Impact of Medical Loss Ratio Requirements Under PPACA on High Deductible Plans / HSAs in Individual and Small Group Markets

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I. INTRODUCTION

This study examines the impact of the medical loss ratio (MLR) requirements under section 2718(b) of the Public Health Services Act (PHSA) on high-deductible health insurance plans (HDHPs) and plans with health savings accounts (HSAs) in the individual and small group comprehensive medical markets. This report was commissioned by the American Bankers Association. HSA-qualified HDHPs have deductible levels of at least $1,200 for single coverage and $2,400 for family coverage. As the average deductible levels for single coverage in the individual and small group markets are approximately $2,700[1] and $1,700[2] respectively, we refer to high-deductible plans in this report as those with deductible levels higher than the average in a given market. The referenced surveys by America's Health Insurance Plans (AHIP) indicate that the average single deductible for HSA-qualified HDHPs was about $3,200 in 2009 for the individual market and $2,800 in 2010 for small groups. Our analysis is based upon 2010 cost levels.

Data used in this report include information from the 2010 National Association of Insurance Commissioners (NAIC) Supplemental Health Exhibit compilations, Milliman's Healthcare Reform Database, Milliman *Health Cost Guidelines*™, and AHIP surveys.

CAVEATS AND LIMITATIONS ON USE

A number of caveats and limitations on use apply to this report:

- The results may not be suitable for purposes other than assessing the relative impact of the MLR on health plans, and in particular, on high-deductible health plans with or without health savings accounts (HSAs).

- This letter has been prepared solely for the internal use of, and is only to be relied upon by, the American Bankers Association. Although Milliman understands that the final results may be distributed to third parties, Milliman does not intend to benefit, or create a legal duty to, any third-party recipient of its work. If the final results are distributed to third parties, they should be distributed only in their entirety.

- The final results are technical in nature and are dependent upon specific assumptions and methods as noted in the report or supporting attachments. No party should rely upon the results without a thorough understanding of those assumptions and methods.

- Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for our analysis. It is certain that actual experience will not conform exactly to the assumptions used in our analysis. Actual experience will deviate because of a variety of influences including, but not limited to, changes in insurance products and practices, and adjustments to reflect new regulations.

- In developing projections or estimates, we relied on data and other publicly available information. We have not audited or verified this data and other information. We performed a review of the data used directly in our analysis for reasonableness and consistency between various publicly available sources. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We have reviewed both historical and the most recent data available during the course of our analysis so that our final results reflect the most current knowledge available to us.

[1] America's Health Insurance Plans (AHIP, October 2009). Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits. Results trended by Milliman to 2010 levels.
[2] AHIP (July 2011). Small Group Health Insurance in 2010: A Comprehensive Survey of Premiums, Product Choices, and Benefits.

- The views expressed herein are made by the authors of this report and do not necessarily represent the opinions of Milliman, Inc.

- Mark Litow, Jim O'Connor, and Al Schmitz are Fellows of the Society of Actuaries and Members of the American Academy of Actuaries. They meet the qualification standards for performing the analyses contained in this report.

- The American Bankers Association may release this report into the public domain as long as it is released in its entirety. No excerpts should be released to the general public without our express written permission.

II. EXECUTIVE SUMMARY

The impact of the medical loss ratio (MLR) requirements under the Patient Protection and Affordable Care Act (PPACA) is likely to be greater on high-deductible health plans (HDHPs), including those with health savings accounts (HSAs), than other types of comprehensive medical plans. The primary issues of concern for HDHPs include:

- On an expected value basis, the claim portion of the premium dollar is lower for HDHPs than that for average deductible plans (the high-deductible plan requires the covered persons to pay more of the cost of care). Therefore, achieving the minimum loss ratio for an HDHP means that expenses and risk charges must be lower on a dollar basis than they are for typical medical plans.

- Because of the high deductibles, fewer policyholders have claims in a year and, when they do, the typical claim amounts are higher for HDHPs. This lower-frequency / higher-average-cost scenario creates more variability in experience. The variability could result in high claims in one year and low claims in another. This increases the likelihood in any given year that high-deductible plans will fall below the 80% MLR threshold and be required to pay rebates.[3] The MLR formula credibility adjustment helps mitigate this for smaller health payers, but provides no help to larger plans. This is of particular concern for the year 2011 MLR rebate determination because the calculation includes only one year of experience. This is also true in 2012 for larger plans. In year 2013, three-year averaging takes place, which will help reduce, but not eliminate, this fluctuation rebate risk for high-deductible plans.

- Often, HDHPs are accompanied by an HSA, which covers much of the first-dollar costs before the plan's deductible is reached. The HSA amounts are currently not reflected in the MLR calculations (as of the writing of this report). Recognition of the HSA would help put the HDHP plans more in line with typical / average medical plans from an MLR impact perspective. For high-deductible and HSA plans to be viable, both from a consumer and carrier perspective under the PPACA, an adjustment to the MLR formula for the impact of HSAs may be necessary. A discussion of potential adjustments is included in Section V.

- Unless the HDHP plan deductibles increase with medical inflation, the expected annual costs under the HDHP will increase faster than under a lower-deductible plan. This means that HDHPs will require larger rate increases than typical / average medical plans, and the "unreasonable rate increase" provisions of the PPACA may make it difficult to obtain approval of the required rate increases.

These items are further discussed and supported in the body of this report. In addition, the potential future impacts of the MLR requirements on HDHPs as additional provisions of the PPACA are implemented are presented throughout.

[3] In this report, we have assumed the impact on a carrier selling only high-deductible plans in order to discuss the viability of such plans in the future.

III. IMPACT OF CLAIM LEVELS ON THE LOSS RATIO AND EXPENSES OF HDHPS

On a relative basis, high-deductible health plans (HDHPs) have lower expected claim costs than a lower-deductible plan. This is due to the greater expected cost sharing of the high-deductible plan. The tables in Figures 1 and 2 show the expected claims of different deductible levels in the group and individual markets, and estimated premiums assuming that each of the plans is priced to an 80% loss ratio.

Figure 1
Individual Market
Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level

	Deductible					
	Market Average ($2,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$164.40	$214.20	$184.55	$156.92	$138.65	$123.25
Premiums (equal to claims / 80%)	205.49	267.76	230.68	196.15	173.31	154.07
Premiums less Claims (expenses and risk margin)	41.10	53.55	46.14	39.23	34.66	30.81
Loss Ratio (claims / premium)	**80.0%**	**80.0%**	**80.0%**	**80.0%**	**80.0%**	**80.0%**

Figure 2
Small Group Market
Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level

	Deductible					
	Market Average ($1,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$266.80	$290.37	$252.43	$219.53	$191.88	$170.11
Premiums (equal to claims / 80%)	333.50	362.97	315.53	274.41	239.85	212.64
Premiums less Claims (expenses and risk margin)	66.70	72.59	63.11	54.88	47.97	42.53
Loss Ratio (claims / premium)	**80.0%**	**80.0%**	**80.0%**	**80.0%**	**80.0%**	**80.0%**

The claim costs in Figures 1 and 2 are developed by calibrating claim experience from the NAIC Supplemental Health Exhibit to a market-average deductible. Then, using the Milliman *Health Cost Guidelines* (HCGs), we estimate the expected costs for other deductible levels (the average deductible assumes embedded single deductibles within family coverage such that the overall average deductible per member is approximately equal to the single deductible).

The premium shown in Figures 1 and 2 are calculated assuming an 80% loss ratio for all deductible levels. The amount of premium dollars available for expense and risk charges decrease by deductible in this scenario.

Because a portion of a company's expense structure includes expenses that are fixed and do not vary by premium level, the MLR requirements result in a significant disadvantage for high-deductible plans, given their lower premiums. Starting with the claim levels by deductible from Figures 1 and 2, we incorporated actual expenses and premiums for the market average deductible from the NAIC Supplemental Health Exhibit to analyze the impact of fixed expenses on loss ratios in the tables in Figures 3 and 4.

Figure 3
Individual Market
Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level*

		Deductible				
	Market Average ($2,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$164.40	$214.20	$184.55	$156.92	$138.65	$123.25
Quality Improvement Expense	1.40	1.82	1.57	1.33	1.18	1.05
Other Variable Expense	24.10	30.99	26.89	23.07	20.55	18.42
Fixed Expense	14.87	14.87	14.87	14.87	14.87	14.87
Subtotal: Administrative Expenses	**$40.37**	**$47.68**	**$43.33**	**$39.28**	**$36.60**	**$34.34**
Premiums	211.77	270.84	235.67	202.91	181.24	162.98
Taxes	6.43	8.23	7.16	6.16	5.51	4.95
Medical Loss Ratio per PPACA	80.8%	82.3%	81.5%	80.5%	79.6%	78.7%

** Before credibility adjustments.*

Figure 4
Small Group Market
Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level*

		Deductible				
	Market Average ($1,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$266.80	$290.37	$252.43	$219.53	$191.88	$170.11
Quality Improvement Expense	2.36	2.57	2.23	1.94	1.70	1.51
Other Variable Expense	27.37	29.70	25.94	22.69	19.96	17.81
Fixed Expense	14.04	14.04	14.04	14.04	14.04	14.04
Subtotal: Administrative Expenses	**$43.76**	**$46.30**	**$42.22**	**$38.67**	**$35.69**	**$33.35**
Premiums	333.24	361.26	316.15	277.06	244.19	218.32
Taxes	11.94	12.94	11.33	9.93	8.75	7.82
Medical Loss Ratio per PPACA	83.8%	84.1%	83.6%	82.9%	82.2%	81.5%

** Before credibility adjustments.*

The values in Figures 3 and 4 were developed as follows.

1. The premium and expense levels for the market-average deductible were calibrated to the NAIC Supplemental Health Exhibit experience.

2. Estimates of the fixed and variable components of those expenses were developed based on a review of sample company assumptions, state filing documents, and judgment. We assumed that 80% of the "Other Administrative" expenses (lines 10.3 and 10.4 of the Supplemental Health Exhibit) were fixed per policy expenses and that 20% of "Claim Adjustment Expenses" (line 8.3 of the Supplemental Health Exhibit) were fixed expenses.

3. Using the Milliman HCGs, net per member per month (PMPM) claim costs were determined for each illustrated deductible level in relationship to the market-average claim costs from the NAIC Supplemental Health Exhibit. Note that these claim costs are identical to those in Figures 1 and 2, respectively.

4. We set the fixed expenses for each illustrated deductible level to be the identical dollar amount as those determined in Step #2 from the Supplemental Health Exhibit.

5. We set the quality improvement and other variable expenses for each illustrated deductible level to be the identical percentage of claims / premium as those determined in Step #2 from the Supplemental Health Exhibit.

6. Similarly, we set the taxes for each illustrated deductible level to be the identical percentage of premium as those determined in Step #2 from the Supplemental Health Exhibit.

7. From the above steps, we then calculated the premium for each illustrated deductible level.

8. We then calculated the resulting medical loss ratios for each illustrated deductible level using the PPACA formula [(benefits + quality improvement expense) / (premiums – taxes)].

As Figures 3 and 4 show, under the above reasonable assumptions, the loss ratios to cover the expenses of higher-deductible plans decrease as the deductible increases. Therefore, a uniform MLR requirement of 80% for individual and small group adversely affects companies that write a significant amount of higher-deductible business. Under normal market conditions, as illustrated, total dollars of expenses are already lower for these plans than for more expensive (i.e., higher-premium) plans. The MLR requirement results in the need to cut these expenses even more, which may create disincentives to offer such lower-cost plans, particularly if the insurer cannot generate reasonable risk margins.

Additional background on the MLR calculations under the PPACA and 2010 premium and expense levels for the individual and small group markets is provided in Appendix A.

The impact of the MLR on high-deductible plans will vary depending on the initial loss ratio level. Loss ratio levels in turn are influenced by many factors, and there is significant variation by state, by company, and by calendar year. Appendix B provides additional information on this variability for 2010 based on the NAIC Supplemental Health Exhibit and the Milliman Healthcare Reform Database.

IV. VARIABILITY OF HDHP CLAIMS LEVELS

One of the characteristics of high-deductible health plans is that fewer policyholders have claims in a year, but when they do, the claim amounts are generally higher than those typical for lower-deductible health plans. This lower frequency / higher average cost attribute of high-deductible plans creates more variability in claim experience from one year to the next than is typical for lower-deductible plans. The variability could result in high claims in one year and low claims in another, or may even result in low claims in several consecutive years followed by very high claims in another. Over the long run, the average loss ratios for these plans may equal or exceed the required minimum MLR thresholds, but because of the experience fluctuations, the carriers of these plans may need to pay out rebates in the good years and have no relief from losses created in poor experience years.

Prior to year 2011, carriers could build up surplus in the good years for these plans that could then be used to cover losses generated in the high claim years. The introduction of MLR rebates changes this dynamic, particularly in years 2011 and 2012. The rebate formula for 2011 considers only the claim and premium experience of 2011. As such, if 2011 claim experience is one of the low claim amount years, the carrier may likely need to pay a rebate to get its MLR up to 80%. If the carrier has a high claim year in 2011 followed by a low claim year in 2012 and does not qualify for a credibility adjustment, each year stands on its own, resulting in having to pay out rebates for its 2012 experience, even though the combined 2011 / 2012 loss ratio may have exceeded the MLR minimum. In year 2013, three-year averaging begins for all carriers, which helps reduce but does not eliminate this fluctuation risk for high-deductible plans.

The MLR credibility adjustment formula helps mitigate this fluctuation risk for smaller health plans, but provides no help to larger plans. The table in Figure 5 shows the relative fluctuation deviation factors of higher-deductible plans to a base $1,000 deductible plan. These are shown at the 25th percentile level, which is consistent with the basis for the MLR credibility adjustment factors,[4] and at the 10th percentile level. This analysis was performed using the data underlying the Milliman *Health Cost Guidelines* as its primary source.

Figure 5
Average Fluctuation Deviation Factor Relative to That of a $1,000 Deductible

	Percentile	
Deductible	**25th**	**10th**
$1,000	1.000	1.000
$2,500	1.009	1.014
$5,000	1.021	1.035
$10,000	1.043	1.068

What these factors indicate is the increased likelihood of variation that is due to deductible size relative to that of a $1,000 deductible plan. If the plan is priced to meet the minimum MLR threshold of 80%, in any given year, there is close to a 50% chance that the claim experience will result in MLRs above 80%. The carrier must pay for losses above the threshold from its surplus. There is also close to a 50% chance that the carrier will need to pay a rebate even though its plan was priced properly to meet the 80% MLR threshold. The dispersion from the target loss ratio increases as deductibles increase, which results in relatively greater rebates being paid as a percentage of premium as deductibles increase. Payment of the rebate will limit the carrier's ability to contribute adequate amounts to surplus to offset high claim payment years.

[4] Note that these are multiplicative factors, while the MLR credibility plan factors are applied to additive factors based on number of insured lives.

V. MLR IMPACT ON HEALTH SAVINGS ACCOUNTS ASSOCIATED WITH AN HDHP

High-deductible health plans (HDHPs) are often accompanied by health savings accounts (HSAs), which cover much of the first-dollar costs before a plan deductible is reached. Presently, minimum medical loss ratio (MLR) rules treat HDHPs the same regardless of the level of HSA funding that might be associated with the plan. As a result, the MLR calculation will not vary whether a plan excludes HSA funding, includes HSA funding that covers a portion of the deductible, or includes HSA funding that covers the full deductible.

For high-deductible and HSA plans to be viable, both from a consumer and carrier perspective under the PPACA, an adjustment to the MLR formula for the impact of HSAs may be necessary. One possible adjustment would include counting HSA claim payments toward benefits and premiums in the MLR calculation. Other potential adjustments such as counting full or partial HSA contributions toward premiums and benefits in the loss ratio calculation could also be considered. Some of these potential changes to the loss ratio calculation mitigate a number of problems because the loss ratios for the insurance piece could now be much closer to loss ratio levels for these plans today, meaning sufficient risk margins for carriers might be possible.

In order for the inclusion of HSAs in the MLR formula to make HDHPs more viable in a post-PPACA environment, it is important that the numerator and denominator of the MLR formula treat the HSA equally. For example, consider a $5,000 deductible HDHP in the individual market (wherein the current MLR is 78.7%, the adjusted earned premium—which comprises the denominator—is $158.03 PMPM, and the numerator is $124.37 PMPM). Assume this HDHP was accompanied by a $1,000 HSA contribution ($83.33 PMPM) of which the average member uses 65% each year. Potential MLR formula revisions accounting for the inclusion of an HSA could produce very different results. Some examples are as follows.

- If there is no HSA adjustment as is currently the case, the MLR would be $124.37 / $158.03 = 78.7%

- If we assume that the total value of the HSA annual contribution was included in both the numerator and denominator, the revised MLR would be ($124.37 + $83.33) / ($158.03 + $83.33) or 86.1%

- If we assume that the claims paid from the HSA was included in both the numerator and denominator, the revised MLR would be ($124.37 + $54.17) / ($158.03 + $54.17) or 84.1%

- If we assume that the total value of the HSA annual contribution was included in the denominator, but the benefit portion of the HSA was used in the numerator, the revised MLR would be ($124.37 + $54.17) / ($158.03 + $83.33) or 74.0%

In the last example above, applying the benefits used from the HSA in the numerator of the MLR calculation but the full value of the HSA annual contribution in the denominator of the calculation actually lowers the calculated MLR (it would increase the MLR if the insured used more than 78.7% of their annual HSA contribution). In addition, as the value of the HSA account belongs to the insured, there may be years where the insured uses much more than 65% of the contribution. This needs to be considered (by capping the amount applied to the MLR to the annual contribution or other adjustment to the formula) in the MLR calculation. Any of the above methods or other adjustment options to the MLR are certainly possible, and any option should be reviewed for all potential impacts including administrative complexity. Further analysis of potential options is outside the scope of this report; however, without some type of reform, the feasibility of these types of products under the PPACA seems poor.

VI. INFLATION IMPACT ON MLR FOR HDHPS

Unless the HDHP deductibles increase with medical inflation, the expected annual costs under the HDHP will increase faster than for a typical plan. A simple example examining the concept of deductible leveraging will help illustrate this impact.

Assume two plans are identical except the deductible of the first plan is $500 and the deductible for the second plan is $3,000. For an $8,000 procedure, the first plan pays $7,500 and the second plan pays $5,000. Assume that the next year, the cost of the $8,000 procedure increases by 5% to $8,400. The first plan would now pay $7,900 ($8,400 – $500) with an overall increase of 5.3%. In this case, deductible leveraging increased trend 0.3% (the difference between the 5.3% increase in the benefits and the 5% increase in the medical costs). The second plan would pay $5,400 ($8,400 – $3,000), resulting in an overall trend of 8.0%. The impact of deductible leveraging on the higher-deductible plan is 3.0% (the difference between the 8.0% increase in the benefits and the 5% increase in the medical costs).

As a result of the inflation impact and deductible leveraging, plans with higher deductibles will require larger rate increases than plans with lower deductibles. Components of the PPACA surrounding provisions for "unreasonable rate increases" may make it difficult to achieve the required rate increases in these situations. The end result could be an unsustainable increase in the loss ratio for high-deductible plans.

High-deductible plans may be more adversely affected if claims increase faster than premiums because loss ratio stability may be more difficult to control. If the reverse occurs, these plans would normally produce risk margins which would then be retained to offset poor experience in other years, but the MLR one-sided rebate formula will prevent this occurrence. Therefore, the MLR rebate requirements, as they are currently applied, appear to create a more serious problem for these types of plans than for lower-deductible plans.

Appendix A

Loss Ratio Background

A medical loss ratio can be simply defined as claims divided by premiums. The loss ratio has been used in health insurance for decades as one measure of return of premium dollars to policyholders. The details of the calculation need to be clearly delineated in order for the calculation to be applied on a consistent basis. Under the PPACA, the minimum medical loss ratio (MLR) requirements are 80% for small group and individual insurance. However, the definition of the MLR is more complex than just claims divided by premium. The calculation of the preliminary MLR from the NAIC Supplemental Health Exhibit is as follows.

> [Total Incurred Claims (line entry 5.0) + Deductible Fraud and Abuse Detection/Recovery Expenses (line entry 4) + Total of Defined Expenses Incurred for Improving Health Care Quality (line entry 6.3)] / Adjusted Earned Premiums (line entry 1.8)

This calculation does not include the credibility adjustment or other add-on adjustment to the loss ratio.

Premium, expense, and loss ratio information from the NAIC Supplemental Health Exhibit is included in the tables in Figures 6 and 7.

Figure 6
Summary of Individual Market Loss Ratios for Average Plan*

Category	Per Member Per Month
Earned Premium	$211.77
Regulatory Fees and Taxes	6.43
Net Adjusted Earned Premium	$205.34
Incurred Medical Claims	$164.40
Quality Improvement	1.40
Claim Adjustment Expenses	8.26
Deductible Fraud and Abuse Detection / Recover Expense**	0.07
Distribution Costs	14.19
Other Administrative	16.52
Total Administrative	$40.37
Risk Margin	**$0.57**
Medical Claims as percent of Earned Premium	77.6%
Administrative Expense as percent of Earned Premium	19.1%
Regulatory Fees and Taxes as percent of Earned Premium	3.0%
Profit as percent of Earned Premium	0.3%
Preliminary MLR (before credibility adjustments)	80.8%

** Data from SNL Financial: NAIC Supplemental Health Exhibit.*
***This adjustment used for MLR development only.*

Figure 7 Summary of Small Group Market Loss Ratios for Average Plan*	
Category	**Per Member Per Month**
Earned Premium	$333.24
Regulatory Fees and Taxes	11.94
Net Adjusted Earned Premium	$321.30
Incurred Medical Claims	$266.80
Quality Improvement	2.36
Claim Adjustment Expenses	8.69
Deductible Fraud and Abuse Detection / Recover Expense**	0.05
Distribution Costs	17.34
Other Administrative	15.38
Total Administrative	$43.76
Risk Margin	**$10.73**
Medical Claims as percent of Earned Premium	80.1%
Administrative Expense as percent of Earned Premium	13.1%
Regulatory Fees and Taxes as percent of Earned Premium	3.6%
Profit as percent of Earned Premium	3.2%
Preliminary MLR (before credibility adjustments)	83.8%

** Data from SNL Financial: NAIC Supplemental Health Exhibit.*
***This adjustment used for MLR development only.*

Appendix B

Loss Ratio Variability

The following tables show the nationwide distribution of companies falling into one of three MLR ranges:

Figure 8
Distribution of Reported Insurance Companies by Preliminary MLR Range
December 31, 2010, Supplemental Health Exhibit*
Individual Companies

MLR Range	Number of Companies	Percentage of Total Premium
Less than 75%	115	35%
75% to 90%	75	34%
Greater than 90%	205	31%

** Source: SNL Financial: NAIC Supplemental Health Exhibits. Before adjustments for credibility. Based on a total of 395 companies.*

Figure 9
Distribution of Reported Insurance Companies by Preliminary MLR Range
December 31, 2010, Supplemental Health Exhibit*
Small Group Companies

MLR Range	Number of Companies	Percentage of Total Premium
Less than 80%	74	7%
80% to 85%	149	57%
Greater than 85%	170	37%

** Source: SNL Financial: NAIC Supplemental Health Exhibits. Before adjustments for credibility. Based on a total of 393 companies.*

We grouped states by 2010 loss ratios from the Supplemental Health Exhibit. This loss ratio grouping is correlated with the level of regulation as described below.

Figure 10
Distribution States by Preliminary MLR Range
December 31, 2010, Supplemental Health Exhibit*
Individual

MLR Range	Number of States
Less than 75%	11
75% to 90%	29
Greater than 90%	10

** Source: SNL Financial: NAIC Supplemental Health Exhibits. Before adjustments for credibility.*

Figure 11 Distribution States by Preliminary MLR Range December 31, 2010, Supplemental Health Exhibit* Small Group	
MLR Range	**Number of States**
Less than 80%	10
80% to 85%	21
Greater than 85%	19

** Source: SNL Financial: NAIC Supplemental Health Exhibits. Before adjustments for credibility.*

For the loss ratio ranges above, we note that the average premium levels for the high-loss-ratio states tend to be higher than the nationwide average premium levels.

Variation by high-, middle-, and low-loss-ratio state groupings, and the resulting impact of fixed costs by deductible level, are included below.

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Figure 12 Individual Market Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level* Less Than 75% MLR Group						
		Deductible				
	Market Average ($2,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$142.92	$186.22	$160.44	$136.42	$120.54	$107.15
Variable Expense	28.99	37.20	32.31	27.75	24.74	22.20
Fixed Expense	15.31	15.31	15.31	15.31	15.31	15.31
Subtotal: Administrative Expenses	**$44.30**	**$52.52**	**$47.62**	**$43.07**	**$40.05**	**$37.51**
Premiums	210.31	268.18	233.72	201.62	180.40	162.51
Taxes	10.83	13.80	12.03	10.38	9.29	8.36
Medical Loss Ratio per PPACA	72.3%	73.8%	73.0%	71.9%	71.0%	70.1%

** Before credibility adjustments.*

Figure 13 Individual Market Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level* 75% to 90% MLR Group						
		Deductible				
	Market Average ($2,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$159.05	$207.24	$178.55	$151.81	$134.14	$119.25
Variable Expense	24.91	32.01	27.78	23.84	21.23	19.04
Fixed Expense	15.03	15.03	15.03	15.03	15.03	15.03
Subtotal: Administrative Expenses	**$39.94**	**$47.05**	**$42.82**	**$38.87**	**$36.27**	**$34.07**
Premiums	203.71	260.32	226.61	195.21	174.45	156.95
Taxes	4.86	6.21	5.41	4.66	4.16	3.75
Medical Loss Ratio per PPACA	80.8%	82.4%	81.5%	80.5%	79.6%	78.6%

** Before credibility adjustments.*

Figure 14
Individual Market
Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level*
Greater than 90% MLR Group

		Deductible				
	Market Average ($2,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$234.93	$306.11	$263.73	$224.24	$198.14	$176.14
Variable Expense	20.60	26.66	23.05	19.68	17.46	15.58
Fixed Expense	13.18	13.18	13.18	13.18	13.18	13.18
Subtotal: Administrative Expenses	**$33.77**	**$39.84**	**$36.23**	**$32.86**	**$30.64**	**$28.76**
Premiums	251.03	323.19	280.22	240.19	213.73	191.42
Taxes	3.93	5.06	4.39	3.76	3.35	3.00
Medical Loss Ratio per PPACA	95.7%	96.8%	96.2%	95.4%	94.8%	94.1%

** Before credibility adjustments.*

Figure 15
Small Group Market
Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level*
Less than 80% MLR Group

		Deductible				
	Market Average ($1,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$242.86	$264.32	$229.78	$199.83	$174.66	$154.85
Variable Expense	31.27	33.92	29.66	25.96	22.86	20.42
Fixed Expense	15.59	15.59	15.59	15.59	15.59	15.59
Subtotal: Administrative Expenses	**$46.86**	**$49.50**	**$45.24**	**$41.55**	**$38.45**	**$36.00**
Premiums	328.00	355.29	311.36	273.28	241.27	216.07
Taxes	16.36	17.72	15.53	13.63	12.03	10.78
Medical Loss Ratio per PPACA	78.8%	79.1%	78.5%	77.8%	77.0%	76.2%

** Before credibility adjustments.*

Figure 16
Small Group Market
Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level*
80% to 85% MLR Group

		Deductible				
	Market Average ($1,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$254.33	$276.80	$240.63	$209.27	$182.91	$162.16
Variable Expense	30.53	33.14	28.95	25.32	22.27	19.86
Fixed Expense	14.55	14.55	14.55	14.55	14.55	14.55
Subtotal: Administrative Expenses	**$45.09**	**$47.69**	**$43.50**	**$39.87**	**$36.82**	**$34.42**
Premiums	321.40	348.31	304.99	267.43	235.86	211.01
Taxes	11.41	12.36	10.82	9.49	8.37	7.49
Medical Loss Ratio per PPACA	82.8%	83.2%	82.6%	81.9%	81.2%	80.4%

** Before credibility adjustments.*

Figure 17
Small Group Market
Estimated Impact of Fixed Expenses on Loss Ratios by Deductible Level*
Greater than 85% MLR Group

		Deductible				
	Market Average ($1,700)	**$1,200**	**$2,000**	**$3,000**	**$4,000**	**$5,000**
Net Per Member Per Month Costs	$304.73	$331.66	$288.31	$250.74	$219.16	$194.30
Variable Expense	27.27	29.62	25.84	22.56	19.80	17.63
Fixed Expense	12.08	12.08	12.08	12.08	12.08	12.08
Subtotal: Administrative Expenses	**$39.36**	**$41.71**	**$37.92**	**$34.64**	**$31.88**	**$29.71**
Premiums	357.06	387.44	338.54	296.15	260.51	232.46
Taxes	9.77	10.60	9.26	8.10	7.13	6.36
Medical Loss Ratio per PPACA	88.4%	88.7%	88.2%	87.7%	87.1%	86.6%

** Before credibility adjustments.*