AMERICAN ACADEMY of ACTUARIES

January 31, 2011

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9998-IFC
Room 445-G, Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Interim Final Rule—Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act

The American Academy of Actuaries'[1] Medical Loss Ratio Regulation Work Group is pleased to provide comments to the Department of Health and Human Services (HHS) on the interim final rule (IFR) implementing Section 2718 of the Public Health Service Act, published in the Federal Register on Dec. 1, 2010, as amended by the corrections published on Dec. 30, 2010.

We have appreciated the many opportunities to provide input while the MLR IFR was under development, both directly to HHS and indirectly via the National Association of Insurance Commissioners (NAIC). Our intent in this comment letter is not to revisit our previous comments, but to provide input on certain technical aspects of the MLR IFR in an effort to improve the clarity and internal consistency of the adopted regulation.

For ease of use, our comments below have been organized according to the MLR IFR section number.

Section 158.103
Definition of "Multi-state Blended Rate"—The concept of "multi-state blended rate" (emphasis added) is defined in Section 158.103. Section 158.140(b)(5)(i), however, refers to "blended rate" instead of "multi-state blended rate." We believe the use of "blended rate" instead of "multi-state blended rate" in Section 158.140(b)(5)(i) is appropriate; it is consistent with the NAIC's adopted recommendations. As such, we suggest that, for optimal clarity, the definition of "multi-state blended rate" be deleted from Section 158.103 and replaced with a definition of "blended rate." The new definition of "blended rate" should be broad enough to incorporate the common situation in which health insurance coverage is provided to a single employer through two or more of an issuer's affiliated companies in the same state (e.g., one entity issuing PPO products while an affiliated entity issues HMO products in the same state). In addition, we recommend utilizing the NAIC's recommended wording of "blended rate" to involve "a set of rates" instead of keeping the current wording involving "a single rate."

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

Section 158.120(c)
Health Insurance Coverage with Dual Contracts—As noted in Section 158.120(c), there are situations in which a policyholder simultaneously enters into two insurance contracts with two affiliated issuers—one contract providing in-network coverage only, and the other contract providing out-of-network coverage only. We agree with the general concept behind the guidance in Section 158.120(c) relative to this situation.

There is confusion, however, created by the fact that Section 158.120(c) has been drafted in such a way that it applies only to group contracts. We recommend deleting the word "group" wherever it is used in Section 158.120(c), as shown below:

> "(c) ~~*Group* *Health Insurance Coverage With Dual Contracts*~~. Where a ~~group~~ health plan involves health insurance coverage obtained from two affiliated issuers, one providing in-network coverage only and the second providing out-of-network coverage only, solely for the purpose of providing a ~~group~~ health plan that offers both in-network and out-of-network benefits, experience may be treated as if it were all related to the contract provided by the in-network issuer. However, if the issuer chooses this method of aggregation, it must apply it for a minimum of 3 MLR reporting years."

Section 158.120(d)(1)
Individual Business Sold Through Group Trust. Under Section 158.120(d)(1) as amended by the Dec. 30, 2010 corrections, individual market business sold through an association should be reported in the "issue State of the certificate of coverage." This is reasonable. We note, however, that individual market business also may be sold through group trusts as mentioned in Section II.C.2.c of the preamble. As written, it appears that the experience for such business would be reported in the state in which the trust was located. It does not seem to make sense to treat individual market business sold through a group trust differently from individual business sold through an association. As such, HHS may want to consider having individual market business sold through a group trust also be reported in the state in which the certificate was issued by the trust. This could be accomplished by making the following change to Section 158.120(d)(1):

> "(d) *Exceptions*. (1) For individual market business sold through an association <u>or group trust</u>, the experience of the issuer must be included in the State report for the issue State of the certificate of coverage."

Section 158.120(d)(2)
MEWA Business—Under Section 158.120(d)(2), the experience of employer business issued through a group trust or a multiple employer welfare association (MEWA) is to be included in the state report for the state "where the employer or the association has its principal place of business." Our understanding of the NAIC's intent with respect to MEWA business was to require inclusion in the state in which the employer has its principal place of business, and not give the issuer a choice between that location and the state in which the MEWA is located. To preserve that intent, the following revision would be needed to Section 158.120(d)(2):

"(2) For employer business issued through a group trust or multiple employer welfare association, the experience of the issuer must be included in the State report for the State where the employer ~~or the association~~ has its principal place of business."

Section 158.120(d)(3)

Defining "Mini-Med" Plans—As discussed in Section II.C.e of the preamble and implemented in Section 158.120(d)(3), the MLR IFR uses "policies that have a total annual limit of $250,000 or less" as a proxy for defining which limited benefit plans are entitled under Section 158.221(b)(3) to a special adjustment for year 2011 to the numerator of the MLR calculation.

We note that there are limited benefit plans that do not have annual policy limits of $250,000 or less but that are priced lower and face similar or greater expense pressures as plans with annual limits of $250,000. Such limited benefit plans tend to have multiple internal benefit limits, but have unlimited annual limits (or annual policy limits greater than $250,000), resulting in an actuarial value that is less than a comprehensive plan having a $250,000 annual policy limit.

We raise this observation for two reasons—first, to seek assurance that the exclusion of these types of limited benefit policies from the 2011 special MLR adjustment was deliberate. If not, further clarification is needed that these other limited benefit plans also are intended to qualify. Second, this observation illustrates a broader issue that we had addressed on pages 4 and 37 of our May 14, 2010 response[2] to the HHS request for comments on Section 2718, namely that an issuer's administrative expenses do not vary materially based on the actuarial value of the underlying policy. As such, different loss ratio expectations are appropriate for policies of different actuarial values. While this issue is prevalent today with respect to limited benefit plans, in the future there will be other contexts in which MLR regulation will need to address this issue. For example, would it be appropriate for platinum plans and bronze plans to be subject to different MLR rebate thresholds given the difference in actuarial values between those plans?

Section 158.130

Measurement Date for Earned Premium—Any measurement of an issuer's earned premium for a particular MLR reporting year essentially has an associated "measurement date"—the date through which activity is included in the measurement, incorporating the portion of the year's premium collected as of the measurement date plus an accrual for the portion uncollected as of the measurement date. One technical issue we raised about the NAIC's recommendation to HHS was that it used a measurement date of Dec. 31 for earned premium, even though it used a measurement date of March 31 for incurred claims. The use of different measurement dates for the numerator and the denominator of the MLR calculation theoretically could introduce anomalies. It is our understanding from informal comments by HHS staff that nothing in the MLR IFR would prevent an issuer from employing a measurement date of March 31 for earned premium. We believe that official confirmation of such a position, perhaps via sub-regulatory guidance, would be useful.

Section 158.140(a)

Definition of Paid Claims Included in Incurred Claims—The preamble to the MLR IFR indicates an intent to adopt the NAIC's recommendation that incurred claims includes "direct paid claims

[2] See http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf.

incurred in the MLR reporting year" (quoting from Section II.C.5 of the preamble). That intent, however, is not made clear in the actual language in Section 158.140(a). To conform the regulatory language to both the NAIC recommendation and the apparent underlying intent of HHS, we recommend the following modification to the first sentence of Section 158.140(a): "The report required in §158.110 of this subpart must include direct claims incurred in the MLR reporting year and paid to or received by providers…"

Section 158.140(a)(4)
Change in "Other Claims-Related Reserves"—The Dec. 30, 2010 correction to the MLR IFR resolved concerns we otherwise would have raised regarding the use in Section 158.140(a)(2) and Section 158.140(a)(3) of "change in reserves" language. We believe, however, that similar corrections should be made to Section 158.140(a)(4) for the sake of consistency.

Section 158.140(a)(5)
Experience Rating Refunds—Under normal accounting principles, incurred experience rating refunds—that is, cash refunds paid or received plus the change in the balance sheet accrual for such refunds—are included as part of earned premium. The NAIC recommendation included adjustments to move these items out of the MLR denominator (premium) and into the MLR numerator (claims). The MLR IFR contains language in Section 158.140(a)(5), and also Section 158.130(b)(3), presumably to affect these adjustments. The language in the MLR IFR, however, refers specifically to "refunds paid or received," which refers to cash-basis accounting rather than accrual-basis accounting. The language needs to be modified to make it clear that the adjustments should reflect the insurer's estimate of experience rating refunds incurred in the MLR reporting year, analogous to the treatment of incurred claims.

Section 158.140(b)(3)
Intent of Subsections (ii) and (iii)—It is our understanding from informal comments by HHS staff that sub-regulatory guidance will be issued in order to clarify the intent of Section 158.140(b)(3)(ii) and Section158.140(b)(3)(iii). As we find this language open to multiple interpretations, we do see a need for clarification regarding the intent of this language.

We observe, however, that the inclusion of this language in the MLR IFR does not appear to be consistent with the NAIC's Issues Resolution Document (IRD) 015, which indicated that all amounts currently included in incurred claims under existing statutory accounting practices should be included in the numerator of the MLR. By contrast, we believe that the effect of Section 158.140(b)(3)(ii) and Section 158.140(b)(3)(iii) would be for issuers to take certain amounts that currently are reported entirely as incurred claims under statutory accounting and bifurcate them, with a portion included in the MLR numerator and a portion excluded from the MLR numerator.

Section 158.220(a)
Aggregation Framework and Interaction with Section 158.120(d)—Section 158.220(a) lays out the general aggregation framework for MLR calculations, namely by market and by state. However, in Section 158.120(d)(3) and 158.120(d)(4), separate reporting requirements are created for mini-med plans and expatriate plans. In this context, the way in which mini-med plans and expatriate plans are intended to be handled from an aggregation standpoint needs to be

clarified. For example, do mini-med plans within a particular state form a separate "market" for MLR calculation purposes, or are mini-med plans included with other markets (individual, small group, large group) as appropriate, after making the experience adjustment described in Section 158.220(b)(3)? Similarly, do expatriate plans form a separate "state" for MLR calculation purposes? Further clarity on these and related issues is needed.

Section 158.220(b)

Data Used in Multi-Year Calculations—There are a number of instances in the MLR IFR in which the issuer's MLR for a particular MLR reporting year is to be calculated based on data spanning more than one year. Consider, as an example, the calculation of an MLR for the 2012 reporting year based on experience from both 2011 and 2012. An ambiguity arises in this example regarding how the incurred claims for 2011 are to be computed, with there being two principal alternatives to consider:

1. *Originally reported data*: Incurred claims for 2011 include claim payments made through March 31, 2012, plus an unpaid claim liability estimate made as of March 31, 2012. This is consistent with the data that the issuer originally would have reported for the 2011 MLR reporting year, but does not reflect the best information available to the issuer at the time the calculation is being performed (i.e., during second quarter 2013).
2. *Restated data*: Incurred claims for 2011 include claim payments made through March 31, 2013, plus an unpaid claim liability estimate made as of March 31, 2013. This means that both the 2011 and 2012 data would be computed using the same measurement date.

Throughout the NAIC process, it seemed more likely that multi-year calculations would be performed using restated data (alternative 2 above). The language used in Section 158.220(b), however, leads one to interpret that HHS may intend for issuers to use originally reported data in multi-year calculations, rather than restated data. Employing restated data in these calculations is preferable from the standpoint of improving calculation accuracy, and we recommend that the MLR IFR be reworded accordingly. If, in the alternative, HHS does intend for issuers to use originally reported data, we encourage HHS to clarify that intent.

Section 158.232(c)(1)(i)

Calculation of Deductible Factor for Policies with Dependents—We have significant concerns about Section 158.232(c)(1)(i), which proposes an approach for determining the Table 2 deductible factor with respect to policies that cover more than one person.

As background, the deductible factors in Table 2 were set by the NAIC based on actuarial modeling that it had commissioned from an actuarial consulting firm. The intent of Table 2 is to recognize that the magnitude of statistical fluctuation in loss ratios increases as deductible levels increase. The problem that Section 158.232(c)(1)(i) is attempting to solve is: How should one treat, in this context, a policy that covers multiple individuals and may have an overall "family deductible" or an overall limit on the amount of claims applied against the individual deductibles of all family members?

This is a common situation and should be addressed in the MLR IFR. We are concerned, however, that the proposed approach for calculating a "per person deductible" for purposes of applying Table 2 is not consistent with the manner in which the Table 2 deductible factors were developed. As a result, implementation of Section158.232(c)(1)(i), as drafted, would cause issuers of high-deductible family policies to report lower deductible factors than we believe would be justifiable in light of the expected level of volatility on those policies. Such a result may discourage issuers from continuing to provide such policies.

As a simple and practical alternative, we propose the following changes to Section 158.232(c)(1)(i):

> "(i) The per person deductible for a policy that covers a subscriber and the subscriber's dependents shall be calculated as follows: The lesser of the deductible applicable to each ~~sum~~ of the individual family member~~s' deductibles~~, or the overall family deductible for the subscriber and subscriber's family~~, shall be~~ divided by two (regardless of the total number of individuals covered through the subscriber ~~(including the subscriber~~)."

Under this proposal, for example, a policy with a $2,000 individual deductible and a $5,000 family deductible would be treated as having a $2,000 per person deductible. A policy with a $3,000 individual deductible and a $5,000 family deductible, however, would be treated as having a $2,500 per person deductible, regardless of the number of individuals covered under the policy.

The rationale for capping the divisor of the per person deductible at two is that, in the vast majority of situations in which a policy's family deductible has been exceeded, a combination of just two persons in the family also would have resulted in the family's deductible being exceeded. As a result, a reasonable simplifying assumption is to view the family deductible as being equivalent to two per person deductibles, even if more than two lives are covered by the family deductible.

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We appreciate the opportunity to offer these comments on the MLR IFR. If you have any questions or would like to discuss any of our comments further, please contact Heather Jerbi, the Academy's senior health policy analyst, at (202) 785-7869 or jerbi@actuary.org.

Sincerely,

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