



AMERICAN ACADEMY *of* ACTUARIES

Nov. 5, 2010

Steven B. Larsen
Director, Office of Oversight
Office of Consumer Information and Insurer Oversight
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Regulatory Implementation of Section 2718 of the Public Health Service Act

Dear Mr. Larsen:

The American Academy of Actuaries'¹ Medical Loss Ratio Regulation Work Group has appreciated the opportunity to provide input over the past several months to both federal and state regulators in connection with the development of regulations related to Section 2718 of the Public Health Service Act.

As the Department of Health and Human Services (HHS) prepares to take the next step in the regulatory process, we want to provide HHS with specific comments on three aspects of the proposal adopted by the National Association of Insurance Commissioners (NAIC) on Oct. 21 and formally transmitted to HHS on Oct. 27. These are:

- Credibility adjustments;
- Exclusion of federal taxes from the MLR denominator;
- The use of three months' runout.

Credibility Adjustments

Under the NAIC proposal, a health insurance issuer would make an additive adjustment to its reported medical loss ratio before comparing it with the statutory threshold to determine whether a rebate is payable. The magnitude of this adjustment is determined by the size of the issuer's block of business for each market within a state and the mix of business by deductible within that block. This concept is consistent with the rules adopted by HHS in 1992 for Medicare Supplement refunds.

We believe that these credibility adjustments are of significant practical and theoretical importance. We encourage you not only to retain this aspect of the NAIC proposal, but also to give further consideration to the amendment to increase the magnitude of the credibility

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.

adjustments that was offered by the New Jersey Commissioner at the Oct. 21 meeting. The opposition to the New Jersey amendment may have been based, in part, on confusion regarding the meaning of the confidence intervals and the effect of the amendment.

To clarify, when an issuer establishes premium rates for a particular block of business, there is an expectation as to what the coming year's medical loss ratio will be—referred to as the *pricing loss ratio*. At the same time, the issuer recognizes that the actual loss ratio almost certainly will vary from the pricing loss ratio. There are a number of reasons for this variance, but the most prominent is statistical fluctuation in claims experience. The expected level of fluctuation (in absolute value terms and measured as a percentage of premium) is inversely correlated to the size of the block of business and to the average actuarial value (AV) of the policies in the block. As such, large blocks of policies with comparatively low levels of policyholder cost-sharing typically would exhibit much less variance from the pricing loss ratio than would small blocks of policies with higher cost-sharing features. We emphasize here that these fluctuations are a matter of probability and statistics.

In the pre-Affordable Care Act (ACA) insurance market, statistical fluctuation in claims experience would affect an issuer's volatility of earnings, but would not influence that issuer's expected long-term level of earnings. This is because statistical fluctuation historically has affected the issuer in a symmetric manner—fluctuations unfavorable to the issuer have in the long run been offset by fluctuations favorable to the issuer.

The introduction of policyholder rebates under Section 2718, however, introduces asymmetry. From 2011 onward, favorable fluctuations may create a need for rebates to be issued to customers in the states (or years) in which those favorable fluctuations occur, rather than be used by the issuer to offset unfavorable fluctuations in other states (or years). This implies that, in setting its future pricing and understanding its expected level of earnings, the issuer will need to consider a new component—the expected cost of policyholder rebates.

In the absence of any mitigation efforts, statistical fluctuations would play a significant role in determining the issuer's expected cost of policyholder rebates for a particular block. As a result, without any mitigation, the expected cost of policyholder rebates would be much larger for smaller blocks of business than for larger blocks, and would be much larger for low-AV blocks of business than for high-AV blocks. This dynamic could have a material impact on consumer choice—particularly in states with small populations. Issuers with smaller blocks of business would face a significant competitive disadvantage relative to issuers having larger blocks of business. Issuers focusing on low-AV products (e.g., high-deductible health plans) similarly would face a significant competitive disadvantage relative to issuers focusing on high-AV products (e.g., many HMOs). Issuers with smaller blocks (which will be common in small-population states) or with portfolios concentrated in low-AV products might therefore consider exiting the market.

The credibility adjustments in the NAIC proposal represent a mitigation effort to overcome the asymmetric impact that statistical fluctuation will have in a post-rebate market. They play an important role in the NAIC proposal. They help to create a more level playing field between different types of issuers, particularly keeping the market attractive for issuers having small

blocks of business in a given state and customer segment (e.g., individual, small group, large group). Having more issuers present fosters more competitive markets and, therefore, possibly lower premiums.

As a matter of theory, however, we have some concern that the magnitude of credibility adjustments proposed by the NAIC may not be high enough to avoid an adverse effect on the functioning of insurance markets.

The credibility adjustments adopted by the NAIC were calculated by its actuarial consultant at the 50th percentile confidence level. It is important to understand what the 50th percentile does, and does not, mean in this context. The confidence level represents a measure of the likelihood of avoiding a *false positive* in the rebate process. By false positive it is meant that, even though the issuer's pricing loss ratio was equal to the applicable rebate threshold (i.e., 80 percent), the issuer pays a rebate as a result of statistical fluctuation.

So, under the NAIC's proposal for the 50th percentile credibility adjustments, if an issuer's pricing loss ratio is consistently equal to the rebate threshold, and if statistical fluctuation were the only source of variance between pricing expectations and actual results, then the issuer still would pay a rebate 25 percent ($= \frac{1}{2} * (1 - 50\%)$) of the time. (In practice, there will be other sources of variance between the pricing loss ratio and the actual loss ratio, resulting from uncertainty in the issuer's ability to estimate inputs to the pricing process.) The overall frequency with which rebates would be paid is going to vary based on a number of other factors, the most critical of which is the relationship between the issuer's pricing loss ratio and the applicable rebate threshold. As such, it would not be accurate to say that issuers would pay rebates 25 percent of the time under the credibility adjustments adopted by the NAIC; the actual frequency of rebate payment in practice may be more, or less, than that.

In our May 20 letter to the NAIC,² we reported on analysis that had been performed by a company and that illustrated the impact that different levels of credibility adjustments could have on issuers of different sizes. The table below highlights information from the table on Page 3 of that letter, but in a slightly different form. (It should be possible to derive similar information from the actuarial modeling performed by the NAIC's actuarial consultant in developing the NAIC's recommended credibility adjustments.)

**Contribution of Statistical Fluctuation to Issuer's
Expected Cost of Policyholder Rebates, as Percent of Premium
(Assuming Issuer's Pricing Loss Ratio = 80 Percent)**

Issuer Block Size (in Life Years)	Level of Credibility Adjustment		
	No Adjustment	50th Percentile	80th Percentile
1,000	5.0%	1.3%	0.1%
5,000	2.4%	0.7%	0.1%
25,000	1.1%	0.4%	0.1%
50,000	0.8%	0.3%	0.1%

² American Academy of Actuaries' Medical Loss Ratio Regulation Work Group letter to the NAIC: http://www.actuary.org/pdf/health/aaa_statistical_credibility_response_100520_final.pdf (May 20, 2010)

The information presented in the table represents the difference between the issuer's expected loss ratio after accounting for policyholder rebates and the issuer's pricing loss ratio. The underlying modeling assumes that statistical fluctuation is the only source of variance between actual and expected results. As such, we refer to the difference defined above as being the contribution of statistical fluctuation to the issuer's expected cost of policyholder rebates.

What this table illustrates is that, even under the 50th percentile credibility adjustments such as those adopted by the NAIC, issuers with larger blocks of business will have a competitive advantage of approximately 0.5 percent to 1.0 percent of premium over issuers with smaller blocks of business, as a result of the mechanics of the policyholder rebates. (This is in addition to any other reasons why issuers with larger blocks may have a competitive advantage over issuers with smaller blocks, such as economies of scale or improved pricing data.)

While 0.5 percent to 1.0 percent of premium may sound small, it is large when viewed in relationship to issuers' earnings targets in the individual and small group markets, which may typically be in the low- to mid-single digits as a percentage of premium. As a consequence, this could significantly affect issuers of smaller blocks of business and, therefore, the insurance markets of small-population states. Faced with the statistical likelihood of paying rebates 25 percent of the time, even if they priced to achieve the applicable rebate threshold, these carriers would need to consider adding margins of conservatism in their pricing, leading to higher premiums—or consider exiting a market.

By contrast, the table above illustrates that if credibility adjustments at the 80th percentile confidence level were used, then there would be much less variation across issuers of different block sizes in the expected cost of policyholder rebates. The New Jersey amendment narrowly rejected by the NAIC last month involved adjustments set at the 80th percentile level, which simply means that the likelihood of a false positive as defined above is no longer 25 percent, but only 10 percent ($= \frac{1}{2} * (1 - 80\%)$). Increasing the magnitude of the credibility adjustments, consistent with the New Jersey amendment, would help maintain a level playing field between issuers of different sizes and, thereby, help maintain competitive private markets in all states (particularly small-population states).

Exclusion of Federal Taxes from MLR Denominator

Under the NAIC proposal, it appears that the issuer will be allowed to exclude from the denominator of the medical loss ratio certain federal taxes, including but not limited to federal income taxes not arising from investment income. By contrast, an August letter to the NAIC signed by several U.S. Senators stated that exclusion of federal income taxes from the loss ratio denominator was not consistent with congressional intent.

We believe it is important, as a matter of equity, for federal income taxes to be excluded from the loss ratio denominator. Some health insurance issuers are exempt from federal income taxes, while most are not. Excluding federal income taxes from the denominator creates a level playing field between tax-exempt and taxable issuers.

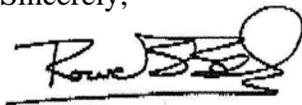
Use of Three Months' Runout

In the NAIC proposal, the issuer's incurred claims for the calendar year are measured using data as of March 31 of the following calendar year or, colloquially, using *three months' runout*. This is a positive aspect of the proposal, as it will enhance the accuracy of the rebate calculation by reducing the reliance on actuarial estimates of unpaid claims, without significantly delaying the payment of rebates to consumers.

As a matter of consistency, however, it is unclear to us why the NAIC proposal does not also apply three months' runout to the calculation of the issuer's earned premium for the calendar year. Retroactive membership adjustments are common with health insurance, and using data as of March 31 of the following calendar year to measure premiums not only would be more accurate, but also would be more consistent with the measurement of claims. Given the level of granularity at which rebate calculations would be performed under the NAIC proposal, anomalous results could arise in the rebate calculation due to a mismatch between premiums (using Dec. 31 data) and claims (using March 31 data).

Thank you for your attention. If you believe that we can be of any further assistance to you at this stage of your deliberations, we would welcome the opportunity to assist. Please feel free to contact us via the Academy's senior federal health policy analyst, Heather Jerbi, at jerbi@actuary.org or (202) 223-8196.

Sincerely,

A handwritten signature in black ink, appearing to read "Rowen B. Bell", with a horizontal line underneath.

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