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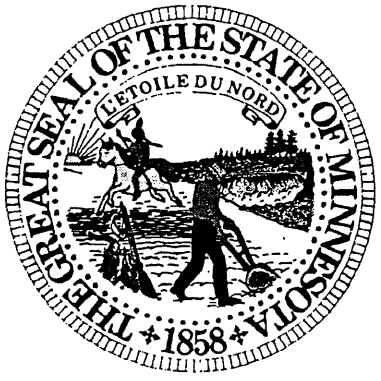
Report of 1998 Loss Ratio Experience in the Individual and Small Group Health Plan Markets

June, 1999



Minnesota Department of Commerce

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Legislative Request for Report

The 1997 Minnesota Legislature passed a law requiring the Commissioners of Commerce and Health to issue a report listing loss ratios for the individual and small group health plan markets. The text of the law appears below:

> **S.F 1208 Article 2, Section 2(g)** The commissioners of commerce and health shall each annually issue a public report listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in this state by the health plan companies that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than June 1 for loss ratios experienced for the preceding calendar year. Health plan companies shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.

Background on the Markets

Size and Trends

The individual and small employer health plan private markets provide critical medical insurance to Minnesotans who otherwise would be forced to rely on their own financial resources or public programs to pay for needed medical care. According to Issue Brief 97-15 prepared by the Health Economics Program at the Minnesota Department of Health, about 9% of Minnesotans are covered by small employer health plans, and about 5% are covered by individual health plans. The remaining population is insured by large employer plans, both fully insured and self-insured (52-55%), public programs such as Medicaid, MinnesotaCare, and Medicare (25%), or remains uninsured (6-9%).

Enrollment in small employer plans has appeared to increase substantially, from about 6% of the population to about 9%, since health care reform took effect in 1993. This is likely due to several factors. The factors include the guaranteed issue requirement that was part of health care reform and the moderate levels of

rate increases. There has apparently also been some movement from individual health plans to small employer plans. In addition, a strong economy has given small employers more ability to offer a costly but attractive benefit to their employees.

Enrollment in individual health plans has appeared to have declined substantially between 1990 and 1996, with the percent of Minnesotans in those plans moving from about 9% to about 5%. Part of the reduction is due to movement into small employer plans.

The percent of Minnesota's population that is uninsured has appeared to remain fairly constant over the last few years, in contrast to the increase in the percentage of the United States population that is uninsured.

Costs

Recently claim cost levels have increased significantly for most health plan companies, leading to higher rate increases for small employer and individual health plans.

Many large employers have moved from fully-insured health plans into self-insured plans, which allow them to reduce cost while having more control over their employee benefits. Self-insured plans are not subject to state benefit mandates or state premium taxes and assessments. This option is not generally available to small employers, because they do not usually have the financial resources to accept the risk of large claims.

How to Use the Data

In order to use the loss ratio data for a specific purpose, it is important to find out additional information relevant to that purpose. As discussed below, loss ratios may not be a good way to compare health plan companies, unless other information is taken into account.

For example, when the Commerce Department reviews health plan rates for compliance with statutory requirements, we ask for additional information to evaluate the rates, including (1) how the loss ratio has been calculated, (2) the benefits that will be offered, (3) any recent changes in rates or benefits, (4) national experience when Minnesota experience is not very credible, (5) an

analysis of the relative newness of the experience, and (6) any other information that will help evaluate whether rates will meet the statutory requirements.

Definition of Loss Ratio

Background

The first report appeared in June, 1998 for 1997 experience. Due to the short lead time for preparing the first report, the Department did not provide detailed guidance for the calculation of the earned premiums and incurred claims. Over the past year, the Department has developed detailed guidance and a technical list of what is included in the loss ratio calculation required by law. This list appears below. We appreciate the many hours of assistance provided by actuaries from health plan companies in the past year and a half in the development of this list.

Data Requested

Companies were asked to provide the total earned premium, incurred claims, and loss ratio for the year ending December 31, 1998, separately for the individual and small employer health plan markets. The small employer market includes non-compliant small employer plans that have been treated as part of the small employer block of business. The small employer market does not include employers with 51 or more employees, even if fewer than 51 employees from a group have enrolled for health plan coverage.

The individual market includes individual policies issued as conversions from group health plan coverage. If a company has conversion policies in force, but no other individual health plan business, it need not report data for the individual market.

Earned Premium

Premium earned during 1998, without adjusting for any payments to the Minnesota Health Care Reinsurance Association (MHCRA) or private reinsurance arrangements. Earned premiums are equal to paid premium for the year plus uncollected premiums minus premiums paid in advance. The number should be based on the most recent available estimates of the premium-related accrual amounts. The number includes any fees from policyholders such as enrollment fees, monthly fees, or processing fees. The number should be calculated without subtracting any commissions or marketing expenses from the premiums.

Premiums do not include any payments for Administrative Services Only (ASO) contracts or any fee-for-service income that was given on a non-insured basis to medical care providers.

Incurred Claims

Incurred claims include the paid-on-incurred claims for the year, plus a reserve for claims incurred but not yet paid, plus the change in any other claim reserves held (such as active life reserves or rate stabilization reserves), plus the expenses incurred during the year for the following items, where expenses for a functional area should include allocated costs such as EDP equipment, office space, management, overhead, and so on.

- Any accrued expected value of withholds, bonuses, or other amounts to be paid to providers for services provided in 1998.
- Any accrued prescription drug rebates or refunds from pharmaceutical companies (a reduction to the claims).
- Case management activities.
- Capitations paid or accrued to providers for claims incurred during 1998.
- Clinical quality assurance and other types of medical care quality improvement efforts.
- Concurrent or prospective utilization review as defined in Minnesota Statutes section 62M.02, subdivision 20.
- Consumer education solely for health improvement.
- Detection and prevention of payment for fraudulent requests for reimbursement.
- Net reinsurance cost (premiums less claims) for the MHCRA and private reinsurance, and assessments by MHCRA.
- Network access fees to Preferred Provider Organizations and other network-based health plans.
- Provider contracting and credentialing costs.
- Provider tax required by Minnesota Rules part 295.52.

Loss Ratio

The ratio of incurred claims to earned premiums.

Unintentional Errors

The earned premiums, incurred claims, and loss ratios that are listed in this report have been provided by the health plan companies. We have not independently

verified the loss ratios, and even the most careful process will sometimes include unintentional errors.

Calculation Methods

There are different ways of calculating a loss ratio, depending on the accounting method used for calculating earned premiums and incurred claims. One method is used for the annual statement, and includes estimates of premiums and claims that have not yet been recorded, and also includes changes in the estimates for the previous year. Another method is commonly used for setting and filing rates. This method restates the earned premium and incurred claims using the most recent information, and does not incorporate adjustments from previous periods. For this report, we have asked the health plan companies to provide loss ratios using the second method.

Loss Ratio is not the Same as Value

The Minnesota Legislature has passed laws requiring health plans to set their rates so as to meet minimum loss ratio standards because the loss ratio is a way to measure value. The loss ratio is a good measure of relative value if two health plan companies are very similar in the benefits they provide and other factors. In that case, the plan with the higher loss ratio would be a better value.

However, health plan companies differ in a variety of ways, and therefore the relative loss ratio is not always indicative of relative value. For example, one health plan company may not spend much effort preventing payment of fraudulent claims, while another may spend much more time and money, resulting in non-payment of many fraudulent claims. The first company would have a higher loss ratio due to the fraudulent claims it paid, but that would not be a value to the honest policyholders. Similarly, one health plan company may pay doctors and hospitals at a higher charge level than another, due to different contractual arrangements. Those higher payments do not represent greater value to the policyholder.

Also, every prospective policyholder is different, with different needs for health care. In order to compare health plan companies, it is necessary to review other aspects of the company affecting value, such as availability of particular medical care providers, quality of patient service, and quality of care management.

Statistical Fluctuation

Loss ratios also are subject to statistical fluctuation. Each individual's health care costs are more or less unpredictable, and the total incurred claims of a health plan company are also more or less unpredictable. Having a high or low loss ratio may have been due to such fluctuations, and may not be repeated in a future time period.

Recent Changes

Any change that has been made in a health plan company's business since the beginning of the reporting period also affects the loss ratio. For example, the rate levels or benefits offered may have changed significantly, due to legislative requirements or improvements offered by the health plan company.

Newness of Coverage

The newness of the health plans also has an effect on the loss ratio. Policies that have been recently sold typically have lower levels of claims than policies that have been in force for a year or more. Thus a health plan company may have a relatively low loss ratio, due to a large proportion of relatively new policies, but their expected future loss ratio may not be low.

How Rates are Regulated

Minnesota Statutes §62A.02 requires all health plan rates to be approved by the Commissioner of Commerce (for HMOs, the Commissioner of Health) before being used. The statutory language is listed in Appendix A of this report. The health plan company must supply actuarial reasons and data demonstrating that the benefits are reasonable in relation to the premiums. The Commerce Department reviews all rates to verify reasonableness and compliance with other statutory limitations such as rate bands. Rate restrictions for small employer plans are specified in M.S. §62L.08, and for individual plans are specified in M.S. §62A.65.

Loss Ratio Standards After 1997 Changes

In addition to being reasonable and meeting rate restrictions, individual and small employer health plan rates must be calculated to meet specific minimum loss ratio standards in Minnesota Statutes §62A.021. The language of this statute is

listed in Appendices B and C of this report, before and after recent changes, respectively. The standards after the changes are summarized below.

A health plan company that has at least 3% of the total health plan market (individual, small employer, and large employer) in Minnesota must meet a loss ratio standard that increases each July 1, from 1994 to 2000. The minimum loss ratio for individual health plans for rates used from July 1, 1998 through June 30, 1999 is 70%. For small employer plans it is 80%. For rates to be used on or after July 1, 2000, the respective minimums are 72% and 82%.

A health plan company that has less than 3% of the market must meet fixed minimum loss ratios (specified in a law that was passed in 1997). Those minimums are 68% for individual health plans, 71% for small employer plans with 10 or fewer employees, and 75% for small employer plans with 11 or more employees.

All health plan companies must include reductions in their rates because of recent legislation. This relief includes the reduced provider tax on medical services, the possible temporary waiver of premium tax for HMOs and health service plan corporations, and the reduction in assessments for the Minnesota Comprehensive Health Association due to partial public funding. When reviewing the filed rates, the Commerce Department verifies that the reductions have been made.

Individual Health Plan Loss Ratios

The following page lists the loss ratios experienced in the individual health plan market in 1998 by companies that cover policyholders in that market. Not all companies with individual health plans in force are included, as some did not respond to our request for information, and some had premium volume lower than $100,000, which we considered too low to include. Page 9 contains a list in order by decreasing premium volume of the companies that responded, and Page 10 contains an alphabetical list.

The loss ratios for 1998 ranged from 36% to 283%. The total loss ratio is 85%, up from 78% last year. Most health plan companies implemented substantial rate increases in 1997 and 1998, so the increase in loss ratio indicates a dramatic increase in medical cost per enrollee. Compared to 1997, loss ratios are up for all except four companies that appear in both lists.

The lowest loss ratios are usually on small, non-credible blocks of business. The highest loss ratios are usually on blocks of business that are primarily polices used as the mandated portability option required by M.S. §62A.65 Subd. 5(b) for insured persons formerly covered in group health plans who have exhausted the mandated continuation coverage.

In spite of significant rate increases, the only companies that experienced growth in premium dollars were BCBSM, Inc., Fortis Insurance Company, Mutual of Omaha Insurance Company, United Teacher Associates Insurance Company, and United Wisconsin Insurance Company.

Questions about this information may be addressed to the Minnesota Department of Commerce, 133 East Seventh Street, St Paul MN 55101.

Premium Order List for Individual

Company	Individual Premiums	Individual Claims	Loss Ratio
BCBSM, Inc.	$ 118,435,527	$ 94,053,772	79%
Fortis Insurance Company	$ 20,179,027	$ 20,287,950	101%
State Farm Mutual Automobile Insurance Company	$ 15,372,113	$ 15,291,805	99%
World Insurance Company	$ 10,799,340	$ 7,927,815	73%
United Wisconsin Insurance Company	$ 9,421,555	$ 9,265,575	98%
American Family Mutual Insurance Company	$ 5,372,343	$ 3,564,678	66%
Golden Rule Insurance Company	$ 4,227,990	$ 3,953,655	94%
Pioneer Life Insurance Company	$ 4,141,985	$ 2,670,217	64%
Mutual of Omaha Insurance Company	$ 3,988,585	$ 3,585,096	90%
Aid Association for Lutherans	$ 2,545,674	$ 3,260,860	128%
American Republic Insurance Company	$ 1,902,771	$ 1,739,634	91%
Principal Life Insurance Company	$ 1,204,807	$ 1,598,909	133%
Bankers Life and Casualty Company	$ 548,750	$ 706,481	129%
Trustmark Insurance Company	$ 532,346	$ 421,621	79%
Central States Health & Life Company of Omaha	$ 476,761	$ 367,122	77%
General American Life Insurance Company	$ 369,962	$ 134,552	36%
Prudential Insurance Company of America (The)	$ 328,443	$ 929,804	283%
United Teacher Associates Insurance Company	$ 325,853	$ 300,973	92%
National Travelers Life Company	$ 325,333	$ 323,382	99%
Washington National Insurance Company	$ 257,347	$ 155,723	61%
Lutheran Brotherhood	$ 215,832	$ 309,546	143%
American Fidelity Assurance Company	$ 102,633	$ 44,960	44%
Lone Star Life Insurance Company	$ 102,595	$ 67,215	66%
Total	$ 201,177,572	$ 170,961,345	85%

Alphabetic List for Individual

Company	Individual Premiums	Individual Claims	Loss Ratio
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State Farm Mutual Automobile Insurance Company	$ 15,372,113	$ 15,291,805	99%
Trustmark Insurance Company	$ 532,346	$ 421,621	79%
United Teacher Associates Insurance Company	$ 325,853	$ 300,973	92%
United Wisconsin Insurance Company	$ 9,421,555	$ 9,265,575	98%
Washington National Insurance Company	$ 257,347	$ 155,723	61%
World Insurance Company	$ 10,799,340	$ 7,927,815	73%
Total	$ 201,177,572	$ 170,961,345	85%

Small Employer Health Plan Loss Ratios

The following pages list the loss ratios experienced in the small employer health plan market in 1998 by companies that cover policyholders in that market. Not all companies with small employer health plans in force are included, as some did not respond to our request for information. Page 12 contains a list in order by decreasing premium volume of the companies that responded, and Page 13 contains an alphabetical list.

The loss ratios for 1998 ranged from 59% to 945%. The total loss ratio for the market as reported is 94%, which represents a loss to the health plan companies to the extent that their expenses exceed 6% of premium. Typical health plan company expenses for small employer health plans range from 20% to 35% of premium, so the 1998 experience represents a year in which the small employer market was generally unprofitable for health plan companies.

Questions about this information may be addressed to the Minnesota Department of Commerce, 133 East Seventh Street, St Paul MN 55101.

Premium Order List for Small Employer

Company	Individual Premiums	Individual Claims	Loss Ratio
BCBSM, Inc.	$ 246,081,539	$ 225,134,443	91%
Federated Mutual Insurance Company	$ 37,431,396	$ 36,685,930	98%
Medica Insurance Company	$ 25,297,156	$ 24,050,671	95%
Principal Life Insurance Company	$ 23,050,385	$ 18,913,158	82%
United Wisconsin Insurance Company	$ 8,579,944	$ 6,262,823	73%
Fortis Insurance Company	$ 6,862,269	$ 6,952,371	101%
Fortis Benefits Insurance Company	$ 5,939,563	$ 7,368,235	124%
John Deere Insurance Company	$ 1,224,101	$ 1,387,957	113%
EPIC Life Insurance Company (The)	$ 1,174,891	$ 956,190	81%
Guardian Life Insurance Company of America (The)	$ 1,141,089	$ 873,933	77%
Trustmark Insurance Company	$ 894,134	$ 588,131	66%
General American Life Insurance Company	$ 849,627	$ 8,026,913	945%
CUNA Mutual Insurance Society	$ 515,611	$ 593,776	115%
Mutual of Omaha Insurance Company	$ 249,930	$ 147,001	59%
Total	$ 359,291,635	$ 337,941,532	94%

Alphabetic List for Small Employer

Company	Individual Premiums	Individual Claims	Loss Ratio
BCBSM, Inc.	$ 246,081,539	$ 225,134,443	91%
CUNA Mutual Insurance Society	$ 515,611	$ 593,776	115%
EPIC Life Insurance Company (The)	$ 1,174,891	$ 956,190	81%
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Principal Life Insurance Company	$ 23,050,385	$ 18,913,156	82%
Trustmark Insurance Company	$ 894,134	$ 588,131	66%
United Wisconsin Insurance Company	$ 8,579,944	$ 6,262,823	73%
Total	$ 359,291,635	$ 337,941,532	94%

Appendix A: M.S. §62A.02

Minnesota Statutes - Insurance Laws
INSURANCE
Chapter 62A -- ACCIDENT AND HEALTH INSURANCE

62A.02 Filing and approval of health plan rates and forms

Subdivision 1. Filing. For purposes of this section, "health plan" means a health plan as defined in section 62A.011 or a policy of accident and sickness insurance as defined in section 62A.01. No health plan shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner. The filing for nongroup health plan forms shall include a statement of actuarial reasons and data to support the rate. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

Subd. 2. Approval. The health plan form shall not be issued, nor shall any application, rider, endorsement, or rate be used in connection with it, until the expiration of 60 days after it has been filed unless the commissioner approves it before that time.

Subd. 3. Standards for disapproval. The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

(1) if the benefits provided are not reasonable in relation to the premium charged;

(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A;

(3) if the proposed premium rate is excessive or not adequate; or

(4) the actuarial reasons and data submitted do not justify the rate.

The party proposing a rate has the burden of proving by a preponderance of the evidence that it does not violate this subdivision.

In determining the reasonableness of a rate, the commissioner shall also review all administrative contracts, service contracts, and other agreements to determine the reasonableness of the cost of the contracts or agreement and effect of the contracts on the rate. If the commissioner determines that a contract or agreement is not reasonable, the commissioner shall disapprove any rate that reflects any unreasonable cost arising out of the contract or agreement. The commissioner may require any information that the commissioner deems necessary to determine the reasonableness of the cost.

For the purposes of this subdivision, the commissioner shall establish by rule a schedule of minimum anticipated loss ratios which shall be based on (i) the type or types of coverage provided, (ii) whether the policy is for group or individual coverage, and (iii) the size of the group for group policies. Except for individual policies of disability or income protection insurance, the minimum anticipated loss ratio shall not be less than 50 percent after the first year that a policy is in force. All applicants for a policy shall be informed in writing at the time of application of the anticipated loss ratio of the policy. "Anticipated loss ratio" means the ratio at the time of filing, at the time of notice of withdrawal under subdivision 4a, or at the time of subsequent rate revision of the present value of all expected future benefits, excluding dividends, to the present value of all expected future premiums.

If the commissioner notifies a health carrier that has filed any form or rate that it does not comply with this chapter, chapter 62L, or chapter 72A, it shall be unlawful for the health carrier to issue or use the form or rate. In the notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the health carrier.

The 60-day period within which the commissioner is to approve or disapprove the form or rate does not begin to run until a complete filing of all data and materials required by statute or requested by the commissioner has been submitted.

However, if the supporting data is not filed within 30 days after a request by the commissioner, the rate is not effective and is presumed to be an excessive rate.

Subd. 4. Repealed. Laws 1992

Subd. 4a. Withdrawal of approval. The commissioner may, at any time after a 20-day written notice has been given to the insurer, withdraw approval of any form or rate that has previously been approved on any of the grounds stated in this section. It is unlawful for the health carrier to issue a form or rate or use it in connection with any health plan after the effective date of the withdrawal of approval. The notice of withdrawal of approval must advise the health carrier of the right to a hearing under the contested case procedures of chapter 14, and must specify the matters to be considered at the hearing.

The commissioner may request a health carrier to provide actuarial reasons and data, as well as other information, needed to determine if a previously approved rate continues to satisfy the requirements of this section. If the requested information is not provided within 30 days after request by the commissioner, the rate is presumed to be an excessive rate.

Subd. 5. Repealed. Laws 1992; 1994

Subd. 5a. Hearing. The health carrier must request a hearing before

the 20-day notice period has ended, or the commissioner's order is final. A request for hearing stays the commissioner's order until the commissioner notifies the health carrier of the result of the hearing. The commissioner's order may require the modification of any rate or form and may require continued coverage to persons covered under a health plan to which the disapproved form or rate applies.

Subd. 6. Appeal. Any order or decision of the commissioner under this section shall be subject to appeal in accordance with chapter 14.

Subd. 7. Filing by domestic insurers for purposes of complying with another state's filing requirements. A domestic insurer may file with the commissioner for informational purposes only a policy or certificate of insurance that is not intended to be offered or sold within this state. This subdivision only applies to the filing in Minnesota of a policy or certificate of insurance issued to an insured or certificate holder located outside of this state when the filing is for the express purpose of complying with the law of the state in which the insured or certificate holder resides. In no event may a policy or certificate of insurance filed under this subdivision for out-of-state use be issued or delivered in Minnesota unless and until the policy or certificate of insurance is approved under subdivision 2.

Appendix B: M.S. §62A.021 Before 1997 Changes

Minnesota Statutes - Insurance Laws
INSURANCE
Chapter 62A -- ACCIDENT AND HEALTH INSURANCE

62A.021 Standards for health care policies and health carriers

Subdivision 1. Loss ratio standards. Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and any types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of

each year, beginning on July 1, 1994, until a 72 percent loss ratio is reached on July 1, 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

Notwithstanding section 645.26, any act enacted at the 1992 regular legislative session that amends or repeals section 62A.135 or that otherwise changes the loss ratios provided in that section is void.

All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall

order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

For purposes of this section, (1) "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and (2) "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

Subd. 2. Compliance audit. The commissioner has the authority to audit any health carrier to assure compliance with this section. Health carriers shall retain at their principal place of business information necessary for the commissioner to perform compliance audits.

Appendix C: M.S. §62A.021 After 1997 Changes

Minnesota Statutes - Insurance Laws
INSURANCE
Chapter 62A -- ACCIDENT AND HEALTH INSURANCE

62A.021 Standards for health care policies and health carriers

Subdivision 1. (LOSS RATIO STANDARDS.) {{(a) }} Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, health care policies or certificates shall not be delivered or issued for delivery to an individual or to a small employer as defined in section 62L.02, unless the policies or certificates can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to Minnesota policyholders and certificate holders in the form of aggregate benefits not including anticipated refunds or credits, provided under the policies or certificates, (1) at least 75 percent of the aggregate amount of premiums earned in the case of policies issued in the small employer market, as defined in section 62L.02, subdivision 27, calculated on an aggregate basis; and (2) at least 65 percent of the aggregate amount of premiums earned in the case of each policy form or certificate form issued in the individual market; calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices. Assessments by the reinsurance association created in chapter 62L and [any] {{all }} types of taxes, surcharges, or assessments created by Laws 1992, chapter 549, or created on or after April 23, 1992, are included in the calculation of incurred claims experience or incurred health care expenses. The applicable percentage for policies and certificates issued in the small employer market, as defined in section 62L.02, increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until an 82 percent loss ratio is reached on July 1, 2000. The applicable percentage for policy forms and certificate forms issued in the individual market increases by one percentage point on July 1 of each year, beginning on July 1, 1994, until a 72 percent

loss ratio is reached on July 1, 2000. A health carrier that enters a market after July 1, 1993, does not start at the beginning of the phase-in schedule and must instead comply with the loss ratio requirements applicable to other health carriers in that market for each time period. Premiums earned and claims incurred in markets other than the small employer and individual markets are not relevant for purposes of this section.

[Notwithstanding section 645.26, any act enacted at the 1992 regular legislative session that amends or repeals section 62A.135 or that otherwise changes the loss ratios provided in that section is void.]

{{(b) }} All filings of rates and rating schedules shall demonstrate that actual expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and aggregate loss ratio from inception of the policy form or certificate form shall equal or exceed the appropriate loss ratio standards.

{{(c) }} A health carrier that issues health care policies and certificates to individuals or to small employers, as defined in section 62L.02, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy form or certificate form duration for approval by the commissioner according to the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. If the data submitted does not confirm that the health carrier has satisfied the loss ratio requirements of this section, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file amended rates that comply with this section. If the health carrier fails to file amended rates within the prescribed time, the commissioner shall

order that the health carrier's filed rates for the nonconforming policy form or certificate form be reduced to an amount that would have resulted in a loss ratio that complied with this section had it been in effect for the reporting period of the supplement. The health carrier's failure to file amended rates within the specified time or the issuance of the commissioner's order amending the rates does not preclude the health carrier from filing an amendment of its rates at a later time. The commissioner shall annually make the submitted data available to the public at a cost not to exceed the cost of copying. The data must be compiled in a form useful for consumers who wish to compare premium charges and loss ratios.

{{(d) }} Each sale of a policy or certificate that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

{{(e)(1) }} For purposes of this section, health care policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

{{(2) }} For purposes of this section, [(1)] {{(i) }} "health care policy" or "health care certificate" is a health plan as defined in section 62A.011; and [(2)] {{(ii) }} "health carrier" has the meaning given in section 62A.011 and includes all health carriers delivering or issuing for delivery health care policies or certificates in this state or offering these policies or certificates to residents of this state.

{{(f) The loss ratio phase-in as described in paragraph (a) does not apply to individual policies and small employer policies issued by a health plan company that is assessed less than three percent of the total annual amount assessed by the Minnesota comprehensive health association. These policies must meet a 68 percent loss ratio for individual policies, a 71 percent loss ratio for small employer policies with fewer than ten employees, and a 75 percent loss ratio for all other small employer policies.

(g) The commissioners of commerce and health shall each annually

issue a public report listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in this state by the health plan companies that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than June 1 for loss ratios experienced for the preceding calendar year. Health plan companies shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.}}

Subd. 2. Compliance audit. The commissioner has the authority to audit any health carrier to assure compliance with this section. Health carriers shall retain at their principal place of business information necessary for the commissioner to perform compliance audits.

{{Subd. 3. (LOSS RATIO DISCLOSURE.) (a) Each health care policy form or health care certificate form for which subdivision 1 requires compliance with a loss ratio requirement shall prominently display the disclosure provided in paragraph (b) on its declarations sheet if it has one and, if not, on its front page. The disclosure must also be prominently displayed in any marketing materials used in connection with it.

(b) The disclosure must be in the following format:

Notice: This disclosure is required by Minnesota law. This policy or certificate is expected to return on average (fill in anticipated loss ratio approved by the commissioner) percent of your premium dollar for health care. The lowest percentage permitted by state law for this policy or certificate is (fill in applicable minimum loss ratio).

(c) This subdivision applies to policies and certificates issued on or after January 1, 1998.}}