



AMERICAN ACADEMY *of* ACTUARIES

Oct. 8, 2010

Commissioner Sandy Praeger
Chairperson, Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

**Re: Regulation for Uniform Definitions and Standardized Rebate Calculation
Methodology for Plan Years 2011, 2012, and 2013 per Section 2718(b) of the Public
Health Service Act**

Dear Commissioner Praeger:

The American Academy of Actuaries’[†] Medical Loss Ratio Regulation Work Group appreciates this opportunity to provide input to the Health Insurance and Managed Care (B) Committee of the National Association of Insurance Commissioners (NAIC B Committee) regarding its Oct. 4, 2010, exposure draft of the above-named regulation (MLR rebate regulation).

We acknowledge and appreciate the sense of purpose with which the NAIC has undertaken its charge, as defined earlier this year with the adoption of Section 2718(c) of the Public Health Service Act, to provide the Department of Health and Human Services (HHS) with swift input relevant to the development of regulations implementing Section 2718 loss ratio reporting and rebate requirements. As actuaries, we are particularly pleased that the NAIC tasked a group of regulatory actuaries, the PPACA Actuarial Subgroup (actuarial subgroup), with primary responsibility for development of the MLR rebate regulation, which we believe is a critical regulatory issue. Consistent with the Academy’s mission, our work group throughout these past five months has sought to provide the actuarial subgroup and other stakeholders with input regarding this subject, and we are pleased that many of the actuarial subgroup’s technical Issues Resolution Documents contain reference to letters written by the Academy’s MLR Work Group. We hope our input has been helpful throughout this technical phase.

Now that the NAIC B Committee has exposed for comment the actuarial subgroup’s draft MLR rebate regulation, however, we believe it is important to take stock of the regulation as a whole. In this letter, our goal is to provide the NAIC B Committee and other stakeholders with our perspectives on the MLR rebate regulation—viewed as much from a public policy standpoint as from a purely technical standpoint. We have attempted to strike a balance between brevity and completeness by including a number of endnotes that refer to places in other documents in which the issues mentioned in this letter previously have been more fully articulated.

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

Guiding Criteria

To start, it is important to state what we see as the relevant guiding criteria for assessing the MLR rebate regulation:

1. *Appropriate construction of the Section 2718 medical loss ratio (rebate MLR) is critical; thresholds for rebate payment always can be recalibrated to achieve public policy objectives, but uncompensated biases in the underlying metric may adversely affect the functioning of insurance markets and thereby may adversely affect consumers.* The decision of whether to include a particular item in the rebate MLR should be based on whether the inclusion of that item produces a more meaningful metric, consistent with other criteria discussed below. With a well-constructed rebate MLR metric, the thresholds (e.g., 80 percent or 85 percent) at which rebate payment are required always can be recalibrated by regulators, if necessary, to achieve desired public policy objectives. But if the design of the rebate MLR metric systematically favors certain types of companies over others, the consequences on competition in insurance markets may be indelible and unwanted, possibly to the detriment of consumers' collective interests.
2. *The rebate MLR should be designed to be as comparable as possible across different types of health insurance issuers.* Many differences exist among health insurance issuers, and those differences manifest themselves via predictable differences in the traditional medical loss ratio (incurred claims divided by earned premium).¹ In an environment in which different types of issuers (e.g., staff model HMOs, group practice HMOs, PPOs, etc.) now find themselves subject to a common measuring stick, care should be taken to define that metric in a way that promotes a level competitive playing field, without rewarding certain types of health insurers and disadvantaging others.
3. *Recognizing that the definition of the rebate MLR will affect future insurer behavior, the rebate MLR should be designed in a manner that promotes, rather than discourages, insurer behavior that is consistent with the underlying aims of the Affordable Care Act.* The MLR rebate regulation can be viewed as an incentive mechanism, discouraging insurers from making expenditures that do not act to increase the insurer's rebate MLR. To that end, the design of the rebate MLR should encourage insurer behavior that would meet the ACA goal of addressing the cost of health care coverage.
4. *The determination of rebates to consumers should be structured in an equitable manner that reasonably reflects how insurers manage and price risks and how insurance is purchased.* The introduction of rebate requirements creates an asymmetry in the insurer's risk profile—upside risk is now returned to consumers while downside risk continues to be borne by the insurer. In this context, requiring rebates to be calculated at a more granular level than the level at which the insurer manages risk would impair the functioning of insurance markets. For example, the one extreme of requiring rebates to be calculated at the policyholder level would be impractical since, in any given year, a small percentage of policyholders generate a large percentage of overall claims. More subtle issues regarding the granularity of rebate calculations arise from situations in which a customer has contracts with multiple related legal entities but where those contracts are

underwritten and priced in an aggregate manner, or situations in which an entity uses multi-state experience for pricing purposes.

5. *The introduction of rebate requirements should be done in a manner that does not impede competition in insurance markets.* In particular, suitable transition mechanisms may be needed in the individual market, in which historical pricing practices have been oriented around lifetime rather than annual loss ratio targets, and in which relatively low medical costs combined with relatively equal administrative costs naturally lead to lower loss ratios.²

Positive Aspects of the Regulation

Many stakeholders have noted that the statutory language of Section 2718 contains a number of ambiguities and internal inconsistencies, which heighten the importance of regulatory interpretation to create a sound basis for implementing the underlying intent of this particular aspect of the Affordable Care Act. In that context, we wish to express our support for a number of interpretive decisions made by the actuarial subgroup during the development of the MLR rebate regulation that, in our view, result in a more sound regulatory framework relative to other potential decisions that could have been made.

Key examples of the positive aspects of the draft regulation include the following:

- *Calendar Year Orientation.* The statute's use of the phrase "plan year" in connection with rebate determination is somewhat confusing. By deeming, within the MLR rebate regulation, that "plan year" simply means "calendar year," the actuarial subgroup has taken a highly practical position, creating consistency with existing insurance regulatory financial reporting practices.³
- *Granularity of Rebate Determination.* The MLR rebate regulation's overall framework is that business is to be grouped together by legal entity, state of policy issuance, and market (individual vs. small group vs. large group) for purposes of determining rebates. Appropriate modifications to this framework have been made to cover specific situations in which risk is legally borne by different legal entities but is priced & managed in a more aggregated fashion (e.g., the "dual option with blended rates" case). The selected regulatory framework is one of several reasonable potential approaches. Given that the actuarial subgroup's selected approach carries with it additional complexities that will create difficulties for both companies and for regulatory auditors, alternate approaches involving greater aggregation may be equally reasonable.
- *Existence of Credibility Adjustments.* All else being equal, a smaller block of business will experience greater fluctuation in actual loss ratios, both above and below target, than a larger block, due simply to statistical fluctuation. This phenomenon has solvency implications in a framework in which rebates to consumers are required when loss ratios are below target, whereas contributions to surplus are reduced when loss ratios are above target. The application of credibility adjustments varying with block size, as done in the MLR rebate regulation and following the long-established precedent of the Medicare

Supplement rebate formula, helps to create a more level playing field between smaller blocks of business and larger blocks, thereby protecting companies' surplus positions and promoting competition in insurance markets.⁴

- *Existence of Denominator Adjustments for Taxes and Fees.* Some health insurance issuers are subject to federal income taxes while others are not. Levels of premium taxes and state regulatory assessments can vary significantly across types of issuers, states, and insurance markets. To be able to make fair comparisons across the entire industry, without putting certain companies at a disadvantage for regulatory factors that may not be within their control, the rebate MLR needs to be designed in a manner that makes adjustments to reflect all of these types of taxes and fees.⁵ We are pleased that the plain language of the statute supports making such adjustments, and that the NAIC has interpreted that statutory language in a relatively broad manner—despite suggestions from some legislators that a narrower interpretation is appropriate.
- *Existence of Numerator Adjustment for Change in Contract Reserves.* Existing pricing practices in the individual market are such that loss ratios may increase materially with the length of time for which the policyholder has maintained insurance coverage. As a result, the overall claims-to-premiums ratio for a block of individual business may be materially influenced by the “duration” of that block—that is, by the mix within the block between recently issued policies and older policies.⁶ Allowing the change in contract reserves to be included in the rebate MLR numerator can help normalize the rebate MLR across different health insurance issuers having individual blocks of varying durations. We believe the statute would allow this adjustment, and the actuarial subgroup has recognized the value of making an adjustment of this type. As discussed later in this letter, however, further technical refinements in this area may be warranted. This may become much more important to the extent that some carriers exit the individual market and the carriers remaining in the market experience a disproportionate mix of new business.
- *Use of a Runout Period for Measuring Incurred Claims.* Financial reports prepared at the end of a calendar year necessarily include estimates of the health insurance issuer's liability for claims incurred but not yet paid. Subsequent variance between actual claim payments and the original liability estimate can distort the loss ratios reported for adjacent calendar years.⁷ Restating the incurred claims for the calendar year using three months' of claims runout, as proposed by Section 6B of the MLR rebate regulation, is an appropriate enhancement to the accuracy of the rebate calculation.

Areas Meriting Further Consideration

While as noted above there are many areas in which we believe the decisions made during the development of the MLR rebate regulation were well-reasoned, there also are several areas in which we would encourage the NAIC B Committee to reconsider the regulatory direction chosen by the actuarial subgroup.

Key areas where we believe further consideration is necessary include the following:

- *Magnitude of Credibility Adjustments.* As noted earlier, we support the inclusion of credibility adjustments, which address the impact of statistical fluctuation on smaller blocks of business. We are somewhat concerned that the magnitude of credibility adjustments selected by the actuarial subgroup may not be sufficiently large enough to mitigate the risks faced by smaller blocks of business in an environment in which upside risk is returned to consumers via rebates. In an earlier letter to the actuarial subgroup, we compared the potential impact of applying 50th percentile adjustments (like those adopted by the actuarial subgroup) against alternatives, such as 80th percentile and 90th percentile adjustments.⁸ As illustrated in that letter, using 50th percentile adjustments rather than 80th percentile adjustments, particularly for a block of business having fewer than 10,000 life-years, may materially reduce the insurer’s expected contribution to surplus from the block. Increasing the magnitude of the credibility adjustments may help keep insurance markets attractive to smaller competitors, which would enhance consumer choice.
- *Cost Containment Expenses (CCE) / Loss Adjustment Expenses (LAE).* Prior to the drafting of the Affordable Care Act, the Academy’s Health Practice Council recommended that any new federal loss ratio requirements should be defined in such a way that insurers’ cost containment expenses, as defined under statutory accounting (SSAP 85), are included in the numerator.⁹ Since then, we have continued to argue that including all CCE within the numerator of the rebate MLR, as opposed to only including those CCE that meet a more stringent definition in the MLR rebate regulation of “expenses to improve health care quality,” would create a better metric and would facilitate comparisons in loss ratios across different entities.¹⁰ We also have noted that the absence of CCE from the rebate MLR creates what economists refer to as a “perverse incentive” with respect to measures insurers take to promote affordability of coverage; this seems misaligned with the underlying affordability objectives of Section 2718.¹¹

In addition, including all LAE in the rebate MLR has some appeal, in that the resulting metric would better reflect differences in business models across issuers and also would reflect the value that consumers receive from the insurer’s benefit-processing activities for healthcare services that do not generate claims in light of policyholder cost-sharing features.¹² Support for this approach is provided by the explicit reference to “loss adjustment expenses” within the statutory language of Section 2718(a); however, the actuarial subgroup has given little weight in its deliberations to the use of this phrase in the statute.¹³ Given the explicit legislative reference to LAE, further regulatory consideration of this issue seems warranted.¹⁴

- *Reinsurance.* The MLR rebate regulation has been drafted in a manner that excludes the impact of most reinsurance arrangements from the calculation. We sympathize with concerns expressed by the actuarial subgroup during its calls that unconstrained credit for reinsurance within the rebate MLR could allow health insurance issuers too much latitude to use reinsurance as a vehicle for manipulating the results of the calculation. We nevertheless believe that the regulation’s incorporation of reinsurance should be expanded somewhat, specifically with respect to allowing issuers to reflect excess risk

reinsurance treaties, which frequently are an important risk management tool for smaller companies.¹⁵

- *Methodologies for Contract Reserves.* As noted earlier, we support the inclusion in the rebate MLR of a change-in-contract-reserves component. But in light of technical nuances in existing statutory accounting guidance, together with an apparent diversity of accounting practice, we previously recommended to the actuarial subgroup that the contract reserves used in the rebate MLR calculation should be uncoupled from the contract reserves reported in the statutory financial statements.¹⁶ (Precedent for a federally defined contract reserve methodology, differing from statutory accounting, already exists within federal health insurance regulation.¹⁷) We continue to believe that greater guidance needs to be specified within the MLR rebate regulation regarding the methodologies and assumptions that may be used to determine contract reserves for rebate MLR calculation purposes, with clarification that those methodologies and assumptions legitimately may differ from those used to calculate the statutory-basis contract reserves (or to justify holding zero statutory-basis contract reserves).
- *Runout Period for Measuring Earned Premium.* As noted above, we support the MLR rebate regulation's use of a three-month runout period for measuring incurred claims. We believe that, for consistency, it is important to also use a three-month runout period for measuring earned premium. Without this, in some cases, significant inconsistencies could arise between the numerator and denominator (e.g., due to retroactive membership adjustments), which could materially distort the rebate calculation.
- *Treatment of 2011/2012 Rebates in 2013 Calculation.* Any mechanism that requires "rebates to be paid on rebates" does not seem consistent with the intent of the Affordable Care Act. Section 10 of the MLR rebate regulation, however, contains such a mechanism—when using cumulative 2011-2013 experience to determine the rebate payable on 2013 premiums, no adjustment to that experience is made for any rebates previously paid on 2011 or 2012 premiums.¹⁸ To the extent that companies have already returned "excess" premium to consumers in the form of rebates, we believe the companies have met their obligations under the law. Disallowing these previous rebate payments in determining the need for rebates in future years could be requiring return of premium in excess of the amounts required under Section 2718.
- *Differences in Plan Benefit Designs.* It is important to appreciate that policy and benefit administration expenses (as opposed to distribution/marketing expenses) as a general rule do not differ materially based on the actuarial value (AV) of the benefits provided.¹⁹ As a result, loss ratios for such policies as HSA-eligible high-deductible health plans naturally will be much lower than loss ratios for more expensive policies having more generous benefit designs. Holding all carriers within a market to a common loss ratio threshold, therefore, will put at a disadvantage carriers whose mix of business is more heavily weighted towards lower-AV products. The NAIC B Committee may wish to consider whether this situation can and should be addressed via regulation. For example, it may be viable to develop a "product mix adjustment factor," analogous to the credibility

adjustment factor found in the MLR rebate regulation in that it would be added to (or subtracted from) the actual MLR before comparing to the relevant rebate threshold.²⁰

Areas Not Adequately Addressed

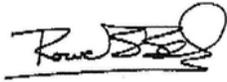
There are a number of aspects of rebate calculation and administration that are not addressed in the MLR rebate regulation, even though they may have been discussed at various times by the actuarial subgroup. The scope of the MLR rebate regulation as exposed presumably is intended to align with the scope of the NAIC's statutory charge to provide input to HHS under Section 2718(c).

Areas in which further elucidation, by the NAIC and/or by HHS, will be important include:

- *Transition Guidance, Particularly for the Individual Market.* We previously have highlighted the need for regulators to consider adopting transitional guidance on the application of Section 2718 to the individual market, and to announce expeditiously that guidance in order to have a timely influence on carrier decision-making processes.²¹
- *Identity of Rebate Recipients.* Read literally, the Section 2718 requirement to make rebate payments to “enrollees” often may be inequitable, to the extent that premiums were paid in full or in part by the policyholder (e.g., an employer benefit plan) rather than by the enrollees.²² Payment of rebates by the insurer to the policyholder would be a fair and appropriate interpretation of the statutory requirement.
- *Clarity on Definitions.* We have observed considerable confusion in understanding precisely what “small employer” means for purposes of Section 2718 in 2011-2013, and to a lesser extent in understanding which types of health insurance products are within the scope of Section 2718 requirements. While we recognize that these fundamentally are issues of statutory construction and interpretation, we nonetheless encourage regulators to clarify these issues as much as possible within regulation.
- *Reporting by Issuers.* Section 2718(a) creates a requirement for health insurance issuers to report on loss and expense ratios to HHS, and ultimately to the public. Over the past few months, the NAIC has developed two different new reporting mechanisms: the Supplemental Health Care Exhibit adopted in August and, most recently, the Rebate Calculation Form included in the MLR rebate regulation. There may be some confusion as to whether either, or both, of these mechanisms is intended to satisfy the Section 2718(a) requirement, or whether a third new reporting mechanism is still to be developed. The proliferation of multiple reporting mechanisms brings with it risks of creating confusion among consumers as to expectations about rebates, as well as risks of inconsistent treatment in the translation of data between reporting formats.

Thank you again for this opportunity to comment. If we can be of further assistance, please contact the Academy's senior federal health policy analyst, Heather Jerbi, at jerbi@actuary.org or 202-223-8196.

Sincerely yours,



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

Cc: Steven Larsen (Deputy Director, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services)

¹ For a discussion of ways in which the classical claims-over-premiums loss ratio varies systematically based on characteristics of the health insurance issuer, please see Pages 4-7 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

² For discussions of historical pricing practices in the individual market and the short-term implications with respect to MLR-based rebate requirements, please see Pages 10-15 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf), and also Pages 3-8 of the MLR Work Group's June 7, 2010, letter to the actuarial subgroup (http://www.actuary.org/pdf/health/AAA_Contract_Reserves_060710_final.pdf).

³ For a more complete discussion of this issue, please see Pages 42-43 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

⁴ For further discussion, please see the MLR Work Group's letters to the actuarial subgroup dated May 12, 2010 (http://www.actuary.org/pdf/health/aaa_statistical_credibility_to_naic_051210_final.pdf) and May 20, 2010 (http://www.actuary.org/pdf/health/aaa_statistical_credibility_response_100520_final.pdf).

⁵ For related comments, please see Pages 6-7, and also Pages 25-26, of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

⁶ For further discussion, please see Pages 3-8 of the MLR Work Group's June 7, 2010, letter to the actuarial subgroup (http://www.actuary.org/pdf/health/AAA_Contract_Reserves_060710_final.pdf).

⁷ For an illustrative example, please see Pages 8-9 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

⁸ The table on Page 3 of the MLR Work Group's May 20, 2010, letter to the actuarial subgroup (http://www.actuary.org/pdf/health/aaa_statistical_credibility_response_100520_final.pdf) illustrates the expected impact of different credibility adjustment levels on the insurer's net-of-rebate loss ratio. That table suggests that using a 50th percentile adjustment, rather than (for example) an 80th percentile adjustment, could disadvantage smaller carriers.

⁹ See Page 3 of the Academy's *Critical Issues in Health Reform: Minimum Loss Ratios* issue brief (http://www.actuary.org/pdf/health/loss_feb10.pdf), originally issued in mid-2009 and reissued in early 2010.

¹⁰ For further discussion, see Pages 1-3, and also Pages 8-11, of the MLR Work Group's May 17, 2010, letter (http://www.actuary.org/pdf/health/aaa_mlr_naic_letter_on_exhibit_051710_final.pdf) to the NAIC Health Care Reform Solvency Impact Workgroup.

¹¹ See Pages 12-13 of the MLR Work Group's May 17, 2010, letter to the NAIC Health Care Reform Solvency Impact Workgroup (http://www.actuary.org/pdf/health/aaa_mlr_naic_letter_on_exhibit_051710_final.pdf) for an illustrative example.

¹² See Pages 10-11 of the MLR Work Group's May 17, 2010, letter to the NAIC Health Care Reform Solvency Impact Workgroup (http://www.actuary.org/pdf/health/aaa_mlr_naic_letter_on_exhibit_051710_final.pdf) for further discussion.

¹³ For example, consider the following passage from Page 4 of the NAIC's May 12, 2010, response to HHS, which originally was drafted by the actuarial subgroup: "It is unclear whether these are the types of expenses intended by the term 'loss adjustment expense' in PPACA, or whether the parenthetical indicates that in this context 'loss adjustment expense' is intended to mean the change in contract reserves."

¹⁴ For a more complete discussion of different ways of reading Section 2718(a), please see Pages 20-25 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

¹⁵ For further discussion of reinsurance issues, please see Pages 31-32 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

¹⁶ See Pages 8-12 of the MLR Work Group's June 7, 2010, letter to the actuarial subgroup (http://www.actuary.org/pdf/health/AAA_Contract_Reserves_060710_final.pdf).

¹⁷ CFR Title 42 §403.253(b)(2)(ii) defines a contract reserve methodology to be used for federal Medicare Supplement loss ratio certifications.

¹⁸ Note that the situation for 2013 is unique, relative to situations that would exist for later years. For example, a carrier's 2013 experience would, due to the statutory use of three-year averaging, partially influence the determination of rebates for each of 2013, 2014, and 2015. By contrast, a carrier's 2011 experience will partially influence the determination of rebates for 2013, even though that same 2011 experience already had total influence over the determination of rebates for 2011. This places outsized emphasis on 2011, the remedy for which is to allow rebates paid on 2011 experience to be incorporated in the 2013 calculation.

¹⁹ For further discussion of this issue, please see Page 4 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

²⁰ It is true that the credibility adjustment factor in the MLR Rebate Regulation includes a component that varies based on deductible. That component, however, is relevant only for partially credible blocks of business. For a fully credible block, no adjustment is made to the rebate MLR to account for mix of business by deductible. In addition, the deductible component within the credibility adjustment factor is intended to account only for increased statistical fluctuation with higher-deductible products. It does not account for the fact that higher-deductible products normally will exhibit higher ratios of administration expenses to premiums.

²¹ Please see the MLR Work Group's April 28, 2010, letter addressed to two NAIC working groups (http://www.actuary.org/pdf/health/letter_academy_mlr_individual_market.pdf), as well as Pages 10-15 of our May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).

²² See a related discussion on Page 44 of the MLR Work Group's May 14, 2010, letter to HHS (http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf).