

**Division of Actuarial, Market and
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May 17, 2010

TRANSMITTED BY E-MAIL

Mr. Lou Felice
Chair, Health Reform Solvency Impact (E) Subgroup
c/o National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: **Request for Comment on the Health Reform Blanks Proposal Exposure
dated May 12, 2010 re: Medical Loss Ratios (MLR)**

Dear Lou:

First, I would like to express my deepest appreciation for all of the work that you and the NAIC staff have done in preparing the blanks proposal to assist regulators in identifying and analyzing the medical loss ratio for comprehensive major medical health insurance as required in the Patient Protection and Affordable Care Act (PPACA) of 2009 (H.R. 3590). I have reviewed the health reform blanks proposal dated May 12, 2010 and have the following comments.

1. The purpose of the exhibit is not clear. I am assuming that the NAIC will be proposing this Exhibit to satisfy both the requirement for insurers to report loss ratio information as required in Section 2718(a) of the Public Health Service Act (as added by PPACA) and for purposes of the rebate calculation provided for in Section 2718(b) of the Public Health Service Act (as added by PPACA). If so, then I think we should state the purpose in the first paragraph of the instructions. Shown below is suggested language

“The purpose of this supplemental exhibit is to assist regulators in identifying and analyzing the medical loss ratio for comprehensive major medical health insurance as required in the Patient Protection and Affordable Care Act (PPACA) of 2009 (H.R. 3590). This exhibit may be used for purposes of submitting a report to the Secretary required by Section 2718(a) of the Public Health Service Act and for calculating rebates provided for by Section 2718(b) of the Public Health Service Act pursuant to the amendments under Title X of the PPACA.”

2. If the schedule will be used for purposes of the annual report of loss ratio information and the annual rebate, then it seems that the report should be provided on an annual basis rather than a quarterly basis. I understand that this will create the need to define what is meant by “plan year.” I think that we should encourage HHS to define “plan year” to be “calendar year.” We will also need to

- recommend some method to adjust for the “lag” in claim payments. My recommendation would be to require a reporting date three to four months after the end of the year with a provision for interest to be paid from the end of the applicable period for the rebate calculation (i.e., the end of the calendar year). We would also need to have entries to reflect this change in measurement period so that it can be tied back to the financial statement.
3. I believe the MLR for both the annual report of loss ratio information and the annual rebate are contemplated to be made based on “earned” premium and “incurred” claims rather than “written” premium and “paid” claims. If so, then I think the calculation of earned premium and incurred claims on the Supplemental Health Care Exhibit – Part 2 should be based upon the calculation for earned premium and incurred claims in the Accident and Health Insurance Experience Exhibit. For example, I believe the calculation of Earned Premium is based upon premiums “collected” not written and also includes adjustments for the change in deferred and uncollected premiums and the change in advance premiums. In addition, I think any additions or subtractions to earned premiums and incurred claims that we are making in order to match the prescribed calculation in the PPACA should be done in Part 1 of the Exhibit rather than Part 2.
 4. Lines 1.5, it is not clear what the reference to “federal assessments” is. Also, income taxes should be allocated based upon sources of profit.
 5. Line 1.7 should contemplate state income taxes. For example, in SC, HMOs pay state income tax in lieu of premium tax.
 6. Line 1.10/1.11, it appears that these items may be double counted unless they are different than items 1.9-1.12 noted in Part 2. If so, I would delete items 1.9-1.12 in Part 2 if they have not been traditionally included in the calculation of earned premium.
 7. It appears that a line should be added to Item 1 in Part 1 for collections or receipts for risk adjustment and risk corridors.
 8. Lines 4.1 and 4.2, it appears that these items may be double counted unless they are different than items 2.11-2.14 noted in Part 2. If so, I would suggest eliminating the items in 2.11-2.14 noted in Part 2, if they have not been traditionally included in the calculation of incurred claims.
 9. Line 4.3 – It appears that the rebates should be on an accrued basis rather than a paid basis.
 10. Lines 6/8/10 – Why isn’t the denominator Line 1.12?
 11. Why do we not have a G&A Expense Ratio?

12. Lines 12. It is my understanding that the information that will be needed to allocate investment income as requested is not available and any approximation will likely result in distortion of actual results. Thus, I would recommend that investment income only be shown in total.

13. Columns 1,2, and 3 It appears that these columns are intended to include all policies offered in the individual market, small group market, and large group market, as defined pursuant to the PPACA, respectively. If so, I think we should state that in the instructions for Column 1, 2 and 3, respectively.

Please let me know if you have any questions or if you would like to discuss this further.

Sincerely,

Leslie M. Jones
Deputy Director
Actuarial, Market and Alternative Risk Transfer Services