AMERICAN ACADEMY *of* ACTUARIES

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To: Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC

Steven Ostlund
Chair, Accident & Health Working Group, NAIC

From: Rowen Bell
Chair, Medical Loss Ratio Regulation Work Group

Re: Considerations Relating to PPACA Medical Loss Ratio Provisions (§2718)

Dear Lou and Steve:

The Health Practice Council of the American Academy of Actuaries[1] (Academy) has recently formed several work groups to focus on specific implementation issues relating to the passage last month of the Patient Protection and Affordable Care Act (PPACA). The work group that I am chairing has as its focus the provisions added by PPACA, via the creation of §2718 of the Public Health Service Act (PHSA), regarding medical loss ratio (MLR) reporting by health insurance issuers and the potential issuance of rebates by health insurance issuers.

Our work group is in the process of analyzing §2718, as well as preparing a response to the Request For Comments on §2718 that was issued by the U. S. Departments of Treasury, Labor, and Health and Human Services and published in the *Federal Register* on April 14, 2010. In our group's initial conversations, we have quickly reached the conclusion that there are a number of important questions that need to be addressed. In light of not only the National Association of Insurance Commissioners' (NAIC) statutory role stipulated by the PPACA as an advisor to the federal government regarding the implementation of §2718, but also the long history of cooperation between the Academy and the NAIC on actuarial regulation issues, we wanted to reach out to your respective groups at an early stage of the PPACA implementation process in order to help frame issues that we believe are particularly important to your upcoming work.

In this letter, we identify eight key questions regarding §2718. While these are not the only questions that we have about the statute, we have singled out these questions because we believe they are fundamental to the NAIC charge. Understanding what the answers to these eight

[1] The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

questions are will aid efforts in developing implementation approaches for §2718. Consequently, we would encourage you to explore these eight questions at an early stage of your work.

In addition to the eight questions posed in this initial letter, our group is also in the process of developing a document that will address some time-sensitive issues relating to the application of §2718 to the individual medical insurance market. We anticipate sharing that document with you as soon as it is ready, hopefully within the next few days.

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#1. What types of health insurance products are subject to the scope of the §2718 MLR reporting and rebate requirements?

§2718 uses such phrases as "health insurance issuer" and "group or individual health insurance coverage." Those terms, however, are not defined within PPACA itself. This has created uncertainty among some observers as to precisely which types of health insurance products are supposed to be included in the scope of the §2718 MLR reporting and rebate requirements. This is a statutory construction question requiring formal regulatory interpretation, not an actuarial or financial question. However, we raise it here because understanding the answer to the question may be of fundamental importance in thinking about how to construct the §2718 reporting mechanism.

With many aspects of PPACA still being interpreted, some of our members have received information arguing that those health insurance products that are considered "excepted benefits" under HIPAA are excluded from the scope of the §2718 requirements. The rationale advanced with this argument rests on PPACA §1562(a)(3), which amends an existing section of PHSA indicating which portions of Title XXVII Part A of PHSA (the part in which new §2718 resides) do not apply to excepted benefits. Again, however, we observe that this is a question requiring regulatory interpretation. Note that the HIPAA definition of "excepted benefits" could include many types of health insurance that carriers filing the NAIC Health Annual Statement would report in columns other than the Comprehensive (Hospital & Medical) column of the Analysis of Operations, such as Medicare Supplement policies, dental-only policies, vision-only policies, hospital indemnity, long-term care, and disability income.

At the same time, there are other types of health insurance not reported in the Comprehensive (Hospital & Medical) column that do not appear to fall under the definition of HIPAA "excepted benefits," such as the Federal Employees Health Benefit Program, Medicare Advantage,[2] standalone Medicare prescription drug plans, and Medicaid risk. Do any or all of these types of policies fall under the scope of §2718? What about specific and aggregate stop loss insurance policies issued to group benefit plans that self-insure their benefits? Does the question of whether or not a stop loss policy falls under the scope of §2718 depend in any way on the level at which the specific attachment point and/or the aggregate protection point is set? (Similar questions also exist for minimum premium plans.) Also, is it possible that there are types of contracts that are

[2] We also note that, separately, §1103 of the Health Care and Education Reconciliation Act of 2010 (HCERA) amends Title XVIII of the Social Security Act in order to impose a minimum loss ratio requirement for Medicare Advantage plans, effective starting in 2014.

accounted for as "uninsured plans" under the NAIC definitions in SSAP 47, but that would be considered for federal regulatory purposes as "health insurance coverage" under PHSA and hence properly included in the scope of §2718? Finally, will future "non-qualified" comprehensive plans (i.e., plans that do not comply with the "Essential Health Benefits Requirements" of PPACA §1302) be included in the scope of §2718?

In summary, with respect to scope: Achieving clarity at an early stage as to which types of health products are included and excluded from the scope of the §2718 requirements would be beneficial to all interested parties, and in particular might help the NAIC formulate appropriate recommendations around §2718 reporting.

#2. Is there value in construing §2718 so as to create a single cohesive form of MLR reporting for both §2718(a) and §2718(b), or is it necessary to construe §2718 as creating two distinct forms of MLR reporting that may not be readily reconcilable with one another?

The first sentence of §2718(a) creates a requirement for health insurance issuers to report "the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or [*sic*][3] change in contract reserves) to earned premiums." For clarity, we will refer to an MLR computed under this definition as being the *§2718(a) MLR*.

The remaining portion of §2718(a) specifies that the reporting requirement also includes separate presentation of the following three ratios:

- In §2718(a)(1), the ratio of expenditures on "reimbursement for clinical services provided to enrollees" to "total premium revenue;"
- In §2718(a)(2), the ratio of expenditures on "activities that improve health care quality" to total premium revenue; and
- In §2718(a)(3), the ratio of expenditures on "all other non-claims costs … excluding Federal and State taxes and licensing or regulatory fees" to total premium revenue.

Later, §2718(b) clarifies that the relevant MLR for purposes of calculating rebates is the sum of the ratio defined in §2718(a)(1) and the ratio defined in §2718(a)(2); that is, the ratio of "reimbursement on clinical services provided to enrollees" plus "activities that improve health care quality" to "total premium revenue."[4] For clarity, we will refer to an MLR computed under this definition as being the *§2718(b) MLR*.

[3] The use of "or" in the statutory language, rather than "and", is confusing. As a matter of theory, the desirability of including loss adjustment expenses in the numerator of an MLR calculation has no relationship to whether or not the underlying insurance contract is of a type where contract reserves are appropriate.

[4] §2718(b) makes it clear that, for purposes of determining whether rebates are required, the "total premium revenue" used in calculating the MLR shall exclude a number of items, such as federal and state taxes and fees. We assume here that the use of the phrase "total premium revenue" in §2718(a) was intended to be consistent with its use in §2718(b), i.e., with the exclusions defined in §2718(b). However, this is yet another area of potential ambiguity with the statute as written.

With this as background, the question we are posing here is whether it would be desirable to view the §2718(a) MLR and §2718(b) MLR as being the same quantity, or whether it is instead necessary to view them as being different quantities?

The answer to this question seems relevant to understanding not only the scope of the §2718 reporting requirements, but also understanding which terms need to be defined under the §2718 regulations. If it is decided that the §2718(a) MLR and §2718(b) MLR are intended to be consistent, then that disclosure might help clarify the issues relating to appropriate numerator and denominator definitions. If the §2718(a) MLR and §2718(b) MLR are instead separate concepts, then there will be a need to establish separate numerator and denominator definitions for both concepts and address whether or not reconciliation of differences will be necessary.

Without commenting in full detail at this time on the pros or cons of having a single cohesive form of §2718 reporting, we note that if there is not a single cohesive form of reporting, then the mere existence of differences between the §2718(a) MLR and the §2718(b) MLR could lead to significant confusion among stakeholders.

#3. Is there discretion in rulemaking to define whether the §2718 MLR reporting and rebate requirements apply on a nationwide basis, or on a more granular level such as on a state-by-state basis?

§2718 may not clearly address whether the reporting rebate requirements apply to a health insurance issuer's entire geographic span of business, or whether they apply at some other level such as a state-by-state basis. §2718(b)(1)(A)(ii) does indicate that, with respect to a health insurance issuer offering coverage in the individual market or small group market, the 80 percent MLR threshold may be increased to a "higher percentage as a State may by regulation determine." The possibility that different states might set different MLR thresholds raises questions as to the intended geographic level of the §2718 requirements.

Getting clarity on this point is relevant to designing the §2718 reporting mechanism. For example, if it is established that the reporting was not intended to be performed on a state-by-state basis, or alternatively that all states using the federal default threshold of 80 percent should be grouped together while only those states using higher thresholds need to be presented separately, then there would be implications as to the geographic granularity of the data that needs to be included in §2718 reporting.

#4. Is there discretion in rulemaking to define whether multiple related legal entities serving the same geographic market may be consolidated under some circumstances for §2718 purposes, or is it necessary to construe §2718 as applying on an entity-by-entity basis?

While NAIC financial reporting is performed at the legal entity level, there are some circumstances in state insurance rate regulation where related legal entities serving the same geographic market are treated as if they were a single entity.[5] The reality is that a health insurer

[5] For instance, see Q5 of the Academy's December 2009 Practice Note, "Actuarial Certification of Restrictions Relating to Premium Rates in the Small Group Market" (http://www.actuary.org/pdf/health/smallgroup_dec09.pdf).

will frequently offer both PPO and HMO coverage to the same group, but where the PPO coverage is issued by one legal entity and the HMO coverage by a separate legal entity. This illustrates the need for, in some circumstances, applying the §2718 requirements in a manner that combines business across multiple legal entities. However, it is not immediately clear that the statute permits such flexibility, given the reference to the §2718 requirements as applying to a "health insurance issuer" (a term defined within PHSA).

#5. To which business does the 80 percent MLR threshold in §2718(b)(1)(A)(ii) apply?

§2718(b)(1)(A)(ii) states that the MLR threshold relevant for determining rebates is 80 percent instead of 85 percent, "with respect to a health insurance issuer offering coverage in the individual market or small group market." Members of our group are currently aware of four alternative interpretations of what this is intended to mean:

(a) If a health insurance issuer offers coverage in the individual or small group markets, then 80 percent is the MLR threshold that applies to the sum of all of the issuer's business falling under the scope of §2718 (i.e., individual and/or small group and/or large group). The 85 percent MLR threshold mentioned in §2718(b)(1)(A)(i) would only apply with respect to an issuer who does not happen to offer coverage in either the individual or small group markets.

(b) If a health insurance issuer offers coverage in the large group market, then 85 percent is the MLR threshold that applies to the sum of all of the issuer's business falling under the scope of §2718 (i.e., individual and/or small group and/or large group). The 80 percent MLR threshold mentioned in §2718(b)(1)(A)(i) would only apply with respect to an issuer who only offers coverage in the individual and/or small group markets.

(c) If a health insurance issuer offers coverage in the individual or small group markets, then 80 percent is the MLR threshold that applies to the sum of the issuer's individual and small group business combined. The 85 percent MLR threshold from §2718(b)(1)(A)(i) applies to the sum of the issuer's large group business.

(d) If a health insurance issuer offers coverage in the individual or small group markets, then 80 percent is the MLR threshold that applies to the sum of the issuer's individual business, and also the threshold that applies to the sum of its small group business, but in two separate calculations (i.e., not a single calculation as in (c) spanning individual and small group combined). The 85 percent MLR threshold from §2718(b)(1)(A)(i) applies to the sum of the issuer's large group business.

Understanding which of these interpretations is correct will be very germane to constructing the appropriate §2718 reporting mechanism. For instance, if interpretation (a) were correct, then there may be no need for the §2718 reporting to make any effort to split an issuer's data into individual versus small group versus large group; whereas if interpretation (d) were correct, such a split would be necessary.

We observe that there is some interplay between the question raised here and the question raised in #3 above regarding nationwide versus state-by-state application of reporting. For instance, suppose it were determined here that interpretation (a) was correct, meaning that the issuer's presence in or absence from the individual or small group market is relevant for determining the MLR threshold applicable to its large group business. There might be some states in which an issuer offers coverage in the large group market as well as in the individual or small group markets, and other states in which an issuer offers coverage in the large group market only; this could complicate the determination of which threshold is applicable to the issuer. As another example, PPACA §1312(c)(3) gives a state the ability to merge its individual and small group insurance markets. If it were determined that interpretation (d) were correct but that the reporting should be done on a nationwide basis, then the existence of states in which the individual and small group markets have been merged could be a complication.

#6. The §2718 MLR reporting and rebate requirements use the phrase "with respect to each plan year." What are the implications of "plan year" here?

The use of the phrase "plan year" in §2718 raises the possibility that the intended reporting basis was an incurral-year basis or policy-year basis, rather than the calendar-year basis inherent in existing NAIC financial reporting. The issue being broached here is whether the set of premiums & claims that is supposed to be included in an issuer's §2718 reporting is different, in a temporal sense, from the set of premiums and claims included in an issuer's NAIC financial reporting. This in turn raises questions as to whether or not there should be a formal tie between existing NAIC financial reporting and §2718 reporting; possibly, the two types of reporting are intending to measure different things.

We also note that the term "plan year" appears not just in the §2718 requirements, but throughout PPACA. As such, decisions about what "plan year" means for purposes of §2718 reporting cannot be made in a vacuum.

An illustration might clarify the issue we are raising here. Consider an insurer's financial reporting as it would be reported in an NAIC Annual Statement for the year ending December 31, 2011. The premium and claim values included in that *2011 calendar year* financial reporting would typically represent a mixture of the following types of information:[6]

(a) Premiums earned and claims incurred in 2011 for policies issued or renewed in 2011;
(b) Premiums earned and claims incurred in 2011 for policies issued or renewed in 2010;
(c) Premiums and claims recognized in the 2011 financial statements but attributable to incurral years prior to 2011, resulting from differences between accruals established in the December 31, 2010 financial statements and the amounts paid in 2011 relating to those accruals (plus the remaining accruals in the December 31, 2011 financial statements attributable to years prior to 2011).

That 2011 calendar year financial reporting would not include the following information:

[6] For purposes of this depiction, we have made the simplifying assumption that all policies have a 12-month policy year, and hence that all premiums due in 2011 would relate to policies issued or renewed in either 2011 or 2010.

(d) Premiums earned and claims incurred in 2012 for policies issued or renewed in 2011.

By contrast, there could be two alternative reporting approaches:

- Reporting for the *2011 incurral year* (i.e., for claims incurred in 2011). This would include (a) and (b), but exclude (c) and (d).

- Reporting for the *2011 policy year* (i.e., for policies issued or renewed in 2011). This would include (a) and (d), but exclude (b) and (c).

A somewhat related issue is the question of what relationship should exist between the measurement date for the §2718 reporting and rebate requirements and the time period being measured (regardless of whether that time period is a calendar year or an incurral year or a policy year). In NAIC financial reporting, the measurement date coincides with the end of the calendar year being measured; this requires significant use of estimates with respect to both incurred claims and earned premium for the calendar year. The longer the delay between the end of the time period being measured and the measurement date, the less reliance needs to be placed on estimates in the reporting process.

#7. How do considerations relative to statistical fluctuation and credibility need to be addressed in responding to the above questions?

By its nature, medical insurance is subject to fluctuations in experience from period to period. Some years have higher loss experience than other years. Even large blocks of business will undergo fluctuations in claims experience, which may point to consideration of the use of multi-year experience, as in §2718(b)(1)(B)(ii), for determining refunds.

Of particular importance is the consideration of statistical fluctuations due to the credibility of the block of business being reported. The experience of a small block of business, whether it is a subset of a larger line of health business (e.g., a very small individual medical line in a company with a large volume of group business) or constitutes the entire health insurance line of a company in a particular state or in total, may not be statistically credible. The greater the granularity at which the §2718 requirements are deemed to apply, the lesser the likelihood that the reported blocks of business are fully credible. Should certain exception guidelines be developed to deal with non-credible results in addressing the refund formula and the questions posed above? We note that currently the statistical credibility of a block of Medicare Supplement business is considered in the refund formula for such business via the inclusion of the "tolerance permitted" component of the formula.

#8. Is there discretion in rulemaking to determine whether the §2718 MLR reporting and rebate requirements apply only to a health insurance issuer's directly-issued business, or to its business net of reinsurance assumed and/or reinsurance ceded?

While §2718 does mention the word "reinsurance," at least arguably that reference is intended to specifically apply to the reinsurance program established in PPACA §1341, "Transitional Reinsurance Program for Individual and Small Group Markets in Each State," and not

necessarily to traditional reinsurance treaties entered into among insurance carriers. In light of the fact that the §2718 requirements are stated as applying to "a health insurance issuer offering group or individual health insurance coverage," it is reasonable to ask whether the statute's requirements need to be construed as applying only to an issuer of insurance policies with respect to its directly-written premiums, as opposed to applying to a company's net-of-reinsurance premiums (without regard to whether or not it directly issues health insurance coverage). This point would appear to be relevant to the NAIC as you deliberate the appropriate degree of alignment between §2718 reporting mechanisms and existing NAIC financial reporting, given that existing NAIC financial reporting emphasizes a net-of-reinsurance presentation.

Without commenting in full detail at this time on the pros and cons of net-of-reinsurance reporting under §2718, we observe that if all reinsurance agreements are taken into account in the §2718 requirements, then it raises the possibility that a health insurance issuer could avoid paying rebates on its policies by using reinsurance to cede risk to a related entity that does not itself issue health insurance and hence may not be technically subject to the requirements of §2718. On the other hand, if no reinsurance agreements are taken into account in the §2718 requirements, then that may unfairly treat smaller health insurance issuers, who are more likely to need to use reinsurance against catastrophic claims as a risk management vehicle.

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We sincerely hope that our articulation of these questions is helpful to you as the NAIC commences its work on §2718 implementation issues, and we look forward to providing you with further input soon. If you have any immediate questions regarding this letter, please contact Heather Jerbi, the Academy's Senior Federal Health Policy Analyst, at jerbi@actuary.org or 202.223.8196.

Sincerely yours,

Rowen B. Bell, FSA, MAAA
Chairperson, Medical Loss Ratio Regulation Work Group
American Academy of Actuaries

Cc: Jay Angoff, Director, Office of Consumer Information and Insurance Oversight, HHS
Richard Kronick, Deputy Assistant Secretary, Health Policy, HHS