cost-sharing reduction (CSR) subsidy payments, based on 2018 per member per month (PMPM) amount: http://us.milliman.com/ACA-state-profiles/. 2019 premium increase: http://avalere.com/expertise/managed-care/insights/2019-premium-increases-lowest-on-average-since-2015. 2019 claim trend: 6% medical trend plus 4.8% morbidity increase (based on 80% MLR). https://www.kff.org/health-costs/issue-brief/how-repeal-of-the-individual-mandate-and-expansion-of-loosely-regulated-plans-are-affecting-2019-premiums/.

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[12] Electronic Code of Federal Regulations, ibid., Section 162, https://ecfr.io//Title-45/sp45.1.158.b#se45.1.158_1162.

[13] In this context, a blended rate refers to a single rate for coverage provided to an employer through multiple affiliates of the same issuer. See the Electronic Code of Federal Regulations, ibid., Section 103, https://ecfr.io//Title-45/sp45.1.158.b#se45.1.158_1103.

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