8/13/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD001

Issue:

Does MLR Rebate formula include Loss Adjustment Expenses (LAE) in numerator?

Subgroup Resolution:

Formula does not include LAE – resolved 6/7/10.

Exceptions:

Portions of the LAE which meet other requirements for inclusion may be included in the numerator.

Description:

2718(a) references a report to the Secretary of incurred claims plus LAE:
"…submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums."

Should LAE be included in the formula in 2718(b) as either an incurred claim (clinical service), or quality improvement expense?

Documentation in support:

Example of argument for including LAE is taken from the letter of April 27, 2010, from BCBSA.

"The introductory sentence to subsection (a) reads (with extraneous words removed), "A health insurance issuer … shall … submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums." The next sentence, which seems to be further clarify the information to be reported, states: "Such report shall include the percentage of total premium revenue … that such coverage expends –

(1) On reimbursement for clinical services provided …
(2) For activities that improve health care quality; and
(3) On all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees. "

"The question is whether it is reasonable to interpret this provision to require each health insurer to submit a report detailing paragraphs (1) through (3) that incorporate incurred claims, loss adjustment expenses, change in contract reserves (if applicable to the business), and earned premiums as outlined in the first sentence of subsection (a). In other words, paragraphs (1) and (2) would include the components of the ratio described in the first sentence of §2718(a), and paragraph (3) would include "all other non-claims costs" (along with the explanation of those costs). Since paragraph (3) refers to "all other non-claim costs," claims costs such as loss adjustment expenses logically must fall under paragraph (1). It should be noted that the NAIC Accounting Practices and Procedures Manual defines both "loss adjustment expenses" and "claim adjustment expenses" to be the costs in connection with the adjustment and recording of claims.

"Under this interpretation, the expenditures for the reimbursement for clinical services, subsection (a)(1), would include the actual incurred costs for clinical services, the associated costs for reimbursement (loss adjustment), and the change in contract reserves, if any (given that contract reserves fund future clinical services).

"The expenditures for activities that improve health care quality, paragraph (2), include costs associated with healthcare quality improvements (yet to be specified), which is a subset of loss adjustment expenses as currently defined by the NAIC. Since the healthcare quality improvement costs are specifically identified in paragraph (2), they need to be excluded from the loss adjustment expenses in paragraph (1).

"The other non-claims expenditures, paragraph (3), would include general administration expenses and commissions, but exclude Federal and State taxes and licensing or regulatory fees. Under this interpretation:

"Ratio (a)(1) equals: *{incurred claims + (loss adjustment expenses – healthcare quality expenses) + change in contract reserves } / {earned premiums}*

Ratio (a)(2) equals: *{healthcare quality expenses} / {earned premiums},* and

Ratio (a)(3) equals: *{general administrative expenses + commissions - Federal/State taxes & fees } / {earned premiums}*

"The rebate provision set forth in §2718(b) relies on the costs reported within the ratios under subsection (a)(1) and (2) for its purposes. While subsection (a) outlines an insurer's total expenditures for public reporting and posting, subsection (b) outlines the reporting for the minimum loss ratios and any resulting rebates. Subsection (b)(1)(A) defines the ratio as "the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees …)." This reduction for taxes and fees in subsection (b), which is apparently not provided for in §2718(a), results in a ratio under §2718(b) which will differ from the sum of the ratios in subsection (a)(1) and (2).1

"Therefore, the subsection (b)(1)(A) ratio equals: *{incurred claims + loss adjustment expenses (includes healthcare quality improvement expenses) + change in contract reserves} / {earned premiums - Federal/State taxes & fees}*

"In support of this interpretation of §2718, we note that the questions in the Request for Comments Regarding Section 2718 of the Public Health Service Act prepared by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (RFI) seem to support the inclusion of LAE in the ratios. The second paragraph of page 7 reads, "Specifically, Section 2718(a) of the PHS Act requires health insurance issuers offering group or individual coverage to submit a report to the Secretary for each plan year, concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums (also known as the medical loss ratio (MLR))."

"This interpretation also seems consistent with the concept of comparing the medical loss ratios across insurers. Capitation payments to providers for clinical services inherently include some loss adjustment expenses. Insurers utilizing capitation arrangements would include the full capitation payment (the amount for clinical services and the amount for loss adjustment) in their incurred claims amounts. For staff model HMOs, the expenditures for doctor and nurse salaries plus owned-facility operating costs, which cover both medical and administrative costs, would be included in their incurred claims amounts. Therefore, the ratios produced under the interpretation outlined above would be comparable across various insurers. We note that §2718's exclusion of federal and state taxes and fees from the ratios evidences an analogous intent to ensure comparable ratios across different insurers given that insurers have varying tax obligations based on their licensures, non-profit status, state laws, and other factors."

Documentation in opposition:

An example of arguments opposed to including LAE is taken from a letter from NAIC Funded Consumer Representatives to Steve Ostlund in response to the foregoing letter.

"Section 2718 consists of five subsections and requires insurers to provide information accounting for their costs in a number of expenditure categories. First, section 2718(a) requires insurers to submit to HHS "a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. This ratio is:

Incurred loss + loss adjustment expenses (or change in contract reserves) / earned premiums

"Second, the report is also supposed to contain three other ratios, namely:

> "the percentage of total premium revenue, after accounting for collections of risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—
> (1) on reimbursement for clinical services provided to enrollees under such coverage;
> (2) for activities that improve health care quality; and

(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

"These ratios are:

Clinical services reimbursement/premium revenue + or – risk pooling
Health care quality activity payments/premium revenue + or – risk pooling
Other non-claims costs – taxes and regulatory fees / premium revenue + or – risk pooling.

"Section 2718(b), the operative section requiring rebates, turns on yet another ratio, different from any of those reported under subsection (a). This ratio is "the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance" for a plan year. . .", represented as:

Clinical services reimbursement + quality activity costs / premium revenues – taxes and regulatory fees + or – risk pooling

"Under 2718(b)(1)(B) this becomes the key formula in the provision. If the ratio falls below 80 percent in the individual or small group market or 85 percent in the large group market (or such higher rate as a state imposes or unless HHS determines that the 80 percent ratio will destabilize the market, the insurer must pay a rebate to its enrollees.

"The operative ratio of 2718(b) does not include loss adjustment expenses in its numerator. Although loss adjustment expenses are included in the numerator of the first ratio described in 2718(a), this is not the ratio that determines the rebate."

Another very specific directive is contained in the May 20, 2010, Harkin-Franken letter.
Some have suggested that "loss adjustment expenses" – administrative expenses incurred in adjusting and settling claims, which include cost containment expenses – should count as spending on clinical services and activities that improve quality. However, while the statute requires reporting of loss adjustment expenses, it is clear that they should not be included for
(continued excerpt from H-F letter:) "purposes of rebates required under the new law. These expenses do not reimburse for clinical services, and they do not improve quality."

Evaluation:

We take most seriously the comments from Chair Harkin and Member Franken.

Section 2718(a) has a confusing reference to "loss adjustment expense (or change in contract reserves)" which indicates care must be taken in our interpretation. The Funded Representatives make a persuasive case the ratios must be considered separately to avoid confusion. While the opposite interpretation is also persuasive we find the interests of the all involved will maximized in total by excluding the LAE from the numerator of the MLR rebate formula.

Because an expense is categorized as LAE in the NAIC reports, does not mean it might not also be considered a Quality Improvement expense on its own merits.

Exception Reference:

None

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD002

Issue:

Should the MLR rebate calculation take place at the "statutory entity" level or should the experience of affiliated carriers be combined?

Subgroup Resolution:

For purposes of MLR calculations, each "statutory entity" (licensed carrier, such as insurer, HMO, or service corporation) should have a separate rebate calculation. Experience of affiliated carriers should not be combined for rebate calculation purposes – resolved 6/28.

Exceptions:

A possible exception will be discussed in IRD 076, concerning coverage where in-network coverage is provided by one carrier and out-of-network coverage is provided by another carrier. Under this arrangement (sometimes called "dual contract") each carrier has its own contract with the policyholder for its portion of the benefits. IRD 076 will address whether affiliated carriers can combine experience for MLR purposes in this situation.

Description:

In some markets, coverage is offered by more than one carrier under common control. One example is that a carrier licensed as an HMO and an affiliated carrier licensed as an insurer will sell different but complementary products in the same market (and in group coverage products from both carriers may be sold to the same group). Other examples are carriers that are the result of recent acquisitions, carriers offering specialty products, and dual contracting arrangements mentioned in the exceptions above.

This raises the question of whether it is more appropriate to calculate minimum loss ratios on an "affiliated" basis rather than statutory entity basis. This possibility was considered but ultimately rejected.

It is carriers, rather than affiliated groups of carriers, that are the fundamental focus of state regulation. Solvency, which is presumed to be our overriding concern, is regulated at the statutory entity level; combining entities for MLR purposes could require a statutory entity to pay a rebate that would affect financial condition.

It also appears that statutory entity is the typical basis for calculation in states that currently require rebates. There are exceptions to this general rule: for instance, New Jersey combines affiliates in the individual, but not the small group, market.

It is also the case that in the Medicare Supplement market, which is state regulated but controlled by federal standards, two affiliated carriers can offer the same products but the experience is not combined for minimum loss ratio purposes.

An advantage of calculating by statutory entity is that administrative expenses may be more closely allocated to products than on an affiliated basis. Additionally, the likelihood of refunds is higher on the non-combined basis.

An advantage of calculating on an affiliated basis is increased credibility due to the combined experience of the affiliates. The affiliated basis also gives carriers more flexibility to allocate administrative expenses (or profit margins) to products without the additional constraint of meeting the MLR requirement on a statutory entity basis.

Documentation:

The law refers to a "health insurance issuer" in discussion of the requirement for rebates. There does not seem to be any discussion or interpretation which settles whether this term refers to a statutory entity or to an affiliated group of companies. Although this is more a legal than an actuarial question, it is probably appropriate to think that health insurance issuer is to be understood as the legal entity itself (which is the entity that has the authority to issue coverage) rather than an affiliated group of carriers.

Evaluation:

A simple example might help to frame the discussion.

ABC HMO and ABC Insurance Co. are affiliates. Here is their individual product experience for 2011.

Carrier	Premiums	Claims	Loss Ratio
ABC HMO	$100 mm	$78 mm	78%
ABC Insurance	$ 50 mm	$45 mm	90%
Total	$150 mm	$123 mm	82%

In this example, ABC HMO would pay a rebate (of exactly or about $2 mm, depending on the formula) on a statutory entity basis, while ABC Insurance would pay nothing. No rebate would be due on a combined basis.

The favored alternative may depend on the perceived purpose of paying a rebate. If the rebate is viewed from the point of view of the policyholder, then the statutory entity method will be favored because it more closely aligns premiums with claims for identifiable groups of policyholders.

If the rebate is viewed from the point of view of the carrier, then it limits the amount of premium available on the average for administrative expenses and profit on an aggregate basis (with no explicit requirement that those expenses be equitably allocated to the policyholders). Since carriers may combine the administration of affiliated statutory entities, it makes some sense to apply this limit at the economic, rather than statutory, level.

Additional Considerations that Support calculation by statutory entity

Likelihood of Refund: The likelihood of rebate is generally higher when the calculation is by statutory entity.

Proxy for Plan: The subgroup may actually favor calculations by plan, but finds such a calculation impractical. In this case, calculation by statutory entity is an imperfect but more practical way of partially achieving calculations by plan.

Complexity of Adjustments: The analysis assumes that loss ratios will be calculated simply as claims over premiums. However, there may be adjustments such as reserves, taxes, allowed quality expenses, credibility, multi-year averaging, large claims adjustments, etc. These adjustments may present some complexity even at the statutory level (allocation to lines of business, for example). There will be an additional level of complexity if statutory entities are combined.

Additional Considerations that Support calculation by affiliate:

Credibility: Affiliated experience may have a higher degree of credibility than the experience of a statutory entity.

Arbitrary allocation of products to statutory entity: Companies are not consistent in which sorts of products they sell from which statutory entities. In some cases, similar products may be available from more than one statutory entity. For a particular customer, the rebate may depend on a fortuitous allocation.

Policyholder perception: The distinction by statutory entity is largely invisible and inconsequential to the policyholder. The policyholder may not understand why some of ABC's policyholders (the HMO ones) are getting refunds, and other policyholders are not.

Proxy for Plan: It was a policy option, which the subgroup apparently did not accept, to require that the loss ratio requirement be met by major plan category (HMO vs. POS vs. PPO, for example). Carriers may sell different plans from different statutory entities. In that case, calculation by entity becomes an imperfect (and inconsistent) way of calculating rebates by plan.

Experience in Other States

New Jersey uses both the statutory entity method (in small group) and the combined entity method (in individual). The distinction is based upon the definition of "carrier" for each market in the enabling statute. It is not clear that the distinction was intended or contemplated in the statute (that is, the definition of "carrier" may have been based on considerations other than calculation of minimum loss ratios.)

South Carolina does not permit HMOs to offer an out of network option. This coverage must be offered by a licensed insurer. Thus, HMOs typically offer out of network coverage through a separately licensed sister insurer.

New York's treatment of out of network options for HMOs is the same as South Carolina's.

Exception Reference:

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD003

Issue:

Is aggregation by state?

Subgroup Resolution:

Aggregation is by state - resolved 6/7/10.

Exceptions:

Possible exception for combining several small blocks by state based upon either interstate compact, or pooling considerations. Possible exception for large group multi-state carriers.

Description:

2718(b) references rebates calculated at the individual, small group and large group level. It is silent regarding any other subset for the purposes of aggregation.

Documentation in support:

Example of argument for aggregating at a state level is taken from the letter of May 14, 2010, from Consumers Union, HHS reference HHS-OS-2010-001-0059.1.

"…(W)e recommend reporting medical loss ratio at a level of aggregation that would allow consumers living in a particular state or other definable geographic region to determine how insurers are spending their premiums."

"Aggregating this information at too high a level will present consumers with misleading averages of multiple, disparate markets."

"Other considerations:

- Insurers should also not be allowed to pool their experience across different states."

Documentation in opposition:

Example of argument against aggregating at a state level is taken from the letter of May 14, 2010, from Freedom Life, HHS reference HHS-OS-2010-001-0055.1.

"Smaller and mid-size companies need much greater levels of aggregation than on a state basis to have credible data…."

Example of argument against aggregating at a state level is also taken from the letter of May 14, 2010, from American General, HHS reference HHS-OS-2010-001-0048.1.

"However, the data from some states may not be totally credible, which if used, could lead to faulty conclusions. Rebates should not be paid out on less than fully credible, inconsistent, non-uniform data."

Example of argument against aggregating at a state level is taken from the letter of May 14, 2010, from America's Health Insurance Plans, HHS reference HHS-OS-2010-001-0067.1.

"Large employers often have multiple work sites and employees in many states. Reflective of this structure, carriers do not generally report MLR information on a state-by-state basis."

Evaluation:

There appears to be general acceptance that geographical aggregation should be at the state level. Currently, insurance is regulated at a state level, resulting in different policy and rating provisions between states. Counter-arguments generally address the potential lack of credible size at the state level and the difference in administration associated with multi-state large carriers.

Compelling guidance is provided by the principle that the consumer should see experience developed from a specific policy available for purchase. To reflect experience from a policy issued in another state and unavailable to the consumer does not seem reasonable. Generally the burden of making appropriate adjustments should lay with the carrier not the consumer.

Exceptions References:

None.

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD004

Issue:

Is aggregation by three pools (individual, small group and large group)?

Subgroup Resolution:

Aggregation is by three pools - resolved 6/7/10.

Exceptions:

None identified.

Description:

2718(b) references rebates calculated at the individual, small group and large group level.

Documentation in support:

Another very specific directive is contained in the May 20, 2010, Harkin-Franken letter.

"…(W)e urge…a methodology that sets minimum percentages for each market segment in each state. The intent of the statute is clear, because it specifies minimum percentages by market segment and allows states to set higher percentages."

Documentation in opposition:

Example of argument against aggregating at a market segment level is taken from the letter of May 14, 2010, from Freedom Life, HHS reference HHS-OS-2010-001-0055.1.

First and foremost, applying the same Medical Loss Ratio ("MLR") standard on individual health insurance that is applied to small group is problematic in that the business dynamics of the two product lines are significantly different. We explain our rationale for this in the body of our letter. Second,

Although the CBO noted that medical loss ratios ("MLRs") under the PPACA were noticeably higher in the individual market and only slightly higher in the small group market, it chose to ignore the substantive differences between the two markets and set the maximum MLR minimum for both markets at 80%, which substantially penalizes the individual market and jeopardizes its continued existence. The political rhetoric surrounding the passage of PPACA has been extraordinary. The individual health insurance sector has been totally vilified for the exclusion of pre-existing conditions despite the significantly lower premium cost provided to the individual market, as discussed below, or the fact that insurance is meant to be a financing mechanism for unknown risks (i.e. a homeowner doesn't have the right to purchase fire insurance while his house is on fire).

The small group market is comprised in most states of small businesses with 2 to 50 employees while the individual market is just that – an individual. Following is a summary of the principal differences between the individual and small group market business models:

- Due to economies of scale (2 to 50 vs. 1), the average cost per insured member for sales, marketing and various policy administration functions (i.e. billing) are substantially lower for the small group market than the individual market. In addition, brokerage fees for group business are often billed directly to the employer and excluded from premium.

- Exclusion of pre-existing conditions is not permitted for small group business which lowers underwriting/issue costs and substantially increases the average premium per member (and dollars available for profit and administrative costs) in comparison to the individual market. For FLICA's Fort Worth, Texas headquarters, group employee insurance family coverage costs $11,390 annually for a $6,000 deductible and $11,600 out of pocket maximum (purchased from a large carrier). In comparison, FLICA's annual premium for a family of four in Fort Worth, Texas, with a primary

insured age 45, is $7,378 for a $5,400 deductible and $10,000 out of pocket maximum. The employee group premium charged to FLICA is 54% higher with a higher out of pocket maximum than the individual premium rate that FLICA charges its customers.

- Small group business is non-renewable on an annual basis, while individual business is guaranteed renewable for life as long as premiums are paid which provides the small group insurer a significant advantage in managing risk as groups with the highest risk exposure are simply non-renewed. Please note that the average "life" of an individual major medical policy is approximately 29 months. FLICA's customer surveys indicate that the principal reason for cancellation of individual health coverage is the acquisition of employer group coverage.

In view of the above market differences, which will persist at historical levels through 2013 at a minimum, we believe that a 70% durational adjusted MLR minimum for the individual market is initially required. In 2014, we expect that an increase in the individual market MLR to 75% would be reasonable if the state exchanges operate as expected. Please note that the minimum MLR requirement for the individual market should always be lower than that of the small group market due to lower economies of scale and greater volatility. Most states have historically set minimum required loss ratios for the individual market between 55% and 65% due to smaller average premiums and higher administration costs than group business. Due to the significant additional business risk for the individual market created by PPACA and reduction in return on capital, some carriers will not be able to justify continuing to allocate capital to this line of business, much less expand capacity to meet expected individual market growth as employers exit the small group market.

Evaluation:

The law clearly defines different MLR standards by the three market segments. While the small group market and individual market share the same MLR standard, they are referenced separately. As noted above, the individual market differs significantly from the small group market, and thus should be evaluated separately. The law provides for the potential different treatment of the individual market to avoid disruption.

Exceptions References:

None.

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD005

Issue:

Should rebates be calculated using calendar year as the plan year?

Subgroup Resolution:

Rebates should be calculated using calendar year as plan year – resolved 6/7/10.

Exceptions:

None identified.

Description:

2718(b) references providing annual rebates with respect to each plan year.

Documentation in support:

Example of argument for using calendar year is taken from the letter of May 14, 2010, from America's Health Insurance Plans, HHS reference HHS-OS-2010-001-0067.1.

Base the MLR Calculation on a Calendar Year: Similar to the model used for the Medicare Supplement program we recommend use of calendar year calculations. A calendar year approach has the advantage of being simpler for consumers to understand. It also better synchronizes with the structure of the vast majority of major medical coverage that includes a deductible and which applies the deductible on a calendar year basis. Moreover, a calendar year approach should not impair reporting or rebating required under Section 2718 given that where the distribution of non-calendar year policy issue and renewal dates are evenly distributed and do not change from one calendar year to the next, the use of a calendar year date creates a reasonable 12 month approximation. By contrast, using an employer group or "ERISA" plan year as the basis of the twelve month period to calculate the MLR will create additional reporting subsets leading to an increase in administrative costs. It could also unnecessarily complicate the MLR calculation and potentially increase the amount of time until a base of statistically credible experience is reported and becomes the basis for potential rebates.

Documentation in opposition:

See HHS regulations for different definitions.

Proposed regulation on dependent coverage to age 26: (REG-114494-10)

These interim final regulations define "policy year" as the 12-month period that is designated in the policy documents of individual health insurance coverage. If the policy document does not designate a policy year (or no such document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year. The Affordable Care Act uses the term "plan year" in referring to the period of coverage in both the individual and group health insurance markets. The term "plan year", however,

is generally used in the group health insurance market. Accordingly, these interim final regulations substitute the term "policy year" for "plan year" in defining the period of coverage in the individual health insurance market.

Interim regulation on early retiree reinsurance: (**RIN 0991–AB64)**

Plan year means the year that is designated as the plan year in the plan document of an employment-based plan, except that if the plan document does not designate a plan year, if the plan year is not a 12-month plan year, or if there is no plan document, the plan year is:
(1) The deductible or limit year used under the plan;
(2) The policy year, if the plan does not impose deductibles or limits on a 12-month basis;
(3) The sponsor's taxable year, If the plan does not impose deductibles or limits on a 12-month basis, and either the plan is not insured or the insurance policy is not renewed on a 12-month basis, or;
(4) The calendar year, in any other case.

Evaluation:

Plan year, if defined as the period from the anniversary to anniversary of a policy, would be difficult if not impossible to implement a program of annual MLR rebates. With pooling across different groups and of a policy form for individual policies, the collection of data for the rebate would require a period of at least two calendar year periods. For ease of understanding by the consumer, and ease of calculation by a company, calendar year seems to be the only viable way to proceed.

Exceptions References:

None.

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD006

Issue:

Should calculation of rebates double-count prior rebates?

Subgroup Resolution:

Calculation of rebates should not double-count prior rebates – resolved 6/7/10.

Exceptions:

None identified.

Description:

2718(b) references calculating annual rebates with respect to each plan year using an average of premiums and claims over the past three years. If the rebate paid in a prior year is not reflected as an adjustment to that year's premium, the average MLR used for the current plan year calculation will be understated.

Documentation in support:

Documentation in opposition:

Evaluation:

The law specifies the level of MLR that will dictate a rebate. The excess premium is to be returned to the policyholder as a rebate. If a company were to be subject to "double jeopardy" by not considering previous refunds, the result would be nonsensical. Consider the case where an individual pool generated a fifty percent MLR. A thirty percent rebate would be required. If the calculation of a later period were to ignore the previous rebate, then the thirty percent rebate would be repeated resulting in the company having paid out 110% of premium for that year, 50% in claims, 30% for first rebate, and 30% for second rebate.

Exceptions References:

None.

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD007

Issue:

Should the definition of clinical services be limited to incurred claims as defined by SSAPs developed by the NAIC?

Subgroup Resolution:

The definition of clinical services should be limited to incurred claims as defined by SSAPs developed by the NAIC – resolved 6/7/10.

Exceptions:

None identified.

Description:

2718(b) references calculating an MLR with the sum of clinical services and quality improvements comprising the denominator.

Documentation in support:

Documentation in opposition:

Evaluation:

We have decided the starting point for definition of clinical services should be based upon all the work that has preceded the law. If we determine exceptions are required, they will be made from this base.

Exception References:

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD008

Issue:

How should the change in contract reserves be defined in the calculation of Medical Loss Ratio (MLR) as described in Section 2718(a) and in the calculation of rebates in Section 2718 (b)?

Subgroup Resolution:

Contract reserves should be defined as described in the Accounting Practices & Procedures Manual (APPM) for entry in the statutory financial statements –resolved 6/28.

Exceptions:

For calculating the MLR, contract reserves should not include "premium deficiency" reserves, as those reserves are recorded in financial statements to reflect the excess of future claims over future premiums and expenses. See IRD036.

In addition, contract reserves should not include reserves for expected rebates, as the rebates are the result of the calculation in Section 2718 (b). Adding a reserve for an expected rebate would reduce the calculated rebate to zero, in a circular calculation.

Also, procedures should be established to evaluate any circumstances in which the statutory financial calculation of contract reserves leads to unintended consequences that are contrary to the purpose of the Affordable Care Act (ACA). For example, in some years the statutory financial contract reserve could result in overstatement of an MLR due to the margins included in the reserve calculation for solvency purposes. In that case, for purposes of calculating the contract reserve for the MLR, the company calculating the MLR should adjust the contract reserves to have a lower margin.

Description:

The methodology for calculating contract reserves for medical coverage subject to the ACA is described in Statements of Statutory Accounting Principles 54 and 55, and in Appendix A-010, which appear in the APPM. This methodology requires companies to hold reserves when the claims are expected to increase faster than the premiums. The earlier premiums must be set at a level to cover the cost of expected claims in later periods.

It is important to note that many companies do not currently hold such contract reserves for individual medical coverage, presumably under the argument that theoretically they could raise their premiums each year to cover the claims that are increasing due to the "wear-off" of underwriting. However, in practice the premiums cannot be raised proportionate to the claims in each policy year. This is partly due to state rating restrictions, and partly due to the potential for healthy policyholders to lapse their policies every year to regain the low rate for newly issued policies. That would lead to a "selection spiral" where the remaining enrollees are even more costly than anticipated, leading to a healthier portion of them lapsing, and so on.

A brief investigation revealed that currently both Blue Cross of Florida and Blue Cross of Minnesota hold duration-based contract reserves in their financial statements for their individual medical blocks, and it is likely that many more companies do so also.

Background Information:

Contract reserves are an accounting tool that insurers use to properly allocate costs to the time period in which associated revenues are received. Just as an expensive piece of equipment may have its costs amortized over its expected useful lifetime, contract reserves are an adjustment that spreads the cost of claim payments over the expected life of a contract.

Over time, the change in contract reserves totals zero, because over the life of a block of policies, the contract reserves are zero at the beginning and also are zero at the end, when no policies are still in force.

Documentation in support:

The following comments regarding contract reserves are taken from the letter of May 14, 2010, from the American Academy of Actuaries, HHS reference HHS-OS-2010-004-xxxx.x

> "*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…"
>
> 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, 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…"

The following comments regarding contract reserves are taken from the letter of June 7, 2010, from the American Academy of Actuaries.

> "The need to consider contract reserves in this context 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. A complicating factor, however, is that current statutory financial reporting does not require companies to establish a contract reserve to reflect expected durational MLR variation of individual medical policies. While most companies in the individual market experience durational MLR variation of some sort (with the magnitude varying significantly by company), we believe comparatively few companies currently record statutory-basis contract reserves for attained-age-rated individual medical policies.

Letter from Birny Birnbaum, Center for Economic Justice, June 2, 2010

> "4. Allow use of contract reserves for MLR calculation. Theoretically, this is a reasonable approach. If, in fact, an insurer can reasonably estimate future claims payments and establishes reserves, the MLR becomes an incurred loss ratio instead of a paid loss ratio -- standard practice in many lines of insurance. The downside is that reserves are subject to manipulation and an insurer would likely simply establish reserves sufficient to meet the MLR standard. In fact, the establishment of such reserves would almost be definitional. If you price a product to achieve an 80% lifetime loss ratio, then your reserves will be the remainder of 80% of premium less claims paid. For this to work, there would have to be a severe penalty for significant over-reserving. Without such a penalty, there is little downside to manipulating reserves to meet the MLR."

Documentation in opposition:

The following comments regarding contract reserves, (indicating that a new formula for contract reserves should be developed) are taken from the letter of June 7, 2010, from the American Academy of Actuaries.

> "We believe regulators, in implementing Sec. 2718 requirements, should give strong consideration to the following idea: ***Establish a new contract reserve calculation that is used specifically for purposes of the individual market MLR calculation for rebate purposes and is not tied in any way to the company's statutory-basis contract reserves***.
>
> Defining a separate contract reserve basis for rebate calculation purposes would avoid the following disadvantages of other potential approaches:
>
> Suppose that the change in 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."
>
> "Suppose that the rebate MLR calculation was defined to include the change in statutory basis contract reserves and no changes were made to current statutory reserve standards. In this case, there are circumstances in which a well-capitalized company's selection of an accounting policy that involves non-zero statutory contract reserves for individual business might result in that company not needing to issue rebates, while a similarly situated company exercising its right to hold zero statutory contract reserves would need to issue rebates."

From a letter from NAIC funded consumer representatives dated June 2, 2010, which also refers to comments from the Center for Economic Justice, the relevant portion of which is attached:

> "3) Recognize transitional reductions in MLRs as an alternative to recognizing contract reserves. Although contract reserves are specifically recognized in the 2718(a) reporting formula, they are not recognized as such in the 2718(b) rebate formula. We believe that recognizing contract reserves as part of the MLR rebate formula will raise difficult issues of tracking and accounting for reserves. For example, if an insurer adds contract reserves to its claims paid in a particular year to meet the 80 percent threshold, how can the consumer be assured that it will receive the value of those reserves in a future year? If the consumer does not renew at the end of the plan year, does the consumer get a rebate for the value of the reserves? While the concept of reserves makes sense for traditional insurance regulation, it is difficult to square with the MLR rebate formula and process. The AAA recommended contract reserves as one approach to dealing with transitional issues. If transitional issues are dealt with through a temporary reduction of the MLR for a particular state, accounting for contract reserves in the MLR formula should be unnecessary and redundant.

Letter from Birny Birnbaum, Center for Economic Justice, June 2, 2010

> "In its May 14, 2010 letter to the Department of Health and Human Services, the American Academy of Actuaries Medical Loss Ratio Regulation Work Group hypothesized about problems in the individual health insurance market associated with the 80% minimum loss ratio (MLR) standard. This document contains the Center for Economic Justice (CEJ) comments on the AAA analysis and proposals for MLR transition for individual health insurance plans.
>
> The premise of the AAA argument is that insurers price individual market policies based on a "lifetime basis" and, consequently, loss ratios increase over time as initial underwriting wears off. There is no empirical evidence presented that this is the case or that the numbers on page 11 are anything other than made up. By the logic of this argument, an insurer would gladly have an individual book of business with very high loss ratios in a particular year because these high loss ratios balance out the low loss ratios of earlier years -- an implausible result."…

Evaluation:

8/25/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD010

Issue:

Should claims reserves be calculated on a run out basis of 3 to 6 months?

Subgroup Resolution:

Resolved – 8/25:
Claims reserves should be calculated on a 3 month run out basis.

Exceptions:

None identified.

Description:

2718(a) references calculating an MLR using incurred claims and contract reserves in the numerator. Incurred claims are assumed to be calculated as paid claims plus an estimate of remaining liabilities.

Documentation in support:

Many states currently use a run-out basis in determining their MLR rebate programs.

Documentation in opposition:

Evaluation:

Run-out reserves are defined as the reserve that has developed over time. It provides a better estimate of the remaining liability than the reserve established at the end of the period under consideration. For example, we could consider a situation where a carrier estimated the remaining outstanding liability for claims incurred during calendar year 2010 as of 12/31/2010, as well as of 3/31/2011. If a claim for service provided in 2010 of $2,000 were paid in February 2011, it would be known as a fact on March 31, but could only have been estimated by the company in December, 2010. Evaluating the remaining liability for claim payments at March 31, allows estimates of claims expected to be paid in the first quarter to mature into actual payments. They become a factual record. Replacing this estimate with known values increases the accuracy of the MLR rebate.

It is possible to wait several years and be assured that all claims have been paid before calculating a potential rebate. This is perhaps most fair to the company and to the consumers. But this would delay any payments, and interest on such potential rebates would accrue to the benefit of the company. We believe a claim reserve should be used to accelerate these potential rebate payments, but the reserve should not be a significant proportion of the "clinical services" evaluated in the rebate formula.

We believe we should balance the duration of the run-out against the delay in making payments to enrollees. The following chart presents data on the theoretical proportion of the ultimate claim payout that is held in a claim reserve during each of the first six months for two separate companies. Regulators developed this chart from department files, so it is a regulator analysis rather than a company analysis and is based upon audited or auditable data.

For each company we evaluated the eventual payments that were made as of a point in time for 2006, 2007, and 2008. We did not evaluate 2009 because it has not had time to fully mature the claim experience. We assumed that the ultimate claim payments were "known" by the company when they set up a reserve at various points in time following year-end. In fact, as stated before, they would only be estimates. But if the reserve is an appropriately small proportion of the total "clinical

services", then we can be comfortable that any errors will not have a significant impact on the calculation of a potential rebate.

We evaluated the size of this theoretical reserve each month for the first six months following year end. We display the amount of total claim payments that have been made through that date and the ratio of the theoretical reserve to the ultimate payout as of each point in time. We did this for each year, and then reproduced the three year calculation where only the remaining reserve for the last year will still be unknown.

We find there is a significant advantage in reducing company administration by asking that reserves entering the formula be calculated on a calendar quarter-end, which ties to regulatory reporting at many levels. So we were biased in evaluating the relative merits of the reserve held as of three months compared to six months. It is interesting that the rate of change in the reserve percentages seemed to moderate at three months. In light of the minimal size of the reserve as of three months and the desire to expedite potential rebate payments, we have resolved to require the three month reserve be used.

It is of interest that one company was generally increasing in size during the period being studied, while the other was decreasing in size. As would be expected by practicing actuaries the former had relatively slower development, (higher ratios for a longer time period), than the latter. These moderate differences were not determined to be worthy of differentiation within the formula.

In reaching our conclusion we determined the potential effect of any "errors" in the calculations would be minimal. This conclusion was reached recognizing that regulators find variances of 10% in such reserves to be acceptable, and such a variance would only represent about $1/20^{th}$ of a percent, or less, effect in the MLR when using the three year calculation. We are aware much greater variance will occur just based upon random variations in actual claim experience. We thus find this minimal potential variation in the claim reserve to be acceptable.

Chart displaying the relative size of claim reserves at various points in time.

Company 1	No Runout	1 Mo. Runout	2 Mo. Runout	3 Mo. Runout	4 Mo. Runout	5 Mo. Runout	6 Mo. Runout
2006							
% Reserve	9.64%	3.26%	1.58%	1.10%	0.65%	0.52%	0.52%
Claims Paid	17,538,331	18,623,165	18,929,718	19,021,109	19,105,281	19,130,188	19,130,188
Reserve	1,691,104	606,269	299,716	208,325	124,153	99,246	99,246
Enrollment	January	7,000	December	14,000			
						Paid as of Aug 2009	19,229,434
2007							
% Reserve	9.40%	2.43%	1.21%	1.06%	1.04%	0.65%	0.21%
Claims Paid	33,363,603	35,633,968	36,062,584	36,118,354	36,125,894	36,266,264	36,425,184
Reserve	3,136,680	866,314	437,698	381,929	374,389	234,018	75,098
Enrollment	January	14,000	December	20,000			
						Paid as of Aug 2009	36,500,282
2008							
% Reserve	9.53%	2.70%	1.42%	1.11%	0.77%	0.14%	0.04%
Claims Paid	48,175,195	51,377,500	52,027,295	52,184,762	52,362,208	52,691,431	52,744,495
Reserve	4,589,516	1,387,211	737,416	579,949	402,503	73,281	20,216
Enrollment	January	20,000	December	23,000			
						Paid as of Aug 2009	52,764,711
Three Year Analysis							
% Reserve	4.42%	1.30%	0.68%	0.54%	0.37%	0.07%	0.02%
Claims Paid	103,904,911	107,107,216	107,757,012	107,914,479	108,091,924	108,421,147	108,474,212
Reserve	4,589,516	1,387,211	737,416	579,949	402,503	73,281	20,216
Enrollment	January	21,000	December	20,000			
						Paid as of Feb 2010	108,494,428

Company 2	No Runout	1 Mo. Runout	2 Mo. Runout	3 Mo. Runout	4 Mo. Runout	5 Mo. Runout	6 Mo. Runout
2006							
% Reserve	10.78%	2.56%	1.23%	0.68%	0.40%	0.26%	0.13%
Claims Paid	60,451,179	65,293,729	66,154,222	66,512,347	66,698,156	66,790,590	66,877,248
Reserve	6,514,743	1,672,193	811,700	453,575	267,766	175,332	88,674
Enrollment	January	320,000	December	27,000			
						Paid as of Feb 2010	66,965,922
2007							
% Reserve	11.39%	3.05%	1.22%	0.70%	0.42%	0.19%	0.17%
Claims Paid	50,611,421	54,711,102	55,695,718	55,987,160	56,139,216	56,273,294	56,284,842
Reserve	5,766,348	1,666,668	682,052	390,610	238,553	104,476	92,928
Enrollment	January	25,000	December	22,000			
						Paid as of Feb 2010	56,377,769
2008							
% Reserve	11.21%	3.06%	1.37%	0.81%	0.33%	0.12%	-0.28%
Claims Paid	49,869,641	53,815,347	54,709,872	55,015,656	55,277,775	55,394,167	55,618,987
Reserve	5,592,269	1,646,563	752,038	446,254	184,135	67,743	(157,077)
Enrollment	January	21,000	December	20,000			
						Paid as of Feb 2010	55,461,910
Three Year Analysis							
% Reserve	3.23%	0.93%	0.42%	0.25%	0.10%	0.04%	-0.09%
Claims Paid	173,213,332	177,159,039	178,053,564	178,359,348	178,621,467	178,737,859	178,962,679
Reserve	5,592,269	1,646,563	752,038	446,254	184,135	67,743	(157,077)
Enrollment	January	21,000	December	20,000			
						Paid as of Feb 2010	178,805,602

Exception References:

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9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD012

Issue:

Can rebates be distributed in the form of premium credits?

Subgroup Resolution:

Resolved 8/5:

Rebates payable to policyholders who are still covered by the issuer owing the rebate may, at the option of the issuer, be paid as a premium credit or in cash. The premium credit shall be applied against the first premium due on or after the due date of the rebate. If the rebate amount exceeds a monthly or other periodic premium, it shall be applied against subsequent premiums until exhausted. In the unlikely event that the rebate payable exceeds the total premium payable to the carrier (for example, a reduction in case size or cancellation early in the rebate period), any excess rebate should be paid in cash. Rebates payable to policyholders who are no longer covered by the issuer must be paid in cash.

Exceptions:

None identified.

Description:

2718(b) references providing an annual rebate of premium in each plan year, but is silent on the allowable distribution method(s):

"(b) (1)(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage,…"

Documentation in support:

As noted above, 2718(b) does not explicitly require that the rebate be paid in cash. A credit against premiums may be a more efficient way of distributing the rebate (avoiding printing of checks and mailing), and so it should be an option for the issuer. On the other hand, the issuer may choose to issue checks to everyone, which avoids the inefficiency of two different payment systems. Policyholders should be economically indifferent between receiving the rebate as a credit or a check.

Documentation in opposition:

Rebates through credits may give the impression that continuing policyholders are being treated differently than non-continuing policyholders, and that one group or the other is being preferentially treated.

Evaluation:

There appears to be little real difference between the two methods of providing rebates, except that the premium credit method will not, in general, be available for all policyholders eligible for a rebate. However, in view of the potential efficiency of the premium credit method, it should be available as an option for issuers who must pay refunds.

Exceptions References:

9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC.

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD014

Issue:

Should credibility adjustments be based upon Medicare Supplement-like adjustments, not classical credibility (Z, 1-Z)?

Subgroup Resolution:

If a credibility adjustment is used, it will be of the additive (Medicare Supplement-like) form – resolved 6/21/10.

Exceptions:

None identified.

Description:

2718(b) references providing an annual rebate of premium in each plan year at the individual, small group and large group levels, but also requires the NAIC to establish standardized methodologies that take into account the special circumstances of smaller plans. If a credibility adjustment is used for this purpose, its form and application need to be determined.

Documentation in support:

Documentation in opposition:

Evaluation:

The use of a Z, 1-Z approach would involve determining a credibility factor, Z, and then determining an adjusted MLR by applying a weight of Z to the experience and a weight of 1-Z to a benchmark. This approach was ruled out due to the likely confusion it would create for the ultimate recipient of any rebates, the consumer, and difficulty in determining an appropriate benchmark.

Exceptions References:

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9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC.

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD015

Issue:

Should modifications or other considerations be given to plans that use varied provider contract terms (capitated versus fee for service, etc.)?

Subgroup Resolution:

Resolved 7/19:

We recommend that no effort be made at this time to recharacterize capitated payments to providers as part claim and part administrative expense. Capitated payments will enter the calculation as clinical services Current statutory reporting requires staff and group model HMOs to accurately report administrative expenses (see Health Blank instructions Statement of Revenue and Expenses and SSAP No. 70 and No. 85). However, we urge Health and Human services and insurance regulators to follow provider contracting trends and keep watch for potential abuses to the intent of the MLR rebate provisions.

Exceptions:

None identified.

Description:

Provider contracts vary significantly among various types of insurers. Managed care organizations involve business models where both insurance risk and some administrative functions are transferred to providers through the provider contracting process. To the extent that these costs involve functions where the expense of the same is prohibited from being included in the numerator of the MLR calculation, issues arise about how these contracts and their costs should be handled.
Expressed concerns related to this IRD include

* whether equity between carriers utilizing different business models is disrupted; and
* whether the minimum loss ratio requirement is effectively violated when administrative expenses are part of the capitated payment.

Documentation in support:

The NAIC working groups have spent a great deal of time identifying what types of expenses may be included in the numerator of the MLR calculation and what types of expenses should be excluded. The American Academy of Actuaries, as well as a number of other entities, has indicated that there are provider contracts in place today that may actually include provisions for functions whose expenses have been identified as not being allowed in the MLR calculation.

Fee-for-service payment methodologies might be characterized as an unbundled business approach. Insurers keep the risks associated with claim severity and utilization. In this model, the insurer would hold and maintain various reserves, including claim reserves and contract reserves. The insurer would incur claim adjudication expenses, as well as any expenses of cost control (such as pre-authorization) and network management.

Towards the other end of the spectrum of payment methodologies, capitation payments might be characterized as a bundled business approach. Insurers transfer to contracted providers risks associated with claim severity and utilization. The need for the insurer to maintain reserves is therefore minimized. Similarly, the insurer's claim adjudication and other expenses are (or can be) greatly reduced.

Continuing along the spectrum of payment methodologies, staff model HMOs are health insurance issuers that employ healthcare providers who are retained by the issuer to provide health care services to enrollees.

According to the Academy, "The fundamental issue with the claims-over-premiums MLR definition… is the difficulty at arriving at a definition of claims that applies consistently across different types of business models." The Academy argues that the MLR rebate requirements weren't meant to give preferential treatment to one business model over another. To this extent, the Academy maintains that the MLR calculation should produce similar results regardless of the business model.

The Academy states, "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-premium ratio than insurers 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 the MLR calculation."

Several years ago, insurance regulators became concerned over the difficulties in comparing medical loss ratios across various regulated companies. SSAP 85 was the regulator response to these concerns. This accounting a standard defines cost containment expenses (CCE). Loss adjustment expenses (LAE), also known as claims adjustment expenses (CAE), are defined in SSAP 85 to include all CCE and expenses associated with benefit adjudication.

Given these categories of expenses, the Academy argues two possible alternative approaches that could be taken to maintain a level playing field among various business models. The first alternative involves parsing the capitation agreements and or salaried costs into these claims and these expense categories. In this manner, carriers would be using more of a common standard for claims in the MLR calculation, regardless of the provider contract.

The second alternative involves including these categories of expenses as part of claims, e.g. making the definition of claims as broad as possible. With this approach, the arbitrary parsing of capitated contracts is avoided. Hence, the Academy prefers this alternative.

Documentation in opposition:

The BCBSA has expressed its concern that all health plans should report their administrative expenses on a uniform basis for meaningful plan comparisons. With their comment letter dated May 24, 2010, to Lou Felice, BCBSA attached correspondence from Douglas Sherlock, CFA, President, Sherlock Company delineating a long list of activities included in provider contracts typically associated with group and staff model HMOs.

Consumer group representatives have expressed similar concerns on some of the public calls. Failure to reflect administrative expenses that are bundled in capitation payments may allow carriers to use capitation to effectively avoid the minimum loss ratio standards (and associated rebates). A hypothetical example might involve an insurance company that, through capitation, transfers all administrative functions and claims risk to a provider group via capitation. The insurance company, through its calculations, easily demonstrates that it is operating at an MLR well in excess of the MLR standards. However, in this instance, the margin (1 minus the MLR) is entirely available for the insurance company's bottom line.

Evaluation:

We are concerned that absent due consideration of varied business models and provider contracts, issuers and providers may work in concert to undermine the intent of the MLR rebate provisions. However, we agree with the Academy that attempts to artificially parse a capitated arrangement into claims and administrative expense components would be arbitrary, and hence, challenging to regulate.

None the less, this concern was not so great as to cause us to recommend including administrative expense items, commonly included in capitated arrangements, among the calculation of incurred claims. We feel where clear delineations can be made between administrative expenses and claims, such distinctions should be maintained, for example, staff and group model HMOs should allocate salaries and overhead to administrative expenses as medical staff often perform these types of tasks.

Moreover, if properly implemented, these fixed dollar business arrangements can result in reduced utilization and reductions in the provision of unnecessary care. Committee members were hesitant to alter any definitional aspect of the funding associated with these contracts that would cause their use in the market place to be lessened. Consumers may find lower cost or a greater degree of care coordination through coverage backed by capitated agreements.

Therefore, we recommend that no effort be made at this time to recharacterize capitated payments to providers as part claim and part administrative expense. However, we support current statutory reporting that requires staff and group model HMOs to accurately report administrative expenses and be monitored for compliance. We urge Health and Human services and

insurance regulators to follow provider contracting trends and keep watch for potential abuses to the intent of the MLR rebate provisions.

With respect to the concern that health insurance issuers could outsource administrative functions to affiliates in order to circumvent the MLR requirements, we considered the fact that that not all capitated arrangements with affiliates are necessarily abusive, and also that existing Form D requirements give state insurance regulators the ability to review all inter-affiliate service agreements and address problematic aspects before those agreements go into effect.

States possess a number of regulatory tools to monitor and prevent potential abuses identified in this IRD. For example, the Form D approval process involves the regulators review and approval of inter-affiliate arrangements.

Exceptions References:

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9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD016

Issue:

Should adjustments to calculated rebates that are used to reflect less than full credibility be forfeited in subsequent years, not deferred?

Subgroup Resolution:

Adjustments to rebates that are used to reflect less than full credibility, as discussed in IRD023, should not be forfeited – resolved 7/26.

Exceptions:

If a block of business never grows to sufficient size to attain even partial credibility over the 3-year reporting period, then no rebates will ever result.

Description:

IRD023 provides that credibility adjustments must be made to MLRs calculated for partially credible but less than fully credible experience. This may result in no rebate being paid even when the unadjusted MLR is below the minimum standard. If a rebate is paid, it will be less than it would have been if based on the unadjusted MLR. The question addressed in this IRD is whether these reductions to rebates should be forfeited or just deferred until credible experience is accumulated.

Documentation in support:

Documentation in opposition:

Evaluation:

For rebates to be calculated in 2014 and after, rebates are to be based on the experience for the 3-year period prior to the reporting year. In other words, for the report due in year Y+1, the MLR and Rebate calculation is based on experience for years Y-2, Y-1 and Y. Therefore, for the report due in year Y+1, any necessary credibility adjustment is based upon the cumulative amount of exposures for the period Y-2 thru Y. For the report due in year Y+2, the MLR and rebate calculation is based upon experience for the years Y-1 thru Y+1, and any credibility adjustment is based upon the cumulative amount of exposures for Y-1 thru Y+1. The credibility adjustment from the Y+1 report can be thought of as a "loss" to consumers since it represents a reduction or elimination of rebates that would otherwise be due to consumers. However, this credibility adjustment is not necessarily permanently lost to consumers. The MLR and rebate calculation and the credibility adjustment from the Y+2 report is based on what is in effect revised experience (i.e. Year Y-2 is dropped and Year Y+1 is added). As experience develops, the block of business subject to the MLR and rebate calculation may become larger and therefore more credible or even fully credible, thereby reducing or eliminating the credibility adjustment and potentially increasing the rebate amount.

Prior to 2014, there are two single year MLR and Rebate calculations due in 2012 (based on 2011 experience) and 2013 (based on 2012 experience). The Credibility adjustment for each of these years is based upon the exposures in each year. As above, the adjustment for the 2012 calculation may not be lost to consumers since a new credibility adjustment will be calculated in 2013. Ultimately, a three year credibility adjustment for 2011-2013 will be calculated that will further modify the previous credibility adjustments.

Exceptions References:

9/15/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD018

Issue:

Should incurred claims and earned premiums used in the calculation of Medical Loss Ratio for rebate calculations be on a net of reinsurance basis?

Subgroup Resolution:

Resolved – 9/15:
No, incurred claims and earned premiums should be on a direct basis. Policies that were originally issued by one company, but were assumed by a second company via assumption reinsurance (thereby effecting a novation of the policies), are direct business for the second company.

Exceptions:

If a block of business was subject to indemnity reinsurance and administrative agreements, effective prior to the effective date of the PPACA (March 23, 2010), such that the second company is responsible for 100% of the issuer's financial risk and takes on all of the administration of the block, then the second company should report the reinsured premiums and claims as part of its MLR and rebate calculations.

Description:

Under Section 2718 (b) of the PPACA, incurred claims and earned premiums used in the calculation of Medical Loss Ratio for rebate calculations should be calculated including the effects of federal programs created by the PPACA that provide reinsurance. Private reinsurance is not listed as an adjustment.

Documentation in Support:

From Allan I. Schwartz, on behalf of the NAIC Consumer Representatives, July 8, 2010:

"My conclusion is that the rebate calculation should be on a direct basis before consideration of private reinsurance purchased from other insurance companies. This is based upon: (i) my understanding of the PPACA legislation as written, (ii) my understanding of the intent of the PPACA legislation and (iii) the potential for abuse if private reinsurance is allowed in the rebate calculation." [more details appear in the letter.]

Documentation in opposition:

From the American Academy of Actuaries letter of May 14, 2010 to HHS in response to the RFI on MLR, page 31:
"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." [more details appear in the letter.]

Evaluation:

Exceptions References:

9/20/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD020

Issue:

Should large claims be pooled in the rebate calculation?

Subgroup Resolution:

Resolved – 9/20:

Large claims should not be pooled.

Exceptions:

None.

Description:

2718(b) references providing an annual rebate of premium in each plan year, but is silent on the treatment of aggregations that are less than fully credible:

2718*(b)(1) (A): "(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and*

Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than--

> *"(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or*
>
> *"(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State."*

The substitution of a large claims pooling charge for claims in excess of the pooling limit could be used to mitigate credibility issues.

However, 2718(c) requires the National Association of Insurance Commissioners to develop standardized methodologies which take into account special circumstances of smaller plans, different types of plans, and newer plans:

''2718 (c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

Documentation in support:

Documentation in opposition:

Evaluation:

Section 2718(c) specifies that methodologies should be developed for smaller plans, different types of plans, and newer plans, and we believe actuarial and statistical considerations require special treatment in the absence of full credibility. Without such treatment the MLRs and the Rebates calculated on experience that is not fully credible would be too variable and subject to random fluctuations to be used for any purposes.

Large claim pooling is one method of increasing credibility. Large claims have a low frequency but can have a significant impact on the MLR due to their size. With large claim pooling, a pooling charge is determined such that the total of pooling charges in all states is equal to the total large claims in all states.

While large claim pooling might be an effective way to increase credibility, we reject this concept due to the added complexity it would entail and because certain issues and potential inequities would be difficult to address. In particular, because of significant disparities among states in health care costs, it may not be valid to assume that all variations by state in the level of large claims are due to statistical fluctuations. While it might be possible to reflect state differences by using a higher pooling point in higher-cost states, it would be difficult to determine the appropriate adjustments. Also this would introduce yet another complexity to the MLR calculation.

Exceptions References:

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9/7/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD021

Issue:

Should the small group market be combined with the individual market for calculating the rebate?

Subgroup Resolution:

Resolved – 9/7:

No. Rebates are to be calculated separately for large group, small group, and individual.

Exceptions:

Some states may merge their individual and small group markets pursuant to 1312(c) below. If these markets are merged, rebates should be calculated for the merged market.

Description:

1312(c) references the merger of the individual and small group markets if a state determines this to be appropriate :

"*(c) Single Risk Pool-*

(1) INDIVIDUAL MARKET- A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) SMALL GROUP MARKET- A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) MERGER OF MARKETS- A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate."

Documentation in support:

Documentation in opposition:

Evaluation:

Exceptions References:

9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD022

Issue:

Should large group experience refunds be subtracted from premium or added to incurred claims in the rebate calculation?

Subgroup Resolution:

Large group experience refunds should be added to incurred claims in the rebate calculation – resolved 6/14/10.

Exceptions:

None identified.

Description:

2718(b) references calculating annual rebates with respect to each plan year using an average of premiums and claims over the past three years:

"(b)(1) (ii) CALCULATION BASED ON AVERAGE RATIO- Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan."

If an experience refund paid to a group in the current or a prior year is not reflected in the calculation, the average MLR used for the current plan year calculation will be understated.

Documentation in support:

Documentation in opposition:

Evaluation:

Some large experience rating groups have a retrospective experience rating arrangement with the issuer where premiums in excess of incurred claims and expenses are refunded to the groups. The experience refunds are mostly due to actual incurred claims being lower than the expected claims. Since the experience refunds are claims related, it is appropriate that the experience refunds be added to the incurred claims in the MLR rebate calculation. Adding back the experience refunds will avoid the double counting of the same payment. Also, treating the experience refunds as claims is consistent with the treatment of rebate as claims in the MLR rebate calculation.

Exceptions References:

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9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD023

Issue:

Should credibility adjustments be made to MLRs calculated for less than fully-credible experience?

Subgroup Resolution:

Credibility adjustments must be made to MLRs calculated for less than fully credible experience – resolved 6/28.

Exceptions:

When the experience is deemed to have no credibility, actions other than credibility adjustments need to be considered. Credibility adjustments are not appropriate in such cases.

Description:

2718(b) references providing an annual rebate of premium in each plan year, but is silent on the treatment of aggregations that are less than fully credible:

"2718 (b)(1) (A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

> *`(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or*
>
> *`(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State."*

However, 2718(c) requires the National Association of Insurance Commissioners to develop standardized methodologies which take into account special circumstances of smaller plans, different types of plans, and newer plans:

''2718 (c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

Documentation in support:

A May 12, 2010 letter from the American Academy of Actuaries addresses this subject:

"The new §2718(b)(1)(A) to the *Public Health Service Act*, as created by the *Patient Protection and Affordable Care Act* (PPACA), requires a health insurance issuer to provide an annual rebate under certain circumstances. While an insurer may report an MLR for a block of business that is below the applicable minimum MLR requirement, it is possible that the variance between the reported MLR and the required MLR represents statistical fluctuation. It may not be good public policy to require the payment of rebates based on essentially random results beyond the insurer's control, which underscores the need for some method to maintain statistical validity in the rebate calculation process. This need becomes greater to the extent that rebate calculations are made at a more granular level. That is, statistical fluctuation is a more significant issue with state-level calculations than with national-level calculations—or with policy form-level calculations than with market-level calculations."

Documentation in opposition:

None.

Evaluation:

Section 2718(c) specifies that methodologies should be developed for smaller plans, different types of plans, and newer plans, and we believe actuarial and statistical considerations require that credibility adjustments be made in the absence of full credibility. Without such adjustments the MLRs and the Rebates calculated on experience that is not fully credible would be too variable and subject to random fluctuations to be used for any purposes. For a company and state, experience for a given type of insurance is considered fully credible when the random, statistical variations in the annual Medical Loss Ratios are within a specified narrow range from year to year. This is achieved when a sufficient number of insureds are covered by a given type of insurance. Lesser numbers of insureds mean the experience is less credible, that is that the annual MLRs are subject to a wider range of random fluctuations from year to year. Therefore, as MLRs become more variable they become less reliable as a basis for rebate calculations. In order to use the calculated MLRs for Rebate calculation purposes it is necessary to (a) apply statistically based adjustments to reflect the variability of the MLRs so that Rebates can be reliably calculated, (b) pool (i.e., combine) experience with a larger block of policies, such as across states or across affiliated entities, (c) combine experience for a longer time period, or (d) some combination of the above. This document deals specifically with whether credibility adjustments are to be used. The issue of the exact method of adjustment is discussed in IRD014 and IRD042. Pooling of only large claims across states or entities is discussed in IRD020. Combining all experience of multiple states is discussed in IRD062. Combining all experience of multiple entities is discussed in IRD067. Combining all experience of multiple years is discussed in IRD061.

At some point the number of insureds is too small to produce MLRs that can be relied upon to any extent. The variability of MLRs from year to year is simply too great. In such a case the experience is not credible, and credibility adjustments are no longer effective. (See IRD044.)

Exceptions References:

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8/18/10

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD026

Issue:

Should the details and results of rebate calculations be reported to the applicable state or to HHS?

Subgroup Resolution:

Resolved 8/18:

The details and results of rebate calculations should be reported to the applicable state.

Exceptions:

Section 1321 allows the Secretary to take any necessary actions to implement requirements of the Act if a state does not implement such requirements. The details and results of the rebate calculation would be reported to HHS if a state fails to implement the necessary requirements for the filing and review of the rebate calculation.

Description:

2718(b) references providing annual rebates with respect to each plan year, but is silent regarding who the rebates should be reported to and evaluated by:

"(b)(1) (A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, …"

Documentation in support:

Documentation in opposition:

Evaluation:

Section 2718 is applicable to a "health insurance issuer' which is defined a "an insurance company , insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance". The payment or nonpayment of rebates to policyholders is an integral part of the financial operations of the "health insurance issuer" and the details and results of the rebate calculations should be reported to the state to enable the proper review of a company's financial condition and fulfill a State's responsibility to assure financial solvency of the licensed "health insurance issuers".

There is additional support for details and results of rebate calculations being reported to the applicable State in Section 2718 (b) (1) (A) (i) & (ii) where a State may determine a higher percentage than 80% or 85%. A State needs the details and results of rebate calculations in order to determine any need to increase the percentages in their State.

Additionally States must establish an Exchange that facilitates the purchase of "qualified health plans" offered by a "health insurance issuer" that is licensed and in good standing to offer health insurance coverage in the applicable State. Again, the State must have the details of any rebate calculation to fulfill its responsibility to monitor the solvency of a "health insurance issuer" wishing to participate in the Exchange.

"Health insurance issuers" are licensed and regulated by the applicable State and these States must have the detailed rebate information to fulfill their regulatory duty.

Exceptions References:

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8/30/10

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD027

Issue:

Should a legal entity that provides both HMO and non-HMO products aggregate at a level lower than legal entity, calculating loss ratios for HMO and non-HMO products separately?

Subgroup Resolution:

Resolved – 8/30:

No, a legal entity with both HMO and non-HMO products should not calculate separate loss ratios for HMO and non-HMO as if the entity were two legal entities.

Exceptions:

Description:

2718(b) references rebates calculated at the individual, small group and large group level. It is silent regarding any other subset for the purposes of aggregation:

> *"(b) (1)(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than--*
>
> > *`(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or*
> >
> > *`(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State."*

Documentation in support:

Documentation in opposition:

Evaluation:

This issue arose because of a concern that carriers using capitated reimbursement could classify administrative expenses as medical costs to the extent that these services (for example claims administration) were delegated to the provider or organization receiving capitation. (IRD ???). It was concluded not to attempt to adjust for this difference, even though, all things being equal, it resulted in higher loss ratios when such capitation was used.

Then, the possibility was considered that separate loss ratios within a carrier by both types of products might ameliorate possible inequality between carriers (since a carrier that offers both HMO and non-HMO products can offset higher HMO loss ratios against lower non-HMO loss ratios). But, the decision to require calculation by statutory entity assumes that there will be such possible inequality.

The distinction HMO vs. non-HMO is imprecise (the classification of an HMO/POS product is unclear). Futhermore, the distinction that gave rise to this concern was between products that use capitation (especially global capitation for categories of services) and products that do not. This is a different distinction that HMO vs. non-HMO. An HMO product can use little or no capitation, and a non-HMO product can choose to capitate many classes of service (including imaging and behavioral health) both in and out of network.

Exceptions References:

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9/20/10

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD028

Issue:

Should the experience for a multi-state employer be included in the policy issue state or apportioned among the states with enrollees?

Subgroup Resolution:

Resolved – 9/20:

The experience of a multi-state employer (under a single group policy) should be included in the calculation for the policy issue state only. If the multi-state employer provides coverage through multiple policies with different states of issue, the experience should be allocated to the separate states of issue.

Exceptions:

An exception to this treatment is extended to contracts with different affiliated issuers in different states at a multi-state blended rate with a single employer. In the exception, the affiliated issuers should be allowed to make an adjustment to the numerator to reflect the overall group experience. The adjustment for each group, prospectively designated as such a group by the affiliated insurers, shall result in each legal entity having the same loss ratio for the group. The adjustment should be according to an objective formula defined before the experience period and applied uniformly to the experience in each rebate calculation. Any issuer choosing to make such an adjustment must use this methodology in their rebate calculations for a minimum of three plan years.

Description:

2718(b) references rebates calculated at the individual, small group and large group level. It is silent regarding allocations to multiple states for the purposes of aggregation:

> *"(b) (1)(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—*
>
> > *`(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or*
> >
> > *`(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State."*

Documentation in support:

The general rule is that rebate calculations are made by state, market, and statutory entity. The resolution reaffirms that in the case of a large group contract covering multistate employees. In a particular case, this may not always express the an economic relationship between an carrier and a purchaser (particularly a large group purchaser). The economic agreement may involve a single contract in a single state covering employees in multiple states, or it may involve multiple contracts in multiple states. But, for loss ratio calculation purposes, experience will be grouped by statutory issuer in the state of issue.

Documentation in opposition:

As noted above, there are situations where multiple contracts in multiple states are intended to imitate a single contract in a single state. There is the possibility of a situation where the loss ratio in a particular state is impacted because of a mismatch between the pricing and the expected claims.

Evaluation:

The possibility raised in the Documentation in Opposition was considered. It was determined that a pre-defined adjustment could be allowed for designated contracts to equalize the loss ratio for such groups. An example of one way to provide the detail necessary to meet this exception requirement is attached. The adjustment is made to the numerator as this is consistent with the adjustment for experience refunds (IRD022). Where contractual agreements between legal entities exist so that the Statutory statements reflect the equivalent of this adjustment, the exception shall not be available.

Exceptions References:

See IRD 077

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9/20/10

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD029

Issue:

Should new business with less than twelve months of experience receive special treatment in the MLR calculation?

Subgroup Resolution:

Resolved – 9/20:

New business with less than twelve months of experience should not receive special treatment in the MLR calculation.

Exceptions:

In a given line of business (i.e. individual, small group, large group), If 50% or more of a company's total premium in a given state comes from new business that is less than 12 months old, then the experience of new business less than 12 months old can be deferred from the current annual MLR calculation and included in the next year's MLR calculation. Experience to be deferred includes allocated quality improvement expenses, taxes and fees.

Description:

There are two underlying aspects to this issue.

The first concerns the statistical credibility of such business. The experience on new business that is less than 12 months old (i.e. first year experience) is likely to be less than fully credible since in a given block of business usually a relatively small portion is in its first year. Even in a fully credible block of business it is therefore likely that the first year portion is not credible, unless the block of business is very large.

The second aspect concerns the nature of new business. Although policies can take effect at any time during a calendar year, deductibles and maximum out-of-pocket limits are (with some modifications) accumulated starting at the beginning of a calendar year. For a cohort of policies that take effect on January 1 of any year, the loss ratios for early months of the year will be suppressed by the effect of deductibles and out-of-pocket maximums. Loss ratios for later months of a calendar year, when deductibles and OOPs are more likely to have been met are, likely to be significantly higher than for the earlier months. A cohort of policies that become effective at times other than January 1 of a calendar year have only the remainder of that year to fulfill deductibles and maximum OOPs. Assume that a cohort of policies takes effect on July 1. It is very likely that the loss ratio for that block for the July-December of the year will be significantly less than the annual target loss ratio for which it was priced (i.e. the PPACA requirements of either 80% or 85%). The experience of this mid-year cohort would work to reduce the overall loss ratio for the total block of business and therefore affect the likelihood and size of potential a rebate.

(An additional aspect of this issue is present during the transition period prior to 2014. In those years medical underwriting will still be in use, and first year loss ratios will be lower due to this. However, this issue is best addressed under IRD041 – Transition Issues.)

The issue is therefore whether experience for new business less than 12 months old should be excluded from the MLR calculation due to these two concerns. 2718(b) references rebates calculated at the individual, small group and large group level. No provisions are made for less than fully-credible experience or for excluding new business of certain durations:

> *"(b) (1)(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total*

amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than--

`(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

`(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State."

Documentation in support:

None

Documentation in opposition:

None

Evaluation:

Excluding the experience of first duration policies only reduces the credibility of the entire block of business, and otherwise serves no useful purpose. To be specific, in the case of a block of business which has no credibility, excluding the first-year experience of such a block serves no purpose since the experience of the remaining block is still not credible. In the case of a block of business with partial credibility, excluding first year experience reduces the credibility of the experience of the remainder of the block, resulting in a non-credible block, or a block with experience that is still partially credible experience but less credible than before. In the case of a fully credible block of business excluding first year experience may result in a remaining block of business that is only partially credible (or the remaining block of business may still be considered fully credible). Credibility is properly addressed at the level of the entire block of business. The issues of credibility, partial credibility, and the related adjustments to experience in the MLR calculation are addressed in IRD020, IRD023, IRD042, IRD044 and IRD061.

For the rebate calculations for the years 2011 and 2012, when the rebate calculation uses the single-year MLR, the following analysis applies.

As noted above, it is very likely that new business in the early months after their policies have taken effect will likely have loss ratios lower than the target loss ratio used in pricing, which under PPACA is either 80% or 85% depending on the line of business. For new business less than 12 months old it is then very likely that the calendar year loss ratio will not meet the PPACA required loss ratios. Depending on the proportion of new business to the total line of business, this will have a downward effect on the overall actual loss ratio, and therefore potentially affect the size of any rebates due, or whether a rebate is even required. However, this does not justify differential treatment for new business less than 12 months old.

As an example, consider the cohort of policies that take effect on July 1 of 2011. At 12/31/2011, due to the effects of deductibles and out-of-pocket maximums, the loss ratio for the period 7/1-12/31 is 70%. (Assume that the experience is fully credible.) In the case where this cohort is the entire of block of business, a rebate equal to 10% of the premium for the 6 month period would be due as the annual rebate 2011. Assuming premium of 50 in 2011, the rebate would be 5. Excluding this business from the rebate calculation has the effect of giving the company a "bonus" of 5, in addition to the 10 or 7.5 (ie.20% or 15%) it retains under the PPACA MLR requirements. Deferring 2011 experience to the 2012 rebate calculation will at best delay any rebate due for 2011, and at worst result in no rebate at all if loss ratio for 2012 increases enough. If the 2012 experience for the 7/1/2011 cohort of policies is 80% (incurred claims of 80 and earned premium of 100), deferring the 2011 experience and combining it with 2012 experience will result in a rebate of 5. In other words, the policyholders receive the rebate a year later that they would have otherwise. If 2012 experience deteriorates to 85% (incurred claims of 85 and earned premium of 100) then no rebate will be paid for 2011 experience.

The above example is of course extremely simplified. In most cases, the MLR calculation will include business issued over multiple years, and therefore the effects shown above will be reduced in relation to the amount of total business is accounted for by business less than 12 months. However, the effects will still be present. The 7/1/11 cohort of policies will still see rebates delayed. Combining new experience with all other 2012 experience will still have the potential to reduce or even eliminate rebates for 2011 new business experience.

For rebate calculations for the years 2013 and beyond, where the MLR based on 3-year averaging is used in the rebate calculation, the following analysis applies.

Since the MLR in these years is based on the average experience of the prior 3 years, the idea of excluding the experience of new business less than 12 months old is no longer relevant. First year experience is averaged in with other years of experience to calculate the MLR.

The conclusion is that there is nothing in the PPACA provisions for rebate calculations which requires or even addresses the issue of differential treatment for first year experience less than 12 months old. The above analysis shows that such treatment for the 2011 and 2012 calculations delays or reduces rebates for such business, and is irrelevant after 2013.

Exceptions References:

None

Attachments:

None

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8/25/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD031

Issue:

How should payments or receipts for risk adjustment, risk corridors and reinsurance be reflected in the MLR calculation?

Subgroup Resolution:

Resolved 6/28: Preliminary resolution - 8/25:

When calculating the MLR:

- Reinsurance contributions paid pursuant to section 1341 of the Public Health Service Act should be deducted from the denominator and reinsurance payments received pursuant to that section should be added to the denominator.

- Risk corridor payments made pursuant to section 1342 of the Public Health Service Act should be deducted from the denominator and payments received pursuant to that section should be added to the denominator.

- Risk adjustment charges paid pursuant to section 1343 of the Public Health Service Act should be deducted from the denominator and payments received pursuant to that section should be added to the denominator. This issue should be revisited, and if necessary, regulations amended, once the criteria and methods to be used to determine charges and payments have been established.

Exceptions:

None

Description:

2718(a) & (b) references accounting for payments or receipts for risk adjustment, risk corridors and reinsurance in the calculation of premium used in the MLR calculation:

> `(a) Clear Accounting for Costs- A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, ***after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance***, that such coverage expends--
>
> > `(1) on reimbursement for clinical services provided to enrollees under such coverage;
> >
> > `(2) for activities that improve health care quality; and
> >
> > `(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.
>
> The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.
>
> `(b) Ensuring That Consumers Receive Value for Their Premium Payments-
>
> > `(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS-

`(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and ***after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act)*** for the plan year (except as provided in subparagraph (B)(ii)), is less than--

`(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

`(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

`(B) REBATE AMOUNT-

`(i) CALCULATION OF AMOUNT- The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of--

`(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

`(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and ***after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act***) for such plan year.

`(ii) CALCULATION BASED ON AVERAGE RATIO- Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

Section 1341 requires states to create a transitional reinsurance program for high-risk enrollees in the individual market for the years 2014-2016. Issuers will pay contributions and will receive payments.

Section 1342 requires the Secretary of Health and Human Services to create a risk corridor program in the small group and individual markets for the years 2014-2016. Qualified health plans may make or receive payments based on their experience.

Section 1343 provides for a risk adjustment mechanism in the small group and individual markets beginning in 2014. Health plans and health insurance issuers may pay charges or receive payments based on the actuarial risk of the enrollees.

Documentation in support:

Documentation in opposition:

Evaluation:

The apparent purpose of the transitional reinsurance program described in 1341 is to ameliorate the effects of the uncertainty associated with the extensive changes that will take effect in the individual market in 2014, including guaranteed issue, modified community rating, mandated coverage, premium and cost-sharing subsidies, and exchanges. The contributions paid are analogous to a premium and therefore should be reflected in the denominator. Payments received are intended to offset

high claims associated with high-risk enrollees and therefore should be reflected in the numerator. However, since the language incorporated into the law is included within the parenthesis modifying premium, it becomes necessary to deviate from "proper accounting" treatment of such payments as would be dictated by Statements of Statutory Accounting Principles.

For the risk corridor program described in 1342, both payments made and payments received are based on claims experience and therefore should be reflected in the numerator. This program implicitly transfers claims experience between plans. Payments made to plans are intended to balance payments made from plans since the formula uses similar factors above and below the "target amount' of claims, and payments are made to and from the Secretary, who would not have another source of revenue to make corrections if payments exceed receipts. Further supporting such an evaluation are the definitions found in 1342 (c) (1) which adjust the numerator (allowable costs) for payments received under 1341 and 1343:

> *(1) ALLOWABLE COSTS-*
>
> > *(A) IN GENERAL- The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.*
> >
> > *(B) REDUCTION FOR RISK ADJUSTMENT AND REINSURANCE PAYMENTS- Allowable costs shall reduced by any risk adjustment and reinsurance payments received under section 1341 and 1343.*

But once again, since the language incorporated into the law is included within the parenthesis modifying premium, it becomes necessary to deviate from "proper accounting" treatment of such payments as would be dictated by Statements of Statutory Accounting Principles and implied by the treatment suggested in 1342 (c) (1).

For the risk adjustment mechanism described in 1343, both charges paid and payments received will be based on the actuarial risk of the enrollees in the plan. The criteria and methods to be used are not yet known but presumably will involve an implicit transfer of expected claims experience from some issuers to others. This implies that the charges and payments should be reflected in the numerator. However, once the criteria and methods are established, this issue should be revisited. It is possible that reflecting charges and payments in the denominator, or reflecting charges in the denominator and payments in the numerator, would be more consistent with the methodology ultimately established. Since once again the language incorporated into the law is included within the parenthesis modifying premium, it becomes necessary to deviate from "proper accounting" treatment of such payments as would be dictated by Statements of Statutory Accounting Principles, we must incorporate all such payments need to be incorporated into the denominator. Using criteria and methods similar to Part C and D of title XVIII of the Social Security Act such treatment may be reflective of proper accounting treatment, despite the treatment indicated in 1342 (c) (1).

So our evaluation rests upon a reading of the law that seems to require all payments under these three sections should be reflected as adjustments to premium in the MLR rebate calculation.

Exceptions References:

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9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD035

Issue:

Should plans that cover people living, working, traveling or studying outside of their home country ("expatriate and international policies") be given special treatment in the MLR (e.g., exclude from the MLR or allow a lower MLR for this type of business)?

Subgroup Resolution:

Resolved 7/19:

Expatriate and international plans do not appear to be subject to the MLR provisions if: 1) the coverage meets the definition of an excepted benefit or 2) the coverage is individual health insurance coverage that is short-term limited duration coverage. However, many expatriate and international plans would not meet either of these two exceptions. If they do not meet these exceptions, then it appears that they would be subject to the MLR requirements of PPACA.

Section 2718 (c) of the PHSA states in pertinent part, “the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) [i.e., the report concerning the MLR] and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in (a)(2) [i.e., activities that improve health care quality]. Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans”

Based upon the information provided, it appears that expatriate and international plans are unique could reasonably considered "different types of plans" and as such, the methodologies referenced in 2718(c) should take into account the "special circumstances" of these plans.

While there may be valid arguments for excluding expatriate and international plans from the MLR or allowing a lower MLR for this type of business, it does not appear that the NAIC has the authority to do this in designing the methodologies to take into account the special circumstances of these plans.

It is possible that HHS has the discretion to exclude expatriate and international plans from the MLR provisions altogether and the industry has presented reasonable arguments for taking this approach to address the special circumstances of these plans. However, in the event that HHS does not exercise this discretion, we recommend the following modifications to the methodology to take into account the special circumstances of these plans:

1) exclude experience for expatriate and international plans from the pool in which it would otherwise be included and perform a separate “national” MLR calculation by pool for this type of business.

2) include in the numerator of the MLR the additional expenses specifically associated with providing the services associated with international and expatriate plans that might not otherwise be considered activities that improve health care quality (e.g., the expenses associated with: a) developing and maintaining quality networks of providers throughout the world; b) mitigating fraud exposure; c) processing claims in multiple currencies and in multiple languages; d) manual handling of claims; e) reimbursement via wire transfer in multiple non-U.S. currencies f) operating multi-lingual 24/7/365 call centers in multiple time zones; g) coverage of medical evacuation and translation services that are not found in domestic health plans; h) translation tools, information websites, mobile tools, and databases especially designed to allow self service, understand, locate and access care as well as help in syncing differing medical practices around the world). For any additional expenses included in the numerator of the MLR, the issuer must be able to clearly document that in the absence of the associated services health care quality may be compromised.

3) aggregate experience for the expatriate and international plans included in each "national" pool across all states (and all countries) to enhance credibility;

In addition, we recommend that issuers be required to disclose to consumers the fact that the additional expenses are included in the MLR calculation.

Other then these modifications, the issuers offering international and expatriate plans should follow the uniform definitions and standardized method for reporting the MLR and calculating the rebate established by the NAIC and certified by the Secretary.

If HHS does exercise discretion to exclude expatriate and international plans from the MLR provisions altogether then, we recommend that consumers be advised of this fact and be given notice of the MLR that international and expatriate plans in fact achieve.

Exceptions:

None

Description:

What are Expatriate or International policies? Expatriate and international policies provide health insurance coverage in a variety of unique circumstances. Some policies are group health insurance policies sold to employers for a unique subset of their employees and their families including primarily expatriates (employees working outside their country of citizenship), third country nationals (employees working outside of their country of citizenship and outside the employer's country of domicile) and key local nationals (citizens working in their home country). For example, such a policy could be sold to a United States multinational employer providing benefits to five American employees working in London, Beijing or Mumbai (expatriates), an Italian and a Japanese employee working in London (third country nationals) and a British employee working in London (a key local national). In addition to covering individuals who are employed as expatriates by corporations, governmental organizations, non-governmental organizations and other organizations, expatriate and international policies also provide coverage to individuals who may own their own businesses or who may have elected to retire outside of their home countries. Finally, expatriate and international policies provide coverage to students who elect to complete some or all of their education outside of their home countries, including a large number of students from other countries who study and train inside the U.S.

By definition, expatriate and international policies cover individuals who travel frequently and who may return to their home countries for both business and personal purposes. Expatriate and international policies offer global coverage and, therefore, generally provide health coverage to individuals while in their home country as well. For example, a policy covering a missionary from the U.S. working in Africa would need to provide coverage for that missionary when he returns to the U.S. for two weeks over the holidays.

The definition below was supplied by HTH:

International Health Insurance Plan: *Other than as excepted by other laws or regulations, international health insurance plans are sold on a group and individual basis and are specifically designed to provide global coverage for people primarily when they are outside of their home country for study, business or leisure, whether into or out of the United States. Plans cover expatriates (U.S. citizens, individuals and their families, working and living outside the U.S.), third country nationals (individuals and their families working and living outside of their country of citizenship and outside the U.S.), key local nationals (employees and their families living in their home country but outside the U.S.) and foreign students (students studying and living outside of their country of citizenship) (e.g. coverage under international student accident and sickness plans).*

Why are Expatriate or International policies different? These policies typically cover a mix of U.S. and non-U.S. citizens (although could be entirely one or the other), individuals who may be entirely based outside the United States, or a mix of individuals in the United States and in foreign countries. The benefits provided under these plans tend to: 1) be designed with additional high-cost features required to meet the unique needs of individuals living, working, studying and traveling abroad; 2) be tailored to each destination country; and 3) include support services, such as coverage of medical evacuation and translation services that are not found in domestic health plans. For this reason, employers often carve out their employees working abroad from their domestic plans or purchase supplemental coverage. The plans for inbound

students provide visiting students with coverage for health services in the U.S. and coverage for the cost of evacuation and repatriation in the event they need to return to their home country for health care or in the event of their death.

The provision of benefits to individuals in multiple countries entails significant additional administrative complexities. For example, developing and maintaining quality networks of providers throughout the world and mitigating fraud exposure requires significant incremental expense. Likewise, processing claims in multiple currencies and in multiple languages adds cost and complexity to the business model. Most international claims require manual handling and many require reimbursement via wire transfer in multiple non-U.S. currencies at a significant cost to the insurer. Operating multi-lingual 24/7/365 call centers in multiple time zones also adds additional cost and complexity to the business model. These unique and additional complexities have caused at least some U.S. insurers to establish entirely separate divisions or subsidiaries to sell and service these international and/or global programs.

Expatriate and international policies also typically experience much more volatility over time, making an annual Medical Loss Ratio ("MLR") assessment subject to large fluctuations. Volatility is driven by (i) the significant growth (and shrinkage) in expatriate and international policies as insured companies expand into new regions (and contract in others); (ii) the low frequency/high severity claim patterns due to the fact that expatriates often work in high-risk industries or locations, or locations with poor healthcare facilities and (iii) fluctuations in the international currency markets. These are policies that often are covering individuals on oil rigs in the North Sea, defense industry contractors in war zones or American mining engineers working in violent developing nations with limited healthcare and significant health risks. Thus, the typical claims are also much more complex than in stateside benefit programs and they may result from uncommon illnesses or exotic diseases, or require medical air evacuation from remote jungles or from geographies experiencing terrorism or other violence. Unlike insurers that operate in the U.S. where doctors and hospitals are highly regulated, international insurers play a significant role in assisting their members in finding qualified English-speaking doctors and high quality hospitals, especially in parts of the developing world where hospitals and doctors are largely unregulated. Additionally, international insurers play an increased role in coordinating care for their members, especially with conditions like mental illness which is difficult to treat outside of an individual's culture.

Finally, the cost structure of expatriate and international policies is materially different from domestic plans in cost. These plans typically offer lower per member per month premiums compared to U.S. domestic health plans, reflecting the lower cost of care outside of the U.S. and the unique pricing needs of the international market.

Although there can be a high degree of volatility in claims cost, on average, claim cost for the international market tend to be substantially lower than claim cost for members residing exclusively in the U.S. Factors contributing to lower medical cost outside the U.S. are price differentials for medical services compared to the U.S. market, the level of intensity at which medicine is practiced outside the U.S., and the lower frequency of use by individuals away from home compared to the U.S. domestic market. For plans covering students, the lower average age may also contribute to lower claim costs. The lower claim costs in many instances result in lower total premium. However, delivery of insurance services to these international populations is an important part of the international care delivery system and can be significantly more costly than providing services in the U.S., making it extremely difficult to maintain insurance services to these populations at the MLR standards mandated by PPACA.

Why might the MLR provisions of PPACA apply to Expatriate and/or International policies issued by U.S. companies?

Section 2718 of the PHSA (i.e. the "MLR provisions") is found in Subpart II (Improving Coverage) of Subpart 1 (Portability, Access, and Renewability Requirements) of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Services Act (PHSA). Both section 2718(a) and 2718(b) apply to *"a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan)"*

Section 1551 of PPACA provides:

SEC. 1551. DEFINITIONS.

Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) shall apply with respect to this title. Section 2791 contains the following definitions:

(a) (1) Definition

The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(1)]) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(b) (1) Health insurance coverage

The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) Health insurance issuer

The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974) [29 U.S.C.A. § 1144(b)(2)]. Such term does not include a group health plan.

(4) Group health insurance coverage

The term "group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(5) Individual health insurance coverage

The term "individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

Section 3(1) of ERISA, referred to in sec. 2791(a)(1), defines "employee welfare benefit plan" as

***(1)** The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).*

29 USC 1003 excludes a number of types of group plans from ERISA coverage, including governmental plans, church plans, workers compensation plans, and plans "maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens." Nothing in PPACA, the PHSA, or ERISA suggests that these plans are not covered by Title XXVII of the PHSA or by PPACA. It appears that they are, therefore, covered by sec. 2718.

The pre-PPACA 42 USC 300gg-21 provided that the requirements of subparts 1 through 3 of Part A of the PHSA did not apply to 1) group plans of less than two enrollees, 2), nonfederal governmental plans that elected to be excluded and 3) excepted benefit plans (as defined in 42 USC 300gg-91) under the following circumstances.

(c) Exception for certain benefits

The requirements of subparts 1 through 3 shall not apply to any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 300gg-91(c)(1) of this title.

(d) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

The requirements of subparts 1 through 3 shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 300gg-91(c)(2) of this title if the benefits—

***(A)** are provided under a separate policy, certificate, or contract of insurance; or*

***(B)** are otherwise not an integral part of the plan.*

(2) Noncoordinated, excepted benefits

The requirements of subparts 1 through 3 shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 300gg-91(c)(3) of this title if all of the following conditions are met:

***(A)** The benefits are provided under a separate policy, certificate, or contract of insurance.*

***(B)** There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.*

***(C)** Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.*

(3) Supplemental excepted benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 300gg-91(c)(4) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

"Excepted benefits" are listed in 300gg-91 and include similar benefits excepted by regulation. The regulations implementing this definition are found at Treas. Reg. 54.9801-2, 29 C.F.R. 2590.732, and 45 CFR 146.145. The regulations do not create significant additional exceptions.

Pre-PPACA section 300gg-63 of the PHSA (dealing with rules governing the nongroup market) provides:

§ 300gg-63. General exceptions
(a) Exception for certain benefits

The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in section 300gg-91(c)(1) of this title.

(b) Exception for certain benefits if certain conditions met

The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 300gg-91(c) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

PPACA renumbers section 2721 (300gg-21) first as 2735 and then as 2722 and amends it twice, both times in section 1563. The amendments are inconsistent. (There are also two sections 1563, but this is the one dealing with technical amendments.) Here is how the House Office of the Legislative Counsel describes the amendments:

[Note: Section 1563[2](a) of PPACA amended subsections (b)(1), (b)(2), (c), (d)(1), and (d)(2) of this section by striking subparts ''1 through 3'' and inserting ''subparts '1 and 2''. Section 1565[3*](c)(12)(B) of PPACA subsequently struck ''subparts 1 through 3'' and inserted ''subpart 1'' each place it appeared in this section; this later amendment could not be executed because of the previous amendment, but the probable intent was to reflect subpart 1 as this provision is in subpart 2 and the reference to subpart 2 would be circular.]*

The amendment to current section 2721 eliminates the exception for groups of one, provides that nonfederal governmental plans cannot elect to be exempt from Subparts I and II of the PHSA (including 2718). It provides the following with respect to excepted benefits (both alternative amendments are provided in bold print):

(b) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of ***subparts 1 and 2 alternative: subpart 1.*** *shall not apply to any individual coverage or any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(1).*

(c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

(1) LIMITED, EXCEPTED BENEFITS.—The requirements of ***subparts 1 and 2 alternative: subpart 1.*** *shall not apply to any individual coverage or any grouphealth plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(2) if the benefits—*

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of ***subparts 1 and 2 alternative: subpart 1.*** *shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(3) if all of the following conditions are met:*

(A) The benefits are provided under a separate policy ,certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.

[Insertion above reflects probable intent; placement of inserted language not specified in section 1563[2](a)(4)(B)(ii) of PPACA.]*

(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part shall not apply to any individual coverage or any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

Whether the excepted benefits exception applies to subparts 1 and 2 or just to subpart 1 is not important for purposes of 2718, if 2718 is considered to be part of subpart 1, which seems to be the case. The House Office of Legislative Counsel adds a note, however, stating

[References in this section to subparts ''1'' and ''2'' appear in law and may be intended to refer to subparts ''I'' and ''II''.]

In this case, it would be important, as 2718 appears in subpart II of Part A and would not apply if only subpart I applied.

Section 2763 excepting excepted benefits from the requirements that apply to individual plans was not amended by ERISA. It may be superfluous, however, as former 2721 (now 2722) applies to group and individual plans, including its provisions excluding coverage of excepted benefits. Moreover, 2763 exempts individual plans from the requirements of Part B of Title XVIII (which may no longer exist), but a new section 2762 subjects individual plans to the requirements of Part A, which includes 2718.

The preface to the grandfather regulations at pages 7 to 10 discusses the application of the PPACA with respect to ERISA plans. It notes that PPACA adds section 715 to ERISA and section 9815 to the IRC applying Part A of the PHSA (including 2718) to ERISA plans, and provides that where ERISA and Part A conflict, Part A prevails. It further states, however, that Part A does not prevail where Part A and ERISA do not conflict, and uses as an example ERISA's exclusion of coverage for groups of one and excepted benefits. (Page 8 of the preface states that the amendments to 2721 could be read to state that only subpart 2 of Part A does not apply to excepted benefit plans and that subparts I and II apply. I do not see this as a

conceivable reading of PPACA). The preface thus states that ERISA's exceptions for groups of one and for excepted benefits continue to apply to group plans. The preface then goes on to say that nothing in PPACA indicates that nonfederal governmental retiree-only plans and nonfederal governmental excepted benefit plans should be treated differently than private retiree-only plans or excepted benefit plans. These plans are not subject to ERISA or the IRC, and thus are not subject to supervision by Labor or Treasury. Because, apparently, it is the policy of HHS under a memorandum of understanding and under section 104 of HIPAA to enforce the law uniformly with respect to ERISA plans and non-ERISA plans, the preface states at page 10 that

HHS does not intend to enforce PPACA against retiree-only plans or excepted benefit plans, and further states

. . . HHS is encouraging States not to apply the provisions of title XXVII of the PHS Act to issuers of retiree-only plans or of excepted benefits. HHS advises States that if they do not apply these provisions to the issuers of retiree—only plans or excepted benefits, HHS will not cite a State for failing to substantially enforce the provisions of part A of title XXVII of the PHS Act in these situations.

Thus it appears that:

1) Section 2718 applies to group and individual plans, but not to short-term limited duration insurance, which is by definition neither group nor individual insurance.

2) Section 2718 does not apply to Medicare Supplement policies and probably does not apply to the other forms of excepted benefits listed in 2791(c) (1) or to those listed in (c)(2) and (3), or any other benefits identified in the regulations, if the conditions imposed by the new section 2722 are met. In any event, HHS does not expect the states to enforce 2718 with respect to excepted benefit plans.

Many expatriate and international policies would not meet either of these two exceptions. If they do not meet these exceptions, then it appears that they would be subject to the MLR requirements of PPACA.

What is the concern if the MLR requirements of PPACA apply to Expatriate and International policies issued by U.S. companies?

These policies contain inherently higher administrative costs attributable to the additional complexities of administering international coverage (e.g., the costs of developing/maintaining provider networks in multiple countries, paying claims cross-border and in multiple countries, mitigating exposure to fraud, manually processing claims in multiple currencies and languages, operating multi-lingual 24/7/365 call centers in multiple times zones, etc.). In addition, the average premium for these types of policies is generally lower than domestic health insurance coverage. Thus, direct application of MLRs to this unique market may have a disruptive effect. An unintended consequence of direct application of the MLR requirements to this unique market may be to disadvantage U.S insurers relative to foreign competitors that are not subject to the same requirements. Finally, there may be additional complexities implementing rebates due to the transient nature of international travelers, students and expatriates. The high cost of transferring funds internationally may make it burdensome and costly for these types of plans to administer and comply with the rebate provisions.

Is there any legal basis for giving expatriate and international policies special treatment under the MLR provisions?

Section 2718 (c) of the PHSA states in pertinent part, "the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) [i.e., the report concerning the MLR] and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in (a)(2) [i.e., activities that improve health care quality]. Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans" Based upon the information provided, it appears that expatriate and international policies could reasonably considered "different types of plans" and as such, the methodologies referenced in 2718(c) should take into account the "special circumstances" of these plans.

Further, Congress has historically recognized the need for international plans and has created exemptions that apply to certain international plans. For example, Medicare does not cover beneficiaries outside the U.S. and CMS recommends beneficiaries purchase additional international coverage. See http:www.ssa.gov/mediinfo.htm. Additionally, the State Department requires certain visa holders to obtain international coverage. See 22 CFR 62.14.

Some states expressly recognize that international plans are “different plans.” For example, Washington State has made MLR exceptions for special plans with characteristics of international plans. See WAC 284-60-090. The New Hampshire Department of Insurance has determined that travel plans should qualify as excepted benefits under the Health Insurance Portability and Accountability Act. See N.H. Ins. Bulleting No. 08-024-AB

Finally, PPACA focuses on domestic primary health insurance. For example, PPACA Section 1501 exempts “An individual who is not a citizen or national of the U.S. or an alien lawfully present in the U.S.” Thus, it could be argued that PPACA was intended to apply only to U.S. citizens and resident aliens and was never intended to apply to expatriate and international policies, especially to the extent they cover students from other countries who study and train inside the U.S., third country nationals and key local nationals.

Documentation in support:

The following are the comments that CIGNA provided in its May 14, 2010 comment letter to Secretary Sebelius on the issue:

The MLR and rebate calculations should exclude plans where "special circumstances" make the MLR calculation inappropriate or less than meaningful. Section 2718(c) of the PHS Act directs that in designing the standardized methodologies for calculating measures of the activities to be reported to the Secretary under Section 2718(a), the National Association of Insurance Commissioners should take into account "the special circumstances of smaller plans, different types of plans, and newer plans."

The following types of plans present "special circumstances" that suggest exclusion from the MLR and rebate calculations:

* Medicare supplement and limited scope dental and vision plans provided under a separate policy of insurance and treated as "excepted benefits" under HIPAA.

* Low cost plans providing limited benefits either on a standalone basis or as a supplement to another plan. The administrative costs of these plans are largely fixed and do not vary with the premium. As a result, a higher percentage of the premium is attributable to administrative costs.

* All plans of health insurance issuers having a total membership that is insufficient to produce a meaningful MLR calculation. Plans of health insurance issuers with less than 75,000 life years of experience would be subject to significant volatility.

* All plans in a health insurance issuer's line of business (large group, small group or individual) if the total membership in that line of business is insufficient to produce a meaningful MLR calculation.

* Any plans in a health insurance issuer's new product line having less than three years of claim experience.

* Any plans offered to multi-national employers to cover expatriates (employees working for a time outside the United States) and non-US citizens. Such plans have inherently higher administrative costs attributable to the additional complexities of administering international coverage (e.g., the costs of developing/maintaining provider networks in multiple countries, paying claims cross-border and in multiple countries, mitigating exposure to fraud, manually processing claims in multiple currencies and languages, operating multi-lingual 24/7 call centers in multiple time zones, etc.). Applying MLR requirements to these plans would have the unintended consequence of disadvantaging domestic insurers in competing with foreign insurers and would likely result in the movement of the expatriate insurance business out of the United States resulting in a loss of jobs and revenue in the United States.

The following are comments that HTH Worldwide provided in its June 21, 2010 comment letter to the NAIC on the issue:

This letter is intended to provide additional information and clarification regarding our request for exemption of international health plans from the medical loss ratio requirement under PPACA Section 1001 amending the PHSA Section 2718.

Exemption from the MLR Requirement

International health plans, which primarily cover individuals outside of their home country (both inbound to the US and outbound from the US), have materially different characteristics that support an exemption from the MLR requirements.

The NAIC has the authority to provide a recommendation to the Secretary that certain plans be exempted or treated differently. Such authority is contained in PHSA Section 2718 as amended by PPACA sec. 1001 which states:

> The Secretary shall promulgate regulations enforcing this section and may provide for appropriate penalties. Not later than 12/31/2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners (NAIC) shall establish uniform definitions of clinical services and activities that improve health care quality and standardized methodologies for calculating measures of such activities, including definitions of which activities qualify. **Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.** [Emphasis added.]

Due the substantial differences in administrative costs, product costs and distribution costs, international products qualify as "different types of plans" and are therefore within the purview of the NAIC for recommendation of exemption from the MLR requirements or recommendation for an alternative application of an MLR requirement for these plans.

Why are International Plans Different

- PPACA focuses on domestic health insurance and does not contemplate the impact on international plans.
- International plans are different as they:
  - Typically command lower premiums, reflecting lower cost of care outside the U.S.
  - Incur higher sales and distribution costs associated with the specialized nature of the product and customer
  - Require materially different and more costly global administrative services:
    - Global medical assistance and care coordination, including critical medical evacuation, appointment scheduling assistance and guarantee of payment
    - International provider network development and maintenance in 200 countries (network costs can run up to $8 to $10 pmpm, or 4 to 5% of premiums)
    - 24/7/365 member services for both medical assistance and customer services, including requirements for multi-lingual customer call services
    - International claims adjudication
      - No standardization of claims forms, coding or information (claims are often submitted in languages other than English)
      - Payment in 100's of currencies, necessity to wire payments, management of currency risks
      - Communications with foreign providers (individual and facilities) regarding methods of treatments, protocols and payments
    - Deployment of tools and services to allow members to understand, access and navigate healthcare in local destinations around the world
  - The following table shows a comparison of approximate premium charges, claims and administrative allowances for a 40 year old priced on the Massachusetts Exchange versus comparable benefits under an HTH expatriate plan:

Plan	**Premium (pmpm)**	**Claims (pmpm)**	**Admin Allowance**	**Actual Admin Costs**
Mass Exchange Plan (Gold Level)	**$487 to $664**	$390 to $531 (80%)	$97 to $133 (20%)	N/A
HTH Expatriate Plan (Same Benefits as Gold Level)	**$243**	$195 (80%)	$49 (20%)	$117 (48%)

- These are small markets in general, and many plans are not credible from an underwriting standpoint. The number of individuals covered under international plans is very small, approximating less than 2% of the domestic market. On a state by state basis, plans are even smaller.
- Due to the unique nature of this business, claims experience is very volatile and typically not credible
- Specialty plans cannot blend or offset higher administrative costs with other domestic business.
- Some states already recognize that international plans are "different plans".
    - Washington State has made MLR exceptions for special plans with characteristics of international plans. (See WAC 284-60-090).
    - New Hampshire Department of Insurance has determined that travel plans should qualify as HIPAA excepted benefit (See N.H. Ins. Bulletin No. 08-024-AB).
- Federal law has created exemptions that recognize the unique operation of international plans. While PPACA left the development of standards for international plans to the expertise of the NAIC and HHS, Congress historically has recognized the need for international plans and has created exemptions that apply to certain international plans.
    - Medicare does not cover beneficiaries outside the U.S. and CMS recommends that beneficiaries purchase additional international coverage. See, http://www.ssa.gov/mediinfo.htm
    - The State Department requires certain Visa holders to obtain international coverage. See 22 CFR 62.14
    - Congress has exempted different types of plans from HIPAA such as limited duration plans. See, 42 USC 300gg-91.
- Enforcement of rebates is impractical given the transient nature of international travelers (e.g. inbound students to the U.S. are often covered for limited periods and return to their home country. Tracking and reaching these individuals would be extremely difficult and burdensome). Beyond the impracticality of maintaining contact, the costs of wiring any amounts would far exceed any anticipated rebates.

Alternative Requirement of MLR

While we strongly favor an exemption from the MLR requirement under PPACA, in the event such an exemption is not possible or not recommended by the NAIC, we recommend an accommodation for international plans that sets the required MLR 25% below the MLRs required under section 2718, to accommodate the special circumstances of international plans.

Letters from various organizations supportive of exempting international health insurance plans from MLR provisions of PPACA

We are writing to express our support for exempting international health insurance plans – that is, those plans that serve people who are working, living, studying, or traveling internationally away from their home country, which includes foreign students coming into the U.S. to study or U.S. students studying abroad – from the medical loss ratio (MLR) requirements under the Patient Protection and Affordable Care Act (PPACA). Our foreign students rely on these specialty plans when they come to the U.S. to study or travel internationally to study abroad, and applying the MLR as outlined by PPACA would have an adverse impact on these plans' affordability and benefits.

Section 2718(c) of PPACA states that the National Association of Insurance Commissioners (NAIC) shall establish "methodologies (of calculating MLR) designed to take into account the special circumstances of smaller plans, different types of plans and newer plans." We believe these international plans are unique and require special consideration.

These plans typically command materially lower monthly premiums than any domestic options and they provide benefits and features that are not found or needed in a domestic health insurance plan. However, these plans also have higher administrative costs. To serve international students coming to study in the U.S. and U.S. study abroad students, customer support lines must be open 24 hours/day, 365 days/year versus just 40 hours/week. Claims administration is often extremely complex and non-standard requiring multi-lingual communications with members and health care providers around the world. Administration requires a unique type of expertise and fluency in a number of languages, as well as an ability to execute transactions in multiple currencies. In addition, developing and maintaining a global network of contracted, qualified foreign health care providers is much more expensive than developing networks in the U.S. alone.

International health plans also provide a range of different benefits than those found in a domestic plan, such as coverage of political and medical evacuation. They also have to build and maintain comprehensive online databases and tools for finding health care in countries all over the world, as well as translating medical terms and phrases. These are unavoidable medical management costs for international health plans.

We therefore respectfully request that that NAIC recommend to the Department of Health and Human Services an exemption for international health care plans from the PPACA MLR requirements because of the plans':

- Lower premiums
- Unique services required to provide care globally
- Challenging cases serviced on a global basis
- Specialized member services and tools

Thank you for the opportunity to be heard and to present a real life consumer's critical perspective on this small, special, but important segment of the insurance industry. By requiring changes to the standards of the policies covering these people, that result in specialized services and specialized benefit designs, will have a chilling effect on the international student market for both foreign students coming into the U.S. and U.S. students studying abroad.

Documentation in opposition:

Timothy Jost, Robert Willett Family Professor of Law, Washington and Lee University, stated the following in his memo dated June 22, 2010:

PPACA section 2718 applies to any "health insurance issuer offering group or individual health insurance coverage." Section 1551 of PPACA provides that the definitions found in section 2791 of the Public Health Services Act (42 USC 300gg-91) apply to title I of PPACA. The PHSA defines "health insurance issuer" to include any licensed health insurance company, "group health insurance coverage" to mean health insurance provided by an employee welfare benefit plan, and "individual health insurance coverage" to mean health insurance offered in the individual market, excluding "short-term limited duration" insurance. PHSA 2722, as amended, probably excludes excepted benefits from the coverage of 2718, although the issue is not wholly clear.

It can be argued that expatriate and international insurance policies are different from other health insurance policies in important respects. Unless they qualify as excepted benefits or consist of "short-term limited duration" individual policies, however, neither HHS nor the NAIC have the discretion to exempt them from the medical loss ratio requirements of 2718.

International and expatriate policies may perhaps be categorized as a "different type of plan," in which case section 2718(c) permits the NAIC to "take account" of their "special circumstances" in establishing a methodology for calculating measures of the activities reported under subsection 2718(a), i.e. reimbursement for clinical services or activities that improve quality of care. It is under 2718(c) that the NAIC is dealing with credibility issues raised by smaller plans or the treatment of reserves held by durationally underwritten plans.

Section 2718(c) does not give the NAIC discretion, however, to reduce the medical loss ratios prescribed by statute. Section 2718 permits deviation from the percentage MLR requirements that must be met by plans under 2718(b) (85% for large group plans and 80% for individual and small group plans) in three circumstances only:

- 2718(b)(1)(A) allows the states to increase the percentage;
- 2718(b)(1)(A)(ii) allows HHS to adjust the percentage in a particular state to avoid destabilization of the individual market; and
- 2718(d) allows HHS to adjust the percentages to account for volatility in the individual market upon the introduction of the exchanges.

Neither the NAIC nor HHS can, therefore, permit particular types of plans to be governed by lower percentage MLRs. Indeed, as a matter of policy granting exceptions would be a bad idea because many other types of plans would argue that they were special in some way and should also be granted an exception.

If expatriate and international insurance policies deserve special treatment as a "different type of plan," it will have to be provided through the use of special definitions of activities or methodologies of calculations of activities. I am not sure how this can be done. Alternatively, HHS, the Department of Labor, and the Department of Treasury could perhaps define some forms of international and expatriate insurance as "excepted benefits" if the coverage they offer fits the requirements for the regulatory recognition of excepted benefits. Otherwise they will have to comply with the statutory requirements.

If some way is found to legally provide them with special treatment, it is imperative that this be disclosed to consumers, and that consumers be given notice of the medical loss ratio that international and expatriate policies in fact achieve. After the medical loss ratio requirements go fully into effect, consumers will expect that any plan they purchase meets the requirements of 2718. If plans are given special treatment in any way, consumers must be made aware of this.

Evaluation:

Expatriate and international policies do not appear to be subject to the MLR provisions if: 1) the coverage meets the definition of an excepted benefit or 2) the coverage is individual health insurance coverage that is short-term limited duration coverage. However, many expatriate and international policies would not meet either of these two exceptions. If they do not meet these exceptions, then it appears that they would be subject to the MLR requirements of PPACA.

Section 2718 (c) of the PHSA states in pertinent part, "the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) [i.e., the report concerning the MLR] and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in (a)(2) [i.e., activities that improve health care quality]. Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans"

Based upon the information provided, it appears that expatriate and international policies are unique could reasonably considered "different types of plans" and as such, the methodologies referenced in 2718(c) should take into account the "special circumstances" of these plans.

These plans typically command materially lower monthly premiums than any domestic options and they provide benefits and features that are not found or needed in a domestic health insurance plan. However, these plans also have higher administrative costs. To serve international students coming to study in the U.S. and U.S. study abroad students, customer support lines must be open 24 hours/day, 365 days/year versus just 40 hours/week. Claims administration is often extremely complex and non-standard requiring multi-lingual communications with members and health care providers around the world. Administration requires a unique type of expertise and fluency in a number of languages, as well as an ability to execute transactions in multiple currencies. In addition, developing and maintaining a global network of contracted, qualified foreign health care providers is much more expensive than developing networks in the U.S. alone.

International health plans also provide a range of different benefits than those found in a domestic plan, such as coverage of political and medical evacuation. They also have to build and maintain comprehensive online databases and tools for finding health care in countries all over the world, as well as translating medical terms and phrases. These are unavoidable medical management costs for international health plans.

While there are valid arguments for excluding expatriate and international plans from the MLR, including those made by the Groom Law Firm in their memo dated June 24, 2010, the NAIC does not believe it has the authority to exclude these plans from the MLR calculation. But rather, the NAIC believes that this is a decision for HHS. However, Section 2718(c) permits the NAIC to "take into consideration" the "special circumstances" of "different types of plans" in establishing a methodology for calculating measures of the activities reported under subsection 2718(a). Thus, our job is to establish the methodology for calculating the MLR. In establishing the methodology, the NAIC may make modifications to the calculation, but may not exclude different types of plans from the MLR altogether.

The following table from the HTH Worldwide letter dated June 21, 2010 shows a comparison of approximate premium charges, claims and administrative allowances for a 40 year old priced on the Massachusetts Exchange versus comparable benefits under an HTH expatriate plan:

Plan	Premium (pmpm)	Claims (pmpm)	Admin Allowance	Actual Admin Costs
Mass Exchange Plan (Gold Level)	**$487 to $664**	$390 to $531 (80%)	$97 to $133 (20%)	N/A
HTH Expatriate Plan (Same Benefits as Gold Level)	**$243**	$195 (80%)	$49 (20%)	$117 (48%)

In addition, HTH makes the following points.

- These are small markets in general, and many plans are not credible from an underwriting standpoint. The number of individuals covered under international plans is very small, approximating less than 2% of the domestic market. On a state by state basis, plans are even smaller.
- Due to the unique nature of this business, claims experience is very volatile and typically not credible

HTH also recommends the following: "in the event such an exemption is not possible or not recommended by the NAIC, we recommend an accommodation for international plans that sets the required MLR 25% below the MLRs required under section 2718, to accommodate the special circumstances of international plans."

Tim Jost argues that the NAIC does not have the authority to reduce the MLR in establishing a methodology for calculating measures of the activities reported under subsection 2718(a). But, rather the NAIC is limited in establishing a methodology for calculating measures of the activities reported under subsection 2718(a) to establishing definitions for activities associated with reimbursement for clinical services or activities that improve quality of care. NAIC staff agrees that the NAIC does not have the authority to reduce the MLR in designing the methodologies to take into account the special circumstances of these plans.

It is possible that HHS has the discretion to exclude expatriate and international plans from the MLR provisions altogether and the industry has presented reasonable arguments for taking this approach to address the special circumstances of these plans. However, in the event that HHS does not exercise this discretion, the following modifications to the methodology may be appropriate to take into account the special circumstances these plans:

1) exclude experience for expatriate and international plans from the pool in which it would otherwise be included and perform a separate "national" MLR calculation by pool for this type of business.

2) include in the numerator of the MLR the additional expenses specifically associated with providing the services associated with international and expatriate plans that might not otherwise be considered activities that improve health care quality (e.g., the expenses associated with: a) developing and maintaining quality networks of providers throughout the world; b) mitigating fraud exposure; c) processing claims in multiple currencies and in multiple languages; d) manual handling of claims; e) reimbursement via wire transfer in multiple non-U.S. currencies f) operating multi-lingual 24/7/365 call centers in multiple time zones; g) coverage of medical evacuation and translation services that are not found in domestic health plans; h) translation tools, information websites, mobile tools, and databases especially designed to allow self service, understand, locate and access care as well as help in syncing differing medical practices around the world) since it can be argued that in the absence of such services the quality of care would suffer significantly. For any additional expenses included in the numerator of the MLR, the issuer must be able to clearly document that in the absence of the associated services health care quality may be compromised.

3) aggregate experience for the expatriate and international plans included in each "national" pool across all states (and all countries) to enhance credibility;

In addition, we recommend that other then these modifications, the issuers offering international and expatriate plans should follow the uniform definitions and standardized method for reporting the MLR and calculating the rebate established by the NAIC and certified by the Secretary.

Tim Jost argues: “If some way is found to legally provide them with special treatment, it is imperative that this be disclosed to consumers, and that consumers be given notice of the medical loss ratio that international and expatriate policies in fact achieve. After the medical loss ratio requirements go fully into effect, consumers will expect that any plan they purchase meets the requirements of 2718. If plans are given special treatment in any way, consumers must be made aware of this.” Thus, our final recommendation is that issuers be required to disclose to consumers the fact that the additional expenses are included in the MLR calculation. If HHS does exercise discretion to exclude expatriate and international plans from the MLR provisions altogether then, we recommend that consumers be advised of this fact and be given notice of the MLR that international and expatriate plans in fact achieve.

Exceptions References:

None

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9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD036

Issue:

Should the change in premium deficiency reserves be included in the definition of incurred claims?

Subgroup Resolution:

No, premium deficiency reserves should not be included. Those reserves are recorded in financial statements to reflect the excess of future claims over future premiums and expenses – resolved 6/28.

Exceptions:

None identified.

Description:

Premium deficiency reserves are required in statutory financial statements as required in the Accounting Practices & Procedures Manual. The requirement appears in Statement of Statutory Accounting Principles #54, as follows:

> "18. When the expected claims payments or incurred costs, claim adjustment expenses and administration costs exceed the premiums to be collected for the remainder of a contract period, a premium deficiency reserve shall be recognized by recording an additional liability for the deficiency, with a corresponding charge to operations. For purposes of determining if a premium deficiency exists, contracts shall be grouped in a manner consistent with how policies are marketed, serviced and measured. A liability shall be recognized for each grouping where a premium deficiency is indicated. Deficiencies shall not be offset by anticipated profits in other policy groupings. Such accruals shall be made for any loss contracts, even if the contract period has not yet started.

Documentation in support:

Documentation in opposition:

Evaluation:

Exception References:

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9/15/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD037

Issue:

Should reserves for future contingent benefits and lawsuits be included in the definition of incurred claims?

Subgroup Resolution:

Resolved – 9/15:

Yes, reserves that represent anticipated claim payments for either future contingent benefits or the resolution of known lawsuits should be included in incurred claims.

Exceptions:

None identified.

Description:

On financial statements, insurers must hold reserves for future contingent obligations that could be due after the termination date of a policy, such as an existing pregnancy, or the remainder of a hospital stay.

On financial statements, insurers also must hold reserves for the estimated future obligations resulting from a particular lawsuit.

Documentation in support:

From letter from AHIP dated May 20, 2010, page 2:

"Reserves for future contingent benefits, however, should be designated as appropriate reserves for inclusion within the determination of incurred claims – i.e. above the line - as they relate to likely claims based on current coverage."

From letter from AHIP dated July 2, 2010, page 2:

"We understand that there are possible changes to this IRD. Our position as stated in our June 25th letter is that reserves for future contingent benefits and lawsuits should be included in this IRD, as they are included in losses incurred under current statutory standards and the potential costs are reflected in premiums so it would be illogical to omit them from the ratio. Current dispute resolutions with providers and other related to claims can at times be passed back to certain groups, including ASO groups and retrospective insured groups."

From email dated July 2, 2010 from Brian Rees, Assurant group:

"With respect to excluding claims expenses for lawsuits from the incurred claims, I would respectfully disagree with that view and recommend that any paid litigation amounts or accrued reserves be included as any other claim, with exclusion of amounts for punitive damages. The amounts would not be representing future benefits but for services that have been rendered in the past. It is not necessarily true that the amount for a past claim is an insignificant amount, especially if it is in a state with a small block of business. The fact that the punitive damages portion may be larger should not disqualify the remaining portions. "

Documentation in opposition:

From email dated July 2, 2010 from Brian Rees, Assurant group:

“I would agree with the initial viewpoint that the Change for Future Contingent Reserves be excluded from the definition of incurred claims for purposes of the MLR Rebate Calculation. It should be noted, however, that this viewpoint differs from that currently proposed and preliminarily adopted by Lou Felice's workgroup (Health Reform Solvency Impact (E) subgroup for the Statutory MLR Exhibit. That workgroup is including the change in "claim reserves" in the calculation of the incurred claims used in the MLR calculation as defined in Part 2 of the Exhibit, Instructions on Line 2.4 as follows:

Line 2.4 – Direct Claim Reserves Current Year

Report reserves related to healthcare services for present value of amounts not yet due on claims and the claims related portion for reserve for future contingent benefits.

This would appear to be relating to reserves reported in Exhibit 6B of the Life Company Blank. I would suggest that this issue be reconciled between Lou's group and the MLR rebate calculation efforts so that there is a consistent definition of incurred claims in order to avoid confusion and misunderstanding of the MLRs.”

Evaluation:

Exception References:

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8/13/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD039

Issue:

Multi-year averaging may be used prior to 2014.

Subgroup Resolution:

Resolved 7/19:

Multi-year averaging may not be used prior to 2014. The formula developed by the NAIC to implement the methodologies as directed in section (c) of the law must use only single plan years of experience prior to 2014.

Exceptions:

While three-year averaging will not begin until 2014, for less than fully credible plans, the formula may include a carry-forward element based on experience in a previous year or years and may use more than one year of experience. These exceptions are addressed in IRD040 and IRD044.

Description:

It would be helpful for smaller plans and newer plans if the rebate calculation formula during the interim period before 2014 could grade into the three year averaging effective 2014. If we can read the law as only requiring three year averaging after 2014, but not barring multi-year averaging before 2014 as a permissible interpretation of the development of a methodology dictated in section (c), we could develop such a grading process. The advantage would be greater credibility associated with the experience developed under smaller plans and newer plans, thus allowing payment of rebates by plans that are not credible on an annual basis. Another advantage would be the development of a more robust formula that smoothly transitions into the multi-year calculation required after 2014.

Documentation in support:

The law says NAIC will establish standardized methodologies (Full section 2718 of the law is copied below under Attachments for context).

SEC. 2718 (c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

Documentation in opposition:

The law says rebates shall be based upon each plan year until January, 2014, (Full section 2718 of the law is copied below under Attachments for context).

SEC. 2718 (b) (1) (A) REQUIREMENT.—…a health insurance issuer offering group or individual health insurance coverage…shall, **with respect to each plan year**, **provide an annual rebate**…if the ratio…for the plan year (except as provided in subparagraph (B)(ii)), is less than…

SEC. 2718 (b) (1) (B)(ii) CALCULATION BASED ON AVERAGE RATIO.—

Beginning on January 1, 2014, the determination… shall be based on the averages… for each of the previous 3 years for the plan.

Evaluation:

The law seems to clearly state that the rebate shall be calculated based upon each year's individual experience, with a parenthetical exception beginning on January 1, 2014. The exception clearly states it begins on January 1, 2014, and makes no reference to the possibility that it may apply prior to 2014.

We could advance the theory that the NAIC could design a methodology that would take into account the developing experience under plans. Such theory would suggest that the details of such methodology could override the clear statements made in the law, instead implementing some underlying intent of the law.

It appears the law does not consider the possibility that a formula could grade between annual calculations and three year average calculations. Having not considered such a possibility, it clearly states the rebate shall be based upon an annual rebate paid for each plan year.

Thus, we must conclude an interim multi-year formula is not permitted.

Exceptions References:

Attachments:

''SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.
''(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—
''(1) on reimbursement for clinical services provided to enrollees under such coverage;
''(2) for activities that improve health care quality; and
''(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees. The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.
''(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—
''(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—
''(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph
(B)(ii)), is less than—
''(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or
''(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.
''(B) REBATE AMOUNT.—
''(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—
''(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and
''(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

‘‘(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.
‘‘(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.
‘‘(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.
‘‘(c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.
‘‘(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

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8/13/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD040

Issue:

Experience that does not yield a rebate in a prior year cannot be used to offset experience that does produce a rebate in the current year.

Subgroup Resolution:

The formula the NAIC will propose in implementing regulations should not allow a calculated rebate in one year to be reduced by prior year experience in excess of the MLR standard – resolved 6/14/10. This resolution is not intended to be applied to the three-year averaging process dictated in the law beginning 1-1-2014.

Exceptions:

Possible exception for "special circumstances of smaller plans, different types of plans, and newer plans." It is anticipated we will develop a credibility adjustment process that will take multiple years into account to enhance credibility of such plans.

Description:

Documentation in support:

The law says rebates shall be based upon each plan year until January, 2014, (Full section 2718 of the law is copied below under Attachments for context). Beginning January, 2014 an average of the previous 3 years is required.

SEC. 2718 (b) (1) (A) REQUIREMENT.—…a health insurance issuer offering group or individual health insurance coverage…shall, **with respect to each plan year**, **provide an annual rebate**…if the ratio…for the plan year (except as provided in subparagraph (B)(ii)), is less than…

SEC. 2718 (b) (1) (B)(ii) CALCULATION BASED ON AVERAGE RATIO.—
Beginning on January 1, 2014, the determination… shall be based on the averages… for each of the previous 3 years for the plan.

Documentation in opposition:

Evaluation:

Before January 1, 2014 the calculation of the rebate is for each plan year based upon the ratio for such plan year. If a carrier had an MLR greater than the standard, say 80%, in a year, the law does not allow consideration of such excess in the next year. In this example, if the carrier had an MLR of 83% in year X and an MLR of 77% in year X+1, the carrier would need to calculate and pay a rebate in year X+1. This rebate would be based upon the 77% MLR in year X+1 and no credit from the 83% MLR for year X would offset such rebate. The rebate would be equal to 3% of the adjusted premium in year X+1.

If a plan has non-credible experience, it will be handled via any methodology that is incorporated to recognize "special circumstances" of such plans. The methodology may mirror in some respect the averaging process anticipated after January 1, 2014.

Exceptions References:

Attachments:

''SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

''(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

''(1) on reimbursement for clinical services provided to enrollees under such coverage;

''(2) for activities that improve health care quality; and

''(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees. The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

''(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

''(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

''(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph
(B)(ii)), is less than—

''(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

''(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

''(B) REBATE AMOUNT.—

''(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

''(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

''(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

''(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

''(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

''(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

''(c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

''(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

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8/13/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD041

Issue:

Should the Secretary of Health and Human Services adjust the Medical Loss Ratio requirement used in calculating rebates as legislated by PPACA Section 2718 (b) for individual health plans in any states? The Secretary is authorized to do so with respect to a state by paragraph (1)(A)(ii) if the Secretary determines that the application of the 80 percent statutory level "may destabilize the market in such state." This may be important as the market transitions to a guaranteed issue environment, where individual medical coverage is purchased through an exchange. That change should lead to reduced expenses for underwriting costs and sales, thereby allowing companies to reach the 80% loss ratio requirement.

Subgroup Resolution:

Resolved 7/19:

The NAIC should recommend that the Secretary consult with the insurance commissioner in each state to decide whether to adjust the 80 percent MLR used for the PPACA rebates in one or more years, considering whether the application of an 80 percent MLR is likely to destabilize that state's individual market. Characteristics that should be considered include the following:

- Input from the insurance issuers of individual policies, consumers, and consumer advocates,
- state laws requiring minimum loss ratios,
- actual historical loss ratios for each individual carrier in the state,
- the number of carriers in the state that offer individual medical policies to new enrollees, and
- an evaluation of the vulnerability of the individual medical market to destabilization.
- The financial impact on policyholders from lowering the minimum loss ratio target.
- State laws and regulations regarding cancellation and non-renewal of health insurances,
- The cost to insurance companies of withdrawing from the individual health insurance market.
- Alternative sources of health insurance coverage to consumers.
- Balancing the interests of consumers and insurance companies.
- Any other relevant considerations.

It may be useful for the NAIC to prepare a standard form for the states and the Secretary to use in evaluating the vulnerability of the individual market in a state.

Description:

Many issuers of individual medical insurance plans may find that the anticipated total of their claim costs, expenses, and rebates during the next few years is substantially higher than the anticipated premiums and investment income from these policies. These companies may cancel the individual policies, if the terms of the policies permit cancellation, and cease offering these plans, if the policies are virtually certain to incur losses. This potential withdrawal could have a severe impact on the currently insured who would lose their policies, and could also limit the choices available to prospective purchasers.

The PPACA, section 2718(b) states "the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State." Such an adjustment may be appropriate to avoid destabilization in some states during the transition to 2014.

The Secretary might, for example, after reviewing the characteristics of a state's individual market with the state insurance commissioner, adjust the rebate calculations in the individual market to be based on 65% for 2011 for a state that currently has a minimum loss ratio of 55%, actual loss ratios for some issuers that are between 55% and 70%, and only four issuers in the state currently offering policies to new enrollees.

Background Information:

Note that this adjustment to protect against destabilization of the individual market is separate from the issue of the effect of durational patterns of claim costs in the individual and small group markets. That issue is addressed in IRD 008, Contract Reserves.

According to the NAIC's database of annual statement filings, there were over eight million people enrolled in individual medical policies at the end of 2009, and they paid about twenty billion dollars for their policies in 2009. They had policies from over four hundred different companies. The greatest enrollment is in the following groups: Aetna, American Family Mutual, Assurant, Blue Cross/Blue Shield plans, Carefirst, HCSC, Highmark, Humana, Kaiser Foundation, UnitedHealth, and Wellpoint.

There are probably millions more enrollees who are not listed in the database, since some people are covered in individual policies sold through a trust or association, and also some insurers are not required to provide their financial filings to the NAIC. From the information in the database, a little under four million enrollees were in policies from about seventy insurers that each had a loss ratio under 75% in 2009, and those people paid about eight billion dollars in premiums in 2009. Using the information for each insurer and some simplifying assumptions, the rebates for individual policies would total about $600 million, which averages about seven percent of the premiums from policies that got rebates. The rebates would range from less than a percent to 48% of the 2009 premium.
Here are the simplifying assumptions:

- A reported loss ratio of 75% corresponds to a PPACA MLR of 80% because of adjustments for quality improvement expenses, durational reserves, and deduction of taxes from the premiums.
- Companies that have fewer than 500 enrollees will not pay rebates because their block is not statistically credible.
- Calculating rebates on a state-by-state basis will increase them by about 50% on average.
- The premium and claim experience in 2009 is representative of a typical period.
- Only the companies that report their experience to the NAIC are considered.

Documentation in support:

An example of argument for a transition is taken from the letter of May 14, 2010, from America's Health Insurance Plans, HHS reference HHS-OS-2010-004-0067.1.

"In practice, Section 2718 assumes the existence of new infrastructure and market rules that will not be in place when the MLR is implemented. This necessitates the need for clear steps that ensure a transition that does not cause instability and disruption in the marketplace…"

"In contrast to the post-2014 environment, the current market is voluntary in nature. This has significant implications for the calculation of MLRs for individual coverage. Approximately, 85% of those with existing individual coverage reside in states where individual coverage is provided on an underwritten, guaranteed renewable basis."

Another example of argument for a transition is taken from the letter of May 14, 2010, from American Academy of Actuaries, HHS reference HHS-OS-2010-004-0130.1.

"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.

"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."

Documentation in opposition:

From a letter from NAIC funded consumer representatives dated June 2, 2010:

"Congress adopted the 80 percent minimum loss ratio in the evidence-based belief that it was reasonable to expect insurers to spend 80 percent of their premium revenues on actual medical care or on activities that promote quality of care. A report the Congressional Research Service released in 2009 found that virtually all major insurers had MLRs well above this ratio. The MLR formula found in the statute is more generous than the MLR ratios used in the past in terms of what it counts and does not count, and should be attainable by a properly-run insurer."
From a letter from Birny Birnbaum dated June 2, 2010:

"As for proposed solutions,

“1. Lower the MLR for grandfathered individual business. First, this defeats the purpose of MLR. Second, it would actually be difficult to implement because, if the reason for this fix is "lifetime pricing," which plans are grandfathered? Third, it would inevitably create unfair competition based on when the plan was started. Fourth, it would invite gaming the system -- once you create a loophole, insurers will seek to use it.

“2. Develop different MLR by policy year or calendar year of issue. This only works, in theory, if the "lifetime pricing" hypothesis is true and accurate. This is complicated, would take time to develop and becomes a nightmare for developing the regulation and monitoring compliance. It is essentially a actuary employment proposal.

“3. Exclude the select period from the MLR calculation. This proposal would exclude the low loss ratio years from the calculation and only include the high loss ratio years? This heads-I-win, tails-you-lose concept is clearly inappropriate and contrary to the purpose of the MLR requirement.

“4. Allow use of contract reserves for MLR calculation. Theoretically, this is a reasonable approach. If, in fact, an insurer can reasonably estimate future claims payments and establishes reserves, the MLR becomes an incurred loss ratio instead of a paid loss ratio -- standard practice in many lines of insurance. The downside is that reserves are subject to manipulation and an insurer would likely simply establish reserves sufficient to meet the MLR standard. In fact, the establishment of such reserves would almost be definitional. If you price a product to achieve an 80% lifetime loss ratio, then your reserves will be the remainder of 80% of premium less claims paid. For this to work, there would have to be a severe penalty for significant over-reserving. Without such a penalty, there is little downside to manipulating reserves to meet the MLR.”

Evaluation:

In an initial evaluation of the issue, the subgroup rejected several scenarios and possible resolutions. However, we continue to have a concern over the current low loss ratios developed historically in some states. Enrollees who have purchased policies are likely to want to retain them, especially if there is no alternative coverage at any price.

If the MLR standard is reduced by the Secretary in some states during a transition period, presumably fewer issuers would cancel their blocks of individual health insurance policies. Reduced MLR minimums allow issuers time to adapt their expense structures to accommodate the rebate requirement, without causing significant and unaffordable financial losses.

Many enrollees would receive smaller or no rebates for three years. Assuming the average reduction of MLR moves to 65%, the rebates would go to about 140,000 people and would total about $18 million on premiums of $250 million, or about seven percent, using the NAIC database and the simplifying assumptions described above.

If no transition were implemented, issuers may cancel their blocks of individual health insurance policies, resulting in possibly several million enrollees who have to shop and apply for coverage elsewhere. In states that allow underwriting, many enrollees may not be accepted due to medical conditions, or would have to pay higher premiums. There would be less consumer choice, and less competition among remaining issuers, possibly resulting in lower quality or higher overall premiums.

In some states, high risk pools are available, but the increased influx of enrollees may strain the funding for the pools.

States or the federal government may need to create a new coverage alternative for those who are ineligible for coverage by an issuer or a high risk pool. The additional cost of this alternative may be relatively modest, since the enrollees are by definition in the aggregate already paying premiums that cover their claims plus more than 25% of premium for expenses.

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8/13/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD042

Issue:

Should credibility adjustments reflect a gradual increase in credibility (either continuous or by discrete ranges) from smaller to larger enrollment or should a line be drawn such that anything larger is considered fully credible and anything smaller is considered non-credible?

Subgroup Resolution:

If a credibility adjustment is used, partial credibility will be reflected rather than using a "cliff" standard – resolved 6/21/10.

Exceptions:

None identified.

Description:

2718(b) references providing an annual rebate of premium in each plan year at the individual, small group and large group levels, but also requires the NAIC to establish standardized methodologies that take into account the special circumstances of smaller plans. If a credibility adjustment is used for this purpose, its form and application need to be determined. Partial credibility is used elsewhere (e.g. Medicare supplement refunds) with no apparent difficulties resulting from any added complexity. Further, it is not clear that a cliff methodology would significantly improve consumer understanding and may even be more confusing.

Documentation in support:

Documentation in opposition:

Evaluation:

It had been suggested that a yes/no ("cliff") credibility determination, under which a block of business is considered either fully credible or fully non-credible, might be simpler to apply and easier for consumers to understand. However, such a methodology would entail serious drawbacks. Depending on where the cutoff point is set, either (A) nor rebate would be paid when some rebate would be payable if a more theoretically sound partial credibility standards were used, or (B) a full rebate would be paid even though the block is not large enough to be fully credible based on more theoretically sound partial credibility standards and has significant statistical fluctuations, or (C) both.

Exceptions References:

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9/20/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD044

Issue:

Should a hierarchy for application of credibility and pooling techniques be used?

Subgroup Resolution:

Resolved – 9/20:

A hierarchy for application of credibility and pooling techniques should be used as outlined in the evaluation below.

Exceptions:

None identified.

Description:

2718(b) references providing an annual rebate of premium in each plan year at the individual, small group and large group levels, but also requires the NAIC to establish standardized methodologies that take into account the special circumstances of smaller plans. If various credibility adjustments are used for this purpose, the form of the adjustments and order of application need to be determined.

Documentation in support:

From the July 2, 2010, letter from America's Health Insurance Plans (AHIP):

> "We believe that a hierarchy will be needed."

From the July 2, 2010, e-mail from Assurant Vice President Brian Rees:

> **"IRD044 - Credibility Hierarchy**
> I fully agree with the outlined list of objectives or factors to consider with respect to the selection of a hierarchy. If I understand the hierarchy and associated examples correctly, it is the intent that a rebate calculation would be done at the end of each year and if the calculation indicates that the experience MLR less the credibility adjustment is below the MLR Standard, then a rebate would be paid. This would be done for each year separately.
>
> … Allowing the hierarchy to extend to 5 years and allowing for interim rebates would likely add to the problems outlined above. There will be additional administrative expense in tracking policyholders over the 5 years in order to distribute any rebate. It would be conceivable that a policyholder who was in force in year 1 but lapsed before year 2 could receive interim rebates for all 5 years if the ultimate results called for a rebate even though they only had coverage during year 1, due to the pooling across years. It would be difficult to argue that a policyholder's experience that contributed to the pooled results shouldn't participate in the outcome of those results. This would not appear to be a logical conclusion of PPACA for this to occur.

Documentation in opposition:

> From the July 2, 2010, e-mail from Assurant Vice President Brian Rees:
>
> It is my belief that paying a rebate before reaching 100% credibility or reaching the end of the hierarchy steps could result in the pooling concept is being violated. Payment of interim rebates before the full calculation period is

completed will not allow for the offsetting nature of the pooling mechanism to work properly and the results will be unequitable to the carriers. I will illustrate via the following example using Company F:

This is a situation where the pooled experience in year 1 is less than 100%. As illustrated, assume that the 2011 experience MLR is 77% and the credibility adjustment is 2%. The hierarchy rules would require a rebate of 1% to be paid (80% - 2% - 77%). The problem will arise in years 2+ if the experience MLR is greater then the MLR Standard. Assume the 2012 experience MLR is 83% and the adjustment is 0% (i.e, 2011-2012 is fully credible). The calculated rebate would be 0% (80% - 0% - 80% with the 2nd 80% being the average of 77% and 83% by combining 2011 and 2012). However, there was already a rebate of 1% paid from 2011 which can't be recovered. In essence, the MLR standard has been increased above 80% (in this example, it is effectively 80.5% due to a rebate of 1% for 1/2 the time period). This is above the level set in PPACA. The pooling across years is negated by the payment of the rebate in earlier year. If the experience MLRs were to be reversed such that 2011 = 83% and 2012 = 77%, the rebate in 2011 would be 0% and the rebate in 2012 would also be 0% (80% - 0% - 80%, the second 80% being the average of 83% and 77%) - $0 rebate from 2011. This generates an inequitable result purely due to timing. If pooling were to work properly in this situation, the results would be the same irregardless of the timing of the experience since the pooling is being done for credibility purposes.

This situation could occur in any scenario where multi-year periods are used for pooling and rebates payable during the interim periods. In addition to paying the non-recoverable rebates, the carrier also incurs the administrative expenses of distribution of the rebates in an era where there will be significant expense reduction pressure.

There would be two, possibly three solutions to this inequality:

1. Do not pay any rebates until the full credibility has been reached or the end of the hierarchy has been reached - This would allow for equitable treatment between the policyholders and the carriers;

2. Calculate the rebates at each year but hold them in a reserve to allowed to be used in offsets in subsequent years in the rebate hierarchy calculations - This would allow for offsetting to occur as the concept of pooling is intended since reserves are available while rebates paid out are not recoverable.

3. A third option of not allowing interyear pooling (although this may not allow for achieving higher levels of credible results)

This will also raise the issue of equity for policyholders across the pooled years. The same policyholder in year 1 who lapsed but had favorable albeit statistically driven results in year 1 received a rebate than a policyholder who was inforce in year 2 who received no rebate due to the pooled results."

From the July 6, 2010, letter from AIS Risk Consultants:

"2. Pooling / combining of business should only be performed to the extent necessary to make a block of business fully credible.

For example, if the large claim experience of a block of business is 30% credible, then in determining the MLR that large claim experience should be given 30% weight, and the next level of experience (i.e., pooled large claim experience) should be given 70% weight.

Similarly, if the experience in a state is 80% credible, then in determining the MLR, that state's experience should be given 80% weight, and the next level of experience (i.e., pooled states experience) should be given 20% weight. A given state that has favorable experience which is not fully credible should not have that experience watered down by other states.

If a block of business for which the experience is not fully credible is completely subsumed into pooled experience, then inappropriate outcomes could result. One such possible scenario is where 2011 and 2012 are both 90% credible, with loss ratios of 83% and 77%, respectively, with a combined loss ratio of 80%. If combined experience is used because 2012 is not completely credible, then with a combined loss ratio of 80% no rebate would be payable. However, if 2012 experience is given its credibility weight of 90%, the credibility weighted loss ratio is 77.6% (= 77% X 90% + 83% X 10%), so that a rebate of 2.4% would be payable. The later result seems more consistent with the intent of the legislation.

In summary, the experience for a block of business should not be completely diluted into a large grouping of business if that block of business has some credibility on its own."

Evaluation:

A hierarchy of approaches, detailed below, will be used to address blocks of business that are not fully credible.

1. Approaches considered most desirable or least objectionable will be higher on the list and will be applied first. Desirability of various approaches will be based on the following factors. These are listed in order of importance, although some may have equal importance.

    a. Rebates should not be required based on experience that is not even partially credible.

    b. Combining states with varying degrees of rate regulation should be avoided.

    c. Methodologies that result in excessive administrative burdens should be avoided.

    d. Inequities among policyholders should be minimized.

    e. Situations in which there is no possibility of a rebate should be minimized.

    f. Situations in which rebates are delayed should be minimized.

    g. Inequities among carriers should be minimized.

2. To the extent the block is still not fully credible after applying the first approach on the list, the second approach will be applied and so on.

3. The hierarchy will be as follows:

    a. If 2011 experience is not fully credible, apply the credibility adjustment (see IRD014 for details) and pay any resulting rebate in 2012.

    b. If 2012 experience is not fully credible, combine 2011 and 2012 experience, apply the credibility adjustment (see IRD014 for details) based on the combined experience, and pay any resulting rebate in 2013.

    c. For experience years after 2012, the MLR will be based on a three-year average (see IRD069). If the three years of experience combined is not fully credible, but at least partially credible, and if (i) the medical loss ratio in at least one of the three years, before applying the credibility adjustment, was equal to or greater than the applicable standard, or (ii) at least one of the three years was not even partially credible, then apply the credibility adjustment (see IRD014 for details) based on the combined experience, and pay any resulting rebate. Otherwise, proceed to step (d).

    d. If the three years of experience combined is not fully credible, but is at least partially credible in each of the three years, and if the medical loss ratio in each of the three years, before applying the credibility adjustment, was below the applicable standard, then rebates must be paid based on the pooled three-year experience with no credibility adjustment. Rationale: If rates are at a level that would result in an MLR equal to the standard but for statistical fluctuations, then the MLR should meet or exceed the standard 50% of the time. In that situation, the probability that the MLR will be below the standard three years in a row is one in eight. Therefore the presumption is that if the MLR is below the standard three years in a row, it is because the rates reflect a lower MLR, whether intentionally or not.

    e. If the block is so small that it is still not even partially credible after three years, no rebate is payable.

Exceptions References:

8/25/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issues Resolution Document

IRD055

Issue:

In the years when the MLR is based on a three-year average, should any rebates be allocated to the other years that are included in the averaging period?

Subgroup Resolution:

Resolved - 8/25:

No, rebates should not be allocated to the other years included in the three-year averaging period.

Exceptions:

See IRD029 for treatment of business with less than 12 months of experience.

Description:

Beginning with calendar year 2014, the MLR is to be calculated based on the experience of the prior three-year period to the rebate calculation, meaning that the premiums, taxes, claims, and quality expenses for the current calendar year are averaged with those from the previous two calendar years to determine the MLR. If that MLR is below the appropriate rebate threshold, then rebates are due. Since three years of experience are included in the MLR percentage, should any rebates be allocated to those previous?

Documentation in support:

The calculation of the MLR is set forth in §2718(b)(1)(A), with the rebate calculation that applies the MLR specified in (B), and the use of 3-year experience based MLR specified in subsection (B)(ii):

(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than…

‘‘(B) REBATE AMOUNT.—

‘‘(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

‘‘(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

‘‘(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

‘‘(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

Documentation in opposition:

None.

Evaluation:

This issue is closely related to the issue discussed in IRD073, and the analysis proceeds along the same line of reasoning. The MLR is initially defined in Section 2718 (b)(1)(A), but is modified for rebate calculations after January 1, 2014 by Section 2718 (b)(1)(B)(ii). This modification relates only to the determination of the MLR to be used in the rebate calculation, and does not change the calculation of the rebate otherwise. Section 2718 (b) (1) (B) describes how the rebate is calculated. It says to use the excess of the percentage described in Section 2718 (b) (1) (A) (i), (85%) or Section 2718 (b) (1) (A) (ii), (80%), over the ratio calculated in 2718 (b) (1) (A), times the premium (adjusted) for the plan year. So 2718 (b) (1) (A), and 2718 (b) (1) (B) (ii) determine the experience MLR to be used, while 2718 (b) (1) (B) (i) describes how to calculate the rebate. Section 2718 (b) (1) (B) (ii) amends the rebate calculation described in (i) by requiring the use of the three-year MLR. The resulting rebate from the calculation, whether it uses the single-year MLR or the three-year MLR, is the result of applying the MLR to the experience of a single year. The three-year MLR is in effect a three-year moving average which smoothes annual experience variations and increases credibility by pooling experience. This smoothing effect is also transmitted to the rebates calculated using the three-year MLR. There is no more reason for an annual rebate calculated using a three-year MLR to be allocated to other years than there is for an annual rebate using the single-year MLR to be allocated.

Exception Reference:

W:\National Meetings\2010\Fall\tf\lha\ahwg\Rebate IRD\IRD055.doc

9/7/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD057

Issue:

Should an exception be made to the general framework established for aggregation in IRDs 002-004 for grandfathered plans such that grandfathered plans would be considered separate from non-grandfathered plans for the purposes of MLR rebate calculation?

Subgroup Resolution:

Resolved – 9/7:

No exception should be made to the general framework for aggregation established in IRDs 002-004 for grandfathered plans. Experience for grandfathered and non-grandfathered plans should be combined within each risk pool pre-2014 for purposes of the MLR rebate calculation.

Exceptions:

None.

Description:

2718(b) states that "a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage,…". It is silent with respect to considering grandfathered plans separately in the rebate calculation.

The general framework for aggregation for purposes of the MLR rebate calculation is set forth in IRDs 002-004.

IRD 002 states that for purposes of MLR calculations, each "statutory entity" (licensed carrier, such as insurer, HMO, or service corporation) should have a separate rebate calculation. Experience of affiliated carriers should not be combined for rebate calculation purposes.

IRD 003 states that aggregation is by state.

IRD 004 states that aggregation is by three pools (individual, small group, large group).

Documentation in support:

Documentation in opposition:

Evaluation:

IRD's 002 through 004 set forth a general framework for aggregation. IRD057 addresses whether or not an exception to that framework should be made for grandfathered vs. non-grandfathered plans.

The following is a excerpt from the AAA response to the HHS RFI on Section 2718 dated May 14, 2010:

"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 nonqualified plans are subject to the §2718 requirements. It would be helpful for the departments to clarify this point within rulemaking.)"

The AAA never directly addressed the issue of whether grandfathered vs non-grandfathered should be made an exception to the general aggregation framework; what they were saying is that if the NAIC decided on an aggregation framework that went below the market/state level, then using grandfathered vs non-grandfathered as one of the aggregation criteria becomes attractive.

IRDs 002 – 004 establish a general framework for aggregation for purposes of the MLR rebate calculation that requires aggregation at the statutory entity level, by state and by pool. Although there may be some differences in benefits for grandfathered plans, there does not appear to be any compelling reason to separate experience for grandfathered plans from non-grandfathered plans for purposes of the MLR calculation pre-2014. Further, requiring separate calculations for grandfathered vs non-grandfathered plans may create problems achieving credibility for both grandfathered plans and non-grandfathered plans. Thus, experience for grandfathered and non-grandfathered plans should be combined within each risk pool pre-2014 for purposes of the MLR rebate calculation to enhance credibility. Treatment of experience for grandfathered plans post-2014 will be addressed at a later time.

Exception Reference:

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8/18/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC.

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD061

Issue:

Should experience be accumulated over a longer period of years when necessary to achieve full credibility?

Subgroup Resolution:

Resolved – 8/18:

Experience should be accumulated over a longer period of years if it would not otherwise be fully credible.Additional years should be added one at a time until full credibility is achieved, except that no more than three years should be combined. While the accumulated experience should be used to determine the MLR, the excess, if any, of the MLR standard over the MLR should be multiplied by only the last year's premium to determine the rebate. (See IRD073.) Because all MLR determinations will be based on three years beginning with the 2011-2013 experience (see IRD069) and 2011 is the first year for which rebates are to be determined, this resolution will only apply to the 2012 calculation. If 2012 experience is not fully credible, experience for 2011 and 2012 will be combined for the 2012 calculation, regardless of whether 2011 experience was fully credible.

Exceptions:

None.

Description:

2718(b) references providing an annual rebate of premium in each plan year, but is silent on the treatment of aggregations that are less than fully credible:

2718*(b)(1) (A): "(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than--*

> *"(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or*
>
> *"(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State."*

Combining multiple years could be used to mitigate credibility issues.

However, 2718(c) requires the National Association of Insurance Commissioners to develop standardized methodologies which take into account special circumstances of smaller plans, different types of plans, and newer plans:

''2718 (c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

Documentation in support:

A May 12, 2010 letter from the American Academy of Actuaries addresses this subject:

"The new §2718(b)(1)(A) to the *Public Health Service Act*, as created by the *Patient Protection and Affordable Care Act* (PPACA), requires a health insurance issuer to provide an annual rebate under certain circumstances. While an insurer may report an MLR for a block of business that is below the applicable minimum MLR requirement, it is possible that the variance between the reported MLR and the required MLR represents

statistical fluctuation. It may not be good public policy to require the payment of rebates based on essentially random results beyond the insurer's control, which underscores the need for some method to maintain statistical validity in the rebate calculation process. This need becomes greater to the extent that rebate calculations are made at a more granular level. That is, statistical fluctuation is a more significant issue with state-level calculations than with national-level calculations—or with policy form-level calculations than with market-level calculations."

Documentation in opposition:

Evaluation:

Section 2718(c) specifies that methodologies should be developed for smaller plans, different types of plans, and newer plans, and we believe actuarial and statistical considerations require special treatment in the absence of full credibility. Without such treatment the MLRs and the Rebates calculated on experience that is not fully credible would be too variable and subject to random fluctuations to be used for any purposes. Combining multiple years is one method of increasing credibility.

For a company and state, experience for a given type of insurance is considered fully credible when the random, statistical variations in the annual Medical Loss Ratios are within a specified narrow range from year to year. This is achieved when a sufficient number of insureds are covered by a given type of insurance. Lesser numbers of insureds mean the experience is less credible, that is that the annual MLRs are subject to a wider range of random fluctuations from year to year. Therefore, as MLRs become more variable they become less reliable as a basis for rebate calculations. In order to use the calculated MLRs for Rebate calculation purposes it is necessary to (a) apply statistically based adjustments to reflect the variability of the MLRs so that Rebates can be reliably calculated, (b) pool (i.e., combine) experience with a larger block of policies, such as across states or across affiliated entities, (c) combine experience for a longer time period, or (d) some combination of the above. This document deals specifically with combining multiple years. Pooling of only large claims across states or entities is discussed in IRD020. Credibility adjustments are discussed in IRD014, IRD023, and IRD042. Combining all experience of multiple states is discussed in IRD062 Combining all experience of multiple entities is discussed in IRD067.

At some point the number of insureds is too small to produce MLRs that can be relied upon to any extent. The variability of MLRs from year to year is simply too great. In such a case the experience is not credible, and credibility adjustments are no longer effective. (See IRD044.)

Exceptions References:

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8/18/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC.

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD062

Issue:

Should experience of multiple states be combined when necessary to achieve full credibility?

Subgroup Resolution:

Resolved - 8/18:

Experience of multiple states should not be combined.

Exceptions:

Expatriate and international plans should be combined in a separate "national" MLR calculation as described in IRD035.

Description:

2718(b) references providing an annual rebate of premium in each plan year, but is silent on the treatment of aggregations that are less than fully credible:

2718*(b)(1) (A): "(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—*

> *"(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or*
>
> *"(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State."*

Combining states could be used to mitigate credibility issues.

However, 2718(c) requires the National Association of Insurance Commissioners to develop standardized methodologies which take into account special circumstances of smaller plans, different types of plans, and newer plans:

''2718 (c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

Documentation in support:

A July 16, 2010 letter from Trustmark addresses this subject:

> "We support the direction that the working group took … by removing the requirement to combine states. The removal of those requirements is necessary to ensure appropriate comparison to MLR standards given similarities in the underlying populations.
>
> "We feel it doesn't make sense to consolidate a state like Wyoming with a state like Massachusetts, where there are dramatic differences in the underlying cost of care, marketplace regulations, and types of products that are most often purchased."

A July 2, 2010 email from Brian Rees of Assurant focused on the difficulty of finding an appropriate way to combine states:

> "Similar with comments for IRD061, interstate pooling can improve credibility. However, it will require that all aspects involved in the MLR rebate level and rules be identical. This would mean that the states used for pooling would need to have identical transition rules for individual medical and levels of credibility over time. If a state is used for pooling in year 1 but due to amount of business, large enough to be fully credible in year 2, how will that state's experience be used if interyear pooling and interstate pooling is utilized as steps in credibility hierarchy? In addition, the products sold in various states may differ significantly and make aggregation across states more difficult, especially if interyear pooling is also used.
>
> "There also may be logistic challenges how the groupings of states are to be determined. Will the NAIC propose allowable groupings? Will it be up to the carriers to select the states to combine? It is for these reasons that use of interstate pooling is more challenging in application rather than it might appear in theory. It would be recommended that the use of interstate pooling is only used for situations where the states involved have identical or very similar rules and that the interyear pooling is no longer than 3 years."

The documentation cited in IRD003 is also relevant: "Example of argument for aggregating at a state level is taken from the letter of May 14, 2010, from Consumers Union, HHS reference HHS-OS-2010-001-0059.1.

> "…(W)e recommend reporting medical loss ratio at a level of aggregation that would allow consumers living in a particular state or other definable geographic region to determine how insurers are spending their premiums.
>
> "Aggregating this information at too high a level will present consumers with misleading averages of multiple, disparate markets.
>
> "Other considerations:
>
> • Insurers should also not be allowed to pool their experience across different states."

See also IRD003 .

Documentation in opposition:

Evaluation:

Section 2718(c) specifies that methodologies should be developed for smaller plans, different types of plans, and newer plans, and we believe actuarial and statistical considerations require special treatment in the absence of full credibility. Without such treatment the MLRs and the Rebates calculated on experience that is not fully credible would be too variable and subject to random fluctuations to be used for any purposes. Combining states is one method of increasing credibility.

For a company and state, experience for a given type of insurance is considered fully credible when the random, statistical variations in the annual Medical Loss Ratios are within a specified narrow range from year to year. This is achieved when a sufficient number of insureds are covered by a given type of insurance. Lesser numbers of insureds mean the experience is less credible, that is that the annual MLRs are subject to a wider range of random fluctuations from year to year. Therefore, as MLRs become more variable they become less reliable as a basis for rebate calculations. In order to use the calculated MLRs for Rebate calculation purposes it is necessary to (a) apply statistically based adjustments to reflect the variability of the MLRs so that Rebates can be reliably calculated, (b) pool (i.e., combine) experience with a larger block of policies, such as across states or across affiliated entities, (c) combine experience for a longer time period, or (d) some combination of the above. This document deals specifically with combining all experience of multiple states. Pooling of only large claims across

states or entities is discussed in IRD020. Credibility adjustments are discussed in IRD014, IRD023, and IRD042. Combining all experience of multiple entities is discussed in IRD067. Combining multiple years is discussed in IRD061)

After careful consideration, it was determined that it would not be appropriate to combine experience of multiple states. While combining the experience of states with similar characteristics (such reasonably similar rating approaches and regulatory environment) would be an effective way to increase credibility of states that are not fully credible by themselves, we could not develop objective standards for determining whether states have similar characteristics. For example, even when two states have the same MLR standard and have rating laws and regulations that appear similar, they be interpreted differently, resulting in the same rate filing being approved in one state and not in another. Also, while not generally stated in rate filings, variations in the competitive environment may affect the degree to which conservative or optimistic assumptions are used. Therefore, while combining states will improve credibility, the allocation of the rebated by state may be inequitable. A secondary reason not to combine states is that it would be difficult to address situations in which experience is for a multi-year period and the MLR standard in one or more states changed during the period.

Exceptions References:

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9/7/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD063

Issue:

Should the same premium be used for calculating the ratios in Section 2718(a) and for calculating the medical loss ratio for rebates in Section 2718(b)?

Subgroup Resolution:

Resolved – 9/7:

Yes, the same premium should be used for calculating the ratios in Section 2718(a) and for calculating the medical loss ratio for rebates in Section 2718(b.

Exceptions:

None identified.

Description:

The ratios in Section 2718 (a) and Section 2718 (b) should be identical

Section 2718(a) of the PPACA requires health insurance issuers to send to the Secretary of HHS an annual report concerning the ratio of incurred claims plus change in contract reserves to earned premiums. The report must include the percentage of total premium revenue expended in three categories:

a1 = clinical services,

a2=quality improvement activities, and

a3=all other non-claims costs.

These percentages are to be calculated after accounting for risk adjustment, risk corridors, and payments of reinsurance, presumably as established under Sections 1341, 1342, and 1343 of the PPACA. The third item, all other non-claims costs, does not include federal and state taxes and licensing or regulatory fees.

Here is an example of how this report might look for a company reporting for the year 2011, before the federal risk adjustment, risk corridors, and reinsurance come into effect:

Incurred claims (not including contract reserves)	$ 74,000,000
Activities that improve health quality	$ 1,000,000
Change in contract reserves	$ 2,000,000
Earned premiums	$100,000,000
Taxes and fees	$ 500,000

For ratio a1, the dollar amount for clinical services is $74 million plus $2 million, or $76 million. The ratio is 76 million divided by (100 million minus 0.5 million), or 0.7638.

For ratio a2, the dollar amount for quality improvement is $1 million. The ratio is 1 million divided by (100 million minus 0.5 million), or 0.0101.

For ratio a3, the dollar amount for all other non-claims costs is the rest of the premium not counted in a1 or a2, specifically excluding taxes and fees, which is (100 million minus 0.5 million 76 million minus 1 million) or $22.5 million. The ratio is 22.5 million divided by (100 million minus 0.5 million), or 0.2261.

The rebate required by section 2718 (b) would be calculated using the sum of the two ratios a1 and a2, which total 0.7739. The rebate would be calculated as 80.00% minus 77.39%, or 2.61% of premiums excluding taxes and fees. The total rebate dollar amount would be 2.61% of $99.5 million, or $2,596,950.

The key question in deciding whether to use the above method of calculating the ratios and the rebate amount is whether taxes and fees should be subtracted from the premiums above in calculating these ratios. The answer is yes, for four reasons.

First, the denominator of the Medical Loss Ratio calculated in section 2718 (b) has taxes and fees specifically removed. There is no discernable reason to have the denominators of the ratios differ, and a difference would require endless explanations of the difference and the explanation that there is no reason for it, "it's just different."

Second, taxes and fees are explicitly excluded from the numerator for ratio a3, and therefore not excluding them from the denominator gives a result that is unnecessarily distorted by changes in the amount of taxes and fees from year to year. In the above example, if taxes and fees are 5.0% of premium instead of 0.5%, the ratio a3 becomes .2368, which looks like a 5% increase in expenses, even though the expenses are unchanged. To avoid this distortion, financial analysts look at pre-tax underwriting income to understand the company's business results without including investment income and taxes.

Third, the three ratios should add to 100%, which only occurs if taxes and fees are removed from earned premiums, since they are removed from the "all other non-claims costs."

Fourth, sound principles of financial reporting require the information to be subject to audit, and that requires the report to the Secretary to contain detailed information about how the ratio is calculated. Therefore requiring the denominators of the ratios to be calculated the same way does not result in losing any information, since the total taxes and fees are reported separately, along with the detailed breakdown and description of all elements of the calculation.

Documentation in support:

From the May 14, 2010 response by the American Academy of Actuaries to the HHS Request for information:

"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)."

"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."

"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."

Documentation in opposition:

From the May 14, 2010 response by the American Academy of Actuaries to the HHS Request for information:

"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."

Evaluation:

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8/25/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD067

Issue:

Should experience of licensed entities within a holding company system be combined when necessary to achieve full credibility?

Subgroup Resolution:

Resolved - 8/25:

Experience of licensed entities within a holding company system should not be combined for the purpose of increasing credibility.

Exceptions:

Large claims should be pooled as described in IRD020.

Description:

2718(b) references providing an annual rebate of premium in each plan year, but is silent on the treatment of aggregations that are less than fully credible:

2718*(b)(1) (A): "(A) REQUIREMENT- Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—*

> *"(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or*
>
> *"(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State."*

Combining affiliated entities could be used to mitigate credibility issues.

However, 2718(c) requires the National Association of Insurance Commissioners to develop standardized methodologies which take into account special circumstances of smaller plans, different types of plans, and newer plans:

''2718 (c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

Documentation in support:

See IRD002.

Documentation in opposition:

Evaluation:

Section 2718(c) specifies that methodologies should be developed for smaller plans, different types of plans, and newer plans, and we believe actuarial and statistical considerations require special treatment in the absence of full credibility. Without such treatment the MLRs and the Rebates calculated on experience that is not fully credible would be too variable and subject to random fluctuations to be used for any purposes. Combining affiliated entities is one method of increasing credibility.

For a company and state, experience for a given type of insurance is considered fully credible when the random, statistical variations in the annual Medical Loss Ratios are within a specified narrow range from year to year. This is achieved when a sufficient number of insureds are covered by a given type of insurance. Lesser numbers of insureds mean the experience is less credible, that is that the annual MLRs are subject to a wider range of random fluctuations from year to year. Therefore, as MLRs become more variable they become less reliable as a basis for rebate calculations. In order to use the calculated MLRs for Rebate calculation purposes it is necessary to (a) apply statistically based adjustments to reflect the variability of the MLRs so that Rebates can be reliably calculated, (b) pool (i.e., combine) experience with a larger block of policies, such as across states or across affiliated entities, (c) combine experience for a longer time period, or (d) some combination of the above. This document deals specifically with combining all experience of multiple entities. Pooling of only large claims across states or entities is discussed in IRD020. Credibility adjustments are discussed in IRD014, IRD023, and IRD042. Combining all experience of multiple states is discussed in IRD062. Combining multiple years is discussed in IRD061)

After careful consideration, it was determined that it would not be appropriate to combine experience of licensed entities within a holding company system. While combining the experience of affiliated entities with similar characteristics (such reasonably similar rating approaches) would be an effective way to increase credibility of entities that are not fully credible by themselves, we could not develop objective standards for determining whether entities have similar characteristics.

Exceptions References:

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9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD069

Issue:

Which plan years' experience should be used for the three-year averaging used to calculate the rebate in plan year 2014?

Subgroup Resolution:

Resolved 8/2:

Experience from plan years 2011, 2012 & 2013 should be averaged for the calculation to be performed in 2014 for rebates payable in 2014.

Exceptions:

None identified.

Description:

2718(b) (1) (b) (ii) states that "*Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.*". There is ambiguity in which 3 years are intended to be averaged.

Documentation in support:

Evaluation:

A parallel can be made with the implementation of rebates in 2011. We are using the experience year 2011 for the first series of rebates being paid in 2012. Consistency indicates the three year averaging could begin with plan year 2014, with calculations performed in 2015.

Counter to this position is the value of obtaining as much credibility as possible, as soon as possible. We will have three years of experience to average, 2011, 2012, 2013, for a calculation performed in 2014. Companies will have less variability in their experience and consumers will see smaller credibility adjustments reducing their rebates if we are able to use 3 years of experience for the 2014 calculation. We believe Congress said 2014 intending to do it as soon as possible.

The language of the law can be parsed to support this approach. "*Beginning on January 1, 2014" can mean for all calculations performed after January 1, 2014. "The determination made" can mean the calculation rather than the distribution. "For the year involved" does not have to be 2014, the "year involved" can be 2013. Thus we have calculations for the rebates due for 2013, made in 2014, shall be based upon three years of experience.*

Exception Reference:

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9/13/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD072

Issue:

Should group conversion charges be included in the experience for group lines of business (both small and large) by adding such charges to the incurred claims for the group lines of business?

Subgroup Resolution:

Resolved – 9/13:

Group conversion charges should be included in the experience of the group (small and large) lines of business when the Medical Loss Ratio is calculated. The group conversion charge is to be added to the incurred claims for the relevant line(s) of group business, and subtracted from the incurred claims for group conversion business.

Exceptions:

None identified.

Description:

There are two approaches to how conversion business experience is accounted for by companies. Companies which have individual lines of business treat conversion policies as part of the individual health insurance line of business. Companies without individual business issue group certificates to cover conversion policies. Because experience for group conversion policies is likely to result in very high loss ratios, companies which include group conversion policies in their individual health insurance business sometimes then a charge to the group (small or large) line of business which is added to earned premium for the individual health line of business.

The issue is whether such charges should be in some way included with the experience for the group lines of business, either by adding such charges to the incurred claims for group business (small or large) or subtracting them from earned premiums.

Documentation in support:

In a memorandum dated July 12, 2010, Bill Weller representing AHIP made the following points:

IRD-004 recognized that in the normal situation there are three separate markets (Individual, Small Group and Large Group). Many companies, however, have internal line of business charges when there is a group conversion. Other companies use group certificates for conversions. Neither of these should be prohibited as a reasonable way for the company to meet its obligations under group conversion requirements. Neither, however, appears to be addressed in the issues list for IRDs.

Companies that issue individual policies to meet group conversion requirements frequently apply a conversion charge to their group line and credit that charge to their individual line, as the individual line is likely to have adverse experience from these policies. In fact, many companies find it necessary to establish a premium deficiency reserve because the premiums for group conversion policies are generally designed to be inadequate by themselves. We believe that the group premiums will (and should) reflect the anticipated conversions (for non-experience rated business) or actual conversion charges (for experience rated business). However, if the IRDs do not establish that these charges should be included as either a reduction to premiums or included as claims, the group line may pay an unjustified rebate. In addition, the individual line will have higher than appropriate premiums since that line alone would be charged with the conversion experience.

Where a company does not use individual policies along with a group conversion charge, it is appropriate to include the group conversion experience within the two group lines and not have it as part of the individual line. This is most obvious where a company does not market individual policies and the only in-force business is the conversion business.

Evaluation:

Allowing companies to add group conversion charges to the incurred claims for small and large group business will lead to a more uniform treatment of group conversion policy experience across companies. Companies that do not have individual lines of business obviously must include group conversion experience in with the experience for their group lines of business. When companies that include group conversion business in their individual health business assess a group conversion charge on their group lines of business and add such charge to group incurred claims they move closer to treating conversion business in the same way as companies that keep conversion business within their group lines of business. This is in turn would lead to greater similarity and comparability in how group conversion experience would be treated across all companies in the calculation MLRs and rebates.

Exception Reference:

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9/22/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD073

Issue:

In calculating the annual rebate, should the excess of the MLR based on three-year averaging over the relevant benchmark be applied to the plan year premium from the third year, or should it be applied to all three years of premium used in the average?

Subgroup Resolution:

Resolved - 8/9:

The ratio developed from MLR benchmark excess over the three-year averaging shall be applied to the plan year premium from the third year. (This is consistent with IRD071, which states that rebates should be payable only to policyholders present during the third year of the three-year MLR calculation period.)

Exceptions:

When the three-year MLR is less than the relevant benchmark loss ratio requirement, no rebate is calculated.

Description:

Section 2718(b)(1)(B)(ii) calls for using averages of premiums and costs for the prior three years in determining the MLR that is to be compared to the applicable MLR minimum instead of the year by year ratios developed in 2718 (b) (1) (A). Section 2718(b)(1)(B)(i) refers to the product of the plan year premium and the difference between the MLR minimum and the three-year average calculation.

Documentation in support:

Evaluation:

The following outline of the provisions of section 2718 (b) (1) clarifies the relationship between the sections describing the ratios being calculated and the rebate being calculated. Generally, the ratio is defined in section (A), but has a parenthetical exception referencing 2718 (b) (1) (B) (ii). This exception relates only to the determination of the ratio to be used in the rebate calculation, it does not change the calculation of the rebate otherwise. Section 2718 (b) (1) (B) describes how the rebate is calculated. It says to use the excess of the percentage described in Section 2718 (b) (1) (A) (i), (85%) or Section 2718 (b) (1) (A) (ii), (80%), over the ratio calculated in 2718 (b) (1) (A), times the premium (adjusted) for the plan year. So 2718 (b) (1) (A), and 2718 (b) (1) (B) (ii) determine the experience MLR to be used, while 2718 (b) (1) (B) (i) describes how to calculate the rebate. Section 2718 (b) (1) (B) (ii) amends the rebate calculation described in (i) by requiring the use of the three-year MLR. Thus, it is clear that the excess of the three-year MLR over the relevant benchmark should be applied only to the third year premium.

Exception Reference:

9/13/10

This is a DRAFT and is Exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD076

Issue:

Sometimes, an employer may purchase coverage with in and out of network benefits by purchasing an in-network contract from an HMO and a contract which provides the out-of-network coverage that supplements the in-network contract from a non-HMO. (This arrangement may be called "dual contracting". It should not be confused with the much more common situation where an employer purchases both an HMO contract which provides in-network coverage only from an HMO and a PPO or POS contract providing both in and out of network coverage, and gives employees the option of choosing one or the other form of coverage, possibly with a difference in employee contribution. The latter situation can be called "dual option" to avoid confusion, and is the subject of IRD077)

Subgroup Resolution:

Final resolution – 9/13:

If the HMO and the non-HMO issuing the two contracts are affiliated, then, for purposes of the rebate calculation, the non-HMO premiums and claims should be included with the premiums and claims of the HMO. Any issuer choosing to combine experience in this manner must use this methodology in their rebate calculations for a minimum of three plan years.

Exceptions:

None identified.

Description:

Documentation in support:

Evaluation:

The first question is why would a carrier or an employer choose a cumbersome situation like dual contracting, when it is easy to offer coverage in and out of network with a single contract.? It must be accepted that there are, or could be, legitimate economic or regulatory constraints that give rise to dual contracting, and it is not really a solution to say that dual contracting should not permitted.

If a dual contract imitates a single contract, no real damage is done to the general principle (calculating by statutory entity) if the premiums and claims of the components are combined within a single carrier, the HMO that that is providing the core coverage and that generally receives the majority of the premium. Note that this may not result in combining the entire financial results of the HMO and the non-HMO for rebate calculation purposes if the non-HMO issues some single contract coverage as well. So, this is more a question of reclassifying premiums and claims from one carrier to the other, rather than a combination of carriers.

There are several secondary advantages, as well. Since it is likely that most coverage of this type is offered by single, rather than dual, contracts, the combination leads to consistent treatment. Furthermore, it may be possible (depending on the extent to which rates are reviewed) for affiliated carriers to manipulate loss ratios by how the premium is allocated between the coverages, and hence between the HMO and the non-HMO, if the experience is placed in different carriers for calculation purposes.

Exception Reference:

9/20/10

This is a DRAFT and is exposed for Comment – It Does Not Represent the Position of the NAIC

A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD077

Issue:

An employer may purchase two or more plans of coverage from two or more affiliated carriers, but typically it purchases an HMO product from an HMO and a more flexible product from a non-HMO. Employees are given the option of coverage either plan (hence the term "dual option"), although the employer may require different employee contributions. The rates paid by the employer are blended rates. For example, while the rates may vary based on benefit differences, the rates do not reflect the selection between the HMO and non-HMO products. The issue is how to determine the premium and claims allocated to each carrier when there is not a contractual premium reallocation agreement in place and reflected in the Statutory statements.

Subgroup Resolution:

Resolved – 9/13:

A pre-defined adjustment similar to that which is available to multi-state groups in IRD028 may be made to the numerator. The adjustment by group shall result in each legal entity having the same loss ratio for the group. An adjustment will be calculated and applied to the experience of each dual option group. Any issuer choosing to make such an adjustment must use this methodology in their rebate calculations for a minimum of three plan years.

Exceptions:

None identified.

Description:

Documentation in support:

Evaluation:

Using a pre-defined approach that is similar to that used for multi-state groups in IRD028 will produce the same loss ratio for all parts of the group's experience without allowing for gaming by the company.

Exception Reference:

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9/20/10

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A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD078

Issue:

The minimum MLR can deviate from that stipulated in PPACA in the case of the Secretary of HHS allowing a lower minimum MLR to avoid market disruption or a state imposing a higher minimum MLR. These possible deviations can result in differing MLR standards within a three-year averaging period. If the minimum MLR does vary, what MLR should be used as the minimum for the rebate calculation in the third year?

Subgroup Resolution:

Resolved – 9/20:

In cases where the minimum MLR is not constant over any three-year averaging period, the average of the minimum MLRs, weighted by the issuer's adjusted earned premium (earned premium less applicable taxes and fees) in each year, shall be used as that issuer's minimum MLR for the rebate calculation.

Exceptions:

None

Description:

Documentation in support:

Evaluation:

Since PPACA allows the use of alternative Minimum Loss Ratios which deviate from the minimum MLRs specified in PPACA, it is very likely that such a deviation (or deviations) will result in one or more three-year periods when the minimum MLR varies during that period. PPACA requires that the average experience for a three-year period be used to compute the actual loss ratio which will be used in the rebate calculation for the third year of the three-year period. The loss ratio for such a three-year period will be heavily influenced by the minimum loss ratios that were applicable during that time period. Therefore, the minimum MLR used in the rebate calculation for the third year must reflect any variations in such minimum MLRs. The best method for developing the minimum three-year MLR in such a situation is to calculate a weighted average of the minimum MLRs that applied to each year of the three-year calculation period. The weight assigned to each minimum MLR is the adjusted earned premiums for each of the three years, divided by their sum.

Exception Reference:

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