MILLIMAN WHITE PAPER

Pandemic-induced medical loss ratio opportunities

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For many populations, medical expenditures in the United States were down in 2020 due to deferred and forgone care associated with the COVID-19 pandemic, leading to lower than expected medical loss ratios (MLRs). For insurers, who must comply with state and federal minimum MLR regulations or pay costly rebates and remittances, this situation brings with it both challenges and new opportunities for strategic investment.

Due to the three-year rolling window for commercial MLR calculation, commercial insurers in particular have a unique opportunity to improve their MLR positions while furthering strategic goals through targeted investment in quality improvement activities.

While actual costs vary by insurer, the Milliman Medical Index showed a 4.2% decrease in 2020 medical costs. Combining that reduction with the expected increase of 4.1% from 2019 to 2020, created higher than expected profits for medical costs and for administrative costs. While the medical costs need to be mitigated to comply with MLR rules, the administrative cost windfall does not. See Figure 1 for an illustration of the effect of the lower medical costs.

While some payers have given premium holidays to mitigate some or all of the medical cost required rebate, and others have aggressively set their 2021 premium rates to offset their 2020 performance in the three-year MLR calculation, a few payers are using the opportunity to make strategic investments in what the MLR regulations call "quality improvement activities." A summary of Milliman's observations regarding payer MLR strategies may be found in our recent report for licensees of the Milliman Health Cost Guidelines, "*COVID-19 impacts and considerations: A supplement to the 2021 Health Cost Guidelines*." An excerpt from that report is provided at the end of this paper.

Milliman has been helping many of our clients navigate this opportunity as they consider how to invest in next-generation clinical management or digitally transform their analytics and reporting.

MedInsight®, Milliman's flagship healthcare analytics system, offers a variety of solutions and services for health insurers. Many of them can be classified in the clinical services and quality improvement category and, thus, count toward MLR.

MedInsight solutions are designed to help health insurers achieve organizational improvement through the leveraging of their data assets for better decision making. MedInsight utilizes a variety of analytic models that identify cost savings and clinical quality of care improvement opportunities, often by significant amounts, and then our consulting experts help insurers develop and execute a plan to pursue these opportunities.

Next-generation clinical medical management strategies leverage technology to increase the portfolio of tools payer and provider organizations can use to positively impact the efficiency and quality of medical care for members and patients.

These strategies include:

1. A renewed focus on primary care that uses powerful claims-based analytics integrated into electronic medical records systems allowing physicians to see a comprehensive "whole patient" view that enables optimal clinical decision support to be part of the physician's standard workflows.
2. Highly flexible provider profiling analytic models that can be customized as needed to meet the ever-increasing complexity of healthcare and the need to be able to match profiling metrics to reimbursement contracts.
3. Leveraging the full value of telemedicine by true integration of telemedicine into healthcare delivery. Examples include using telemedicine as a standard follow-up for many procedures and illness-driven office visits.
4. Assessment of the effectiveness of current population health programs to improve quality of care, eliminate waste, and reduce avoidable utilization.
5. Measuring and monitoring population disease burden to allow for community-based public health planning.
6. Customized and multifactorial case finding for current population health clinical programs.
7. Measurement and ongoing monitoring of clinical guidelines compliance and opportunity improvement guidance.

Technology innovations have opened up tremendous opportunities to improve payer performance using analytics and reporting. To leverage these advancements, many health companies are implementing some type of digital transformation. Many of these strategies could qualify under the MLR regulations as Quality Improvement Activities. For example:

1. Improved analytics and reporting that help providers identify opportunities to improve cost efficiency and close quality gaps.
2. Increased use of cloud technologies to speed up reporting, reduce full-time equivalent (FTE) employee needs, and improve data exchange with providers and vendors.
3. Increased use of advanced analytics, such as Milliman products including the Health Waste Calculator, Guideline Analytics, Milliman Advanced Risk Adjusters™ (MARA™) risk scores, Chronic Conditions Hierarchical Groups (CCHGs), GlobalRVUs (GRVUs), and MedInsight Benchmarks.
4. Improved benchmarking that accounts for patient differences and mitigates the oft cited provider concern that "my patients are sicker."
5. Adding new data sources like electronic medical records, lab values, and social determinants of health.

FIGURE 1: SIMPLIFIED SINGLE-YEAR MLR CALCULATION – ILLUSTRATIVE EXAMPLE OF PANDEMIC IMPACT AND STRATEGIC QIA INVESTMENT OPPORTUNITY

Line Item	No Pandemic (baseline scenario)	Pandemic (suppressed medical expenditures)	Pandemic, With Strategic QIA Investment
A. Adjusted Incurred Claims PMPM	$500	$460	$460
B. Improving Healthcare Quality Expenses	$0	$0	$30
C. Federal Risk Adjustment Program Net Receivable	$30	$30	$30
D. Medical Loss Ratio Numerator (A+B-C)	$470	$430	$460
E. Total Direct Premium Earned	$600	$600	$600
F. Federal and State Taxes and Licensing or Regulatory Fees	$25	$25	$25
G. Medical Loss Ratio Denominator (E-F)	$575	$575	$575
H. Medical Loss Ratio (D/G)	81.7%	74.8%	80.0%
I. Anticipated Rebated (max of $0 and [80% - H] x G)	$0	$30	$0
J. Administrative Costs	$86	$86	$86
K. Gain/(Loss) Margin (G – D – J – I)	$19	$29	$29
L. Gain/(Loss) % of Premium (L / E)	3.1%	4.8%	4.8%
M. Additional Funds for Strategic Investment vs. No Pandemic (Δ in [B+L])	N/A	$10	$40

Figure 1 is a simplified one-year illustration for a payer's individual coverage Affordable Care Act (ACA) business. The first column shows the planned results. The second column shows the impact of pandemic-impacted medical costs. Note that of the $40 in reduced medical costs, only $30 per member per month (PMPM) must be mitigated for MLR rules and $10 PMPM is additional profit that can be used for strategic investments. In the third column, we show that if the $30 can be invested within three years in quality improvement activities (QIA), then the full $40 PMPM could be used for strategic investments.

Medical loss ratio reporting and requirements excerpted from: COVID-19 impacts and considerations: A supplement to the 2021 Milliman Health Cost Guidelines™. The full supplement for 2021, as well as the forthcoming 2022 version, is available to clients who license the Milliman Health Cost Guidelines.

Due to deferred and forgone care associated with the pandemic, insurers may post historically low medical loss ratios* (MLRs) in 2020 across their lines of business. This raises significant strategic implications and opportunities for insurers seeking to mitigate poor MLR performance and substitute targeted investments in place of a steep rebate liability. These implications and opportunities are unique for issuers in commercial markets, as the rolling three-year window for commercial MLR calculation means financial results will persist in reported MLRs through the 2022 reporting year. For example:

- **Aggressive rating:** Commercial insurers that anticipate being in a rebate position may be in a position to take on more risk and set 2021 and 2022 rates more aggressively or with lower margins than would otherwise be the case. This is because the MLR rebate math effectively blunts both the upside of raising rates (as increased revenue will only lead to higher rebates) and the downside of excess benefit expenses (as increasing the MLR numerator reduces the accrued rebate liability). However, temporary distortions on competitive rate relationships introduced by this approach could begin to unwind as the impact of low 2020 MLRs diminishes in future reporting periods.
- **Provider payment increases:** Foreseeing that they are already in a rebate position, plans may be willing to draw this accrued liability down by negotiating higher reimbursement with providers than they would otherwise, in return securing a broader network and/or additional quality and care management commitments from providers.
- **Quality improvement activities:** Plans can count expenditures for certain qualifying quality improvement activities (QIA) toward the MLR numerator. Investments in QIA can provide an appealing alternative to rebates, by simultaneously adding value and improving health outcomes while reducing rebate liability through a higher MLR numerator. In order to receive this credit in the MLR numerator, plans must fulfill specific documentation and accounting requirements to demonstrate that the expenses comply with CMS guidance and the regulatory definition of QIA.
- **Midyear benefit increases and premium credits:** In markets that permit midyear changes in benefits and premiums, insurers may consider increasing enrollees' benefits or applying premium credits to temporarily reduce the cost of coverage. CMS has explicitly authorized premium credits for this reason in the individual and small group markets. Such measures improve a plan's MLR position by increasing benefit expenses or reducing revenue while also providing immediate value to members (in contrast to the delayed timeline for rebate distribution). Furthermore, the goodwill created by these measures may improve customer loyalty and likelihood of reenrollment.
- **Community benefit expenditures:** In some circumstances and subject to limitations, health plans can reduce the MLR denominator with expenditures for activities or programs in the broader community that seek to improve health outcomes, improve access to care, and enhance public health, referred to as community benefit expenditures (CBE). In most situations, commercial health plans can exempt CBE expenses from the MLR denominator for an amount up to the highest premium tax rate in the state or, in some situations, 3% of earned premium. To the extent that plans have some remaining allowance for a CBE exemption, they may choose to invest in CBE, which can have both short-term and long-term benefits to their healthcare systems and the general public.
- **Defer new business reporting:** In cases where at least half of an issuer's business is attributable to new policies, MLR regulations permit the organization to defer all revenue and expenses to the subsequent year's calculation. This allows the insurer to delay liability for rebate payments by a year and can sometimes result in a lower ultimate liability (e.g., if the MLR exceeds the minimum threshold the following year).

Some payers have also given cash advances to providers for anticipated future claims liabilities in order to help providers bridge COVID-19-related cash flow disruptions. However, these advance payments are not eligible to be counted in the MLR numerator for a reporting period in the absence of a qualifying covered benefit provided in return. Expenses must be accounted for on an incurred basis, gross of reinsurance, and can only be considered as benefit expenses if paid in return for a qualifying covered benefit (otherwise, the expense would be counted as an administrative expenditure).

* The ACA introduced a federal minimum medical loss ratio (MLR) requirement for insurers issuing commercial (beginning in 2011) and Medicare Advantage (beginning in 2014) health plans, requiring insurers to demonstrate that a sufficient portion of revenue is spent in service of its members, rather than toward administrative expenses or organizational surplus. The Medicaid and Children's Health Insurance Program (CHIP) managed care final rule required an MLR financial reporting requirement for all Medicaid managed care plans with contracts beginning on or after July 1, 2019.

To gloss over some nuances, it essentially represents the ratio of risk-adjusted benefit expenses plus quality improvement activities (QIA, together the numerator) divided by premium revenue less taxes and fees (the denominator). In commercial markets this ratio is calculated using a rolling three-year average through the reporting year, whereas for Medicare Advantage and Part D it is limited to experience from the reporting year. The requirement to rebate, rather than only report, for Medicaid managed care plans is determined by each state separately.

In cases where the calculated MLR exceeds a federally or state-mandated minimum, the insurer must issue rebates. These rebates are payable to individual insurance policyholders, group insurance sponsors, and potentially to employer plan members in commercial insurance, due as "remittances" to CMS for Medicare Advantage organizations, and may be payable as rebates to the Medicaid program by Medicaid managed care plans. CMS may apply additional penalties to Medicare Advantage organizations that fail to meet minimum MLR requirements for multiple consecutive years.

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