A&HWG PPACA Actuarial Subgroup Issue Resolution Document

IRD034

Issue:

Should there be a transition period before 2014?

Resolved:

Referred 6/1/10.

Exceptions:

Description:

2718(b) references "that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State." Such an adjustment may be appropriate to avoid destabilizing during the transition to 2014.

Documentation in support:

Example of argument for a transition is taken from the letter of May 14, 2010, from America's Health Insurance Plans, HHS reference HHS-OS-2010-004-0067.1.

"In practice, Section 2718 assumes the existence of new infrastructure and market rules that will not be in place when the MLR is implemented. This necessitates the need for clear steps that ensure a transition that does not cause instability and disruption in the marketplace.

"Durational related issues for individual coverage.

"In contrast to the post-2014 environment, the current market is voluntary in nature. This has significant implications for the calculation of MLRs for individual coverage. Approximately, 85% of those with existing individual coverage reside in states where individual coverage is provided on an underwritten, guaranteed renewable basis. This creates a "durational" dynamic where loss ratios are low in the early years of coverage and then rise significantly in later years. Consequently, the relevant NAIC model and most states provide that loss ratios are to be filed on a "lifetime basis" along with a schedule of yearly targets signifying whether coverage is on track to comply with the lifetime target."

Example of argument for a transition is taken from the letter of May 14, 2010, from American Academy of Actuaries, HHS reference HHS-OS-2010-004-0130.1.

"Considerations when determining if a given minimum MLR standard would destabilize the individual market in a particular state should include the following:

- the loss of carriers marketing products;

- the loss of the ability of customers to easily find product offerings due to the reduction or
- elimination of marketing channels;
- the possibility of customers having their current coverage changed materially or canceled;
- the inability of canceled customers to find new coverage that covers pre-existing conditions; and
- the potential for increased volatility in premium rates.

"We are concerned that all of the situations listed above could occur during the transition period between now and 2014 if products currently in force in the individual market are held to an annual MLR standard at the level included in the legislation. Of course, the many open issues as to what the §2718 MLR definition actually means (as discussed in our response to Question B.1a below) and what levels of aggregation are contemplated in §2718 (as discussed in our responses to Questions C.1 and C.2 below) make it difficult to say with certainty that destabilization would or would not occur. Nevertheless, we believe the risk of destabilization with respect to the individual market is significant enough that regulators should consider preemptively addressing that risk in the rulemaking process."

And:

"As an illustrative example, a block of underwritten individual business might exhibit a pattern of relative claim costs by policy duration (expressed as a ratio of the ultimate claim cost in later durations) like the following:

Policy Year (Duration) Relative Claim Cost	
1	0.563
2	0.839
3	0.931
4	0.977
5	0.989
6+	1.000

"To compute a loss ratio pattern that corresponds to this illustrative claim cost pattern and that produces a lifetime loss ratio of 80 percent, one needs to make assumptions about policyholder persistency—the extent to which policyholders continue to maintain their coverage over time.

"The table below is an illustration of loss ratio patterns by policy duration that are consistent with the table above and also consistent with policyholder persistency patterns typically observed in the recent past:

Policy Year (Duration) Annual MLR	
1	49%
2	73%

3	81%
4	85%
5	86%
6+	87%

“For many carriers currently active in the individual market, the greatest amount of business is in the early durations. Many policyholders drop individual coverage when they become eligible for employer-based coverage, and others may remain in the individual market but switch issuers.”

And:

“Moreover, the 80 percent level may not be a realistic target for companies to meet during the transition period with business originally priced in the traditional fashion. Going forward, it may be possible for companies to renegotiate distribution contracts and adjust first year expenses to allow them to meet an 80 percent lifetime MLR on business issued after these renegotiations.

“However, they may be unable to adjust distribution contracts on business currently in force. In addition, while new business may be issued based on meeting a higher lifetime loss ratio, the newly-issued business will still have an annual loss ratio well below the lifetime target loss ratio during the early durations. The result is that actual experience could be much lower than the 80 percent MLR annual refund target during the transition period, even as the companies seek to achieve the higher loss ratio requirements on a lifetime basis.

“Potential implications of applying an annual 80 percent MLR standard to the current individual major medical market could include the following:

- Some companies may remain in the market but may lack an effective distribution channel due to their need to significantly lower their distribution costs to meet the 80 percent MLR standard. Many insurance agents could discontinue selling individual health insurance if insurers materially decrease agent compensation for that product, which could inhibit consumers’ access to the individual market in the years prior to the introduction of insurance exchanges.
- Other companies may decide if it is more advantageous for their long-term solvency to stop selling individual medical products, cancel their currently in-force business, or both.
- To the extent that companies cancel their currently in-force business, it may be difficult for their former policyholders to find new individual coverage in the transition period prior to 2014. For reasons discussed above, fewer companies may be marketing individual products during the transition. Also, guaranteed issue requirements in the individual market will not yet be applicable, and people whose coverage was canceled but who cannot meet underwriting requirements for new products will be subject to a six month waiting period before becoming eligible for coverage under the new federal high risk pools created by PPACA §1101.
- Individual policyholders may be subject to greater volatility and uncertainty with respect to premium rate changes on policy renewal. An annual loss ratio requirement could lead to an environment in which premium rate actions on renewal need to account not only for claims trend and aging, but also for underwriting selection wearoff, which in the early renewal years would potentially be very significant.

“There are some anecdotal indications that some companies are already starting the evaluation process so as to be prepared to cancel their blocks of individual major medical insurance if the implementation of §2718 requirements would result in them having to operate at a loss during the transition. To avoid being required to participate in the 2011 refund cycle, an insurer would need to cancel all its business by Dec. 31, 2010. Under PHSA §2742(c)(2)(A)(i), companies must give 180 days notice to their policyholders of cancellation. This means that companies would need to make final decisions on block cancelations in mid-June in order to exit their business prior to 2011. This highlights the need to clarify these issues quickly.

“Due to the inherent inconsistency between the lifetime pricing methodology required for this type of business, the durational variation in loss ratios for medically underwritten business already in force, and the annual MLR computation, it may be appropriate to consider options in the MLR computation for the individual major medical product. To avoid disruptions in this market, these options need to be announced by mid-June of 2010 to have an impact on carrier decisions for their existing blocks of individual business.

Potential Approaches

“We now discuss several options that may be available to regulators in order to mitigate this situation. These options are not mutually exclusive, and combinations of two or more of the approaches described below may be worth considering. We recognize that potential avenues open to regulators are likely restricted by the existence of the statute; however, we wanted to present a wide array of options and leave it to regulatory judgment as to the extent to which each of these options may or may not be compatible with the statute.

(1) *Lower the 80 percent threshold for grandfathered individual business*. One option would be to lower the threshold on a permanent basis, recognizing that many blocks of grandfathered business were priced to a lifetime loss ratio below 80 percent.

Alternatively, while a lower threshold could be established for the immediate future, over time that threshold could grade up to 80 percent, reflecting that the aggregate MLR of grandfathered individual business can be expected to rise over time as the average policy duration of that closed block increases.

This solution is comparatively easy to implement. However, it would still result in a calculation that disproportionately affects insurers whose blocks have a high concentration of early-duration business, as opposed to issuers with more mature blocks.

(2) *Rather than applying an 80 percent MLR threshold in aggregate, develop different MLR thresholds that vary by policy year or by calendar year of issue*. These different MLR thresholds by year would be chosen in a way that targets an 80 percent lifetime MLR. (Note that this may involve thresholds in later durations being above 80 percent and thresholds in earlier durations below 80 percent.)
This approach is attractive because it directly addresses the potential for disproportionate impact across carriers based on their durational mix.

Several variations on this general approach could be adopted. For instance, in light of credibility concerns (see further discussion later in this document), tolerance adjustments could apply to each of the different MLR thresholds, where rebates would not be payable if the actual annual experience was below the MLR threshold but within the tolerance adjustment. In that context, it might be appropriate to have wider tolerance adjustments in the earlier years of issue, narrowing over time (and possibly becoming negative), and it might be appropriate for the tolerance adjustments to somehow incorporate the extent to which the original pricing lifetime loss ratio for grandfathered products varies from 80 percent. Tolerance adjustment concepts such as these might provide insurers with a longer span of time to adapt to the new 80 percent standard in a manner that is relatively non-disruptive to consumers.

(3) *Exclude experience in the select period of underwritten individual business from the scope of the MLR rebate calculation*. By "select period," we mean the period of time in which underwritten individual business is expected to exhibit annual loss ratios that are materially below the lifetime loss ratio, due to the impact of underwriting. The select period could be deemed by regulation (e.g., two or three years). As such, under this approach a policy would not be subject to rebate provisions during the first two (or three) years, but then rebates would start to be applicable to that policy thereafter.

This approach has the advantage of preserving the statutorily-imposed 80 percent MLR threshold, at least for part of the market. This approach also addresses the concern about disproportionate impact on carriers based on their mix of business by duration. On the other hand, this approach would mean that a large segment of the individual market business would not be immediately subject to the scope of rebates, even though those blocks would eventually become subject to rebates as they mature.

(4) *Allow issuers for purposes of §2718 to calculate contract reserves using a federally defined methodology*[3] *and include the change in contract reserves in the numerator of the §2718 MLR*. As discussed later in this document, language in §2718(a) suggests that changes in contract reserves were intended to be part of the MLR numerator. Practice varies widely today among issuers as to whether or not contract reserves are established, for purposes of NAIC financial reporting, to reflect the durational pattern of loss ratios for underwritten individual medical business. Without regard to whether an insurer currently establishes contract reserves in its NAIC financial reporting, it may be desirable and appropriate for issuers to calculate contract reserves, using a federally-defined methodology, for purposes of determining the §2718 MLR.

This approach has the theoretical appeal of directly addressing each insurer's own situation regarding the durational mix issue, rather than applying one-size-fits-all solutions as in the approaches discussed above. On the other hand, this approach would require additional regulatory oversight with respect to assessing the appropriateness of

[3] We note that there is existing precedent in federal regulation for this type of approach, in CFR Title 42 §403.253(b)(2)(ii) with respect to federal Medicare Supplement loss ratio certifications.

the issuer's calculation of contract reserves. This can be partially mitigated by requiring an actuarial certification of the contract reserves computed for this context.

Variations on this approach would include different choices for technical details of the reserving methodology, whether issuers are required to calculate contract reserves or instead can elect to do so, and whether the contract reserve calculation applies to all individual business or only subsets (e.g., business issued on or after a particular date).

"We should point out that although the issues regarding the 80 percent MLR threshold are most pronounced for grandfathered individual business, issues do exist for business written after the adoption of PPACA but before 2014 and for business written after 2014:

- Individual policies written after the adoption of PPACA but before 2014 will continue to exhibit durational variation of medical loss ratios. As such, approaches like (2), (3), and (4) above are relevant to this category of business. A company's willingness to issue new individual medical business prior to 2014 may be jeopardized if the newly-written business must immediately meet an 80 percent annual MLR standard, without recognition of the impact that policy duration has on loss ratios.
- It is unclear at this time to what extent individual policies written in 2014 and later, after the introduction of guaranteed issue requirements, will continue to exhibit durational variation in loss ratios. For example, if guaranteed issue is implemented via an annual open enrollment period, then insurers may still employ some underwriting techniques at times other than the open enrollment. In that case, we may still see some impact of policy duration on loss ratios, and approaches such as (2), (3), and (4) above may remain relevant to business issued in 2014 and later.

"As the individual market is unlike any other major medical market, the Academy would be willing to provide further assistance on these issues to help in the rulemaking process."

Documentation in opposition:

Evaluation:

Exceptions:

Attachments: