



AMERICAN ACADEMY *of* ACTUARIES

June 7, 2010

To: Steven Ostlund
Chair, PPACA Actuarial Subgroup, Accident & Health Working Group
National Association of Insurance Commissioners

From: Rowen Bell
Chair, Medical Loss Ratio Regulation Work Group
American Academy of Actuaries

Re: Contract Reserves and the Individual Market

Dear Steve:

In our April 28 letter¹ to the NAIC, the American Academy of Actuaries'² Medical Loss Ratio Regulation Work Group highlighted a number of concerns about the application of medical loss ratio (MLR) and rebate provisions to the individual medical market as required by Sec. 2718 of the Public Health Service Act (PHSA). We elaborated on those concerns, and provided some preliminary ideas on how to mitigate them, in pages 10-15 of our May 14 letter³ to the Department of Health and Human Services, in response to the department's request for comments on Sec. 2718.

Our purpose in writing today is to provide input on the inclusion of a component representing a change in contract reserves as part of the numerator of the MLR calculation used to determine rebates in the individual market.⁴

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

¹ American Academy of Actuaries letter to the NAIC (April 28, 2010) on potential individual market disruption—http://www.actuary.org/pdf/health/letter_academy_mlr_individual_market.pdf.

² The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

³ American Academy of Actuaries letter to the Department of Health and Human Services in response to its request for comments on Sec. 2718—http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf

⁴ For purposes of this letter, we are using “contract reserves” the same way the term is used within the NAIC Health Insurance Reserves Model Regulation and within Appendix A-010 of the NAIC Accounting Practices & Procedures Manual (i.e., to describe a reserve reflecting a mismatch across different policy years between premiums and benefits). We are not addressing in this letter other types of reserves that are sometimes aggregated with contract reserves within NAIC financial reporting (e.g., premium deficiency reserves).

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.

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.***⁵

The contract reserve calculation used for rebate MLR purposes would employ a net level premium (as opposed to a full preliminary term) methodology. Key assumptions in this contract reserve calculation would include assumptions implicit in the company's rate filing, most notably the durational MLR pattern and policyholder persistency. Multiple approaches to implementing this new contract reserve calculation are feasible. Perhaps the most natural approach would be to allow companies to use their own assumptions, subject to actuarial certification. Another approach would be for regulators to specify the assumptions that all companies would use, even though those assumptions might not accurately reflect a particular company's own experience; however, this approach could have some undesirable consequences relating to the timing of the rebate payment.

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.

⁵ Note that there is precedent within federal health insurance regulation for a "federal contract reserve" calculation that does not necessarily tie to statutory financial reporting. (See CFR Title 42 Sec. 403.253(b)(2)(ii) with respect to federal Medicare Supplement loss ratio certifications.)

- Suppose that the rebate MLR calculation was defined to include the change in statutory-basis contract reserves, and statutory reserve standards were changed in order to mandate that companies establish contract reserves reflecting durational MLR variation. If the change only affects newly issued policies, then issues relating to existing blocks of business remain unaddressed, while the solvency strain associated with establishing reserves on new business could discourage companies from actively marketing new policies. However, making the change retroactively would involve establishing reserves that are not needed for solvency purposes and were not contemplated in pricing. As such, this would risk creating significant solvency concerns for certain companies, which could influence some companies to exit the individual market.

An alternative approach to reflecting durational MLR variation within the rebate MLR calculation would be to base the rebate calculation on an actual-to-expected (A-to-E) comparison of loss ratios, without a change in the contract reserves component. This approach has precedent in state-level rebate MLR calculations (e.g., Kentucky). However, recognizing that it may be more difficult to interpret Sec. 2718 in a manner that permits the use of this approach, we have focused this letter on the contract reserve approach.

Note that the issues described in this letter are primarily relevant to policies issued prior to the introduction of PPACA insurance market reforms in 2014. It is unclear at this time to what extent these concepts will be relevant to policies issued in 2014 and beyond.

The remainder of this letter provides supporting background and development of these ideas, organized into the following sections:

- Why individual claim costs vary by duration;
- Why individual loss ratios vary by duration;
- Calendar-year loss ratios and rebates;
- Contract reserves and current statutory-accounting practices;
- Creating contract reserves specifically for rebate-calculation purposes;
- Other alternatives.

Given time constraints, we did not provide any numerical examples. Please let us know if you are interested in seeing examples of the concepts discussed herein.

Why Individual Claim Costs Vary by Duration

Policies historically issued in the individual market, as well those that will be issued prior to 2014, generally make use of underwriting. Prior to the issuance of a policy, prospective policyholders are required to provide information about their existing medical conditions to the company. Based on the information provided, the company may decide not to issue a policy or may decide to issue a policy but at a higher rate. Also, after a policy is issued, a company may become aware that material information on existing medical conditions was not disclosed at the time of issuance. This could lead to a denial of claims associated with those conditions under the contract's provision excluding pre-existing conditions. This provision and underwriting represent two essential risk management practices in the current regulatory environment. The objective of

both of these practices is the same—that the company only cover expenses associated with medical conditions that manifest themselves after a policy is issued, except to the extent that the company deliberately assumes the risk of covering expenses associated with existing medical conditions. While these risk management practices will change dramatically on policies issued in 2014 and later, due to the PPACA insurance market reforms, they remain relevant for individual policies issued prior to 2014.

As a result of these processes, expected claims for an individual policy typically increase as the policy duration increases and new illnesses or accidents covered by the policy but not present at the time of issuance occur. This phenomenon is often referred to as the “wear off” of underwriting. Another phenomenon also leads to an increase in claim costs by duration, namely “cumulative antiselection.” This refers to the observation that insured individuals whose health status is good are more likely to lapse their policies than insured individuals whose health status is poor. As a result, the aggregate risk profile across a block of individual policies worsens as the policy duration increases.⁶ These increases in claim costs by policy duration are above and beyond increases due to other factors, such as medical trend and policyholder aging.

In 2006, the Society of Actuaries (SOA) published a study,⁷ *Variation by Duration in Individual Health Medical Insurance Claims*. The table below is excerpted from Table III-1 of that study, and reflects the aggregate experience of five of the seven companies that contributed data.⁸ This table illustrates how claims increase with policy duration.⁹ The value shown represents the ratio of claim costs in a given policy duration to the claims costs in the second policy duration. For example, claims in year 4 are about 20 percent greater than claims in year 2, all else being equal.

Durational Year	Durational Factor
1	0.812
2	1.000
3	1.054
4	1.198
5	1.282
6	1.293
7+	1.465

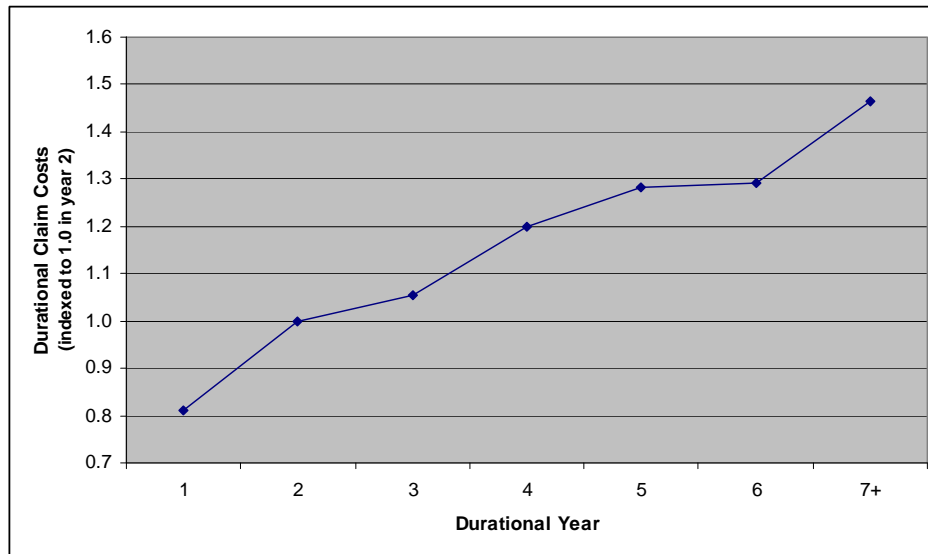
⁶ From the 2007 book *Individual Health Insurance* by William F. Bluhm: “High risk individuals are (1) less likely to be able to find coverage elsewhere, (2) less likely to be willing to become uninsured, and (3) emotionally less willing to change their current insurance situation.” (page 101) Under the PPACA insurance market reforms effective in 2014, these sources of cumulative antiselection may be diminished.

⁷ Wachenheim, Leigh. *Variation by Duration in Individual Health Medical Insurance Claims*. Society of Actuaries: October 2006. http://www.soa.org/files/pdf/IH%20Durational%20Study_Final%201006.pdf

⁸ The SOA study notes that the other two companies that contributed data exhibited durational claim costs very different than those of the five companies whose aggregate experience is shown in the table. More generally, the SOA study observes that durational claim costs appear to vary across companies for a variety of reasons, including differences in underwriting, pricing, and brokerage-compensation practices.

⁹ Although the table presents data by durational year, there is often noticeable variation in claim costs by durational month, particularly during the first three years; see Appendix B of the 2006 SOA study.

Actuaries will often speak about the “durational claims cost curve,” converting the table of values shown above to a graph, as follows:



However, any particular company’s durational claims cost curve could vary materially from the curve depicted above. A variety of factors can influence the slope of a company’s durational claims cost curve, including, but not limited to, the company’s pricing strategy, a subject discussed in the next section.

Why Individual Loss Ratios Vary by Duration

In the previous section, durational variation in claim costs was examined, as opposed to durational variation in loss ratios. To understand how the durational variation in claim costs leads to durational variation in loss ratios, it is necessary to discuss different pricing approaches that exist in the individual market.

This raises the question: If claim costs are expected to increase each year, based not only on trend and aging but also due to a durational effect, then why not simply set prices each year to closely match the expected pattern of claim costs?

There are a number of interrelated reasons why individual market pricing does not generally follow that approach. Companies must find a delicate balance in what can be a negative feedback loop. If a company started with a low premium commensurate with the lower expected claims cost in the first duration, the required rate increase at renewal would be higher than the rate increase required by another company whose initial premium rates were higher. The higher the rate increase, the more likely any given customer will look for coverage elsewhere. Customers whose health status is still good will be more likely to switch to a better deal than those whose health status has deteriorated, making it more difficult to obtain coverage elsewhere. As such, a company that starts with lower premiums but reflects the wear off of underwriting via higher annual rate increases may find it more difficult to manage its cumulative antiselection risk. Considerations arising from policy distribution also enter into the equation. Most companies

market individual policies via brokers, and most brokerage arrangements offer higher commissions for first-year policies than for renewal policies. This recognizes the broker’s efforts in finding the customer and assisting him or her with the application process. However, it also creates incentives for brokers to move their healthy customers from company to company, helping those customers take advantage of new business rates that may be lower than renewal rates.

Over time, different companies have adopted different pricing strategies in the individual market. One of the most important distinguishing characteristics of a company’s pricing strategy is the degree to which it tries to minimize the difference between new business and renewal rates for otherwise identical policyholders.

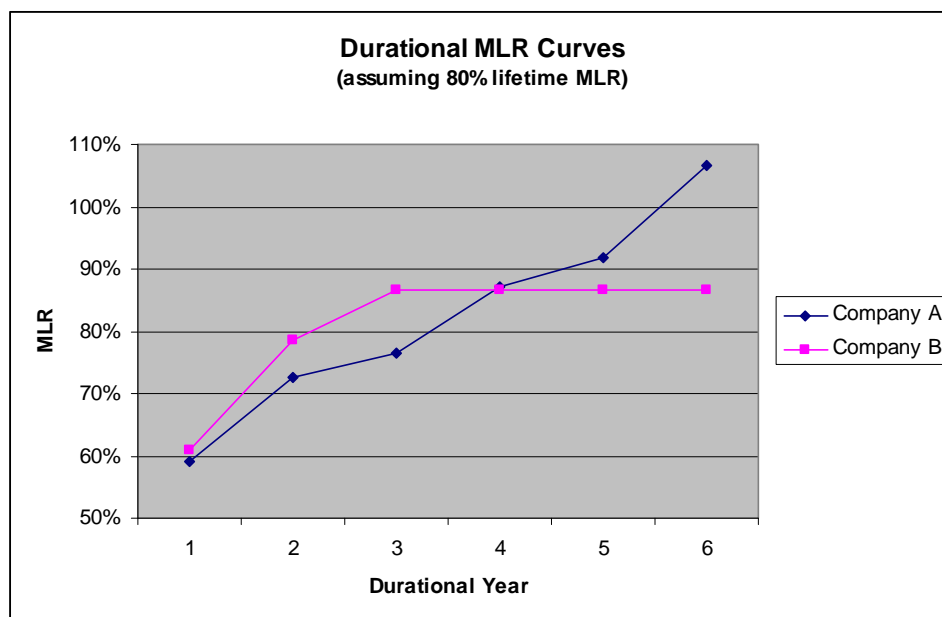
Some companies consciously strive to minimize the difference between new business and renewal rates. These companies will typically see significant durational variation in MLR, consistent with the durational variation in claim costs. Other companies try to flatten the durational MLR ratio curve by charging lower rates for new business and imposing larger rate increases subsequently; this is sometimes called “durationally tiered pricing.” Of course, dividing companies into two categories is an oversimplification. In reality, the differences between companies’ pricing strategies are less absolute and more a question of degree.

Companies that strive to keep renewal rates close to new business rates will tend to have higher new business rates, lower renewal rate increases, and lower lapse rates than companies employing durationally tiered pricing strategies. Assuming similar cost structures, both types of companies would be trying to achieve similar target lifetime loss ratios. However, the expected loss ratios for each policy duration would be very different across company types.

The table below illustrates potential durational MLR curves for two hypothetical companies that are pricing to achieve an 80 percent lifetime loss ratio, but applying different pricing strategies as discussed above. (Of course, business currently in force may have been originally priced to achieve a lifetime loss ratio lower than 80 percent.) Company A is assumed to exhibit durational variance in both claim costs and loss ratios that is consistent with the table shown in the previous section; Company B is assumed to exhibit less durational variance in its loss ratios due to its pricing methodology.

Durational Year	Company A	Company B
1	59.0%	60.9%
2	72.7%	78.6%
3	76.6%	86.5%
4	87.1%	86.5%
5	91.7%	86.5%
6	106.5%	86.5%

Again, it is common to graph these values and refer to the “durational MLR curve,” as follows:



Calendar-Year Loss Ratios and Rebates

In the previous section, variance in individual market medical loss ratios by policy duration was addressed. At any given time, a particular company's block of individual business consists of a mix of policies at different durations. Consequently, in light of durational MLR variation, the company's expected MLR in any given calendar year will depend not only on the lifetime MLR used in its pricing, but also on the company's mix of business by policy duration.

Consider Company A from the previous section, with business priced to a lifetime MLR of 80 percent but significant durational MLR variation. If the company's book of individual business is relatively mature and stable, then its expected MLR in the current calendar year is likely to be fairly close to 80 percent. On the other hand, if the company's book of individual business is fairly new, or has seen substantial growth in recent years, then its expected MLR in the current year is likely to be substantially less than 80 percent, since the book of business is more heavily weighted towards newer policies that are expected to have a lower MLR in the current year.

This phenomenon becomes potentially problematic once a rebate requirement, based on a calendar-year MLR target, is imposed. Unless some form of adjustment is made within the rebate calculation to reflect durational issues, the amount of rebates payable to a company's individual policyholders in a given year will be highly dependent on the company's mix of business by duration. Furthermore, this may be an undesirable state of affairs from the standpoint of market competition.

As an extreme example, suppose that Company A has just entered the individual market with a product priced to a lifetime MLR of 80 percent, so that rebate requirements first apply to the company's entire book of individual business in duration 1. If the rebate calculation is based strictly on an 80 percent calendar-year MLR without any incorporation of durational variation,

then the company would need to refund substantial amounts of money in early years. According to the table above, the company's expected MLR would be 59 percent in the first year, somewhere between 59 percent and 73 percent in the second year depending on the mix of sales by year, etc. Over time, the company's mix of business would change, and the average duration might increase to the point at which the calendar-year MLR reaches 80 percent and further rebates would not be required. Perhaps, given even more time, the company's average duration would increase further to the point at which the calendar-year MLR exceeds 80 percent. In that case, the company could seek to implement additional rate increases to bring the MLR down to 80 percent. Of course, such additional rate increases (if granted by regulators) might exacerbate concerns about cumulative antiselection. We note that these higher rate increases given to policyholders remaining in the later durations—who generally are less healthy than average—would in essence be “post-funding” the rebates paid to policyholders in the early durations—many of whom were healthier than average and subsequently lapsed. This appears contrary to the usual purpose of risk pooling.

In summary, the expected lifetime MLR on a net-of-rebate basis in this “new market entrant” example could be in excess of the gross lifetime pricing MLR of 80 percent, and it could decrease to 80 percent only to the extent that persisting policyholders receive higher rate increases in later years to post-fund the rebates given in earlier years. By contrast, if Company A had a mature book of individual business priced to a lifetime MLR of 80 percent, then we would find that the expected calendar-year MLR in each year is much closer to 80 percent. Hence, the expected lifetime MLR on a net-of-rebate basis is much closer to 80 percent. Among other things, this suggests that applying a calendar-year MLR rebate calculation to blocks of individual business without some form of adjustment for durational MLR variation may place newer companies at a significant disadvantage and may discourage companies from entering new individual markets in years prior to 2014.

Contract Reserves and Current Statutory Accounting Practices

As discussed above, variation in claim costs ultimately leads to differences between the calendar-year MLR for a block of individual business and the lifetime MLR at which that block was priced, and as a consequence imposing rebates based on a calendar-year MLR may lead to competitive inequities.

Theoretically, this problem can be mitigated by considering contract reserves within the rebate MLR calculation. The durational MLR curve discussed above reflects that, when the durational claim cost curve is combined with the company's pricing strategy, some portion of each individual policyholder's future benefit costs is effectively being funded out of past premiums rather than fully through future premiums. A contract reserve is the usual vehicle used to reflect this mismatch between future benefits and future premiums.

However, the situation here is complicated by the fact that, under current statutory accounting guidance, there is no requirement for companies to hold a contract reserve for individual medical business on account of variation in durational loss ratios. Some companies establish a contract reserve for this purpose, but most do not. As such, including the change in statutory-basis contract reserves in the rebate MLR calculation would not adequately resolve the situation.

The reasons why most companies do not currently hold statutory-basis contract reserves to reflect durational variation in loss ratios are complex, but there are three main factors:

1. Current guidance on contract reserves for health insurance, in paragraphs 33.a.ii and 33.a.iii of Appendix A-010 of the NAIC Accounting Practices and Procedures Manual, states:¹⁰

“Contract reserves are required...for...individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. This evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary should state in the certification that premiums for the rating block were developed such that each year’s premium was intended to cover that year’s costs without any prefunding. ... If rates are determined such that each year’s premium is intended to cover that year’s cost, the rating block approach results in no contract reserves....”

In other words, the guidance allows the company to record zero contract reserves for a block of individual business if, aggregated across the block as a whole, the current year’s premiums are designed to cover the current year’s claims. This is the case even though, at the policy level rather than the block level, some portion of the current year’s premiums are intended to prefund elevated levels of claims in later policy durations (attributable to the wear-off of underwriting and cumulative antiselection).

2. Paragraph 34.b.i of Appendix A-010 indicates that minimum statutory contract reserves for individual medical insurance are to be calculated using a two-year full preliminary term (2-yr FPT) methodology, in which the reserve balance is zero during the first two policy years. The use of 2-yr FPT, rather than a net level premium methodology as in GAAP, is motivated in part by the fact that individual policies tend to have high acquisition costs (underwriting costs, plus the excess of first-year commissions over renewal commissions), and statutory accounting does not allow those costs to be deferred and then amortized into expense over the lifetime of the policy. As such, allowing the 2-yr FPT reserve methodology helps alleviate the “statutory strain” associated with the issuance of new policies, by not requiring contract reserves until after the portion of the policy lifetime where acquisition costs are incurred.

However, a 2-yr FPT methodology is not particularly compatible with establishing a contract reserve on account of durational MLR variation. As illustrated by the table on page 6, most of the significant durational variation in loss ratios occurs during the first two policy years. As such, a durational contract reserve calculated using 2-yr FPT would have at most a very minimal impact. In particular, for the example Company B considered earlier, such a reserve would always be zero, since we assumed that Company B had no durational MLR variation after the first two years.

¹⁰ Similar wording is found in paragraph 13 of SSAP 54.

3. A 2004 Academy task force report to the NAIC¹¹ explored the implications of requiring companies that issue individual medical policies to establish, for statutory reporting purposes, a contract reserve that reflects durational variation in loss ratios. This would result in an explicit pre-funding on the company's balance sheet of the component of future rate increases associated with durational effects. That report concluded that even a partial implementation of this concept, using a 1-yr FPT methodology rather than a net level premium methodology, would require companies to significantly increase premium rates for new business—or, in the alternative, require companies to recognize significant solvency strain from holding the reserves without increasing premiums.

Creating Contract Reserves Specifically for Rebate-Calculation Purposes

In the previous section, we noted that it may be appropriate to include, when using a calendar-year MLR calculation to determine rebates, the annual change in a contract reserve that reflected durational variation in loss ratios for individual business. However, we also noted that for a variety of reasons, most companies active in the individual market do not currently record such a contract reserve in their statutory financial reporting, even though they experience durational MLR variation. Consequently, allowing companies to include the annual change in statutory-basis contract reserves within the rebate MLR calculation would not adequately address the impact of durational MLR variation on rebates.

Instead, a suitable solution may be as follows: *Establish a new contract reserve calculation that is used specifically in the individual market MLR calculation for rebate purposes and is not tied in any way to the company's statutory-basis contract reserves.*

While this solution may be unusual there is precedent for it within existing federal health insurance regulation. CFR Title 42 Sec. 403.253(b)(2)(ii) specifies a methodology that companies are to use in calculating a contract reserve for purposes of federal Medicare Supplement loss ratio certifications, and that methodology may be different from what the company uses in its statutory financial reporting.¹² Moreover, this approach appears to be within the scope of the NAIC's mandate under Sec. 2718(c) to provide recommendations to the federal government on methodologies for implementing the Sec. 2718 rebate requirements, noting that the first sentence of Sec. 2718(a) makes specific reference to "change in contract reserves."

The intent of the new "rebate contract reserve" basis would be to present a current-period loss ratio (inclusive of the change in contract reserves) that reasonably approximates a lifetime loss ratio. This would mean, roughly speaking, that rebates would be paid out in a given calendar year to the extent that the lifetime loss ratio is below 80 percent, and would not be paid out to the extent that the lifetime loss ratio is not below 80 percent. This approach creates a better alignment between the issuance of rebates and the underlying policy objectives of Sec. 2718 as we understand them, namely that policyholders receive adequate value for their premium payments.

¹¹ Letter to the NAIC from the Academy's Rate Filing Task Force dated May 13, 2004—http://www.actuary.org/pdf/health/rate_may04.pdf.

¹² The fact that *federal* Medicare Supplement loss ratio certifications may be very rare, in practice, should not diminish the precedential value of this regulatory construct.

If a new rebate contract reserve is established, it is important to keep this contract reserve basis separate and distinct from the contract reserves used in statutory financial reporting. Requiring all companies to start including “rebate contract reserves” in their statutory financial reporting could create significant solvency concerns.

From a purely theoretical perspective, the best way to implement the rebate contract reserve would be to allow a company to follow the net level premium methodology, and use a company’s unique assumptions (as supported by its experience) for realistic lapse expectations and durational claim-cost patterns, taking the company’s own underwriting and pricing practices into account. The 2006 SOA study referenced earlier indicated that there are significant variations among companies in durational claim cost patterns and, hence, in durational loss ratio patterns. As such, allowing each company to reflect its own specific circumstances in selecting assumptions for the rebate contract reserve is theoretically appropriate. Even so, selection of assumptions may be difficult for the following reasons:

- The company’s experience may not be mature enough to project the future;
- The future environment may not be representative of the past (particularly with respect to lapse rates as we move closer towards the market reforms of 2014), so the actuary will need to make adjustments to experience based on professional judgment;
- A company may be new to the business, so it might have to rely on published data, such as the 2006 SOA study.

We recognize that there are pragmatic considerations from a regulatory perspective, as well. However, allowing company-specific assumptions but requiring a formal actuarial certification of the assumptions used for the rebate contract reserve might be a suitable oversight approach.

An alternative approach would be for regulators to dictate the assumptions to be used in the rebate contract reserve calculation. While this would address regulatory concerns about allowing the company to select its own reserve assumptions, it introduces a problem of timing with respect to when rebates are paid, as is discussed below.

In most circumstances, a company using a specified set of assumptions in the rebate contract reserve will ultimately pay out the “correct” amount of rebates, but not necessarily in the same years that rebates would have been paid if the company’s own assumptions were used in the rebate contract reserve. However, if the standard set of assumptions uses a relatively flat durational MLR curve, then there are circumstances under which a company would pay out a rebate in early durations when, had the company been able to use its company-specific assumptions, no rebate would ever be paid. This possibility suggests that if standard assumptions are used, they should be selected in a manner that minimizes the likelihood of paying out rebates earlier in a policy lifetime that cannot be recovered. An example of how this might work would be to set the standard claim cost curve at the steepest level that is commonplace in the market.

Similar issues exist with respect to setting termination rate assumptions. Paragraph 34.a.iii.(a) of Appendix A-010 specifies an 8 percent cap on annual termination rates for statutory contract reserve calculations. By contrast, historical annual termination rates in the early durations of

individual medical policies have been more typically in the 15 percent to 30 percent range. If lower-than-expected termination rates are used in the rebate contract reserve calculation, then the rebate contract reserves will be higher in the earlier durations, which would significantly affect the timing of when rebates are paid. This suggests that applying the normal 8 percent cap under these circumstances may produce undesirable results.

We appreciate that the concepts discussed in this section might be more easily illustrated via numerical examples, and if desired we could make an effort to assemble some illustrations for your review.

Other Alternatives

Instead of developing a new type of contract reserve calculation for rebate purposes, a somewhat related but less complicated approach would involve having each company calculate its expected MLR for the calendar year, based on the durational mix of its business. The rebate for each calendar year would be calculated by comparing the company's actual MLR against its expected MLR, rather than against a fixed target of 80 percent.

This approach would address not only the durational mix issues discussed throughout this letter, but also the reality that many existing blocks of individual business were priced to lifetime loss ratios below 80 percent. There is state-level precedent (e.g., Kentucky) for such an approach to determine rebates. However, the ability of regulators to interpret Sec. 2718 in a manner that would permit this approach is somewhat unclear.

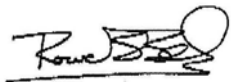
Please also see related remarks on alternative approaches, made in pages 13-14 of our May 14, 2010 response to the request for comments on Sec. 2718.

Conclusion

We recognize that your group's time is limited and appreciate your consideration of the issues raised in this letter. We believe the inclusion of contract reserves in the MLR calculation is an important technical issue to be confronted as you contemplate approaches to implementing Sec. 2718. If we can be of further assistance in this area, please let me know.

If you have any questions, please contact Heather Jerbi, the Academy's senior health policy analyst, at 202.223.8196 or jerbi@actuary.org.

Sincerely,



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