

# Implications of the COVID-19 pandemic on medical loss ratio for health plans

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The COVID-19 pandemic will have a significant impact in all segments of healthcare for a prolonged period. As such, health plans have critical financial decisions to make in the upcoming months with limited data available and wide uncertainty on how the pandemic will transition toward the end of 2020 and into 2021. This paper explores how COVID-19 may impact a health plan's medical loss ratio (MLR) requirements in general and provides specific considerations for the commercial, Medicare Advantage, and Medicaid markets in 2020 and going forward.

## Medical loss ratio formula

The medical loss ratio (MLR) measures a health plan's spending on medical claims and allowable quality investments as a portion of total premium revenue net of taxes and allowable deductions. The Patient Protection and Affordable Care Act (ACA) standardized federal MLR requirements and introduced minimum MLR standards in the commercial and Medicare Advantage markets. The Medicaid Managed Care final regulation published in May 2016 introduced standards for the calculation and reporting of MLR for Medicaid plans. There are key differences between each market and across states, but in general, if a health plan's MLR for a particular state or market is below the prescribed minimum for that state or market, it must pay a rebate based on the difference between the calculated MLR and the prescribed minimum.<sup>1</sup> This rebate is payable to individual consumers in the commercial market, to the federal government for Medicare, and split between states and federal government for Medicaid in states that require remittance.

The MLR formula varies by line of business, but the basic structure of the MLR formula in each market is as follows:

$$MLR = \frac{\text{Incurred Claims} \pm \text{Numerator Adjustments}}{\text{Earned Premium} \pm \text{Denominator Adjustments}} + \text{Credibility Adjustment}$$

Adjustments and MLR standards specific to each market segment are provided in Figure 1 on page 2.

## COVID-19 initial MLR impact

### NET CLAIMS REDUCTIONS

Due to the COVID-19 pandemic, many healthcare services have been deferred and/or eliminated in 2020, leading to a reduction in 2020 claims relative to prior years. The claims reduction for the second quarter of 2020 was more pronounced due to the lockdown provision in effect in most states. Based on national Bureau of Economic Analysis data published by the U.S. Department of Commerce, personal consumer expenditures on nonpharmaceutical healthcare services declined by over 18% in the second quarter of 2020 relative to the second quarter of 2019. The main drivers are outpatient services, which declined by approximately 20%, and dental services, in particular, which declined by nearly 45% during this time period.<sup>2</sup>

The behavior for the third and fourth quarters of 2020 is harder to predict and will vary depending on local conditions, government reactions to how the pandemic continues to develop, and the possibility of a second COVID-19 wave. Pent-up demand from the significant reductions experienced was expected at first to offset the initial reductions, but the prolonged high incidence rate of COVID-19 may still generate additional deferrals of care as well as limit provider availability to maintain or exceed the volume of patients prior to the pandemic. If overall 2020 incurred claims are lower than were projected by health plans when setting premium rates, this would result in a decrease to the MLR relative to expectations.

FIGURE 1: MLR FORMULA NUANCES FOR COMMERCIAL, MEDICARE ADVANTAGE, AND MEDICAID MARKETS

|                                     | COMMERCIAL <sup>3</sup>  | MEDICARE ADVANTAGE <sup>4</sup>  | MEDICAID <sup>5</sup>  |
|-------------------------------------|--|--|--|
| <b>Minimum MLR</b>                  | 80% individual and small group <sup>6</sup><br>85% large group           | 85%  | At least 85% if remittance required by the state   |
| <b>Level of aggregation</b>         | State and market segment   | Contract   | Determined by the state  |
| <b>MLR numerator adjustments</b>    | + Quality improvement expenses<br>+/- Premium stabilization programs**   | + Part D federal reinsurance subsidy<br>+ MA rebate for Part B premium<br>+ MSA enrollee deposit<br>+ Quality improvement expenses****           | + Quality improvement expenses<br>– Provider pass-through payments and reimbursements<br>+ Value-added services that are nonstate plan services<br>+/- Applicable state solvency fund payments or receipts |
| <b>MLR denominator adjustments*</b> | – Taxes and fees   | + Part D federal reinsurance subsidy<br>+ MA rebate for Part B premium<br>+ MSA enrollee deposit<br>+/- Part D risk corridor<br>– Taxes and fees | – Taxes and fees<br>– Bonus incentives paid to MCOs<br>– Provider pass-through payments and reimbursements<br>+ Uncollected copayments   |
| <b>Credibility adjustment</b>       | Between 1,000 and 75,000 life years include deductible factor adjustment | MA: Between 2,400 and 180,000 member months<br>PDP: Between 4,800 and 360,000 member months  | Standard plans: Less than 380,000 member months<br>LTSS only: Less than 45,000   |
| <b>MLR time period</b>              | Three years***   | One year   | Twelve month rating period defined by the state  |

\* Medicare Advantage MLR denominator includes CMS risk-adjusted revenue.

\*\* Includes risk adjustment, reinsurance, and risk corridors.

\*\*\* MLR rebates based on three-year averaging beginning in 2014.

\*\*\*\* Includes contingent benefit and lawsuit expenses, fraud reduction expenses, and improving healthcare quality expenses.

## PREMIUM CREDITS AND COST-SHARING RELIEF

In response to lower claims, many health plans from small to large health insurers and across all markets have offered premium credits or holidays and/or cost-sharing relief to consumers.<sup>7</sup> Many health plans and the Centers for Medicare and Medicaid Services (CMS) have instituted cost-sharing reductions and/or waivers to support members in accessing care. In addition, partly due to government emergency requirements, many preauthorizations or managed care procedures are waived during the pandemic. Finally, other plans have expanded benefit coverages, including nonprimary health-related benefits for Medicare Advantage plans, to further support members. Many of these actions would result in higher MLRs, either as a decrease to the premium or as higher paid claims and/or eligible quality initiatives.

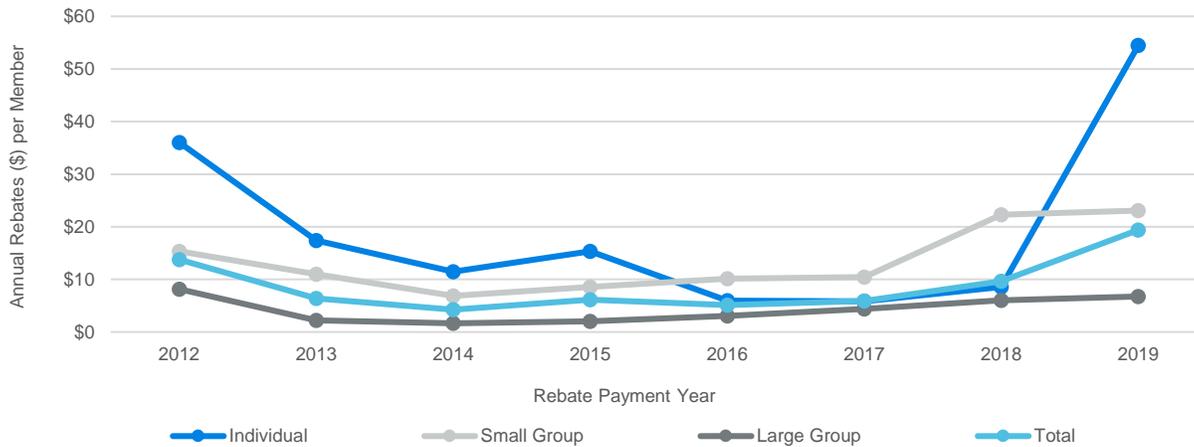
## Market-specific considerations

### COMMERCIAL

The minimum MLR requirements under the ACA first took effect in the individual and group commercial markets in 2011 and were first payable to consumers in 2012.<sup>8</sup> Total MLR rebates paid to consumers across the fully insured individual, small group, and large group commercial markets declined from over \$1 billion in 2012 to \$0.5 billion or less each year from 2014 to 2017, but have since increased dramatically to \$0.7 billion in 2018 and \$1.4 billion in 2019.<sup>9,10</sup> Furthermore, MLR rebates are projected to exceed \$2.5 billion in 2020.<sup>11</sup>

Figure 2 shows MLR rebates paid per insured member each year by market segment. This figure demonstrates that the growth in recent years is mainly attributable to the individual market, which has experienced high volatility in premium rates in recent years, largely in response to the federal defunding of cost-sharing reduction (CSR) subsidies and the removal of the individual mandate penalty. As a result, the average one-year individual market MLRs have declined from a peak of 103% in the 2015 reporting year to 70% in 2018 and 79% in 2019.<sup>12</sup>

FIGURE 2: MLR COMMERCIAL REBATES PER MEMBER BY YEAR AND MARKET



Source: Milliman's analysis of MLR Public Use files for 2011-2018 Reporting Year (see <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr>).

Since 2014, MLR rebates in the commercial market are based on a three-year averaging methodology in which MLR rebates paid in a given year are based on financial results from the prior three calendar years. As such, the lower claims in 2020 as well as the historically low MLR results in 2018 and 2019 will have implications on MLR rebates paid in 2021 to 2023. These considerations may have contributed to the relatively low impact that individual and small group market health plans attributed to COVID-19 in their 2021 premium rates.<sup>13</sup>

For individual plans approaching the MLR rebate threshold, there are a number of strategies described in Milliman's white paper on MLR rebates in the individual market. Strategies include deferring new business reporting and utilizing all permitted adjustments under the prescribed MLR calculation, such as applying a credibility adjustment when applicable and using the default allowable quality improvement expense of 0.8% of earned premium if beneficial.<sup>14</sup> One such strategy allows health plans that owe rebates the option to look at each individual reporting year's rebate using the current year's credibility adjustment, cap the total rebate at the three-year aggregate amount, and take credit for rebates paid in prior years to determine an outstanding rebate liability.<sup>15</sup> This approach is one way to limit lower loss ratios in one year (e.g., 2020) from carrying forward to the future.

Both state and federally run ACA-compliant markets have taken action in 2020 in response to COVID-19 that may have implications on MLR. In state-based markets, 12 states implemented COVID-19 special enrollment periods allowing the uninsured to sign up for coverage outside the annual enrollment period.<sup>16</sup> While federal marketplaces did not adopt these special enrollment periods, CMS issued guidance in August 2020 temporarily allowing individual and small group health plans to

offer premium credits in 2020.<sup>17</sup> For MLR reporting purposes, CMS issued an interim rule clarifying that these premium credits would be treated as reductions to earned premium in the denominator of the MLR formula.<sup>18</sup> Therefore, by offering premium credits, commercial health insurers can offset decreases in 2020 MLRs that would result from lower claims.

#### MEDICARE ADVANTAGE

Medicare Advantage organizations (MAOs) not only have to think about potential rebate remittances to CMS for the 2020 MLR reporting year but also must take into account possible additional CMS sanctions. MAOs with an MLR less than 85% for three or more consecutive years are prohibited from enrolling new beneficiaries. If an MAO's MLR is less than 85% for five consecutive years, CMS can terminate the contract.

Another consideration for 2020 MLR reporting is how the COVID-19 pandemic will impact different types of MA plans, such as general enrollment plans versus special needs plans (SNPs). In particular, institutional SNPs (I-SNPs) were hit hard by COVID-19, given that about 40% of U.S. COVID-19 deaths are linked to individuals in nursing homes.<sup>19</sup> MAOs with I-SNPs should review the 2020 claims and revenue of those members who have passed away and the profitability of those members to understand the impact on their 2020 MLRs.

For 2021 MLR reporting, MAOs need to consider how claims deferrals will affect their 2021 risk-adjusted premium earnings in their MLR formulas. The 2021 risk scores used in the risk adjustment are based on 2020 diagnoses, which could result in a reduction of 3% to 7% in 2021 risk scores (depending on the level of resumed claims for 2020), as members avoided medical care in early 2020.<sup>20</sup> Given this, 2021 MLRs could be higher as the risk-adjusted revenue could be lower. However, CMS

provided guidance on April 10, 2020, that will allow MAOs to submit diagnoses from telehealth visits for risk adjustment.<sup>21</sup> This should dampen the reduction in revenue from deferred claims as these diagnoses will count toward risk adjustment.

Looking beyond 2021, star rating implications on revenue and, in turn, on MLR need to be considered. A MAO's star rating affects CMS revenue (MLR denominator) as a star rating of 4.0 or greater results in bonus payments and, therefore, a lower MLR. Based on CMS guidance,<sup>22</sup> the 2022 plan year star rating is expected to be the same as the 2021 star rating because CMS is delaying the data submission requirements due to COVID-19. Further, the 2023 plan year star rating is based on 2020 dates of services, which can result in lower star ratings and lower revenue if MAOs don't focus on quality initiatives in 2020.

## MEDICAID

Medicaid is funded jointly by states and the federal government, but administered by states according to federal requirements.<sup>23</sup> As such, each individual state or territory determines how to run its own program. Vast differences exist, ranging from fee-for-service (FFS) programs to fully integrated managed care models. This flexibility also applies to the MLR requirements. States have flexibility in deciding whether a remittance payment is required, as well as setting up the minimum MLR, as long as it is at least 85%. Additional considerations specific to Medicaid plans are discussed in detail in the referenced Milliman white paper.<sup>24</sup>

As discussed in detail in Milliman's white paper on Medicaid emergency waivers during the COVID-19 pandemic,<sup>25</sup> states have access to Section 1135 "blanket waivers" issued by CMS, which are related to ensuring that sufficient capacity is available to meet the needs of Medicaid recipients. Additional flexibility is available under emergency 1115 waivers to assist states in making temporary eligibility changes as well as to enable program changes and emergency funding options. Although subject to CMS approval, 1115 waivers could be used to enable hardship payments to providers, invest in infrastructure or new services that will better prepare the state to deal with future emergencies, expand eligibility for affected individuals or other enrollment process waivers, and enhance covered services, among other uses. The referenced paper provides a nuanced discussion of each of these options as well as provides a broader look at 1135 waivers and specific considerations for managed care contracts.

CMS also provided additional guidance for states to consider possible adjustments to managed care contracts and rates, in particular as they relate to providers.<sup>26</sup> Opportunities are

available for Medicaid agencies to provide funding to healthcare providers, but it is important to evaluate the corresponding federal requirements as they relate to the amount and structure of provider payments.<sup>27</sup> Among the options available are adjustments to the capitation rates for temporary increases to FFS provider payments, requiring retainer payments to certain providers to maintain capacity and access to services, and other temporary enhanced provider payments.<sup>28</sup>

The use of waiver dispositions would likely result in additional payment flows that ideally, when coordinated among state Medicaid agencies and participating managed care organizations, could result in supporting provider shortfalls while ensuring beneficiary access to care. Well-designed strategies that, for example, increase provider payments as utilization is reduced could be combined with MLR requirements to maximize the availability and efficiency of healthcare funds. In addition, several states have enacted risk sharing and risk corridor mechanisms that can also mitigate the impact of potential MLR rebates.

Medicaid plans will also likely be affected by an increase in enrollment as the economic toll of the pandemic continues to have a significant impact on unemployment. At the same time, health plans can anticipate budgeting challenges as both state and federal government deficits continue to increase and additional pressure on achieving additional savings is passed on to managed care targets. Given the significant difference in how each state manages the Medicaid program, health plans should reach out to their respective Medicaid agencies to evaluate resulting experience and coordinate appropriate steps to mitigate the impact of COVID-19 utilization shifts.

## COVID-19 future implications and considerations

There are infinite implications related to COVID-19 that will continue to challenge health insurers and the general healthcare market. Many will require innovative approaches and coordination among stakeholders to efficiently manage the pandemic. As it relates to the MLR requirements, the following list provides some initial considerations that can help address the risk identified above. As is often the case for COVID-19, there are more questions than answers at this stage.

- **Telehealth:** Will telehealth replace certain in-person office visits? Can telehealth reduce or increase health insurer claims costs? Prior to COVID-19, telehealth visits were typically less expensive than in-person office visits. However, telehealth could result in increased utilization as individuals find telehealth visits convenient.<sup>29</sup>

Additionally, there has been tremendous flexibility in telehealth services due to COVID-19 such as expanded service range to include metropolitan areas, expanded professional types and services, including audio-only services, etc.<sup>30</sup> Can these new flexible benefits be the new "norm" going forward?

- **Vaccine availability:** When will a vaccine be available? Will members feel confident about its safety and efficacy to take it when it is available? How much will it cost? Who will pay for the vaccine—health insurers, or will there be federal funding? If health insurers pay for the vaccine, will there be cost-sharing relief as with COVID-19 testing? At this point, there are many unknowns about the COVID-19 vaccine, but the U.S. Department of Health and Human Services (HHS) and Department of Defense (DoD) have recently released information on the distribution strategy, which should be considered by health plans.<sup>31</sup>
- **Enrollment shifts:** Will there be shifts in enrollment in 2021 across markets as seen in 2020? How will these shifts across markets affect claims costs as potentially sicker or healthier members enroll? The U.S. unemployment rate was 14.7% in April 2020,<sup>32</sup> resulting in a shift in health insurance coverage as individuals lost their employer-sponsored insurance (ESI). A Milliman study projects that in 2021 approximately 6.2 million people across the United States will have lost ESI coverage due to COVID-19. Of those 6.2 million, approximately 45% are expected to become uninsured, about 40% will enroll in Medicaid and the Children's Health Insurance Program (CHIP), and 15% will enter the ACA individual market.<sup>33</sup> Additional Medicaid and CHIP enrollment is also anticipated to shift from the uninsured and the ACA individual markets in 2021.
- **2022 premium rate setting:** How will health plans' 2020 claims experience affect future premium ratings? There will be added complexity around 2022 premium rate setting for all markets as base experience will not only reflect COVID-19 claims and testing but also low claims volume as members avoided the doctor. However, some of these deferred services could be rendered in the latter half of 2020 as health plans reach out to members to ensure they fill those avoided services.
- **Pent-up demand:** What level of deferred services will come back in 2020 versus 2021? Will there be a second COVID-19 wave in 2020 resulting in more 2021 pent-up demand? There is a high level of uncertainty on not only 2020 claims levels but also 2021. The pent-up demand will vary by state as COVID-19 is spreading across the country at different times and rates. The timing of when deferred services are expected to come back (if at all) is based upon many

assumptions such as when lockdown began, the strength and duration of the lockdown, the time period that deferred services are expected to return, and the expected shape of the return curve (returns peak sooner or later, or assuming a normal distribution).

Significant research and information is being provided by academics, health experts, economists, and others who can aid actuaries in developing scenarios to evaluate the financial impact of COVID-19. The estimates need to account for both the initial impact of the outbreak as well as short-term to mid-term considerations that affect MLR estimates (i.e., periods of one to three years). Based on the development of prior influenza pandemics,<sup>34</sup> Figures 3 and 4 are illustrative graphs that can be used as a starting point to evaluate the anticipated level of deferred care based on the infection or incidence rate.

Figure 3 on page 6 represents a "Double Wave" scenario with a second COVID-19 wave (or second spike in infection rates) in the fourth quarter of 2020 accompanied by another spike in deferral in care (although not as large as the second quarter of 2020).

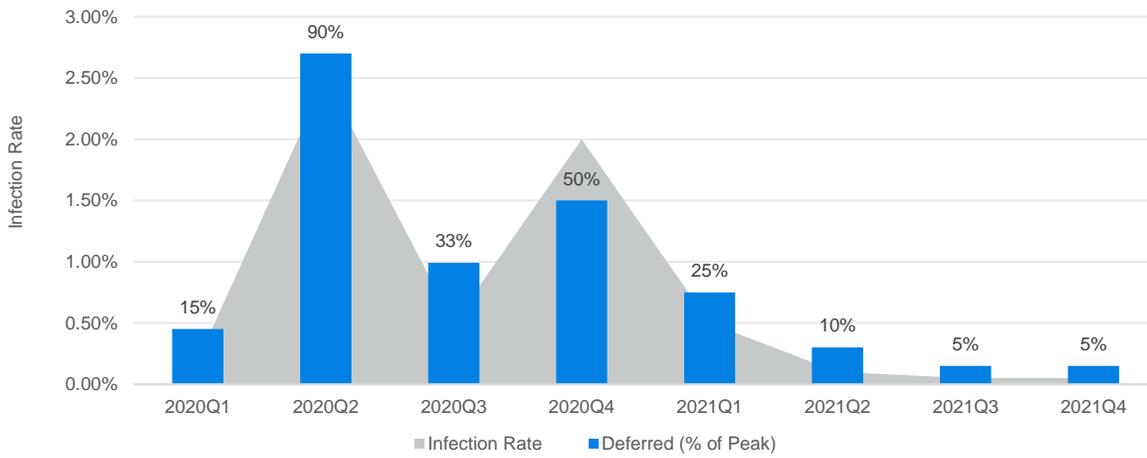
Figure 4 on page 6 represents a "Slow Burn" scenario where COVID-19 cases slowly decline through the end of 2021. In general, we anticipate higher levels of deferred care and subsequent pent-up demand as the infection rate increases. The highest level of deferred care occurred in the initial lockdown period in the second quarter of 2020. As the pandemic progresses, we can anticipate that additional levels of deferred care will remain and can increase if another infection rate spike occurs.

Additional models would be needed to project the impact of how pent-up demand will affect future cost, as well as the cost increases driven by the cost of care and/or testing for COVID-19. By creating multiple scenarios and closely monitoring emerging experience, actuaries can better advise their health plans.

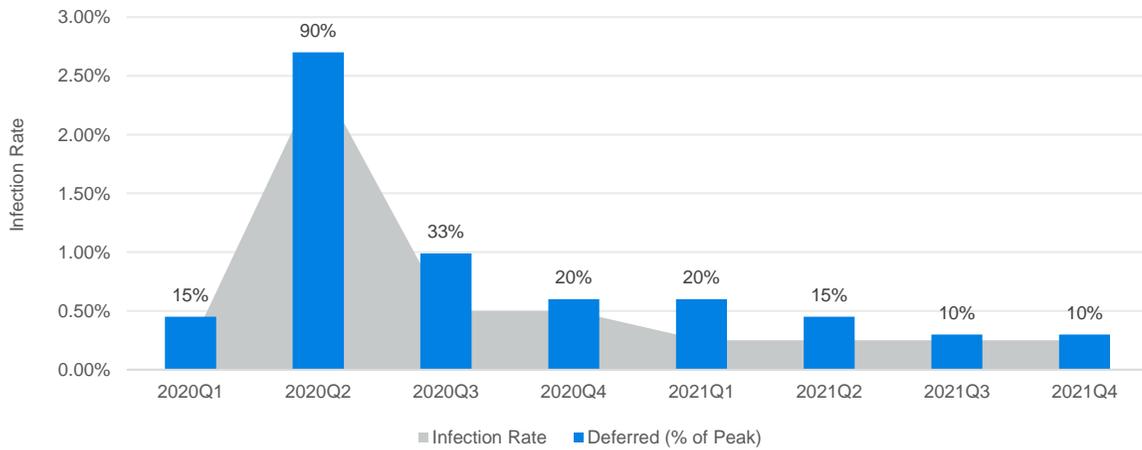
## Limitations and caveats

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**FIGURE 3: ILLUSTRATION OF "DOUBLE WAVE" SCENARIO WITH A SECOND COVID-19 WAVE IN THE FOURTH QUARTER OF 2020**



**FIGURE 4: ILLUSTRATION OF "SLOW BURN" SCENARIO WHERE COVID-19 CASES SLOWLY DECLINE THROUGH THE END OF 2021**





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## ENDNOTES

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