Carriers that provide comprehensive individual and group health insurance have filed their 2011 SHCE (due April 1) with the NAIC and State insurance regulators. The form is filed on a State by State basis and in grand total. Line 7 on Part 1 reports a “Preliminary MLR” for the individual, small group and large group market segments. The line is meant to report exactly that, a preliminary MLR. It is not meant to represent the actual MLR for rebate purposes.

The SHCE was designed to fulfill reporting requirements imposed by the Federal Patient Protection and Affordable Care Act (ACA). A primary objective is to provide HHS and State regulators with a redefined MLR and with financial data that closely ties to the annual statements filed by the carriers each year in order to facilitate solvency review. The SHCE uses definitions developed by the NAIC and adopted by HHS for components that were added to the traditional MLR calculation by the ACA requirements. The exhibit highlights those new definitions and components, especially the most significant new component of MLR, quality improvement expenses.

The ACA’s redefined MLR adds quality improvement expenses to claims incurred in the MLR numerator (a limited allowance for fraud detection and mitigation expenses is also added). Taxes, regulatory fees and assessments are deducted from premiums earned in the denominator of the ACA’s MLR definition.

As described above, the preliminary MLR reported on Part 1, Line 7 of the SHCE discloses the impact of the new definition / component changes only. The HHS Rebate Form (developed with significant actuarial input from the NAIC) and due on June 1 each year, is designed to provide a final MLR number for the individual, small group and large group business market segments. That MLR / rebate calculation incorporates actuarial and some product aggregation adjustments in addition to considering the impact of the reworked MLR definition. These adjustments include (but are not limited to) the following:

- The HHS Rebate Form includes a credibility adjustment that adjusts the reported MLR whenever the market segment has less than 75,000 member years. It can be expected that one or more market segment of many companies will be impacted by this adjustment which is not reflected in the SHCE.
- Premiums and claims for new business written each year can be excluded from the rebate calculation for that year if such new business accounts for 50% or more of the market segment. If excluded, the data would be added back in the subsequent years’ calculation for that market segment. The SHCE reflects all premium and claims data in the year it is earned or incurred.
- The HHS rebate calculation recognizes situations where coverage issued by two affiliated legal entities is coordinated into a single policy. The experience of these policies is pooled for rebate purposes. It is reported separately each carrier in the SHCE.
- After 2011, and certainly after 2012, multiple years’ data will be included in the calculation of the actual rebate. The SHCE is meant to cover a single calendar year of data.

Further the rebate form which will not be filed with HHS until June 1, allows for a restatement of claims incurred to reflect three months of claims run out for enhanced accuracy.
A goal for the SHCE is to give regulators information about the impact of the definitional changes alone on MLR. The Rebate form takes that to a conclusion by adding the actuarial adjustments to arrive at the final MLR for rebate purposes. Thus regulators will now have all three parts to better understand the financial and market impacts for the MLR:

1. **Traditional MLR before ACA adjustments (calculated from Annual Statement data).**
2. **Impacts of change in MLR elements and definitions on the traditional MLR (this is the “Preliminary MLR” calculated in the SHCE).**
3. **Impact of actuarial / aggregation and timing adjustments on MLR (from the HHS Rebate Form).**

Another goal is to have the definitions and location of data reported on the SHCE be consistent with that reported on the HHS Rebate Form, leaving only the numerical differences. Since HHS did not accept all of the NAIC recommendations, the definitions are not currently completely in sync. Since it is too late for 2011, some adjustments will be required to the SHCE for 2012, and the NAIC has begun the process of developing reconciliation between the SHCE and the Rebate Form for 2012 and beyond. This will rely heavily on input from the health industry and other interested parties.

For those looking for a more representative number on the SHCE for an actual rebate, Part 1, Line 5.5 for Columns 1, 2 and 3 provides the company’s best estimate at 12/31/11 for a rebate to be paid on 2011 policies for each market segment (individual / small group / large group). While regulators will expect to see a relatively high degree of accuracy in this number, insurers have been raising warnings that while the total estimate across all States will be reasonably accurate, State by State estimates may vary in quality by carrier for 2011.

It should also be noted that the 2011 SHCE is based on earlier HHS guidance that indicated that the definition as well as the numerical threshold used for separating individual policies from group policies and small groups from large groups for rebate purposes would be deferred to State market definitions. That has changed and now defaults to the federal definition, but allows the numerical threshold to remain at 50 until 2016 if so dictated in State statute or rule. That HHS decision may also create a difference in how the market columns line up in the SHCE vs., the HHS Rebate Form. In addition, where the Federal group and group size definition differs from State law or rule it will necessarily create a disconnect between rating, which follows State group size requirements, and rebates which follow Federal group size requirements. The NAIC is conducting a survey to determine how pervasive the difference in group size definition is across the States.