



AMERICAN ACADEMY *of* ACTUARIES

April 28, 2010

To: Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC

Steven Ostlund
Chair, Accident & Health Working Group, NAIC

From: Rowen Bell
Chair, Medical Loss Ratio Regulation Work Group

Re: PPACA Medical Loss Ratio Provisions and Potential Disruption to Individual Market

Dear Lou and Steve:

The American Academy of Actuaries'¹ (Academy) Medical Loss Ratio Regulation Work Group recently sent you an initial letter outlining several technical issues germane to your groups' work regarding implementation of the medical loss ratio (MLR) and rebate provisions added to §2718 of the Public Health Service Act (PHSA) by the Patient Protection and Affordable Care Act (PPACA). In this second comment letter, we would like to raise a broader policy concern—namely, the potential disruptive impact that the implementation of §2718 could have on the individual health insurance market prior to (and potentially beyond) the effective date of the guaranteed issue requirements, due in large part to historical pricing practices employed in the individual market. This concern is primarily relevant in those states that permit medical underwriting of individual insurance. We are continuing to evaluate potential approaches to mitigating this concern and look forward to further discussions on this subject.

This potential disruption to consumers in the individual market would likely occur from three different, albeit related, perspectives:

1. Applying an 80 percent MLR requirement to existing individual business that had originally been priced under different (lower) MLR expectations may require a company to reduce the premiums it ultimately retains (i.e., collected premiums less rebates) to levels that create losses, with little to no ability to recover those losses. Materially reducing the non-claims costs associated with existing business in order to reduce financial losses is unlikely to be feasible. Such a situation might lead some companies currently active in the individual market to terminate the existing blocks of business and leave the market, in an effort to avoid those future losses and the potential solvency concerns associated with those future losses. If some companies do exit the individual market, then those companies' former policyholders may find themselves unable to find new coverage in the individual market for a period of years (noting that guaranteed issue requirements do not take effect until 2014), and would not be eligible for the new high risk pools created by PPACA §1101 during the first six months after cessation of coverage.

¹ 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.

2. Individual policies underwritten and issued prior to the introduction of guaranteed issue requirements in 2014 will continue to exhibit traditional patterns of having loss ratios that increase by policy duration. Issuing new underwritten policies over the next few years would therefore tend to make it more difficult for an insurer to achieve an 80 percent annual MLR across its entire block of individual medical business. This could serve as an incentive for carriers who remain in the individual market to minimize their marketing activity prior to 2014, creating a potential lack of product availability in the individual market over the next few years.
3. Since the MLR for underwritten individual products typically increases with policy duration, a company whose individual book of business has a higher proportion of recently-sold business may find it more difficult to achieve an 80 percent annual MLR in the near future than a company having a more mature book of business (and a correspondingly higher MLR). As such, the application of uniform annual MLR requirements could have a disproportionate impact across companies, which could lead to additional volatility in premium and rate change levels in the individual market.

In order to mitigate these potential disruptive factors in the individual market, the NAIC may wish to explore alternatives to a straight-forward application of an annual MLR threshold to the individual market, at least in a transition period over the next few years. For example, it may be desirable to take a carrier's durational mix of business into account when assessing its individual market MLR for §2718 rebate purposes.

Moreover, any such alternative applications of MLR requirements for the individual market will be most effective if they are developed in the very near future. As noted above, some carriers may seek to exit the individual market out of concern about the impact that rebate requirements in 2011 may have on their existing book of business and potentially on their solvency. Carriers will likely need to reach decisions on this point in the next several weeks; in order for a carrier to effect its exit from the market as of January 1, 2011, an announcement may need to be made in June 2010 to satisfy the six-month advance notice requirements of the Health Insurance Portability and Accountability Act (HIPAA). Consequently, any transitional alternatives will be more effective, in terms of minimizing potential individual market disruption, if they are announced in the next several weeks.

In analyzing this issue, it is important to note that the individual market has several unique characteristics that are typically not seen in either the small group or large group markets. Due to the selection of risks through underwriting in a voluntary market, historically the expected MLR of individual business has been significantly lower in the early policy durations, increasing over time as new illnesses 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). In the individual market, pricing has traditionally been done using a lifetime target MLR, built up from a target MLR at each policy duration and the expected amount of business in force at each duration. By contrast, group insurance pricing is typically performed on an annual rather than lifetime basis. As PPACA's guaranteed issue requirements take effect, companies will likely revisit their approaches to pricing new business in the individual market in order to adapt to changes in the underwriting and the expected MLR pattern vis-à-vis the annual MLR requirements. However, business issued prior to that time—including not only grandfathered individual coverage, but also new business written after the adoption of PPACA but before the imposition of guaranteed issue requirements—will in most cases have been priced on a lifetime rather than annual basis.

Moreover, the lifetime MLR at which these existing blocks of individual medical insurance were priced has frequently been less than the 80 percent threshold discussed in §2718. We note two particular reasons why historically the lifetime pricing MLR in the individual market may have been lower than 80 percent.

First, product designs popular in the individual market have typically had lower “actuarial values” (i.e., higher policyholder cost-sharing features and lower medical costs) than product designs popular in the group market. At the same time, the per-enrollee costs of claims administration and policy administration are generally not any lower, and may actually be higher, for individual policies relative to group policies. The combination of these observations generally results in higher claims administration and policy administration costs, when expressed as a percentage of premium, in the individual market than in group markets. Second, the individual market has historically relied heavily on agents and brokers, which generate high distribution expenses, particularly in the first policy year. These agent and broker expenses are established by contracts and cannot be adjusted easily, if at all, on policies issued prior to the enactment of PPACA.

In summary, we have concerns regarding the application of the required annual MLR calculation to individual business priced to a lifetime MLR target. Due to the inherent inconsistency between the lifetime pricing methodology used for individual underwritten medical business, including the expected pattern of durational loss ratios, and an annual MLR computation, it may be prudent for the NAIC to swiftly consider options for adjusting the MLR computation for individual medical products.

We hope that our discussion of this issue is helpful to you as the NAIC continues its work on MLR implementation issues. If you have any immediate questions regarding this letter, please contact Heather Jerbi, the Academy’s senior federal health policy analyst, at jerbi@actuary.org or 202.785.7869.

Sincerely yours,

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

Cc: Jay Angoff, Director, Office of Consumer Information and Insurance Oversight, HHS
Richard Kronick, Deputy Assistant Secretary, Health Policy, HHS