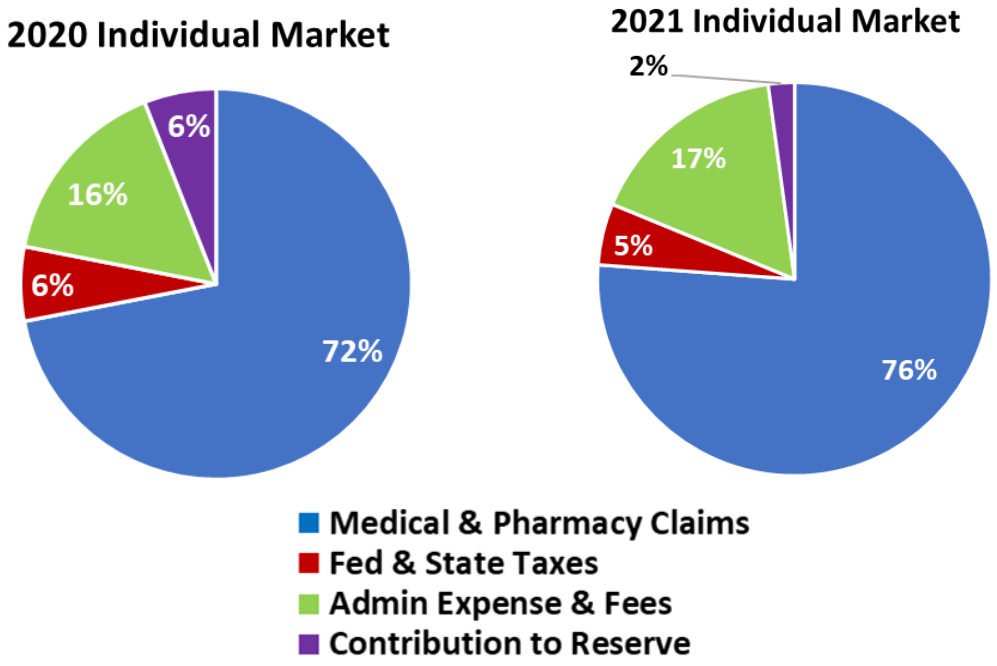
Rhode Island Market Summary- Part II: Loss Ratios, Profitability & Risk Adjustment

April 11, 2023

Gorman Actuarial, Inc.

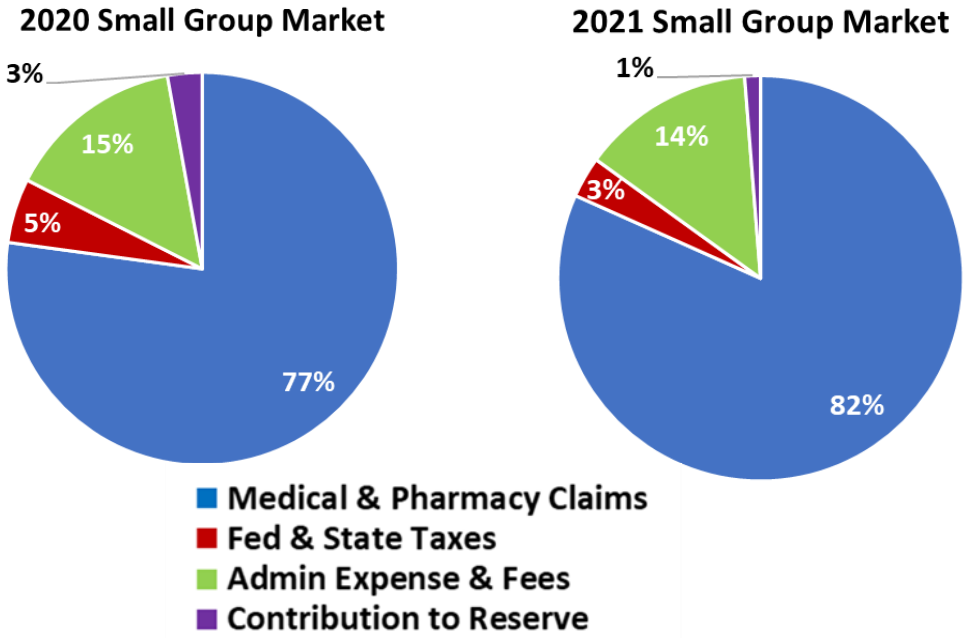
In the Individual Market, 76% of premium was used for medical and pharmacy claims in 2021



- This slide is based on RI OHIC's Financial Loss Ratio, which is not the same as the Federal MLR for rebate purposes. See slide 10 for further explanation.
- In the Individual Market, the percentage of premium used for medical and pharmacy claims has increased from 72% in 2020 to 76% in 2021, while the contribution to reserve has decreased from 6% to 2%.
- Federal & state taxes and admin expenses & fees have been consistent from 2020 to 2021.

Source: Federal MLR Reports. Adjustments were made to one insurer's data to account for discrepancies between the federal MLR data and other data sources. One insurer's data was incomplete for the "Other General Administrative Expenses" and data from SHCE was used instead. There were no federal MLR rebates incurred in 2020 and 2021. The ACA insurer tax was reinstated in 2020, but then repealed in 2021.

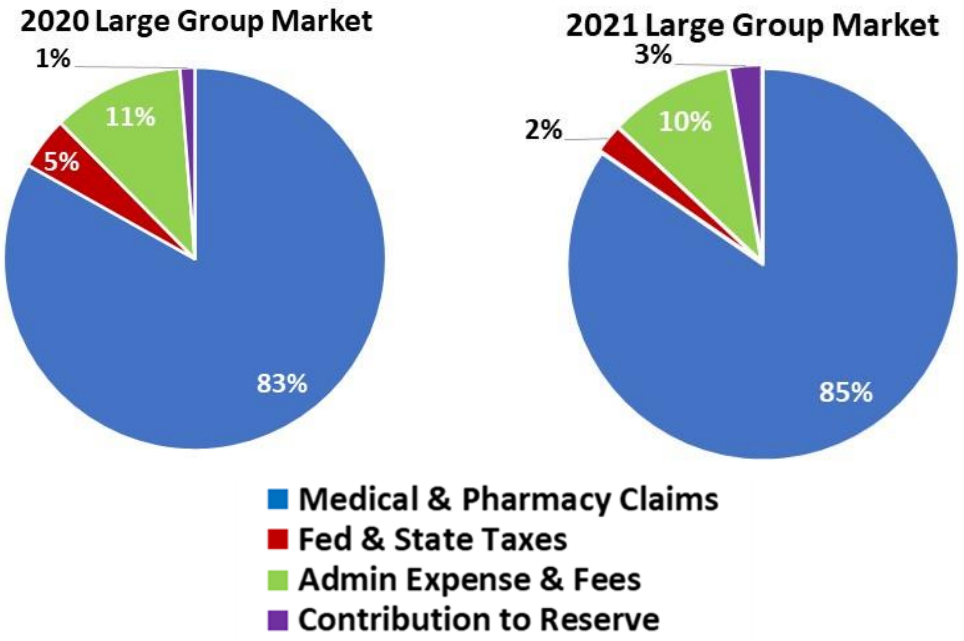
In the Small Group Market, 82% of premium was used for medical and pharmacy claims in 2021.



- This slide is based on RI OHIC's Financial Loss Ratio, which is not the same as the Federal MLR for rebate purposes. See slide 10 for further explanation.
- In the Small Group Market, the percentage of premium used for medical and pharmacy claims has increased from 77% in 2020 to 82% in 2021, while the contribution to reserve has decreased from 3% to 1%.

Source: Federal MLR Reports. Adjustments were made to one insurer's data to account for discrepancies between the federal MLR data and other data sources. One insurer's data was incomplete for the "Other General Administrative Expenses" and data from the SHCE was used instead. There were no federal MLR rebates incurred in 2020 and 2021. The ACA insurer tax was reinstated in 2020, but then repealed in 2021.

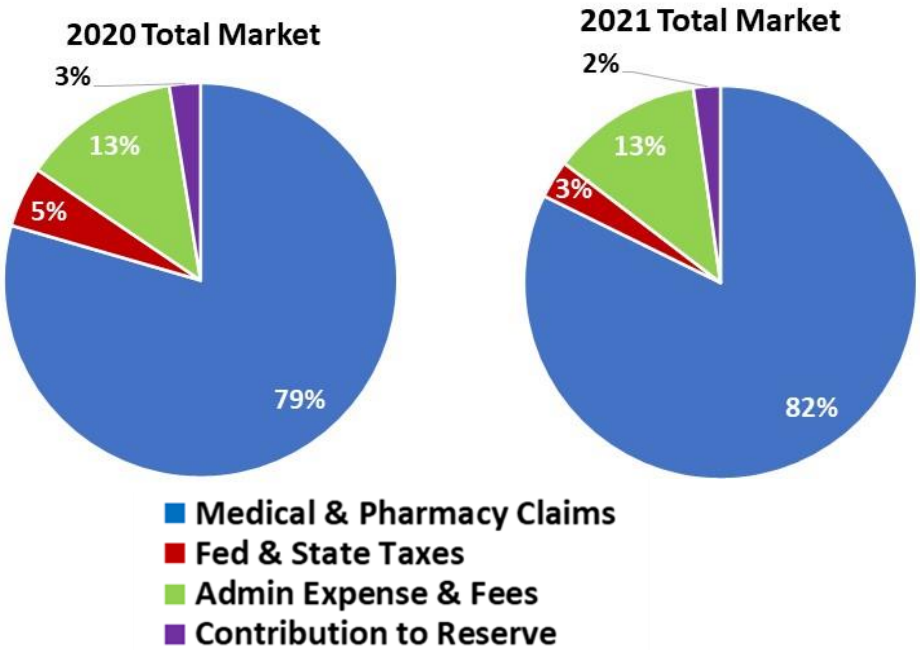
In the Large Group Market, 85% of premium was used for medical and pharmacy claims in 2021.



- This slide is based on RI OHIC's Financial Loss Ratio, which is not the same as the Federal MLR for rebate purposes. See slide 10 for more explanation.
- In the Large Group Market, the percentage of premium used for medical and pharmacy claims has increased from 83% in 2020 to 85% in 2021 and the contribution to reserve has increased from 1% to 3%. This is offset by decreases in administrative expenses and federal & state taxes.
- Compared to the Individual and Small Group Market, the Large Group Market has lower administrative expenses as a percentage of premium.

Source: Federal MLR Reports. Large Group Market is fully-insured only and includes FEP. Adjustments were made to one insurer's data to account for discrepancies between the federal MLR data and other data sources. One insurer's data was incomplete for the "Other General Administrative Expenses" and data from the SHCE was used instead. There were no federal MLR rebates incurred in 2020 and 2021. The ACA insurer tax was reinstated in 2020, but then repealed in 2021.

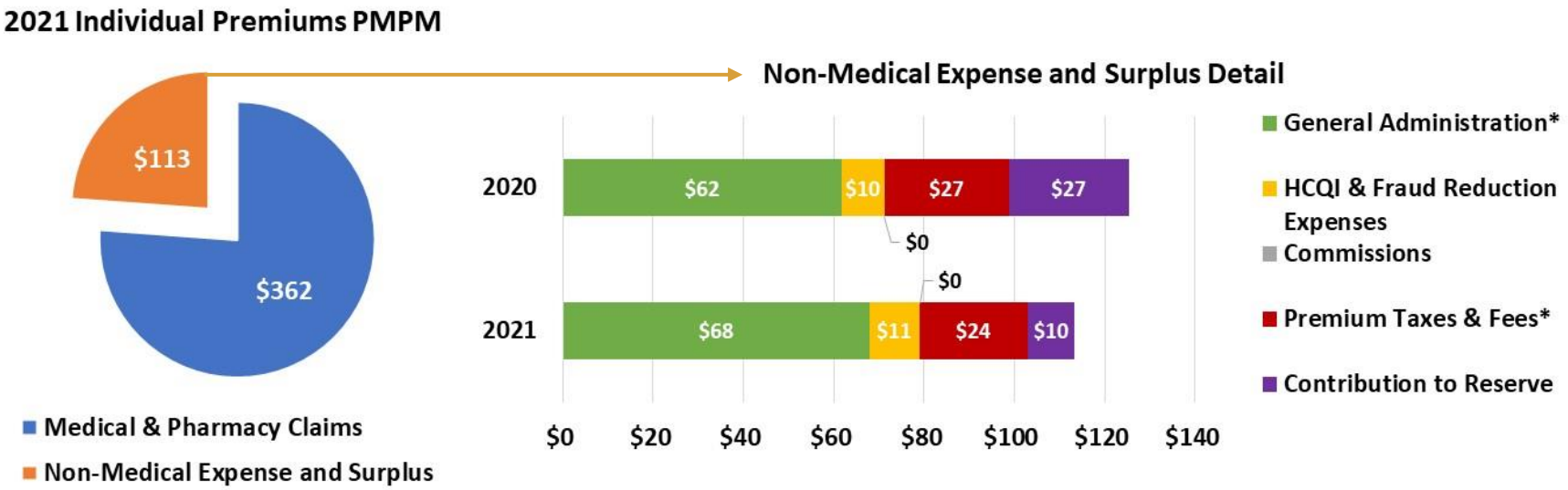
In the overall Fully-Insured segment, 82% of premium was used for medical and pharmacy claims in 2021.



- This slide is based on RI OHIC's Financial Loss Ratio, which is not the same as the Federal MLR for rebate purposes. See slide 10 for more explanation.
- In the overall Fully-Insured Market segment, the percentage of premium used for medical and pharmacy claims has increased from 79% in 2020 to 82% in 2021 and the contribution to reserve has decreased from 3% to 2%.

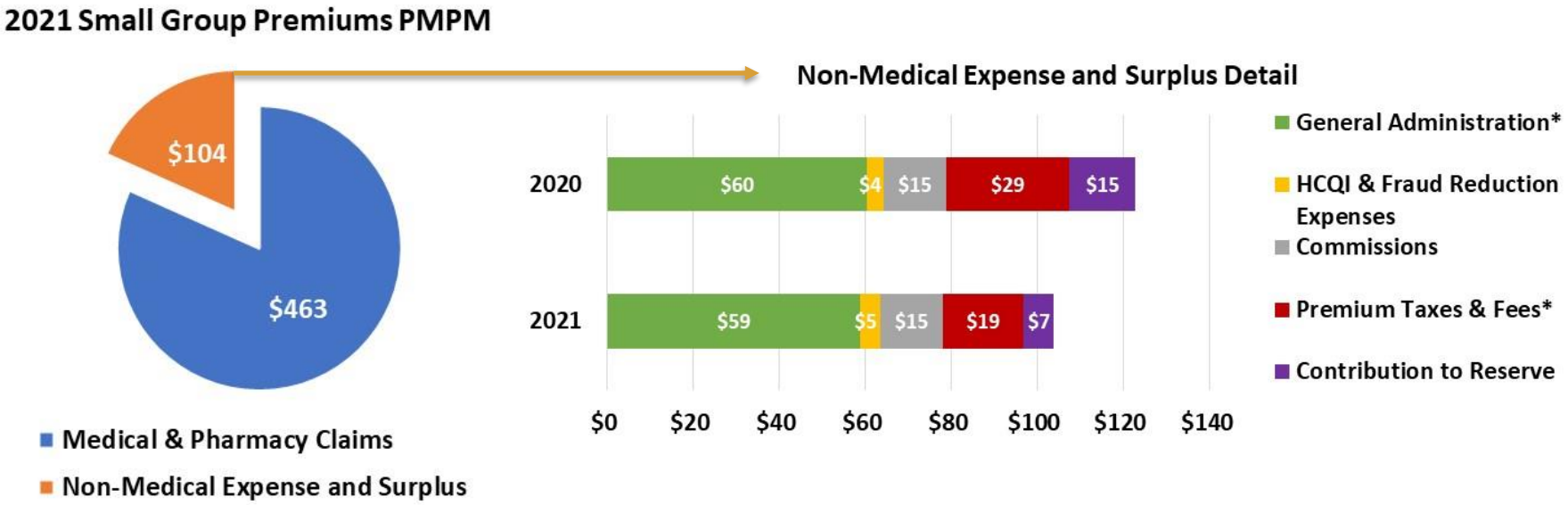
Source: Federal MLR Reports. Large Group Market is fully-insured only and includes FEP. Adjustments were made to one insurer's data to account for discrepancies between the federal MLR data and other data sources. One insurer's data was incomplete for the "Other General Administrative Expenses" and data from the SHCE was used instead. There were no federal MLR rebates incurred in 2020 and 2021. The ACA insurer tax was reinstated in 2020, but then repealed in 2021.

Non-Medical Expense and Surplus Detailed Breakdown: Individual Market



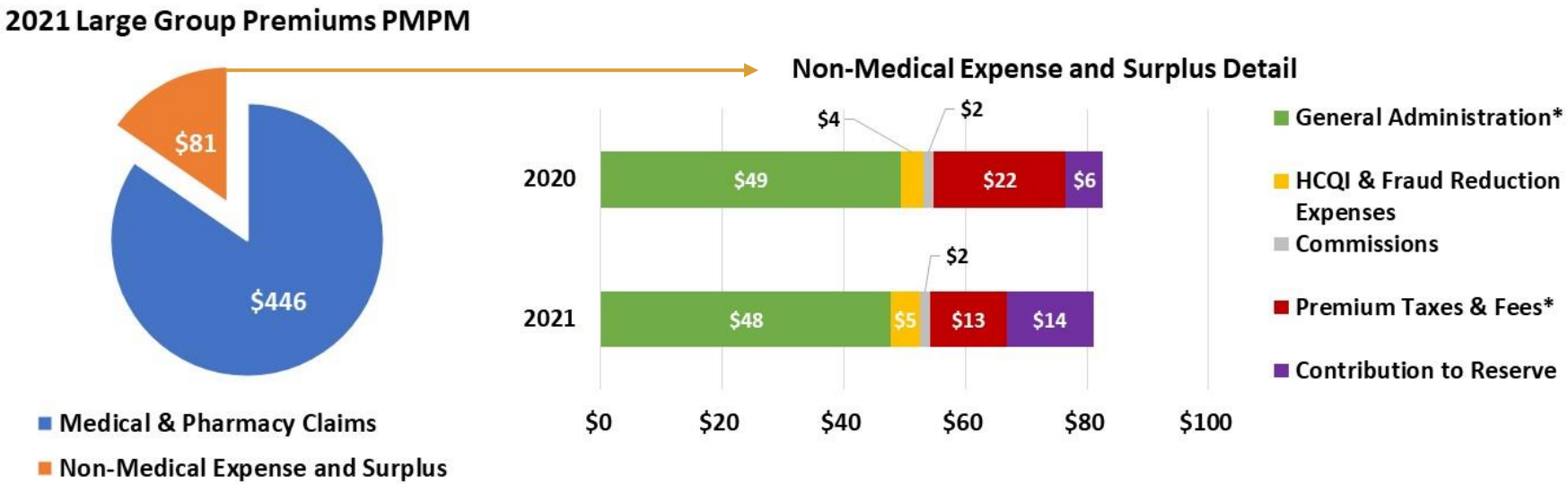
Source: Federal MLR Reports. Adjustments were made to one insurer's data to account for discrepancies between the federal MLR data and other data sources. One insurer's data was incomplete for the "Other General Administrative Expenses" and data from the SHCE was used instead. There were no federal MLR rebates incurred in 2020 and 2021. The ACA insurer tax was reinstated in 2020, but then repealed in 2021. *Taxes that are not part of the adjustments in the Federal MLR formula are included in Other General Admin.

Non-Medical Expense and Surplus Detailed Breakdown: Small Group Market



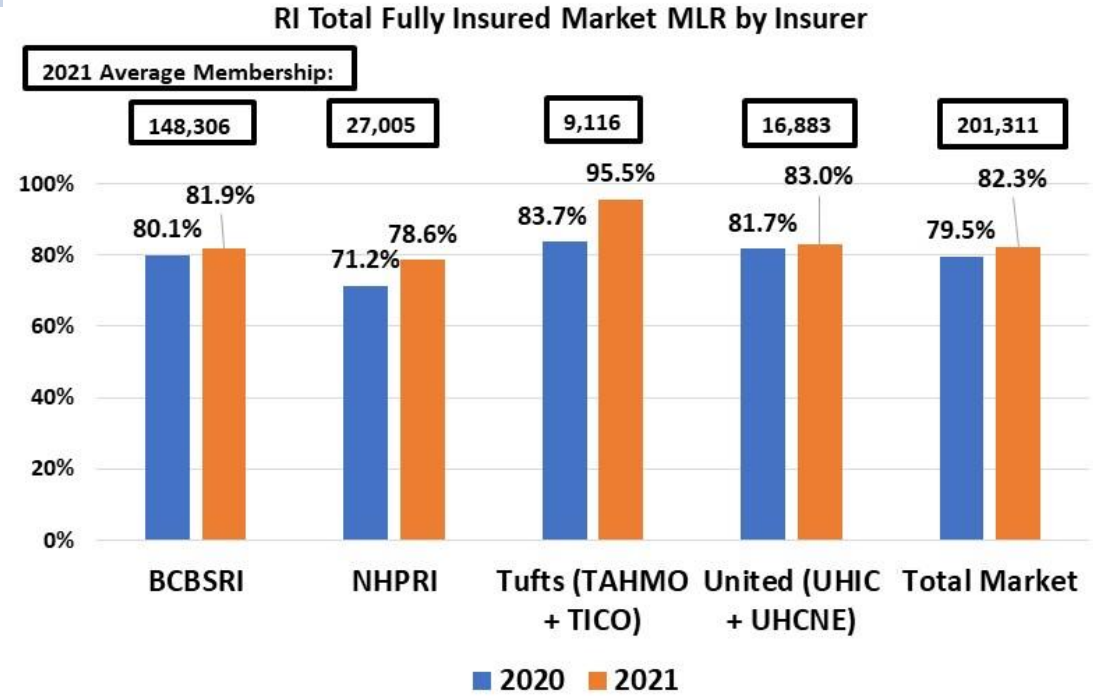
Source: Federal MLR Reports. Adjustments were made to one insurer's data to account for discrepancies between the federal MLR data and other data sources. One insurer's data was incomplete for the "Other General Administrative Expenses" and data from the SHCE was used instead. There were no federal MLR rebates incurred in 2020 and 2021. The ACA insurer tax was reinstated in 2020, but then repealed in 2021. *Taxes that are not part of the adjustments in the Federal MLR formula are included in Other General Admin.

Non-Medical Expense and Surplus Detailed Breakdown: Large Group Fully-Insured Market



Source: Federal MLR Reports. Large Group Market is fully-insured only and includes FEP. Adjustments were made to one insurer's data to account for discrepancies between the federal MLR data and other data sources. One insurer's data was incomplete for the "Other General Administrative Expenses" and data from the SHCE was used instead. There were no federal MLR rebates incurred in 2020 and 2021. The ACA insurer tax was reinstated in 2020, but then repealed in 2021. *Taxes that are not part of the adjustments in the Federal MLR formula are included in Other General Admin.

Financial Medical Loss Ratios (MLRs) increased for each insurer from 2020 to 2021.



- This slide is based on RI OHIC's Financial Loss Ratio, which is not the same as the Federal MLR for rebate purposes. See slide 10 for more explanation.
- Each insurer experienced an increase in their financial MLR from 2020 to 2021 with Tufts Health Plan increasing the most from 83.7% to 95.5%. Tufts Health Plan also has the smallest average number of members in 2021.

Source: Federal MLR Reports. Large Group Market is fully-insured only and includes FEP. Adjustments were made to one insurer's data to account for discrepancies between the federal MLR data and other data sources.

Comparison of the Federal MLR versus the RIOHIC Financial Loss Ratio shown in this presentation.

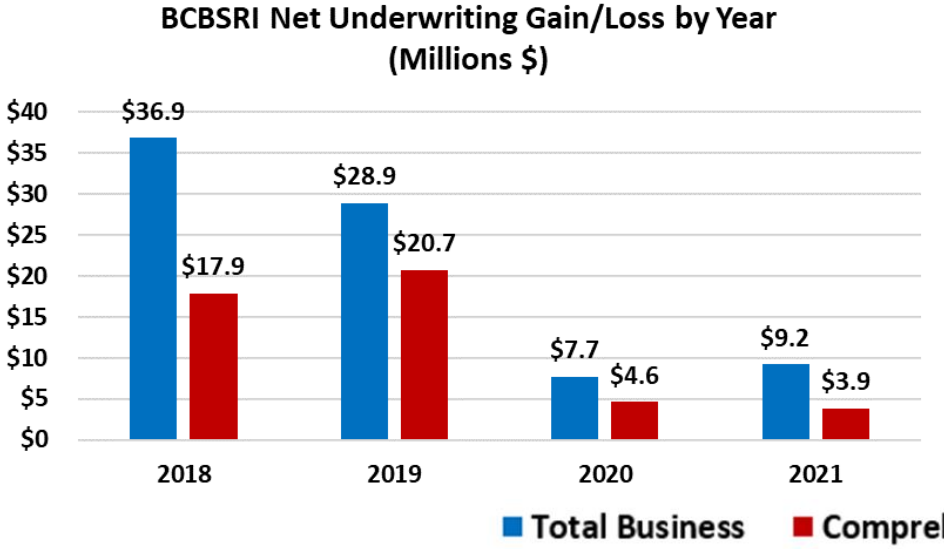
	Federal Medical Loss Ratio	RIOHIC Financial Medical Loss Ratio in this Presentation
Purpose	To determine compliance with MLR thresholds and to calculate the MLR rebate amounts, if applicable.	To measure the percentage of premiums spent on members' medical and pharmacy claims and the percentage retained for other expenses.
Population	By licensed insurer and market segment in the fully-insured market.	Across all insurers. By market segment in the fully-insured market.
Time Period	Average over three calendar years.	One calendar year.
HCQI and Fraud Reduction Expenses	Add to incurred claims.	Included with administrative expenses.
MLR Rebates	Not considered.	Subtracted from earned premium.
Taxes & Fees	Subtracted from earned premium.	Included as its own category.
Risk Adjustment	Reflected in incurred claims.	Reflected in incurred claims.

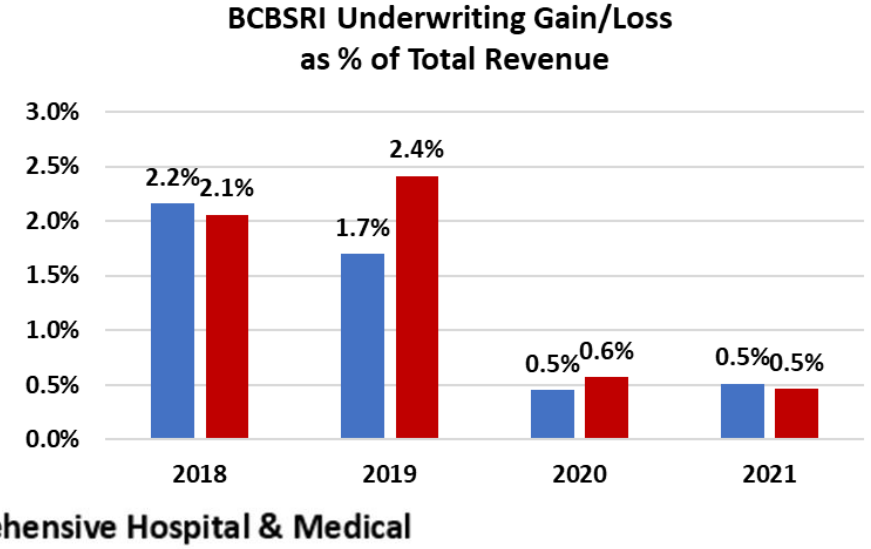
Financial Performance of Rhode Island Domestic Health Insurers

Background on Financial Oversight

- Oversight of health insurance company finances and solvency is determined by where the company is domiciled.
- Rhode Island conducts oversight of its domestic insurers. In the fully insured market these insures include BCBSRI, NHPRI, and UHCNE. Other insurers, such as Point32Health, UnitedHealthcare Insurance Company, Cigna and Aetna sell policies in Rhode Island but are domiciled in other states.
- Each insurer is different in terms of the lines of business that it sells and its market presence. For example, BCBSRI and NHPRI only operate in the Rhode Island market, whereas UHCNE is a multi-state market participant.
- Underwriting gain/loss refers to the difference between earned premium and costs incurred (administrative and claims costs).
- RBC refers to Risk-based Capital. The RBC Ratio is the ratio of total adjusted capital (TAC or “surplus”) to authorized control level capital (ACL). In addition to income from operations, RBC is driven by investment gains/losses.

BCBSRI Underwriting Gain/Loss by Year
Total Business versus Commercial

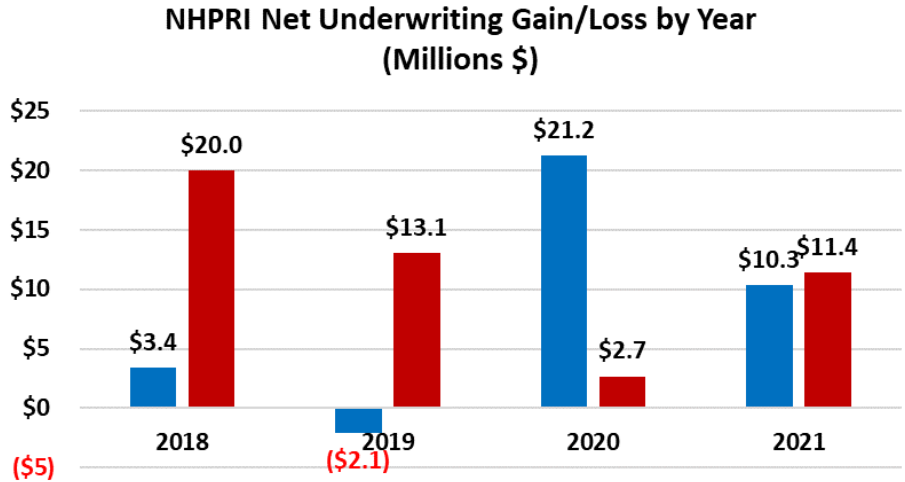


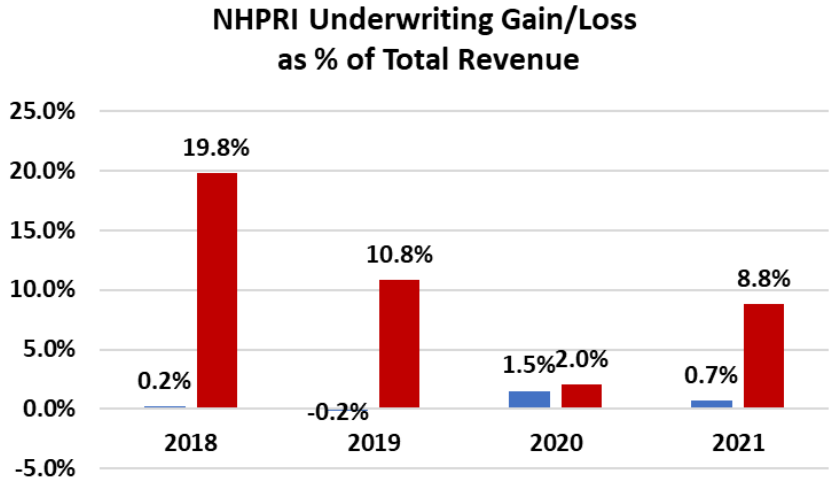


Total Business Comprehensive Hospital & Medical

Year	2018	2019	2020	2021
Total Business RBC	520.0%	638.1%	709.4%	686.5%

NHPRI Underwriting Gain/Loss by Year
Total Business versus Commercial



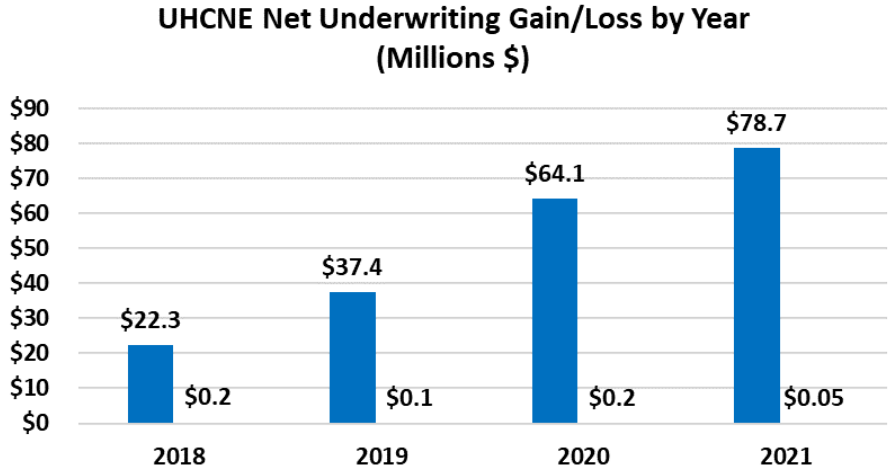


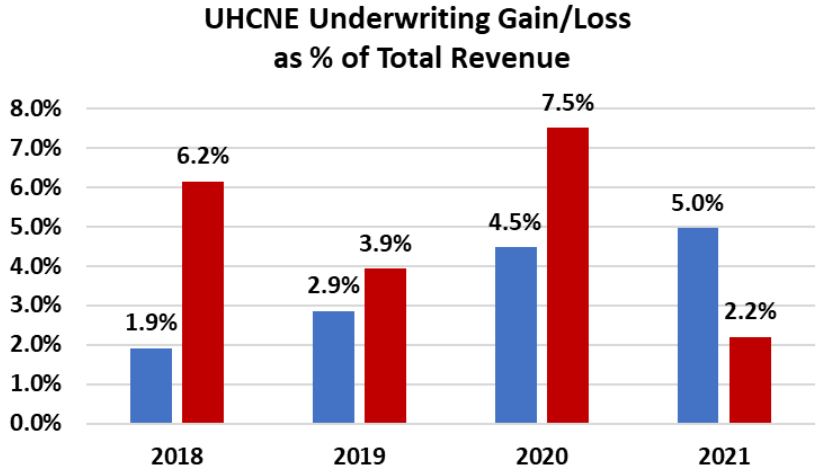
Total Business Comprehensive Hospital & Medical

Year	2018	2019	2020	2021
Total Business RBC	204.8%	211.2%	252.8%	236.4%

UHCNE Underwriting Gain/Loss by Year
Total Business versus Commercial

UHCNE's business spans multiple states and much of it consists of government plan business such as Medicaid and Medicare.





Total Business Comprehensive Hospital & Medical

Year	2018	2019	2020	2021
Total Business RBC	372.3%	379.1%	522.0%	617.3%

Regional Premium Comparisons

Overview of Data Source

- The following data on individual market and small group market premiums come from the federal Risk Adjustment Program.
- The Risk Adjustment Program is a risk mitigation and premium stabilization program to ensure an equitable distribution of funds based on the risk profile of an insurer's population. The calculation ultimately determines which insurers receive funds and which insurer pay funds as part of a redistribution of profits/losses to ensure premium stability in the markets.
- Only individual market and small group market plans are included in the Risk Adjustment Program.

Glossary of Key Terms

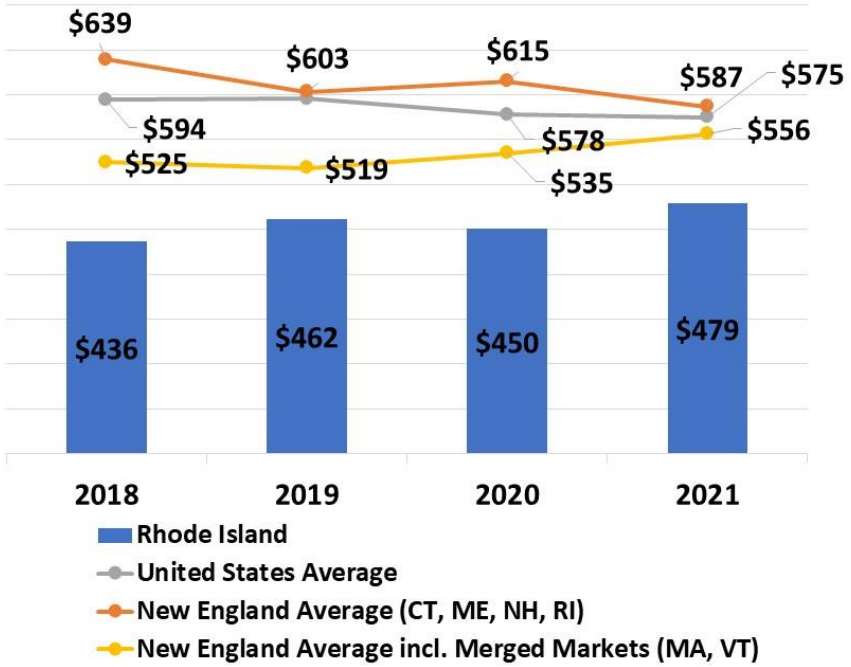
The **Plan Liability Risk Score** (PLRS) is a risk score that is intended to reflect the insurer's expected cost for covering services related to its enrollees' medical conditions or health status. This risk score is calculated based on the HHS-HCC risk adjustment model from CMS. It is calculated based on claims data and includes factors to account for severe cases, age, enrollment duration, prescription drug use, and induced demand attributable to the receipt of cost sharing reduction ("CSR") subsidies. A higher PLRS is intended to reflect a sicker and riskier population (i.e., a population that is more costly for the insurer to insure.)

Actuarial Value (AV) is a measure of benefit richness. The higher the AV score, the richer the benefits and therefore less cost sharing paid by the member. In the ACA risk adjustment model, each plan ID is assigned a metal AV of either .60 (Bronze), .70 (Silver), .80 (Gold) and .90 (Platinum) based on their benefit richness as determined by the Federal AV calculator. An AV of 1.0 means there is no cost sharing.

The **Average Rating Factor** (ARF) is the average rating factor which is equivalent to the average age factor. CMS has a standard set of age factors where each member in a population is assigned a score based on their age. These scores increase as the members' age increases because older members generally use more health care services as compared to younger members. CMS limits the age factors to a 3:1 band for adults, meaning the age factor for the oldest members (age 64 and older) is limited to being three times the average age factor for a 21-year-old.

Rhode Island Individual Market average premium is consistently lower than the New England average and United States average.

Individual Market Average Premium PMPM



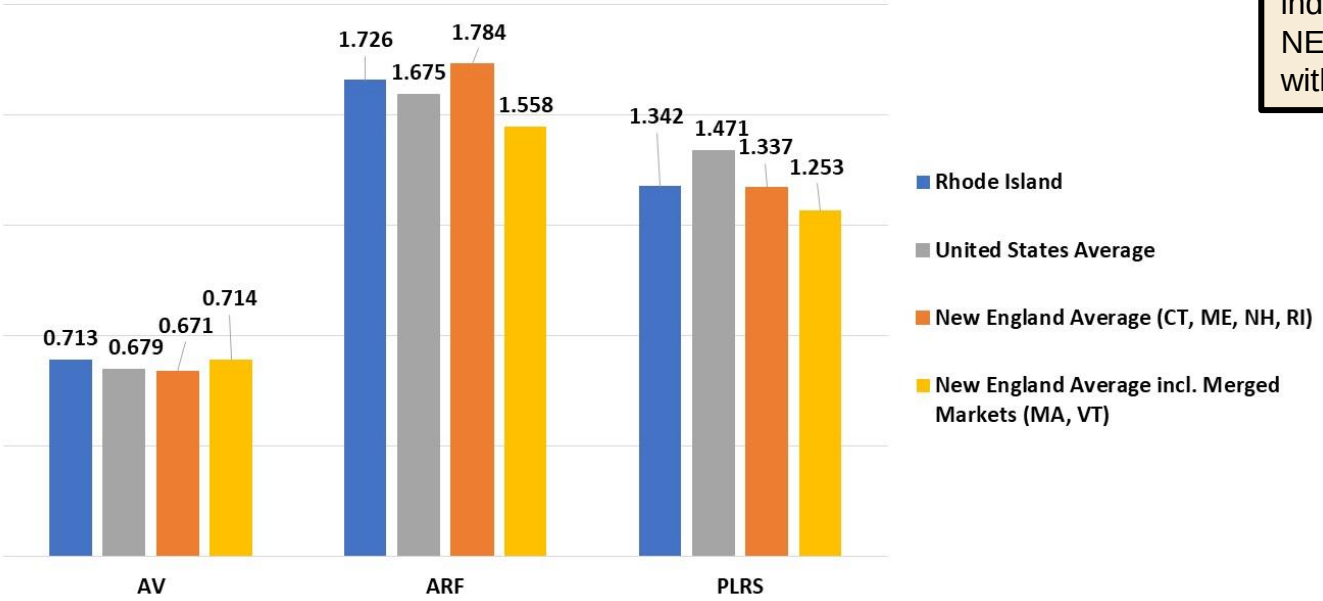
- This data is from the publicly available CMS risk adjustment reports.
- In 2021, Rhode Island average premiums are 17% lower than the United States average and 18% lower than the New England average including CT, ME, NH and RI.
- Premiums will vary by state due to plan design, demographics, and regional cost differences along with availability of a reinsurance program.

Source: Centers for Medicare and Medicaid Services. Risk Adjustment Report Appendix A for 2018, 2019, 2020 and 2021 benefit years. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html.

Compared to the New England average (including CT, ME, NH & RI), Rhode Island has higher metal AVs (richer benefits) but lower allowable rating factor.

2021 State Average Actuarial Value, Allowable Rating Factor, and Plan Liability Risk Score for New England States

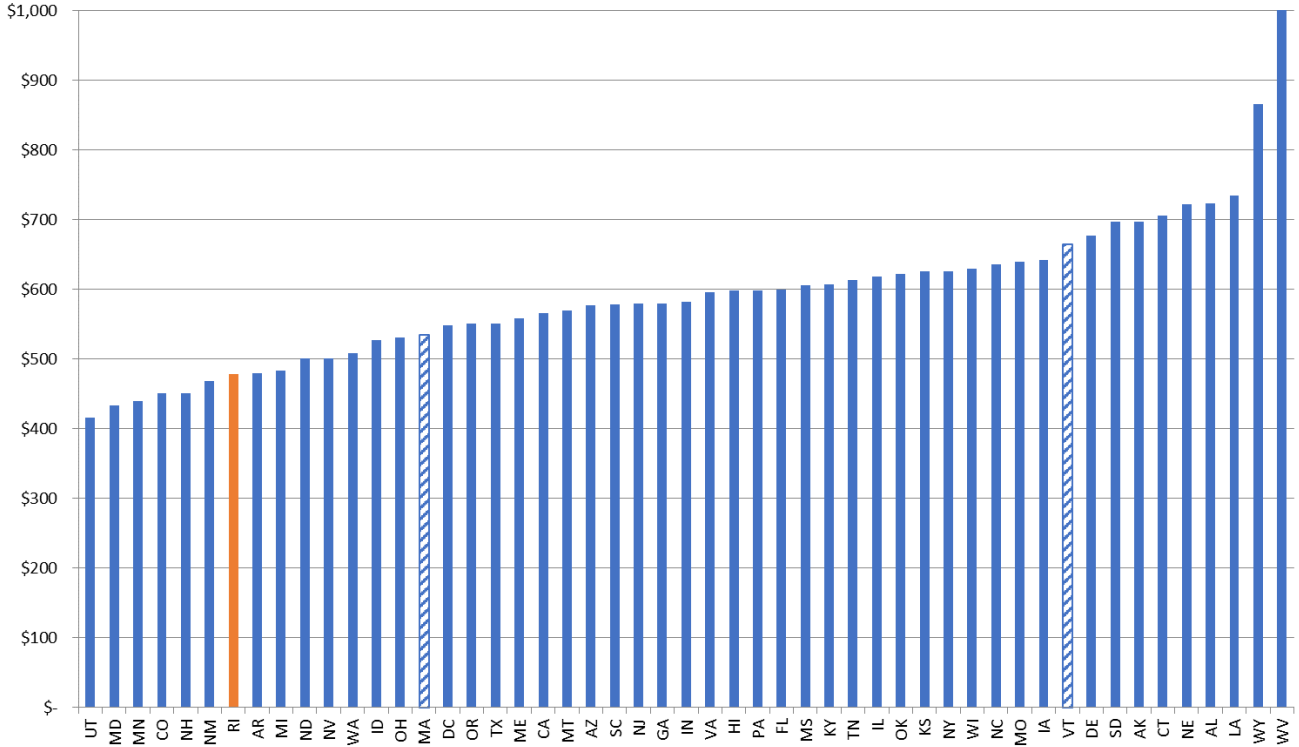
Individual (RI, CT, ME, NH) & Merged Markets (MA, VT)



Note: The NE average is represented in two ways. MA and VT merge their individual and small group markets. The NE average is represented with and without these merged market states.

Source: Centers for Medicare and Medicaid Services. Risk Adjustment Report Appendix A for 2021 benefit year. AV = Actuarial Value. ARF = Allowable Rating Factor. PLRS = Plan Liability Risk Score. Note that the PLRS includes an adjustment for CSR enrollees, therefore the PLRS will vary based on the number of CSR enrollees. Per the CMS Open Enrollment Reports for 2021, 38% of Exchange enrollment in Rhode Island is eligible for CSR compared to 47% across the United States.

In 2021, Rhode Island had the 7th lowest Individual Market average premium compared to other states.

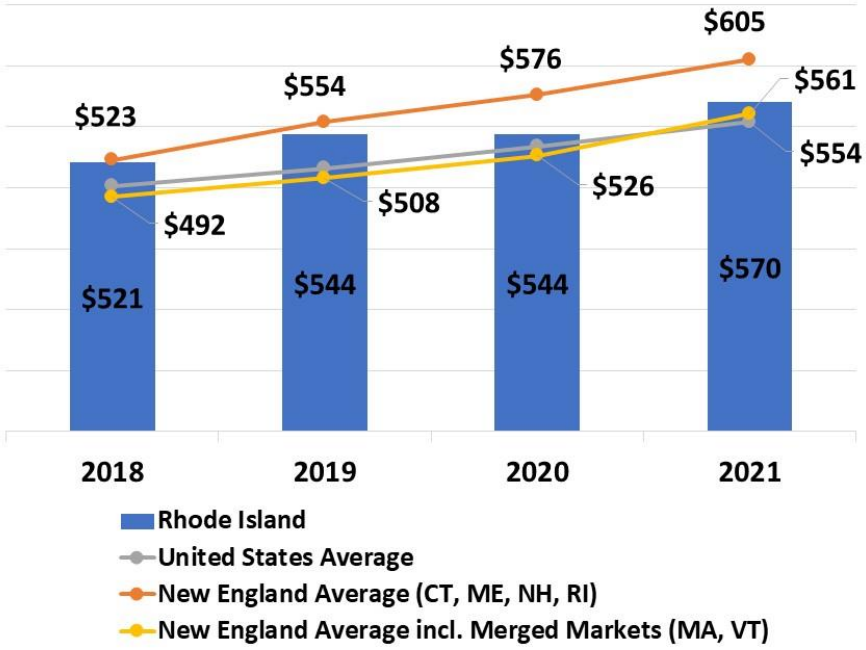


Source: Centers for Medicare and Medicaid Services. Risk Adjustment Report Appendix A for 2021 benefit year. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html. Premiums will vary by state due to plan design, demographics and regional cost differences along with availability of reinsurance.

This chart includes states with merged market premiums (MA, VT).

Rhode Island Small Group Market average premium is higher than the United States average but lower than the New England average (including CT, ME, NH, & RI.)

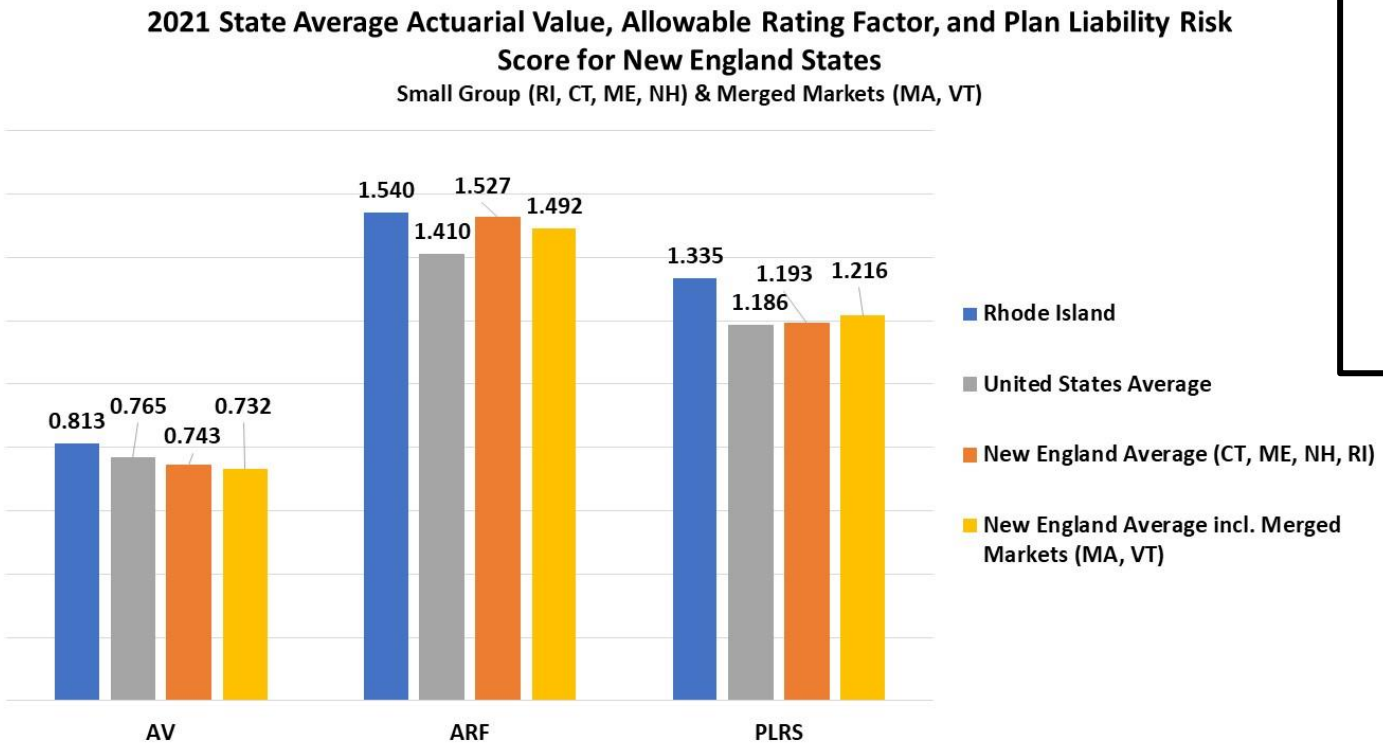
Small Group Market Average Premium PMPM



- This data is from the publicly available CMS risk adjustment reports.
- In 2021, Rhode Island average premiums are 3% higher than the United States average and 6% lower than the New England average including CT, ME, NH and RI.
- Premiums will vary by state due to plan design, demographics and regional cost differences.

Source: Centers for Medicare and Medicaid Services. Risk Adjustment Report Appendix A for 2018, 2019, 2020 and 2021 benefit years. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html.

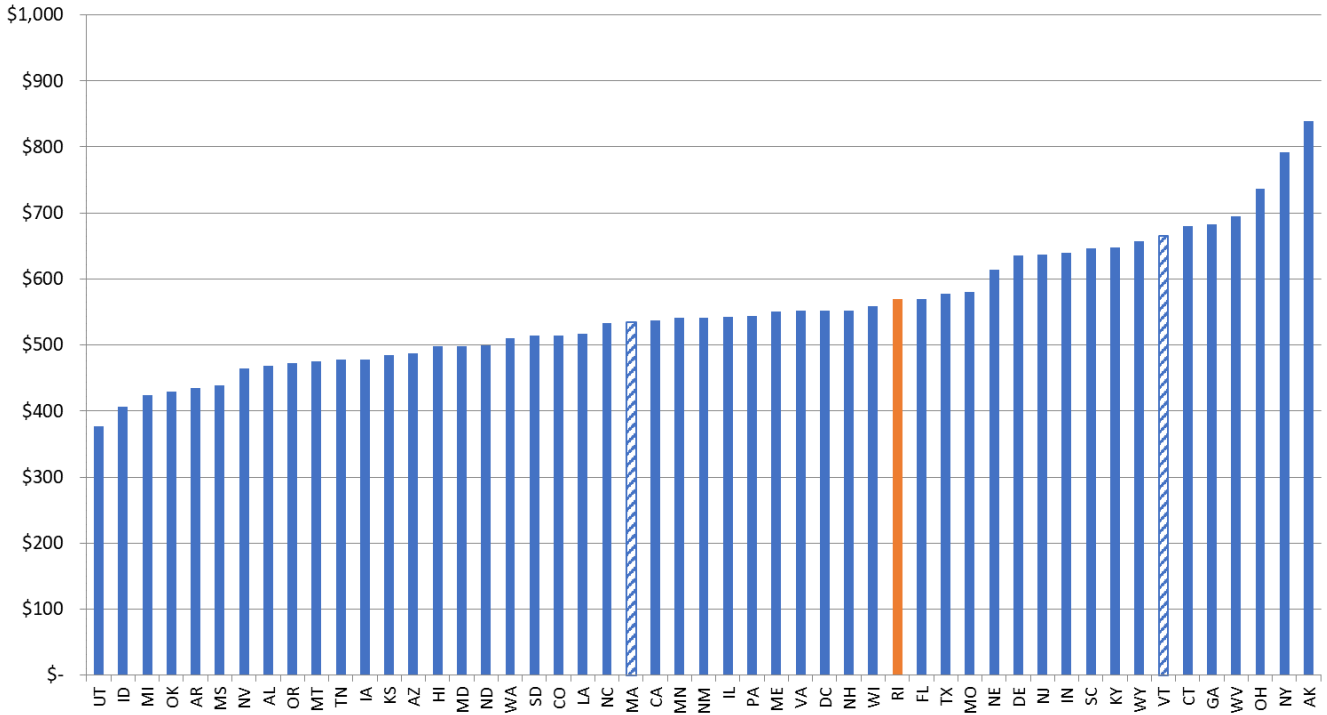
Rhode Island has higher average metal AVs, allowable rating factors, and risk scores compared to the United States average and New England averages.



- While Rhode Island Small Group has lower premiums than the New England average (including CT, ME, NH & RI), the metal AVs, allowable rating factors, and plan liability risk scores are higher.

Source: Centers for Medicare and Medicaid Services. Risk Adjustment Report Appendix A for 2021 benefit year. AV = Actuarial Value. ARF = Allowable Rating Factor. PLRS = Plan Liability Risk Score.

In 2021, Rhode Island has the 18th highest Small Group Market premium compared to other states.



Source: Centers for Medicare and Medicaid Services. Risk Adjustment Report Appendix A for 2021 benefit year. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html. Premiums will vary by state due to plan design, demographics and regional cost differences along with availability of reinsurance.

This chart includes states with merged market premiums (MA, VT).

Federal Risk Adjustment Program Results

Risk Adjustment Payouts: Individual Market

Individual Market - Federal Risk Adjustment Program[1]	2019 Risk Adjustment ($ millions)	2020 Risk Adjustment ($ millions)	2021 Risk Adjustment ($ millions)	2021 Risk Adjustment (PMPM)
Blue Cross & Blue Shield of Rhode Island	$3.4	$2.2	$9.4	$45.74
Neighborhood Health Plan of Rhode Island	($3.4)	($2.2)	($9.4)	($31.09)
Total	**$0.0**	**$0.0**	**$0.0**	**($0.00)**
Total $ Amount Distributed	***$3.4***	***$2.2***	***$9.4***	

[1] Negative = Company was a PAYER; Positive = Company was a RECEIVER

Risk Adjustment Payouts: Small Group Market

Small Group Market - Federal Risk Adjustment Program	2019 Risk Adjustment ($ millions)	2020 Risk Adjustment ($ millions)	2021 Risk Adjustment ($ millions)	2021 Risk Adjustment (PMPM)
Blue Cross & Blue Shield of Rhode Island	$5.0	$2.0	$1.9	$3.80
Neighborhood Health Plan of Rhode Island	($1.4)	($1.7)	($1.2)	($57.40)
Tufts Associated Health Maintenance Org	($1.7)	($0.3)	($0.3)	($16.12)
Tufts Insurance Company	($1.4)	$0.1	$0.4	$36.03
UnitedHealthcare Insurance Company	$0.0	$0.4	($0.9)	($33.23)
UnitedHealthcare of New England, Inc.	($0.5)	($0.4)	$0.2	$22.64
Total	**$0.0**	**$0.0**	**$0.0**	**$0.00**
Total $ Amount Distributed	***$5.1***	***$2.5***	***$2.5***	

ıpany was a PAYER; Positive = Company was a RECEIVER

Disclosures and Limitations

Limitations and Data Reliance

Gorman Actuarial prepared this presentation for use by the Rhode Island OHIC. While we understand that this document may be distributed to third parties, Gorman Actuarial assumes no duty or liability to any third parties who receive the information herein. This report should only be distributed in its entirety.

Analysis in this report was based on data provided by the insurers in the Rhode Island health insurance markets in the annual rate filings, federal Medical Loss Ratio forms, and other public sources. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data are inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete. As noted in the slides, adjustments were made to one carrier's data to account for discrepancies between the federal MLR data and other data sources.

The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of March 2023. If subsequent changes are made, these statements may not appropriately represent the expected future state.

Qualifications

The analysis in this report is based on work conducted by Bela Gorman, Amy Kwong, and Jennifer Smagula, each of whom are members of the American Academy of Actuaries. Amy Kwong is an Associate of the Society of Actuaries. Jennifer Smagula and Bela Gorman are Fellows of the Society of Actuaries. They each meet the qualification standards for performing the actuarial analyses presented in this report.