

issue brief

Recognizing Destabilization in the Individual Health Insurance Market

Executive Summary

As health reform moves forward, the medical loss ratio (MLR), designed to indicate how much of the premiums collected from consumers actually pay for health care services and clinical quality, will take on new significance for plans competing in health insurance markets. Plans that do not meet minimum statutory MLR standards will be required to provide rebates to enrollees. For the individual market, the law gives the secretary of the Department of Health and Human Services (HHS) the authority to make adjustments to the MLR standard if she determines that it may destabilize a state's health insurance market.

The MLR requirements for rebates go into effect Jan. 1, 2011, while the broader market reforms including guaranteed issue and elimination of medical underwriting will not be implemented until 2014. Market analysts, industry representatives and actuaries, and regulators participating in a one-day meeting conducted by the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) initiative generally anticipate that, after an initial period when many insurers will experience significant uncertainty, most of the large, established carriers offering coverage in the individual market will be able to meet the MLR thresholds, but other insurers may leave the market. In the short term, the greatest opportunities for improving the MLR may be reducing distribution costs, but the contractual ability available to do so may be limited. If insurers choose to terminate product lines or withdraw entirely from the market before 2014, some consumers may be unable to find affordable alternative coverage. Meeting participants estimated that up to one fourth of people whose primary insurance coverage is purchased

in the individual market might be at increased risk of losing or needing to change coverage during the transition period, and that some proportion of these could be "stranded," i.e. unable to obtain replacement coverage.

Meeting participants identified warning signs of market destabilization that could inform policy-makers' determinations about market stability. Some focus directly on market contraction, (e.g., carriers reducing marketing or products, surrendering licenses, closing blocks of business, or arranging for assumption reinsurance) and others on market volatility (e.g., large changes in premiums, shifts in marketing strategies, complaints to state regulatory agencies, and demographic changes in coverage or access). During the transition period, the absence of consistent definitions and lack of complete, reliable data, and, more importantly, reductions in the types of insurance products available to consumers in the individual markets in each state will mean that regulators will need to apply substantial judgment, rooted in an understanding of local circumstances, to appropriately recognize when a market is at risk of destabilizing. Participants also identified a variety of approaches that states have taken in the individual markets that might protect consumers stranded by contraction of individual insurance options in the 2011-2013 period. Examples of such protections include extending continuous coverage protection to consumers stranded by market exits, guaranteed issue for some individuals for some products, designating "insurers of last resort," requiring HMOs to offer some form of individual coverage, requiring carriers with blocks of other types of business to continue marketing individual coverage, and opening state high-risk pools to all qualified uninsured individuals, not just those who are medically eligible. Better understand-



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Changes in Health Care Financing and Organization is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth.

ing of these policies and how well they have worked could help state and federal policymakers to be ready if individual markets cannot meet consumer needs. States, with the help of the federal government, will need to craft policies that address problems that may occur during the next few years without undermining broader goals of insurance reforms that will be in place by 2014.

Overview

As health reform moves forward, the medical loss ratio (MLR) will become a critical measure of efficiency for health plans competing in health insurance markets. The Patient Protection and Affordable Care Act (PPACA) enacted on March 23, 2010, requires insurers, beginning Sept. 23, 2010, to submit annual reports summarizing their MLR experience. Based on this information, insurers who do not meet the minimum standards set out in the legislation — 85 percent in the large group market; 80 percent in the small group and individual markets — must provide rebates to enrollees for plan years beginning Jan. 1, 2011.

As defined in the law, the MLR for purposes of rebate calculation is the ratio of:

Expenditures on reimbursement for clinical services and activities that improve health care quality,

to:

Total amount of premium revenue, excluding taxes and fees, and after payments or receipts for risk adjustment, risk corridors, and reinsurance (as defined in the PPACA).

The PPACA charges the National Association of Insurance Commissioners (NAIC) with developing standards and definitions associated with the law's MLR provisions. Working through the wide range of technical issues involves understanding the huge variation in insurance markets and regulatory systems that developed across the states over decades, as well as the policy goals and potential consequences of the PPACA reforms.

For the individual market, the law gives the HHS secretary the authority to “adjust [the minimum MLR] percentage with respect to a State if the Secretary determines the application of such 80 percent may destabilize the individual market in such State.” Determining how the new MLR provisions, in conjunction with the wide range of coverage and benefit reforms included in the PPACA may affect health insurance markets and the consumers who depend on those markets, poses a particularly challenging task. In June 2010, The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative convened a meeting designed to foster discussion by experts focused on the relationship between MLRs and the stability, or destabilization, of insurance markets.¹ The meeting focused on key policy, research, and regulatory questions, including:

- What do we know about the relationship between MLR standards and insurance market stability? What do experts predict about the likely impact of the new MLR requirements on the individual insurance market?
- How, and how quickly, can insurers reduce administrative costs or other components to meet MLR thresholds established in the PPACA? What is known about the components of MLRs? How do the metrics vary across states or types of insurers?
- How will regulators and policymakers know when an insurance market becomes destabilized? What are the “early warning signs” of market destabilization associated with MLR requirements? How can these be monitored or measured now? What infrastructure will be needed to track the effect of MLR standards over time?

MLR Requirements and Market Instability

Wide variation in the structure and oversight of individual insurance across the states amplifies the challenges of under-

standing, or predicting, how MLR requirements will affect the availability or cost of individual insurance products. The MLR standards are only one of many factors that might affect insurers' decisions to enter or leave markets, or how they manage existing blocks of business. Restrictions on rating and underwriting, new minimum benefit standards, administrative and reporting requirements, expanded access to Medicaid, subsidies available to low-income enrollees, exchanges that provide a new means of marketing, and the emergence or expansion of other types of plans (e.g., CO-OPs, multi-state plans, or association health plans), among other reforms, all may affect individual insurance markets in different ways within and across states and sub-state regions. And, because the MLR standards will be implemented before the other reforms are fully implemented in 2014, there will be a transition period when existing plans are subject to the new MLR requirements that will be applied by the secretary based on experience that may be very different from what it will be several years from now.

Market analysts, industry representatives, actuaries, and regulators participating in the HCFO meeting all indicated that they believed that most of the large, established carriers offering coverage in the individual market will probably be able to meet the MLR thresholds. This would, however, depend on a range of assumptions. Regulations and guidance for calculating MLRs are not yet available, and participants also cited a number of other factors that could affect carriers' business decisions, such as the impact of the MLR definitions on health plan activities and investments related to quality, health IT, and protecting against fraud and abuse. One participant provided an analysis of NAIC data suggesting that while a significant number of carriers, mostly small companies, reported MLRs below the threshold (for 2008 experience), many were just below the required level of 80 percent.² Most, if not all of the publicly traded companies and Blue Cross Blue Shield plans are expected to meet the standards within

a short period. A small number of large health plans with substantial enrollment in the individual market may be unable to meet the MLR threshold, at least in the short term. Participants also believed that some companies unable to meet the 80 percent threshold would seek to maintain their market position in order to gain new business in 2014, and would probably be more likely to work to minimize rebates to consumers than exit markets.

The transitional period, 2011-2013, creates special concerns for insurers and for consumers. Insurers are facing uncertainty about how the MLR standard will actually be defined and how it, along with other reform provisions, will affect their lines of business. For some consumers, significant disruption in the private insurance market could pose a serious problem. If insurers choose to terminate product lines or withdraw entirely from the market before 2014, enrollees who have pre-existing conditions could, depending on the regulations in place in their state, be unable to find affordable alternative coverage.

Meeting participants worked through an educated guess of the number of covered lives that could be stranded by the contraction of individual insurance options triggered by the MLR requirements in the 2011-2013 period. Assuming that about 12-15 million people are covered at any point in time,³ and, based on industry estimates, about three fourths of the covered lives are in the large, stable plans, some percentage of 3 to 4 million covered lives might be at increased risk of losing coverage from their current insurer because of firm exit from the market. Some of these people will be able to obtain coverage from another source, but others might not be able to obtain replacement coverage because of pre-existing health conditions.

Individual health insurance markets in most, if not all, states have been tightly underwritten. Obtaining affordable coverage in the individual market, particularly for people

with pre-existing conditions, has been a serious problem in most states. The extent to which MLR requirements exacerbate these problems over the transitional period may be relatively small. But even a relatively small number of people stranded by loss of coverage in the individual market in the transition period would be highly problematic, not only for them, but politically as well, if it were seen as a negative outcome of the federal health reform legislation.

What do we know about MLRs, and what the new standard might mean for markets and consumers?

Traditionally, MLRs have been important tools in the health regulation arena, particularly with respect to assessing health plan solvency, and have also been used to assess whether a proposed premium increase is warranted.⁴ Most states have some form of minimum loss requirements for health insurance plans in the individual market.⁵ But while the current NAIC reporting system collects MLR data, there are variations among state definitions and requirements, and the statutory definition in the PPACA differs in substantive ways from the definitions used by the states. States typically calculate MLR as incurred claims costs divided by earned premiums, with none or different variants of the adjustments for premiums for costs or taxes and fees, or costs related to improving quality that are set out in the PPACA.

Although the regulations that will establish precisely how the MLR will be calculated have not been issued, there was general consensus among HCFO meeting participants that the inclusion of costs directed to improving quality of care and premium reductions for eliminating taxes will result in increases in the MLRs for some insurers, perhaps increasing the currently reported MLRs by approximately five percent. In the individual market, however, since plans underwrite for health reasons, the use of medical management activities, such as care coordination, may be lower than in group insurance (since underwritten members are

healthier at policy issue), so impact of the new definition may be small, at least relative to the group product lines.

Uncertainty surrounding MLR thresholds is a significant concern for insurers. Like other businesses, they need to plan strategically for changes in products, marketing approaches, and administrative and data systems that may take several years to implement. Generally, under HIPAA, insurers need to give six months advance notice before exiting a market. Therefore, decisions for 2011 need to be made by mid-2010.

Some changes in benefit design could affect administrative costs; high deductible plans, for example, may have lower administrative costs since fewer small claims are processed, but higher percentage of fixed administrative costs per premium dollar. Making major changes in benefit design or marketing strategies for the transitional period could, however, be impractical, both in terms of the administrative costs involved and, depending on the regulatory requirements in place in the state, the time and effort involved in state filing and rate review. Changing products could also create backlash with consumers in advance of the more sweeping changes that will come after the transition period, and may not be feasible in light of the implementation of several near-term PPACA provisions relating to coverage and benefits.

In the short term, the greatest opportunities for improving MLRs in the individual market may be reducing distribution costs, but the means available to do so may be limited. Lowering broker commissions, a relatively large component of administrative costs in the individual market (more than 10 percent in some cases), may be constrained by existing contractual agreements, and the willingness of brokers to accept large reductions in commissions in the market today. Meeting participants offered several different perspectives on the prospects of significant changes in the distribution costs in the individual market.

Some predicted that major reductions in broker commissions could destabilize the individual market. Brokers play an important role in the individual market in many states, helping consumers to find products that are open to them and also to navigate the process of providing information and sometimes negotiating with carriers regarding specific benefits, exclusions, riders, etc. From a longer-term business perspective, others suggested that broker commissions could be reduced without undermining the distribution system. Some noted that because commissions are based on the cost of the premium, brokers have been making more income, and will continue to make more per sale as the cost of insurance increases. Further, the influx of new enrollees would create new opportunities to increase sales (making up for lower commission rates per policy sold).

The PPACA calls for the establishment of a network of state-based insurance market exchanges. The creation of the exchanges raises the prospect that over time, there could be significant changes in the organization and costs of the distribution channels in the individual market. In Massachusetts, for example, where there is guaranteed issue, modified community rating, and a set of standard plan options, consumers sort through options without brokers in the individual market. The state's Connector provides an on-line insurance market.⁶ Greater standardization could facilitate the use of e-marketing of insurance, and the establishment of exchanges where consumers can compare plans could also lead to lower administrative costs. During the transition period, however, there will be consumers in some, possibly many states who want to continue to work with brokers who can help them sort through coverage options subject to underwriting and rating and assist them with filling out the necessary paperwork.

How will we know if individual insurance markets become unstable?

Because MLR standards are intertwined with other dynamic factors shaping the individual insurance market, implementing the standards and making exceptions to them involves interrelated analytical tasks: 1) determining

if there is currently an unacceptable level of instability in individual insurance markets; and 2) determining what role the MLR standards play in the destabilization of individual insurance markets.

There does not appear to be empirical evidence supporting a particular formula for deciding how many carriers need to be in an individual group market serving a state, or part of a state. Some participants in the HCFO session generally agreed that a relatively small number of carriers—in the range of three to five—could be enough to support a functional state or regional individual insurance market if they provide a wide range of products. Some in fact argued that more than five would not provide additional stability, and that consumers may actually prefer to have limited choice, *as long as that choice included a range of plan options that meet their needs or expectations.*

In Washington state, for example, there are three commercial carriers⁷ actively serving the individual market. In 1999, these same carriers began leaving the individual market because of the significant adverse selection taking place. In 2001 the legislature passed individual market reforms that provided incentives to carriers to offer plans in the individual market. Those reforms included requiring consumers seeking coverage to fill out a health questionnaire; carriers are allowed to refer the 8 percent most costly applicants (based on their reported health experience) to the state's high risk

pool. Consumers are also subject to a nine month pre-existing condition waiting period upon enrollment. While the state's individual market is much more stable currently, signs point to a market unable to meet the needs of the population, most notably the prominence of high deductible health plans.⁸ In Massachusetts, the number of carriers in the individual market has increased since the passage of the state's health reforms. The baseline in Massachusetts, however, reflected prior reform efforts that had reduced the size of the individual market and increased premiums for individual policies. In addressing these problems, Massachusetts merged its individual and small group markets. A large number of carriers offer individual coverage in Texas,⁹ with about 30 likely to account for most of the individual market business. Across the states, a small number of carriers often account for a large part of the individual market.

Short of actually exiting a market, carriers can also change plan benefits designs or rating mechanisms, within constraints established by state regulatory systems. In some cases, market exits could indicate a carrier's determination that the regulatory climate or business opportunities are no longer favorable, but it can also reflect a carrier's inability to perform efficiently or offer a quality product. There was general agreement among meeting participants that some, possibly many, "marginal" carriers, including plans with very small enrollment

Summary of Warning Signals of Market Destabilization from Lists Submitted by Meeting Participants

- Insurers surrendering licenses
- Closing blocks of business
- More assumption reinsurance
- Changes in marketing
- Complaints (brokers, consumers)
- Demographic changes in coverage (sudden declines in coverage)
- Increased applications to state high risk pools
- Premium volatility
- Benefit design changes (offering only high-deductible plans)

and plans offering low quality products will not survive after the PPACA insurance reforms are fully in place regardless of MLR standards. Some meeting participants suggested that this sort of market exit should serve to strengthen, rather than destabilize, the individual market post 2014. Others noted that during the transition, individuals who may have enrolled in these plans based on personal preferences may be unable to find an acceptable alternative coverage option.

Market Contraction

In reviewing the characteristics of unstable markets, meeting participants focused on the difficulty of clearly defining even seemingly obvious indicators such as “exiting a market.” Meeting participants identified several early warning signals of market contraction, including the “nuclear option,” when carriers formally exit a market for new sales and terminate existing blocks of business. Other signals may be increases in assumption reinsurance, where carriers selling guaranteed-renewable policies arrange for another organization to completely assume the risk for these products, and, in some cases, selling blocks of business to companies (sometimes referred to as “vulture companies”) that specialize in closing them down and “running off the business.”

These potentially destabilizing actions generally require some form of notification to the state, if not formal approval, by state regulators. Some may also be subject to federal oversight, but meeting participants indicated that there are areas of uncertainty regarding responsibility for oversight. They generally agreed, however, that brokers actually working in the field are among the first to know about potential problems, and that state insurance regulators can obtain market intelligence by maintaining close contact with them. Calls or complaints from brokers and from consumers can provide early warning to insurance regulators, but whether market contractions are destabilizing requires an understanding of the local context.

Market Volatility

Large changes in premium rates or MLRs could signal structural problems in the individual market. Some of this movement is normal in the market, due to changes in product offerings, economic and demographic, and regulatory changes. Actuaries and industry analysts participating in the HCFO session agreed that while MLRs tend to be stable over time among the large carriers, highly-regarded insurers often have significant fluctuation in MLRs from year to year. But rapid changes could also indicate long-term issues in plan financial viability. Changes in marketing activity can also signal problems in markets. For example, rather than terminating a block of business, an insurer might suddenly stop actively marketing it, and phase out or terminate entirely any arrangements to make a particular product available through brokers.

Financial analysts evaluating insurance markets also look at indicators such as MLRs and premiums, along with various aspects of capital investment. The stock market may provide a general indication of how investors think that health insurance companies will fare under health reform, but does not provide a lot of insight about the individual market, because the individual insurance segment generally represents a small part of companies’ total business. Publicly traded companies tend to be larger and their experience and outlook may therefore not be indicative of smaller companies. Analysts view the MLR standards as a cap on profit rates, but the general industry outlook is positive because the market believes that so many more people will be insured in the private markets in 2014. But at the same time, some analysts express concerns over the strength of the coverage requirement in ensuring a well-balanced risk pool when the long-term insurance market reforms requiring “guarantee issue” of coverage begin. Wall Street does watch for sudden shocks, such as the sharp changes in premiums announced or proposed recently by several major carriers. These provide insights into ways that insurers are positioning their business,

and, in a broader context, how markets are viewed from the different perspectives of investors, carriers, and regulators.

Monitoring Markets and Protecting Consumers

Some rapid changes in the individual market can be identified in the data reported to states and/or NAIC, but there is generally some lag time as data are compiled and organized for analysis. For example, plan data for a given year are generally available from NAIC shortly after the filing deadline of April of the following year. The NAIC is working with HHS to develop standard definitions, uniform methodologies for calculating the MLR, and reporting forms. These will produce valid, reliable data on insurance rate filing across the states, including the data to calculate MLRs.¹⁰ But until these systems are in place, regulators will need to sort through data that are often unverified as well as incomplete. In addition, there are also only a small number of publicly available data sets that include information on private sector enrollees’ demographic characteristics, such as data needed for risk adjustment collected in Massachusetts.¹¹ The implementation of the risk adjustment provisions of the PPACA will mean that data will be collected in the future, but in the transition period special studies may be needed.

Because the individual market is small, identifying changes in demographics, such as significant increases in numbers of people having problems obtaining coverage in the private market, or changes in the health status or medical risk of people entering or leaving the individual market may require special surveys.

Meeting participants repeatedly focused on substantive differences between the current state of individual insurance market and the new environment that will emerge when reforms are fully in place in 2014. During the transition period, the absence of consistent definitions or data, and fundamental differences in the types of insurance products available to consumer in the individual markets in each state will mean that state regulators will need to apply considerable

judgment, rooted in understanding of local circumstances, to appropriately recognize when a market is at risk of destabilizing.

The diversity of state experience could, however, provide an advantage. Participants identified a variety of approaches that states have taken to protect consumers in the individual markets short of mandating guaranteed issue of all products sold in the individual market. Examples included:

- Extending continuous coverage protection to consumers stranded by a market exit to allow them to obtain similar coverage from other carriers without pre-existing condition exclusions;
- Guaranteed issue for some individuals for some products;
- Periodic (open season) guaranteed issue for some (or all) individuals for some products;
- Requiring that Blue Cross Blue Shield plans serve as “insurers of last resort”;
- Requiring HMOs to offer some form of individual coverage;
- Requiring carriers with relatively large blocks of business to continue marketing individual coverage; and
- Opening state high-risk pools to all qualified uninsured individuals, not just those who are medically eligible.¹²

Meeting participants also pointed to the need for identifying the potential unintended consequences of these measures. These include, for example, the risk that these measures could increase the cost of coverage for those not at risk of losing coverage due to the MLR ratios. Alternative policies need to be weighed against other potential options such as the development of a transition plan that could help prevent destabilization of the individual market in the first instance.

The timeframe to address possible disruptions in markets, and in insurance coverage for at-risk populations is short. Problems that arise in individual insurance markets will reflect local circumstances, increasing the burden on already busy state regulatory agencies. The federal government could, as meeting participants suggested, help states through the transition by providing guidance about the definitions, standards and data to guide decisions about market stability. But many participants also called for increased communication that would allow states to address problems, quickly, and without unnecessary bureaucratic impediments. Participants were clearly interested in sharing information about the options that might be available to states to mitigate possible disruptions in coverage over the next few years, whether due to general instability of the individual insurance market or more specific issues related to the new MLR standards. They also identified a need to better understand the capacity of state high-risk pools, both those already in place and new systems established under the PPACA, to absorb consumers stranded by market exits.

About the Author

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Endnotes

- 1 Washington, D.C. in June 2010, AcademyHealth convened an invitational meeting of experts, including industry analysts, insurers, actuaries, state regulators, federal health policy experts, and academic researchers to participate in a discussion of market destabilization and medical loss ratio standards in the individual insurance market. The meeting was moderated by John Bertko. This policy brief provides an overview of that discussion, including examples of relevant research and data, issues, perspectives, and topics for future policy and research work to support the goals of insurance reform.
- 2 The data analyzed consisted of national loss ratios; for carriers operating in more than one state, state level loss ratios could show significantly greater variation.
- 3 This estimate of the number of people whose primary coverage is from individual market insurance is based in part on data from the Current Population Survey (see Table HIA-6. Health Insurance Coverage Status and Type of Coverage by State—Persons Under 65: 1999 to 2008, at <http://www.census.gov/hhes/www/hlthins/data/historical/index.html>), and Kaiser Family Foundation estimates (see “How Private Health Coverage Works: A Primer”, 2008 Update, at <http://www.kff.org/insurance/upload/7766.pdf>). Additional adjustments to these figures take into account several factors that may contribute to overestimates of private coverage, including double counting coverage in family units with multiple sources of coverage, counting a variety of products sold in the individual market that provide only very limited coverage and/or apply only to special conditions or diseases, and changes in coverage since 2008.

- 4 In June 2010, New York’s Governor signed legislation that reinstated the Insurance Department’s authority to review and approve health insurance premiums before they take effect, and added a medical loss ratio that insurers must meet (increasing the MLR standard for individual plans from 80 percent to 82 percent. See <http://www.healthleadersmedia.com/print/FIN-252274/New-York-Enacts-Health-Insurance-Law-With-New-Medical-Loss-Ratio>.
- 5 The NAIC Model Regulation for Filing of Rates includes MLR requirements, which are enforced through most states’ rate filing processes. American Academy of Actuaries, “Critical Issues in Health Reform: Minimum Loss Ratios.” Washington, D.C., February 2010, available at http://www.actuary.org/pdf/health/loss_feb10.pdf.
- 6 <https://www.mahealthconnector.org/portal/site/connector/>
- 7 Several health maintenance organizations in Washington State also offer individual coverage.
- 8 While concern exists about the fragility of Washington’s individual market, the small group market is showing even greater stress. Enrollment in small group plans has been rapidly declining, while enrollment in association health plans, which do not have to meet the same rating standards, is increasing.
- 9 Many of the Texas carriers are small, and do not report data to NAIC.
- 10 The PPACA established a grants program for states to help them improve their health insurance review and reporting processes, including developing needed infrastructure and data. See http://www.hhs.gov/ociio/initiative/final_premium_review_grant_solicitation.pdf.
- 11 A growing number of states and regional associations of states are developing all payer data bases that could provide information on health care utilization and patient characteristics. Data definitions and system architecture varies across these systems, as do the rules governing access to the data. See, for example, *Establishing A Plan For Standardizing All-Payer Claims Data Collection, Meeting Minutes*, May 6, 2009, National Association Of Health Data Organizations, Regional All-Payer Health Information Council, available at http://www.raphic.org/pdf/200905_stakeholders_meeting_minutes.pdf.
- 12 Additional information on state-mandated individual market guarantees is provided in the Kaiser Family Foundation State Health Facts report, posed at <http://www.statehealthfacts.org/comparabletable.jsp?ind=353&cat=7>.