



AMERICAN ACADEMY *of* ACTUARIES

May 17, 2010

To: Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup
National Association of Insurance Commissioners

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

Re: Exposure Draft—Supplemental Health Care Exhibit

Dear Lou:

On behalf of the American Academy of Actuaries'¹ Medical Loss Ratio Regulation Work Group, I appreciate this opportunity to provide comments to the NAIC Health Care Reform Solvency Impact Subgroup on the May 12, 2010 exposure draft of a new proposed financial reporting exhibit—the Supplemental Health Care Exhibit.

As we understand it, one of the subgroup's main purposes in exposing the exhibit is to delineate the NAIC's stance on appropriate definitions to be used in calculating medical loss ratios (MLR) for federal rebate purposes, under the new requirements added to Sec. 2718 of the *Public Health Service Act* by the recently enacted *Patient Protection and Affordable Care Act* (PPACA). It is also our understanding that the exhibit was not intended to be used as the official means by which health insurance issuers would report MLR to federal regulators for Sec. 2718 purposes. As such, we have divided our response into two sections: general comments regarding the overall approach to defining the MLR in the exhibit; and technical comments on specific aspects of the exhibit and its instructions.

General Comments

In broad terms, we would characterize the subgroup's definition of the MLR numerator in the exposure draft of the exhibit as follows:

- Items traditionally included in NAIC reporting as “incurred claims” (inclusive of the change in contract reserves, but exclusive of reinsurance assumed and ceded) are included in the numerator; and
- Items traditionally included in NAIC reporting as “cost containment expenses” (CCE) or “other claim adjustment expenses” (other CAE) are excluded from the numerator, except

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that a small number of such expenses meeting the subgroup's new definition of "improving health care quality expenses" are included.

We recognize that, in selecting this definition, the subgroup may believe that it is necessary to interpret the statutory language of Sec. 2718 in a manner supporting that definition. Nevertheless, we are concerned that the practical affect of this definition may be to create an unlevel playing field across different types of health insurance issuers, due to differences in their underlying business models.

We recently wrote at length on this subject, in our response to the recent request for comments (DHHS-2010-MLR) about Sec. 2718. In Appendix A to this letter, we have reproduced some of the relevant portions of that response. To briefly summarize those views:

- Some issuer's business models lead to expenditures that are reported entirely in incurred claims, but in which some portion of the expenditure has an administrative nature and/or relieves the issuer of administrative expenses it would incur under a different business model. Capitation payments, which are reported entirely as incurred claims, are one example.
- As a result, issuers with business models that make extensive use of capitations or directly provide care to enrollees would be structurally advantaged under an MLR calculation that includes incurred claims in the numerator without including other expenditures, such as CCE (which includes case management, disease management, 24-hour nurse hotlines, wellness programs, provider network development, as well as fraud detection and prevention programs) and/or other CAE.
- One way to ameliorate this situation, and produce a metric that is comparable across all types of health insurance issuers without regard to their underlying business models, would be to broaden the numerator of the MLR metric by including CCE and/or other CAE together with incurred claims. Existing NAIC financial reporting already recognizes the potential value of including all claim adjustment expenses (both CCE and other CAE) in the numerator of the metric (e.g., in the Underwriting and Investment Exhibit Part 2C Section C).

As such, we think policymakers should be concerned that the MLR definition proposed in the exposure draft of the exhibit could have a number of unintended consequences. One such unintended consequence is the concern articulated above, regarding the creation of an unlevel playing field across different types of health insurance issuers. A second possible unintended consequence is the creation of incentives for health insurance issuers to de-emphasize their existing cost containment efforts. This would lead to higher claim costs and, thus, higher premiums. We illustrate this with a hypothetical numerical example, shown in Appendix B to this letter.

We conclude this section of our letter with the following critical point: if the definition of the MLR numerator is drawn broadly—for example, by including CCE and/or other CAE—and early experience indicates that the underlying public policy objectives of Sec. 2718(b) are not

being met, then regulators may have an available remedy. They could increase the MLR rebate thresholds in a manner that increases rebate levels, without jeopardizing the solvency of health insurance issuers or destabilizing insurance markets. On the other hand, if the definition of the MLR numerator for Sec. 2718(b) purposes creates persistent biases favoring certain types of health insurance issuers, as seems to be true of the current exposed NAIC definition, then it is unclear how to remedy the situation.

Technical Comments

We have organized our technical comments on the exhibit into the following categories, listed in alphabetical order:

- Accounting for Rebates
- Contract Reserves
- Different Annual Statement Types
- Federal Taxes and Underwriting Gain
- Quarterly Presentation
- Reinsurance
- Relationship of Parts 1 and 2
- Scope Exclusions
- State Allocations
- Timing

Accounting for Rebates

One of the apparent purposes of the exhibit is to create reconciliations with other aspects of NAIC financial reporting (e.g., the Orange Blank's Statement of Revenue and Expenses). This is a worthwhile objective. In order to accomplish it, however, some thought needs to be given to how rebates under PPACA will be accounted for in the Statement of Revenue and Expenses.

There appear to be (at least) three ways in which one can approach that issue:

1. Rebates will be accounted for as a reduction of premium revenue. Proponents of this view draw an analogy between PPACA rebates and premiums returned to policyholders under retrospectively rated group contracts, which are currently accounted for as a reduction of premium revenue. Holders of this view also expect that, when regulators review premium rate increase requests, it will be more obvious to look at the requested increase in relation to the previous premiums net of rebates rather than gross of rebates, which suggested viewing rebates as a reduction to premiums. Finally, holders of this view question whether premiums initially collected, but ultimately rebated to policyholders, are appropriately included in a top-line revenue measure.
2. Rebates will be accounted for as a new type of claims expense. Proponents of this view note that Sec. 2718(b)(1)(B)(i) requires that the amount of rebates paid by an issuer be equal to premiums, multiplied by the difference between the applicable MLR threshold and the actual MLR. From a mathematical standpoint, this approach calculates rebates as the additional numerator adjustment needed to achieve the applicable MLR threshold,

given the existing denominator—which is a claims-like treatment. (The alternative premium-like treatment would involve calculating rebates as the additional denominator adjustment needed to reach the applicable MLR threshold, given the existing numerator. That, however, is not the approach found within PPACA.) This view also may be more consistent with the public understanding of how the MLR and rebate are intended to work.

3. Rebates will be accounted for outside of Underwriting Gain. Proponents of this view believe that presenting an issuer's Underwriting Gain on a pre-rebate basis is most useful to readers of the financial statement, and that the impact of PPACA rebates should be isolated to a line item not included in the calculation of Underwriting Gain.

Depending on which view the NAIC reaches on this accounting issue, different types of conforming adjustments might be needed in the exhibit.

If rebates are accounted for as a reduction of premium, then:

- For rebate MLR calculation purposes, the adjusted premiums earned measure defined in Line 1.9 of Part 1 of the exhibit would want to exclude the issuer's incurred rebates for the period being measured. Since the premiums shown in the Statement of Revenue and Expenses would include incurred rebates (as a reduction to premiums), there would need to be additional reconciling entries made after Line 1.9 in order to end up with something that reconciles with the Statement of Revenue and Expenses.
- Depending on what decisions are made regarding how the rebate MLR calculation will work from 2014 forward, in light of the Sec. 2718(b)(1)(B)(ii) requirement to switch from one-year data to three-year data, there might be a need to adjust incurred claims so as to reflect incurred rebates. It may be premature to address this issue at this time, however.

If rebates are instead accounted for as an increase to claims, then:

- For rebate MLR calculation purposes, the total incurred claims measure defined in Line 4.0 of Part 1 of the exhibit would need to exclude the issuer's incurred rebates for the period being measured. Since the incurred claims shown in the Statement of Revenue and Expenses would include incurred rebates (as an increase to claims), there would need to be additional reconciling entries made after Line 4.0 in order to end up with something that reconciles with the Statement of Revenue and Expenses. This appears to be what current Line 4.3 is trying to do, except that instead of being labeled "Rebates Paid" it more properly would be "Rebates Incurred."

If rebates are not included within Underwriting Gain, but are included within net gain, then a new reconciling line item would need to be added near the bottom of the exhibit in order to build back to the issuer's net gain.

Contract Reserves

The exhibit appears to make the implicit assumption that the change in the issuer's statutory contract reserves will be relevant for purposes of the federal MLR definition. In our recent response to the request for comments (DHHS-2010-MLR), we noted that not all issuers of individual medical products currently record contract reserves for statutory financial reporting to reflect durational variations in loss ratios on underwritten individual products. We also noted in our response that federal regulators may wish to develop a federal contract reserve standard for purposes of determining an issuer's MLR in the individual market for Sec. 2718 purposes. If a federal contract reserve standard is adopted for Sec. 2718 purposes, then the federally reported MLR for individual business could differ materially from the MLR reported in the NAIC's draft exhibit, to the extent that the change in federal contract reserves differs materially from the change in statutory contract reserves.

Different Annual Statement Types

While many of the issuers subject to Sec. 2718 requirements file the NAIC's Orange Blank, many others file the NAIC's Blue or Yellow Blanks. It ultimately would be helpful if the instructions to this new exhibit could be expanded to indicate appropriate cross-references to other NAIC financial reports, not just for Orange Blank filers, but also for Blue and Yellow blank filers. We recognize that this is a relatively low priority for the immediate future given other demands on the subgroup's time, but we encourage the subgroup to return to this point later (e.g., after June 1).

Federal Taxes and Underwriting Gain

Line 1.5 of Part 1 of the exhibit is currently labeled "Federal Taxes & Federal Assessments." It appears to us that this line really needs to be split into two pieces: one for federal income taxes, and one for other federal assessments (which we presume includes the new federal insurer fee created by PPACA Sec. 9010).

The reason for splitting this out is that federal income taxes are not included in Underwriting Gain, whereas we would expect that other federal assessments (such as the PPACA insurer fee) would be included in Underwriting Gain. As such, in Line 10 of Part 1 of the exhibit, to reconcile to Underwriting Gain you need to subtract federal income taxes from Line 1.9, but at the same time you do not want to subtract other federal assessments from Line 1.9. Line 1.5 therefore needs to be split, so that the line for federal income taxes can be subtracted in the calculation made in Line 10.

Similarly, the material in Line 11 of Part 1 of the exhibit, "Administering Self-Insured Business," should be moved above current Line 10 and incorporated into the calculation of Underwriting Gain on current Line 10, since those items are part of Underwriting Gain as currently defined.

Quarterly Presentation

The exposure draft indicates that this exhibit is to be submitted by issuers on a quarterly basis. We question the value of requiring quarterly calculations of an MLR that, for rebate purposes, will be measured annually.

Health insurance products typically are expected to experience non-level loss ratios throughout the year. Most comprehensive major medical products experience a non-linear pattern of incurred claims even before consideration of cost sharing. In addition, products subject to deductibles tend to have lower loss ratios in the beginning of the year and higher loss ratios at the end of the year, with the magnitude of the effect increasing as the deductible level increases. Any prior-year claim-liability adjustments also can have a particular affect on the first quarter reported loss ratio.

As a result, quarterly loss ratio information often will not be indicative of the full year's experience and could be expected to result in extreme confusion for regulators and consumers. In particular, it may be commonplace to see loss ratios reported for individual and small group markets in early quarters that are substantially below the federal MLR thresholds, even for blocks of business in which the full-year loss ratios ultimately will be above those thresholds.

Reinsurance

In our letter to you dated April 20, 2010, one of the issues we raised was the extent to which reinsurance was incorporated into Sec. 2718 requirements. Based on the exposed instructions, it appears you have tentatively concluded that reinsurance should be excluded, except for assumption reinsurance and similar 100 percent coinsurance treaties.

We note that it may be appropriate to allow certain other types of reinsurance treaties, such as excess risk treaties employed for risk management purposes, to be reflected in the Sec. 2718 calculation. (Although in today's market such treaties generally are employed by smaller issuers, it is likely that their use will expand in the future, in light of PPACA's prohibition on lifetime coverage limits.) While we recognize that there may be difficulties in reflecting reinsurance given the statutory language, an approach that allows regulators to review an issuer's reinsurance treaties and conclude which ones should be included in the MLR definition for Sec. 2718 purposes may be an attractive solution.

Relationship of Parts 1 and 2

It is not entirely clear to us how Part 2 of the exhibit is intended to flow into Part 1. A reasonable supposition is that Line 1.8 of Part 2 becomes Line 1.1 of Part 1, and that Line 2.10 of Part 2 becomes Line 2.1 of Part 1. If indeed that were the intent, however, then Line 3 of Part 1 ("Incurred medical incentive pools and bonuses") should be removed, since those items already have been counted in Line 2.10 of Part 2 (via Line 2.8).

Scope Exclusions

In the same April 20, 2010 letter, we also raised the desirability of clearly communicating which lines of business are in the scope of Sec. 2718 requirements. The instructions to the exhibit take major steps in that direction. We have two additional comments, however. First, while the instructions to Column 5 indicate that Medicare Supplement policies are excluded, it might be helpful also to include Medicare Supplement in the list of exclusions appearing earlier on that page (the sentence starting "Do not include business"). Second, we see no specific mention of stop loss insurance in the instructions; it would be helpful to clarify its status.

State Allocations

We note with interest the following language from the instructions to the exhibit:

“The allocation of premium between jurisdictions should be based upon situs of the contract. For purpose of this exhibit, situs of the contract is defined as ‘the jurisdiction in which the contract is issued or delivered as stated in the contract.’”

Our response to the request for comments (DHHS-2010-MLR) included the following statement: “If a state-level paradigm is desired under §2718, the appropriate way of implementing that paradigm is to apportion each policy to exactly one state, namely the state that has responsibility for premium rate review.” The NAIC’s tentative decision to use situs as the allocation basis seems to be directionally consistent with the principle we advocated; it is not immediately clear to us whether or not the two approaches are identical. There may be a need for further delineation on how these allocation instructions apply to associations and nonemployer group trusts.

In addition, we believe the instructions should clarify that the exhibit’s allocation of claims by state should be performed in a manner consistent with the allocation of premiums by state, since no apparent purpose would be served by having different allocation approaches for these two items.

Timing

The proposed exhibit appears to be oriented around existing NAIC financial reporting processes, which involve a calendar-year presentation and a measurement date (as opposed to reporting date) coincident with the end of the calendar year. Federal MLR reporting standards may not revolve around a calendar-year calculation, and may have a gap in time between the end of the reporting period and the measurement date (in order to allow for partial claims runout). To the extent either or both of those items are true, the MLR calculated in the NAIC exhibit likely will vary from the federally reported MLR. Such variances may be confusing to regulators and consumers.

Thank you for your attention to these comments. If we can be of further assistance, please contact Heather Jerbi, the Academy’s senior health policy analyst, at 202.785.7869 or jerbi@actuary.org.

Sincerely,



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APPENDIX A

The material excerpted below originally appeared in our Academy work group's response dated May 14, 2010 to Question B.1 of the request for comments on Sec. 2718 medical loss ratio provisions. Please see http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf for a complete copy of our response to the request for comments.)

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NAIC financial reporting involves a myriad of different quantities and is governed by various pieces of accounting literature, most notably Statements of Statutory Accounting Principles (SSAP) and Annual Statement Blanks and Instructions promulgated by the NAIC. The most commonly referenced MLR-related statistic from NAIC financial reporting is simply the ratio of incurred claims to earned premiums, with specific definitions influencing the definition of “claims” and “premiums.” However, there are other MLR-related statistics appearing in NAIC financial reporting besides the basic ratio of incurred claims to earned premiums. We believe it is important, in the context of thinking about rulemaking under §2718, to understand these other MLR-related statistics and the extent to which they ameliorate potential deficiencies in the basic claims-over-premiums MLR. To motivate that subject, we need to start with a discussion of business models employed by the health insurance industry.

Different health insurance issuers deliver coverage to their enrollees through several different business models. Under the most common model, a health insurance issuer does not directly provide healthcare services, but instead enters into contracts with unaffiliated healthcare providers who provide care to the issuer's enrollees and accept payments under the terms of the issuer-provider contracts, frequently on a fee-for-service basis. An important variation on this model involves the payment of capitations by issuers to providers, in lieu of reimbursement by issuers to providers for claims generated by specific healthcare services. Capitations are per-enrollee-per-month (PEPM) payments that may cover all types of healthcare services or only certain types (e.g., mental health services). At the other end of the spectrum of models, are health insurance issuers that employ healthcare providers who directly provide healthcare services to the issuer's enrollees (e.g., staff model HMO, prepaid group practice) or that deliver care through an owned-and-operated integrated delivery system including facilities and pharmacies.

The fundamental issue with the claims-over-premiums MLR definition, viewed in this context, is the difficulty of arriving at a definition of claims that applies consistently across different types of business models. The notion of claims involves payments made to those healthcare providers delivering care to the issuers' enrollees.⁴ Under some models, such payments made by an issuer to providers may also implicitly relieve the issuer of administrative burdens it would have if it operated under a different model. An example is a capitation to a provider group, which relieves the issuer of the need to separately adjudicate a claim to that provider group for each and every healthcare service provided by that provider group to the issuer's enrollees. As such, on some theoretical level a capitation represents a mixture of a “claim” and an “administrative expense.”

⁴ However, we note that existing NAIC definitions specifically indicate that certain items are to be reported as part of claims, even if they do not directly represent payments to providers of care. For example, certain health related assessments imposed by states, as defined in SSAP 35, are considered claims by the NAIC.

However, since any attempt to bifurcate the capitation into such pieces would be artificial, in practice the entire capitation payment is reported as claims. Another example involves care management services. Under some models these services may be performed by issuer employees (or contractors) that do not otherwise provide care to enrollees. Under other models, however, these services may be implicitly bundled with the provision of healthcare services, and the issuer's payment for these services likewise may be implicitly bundled with its payment for healthcare services, in a manner that does not readily admit unbundling.

The result of this conundrum is that a claims-over-premiums MLR may not be consistently calculated across different types of health insurance issuers, due to differences in those issuers' underlying business models. 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-premiums ratio than issuers 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 that MLR calculation.

In the context of NAIC financial reporting, which is primarily oriented around helping insurance regulators assess the solvency condition of health insurance issuers, these inconsistencies are not particularly salient. This is largely due to the fact that, today, what an issuer reports in its NAIC financial reporting as its MLR does not in and of itself have any economic consequences. However, in the context of §2718 requirements, federal MLR reporting will have economic consequences to issuers via the rebate mechanism. Given the lack of any apparent legislative intent to create an unlevel playing field across different types of health insurance business models, it is important that the §2718 MLR definitions are designed to avoid creating structural inconsistencies whose effect may be to favor some business models over others. (We will explore this theme further below in our response to Question B.1a.)

Several years ago, some insurance regulators became concerned over the difficulties in comparing medical loss ratios across the different companies that they regulate, due to differences in business models as well as differences across companies in how similar types of expenditures were classified. The outgrowth of that regulatory concern was the adoption of an accounting standard called SSAP 85, which defined a health insurance accounting concept called cost containment expenses (CCE).⁵ By isolating CCE, the NAIC made it possible for users of NAIC financial reporting to calculate a second type of MLR-related statistic, namely incurred claims plus CCE divided by earned premiums. One of the leading exhibits in the NAIC's annual statement for health insurers, the five-year historical exhibit, shows claims-over-premium and CCE-over-premium ratios, allowing users to compute the insurer's MLR both with and without CCE included in the numerator.

From a theoretical perspective, an MLR in which the numerator includes both claims and CCE (instead of just claims) is attractive for two main reasons. The first is that the inclusion of CCE in the numerator helps mitigate the comparability concerns discussed at length above. The ratio of claims-plus-CCE to premium creates a fairer comparison across different types of health

⁵ We assume that other parties responding to this request for comments will be providing the departments with further information about the existing definition of SSAP 85 cost containment expenses, so we have decided not to discuss those definitions per se, in favor of instead discussing the utility of the CCE concept.

insurance issuers than does the claims-to-premium ratio. The second is that, as one might expect from the name cost containment expenses, the amounts that a health insurance insurer spends on CCE activities lead directly to decreases in the amounts the issuer would need to spend on claim payments under its insurance contracts. As such, it would be somewhat perverse to make comparisons between different issuers as to the proportion of premiums that go towards claims, without simultaneously taking into account the proportion of premiums that go towards activities that explicitly help control the cost of claims, particularly in an environment in which health insurers are being challenged by policymakers to do more to bend the cost curve. (We return to this theme in our response to Question B.1a below.)

While including CCE in the numerator of an MLR-related statistic helps mitigate the potential for inconsistencies across different health insurance issuer business models, it does not completely resolve those inconsistencies. Similarly, while including CCE in the numerator helps address ways in which the insurer provides value to policyholders apart from claims, it does not fully capture all dimensions of value.

Consider once again the example of a capitation payment made by an issuer to a provider group, obviating the need for the issuer to separately adjudicate benefits for each and every healthcare service obtained from that provider group by the issuer's enrollees. Clearly, the amount that the issuer will need to spend on administering the payment of such capitations is significantly less than the amounts that the issuer would need to spend on adjudicating claims for the affected enrollees, were there no capitation arrangement. Similarly, there will be differences from the provider group's standpoint in terms of the amount of its resources it needs to devote to ongoing interactions with the issuer under a capitation arrangement versus a fee-for-service arrangement. Both of these differences will naturally influence negotiations between issuer and provider in setting the level of capitation payment versus the level of payment under a fee-for-service arrangement.⁶ Therefore, in order to get a fair comparison between different issuer business models, it would be necessary to include the issuer's expenses of administering claim payments to providers, together with those claim payments themselves, in the numerator of the medical loss ratio.

The above paragraph motivates the potential value of an MLR definition in which the numerator is broader than the claims-plus-CCE definition discussed previously—broadened via the inclusion of all of the issuer's loss adjustment expenses (LAE). LAE, also known as claims adjustment expenses (CAE), is defined within SSAP 85 to include not only all CCE but also the costs of adjudicating benefits under the enrollee's insurance contract.

The term LAE is also used in other contexts, such as property and casualty insurance. However, with health insurance, it is worthwhile to note that the insurer's LAE activities provide direct and immediate value to the enrollee, independent of the claims to which the enrollee is entitled under

⁶ To make this observation more concrete, we offer a simplified example. Suppose that an issuer believes that claims paid under a fee-for-service contract for a particular population would likely cost \$200 PEPM, and that it would cost the issuer \$15 PEPM to adjudicate claims under a fee-for-service contract. If the issuer also believes in the alternative that it would only cost \$5 PEPM to adjudicate capitations, then the issuer may be willing to enter into a capitation arrangement involving a PEPM payment at a level in excess of the issuer's expected PEPM fee-for-service claims, such as \$205 PEPM.

the policy. This is because the issuer's adjudication process mitigates the enrollee's out-of-pocket costs for all healthcare services, even those that do not generate insurance claims (e.g., before the enrollee's deductible is satisfied), since the issuer's contractual arrangements with healthcare providers are extended to all of the enrollee's healthcare services.

In the NAIC's annual statement for health insurers, one of the most detailed exhibits is the Underwriting and Investment Exhibit Part 2C, which presents historical information on an issuer's claims experience by product. Section C of that exhibit shows ratios of claims-plus-LAE to premiums by product, underscoring the potential value that this broader definition has to regulators.

We have now discussed two alternatives, already depicted within different aspects of NAIC financial reporting, to the claims-over-premium loss ratio definition: one in which the numerator involves claims plus CCE and one in which the numerator involves claims plus LAE. There is a third alternative definition currently used within another aspect of NAIC financial reporting, namely one where the numerator involves claims plus the change in contract reserves; this definition appears in the Accident and Health Policy Experience Exhibit, which presents information on an issuer's current-year experience by product. See further discussion of contract reserves in our response to Question B.1c below.

In summary, multiple definitions of MLR-related statistics exist today within NAIC financial reporting, and increasingly broader definitions help ameliorate deficiencies of the basic claims-over-premium MLR with respect to comparability across issuers and capturing all dimensions of the health insurer's value proposition to consumers.

Finally, we note that none of the MLR-related statistics from current NAIC financial reporting that we have been discussing involve adjustments to the denominator. Nevertheless, as discussed in our response to Question A.1, deducting certain types of federal and state taxes and regulatory fees from the denominator of an MLR calculation is technically sound, from the standpoint of improving comparability across issuers. We discuss this further in our response to Question B.1a.

APPENDIX B

Consider the following hypothetical and simplified example:

\$850	Claims, before cost containment measures
<u>(\$60)</u>	Impact of cost containment measures on claims
\$790	Claims, net of cost containment measures
\$150	Expenses, before cost containment expenses
<u>\$20</u>	Cost containment expenses
\$170	Total expenses
\$40	Provision for risk margin
<u><u>\$1,000</u></u>	Premiums

Here we assume that an issuer: (a) seeks to achieve a margin equal to 4 percent of premium; (b) currently spends 2 percent of premiums on cost containment activities; and (c) manages to reduce claims by \$3 for every \$1 that it spends today on cost containment activities. We also assume that the applicable minimum MLR, for PPACA rebate purposes, is 80 percent.

If cost containment expenses were included in the numerator of the MLR, then in this example the issuer would report an MLR of 81 percent (\$790 plus \$20, divided by \$1000), and hence would not pay out any rebates.

On the other hand, assume that cost containment expenses are not included from the numerator of the MLR, as in the NAIC's exposed definition. The issuer would then report an MLR of 79 percent, and hence would pay out rebates equal to 1 percent of premium, or \$10.

However: If the issuer has to pay out rebates of 1 percent of premium, then its margin has decreased, from 4 percent to 3 percent. To the extent that the issuer believes it needs to achieve a margin of 4 percent in this line of business, it will seek to change its behavior in order to obtain a margin of 4 percent. One of the ways in which the issuer may decide to change its behavior is by reducing the amount that it expends on cost containment activities.

Suppose that the issuer decides to reduce its spending on cost containment activities by 50 percent. This would lead to the following:

\$850	Claims, before cost containment measures
<u>(\$30)</u>	Impact of cost containment measures on claims
\$820	Claims, net of cost containment measures
\$150	Expenses, before cost containment expenses
<u>\$10</u>	Cost containment expenses
\$160	Total expenses
\$40	Provision for risk margin
<u><u>\$1,020</u></u>	Premiums

After the issuer has changed its behavior, total expenses are lower yet, in light of increased claims, premiums are 2 percent higher than they otherwise would have been. The issuer now reports an MLR of 80.4 percent ($\$820$ divided by $\$1020$), so the issuer does not pay out any rebates and achieves a margin equal to 3.9 percent of premium ($\$40$ divided by $\$1020$).

From a consumer perspective, in this example the outcome is actually worse with cost containment expenses excluded from the numerator (after the issuer behavioral change), than with cost containment expenses included in the numerator (in which case the issuer would have no reason to change its behavior): Premiums are $\$1020$ in the former case, but only $\$1000$ in the latter, with no rebates paid in either case.