



AMERICAN ACADEMY *of* ACTUARIES

February 14, 2012

Division of Regulations Development
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare and Medicaid Services
Attention: Document Identifier CMS-10418
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medical Loss Ratio (MLR) Annual Reporting Form

To whom it may concern:

On behalf of the American Academy of Actuaries'¹ Medical Loss Ratio Regulation Work Group, I appreciate this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the December 16, 2011 exposure draft of the Medical Loss Ratio (MLR) Annual Reporting Form required by Section 2718(a) of the Public Health Service Act (PHSA).

Our comments are limited to the instructions for Line 2.6 of Part 2 of the form, as shown on page 20 of the draft form instructions, and quoted below (emphasis added):

*“Line 2.6 – Direct contract reserve current year. Report the amount of reserves required when due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves. **The only contract reserves that are allowed to be used in the calculation are those used for the purpose of leveling the emerging cost due to advancing demographic age under an issue age priced contract.**”*

The sentence bolded above represents a material change from our understanding of the intent expressed by the National Association of Insurance Commissioners (NAIC) in 2010 when it provided technical recommendations to the Department of Health & Human Services (HHS) regarding MLR methodologies. From an actuarial perspective, the bolded sentence excludes a significant type of contract reserves that are of particular importance in equitably measuring the loss ratio for individual health insurance policies. We therefore recommend this sentence be deleted in the final instructions. As an alternative, the sentence could be retained but modified by striking the clause “due to advancing demographic age under an issue age priced contract.”

¹ The American Academy of Actuaries is a 17,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

The underlying issue admittedly is highly technical in nature. The following is a brief summary of our concerns.²

Contract reserves in individual health insurance typically arise for one of two distinct reasons. One reason is the situation described in the sentence bolded above. This is relatively rare in the current individual medical insurance market (although nearly universal in the individual disability and long term care insurance markets). The rating structure of the policy is based on the policyholder's age at original policy issuance, and some portion of current premiums therefore is intended to prefund higher claims that arise in later policy years due to the aging of the policyholder. The other reason, which is relatively more important in the current medical insurance market due to the historical use of medical underwriting and other risk classification techniques by insurers, involves expected variation in claims experience based on the policy duration (i.e., on the amount of time that has elapsed since policy issuance). For many insurers, some portion of current premiums is intended to prefund higher claims expected to arise in later years due to the passage of time since policy issuance.

As we wrote in our June 7, 2010 letter to the NAIC:

“The need to consider contract reserves [in the context of the MLR under PHS Act Section 2718] is important because of the potential tension that arises from using a calendar-year MLR to determine rebates in a market that typically exhibits material durational variation in the MLR and in which, consequently, pricing is often based on a lifetime rather than annual MLR. This tension can be mitigated to the extent that the contract reserves incorporated into the rebate calculation take into account durational MLR variation.”

The NAIC's recommendations to HHS, contain an apparent allowance for insurers to include in their Section 2718 MLR both types of contract reserves—not only contract reserves associated with age-related prefunding, but also, and more importantly, contract reserves associated with duration-related prefunding. The reference in the bolded sentence in Line 2.6 made in mid-December 2011 was, to our knowledge, the first instance that HHS has indicated a divergence from the NAIC's intent on this issue. No mention was made by HHS about excluding durational contract reserves from the MLR calculation in either the Interim Final Rule (late 2010), associated Technical Guidance (mid-2011), or the Final Rule (December 2011).

If insurers are not allowed to include durational contract reserves in the Section 2718 MLR, then the availability of new individual health insurance products in the years leading up to 2014 could be impaired. As we wrote in a June 7, 2010, letter to the NAIC:

² For further background on this subject, please see pp. 10-15 of the Academy's May 14, 2010 response to the HHS request for information on PHSA Section 2718:

http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf, Also see the Academy's June 7, 2010 letter to the NAIC's PPACA Actuarial Subgroup:

http://www.actuary.org/pdf/health/AAA_Contract_Reserves_060710_final.pdf

“Suppose that the change in [durational] contract reserves was not included in the rebate calculation, and no other mechanisms were adopted to reflect durational MLR variation within the rebate calculation. This would create an unlevel playing field among companies, weighted in favor of companies that have mature blocks of individual business and against new entrants or companies with growing blocks of individual business. In particular, we believe this could severely discourage companies from entering the individual market between now and 2014. Furthermore, this could provide an incentive for companies to discourage or even shut down new sales in the individual market between now and 2014 in states in which they did not have large mature blocks.”

We welcome the opportunity to discuss any of the comments presented in this letter with you at your convenience. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy’s senior health policy analyst (202-785-7869; Jerbi@actuary.org).

Sincerely yours,

Rowen B. Bell, FSA, MAAA
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American Academy of Actuaries