AMERICAN ACADEMY *of* ACTUARIES

May 14, 2010

Department of Health and Human Services
Attention: DHHS–2010–MLR
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medical Loss Ratios—Request for Comments Regarding Section 2718 of the Public Health Service Act

Dear Sir/Madam:

On behalf of the American Academy of Actuaries'[1] Medical Loss Ratio Regulation Work Group, I appreciate this opportunity to provide comments to the Departments of Health and Human Services, Treasury, and Labor in response to the recent request for comments on the new Section 2718 of the *Public Health Service Act* (PHSA), added via the recent enactment of the *Patient Protection and Affordable Care Act* (PPACA).

The PPACA provisions of §2718 place new requirements on health insurance issuers with respect to reporting of medical loss ratios (MLR) and potential issuance of rebates by insurers in situations where an insurer's actual MLR is below certain established thresholds. These provisions could have a significant effect on the structure of and competition within the health insurance industry and, consequently, have an effect on consumers. Over the next several years, the way in which §2718 is implemented could affect the number of choices available to consumers stemming from the amount of market competition as insurers decide whether or not to remain active in the health insurance market; the premium levels charged by insurers for their products; the manner in which those products are distributed and the associated compensation format and levels for brokers; the percentage of the population without insurance coverage; the manner in which insurers contract with providers; the administrative practices of insurers and the level of care management services provided by insurers to consumers; the solvency risks for insurers remaining in the market; and the willingness of providers of capital to invest in the health insurance industry.

As with any issue having such potentially far-reaching impact, it is important for regulators to act with great care in conducting regulatory rulemaking around §2718. The need for well-drawn regulations is made even more important by the following two factors. First, the statutory language of §2718 leaves open numerous interpretations, heightening the importance of the

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rulemaking process (and perhaps the need for technical legislative corrections) in bringing clarity to an ambiguous situation. Second, there are a number of important technical details not addressed within the statutory language of §2718 but that require delineation within rulemaking, in addition to the reference within §2718 anticipating the need for regulators to take "special circumstances" into account during rulemaking.

At the same time, however, the regulatory development process needs to be swift. Given that the statute calls for the rebate requirements to apply at the latest for plan years beginning Jan. 1, 2011, and that insurers typically need to set their premium rates some months before those rates take effect, it would be particularly beneficial to all stakeholders to clarify the technical aspects of the §2718 requirements in mid-2010, rather than waiting until early 2011. However, the need for swift action should be balanced against the potential benefits of a measured approach to implementation. Implementation of §2718 requirements could result in unintended consequences that might be difficult to unwind. A more gradual approach to §2718 implementation, to the extent permitted under the statute, would have the advantage of enabling additional changes or revisions to be made to the regulatory scheme as further knowledge and experience emerges.

The Academy has a long history of providing objective technical advice on areas affecting health insurance regulation, leveraging our members' professional expertise and familiarity with health insurance from a variety of perspectives. As such, our objective in responding to the request for comments is not to advocate for a particular regulatory outcome but, rather, to explore different alternatives and provide our profession's insights on the pros and cons of those alternatives. The work group that developed this response includes actuaries who work either directly or as consultants in state insurance regulation, the health insurance industry, and public accounting firms. Consequently, our intent in this response is to provide a balanced perspective on these important issues, in the hopes of contributing to the swift development of technically sound rulemaking regarding §2718.

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In the remainder of this document, we provide responses to many, but not all, of the questions posed in the request for comments. We have chosen not to respond to several questions where we felt that the Academy, or the actuarial profession, in general, did not have a unique perspective to offer and where other respondents were likely in a better position to provide salient input. Naturally, we would welcome the opportunity to further discuss any or all of our responses with interested regulators or provide additional input as you develop regulations.

Given the length of our overall response to the request for comments, we thought it would be helpful to briefly summarize some of the major issues explored in our response, with references to where in this document those issues are explored in greater detail:

1) *Dimensions of loss ratio variation*. There are many reasons why medical loss ratios vary across different markets (pp. 4-7), across different years for the same issuer (pp. 7-10), across different policy durations for underwritten individual insurance (pp. 10-11), and across issuers due to differences in their business models (pp. 16-19). These reasons need

to be understood in order to avoid unintended consequences of the specific approach taken to implementing §2718.

2) *Issues particular to the individual market*. Individual medical insurance has historically been priced on a lifetime rather than annual basis, and the introduction of an annual MLR requirement has the potential to significantly disrupt the individual market (pp. 10-13). Regulators may wish to explore alternative approaches for implementing §2718 requirements in the individual market in an effort to forestall destabilization of that market (pp. 13-15).

3) *Medical loss ratio definitions for reporting and rebates*. The statutory language in §2718 surrounding the definition of medical loss ratios for reporting and for rebate calculations is somewhat confusing and open to multiple interpretations as to the underlying intent (pp. 20-21). We identify two main views of how to read the statute (pp. 21-23) and discuss the pros and cons of those two main views (pp. 23-25). An important principle is that the implementation of rebate requirements should be done in a way that seeks to maintain a level playing field across different types of health insurance issuers, as opposed to creating a structural advantage for insurers employing particular types of business models (pp. 16-19).

4) *Aggregation issues*. The intent of §2718 is not entirely clear with respect to aggregation across different insurance markets (pp. 34-36), aggregation across geographies (pp. 38-40), aggregation across related legal entities (p. 37), or disaggregation within a specific insurance market (pp. 35-36). As regulators consider different approaches to aggregation in implementing §2718, a key consideration is the credibility of the blocks of business for which rebate calculations are being made and the desirability of avoiding payment of rebates for essentially random reasons (pp. 28-29).

5) *Timing issues*. The intent of §2718 is not clear with respect to timing, not only in terms of which sets of premiums and claims will get included in the MLR calculation for a particular period (pp. 42-43) but also in terms of how much time should elapse between the end of an established period and the measurement and reporting of the MLR for that period (pp. 40-41).

6) *Other technical issues*. In addition to the issues mentioned above, there are a number of other technical issues that need to be addressed. Among these are the treatment of reinsurance (pp. 31-32); the treatment of existing mechanisms through which portions of premium are returned to policyholders, such as experience-rating mechanisms in retrospectively-rated contracts (p. 32) and policyholder dividends (p. 33); and the determination of which parties receive rebates after it has been concluded that rebates are payable (pp. 44-45).

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A. Actual MLR Experience and Minimum MLR Standards

A.1.   How do health insurance issuers' current medical loss ratios for the individual, small group, and large group markets compare to the minimum standards required in PPACA?

For any given health insurance issuer, medical loss ratios generally have varied in a predictable fashion across the different market segments. In particular, loss ratios for individual market policies tend to be lower than in the small group market, which in turn tend to be lower than in the large group market. Several factors contribute to these differences, including:

(1)   *Insensitivity of administrative expenses to actuarial value.* Actuarial value (AV) is a measure of the level of insurance protection provided by a particular health benefits plan design. Plan designs with relatively large policyholder cost-sharing elements, such as deductibles, will have a lower AV than plan designs with relatively small policyholder cost-sharing elements. As such, high-AV policies have higher expected claim costs, and hence higher premiums, than low-AV policies.

However, many of the administrative services performed by an insurer do not differ significantly based on the actuarial value of the underlying policy. Services such as enrollment processing, insurance card issuance, billing and collection, policyholder communications, compliance, and actuarial functions are not proportionate to claims or premium levels. Furthermore, this is even true of claims processing expenses. A health insurer not only adjudicates benefits on those healthcare services that ultimately generate claims under the insurance policy, it also adjudicates benefits on all healthcare services, many of which may not ultimately generate claims under the policy, such as services provided before the policyholder's yearly deductible has been met.

Consequently, the per-enrollee amount that an insurer needs to spend on claims processing and other administration does not vary significantly with the actuarial value of that policyholder's benefit plan. Premiums, on the other hand, do vary significantly with actuarial value. Therefore, when measured on a percent-of-premium basis, low-AV policies are intrinsically more expensive to administer than high-AV policies. And, as a result, all else being equal, loss ratios will be lower for low-AV policies than for high-AV policies.

(2)   *Policyholder preferences in different markets.* At present, people purchasing insurance via the individual market pay the entire premium, with no employer subsidy and no associated tax deductions. For affordability reasons, participants in the individual market have tended to select products with a lower actuarial value (e.g., high-deductible products eligible for Health Savings Accounts) than the products usually purchased in employer-based markets. Because, as noted above, loss ratios are lower for low-AV policies, loss ratios in the individual market will generally be lower than loss ratios in the group market.

Similarly, participants in the small group market have historically tended to buy lower-AV products than participants in the large group market. This tendency may relate to the fact that while the vast majority of large groups have offered health benefits to their employees, many small groups have not due to affordability concerns. Therefore, the small groups that decide on the margins to offer coverage will likely do so via low-AV policies in order to minimize the employer's outlay. This factor tends to result in lower loss ratios in the small group market than in the large group market.

It is also notable that younger (and healthier) people will tend to select lower-AV product options than older people, due to a combination of affordability and health status. This tends to drive down the average premium for lower-AV products beyond its AV relative to richer benefit plans, which exacerbates the difference in expense ratios and medical loss ratios between products at different AV levels.

(3)   *Intrinsic expense differences by market*. Premiums in the individual and small group typically have needed to incorporate expenses beyond those included in large group market premiums. For instance, products in the individual and small group markets are frequently sold through a brokerage distribution channel, and compensation for the services performed by agents and brokers is achieved via commissions included in premiums, rather than via direct payments to agents and brokers by the policyholder. In the large group market, these same services may be undertaken by consultants and human resources staff, whose compensation is paid separately by the employer and not embedded in the premiums paid to the insurer. These differences are factors leading to the ability of companies to operate with higher loss ratios in the large group market. Similarly, the frequency of policyholder services provided to the individual market can be higher than in the group market, as enrollees need to work directly with the insurer (rather than via employer human resources staff) to handle items like address changes or benefit changes. Also, some of the insurer's administrative expenses emerge on a per-policy basis, such as the initial policy entry into the insurer's administrative systems. These per-policy expenses are spread over a larger base of premiums with a large group policy than with an individual or small group policy, which contributes to higher loss ratios in the large group market than in the individual or small group markets.

(4)   *Compensation for bearing risk*. Due in part to relatively lower customer participation rates, the individual and small group markets have a greater risk of adverse selection than the large group market and fewer individuals across whom to spread that risk. In other words, in a voluntary market, insurers in the individual and small group markets are more at risk for enrolling individuals with higher than average health care needs. As a result, insurers participating in the individual or small group markets often require higher margin targets as compensation for bearing this increased selection risk, compared to the margin targets they require in order to participate in the large group market. These higher target margins are a factor leading to lower loss ratios in the individual and small group markets.

Note that in light of these differences in medical loss ratios by market segment, differences in the mix of business between two different health insurance issuers will lead to differences in overall medical loss ratios across insurers.

In addition to these differences by market segment, there are a number of other factors that may influence the level of medical loss ratios across states and across insurers, including the following:

- State-specific laws or regulations that lead to higher expected claims costs will tend to lead to higher loss ratios, as premiums are higher but administrative costs are essentially fixed. Examples of such laws include benefit mandates and guaranteed issue requirements. Similarly, states in which health care costs are relatively high (e.g., due to patterns of care, differences in population morbidity, or differences in provider reimbursement rates) will tend to lead to higher loss ratios for the same reason.

- Some health insurance issuers sell multiple products to employer groups within the group market. For example, an employer group may offer both an HMO and a PPO product to its employees, and one product may attract a different profile of risks due to plan design differences. Cross-subsidization in premiums across product lines may lead to distortions in reported medical loss ratios for PPO products relative to HMO products in this situation.

  This is particularly salient within the context of §2718 in light of the fact that in the situation described above, the PPO and HMO products are often written by two distinct, but related, legal entities. (For historical reasons, most companies' HMO products are issued out of a different legal entity than their non-HMO products.) As such, in order to appropriately tie the calculation of rebates back to how products are priced, it could be appropriate in some circumstances to commingle experience across different related legal entities. See related comments below in Questions B.4 and C.1.

- An insurer will tend to have lower loss ratios in states having higher premium taxes or insurer assessments because higher levels of these items cause premiums to be higher while expected claims remain level.

  This effect can be mitigated by defining the loss ratio with a deduction of state premium taxes and insurer assessments from premiums in determining the denominator. Note that while §2718 supports this definition, most loss ratios reported today do not exclude such taxes and assessments from the denominator. See related comments below in Question B.1a.

- Insurers exempt from federal income taxes tend to have higher loss ratios than taxable insurers, as premiums do not need to include a component designed to fund the insurer's federal income taxes.

  This effect can be mitigated by defining the loss ratio with a deduction of federal income taxes from premiums in determining the denominator. Note that while §2718 supports

this definition, most loss ratios reported today do not exclude federal income taxes from the denominator. See related comments below in Question B.1a.

- Some health insurance issuers' business models generate items that are not readily decomposed into a claims piece versus an administrative expense piece. For example, consider salaries paid by a staff model HMO to employee doctors and nurses who provide both patient services and administrative services. This can lead to distortions in attempting to compare medical loss ratios across different types of health insurance issuers unless care is taken in the MLR definition. We will return to this concept at length in our response to Question B.1.

As we will discuss below in our response to Section B, there is considerable uncertainty as to how the §2718 medical loss ratio definitions should be interpreted and how these various interpretations relate to the MLR definitions most commonly used today—e.g., the definitions used in statutory financial reporting promulgated by the National Association of Insurance Commissioners (NAIC). As such, it is difficult to say definitively how insurers' current medical loss ratios compare to the new thresholds defined in §2718 until the rulemaking process provides further definition to the §2718 requirements. Several of the bullet points above illustrate potential areas of difference between current NAIC definitions and the §2718 definitions.

A.1.a. What factors contribute to annual fluctuations in insurers' medical loss ratios?

Health insurance is, at its core, a business of pooling and managing risk. For a given pool of insured risks, a health insurance issuer needs to set its future premium rates in advance, based on an estimate of the pool's future expected claim costs. Inevitably, the actual future claims experience of the pool will vary from the issuer's pricing estimates; while pooling may mitigate risk, it does not eliminate it. Therefore, as a fundamental matter, one should always expect to see statistical fluctuations in an insurer's medical loss ratio from year to year.

Having said that, there are a myriad of other factors that can contribute to annual fluctuations in a given insurer's medical loss ratio, including the following:

(1) *Changes in mix of business*. As noted in our response to Question A.1, medical loss ratios can vary significantly across different health insurance markets and across different geographical areas. If an insurer's mix of business by market or by geography changes from year to year, that change alone would drive a change in the insurer's MLR. Similar changes could result from shifts in the insurer's product portfolio.

A related issue can arise within the individual market, with respect to the insurer's mix of business by policy duration (i.e., the number of years that have elapsed since the policy was originally issued). For reasons we will discuss more fully in our answer to Question A.2, historically the expected MLR of a block of individual policies increases as the policy duration increases. Consequently, if the average policy duration of an insurer's block of individual business increases (e.g., by de-emphasizing the issuance of new policies), the insurer's annual MLR for its individual business would be expected to increase over time. Conversely, if the average policy duration of the block decreases

(e.g., by significant issuance of new policies), the insurer's annual MLR for individual business would likely decrease. This observation has important implications with respect to the potential destabilizing effects of §2718 on the individual market, as we will discuss in our response to Question A.2.

(2)   *Sample size issues*. We observed above that medical loss ratios are naturally subject to random fluctuations. The fewer policies included within the scope of an MLR calculation, the greater those fluctuations are likely to be. As such, medical loss ratios calculated at a very granular level will exhibit greater fluctuation than those calculated at a more aggregated level; and medical loss ratios calculated for smaller companies or smaller blocks of business will exhibit greater fluctuation than those calculated for larger companies or blocks. So-called "catastrophic claims" from a single policyholder may have little impact on the MLR of a large block of business but have a significant impact on the MLR of a small block of business. We note also that many companies with small blocks of business seek to reinsure against a high level of catastrophic claims using excess risk reinsurance. This is a recognized risk management tool, a side effect of which is to minimize annual fluctuations in the MLR. Its use should not be discouraged in the development of §2718 regulations. See related comments below in our response to Question B.4.

(3)   *Correction of prior estimates*. Depending on the calculation rules and timing, estimates may play a significant role in an MLR calculation, particularly the estimate of the insurer's end-of-period unpaid claim liability. Actuarial professional standards apply to unpaid claim liability estimation. Nevertheless, an insurer's actual claims runout will almost certainly vary from the actuarial estimate of the unpaid claim liability. In calendar-year financial reporting, any estimation variance in the end-of-period unpaid claim liability will affect the insurer's reported MLR for both that year and the subsequent year—but in opposite directions.

As a simplified example, suppose that an insurer starts business in year 1 and earns $1,000 of premium in each of Years 1 and 2. In Year 1, the insurer pays $700 of claims and estimates its year-end unpaid claim liability as being $125. Measured at the end of Year 1, the insurer's MLR for calendar year 1 would be 82.5 percent (numerator of $700 + $125, divided by a denominator of $1,000). Now suppose that in Year 2, the insurer pays $860 of claims, of which $150 were incurred in Year 1, and estimates its year-end unpaid claim liability (all of which pertains to year 2 claims) as being $140. Measured at the end of Year 2, the insurer's MLR for Calendar Year 2 would be 87.5 percent (numerator of $860 – $125 + $140, divided by a denominator of $1,000).

However, in this example the annual fluctuation in the reported MLR from 82.5 percent in Year 1 to 87.5 percent in Year 2 is entirely attributable to estimation variance in the unpaid claim liability at the end of Year 1. Imagine instead that the insurer had enjoyed perfect foresight and had estimated its unpaid claim liability at the end of Year 1 as being $150, instead of $125. Now, the insurer would have reported its Year 1 MLR as being 85.0 percent (numerator of $700 + $150) and also would have reported its Year 2 MLR as being 85.0 percent (numerator of $860 – $150 + $140).

This component of annual MLR fluctuation can be mitigated somewhat by decisions made regarding the timing of MLR reporting. The above example presumes there is no gap between the end of the period being measured and the date of measurement, leading to the need for a relatively large estimate of unpaid claims in the MLR calculation. While this is true with respect to the medical loss ratios derived from current NAIC financial reporting, a different approach may be desirable for §2718 purposes. See related comments below in our response to Question D.2.

(4)   *Inflationary effects*. In recent experience, the rate of inflation in health insurers' claim costs has outpaced general inflation (as a result of increases in both prices charged and frequency/intensity of services provided) and, in particular, has outpaced the rate of inflation in health insurers' administrative expenses. If claims continue to inflate at a higher rate than expenses, then insurers' medical loss ratios will drift higher over time. Conversely, if claims inflation is less than expense inflation in the future, medical loss ratios would drift lower over time.

(5)   *Unanticipated environmental changes*. As noted above, insurers set their future premium rates in advance, and in doing so need to make a variety of assumptions. There are a number of reasons why those assumptions may end up being invalid, resulting in an unexpected fluctuation in the insurer's MLR. We note four representative reasons. First, incidence of influenza outbreak may be different than the insurer expected in its pricing (e.g., the H1N1 virus in late 2009), leading to a variance in the insurer's utilization assumptions. Second, the outcome of an insurer's contract negotiations with healthcare providers may be different than the insurer expected in its pricing, leading to a variance in the insurer's unit cost assumptions. Third, recently introduced medical technologies or pharmaceutical therapies may drive changes in consumer utilization patterns from those anticipated by the insurer in its pricing. Fourth, competitor behavior in the insurance market may be different than the insurer expected in its pricing, leading to a variance in the pool of risks that the insurer attracts.

(6)   *Insurer market strategy*. Some component of the annual fluctuation in an insurer's medical loss ratio may represent a conscious attempt by the insurer to adjust its positioning in the market. For example, an insurer may seek to expand its share in a particular market and be willing to accept lower margins in exchange. Or, in response to adverse experience in a particular market, an insurer may be trying to rebuild its margins over time. A complicating factor here is the long interval that occurs with health insurance between the point at which an insurer recognizes that its prior pricing did not meet its objectives and the insurer's ability to influence the financial reporting of pricing decisions. For instance, by the time an insurer fully realizes that its pricing expectations in Year 1 were not met, it is likely already too late to affect pricing for Year 2, so pricing actions taken in response to the Year 1 experience may not have an impact until Year 3 and not fully realized until the financial reports for Year 4.

(7)   *Influence of regulatory rate review process*. Many states require the review and approval of some premium rates prior to those rates being effective. This is particularly true for the

individual market and true to a lesser degree in the small group market; in the large group market, this level of regulatory review is rare and has generally been considered unnecessary given the sophistication of larger employers. Some portion of annual fluctuations in an insurer's medical loss ratio may be attributable to decisions by regulators to delay the timing of a rate change or approve a lower rate change level than what the insurer sought.

A.2.   What criteria do States and other entities consider when determining if a given minimum MLR standard would potentially destabilize the individual market? What criteria could be considered?

Considerations when determining if a given minimum MLR standard would destabilize the individual market in a particular state should include the following:

- the loss of carriers marketing products;

- the loss of the ability of customers to easily find product offerings due to the reduction or elimination of marketing channels;

- the possibility of customers having their current coverage changed materially or canceled;

- the inability of canceled customers to find new coverage that covers pre-existing conditions; and

- the potential for increased volatility in premium rates.

We are concerned that all of the situations listed above could occur during the transition period between now and 2014 if products currently in force in the individual market are held to an annual MLR standard at the level included in the legislation. Of course, the many open issues as to what the §2718 MLR definition actually means (as discussed in our response to Question B.1a below) and what levels of aggregation are contemplated in §2718 (as discussed in our responses to Questions C.1 and C.2 below) make it difficult to say with certainty that destabilization would or would not occur. Nevertheless, we believe the risk of destabilization with respect to the individual market is significant enough that regulators should consider preemptively addressing that risk in the rulemaking process.

Individual Market Pricing

To better understand the potential for market disruption, it is important to consider that the individual marketplace has several unique characteristics that are typically not seen in either the small or large group marketplace. Pricing for individual products has traditionally been done on a lifetime basis versus an annual basis, with a lifetime target loss ratio that is developed from the cumulative experience of historically increasing durational loss ratios and the amount of business in force at each duration. Due to underwriting at policy issuance (but not thereafter), typically the expected loss ratios of individual business are low in the early policy durations relative to the

later durations. Expected claims increase as the policy duration increases, as new illnesses or accidents covered by the policy but not present at the time of policy issuance manifest themselves (often referred to as the "wear off" of initial underwriting). When premium increases from one policy duration to the next are limited to general medical expense trends, the mathematical consequence is that loss ratios will increase by policy duration.

As an illustrative example, a block of underwritten individual business might exhibit a pattern of relative claim costs by policy duration (expressed as a ratio of the ultimate claim cost in later durations) like the following:

Policy Year (Duration)	Relative Claim Cost
1	0.563
2	0.839
3	0.931
4	0.977
5	0.989
6+	1.000

To compute a loss ratio pattern that corresponds to this illustrative claim cost pattern and that produces a lifetime loss ratio of 80 percent, one needs to make assumptions about policyholder persistency—the extent to which policyholders continue to maintain their coverage over time. The table below is an illustration of loss ratio patterns by policy duration that are consistent with the table above and also consistent with policyholder persistency patterns typically observed in the recent past:[2]

Policy Year (Duration)	Annual MLR
1	49%
2	73%
3	81%
4	85%
5	86%
6+	87%

For many carriers currently active in the individual market, the greatest amount of business is in the early durations. Many policyholders drop individual coverage when they become eligible for employer-based coverage, and others may remain in the individual market but switch issuers. In light of these market dynamics, some members of our work group note that, in their experience,

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[2] We caution readers of this example that there is a real possibility that existing blocks of individual business, as well as new blocks issued prior to 2014, may experience significantly different policyholder persistency patterns in the future than those observed historically in the individual market. Changes in policyholder behavior may occur from 2014 onward due to the introduction of guaranteed issue requirements and the introduction of standard benefit packages different than the historically offered benefits. Different policyholder persistency patterns applied to the same pattern of relative claim costs will produce different durational MLR patterns in trying to achieve the same lifetime MLR.

the average length of time that people keep individual coverage in the current market appears to be around three years. Because of the pricing pattern required by these situations, the lifetime loss ratio is not met until product maturity has been achieved, as noted in the illustrative table above. An annual MLR calculation does not account for this pricing pattern. In particular, meeting an annual MLR target could be particularly difficult for companies with newer blocks of business that are only in early durations, or for companies that have been rapidly growing their individual business in recent years.

Moreover, the 80 percent level may not be a realistic target for companies to meet during the transition period with business originally priced in the traditional fashion. Going forward, it may be possible for companies to renegotiate distribution contracts and adjust first year expenses to allow them to meet an 80 percent lifetime MLR on business issued after these renegotiations. However, they may be unable to adjust distribution contracts on business currently in force. In addition, while new business may be issued based on meeting a higher lifetime loss ratio, the newly-issued business will still have an annual loss ratio well below the lifetime target loss ratio during the early durations. The result is that actual experience could be much lower than the 80 percent MLR annual refund target during the transition period, even as the companies seek to achieve the higher loss ratio requirements on a lifetime basis.

Potential implications of applying an annual 80 percent MLR standard to the current individual major medical market could include the following:

- Some companies may remain in the market but may lack an effective distribution channel due to their need to significantly lower their distribution costs to meet the 80 percent MLR standard. Many insurance agents could discontinue selling individual health insurance if insurers materially decrease agent compensation for that product, which could inhibit consumers' access to the individual market in the years prior to the introduction of insurance exchanges.

- Other companies may decide if it is more advantageous for their long-term solvency to stop selling individual medical products, cancel their currently in-force business, or both.

- To the extent that companies cancel their currently in-force business, it may be difficult for their former policyholders to find new individual coverage in the transition period prior to 2014. For reasons discussed above, fewer companies may be marketing individual products during the transition. Also, guaranteed issue requirements in the individual market will not yet be applicable, and people whose coverage was canceled but who cannot meet underwriting requirements for new products will be subject to a six-month waiting period before becoming eligible for coverage under the new federal high risk pools created by PPACA §1101.

- Individual policyholders may be subject to greater volatility and uncertainty with respect to premium rate changes on policy renewal. An annual loss ratio requirement could lead to an environment in which premium rate actions on renewal need to account not only for claims trend and aging, but also for underwriting selection wearoff, which in the early renewal years would potentially be very significant.

There are some anecdotal indications that some companies are already starting the evaluation process so as to be prepared to cancel their blocks of individual major medical insurance if the implementation of §2718 requirements would result in them having to operate at a loss during the transition. To avoid being required to participate in the 2011 refund cycle, an insurer would need to cancel all its business by Dec. 31, 2010. Under PHSA §2742(c)(2)(A)(i), companies must give 180 days notice to their policyholders of cancellation. This means that companies would need to make final decisions on block cancelations in mid-June in order to exit their business prior to 2011. This highlights the need to clarify these issues quickly.

Due to the inherent inconsistency between the lifetime pricing methodology required for this type of business, the durational variation in loss ratios for medically underwritten business already in force, and the annual MLR computation, it may be appropriate to consider options in the MLR computation for the individual major medical product. To avoid disruptions in this market, these options need to be announced by mid-June of 2010 to have an impact on carrier decisions for their existing blocks of individual business.

Potential Approaches

We now discuss several options that may be available to regulators in order to mitigate this situation. These options are not mutually exclusive, and combinations of two or more of the approaches described below may be worth considering. We recognize that potential avenues open to regulators are likely restricted by the existence of the statute; however, we wanted to present a wide array of options and leave it to regulatory judgment as to the extent to which each of these options may or may not be compatible with the statute.

(1)   *Lower the 80 percent threshold for grandfathered individual business*. One option would be to lower the threshold on a permanent basis, recognizing that many blocks of grandfathered business were priced to a lifetime loss ratio below 80 percent. Alternatively, while a lower threshold could be established for the immediate future, over time that threshold could grade up to 80 percent, reflecting that the aggregate MLR of grandfathered individual business can be expected to rise over time as the average policy duration of that closed block increases.

       This solution is comparatively easy to implement. However, it would still result in a calculation that disproportionately affects insurers whose blocks have a high concentration of early-duration business, as opposed to issuers with more mature blocks.

(2)   *Rather than applying an 80 percent MLR threshold in aggregate, develop different MLR thresholds that vary by policy year or by calendar year of issue*. These different MLR thresholds by year would be chosen in a way that targets an 80 percent lifetime MLR. (Note that this may involve thresholds in later durations being above 80 percent and thresholds in earlier durations below 80 percent.)

       This approach is attractive because it directly addresses the potential for disproportionate impact across carriers based on their durational mix.

Several variations on this general approach could be adopted. For instance, in light of credibility concerns (see further discussion later in this document), tolerance adjustments could apply to each of the different MLR thresholds, where rebates would not be payable if the actual annual experience was below the MLR threshold but within the tolerance adjustment. In that context, it might be appropriate to have wider tolerance adjustments in the earlier years of issue, narrowing over time (and possibly becoming negative), and it might be appropriate for the tolerance adjustments to somehow incorporate the extent to which the original pricing lifetime loss ratio for grandfathered products varies from 80 percent. Tolerance adjustment concepts such as these might provide insurers with a longer span of time to adapt to the new 80 percent standard in a manner that is relatively non-disruptive to consumers.

(3) *Exclude experience in the select period of underwritten individual business from the scope of the MLR rebate calculation*. By "select period," we mean the period of time in which underwritten individual business is expected to exhibit annual loss ratios that are materially below the lifetime loss ratio, due to the impact of underwriting. The select period could be deemed by regulation (e.g., two or three years). As such, under this approach a policy would not be subject to rebate provisions during the first two (or three) years, but then rebates would start to be applicable to that policy thereafter.

This approach has the advantage of preserving the statutorily-imposed 80 percent MLR threshold, at least for part of the market. This approach also addresses the concern about disproportionate impact on carriers based on their mix of business by duration. On the other hand, this approach would mean that a large segment of the individual market business would not be immediately subject to the scope of rebates, even though those blocks would eventually become subject to rebates as they mature.

(4) *Allow issuers for purposes of §2718 to calculate contract reserves using a federally defined methodology[3] and include the change in contract reserves in the numerator of the §2718 MLR*. As discussed later in this document, language in §2718(a) suggests that changes in contract reserves were intended to be part of the MLR numerator. Practice varies widely today among issuers as to whether or not contract reserves are established, for purposes of NAIC financial reporting, to reflect the durational pattern of loss ratios for underwritten individual medical business. Without regard to whether an insurer currently establishes contract reserves in its NAIC financial reporting, it may be desirable and appropriate for issuers to calculate contract reserves, using a federally-defined methodology, for purposes of determining the §2718 MLR.

This approach has the theoretical appeal of directly addressing each insurer's own situation regarding the durational mix issue, rather than applying one-size-fits-all solutions as in the approaches discussed above. On the other hand, this approach would require additional regulatory oversight with respect to assessing the appropriateness of

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[3] We note that there is existing precedent in federal regulation for this type of approach, in CFR Title 42 §403.253(b)(2)(ii) with respect to federal Medicare Supplement loss ratio certifications.

the issuer's calculation of contract reserves. This can be partially mitigated by requiring an actuarial certification of the contract reserves computed for this context.

Variations on this approach would include different choices for technical details of the reserving methodology, whether issuers are required to calculate contract reserves or instead can elect to do so, and whether the contract reserve calculation applies to all individual business or only subsets (e.g., business issued on or after a particular date).

We should point out that although the issues regarding the 80 percent MLR threshold are most pronounced for grandfathered individual business, issues do exist for business written after the adoption of PPACA but before 2014 and for business written after 2014:

- Individual policies written after the adoption of PPACA but before 2014 will continue to exhibit durational variation of medical loss ratios. As such, approaches like (2), (3), and (4) above are relevant to this category of business. A company's willingness to issue new individual medical business prior to 2014 may be jeopardized if the newly-written business must immediately meet an 80 percent annual MLR standard, without recognition of the impact that policy duration has on loss ratios.

- It is unclear at this time to what extent individual policies written in 2014 and later, after the introduction of guaranteed issue requirements, will continue to exhibit durational variation in loss ratios. For example, if guaranteed issue is implemented via an annual open enrollment period, then insurers may still employ some underwriting techniques at times other than the open enrollment. In that case, we may still see some impact of policy duration on loss ratios, and approaches such as (2), (3), and (4) above may remain relevant to business issued in 2014 and later.

As the individual market is unlike any other major medical market, the Academy would be willing to provide further assistance on these issues to help in the rulemaking process.

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B. Uniform Definitions and Calculation Methodologies

B.1.   What definitions and methodologies do States and other entities currently require when calculating MLR-related statistics?

Today, there are three main situations in which states and other entities influence the definitions and methodologies used by health insurers to calculate MLR-related statistics:

1) MLR-related statistics may be derived from so-called "statutory" financial reports submitted to state insurance departments by the vast majority of health insurers and based on accounting principles and financial reporting conventions promulgated by the NAIC.

2) MLR-related statistics may be derived from general-purpose financial reports submitted to the Securities and Exchange Commission (SEC) by some (but not most) health insurers and consistent with generally accepted accounting principles (GAAP).

3) MLR-related statistics may be cited in documentation developed by health insurers and submitted to state insurance departments to support premium rate filings.

In our response to this question, we focus on the first of these three situations. Definitions for the second situation are less well-specified in the literature and more dependent on the discretion of the company involved, subject to oversight from their independent public accounting firm and ultimately from the SEC. In particular, the definitions used to compute a company's MLR as reported in its SEC financial reporting are not necessarily the same as those used to compute its MLR in its NAIC financial reporting. And, SEC reporting is likely to be at a much less granular level than NAIC reporting. Definitions and methodologies for the third situation are likely to rely in whole or in part on definitions established for NAIC financial reporting, but nuances may vary by state and/or by insurance product.

NAIC financial reporting involves a myriad of different quantities and is governed by various pieces of accounting literature, most notably Statements of Statutory Accounting Principles (SSAP) and Annual Statement Blanks and Instructions promulgated by the NAIC. The most commonly referenced MLR-related statistic from NAIC financial reporting is simply the ratio of incurred claims to earned premiums, with specific definitions influencing the definition of "claims" and "premiums." However, there are other MLR-related statistics appearing in NAIC financial reporting besides the basic ratio of incurred claims to earned premiums. We believe it is important, in the context of thinking about rulemaking under §2718, to understand these other MLR-related statistics and the extent to which they ameliorate potential deficiencies in the basic claims-over-premiums MLR. To motivate that subject, we need to start with a discussion of business models employed by the health insurance industry.

Different health insurance issuers deliver coverage to their enrollees through several different business models. Under the most common model, a health insurance issuer does not directly provide healthcare services, but instead enters into contracts with unaffiliated healthcare providers who provide care to the issuer's enrollees and accept payments under the terms of the issuer-provider contracts, frequently on a fee-for-service basis. An important variation on this model involves the payment of capitations by issuers to providers, in lieu of reimbursement by issuers to providers for claims generated by specific healthcare services. Capitations are per-enrollee-per-month (PEPM) payments that may cover all types of healthcare services or only certain types (e.g., mental health services). At the other end of the spectrum of models, are health insurance issuers that employ healthcare providers who directly provide healthcare services to the issuer's enrollees (e.g., staff model HMO, prepaid group practice) or that deliver care through an owned-and-operated integrated delivery system including facilities and pharmacies.

The fundamental issue with the claims-over-premiums MLR definition, viewed in this context, is the difficulty of arriving at a definition of claims that applies consistently across different types of business models. The notion of claims involves payments made to those healthcare providers

delivering care to the issuers' enrollees.[4] Under some models, such payments made by an issuer to providers may also implicitly relieve the issuer of administrative burdens it would have if it operated under a different model. An example is a capitation to a provider group, which relieves the issuer of the need to separately adjudicate a claim to that provider group for each and every healthcare service provided by that provider group to the issuer's enrollees. As such, on some theoretical level a capitation represents a mixture of a "claim" and an "administrative expense." However, since any attempt to bifurcate the capitation into such pieces would be artificial, in practice the entire capitation payment is reported as claims. Another example involves care management services. Under some models these services may be performed by issuer employees (or contractors) that do not otherwise provide care to enrollees. Under other models, however, these services may be implicitly bundled with the provision of healthcare services, and the issuer's payment for these services likewise may be implicitly bundled with its payment for healthcare services, in a manner that does not readily admit unbundling.

The result of this conundrum is that a claims-over-premiums MLR may not be consistently calculated across different types of health insurance issuers, due to differences in those issuers' underlying business models. Generally speaking, insurers that make heavy use of capitation payment mechanisms, and/or directly provide healthcare services to their enrollees via their own employees or facilities, will tend to have a higher claims-over-premiums ratio than issuers who do not. This is not because their business models are necessarily more efficient at delivering value to enrollees but, rather, simply because of definitional issues within that MLR calculation.

In the context of NAIC financial reporting, which is primarily oriented around helping insurance regulators assess the solvency condition of health insurance issuers, these inconsistencies are not particularly salient. This is largely due to the fact that, today, what an issuer reports in its NAIC financial reporting as its MLR does not in and of itself have any economic consequences. However, in the context of §2718 requirements, federal MLR reporting will have economic consequences to issuers via the rebate mechanism. Given the lack of any apparent legislative intent to create an unlevel playing field across different types of health insurance business models, it is important that the §2718 MLR definitions are designed to avoid creating structural inconsistencies whose effect may be to favor some business models over others. (We will explore this theme further below in our response to Question B.1a.)

Several years ago, some insurance regulators became concerned over the difficulties in comparing medical loss ratios across the different companies that they regulate, due to differences in business models as well as differences across companies in how similar types of expenditures were classified. The outgrowth of that regulatory concern was the adoption of an accounting standard called SSAP 85, which defined a health insurance accounting concept called cost containment expenses (CCE).[5] By isolating CCE, the NAIC made it possible for users of NAIC financial reporting to calculate a second type of MLR-related statistic, namely incurred

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[4] However, we note that existing NAIC definitions specifically indicate that certain items are to be reported as part of claims, even if they do not directly represent payments to providers of care. For example, certain health related assessments imposed by states, as defined in SSAP 35, are considered claims by the NAIC.

[5] We assume that other parties responding to this request for comments will be providing the departments with further information about the existing definition of SSAP 85 cost containment expenses, so we have decided not to discuss those definitions per se, in favor of instead discussing the utility of the CCE concept.

claims plus CCE divided by earned premiums. One of the leading exhibits in the NAIC's annual statement for health insurers, the five-year historical exhibit, shows claims-over-premium and CCE-over-premium ratios, allowing users to compute the insurer's MLR both with and without CCE included in the numerator.

From a theoretical perspective, an MLR in which the numerator includes both claims and CCE (instead of just claims) is attractive for two main reasons. The first is that the inclusion of CCE in the numerator helps mitigate the comparability concerns discussed at length above. The ratio of claims-plus-CCE to premium creates a fairer comparison across different types of health insurance issuers than does the claims-to-premium ratio. The second is that, as one might expect from the name cost containment expenses, the amounts that a health insurance insurer spends on CCE activities lead directly to decreases in the amounts the issuer would need to spend on claim payments under its insurance contracts. As such, it would be somewhat perverse to make comparisons between different issuers as to the proportion of premiums that go towards claims, without simultaneously taking into account the proportion of premiums that go towards activities that explicitly help control the cost of claims, particularly in an environment in which health insurers are being challenged by policymakers to do more to bend the cost curve. (We return to this theme in our response to Question B.1a below.)

While including CCE in the numerator of an MLR-related statistic helps mitigate the potential for inconsistencies across different health insurance issuer business models, it does not completely resolve those inconsistencies. Similarly, while including CCE in the numerator helps address ways in which the insurer provides value to policyholders apart from claims, it does not fully capture all dimensions of value.

Consider once again the example of a capitation payment made by an issuer to a provider group, obviating the need for the issuer to separately adjudicate benefits for each and every healthcare service obtained from that provider group by the issuer's enrollees. Clearly, the amount that the issuer will need to spend on administering the payment of such capitations is significantly less than the amounts that the issuer would need to spend on adjudicating claims for the affected enrollees, were there no capitation arrangement. Similarly, there will be differences from the provider group's standpoint in terms of the amount of its resources it needs to devote to ongoing interactions with the issuer under a capitation arrangement versus a fee-for-service arrangement. Both of these differences will naturally influence negotiations between issuer and provider in setting the level of capitation payment versus the level of payment under a fee-for-service arrangement.[6] Therefore, in order to get a fair comparison between different issuer business models, it would be necessary to include the issuer's expenses of administering claim payments to providers, together with those claim payments themselves, in the numerator of the medical loss ratio.

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[6] To make this observation more concrete, we offer a simplified example. Suppose that an issuer believes that claims paid under a fee-for-service contract for a particular population would likely cost $200 PEPM, and that it would cost the issuer $15 PEPM to adjudicate claims under a fee-for-service contract. If the issuer also believes in the alternative that it would only cost $5 PEPM to adjudicate capitations, then the issuer may be willing to enter into a capitation arrangement involving a PEPM payment at a level in excess of the issuer's expected PEPM fee-for-service claims, such as $205 PEPM.

The above paragraph motivates the potential value of an MLR definition in which the numerator is broader than the claims-plus-CCE definition discussed previously—broadened via the inclusion of all of the issuer's loss adjustment expenses (LAE). LAE, also known as claims adjustment expenses (CAE), is defined within SSAP 85 to include not only all CCE but also the costs of adjudicating benefits under the enrollee's insurance contract.

The term LAE is also used in other contexts, such as property and casualty insurance. However, with health insurance, it is worthwhile to note that the insurer's LAE activities provide direct and immediate value to the enrollee, independent of the claims to which the enrollee is entitled under the policy. This is because the issuer's adjudication process mitigates the enrollee's out-of-pocket costs for all healthcare services, even those that do not generate insurance claims (e.g., before the enrollee's deductible is satisfied), since the issuer's contractual arrangements with healthcare providers are extended to all of the enrollee's healthcare services.

In the NAIC's annual statement for health insurers, one of the most detailed exhibits is the Underwriting and Investment Exhibit Part 2C, which presents historical information on an issuer's claims experience by product. Section C of that exhibit shows ratios of claims-plus-LAE to premiums by product, underscoring the potential value that this broader definition has to regulators.

We have now discussed two alternatives, already depicted within different aspects of NAIC financial reporting, to the claims-over-premium loss ratio definition: one in which the numerator involves claims plus CCE and one in which the numerator involves claims plus LAE. There is a third alternative definition currently used within another aspect of NAIC financial reporting, namely one where the numerator involves claims plus the change in contract reserves; this definition appears in the Accident and Health Policy Experience Exhibit, which presents information on an issuer's current-year experience by product. See further discussion of contract reserves in our response to Question B.1c below.

In summary, multiple definitions of MLR-related statistics exist today within NAIC financial reporting, and increasingly broader definitions help ameliorate deficiencies of the basic claims-over-premium MLR with respect to comparability across issuers and capturing all dimensions of the health insurer's value proposition to consumers.

Finally, we note that none of the MLR-related statistics from current NAIC financial reporting that we have been discussing involve adjustments to the denominator. Nevertheless, as discussed in our response to Question A.1, deducting certain types of federal and state taxes and regulatory fees from the denominator of an MLR calculation is technically sound, from the standpoint of improving comparability across issuers. We discuss this further in our response to Question B.1a.

B.1.a. What assumptions and methodologies do issuers use when calculating MLR-related statistics? What are some of the major differences that exist, as well as pros and cons of these various methods?

We view this question as the appropriate forum in which to address the following critically important issues:

- Ambiguities that exist within the statutory language of §2718(a) impacting the definition of medical loss ratios; and

- Potential ways of interpreting the definitions of medical loss ratios in §2718 and the pros and cons of those interpretations given the objectives of §2718.

Before discussing those issues, we observe that issuers currently calculate many different types of MLR-related statistics for many different purposes. A medical loss ratio calculation is dependent on a number of different choices, including which time period to measure, the date as of which the measurement is to be performed, an accounting basis (e.g., cash basis versus accrual basis), which insurance policies to include in the measurement, and definitions on what to include in the numerator and denominator of the calculation. Different choices are made today for different purposes. Rather than discuss that aspect of current practice at length, we feel it is more important to focus on issues relevant to the intended purpose of MLR-related statistics within the context of §2718.

Ambiguities in Statutory Language of §2718(a)

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 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 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. For clarity, we will refer to an MLR computed under this definition as being the *§2718(b) MLR*.

The first ambiguity within §2718(a) involves potential exclusions from the denominator of the loss ratios. Section 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 federal and state taxes and licensing or regulatory fees. It seems reasonable to assume here that the use of the

phrase "total premium revenue" in §2718(a)(1) through §2718(a)(3) was intended to be consistent with its use in §2718(b), i.e., with the exclusions defined in §2718(b). (If this were not the case, then the calculation of rebates in §2718(b) would be based on ratios different from those defined in §2718(a), which would appear to be both pointless and confusing.) The next question becomes, is earned premiums in the first sentence of §2718(a) intended to carry the same meaning as total premium revenue and reflect the exclusions defined in §2718(b)?

The second, and more fundamental, ambiguity within §2718(a) involves trying to determine the relationship between the first sentence of §2718(a) and the remainder of §2718(a); or, using the terms we defined above, trying to reconcile the §2718(a) MLR with the §2718(b) MLR. While the statutory language is confusing, there appear to be two main views on how §2718(a) can be read.

One view is that the intent was to create a single cohesive set of reporting regarding issuers' loss ratios. Put differently, this view places primary weight on the first sentence of §2718(a) in interpreting the intent of the statute's rebate requirements. Under this reading, the §2718(a) MLR and the §2718(b) MLR were intended to be the same thing, even though different wording was used to describe the two concepts. Below, we refer to this as the *cohesive view* of §2718(a). This view achieves an internally consistent reading of the §2718 reporting and rebate requirements, but arguably by taking liberties with some of the wording used within §2718(a).

The other view is that the §2718(a) MLR and §2718(b) MLR were intended to be two distinct quantities. Put differently, this view deemphasizes the first sentence of §2718(a) and places greater weight on the remainder of §2718(a) in interpreting the intent of the statute's rebate requirements. Insurers would report the ratio defined in the first sentence of §2718(a) and the three ratios defined in §2718(a)(1) through §2718(a)(3) without there being clear relationships between those different ratios. Below, we refer to this as the *literal view* of §2718(a), in that it focuses on taking a literal interpretation of some of the wording used within §2718(a) at the expense of internal cohesion.

Potential Interpretations

We have defined two ways of interpreting §2718(a), which we called the *cohesive view* and the *literal view*. We now discuss what we meant by these two views in greater detail and discuss the pros and cons of these two different approaches to interpreting §2718(a).

Under the cohesive view:

- In interpreting the intent of the statute, greater weight is placed on the first sentence of §2718(a), as opposed to the remainder of §2718(a).

- An issuer would start by reporting an MLR in which the numerator is equal to incurred claims plus LAE plus change in contract reserves (if any). This is consistent with the first sentence of §2718(a). The issuer would calculate the denominator as earned premiums less the excluded types of taxes and fees, equal to total premium revenue.

- After that, an issuer would decompose the MLR described in the previous bullet point into two pieces using the same denominator, in order to comply with the statutory requirements of §2718(a)(1) and §2718(a)(2). In this manner, every item included in claims plus LAE plus change in contract reserves would, as a matter of pure definition, be deemed to constitute either "reimbursement for clinical services provided to enrollees" (the (a)(1) category) or "activities that improve health care quality" (the (a)(2) category).

  There would be a need to provide guidance to issuers on which portions of claims plus LAE plus change in contract reserves should be allocated to the (a)(1) category and the (a)(2) category. However, apart from that, there would not be a need to develop separate definitions for the (a)(1) and (a)(2) categories. Instead, the focus would be on definitions for claims, for LAE, and for change in contract reserves—each of which are terms currently in use today (e.g., in NAIC financial reporting).

- As a result of these definitions, the rebates to enrollees under §2718(b) would be calculated using exactly the same MLR defined in the first sentence of §2718(a), namely with claims plus LAE plus contract reserves in the numerator.

- In addition, an issuer would also report the ratio of all other non-claims costs (the (a)(3) category) to the same denominator. By definition, in this context anything included in claims plus LAE plus change in contract reserves would not be included in the (a)(3) category, since those items were already consumed in total by the (a)(1) and (a)(2) categories. As such, the (a)(3) category would not include claims processing expense but would include an issuer's general administrative expenses and distribution costs.

Under the literal view:

- In interpreting the intent of the statute, little weight is placed on the first sentence of §2718(a) and greater weight is placed on the remainder of §2718(a).

- As with the cohesive view, an issuer would start by reporting an MLR in which the numerator is equal to incurred claims plus LAE plus change in contract reserves (if any). The denominator would be earned premium, consistent with the current meaning of the term, and without the exclusions defined in §2718(b) for taxes and fees. This would satisfy the statutory requirements of the first sentence of §2718(a). However, in light of the items discussed below, it is no longer clear what purpose is served by having imposed this reporting requirement, since this MLR is disconnected from the MLR that determines rebates in §2718(b).

- The insurer would then calculate three different ratios, corresponding to the (a)(1), (a)(2), and (a)(3) categories. In this view, it would be necessary to develop new and specific definitions of the terms "reimbursement for clinical services provided to enrollees," "activities that improve health care quality," and "non-claims costs"—terms not generally in common use today (e.g., in NAIC financial reporting).

Unlike in the cohesive view, there would not be any automatic connections between these three categories, and the numerator of the previously-reported ratio (claims plus LAE plus change in contract reserves). The denominator would be different as well, since here the denominator would exclude taxes and fees. Depending on the precise definitions made for these three new categories, we might see the following effects:

- Most items currently reported in claims would likely fall into the (a)(1) category. However, if the definition of "reimbursement for clinical services" is made sufficiently literal, there may be items currently considered as claims that do not qualify for (a)(1) treatment.[7]

- Some items currently reported in LAE might qualify for the (a)(2) category, while other items might fall into the (a)(3) category. The amount of overlap between LAE and the (a)(2) category would depend on how strict a definition of "health care quality" is used.

- It is not immediately clear how an item like the change in contract reserves (which could be either positive or negative) would be treated. If the definitions for the (a)(1) and (a)(2) categories were sufficiently literal, this item might fall into the (a)(3) category or perhaps not be a part of any of the ratios.

- If the definition of "activities that improve health care quality" is fairly broad, then there might be costs that would qualify for the (a)(2) category under the literal view but that are not in LAE—and, thus, would be reported in the (a)(3) category under the cohesive view. A potential example could be the issuer's expenses on new forms of health information technology, such as electronic medical records.

- In particular, the MLR used for the calculation of rebates in §2718(b) would not have any defined relationship to the MLR being reported under the first sentence of §2718(a). Additional reporting would be needed in order to reconcile the §2718(a) MLR with the §2718(b) MLR.

The main advantages of the cohesive view, as we see it, are three-fold:

1) As argued at length in our response to Question B.1, including LAE in the numerator of the MLR has great theoretical appeal in situations where comparisons are being made across health insurance issuers, particularly across issuers having different underlying business models. Including LAE in the numerator, as done under the cohesive view, would have the effect of putting all different types of health insurance issuers, regardless of their business model, on a level playing field. We believe that this is an appropriate policy objective. If this is not done, then the implementation of §2718 requirements could

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[7] For example, in a previous footnote we mentioned SSAP 35 health related assessments, which are considered claims by the NAIC, but which represent payments to states rather than to enrollees. It will be necessary to interpret the phrase "reimbursement for clinical services provided to enrollees" somewhat broadly if types of claims, such as SSAP 35 health related assessments, are to be included therein.

create biases unintended by the framers of PPACA, favoring some types of health insurance issuers over others.

2) The cohesive view has the advantage, for both regulators and issuers, of being able to rely on existing financial reporting concepts that are well-understood—claims, LAE, and contract reserves.

3) The MLR used to calculate rebates in §2718(b) is exactly the same as the MLR being publicly reported under the first sentence of §2718(a), which will minimize confusion.

The main disadvantage of the cohesive view is that it requires that different terms be essentially matched to other terms.

The main advantage of the literal view is that it may be more aligned with the underlying public policy objectives of §2718. Such an argument relies on the observation that issuers would tend to report higher medical loss ratios for rebate purposes under the cohesive view than under the literal view. (The cohesive view would allow full inclusion of LAE in the numerator whereas the literal view would likely allow inclusion of only some subset of LAE in the numerator.) As such, the potential concern here is that application of the cohesive view could lead to lower levels of rebates to consumers, which may not reflect the stated intent of §2718(b), namely "ensuring that consumers receive value for their premium payments."

There are two main disadvantages of the literal view:

1) It would be necessary for regulators to develop new definitions of such terms as "reimbursement for clinical services provided to enrollees" and "activities that improve health care quality," which will be particularly difficult given the aforementioned need to issue regulatory guidance swiftly. Moreover, it would be necessary for issuers to interpret these new definitions and modify their systems to track their components, and it would be necessary to develop new mechanisms for monitoring issuers' compliance with those definitions. Developing new definitions, rather than leveraging existing definitions, may lead to significant inconsistencies between issuers in their efforts to comply with §2718, particularly over the next few years while the concepts involved remain new.

2) Under the literal view, there is a disconnect between the publicly reported MLR under the first sentence of §2718(a) and the MLR used in §2718(b) to calculate rebates. This could lead to the creation of expectations of rebates when they are not technically owed, if the §2718(a) MLR is below the threshold while the §2718(b) MLR is above. Such a state of affairs could be confusing.

We note that §2718(b) explicitly provides regulators with the ability to increase the MLR rebate thresholds from their current levels of 80 percent and 85 percent. Consequently, if the cohesive view prevails and early experience indicates that the underlying public policy objectives of §2718(b) are not being met, then regulators may have an available remedy: increasing the MLR rebate thresholds in a manner that increases rebate levels, without jeopardizing the solvency of health insurance issuers or destabilizing insurance markets. On the other hand, if the literal view

prevails, and if the adopted MLR definitions do create persistent biases favoring certain types of health insurance issuers due to a narrowly-drawn numerator for §2718(b) purposes, then it is unclear how to remedy the situation.

In the event that the literal view prevails, there are two specific technical issues that we believe are important in drawing up the new definitions of "reimbursement for clinical services provided to enrollees" and "activities that improve health care quality":

- We believe it is important for the change in contract reserves to be included in the definition of "reimbursement for clinical services provided to enrollees" so that the MLR used for rebate purposes incorporates the change in contract reserves. See related discussion in response to Question B.1c.

- We would encourage regulators to take a broad view of the word "quality" in thinking about the definition of "activities that improve health care quality." In particular, we believe that all cost containment expense activities as currently defined in SSAP 85 should be deemed as meeting the definition of this category, under the view that affordability and quality are interrelated. As observed in our response to Question B.1, a failure to include CCE in the numerator of the MLR used for rebate purposes could create perverse incentives for health insurance issuers. In effect they would be encouraged to not spend additional funds on cost containment initiatives, to the extent that such expenditures would be classified in the (a)(3) category rather than the (a)(2) category. Exclusion of CCE would also, as discussed in our response to Question B.1, exacerbate comparability concerns across different issuers.

Deductions from MLR Denominator

We observed earlier that §2718 contemplates making adjustments to the MLR denominator, in order to deduct federal and state taxes and licensing or regulatory fees. In our response to Question A.1, we noted several examples of how these types of taxes and fees can lead to differences in medical loss ratios across issuers, or across states within a particular issuer, unless adjustments are made to the denominator. As such, the adjustments contemplated in the statutory language are technically equitable; it is a good thing in our view that the drafters of the statute addressed this nuance.

Interpretive guidance could be necessary in order to clarify for issuers which types of taxes and fees qualify for deduction from the denominator, and which (if any) do not. Deduction treatment is clearly warranted on theoretical grounds for those types of taxes and fees that are most likely to vary materially by issuer and/or state and most likely to be explicitly taken into account in an issuer's pricing methodology. Such types of taxes and fees would include (but not be limited to):

- State premium taxes;

- State regulatory assessments (e.g., assessments to fund high-risk pools);

- Federal income taxes (we noted earlier that some issuers are exempt from such taxes, so a failure to exclude these taxes from the denominator would create an unlevel playing field in favor of those issuers);

- The new annual fee on health insurance providers created in PPACA §9010.

On the other hand, there are other types of federal and state taxes that are unlikely to be separately accounted for in an issuer's pricing methodology and that are unlikely to vary as materially by issuer and/or state (e.g., federal payroll taxes). The public policy rationale for deducting these taxes from an MLR denominator is less clear; however, the plain language of the statute may imply that these taxes are to be deducted.

B.1.c. What kinds of assumptions and methodologies do issuers currently use when calculating the loss adjustment expense (or change in contract reserves)? What are the pros and cons of these various methods?

The statute's use of the phrase "loss adjustment expense (or change in contract reserves)" is somewhat confusing, as these are two completely separate financial reporting concepts. All health insurance contracts generate loss adjustment expenses; not all health insurance contracts generate contract reserves. However, whether one would want to include loss adjustment expenses in a medical loss ratio is independent of whether contract reserves are established. As such, we assume that "or" was intended to be "and/or."

As mentioned in our response to Question B.1, NAIC SSAP No. 85 defines loss adjustment expenses (also called "claim adjustment expenses") as costs expected to be incurred in connection with the adjustment and recording of health claims. It further subdivides loss adjustment expenses into cost containment expenses and other claim adjustment expenses. Loss adjustment expenses include the actual settlement costs related to claims paid during the year plus an estimate for settlement costs associated with claims that are incurred but not yet paid. This recognizes that the administrative expense of adjudicating the claim is incurred at the same time as the claim is incurred.

NAIC SSAP No. 54 defines contract reserves (also called additional reserves) as the reserves required:

1. When premiums and benefits are not earned or incurred at the same incidence over the policy period;

2. When, due to the gross premium structure, the present value of future benefits exceeds the present value of future net premiums; or

3. When the contract provides for the extension of benefits after the termination of the coverage.

Statutory accounting prescribes the methods and most assumptions used to calculate the contract reserves, as outlined in Appendix A-010 of the NAIC Accounting Practices and Procedures Manual. Some assumptions may be based on the insurer's actual experience. The NAIC Health Reserves Guidance Manual provides additional discussion regarding contract reserves.

Some individual major medical policies have premium rates based on the policyholder's age at policy issuance (issue-age rated policies), instead of based on the policyholder's current age (attained-age rated policies). Issue-age rated policies generally require contract reserves, since future premium increases will not reflect the aging of the policyholder, implying that some portion of past premiums needs to be set aside in order to "prefund" cost increases from aging.

Some attained-age rated individual major medical policies may prefund some of the future cost increases due to the wear-off of underwriting and cumulative adverse selection. Some carriers establish contract reserves for such policies. The decision of whether or not to establish contract reserves in this situation depends on how the carrier determines the value of future benefits and valuation net premiums, as well as items such as first-year surplus strain or front-loading of commissions and acquisition costs.

Under GAAP accounting, health insurers usually classify their products into short-duration or long-duration. Contract reserves are not reported for short-duration products. However, products that are classified as long-duration will generally report contract reserves (benefit reserves or active life reserves) since products are generally priced on a lifetime-loss-ratio level including prefunding of claims in early durations.

There are many different methodologies and assumptions that are currently used to calculate contract reserves in different contexts. On a GAAP basis, assumptions are locked in at issue, meaning that claim costs, lapse rates, morbidity, and interest rates remain fixed. Often, health insurers use the net level premium reserving methodology, together with deferral of policy acquisition costs. On a statutory basis, the minimum statutory reserve standards provide for a one-year or two-year preliminary term method to be used in the calculation of contract reserves. This is meant to allow for the recovery of initial expenses prior to the establishment of contract reserves, given that acquisition costs are not deferred in statutory accounting. Where the premiums in the first years are more than sufficient to cover both claims and initial expenses, the prefunding of future claims may require an earlier starting point for contract reserves. Different health insurers use different assumptions based on historical data, industry experience, or pricing assumptions. Unlike in GAAP, health insurers are allowed to update assumptions for calculating statutory contract reserves.

There may be some technical issues that need to be addressed with respect to the inclusion of the change in contract reserves in a §2718 MLR calculation. A threshold question is: Are issuers to use the change in statutory contract reserves as reported in NAIC financial reporting, or are issuers to use some other defined methodology or assumptions for §2718 purposes? Please see our related comments regarding the potential use of a federally mandated contract reserving methodology for §2718 purposes in our response to Question A.2.

B.1.e. **What kinds of criteria do States and other entities use in determining if a given company has credible experience for purposes of calculating MLR-related statistics?**

The issue is not whether a company has credible experience for purposes of calculating MLR-related statistics, but rather whether or not a company has credible experience for purposes of regulatory actions derived from the company's calculated MLR-related statistics.

To the extent that more granular levels of aggregation are used, an adjustment to reflect the resulting lower credibility of the MLR results at these more detailed levels would be actuarially appropriate to avoid payment of rebates for essentially random reasons. Note that this could result in a situation where the company is not required to pay any rebate, despite having reported an MLR under §2718 that is lower than the requirements.

The Academy was recently asked by the NAIC to provide input on this subject. While our thinking on this subject continues to evolve as of this writing, the following two general approaches appear attractive but would require a number of technical details to be fleshed out:

1. *Aggregation of multiple blocks of business to enhance credibility*. Under this approach, a carrier would aggregate multiple blocks of business at a higher level of aggregation than under the general aggregation framework ultimately established by the rebate regulations, based on consideration of the carrier's specific situation. (See also our comments in Questions C.1 and C.2 below regarding aggregation approaches.)

2. *Application of adjustments for statistical tolerance*. Under this approach, a carrier would add to its actual MLR an adjustment, based on the size of the carrier's membership in the market for which the calculation is prepared, to remove the potential impact of statistical fluctuation, prior to comparison with the minimum MLR for that line of business. This is similar to an existing approach used with Medicare Supplement refund requirements, but the details would need to be tailored to the current context.[8]

3. *Application of large claim pooling mechanisms*. Under this approach, carriers would be able to employ accounting mechanisms in its MLR calculations in order to spread the impact of large, or catastrophic, claims across its business and/or across different years. This approach could be used in conjunction with the above approach, which would have the effect of reducing the magnitude of the adjustments for statistical tolerance.

Also, at more granular levels of aggregation, when using appropriate adjustments for credibility, most portions of some companies' business will reach the credibility level while no portion of other companies' business may be determined to be credible even when three years of data are accumulated. Insurance is meant to pool risks and the value of pooling is increased as pools increase in size. The use of three-year average results in §2718(b)(1)(B)(ii) is one type of pooling. Applying a high level of aggregation to the requirements of both parts of §2718 is another way; please see our related comments in our response to Question C.

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[8] The Medicare Supplement refund calculation includes a tolerance adjustment to address situations where there is less than full credibility. At present, when there are less than 500 life years, it is assumed that there is no credibility to the values for that segment. There are various adjustments to the actual loss ratio for increasing numbers of life years until it is assumed that full credibility exists for 10,000 life years. It has been recognized that in states with lower populations and/or for some of the less popular Medicare Supplement product designs, some companies cannot sell enough business to have results that reach minimal credibility, even after many years.

B.1.f. What kinds of special considerations, definitions, and methodologies do States and other entities currently use relating to calculating MLR-related statistics for newer plans, smaller plans, different types of plans or coverages?

States and other entities will tend to make special considerations related to calculating MLRs, and/or the ways in which calculated MLRs are used for regulatory purposes, based upon the characteristics of the business being reviewed. Much of the discussion related to other questions in this document discusses these characteristics and MLR considerations. In particular, in regard to loss ratio requirements for individual medical business rate filings, the NAIC and various states typically make the following considerations:

- They have formulas that allow lower minimum loss ratios for plans with low average premiums and higher minimum loss ratios for plans with high average premiums.

- They often make exceptions for non-credible blocks of business or allow such blocks to be aggregated with other more credible blocks.

- They recognize the durational aspects of individual business by requiring justification of the reasonableness of the premium rates based on a lifetime loss ratio rather than just an annual loss ratio. This includes a two-stage test: 1) the expected future loss ratios equaling or exceeding the minimum required loss ratio and 2) the past experience plus the future expected experience resulting in a lifetime loss ratio of at least the minimum required.

- They will make exceptions for new blocks of business that incur large start-up expenses and initial acquisition and marketing expenses.

- They may recognize other factors that may require special treatment, such as acquisitions, particularly of imperiled blocks of business for which special treatment is needed in order to remain viable.

- They will make allowances for plans with a high risk of claim fluctuation due to the catastrophic or experimental nature of the particular coverage.

B.2. What are the similarities and differences between the requirements in Section 2718 compared to current practices in States?

The two most significant differences are (1) how the MLR is defined in §2718 compared to current industry practices and (2) the rebate requirement, which is somewhat unusual today outside of the Medicare Supplement market.

Aspects of the MLR definitions have been covered in depth above, particularly in our responses to Questions A.1, B.1 and B.1a. The overriding point is that only after the issuance of regulations supporting §2718 will it be clear what similarities and differences exist between §2718 MLR

reporting requirements and current practices, given the large number of issues requiring regulatory clarification.

Responses concerning rebates are provided in Section E. Outside of the Medicare Supplement market, a few states currently require rebates or premium credits for the individual market, with even fewer requiring rebates or premium credits in the small group market. The issuance of rebates for both of these markets will be a substantial change in the majority of states.

B.2.a. What MLR-related data elements that are required by PPACA do issuers currently capture in their financial accounting systems, and how are they defined? What elements are likely to require systems changes in order to be captured?

Whether or not issuers currently capture certain data elements is highly dependent on how those elements are defined via regulation and on what decisions are made regarding aggregation.

Generally, most, if not all, issuers capture claims and premium data separately for large group, small group and individual business; however, the definitions currently used to apportion group business into "small" versus "large" in financial systems may reflect the definition of "small group" under state law, as opposed to federal law. Similarly, current allocation by state of premiums and claims in financial systems may be based on different methodologies than those appropriate for use under §2718. Please see further discussion of this point in our response to Question C.2.

Some administrative expenses, taxes and fees are captured in total (i.e., not separately for each market segment and/or geography) and may require an allocation methodology for §2718 purposes, which may or may not require systems changes. This is particularly true for federal income taxes. Current NAIC financial reporting does not require health insurers to perform any allocation of the entity's federal income taxes down to market segments, and in our experience most insurers assess the performance of market segments on a pre-tax basis.

To the extent that an insurer's financial management will need to develop methodologies for allocating many items to an appropriate level for §2718 purposes, actuarial support will have to be given to this effort to ensure that allocations for reporting purposes are in line with rating methodologies and avoid mismatches.

B.4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarifications would be useful?

Throughout this document we have identified a wide variety of areas where the statutory language invites multiple interpretations and where additional technical clarification will be necessary. In responding to this particular question, we raise several additional areas not covered elsewhere in this document.

Overall Scope

It appears likely to us that, in light of PPACA §1562(a)(3), the §2718 requirements were not intended to apply to those types of health insurance that are defined as "excepted benefits" in PHSA §2791(c) (e.g., Medicare Supplement insurance). It would be helpful to interested parties if the rulemaking were to clarify this point. Inadvertent application of §2718 MLR thresholds to many "excepted benefits" health insurance markets, such as the accident-only or dental markets, might threaten their viability.

Reinsurance

Regulations must consider the manner in which some aspects of (existing or new) reinsurance arrangements among insurance carriers are reflected in §2718 reporting and rebates. Note that we are not referring to the new transitional reinsurance program established by PPACA §1131, the treatment of which for §2718 purposes is explicitly addressed within the statute.

If the §2718 MLR calculation is always performed on a net-of-reinsurance basis without restriction, then that would open the door to possible misuses of reinsurance by carriers in order to reduce or avoid rebates payable to enrollees. On the other hand, if the §2718 MLR calculation is always performed on a gross-of-reinsurance basis, then that would cause a number of distortions as discussed below. The §2718 regulations should allow carriers to reflect reinsurance agreements that serve legitimate risk management purposes.

In discussing the issues, we distinguish between four broad types of reinsurance arrangements: excess risk reinsurance, quota share reinsurance, risk adjustment/pooling among affiliates, and assumption reinsurance. This may not be an exhaustive list of the relevant reinsurance types.

Excess risk reinsurance uses an attachment point (the dollar amount of claims necessary for the reinsurer to begin sharing the risk) that reduces the issuer's fluctuations due to large claims. As discussed earlier in our response to Question A.1a, the use of excess risk reinsurance may represent sound risk management practice, particularly for companies with smaller blocks of business, and may create greater stability in loss ratios from year to year. To the extent that the attachment point is substantially higher than the deductible for the underlying coverage, the issuer's total premium is only slightly reduced, while the magnitude of the reduction in claims will vary from year to year depending on the number of claims subject to reinsurance.

Quota share reinsurance uses a percentage (most often the same percentage) of premiums and claims to transfer some of the issuer's risk to the reinsurer. The issuer is generally responsible for the administration of the business but may utilize the expertise of the reinsurer in the setting of premiums or dealing with potentially high cost claims. We would expect that such future contracts could equitably adjust for the sharing of rebate liabilities. However, existing reinsurance contracts may not have anticipated such requirements or the impact of the totality of the MLR requirements.

Risk adjustment/pooling among affiliates is used to address groups that want several different options for health coverage for their employees but where different affiliated legal entities write

different options (e.g., both PPO and HMO coverage). Since some options appeal to those with greater health needs, the sharing of equal premiums generally will not share equal risks. States have acted to prevent one of these entities from being overwhelmed with losses. A risk adjustment factor or simple pooling among affiliates would work in the §2718 environment where annual MLR statistics are reported and used to calculate rebates. See related comments in Question C.1 under *Aggregation across Health Insurance Issuers*.

Assumption reinsurance is, for purposes of this paragraph, considered to include two types of reinsurance arrangements. The first type involves a formal assumption reinsurance contract, under which a block of insurance contracts originally issued by one insurance company has been formally novated by policyholders over to another insurance company, absolving the original issuer of any ongoing obligations. The second type is where a block of insurance contracts originally written by one insurance company has been effectively purchased by a different insurance company using quota-share reinsurance is being or will be administered by the purchasing company instead of the original issuer, but hasn't yet had formal novations of contracts made from the original issuer to the purchasing company. It is not realistic to impose §2718 reporting and rebate requirements on a company which several years ago sold a block of health insurance policies and has essentially no continuing involvement in the administration of that block. Whether the assuming carrier reports the acquired policies as a separate block or in combination with other business may depend on how the block is being managed. See a related discussion in Question C.1 under *Disaggregation within an Insurance Market*.

Group Contracts with Retrospective Rating Features

The manner in which retrospectively-rated group contracts are reflected in annual MLR calculations must also be considered. These contracts, which exist only in the large group market, are generally designed to adjust premiums upward if claims are higher than anticipated and reduce premiums if claims are lower than anticipated. There is generally a contractual maximum impact on premiums in any one year, however. The policyholder may choose to leave accumulated rate credits on deposit with the insurer, in the form of premium stabilization reserves, which can be drawn upon by the group policyholder in future years to offset the need for additional premiums. Conversely, to the extent that cumulative past experience has been adverse, future favorable experience may not immediately be credited to the policyholder but may first be applied to offset past notional deficits. One subtle issue to be considered is the impact on an issuer's annual MLR if a group policyholder decides to withdraw part or all of a premium stabilization reserve that represented amounts accumulated over several years. It may be appropriate for §2718 MLR reporting purposes to exclude from the definition of earned premiums changes in premium stabilization reserves attributable to experience prior to the period being measured, while still allowing the definition of earned premium to include changes in such reserves attributable to the experience of the period being measured.

Policyholder Dividends

Some health insurance issuers are organized as mutual insurance companies. Mutual insurers may, subject to issuer board approval and/or regulatory approval, return a portion of policyholders' premium in the form of policyholder dividends. This practice is uncommon today

with respect to mutual health insurers but very common with respect to mutual property and casualty insurers and mutual life insurers. For purposes of the §2718 MLR reporting and rebate requirements, mutual insurers should adjust the denominator of the MLR to reduce premium revenue by any policyholder dividends paid or apportioned to policyholders. This adjustment would reflect the fact that a policyholder dividend can be viewed as accomplishing the same underlying policy objective as premium rebates, namely, ensuring that policyholders receive sufficient value from their premium payments. If policyholder dividends were not taken into account in the §2718 MLR definition, then mutual insurers could be dissuaded from declaring dividends to policyholders, due to the possibility of punitive double-counting (rebates on top of dividends).

Premium Deficiency Reserves

NAIC financial reporting for health insurers includes the concept of a premium deficiency reserve, which effectively represents an acceleration of expected losses from future years into the current financial reporting period. We recommend that, for purposes of §2718 requirements, premium deficiency reserves should not be included as either an increase to incurred claims or as a reduction of earned premium. Any potential rebates to consumers, in our view, should reflect the actual claims experience of the period being measured, without being affected by accruals for expected losses in future periods and/or the reversal of accruals made in prior periods for expected losses in the current period.

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C. Level of Aggregation

C.1.   What are the pros and cons associated with using various possible level(s) of aggregation for different contexts relating to implementation of the provisions in Section 2718 (that is, submitting medical loss ratio-related statistics to the Secretary, publicly reporting this information, determining if rebates are owed, and paying out rebates)?

There are a number of distinct issues to be addressed here. For ease of use we have split our response to this question into several sections.

Aggregation Consistency between §2718(a) and §2718(b)

We note that §2718 requires the calculation of loss ratios for two different purposes. Section 2718(a) requires a loss ratio calculation for purposes of public reporting. Section 2718(b) specifies a calculation for determining whether a rebate is required to be paid by the health insurance issuer. In our response to Question B.1a, we discussed the confusion over definitional consistency between these two sections. A separate issue is aggregation consistency—whether the two sections would use the same level of aggregation or different levels. The following are considerations relating to aggregation consistency:

- The resulting publicly reported MLR values from the first sentence in §2718(a) may become the basis for anticipation of rebates by policyholders under §2718(b). As such, using the same level of aggregation for both reporting and rebate calculation will help minimize any confusion between the two sets of values.

- Without consistency, reporting the public values—based on the first sentence of §2718(a)—at a higher level of aggregation than that used for the calculation of rebates in §2718(b) could lead to expectations for rebates by some portions of the policyholders who would not receive a rebate based on the use of more granular levels of aggregation for §2718(b).

- Even if the public reporting under §2718(a) is required at multiple levels of granularity, such that the most detailed level is identical to that required for §2718(b), expectations may still differ from reality. Due to the potential use of credibility criteria for determining rebates, as discussed in our response to Question B.1e, individuals may not be entitled to a rebate even if the loss ratio shown for their plan is less than the minimum required.

A closely related issue is temporal consistency between §2718(a) and §2718(b), particularly after 2014 when, per §2718(b)(1)(B)(ii), the rebate calculation is performed using three-year averages. If §2718(a) reporting continues to be performed using one-year averages while rebates are calculated using three-year averages, that could lead to confusion in a manner to similar to that discussed above.

Aggregation by Insurance Market

The statutory language of §2718(b)(1)(A) is relatively ambiguous, in our view, as to the level of aggregation across insurance markets anticipated by the statute. We can imagine four viable interpretations of the statutory language, as follows:

(1) If a health insurance issuer offers coverage in the individual or small group markets, then 80 percent is the MLR threshold that applies to 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.

(2) If a health insurance issuer offers coverage in the large group market, then 85 percent is the MLR threshold that applies to 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)(ii) would only apply with respect to an issuer who only offers coverage in the individual and/or small group markets.

(3) 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 issuer's individual and small group business combined. The 85 percent MLR threshold from §2718(b)(1)(A)(i) applies to the issuer's large group business.

(4) 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 issuer's individual business and the threshold that applies to its small group business—but in two separate calculations (unlike a single calculation, as in (3), that combines the individual and small group markets). The 85 percent MLR threshold from §2718(b)(1)(A)(i) applies to the issuer's large group business.

However, language used within the request for comments document suggests that the departments may have already ruled out interpretations (1) and (2).[9] As such, the pros and cons of interpretations (1) and (2) may be of academic interest only, and we focus here on the pros and cons of interpretation (3) versus interpretation (4)—that is, the pros and cons of aggregating the individual and small group markets together for §2718 purposes:

- Combining the individual and small group markets has the advantage of simplicity but it could create competitive inequities. As observed in our response to Question A.1, there are structural reasons why loss ratios in the small group market are typically higher than those in the individual market. As such, aggregating the individual and small group markets together for purposes of the §2718 rebate requirements could lead to a competitive advantage for carriers who participate in both the individual and small group markets, relative to carriers who participate in only the individual market. Merging the two markets would enhance the credibility associated with the merged market, helping mitigate issues noted elsewhere over credibility of blocks.

- As noted in our response to Question A.2, application of an 80 percent annual MLR standard to the individual market may have a destabilizing effect, particularly in years prior to 2014. If alternatives to the annual MLR mechanism are developed to mitigate the risk of destabilization, those alternatives probably should only apply to the individual market and not on a combined basis to the individual and small group markets. The pricing issues involved are unique to the individual market. Many of the relevant insurance carriers are not active in the small group market, so allowing them to combine the individual and small group markets for §2718 purposes would not in practice mitigate the situation.

- Under PPACA §1312(c)(3), a state may decide to merge its individual market and small group market for rating and underwriting purposes. For those states that do so, it may be advantageous and more equitable to also combine these markets for reporting and rebate purposes.

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[9] Specifically, we refer to the following sentence: "The PPACA sets an 85 percent minimum standard for the percentage of premiums that coverage in the large group market spends on reimbursement for clinical services and activities that improve quality, and an 80 percent minimum standard for the small group and individual markets - allowing for higher State-level standards where appropriate (if they are specified in regulations)." This sentence seems to indicate a belief that the minimum standard clearly is a characteristic of a line of business, as in our interpretations (3) and (4), rather than being a characteristic of the issuer that varies based on the markets in which the issuer participates, as in our interpretations (1) and (2).

- In situations where the individual and small group markets have not been merged, however, combining these markets for rebate calculation purposes may result in implicit cross-subsidization of one pool of an insurer's customers by another pool of its customers.

Disaggregation within an Insurance Market

Another aggregation issue left open by the statutory language of §2718 is whether, and, if so, to what extent, multiple rebate calculations would be performed within a particular market for subsets of that market; that is, to what extent would there be disaggregation within an insurance market. (Note that we also address the issue of geographic disaggregation in our response to Question C.2.)

In thinking about this issue, it is important to consider that health insurance is, at its core, a business of pooling and managing risk. This argues against trying to calculate and distribute rebates at a more granular level than the level at which an insurer actually pools and manages its risks. For instance, while in principle MLR could be calculated at the policyholder level, it would be highly imprudent to distribute rebates based on policyholder-level experience, since doing so would contradict the very nature of insurance, namely risk pooling.

As such, if disaggregation within a market is desired, one potentially attractive approach would be to strive for consistency with the pricing methodology being used by the insurance health issuer. This approach would directly relate any potential rebates to the insurer's own pricing methodology, thereby avoiding any rebate cross-subsidization between risk pools that are managed separately. To illustrate the implications of this approach:

- If the issuer's pricing methodology treats all of its business within a specific market and state as being a single pool, then rebates would be calculated based on the aggregate experience of that entire pool;

- If the insurer establishes multiple risk pools for pricing purposes within a specific market and state, then each pool's experience would drive the calculation of rebates for that pool, rather than aggregating the pools;

- If instead the insurer aggregates several different states within a specific market for pricing purposes, then those states' experience would be aggregated for rebate calculation purposes.

Credibility could be of concern with this approach. (See also our general comments in Question B.1e concerning credibility.) However, to the extent that a carrier does not price over a credible block of business, it takes a fluctuation risk that could also apply to its determination of the rebate. Lack of credibility might not be a reason for adjustment since it is a risk the carrier has chosen. The exception may be for a carrier whose business in a given market could not be aggregated in any way to reach a credible mass.

An example of having multiple risk pools for pricing purposes within a specific market and state could occur post-2014 with grandfathered plans versus qualified plans (as defined by PPACA §1301) versus non-qualified plans (i.e., non-grandfathered plans that do not meet the PPACA §1302 essential health benefit requirements). It is likely that each of these categories will be managed differently due to their inherent variation in terms of plan design, rating, underwriting, and the demographic differences that are likely to exist between the plans. This is an argument for keeping them separate for purposes of §2718 aggregation. (We are assuming here that non-qualified plans are subject to the §2718 requirements. It would be helpful for the departments to clarify this point within rulemaking.)

A remaining aggregation question in the post-2014 market involves the different levels of coverage defined by PPACA §1302(d). In our response to Question A.1, we discussed the theoretical reasons why lower-AV products, such as §1302(d) bronze products, can naturally be expected to have lower loss ratios than higher-AV products, such as §1302(d) platinum products. This suggests that if all levels of coverage are aggregated and held to the same fixed MLR threshold, then carriers whose mix of business includes relatively larger amounts of lower-AV products may find it more difficult to meet the MLR threshold than carriers whose mix of business is oriented towards higher-AV products. This may not be a desirable policy outcome. To the extent that it is not, regulators could mitigate the situation in one of two ways. First, the levels of coverage could be disaggregated for rebate purposes, with different MLR thresholds set for each level of coverage; however, we note that this would exacerbate some of the credibility issues we discuss. Second, the MLR threshold could be established in a way that varies from carrier to carrier, based on that carrier's mix of business across different levels of coverage.

Aggregation across Health Insurance Issuers

As noted in our response to Question A.1, it is common for a health insurer to issue both PPO and HMO coverage to the same employer group but where the two coverages are issued by different legal entities. In that situation, the insurer's pricing methodology may involve an explicit cross-subsidization between the PPO and HMO premium rates, recognizing that when members of the group face a choice between PPO and HMO plans, self-selection may result in the PPO pool having higher morbidity experience than the HMO pool.

In light of this common circumstance, regulators may wish to consider whether they have the flexibility under §2718 to aggregate the experience of different health insurance issuers that are under common control (e.g., both wholly-owned subsidiaries of the same insurance holding company) and write products in the same geographic area, for the purposes of MLR reporting and determination of rebates. See also related comments in our response to Question B.4., under the discussion of reinsurance.

Additional Thoughts

Aggregation issues must be considered in conjunction with the potential amount of premium available for risk charges and profits.

Insurers include a risk margin in every premium. In the current environment, the insurer's chosen level of risk margin anticipates that poor experience can be offset by good experience. Going forward, however, good experience will lead to rebates and, thus, will contribute only an average (rather than above-average) realized margin, while poor experience will continue to lead to below-average realized margins. Thus, after the introduction of rebates, realized margins can never be as high as the average margins anticipated under the current environment.

It is unclear whether the required loss ratios in §2718 will allow companies to increase the assumed risk margin to compensate for the inability to average results under certain levels of aggregation. The higher the level of aggregation, the more likely that the resulting risk margins will be close to the average. The lower the risk margins, the more likely that actual results will have wide fluctuations, even to the point where the average risk margin on the portions with good experience is not sufficient to offset losses on the portions with poorer experience and the company's solvency position is affected. This reduces the company's ability to withstand the infrequent situations where all portions experience losses (e.g., catastrophes).

To the extent that, in light of granular application of §2718 rebate requirements, a company deems the potential for their risk margins to be inadequate, the company would appear to have two options. The first would be to withdraw from smaller market segments where the company's results, after whatever adjustments for credibility are allowed by regulation, are seen as too volatile. The second would be to rate all portions with the expectation that they would provide rebates to all portions and thus achieve their intended risk margin (less the cost of administration of the rebates). Some see the first of these options as a positive, while others see it as a negative to the market. We do not believe that anyone sees the second option as an argument in favor of the use of lower levels of aggregation within the §2718 regulations.

C.2. **What are the pros and cons associated with using various possible geographic level(s) of aggregation (e.g., State-level, national, etc.) for medical loss ratio-related statistics in these same contexts (i.e., submitting medical loss ratio-related statistics to the Secretary, publicly reporting this information, determining if rebates are owed, and paying out rebates)?**

Considerations for choosing state-level aggregation versus higher levels of geographic aggregation, most notably national aggregation, include the following:

- States will continue to be the primary body responsible for the financial reporting, premium rate review, and solvency of the insurance companies. Rating, underwriting, and plan benefit design requirements may vary by state. These facts suggest that it may be more natural to apply rebate and reporting requirements at the state level.

- Section 2718 indicates that states can impose higher MLR thresholds than those defined in the statute. If §2718 reporting and rebates are calculated on a national basis rather than a state-level basis, it is unclear how state-specific MLR thresholds could be taken into account.

- If rebates are determined on a national basis, that may create a competitive imbalance between carriers operating in a given state. Many health insurance issuers operate in only one state or in a small number of states, while others operate on a nationwide basis. Under a nationwide rebate calculation structure, a carrier operating in multiple states may be able to achieve a competitive advantage in one particular state, relative to carriers who only operate in that state, via cross-subsidization from other states in which it operates.

- We observed in our response to Question C.1 that PPACA §1312(c)(3) gives a state the ability to merge its individual and small group insurance markets. If it is decided that the individual and small group markets are to be viewed as separate markets for §2718 calculation purposes, then it may be difficult to apply reporting for each of those markets on a national basis if some states have merged the two markets.

- National reporting and rebate calculations would be easier administratively (excepting the special case discussed in the previous bullet point) but would not likely be as equitable as state–level rebates.

- Use of national reporting would mitigate many of the potential credibility issues, since it would lead to larger block sizes than would state-level reporting. This is particularly true in situations where the carrier's pricing methodology for a particular state was based on national experience rather than state-specific experience, as may be the case in situations where a carrier has a small amount of business in a particular state.

In the event that state-level reporting is used, a technical issue arises: how should policies be apportioned by state for §2718 purposes?

Today, carriers do apportion premiums and claims by state for purposes of NAIC financial reporting. However, there is a wide variety of practice in how that apportionment is performed, and the purpose of that apportionment is driven by considerations not entirely relevant to the context of §2718 (e.g., compliance with state premium tax laws). An individual policyholder may have purchased a policy while living in state A, and although the individual has subsequently moved to state B, for premium rate review purposes the policy continues to be regulated by state A. Practice varies among health insurers as to whether that policy is reported for NAIC financial reporting purposes as being in state A or state B. Similarly, an employer may be headquartered in state C and may have purchased a group policy that is subject to state C's premium rate review process, but some of the employees covered by the policy reside in other states. Practice varies among health insurers as to whether the policy is reported for NAIC financial reporting purposes as being entirely in state C or whether portions of the policy's premiums and claims are allocated to one or more other states.

If a state-level structure is desired under §2718, the appropriate way of implementing that arrangement is to apportion each policy to exactly one state, namely the state that has responsibility for premium rate review. (For many carriers, this type of apportionment would differ from current apportionments made in NAIC financial reporting.) To do otherwise could lead to very odd results. One can imagine that, if other apportionment rules are used, a group with a home office in one state and a branch office in another state could be told that it is owed a

rebate for the small number of employees that reside in the branch office state but not for the larger number of employees that reside in the home office state, or vice versa—even though the premium rates for those two sets of employees may be identical.

<p style="text-align:center">* * * * *</p>

D. Data Submission and Public Reporting

D.2.   How soon after the end of the plan year do States and other entities typically require issuers to submit the required MLR-related statistics? What are the pros and cons associated with various timeframes?

Three time elements are relevant to a medical loss ratio calculation: the period of time being measured, the end of which we refer to as the "cutoff date;" the date as of which that period is being measured, which we refer to as the "measurement date;" and the date at which the measurement needs to be submitted to regulators, which we refer to as the "reporting date."

There will always be a gap between the reporting date and the measurement date, reflecting an allowance for time for the issuer to prepare and review the calculation. There may or may not be a gap between the cutoff date and the measurement date. The longer the gap between the cutoff date and the measurement date, the less the MLR calculation is dependent on estimates. The principle estimate relevant to an MLR calculation is the unpaid claim liability, an actuarial estimate of the claims incurred during the period of time being measured but not yet paid as of the measurement date. Estimates may also be relevant to the measurement of earned premium.

In insurers' current annual financial reporting to state regulators, the period of time being measured is the calendar year so the cutoff date is Dec. 31, the measurement date is also typically Dec. 31, and the reporting date is typically March 1. As such, an MLR calculated from current financial reporting includes a significant estimation component, particularly regarding the unpaid claim liability. (See our comments in response to Question A.1a about the role that estimation error in the unpaid claim liability can play with respect to annual fluctuation in loss ratios.) By contrast, in current MLR reporting for Medicare Supplement refund calculation purposes, the cutoff date is Dec. 31 but the reporting date is May 1. This typically allows insurers to use a measurement date of March 31 instead of Dec. 31, which allows for greater inclusion of paid claims and less reliance on an estimate of the unpaid claim liability.

For §2718 purposes, a significant lag between the cutoff date and the measurement date is appropriate, allowing for more accurate reporting of both the claims and premiums components of the MLR. The less that the §2718 MLR is dependent on estimates, the more accurate the calculation will be and the less likely it will be that rebates will be based on an incorrect MLR. We recommend a six-month lag between the cutoff and measurement date, followed by an additional lag of 30-60 days between the measurement date and reporting date. There are two reasons why we believe that the lag between the cutoff and measurement date for §2718 purposes should be longer than the analogous lag for existing Medicare Supplement refund purposes. First, the Medicare Supplement refund calculation involves a lifetime MLR rather than an annual MLR, and the magnitude of impact from estimation variance in the unpaid claim

liability is larger for an annual MLR than it is for a lifetime MLR. Second, the average lag between providing a healthcare service and the payment of the associated claim is generally longer for major medical policies than for Medicare Supplement policies for a variety of reasons.

D.6.   Are there any industry standards or best practices relating to submission, interpretation, and communication of MLR-related statistics?

Given the potentially critical nature of estimates of future experience that underlies all insurance products, companies and regulators have recognized the valuable role of actuaries. State insurance regulators have incorporated a mandatory use of actuaries within the financial statement structure and rely on the professionalism of the actuarial profession. Although there is no prohibition on non-credentialed individuals to generally utilize the title "actuary," regulators have recognized that actuaries who are credentialed through one or more of the five U.S.-based actuarial organizations are required to adhere to high standards of qualification and practice. A clearly defined role for actuaries meeting these professional standards would be an important part with respect to the three areas (submission, interpretation, and communication).

Existing U.S. Actuarial Standards of Practice (ASOPs) that might be applicable to submission, interpretation, and communication of MLR-related statistics in various contexts include the following:

- ASOP No. 5, *Incurred Health and Disability Claims*

- ASOP No. 8, *Regulatory Filings for Health Plan Entities*

- ASOP No. 11, *Financial Statement Treatment of Reinsurance Transactions Involving Life or Health Insurance*

- ASOP No. 12, *Risk Classification*

- ASOP No. 21, *Responding to or Assisting Auditors or Examiners in Connection with Financial Statements for All Practice Areas*

- ASOP No. 23, *Data Quality*

- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*

- ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*

- ASOP No. 28, *Compliance with Statutory Statement of Actuarial Opinion Requirements for Hospital, Medical, and Dental Service or Indemnity Corporations, and for Health Maintenance Organizations*

- ASOP No. 41, *Actuarial Communications*

- ASOP No. 42, *Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims*

D.7.   What, if any, special considerations are needed for non-calendar year plans?

The use of the term "plan year" within §2718 has been a source of confusion for those interested in understanding the statute. As such we are using this question as the appropriate forum for discussing issues surrounding how to define, temporally, which sets of premiums and claims are included in an annual §2718 calculation.

Existing NAIC financial reporting is performed on a calendar year basis. The premium and claim values included in *2011 calendar year* financial reporting would typically represent a mixture of the following types of information:

(a) Premiums earned and claims incurred in 2011 for policies issued in 2011;[10]
(b) Premiums earned and claims incurred in 2011 for policies renewed in 2011;
(c) Premiums earned and claims incurred in 2011 for policies issued or renewed in 2010;
(d) 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 Dec. 31, 2010 financial statements and the amounts paid in 2011 relating to those accruals (plus the remaining accruals in the Dec. 31, 2011 financial statements attributable to years prior to 2011).

In many respects this calendar year basis would be the most natural way of implementing §2718 requirements, given that existing financial accounting systems of issuers are already organized around this concept.

An alternative approach would be to base §2718 requirements on "policy years starting within a calendar year." Under that approach, *2011 policy year* reporting would differ from 2011 calendar year reporting in that it would exclude items (c) and (d) above, but would instead include:

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

Another alternative approach would be to base §2718 requirements on "deductible years starting within a calendar year." Under this approach, *2011 deductible year* reporting would include premiums earned and claims incurred in 2011 or 2012 under policies in which the deductible year started in 2011, but it would exclude premiums earned and claims incurred in 2011 under policies in which the deductible year started in 2010.

If "plan year" was intended to refer to a year defined in an employer's underlying benefit plan documents, then in principle one could consider annual reporting for "plan years starting within a calendar year." In this case, *2011 plan year* reporting would include premiums earned and claims incurred in 2011 or 2012 for policies in which the plan year started in 2011, but it would exclude

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[10] We note that, with the exception of policies issued on Jan. 1, 2011, the premiums and claims included from this category in a 2011 calendar year report would represent less than a full year of policy experience. In light of deductibles, the loss ratio for such partial year experience included in the 2011 calendar year will often be less than the loss ratio for the full policy year. This observation provides theoretical grounds, in the context of a calendar year MLR calculation, for considering an exclusion from the calculation scope for new policies issued in the current calendar year, similar to what is done in the Medicare Supplement refund calculation.

premiums earned and claims incurred in 2011 for policies in which the plan year started in 2010. However, from a practical standpoint, issuers may not possess knowledge about the plan year defined in their customers' underlying benefit plans, making it impractical to compute numbers on this basis.

The main advantage of calendar year reporting under §2718 is consistency with existing industry financial reporting practices. Implementation of any approach other than calendar year will likely require extensive systems changes by issuers and could potentially require the use of data not currently collected by issuers.

A secondary advantage of calendar-year reporting, relative to other methods, involves the time lag between the start of the reporting year and the submission of MLR reporting for potential rebate issuance purposes. As we argued in our response to Question D.2, there needs to be a gap of about seven to eight months between the end of the time period for which MLRs are to be calculated (cutoff date) and the date at which the MLR calculation is submitted (reporting date). With calendar-year reporting, the cutoff date for the 2011 calculation would be Dec. 31, 2011, which means the first reporting date could be in third quarter of 2012. On the other hand, with other annual forms of reporting, such as policy-year reporting, the cutoff date for the 2011 calculation would not be until November or December 2012. This is because policies issued in December 2011 would fall within the scope of the 2011 annual calculation, but the 12th month of premiums and claims on those policies would not occur until November (for policies issued on Dec. 1) or December (for policies issued on other December dates) of 2012. As such, the reporting date for the 2011 calculation might not be until second or third quarter of 2013 under non-calendar-year forms of annual reporting.

A minor disadvantage of calendar-year reporting, applicable only to the initial year of MLR reporting, is that a 2011 calendar-year report would include premiums and claims on policies that were issued or renewed prior to the effective date of §2718 requirements. This could be mitigated by instructing that issuers, for 2011 only, to exclude premiums earned and claims incurred in 2011 that are attributable to policy years beginning before a certain date, such as Sept. 23, 2010 or Jan. 1, 2011.

Throughout this discussion, we have assumed that issuer reporting under §2718 would be performed on an annual basis, with one reporting requirement per annum. There may be alternate interpretations, under which an issuer would face multiple reporting requirements per annum. (For instance, instead of grouping all deductible years starting within a calendar year into one cohort, as above, one could imagine having separate reporting cohorts based on the starting date of the deductible year. This could lead to multiple reporting requirements per annum, one for each deductible year starting date.) The imposition of multiple reporting requirements per annum, in this sense, would exacerbate concerns raised elsewhere about pooling and credibility, in addition to creating additional administrative complexity for issuers and regulators.

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E.3. **What are the pros and cons of various timeframes and methodologies for calculating rebates?**

Please see related comments on timeframes in our responses to Questions D.2 and D.7 and on the desirability of integrating credibility considerations into the rebate calculation in our response to Question B.1e.

4. **How do States and other entities currently determine which enrollees should receive medical loss ratio-related rebates?** [*Footnote:* **For example: current policyholders, current policyholders who were enrolled in the coverage during the applicable time period, or all policyholders who were enrolled in the coverage during the applicable time period (regardless of whether they are still active policyholders).]** **What are the pros and cons associated with these approaches?**

Section 2718(b) indicates that an issuer shall provide rebates to each enrollee. The statute's use of "enrollee" rather than "policyholder" in this context is problematic, since issuers collect premiums from policyholders rather than from enrollees. (The departments' use of "policyholders" rather than "enrollees" in the wording of the footnote to Question D.4 may indicate an existing awareness by the departments of this issue.)

The underlying funding of the premium submitted by the policyholder to the issuer has likely been split between the policyholder and the enrollees in some fashion; as a simplified example, an employer group may fund 100 percent of the premium for employee coverage but require that enrollees fund 100 percent of the premium for dependent coverage. The issuer typically does not know who funded which portions of the premium paid by the policyholders. As such, the issuer is required to calculate rebates on a pro rata basis and submit those rebates directly to the enrollee. This may result in some enrollees receiving rebates that exceed their underlying contribution to the premiums and result in some parties that made significant contributions to premiums (e.g., employers) receiving no portions of the rebates.

We believe a fairer interpretation would be to deem that the issuer's requirement to pay rebates to enrollees is satisfied by payment of a rebate to policyholders. This would leave it up to policyholders to equitably distribute the rebate back to individual enrollees, which is appropriate given that it is the policyholder, and not the issuer, who understands the extent to which the enrollees made contributions towards the original payment of premium to the issuer.

Leaving aside that threshold issue, the question remains, to which set of enrollees/policyholders should MLR-related rebates be paid?

From a pure equity perspective, it makes sense to return the rebates to the precise same set of policyholders whose experience led to the need for the rebate, namely all policyholders who had coverage at some point during the applicable time period, regardless of whether they are still active policyholders. For those policyholders who are entitled to a rebate but remain active, it may be desirable to permit an option to spread the rebate out as a credit against future premiums, rather than requiring the rebate to be remitted to the policyholder as a single lump sum. One

difficulty with this approach is that an issuer may not be able to track down all of its former policyholders who are entitled to rebates. This would raise the question of what the issuer should do with rebates issued but not claimed.

Equity considerations would also suggest that, within a credible block of business for which a rebate was calculated, issuers should be allowed some discretion on how rebates are apportioned to different subsets of policyholders within the block, so as to direct higher levels of rebate to subsets of the block that had lower loss ratios. However, the statutory use of the words "pro rata basis" in §2718(b)(1)(A) may take such discretion out of the hands of the issuer, as it seems to imply that all policyholders within a rebate block need to receive the same percentage-of-premium rebate amount.

E.6. Are there any important technical issues that may affect the processes for determining if rebates are owed, and calculating the amount of rebates to be paid to each enrollee?
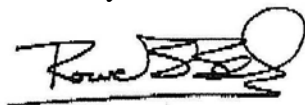
A number of interesting technical issues on rebates will arise after 2014, when according to §2718(b)(1)(B)(ii) the data used in the rebate calculation will transition from a one-year calculation to a three-year calculation. As an example, the methodology used for the three-year calculation will need to reflect the rebates previously paid with respect to either or both of the first two years within that period. Also, the use of the word "averages" in §2718(b)(1)(B)(ii) makes it unclear whether the calculation is based on averaging three different one-year MLR values or based on accumulating experience over the three-year period and calculating an MLR for that three-year period.

Since these issues are not yet imminent, we would encourage the departments to focus on other more immediate issues in current rulemaking and return to issues relating to §2718(b)(1)(B)(ii) in subsequent rulemaking.

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Thank you again for allowing us to provide input into this critically important rulemaking initiative. We would be delighted to engage in further discussions about this topic. If you have any questions, please contact Heather Jerbi, the Academy's senior federal health policy analyst, at jerbi@actuary.org or 202.785.7869.

Sincerely,

Rowen B. Bell, FSA, MAAA
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