

Submitted by Rick Diamond  
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This draft is for discussion purposes and reflects ~~only~~ my own thoughts supplemented by comments from and discussions with other state regulators, the American Academy of Actuaries, insurance industry groups, consumer representatives, and others. Changes from the April 24 draft are shown in Track Changes mode. Further comments are invited by Friday, May 9 (sooner is better). The language will be finalized for delivery to NAIC leadership by May 11.

The questions below are from the Federal Register on April 14, 2010. My draft responses are in *blue italics*. Also, some areas where I have questions are noted in *bold*.

**Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act**

**AGENCIES:** Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of the Secretary, Department of Health and Human Services.

**ACTION:** Request for information.

**General Comment**

*Several of the specific questions ask what states require or how they will be impacted. We surveyed the states concerning these questions. Due to time constraints, responses were only received from 22 states. A spreadsheet showing the responses is being submitted with this document. The American Association of Health Plans (AHIP) publishes a chart with information about the requirements of all states that have such requirements. As part of our survey, we asked states to verify the information in the AHIP chart. Several corrections were noted and are shown in the first row of the spreadsheet. On the whole, it appears the AHIP chart is fairly accurate, although some details and nuances are not reflected. For the states that did not respond to our survey, we believe the AHIP chart is the best readily available source of information, with the caveat that it contains some inaccuracies.*

Specific Areas in Which the Departments Are Particularly Interested Include the Following:

**A. Actual MLR Experience and Minimum MLR Standards**

The PPACA sets an 85 percent minimum standard for the percentage of premiums that coverage in the large group market spends on reimbursement for clinical services and activities that improve quality, and an 80 percent minimum standard for the small group and individual markets - allowing for higher State-level standards where appropriate (if they are specified in regulations). The PPACA allows the Secretary to adjust this percentage for the individual market in a given State: 1) if the Secretary determines that application of the 80 percent standard may destabilize the individual market in that State, and/or 2) on account of the volatility of the individual market due to the establishment of State Exchanges.

**1. How do health insurance issuers' current medical loss ratios for the individual, small group, and large group markets compare to the minimum standards required in PPACA?**

*It is difficult to compare because the definition of the MLR in PPACA is quite different from the MLR typically used by the NAIC and various states. ~~Furthermore the details of the PPACA MLR calculation are still unclear. Some things are clear though. The denominator (premiums) in the PPACA MLR is reduced by federal and state taxes and licensing or regulatory fees and the numerator (claims) is increased by expenses for activities that improve health care quality. Typically MLR's currently in use do not adjust premiums for taxes, and do not increase claims by quality improvements.~~ Both of these adjustments will result in a higher MLR than one calculated as incurred claims divided by earned premiums with no adjustment. As discussed below (question B.1.c), PPACA could be read to also include loss adjustment expenses in the numerator, which would further increase the result. In either case, we believe current MLR's for most issuers in the small group and large group markets, when calculated with the PPACA adjustments, would be higher than the PPACA minimums. The situation is less clear in the individual market. Some issuers would likely have MLR's below 80% even after the adjustments, while others would be well above the minimum.*

**a. What factors contribute to annual fluctuations in issuers' medical loss ratios?**

*Several factors result in fluctuations from year to year, including but not limited to the following:*

- The smaller a block of policies is, the more experience will fluctuate due to random variations. For example, one large claim can cause a sharp increase in the MLR for a very small block.*
- Rates are generally set based on projected trends, which in turn are based on past trends and expectations about future changes. Actual trends will usually turn out to be higher or lower, resulting in fluctuations in the MLR.*
- At least in some markets for some time periods, cyclical variations have been observed, where MLR's are lower for a few years and then higher for a few years. This is called the "underwriting cycle."*
- For individual policies, especially in the majority of states where medical underwriting is permitted, MLR's are much lower in the early years after a policy is issued and increase over time as underwriting "wears off" and more health problems develop. If the block of policies being measured contains a steady mix of older and newer policies, they will offset each other, but for a relatively new plan, where all of the policies are in their early years, the MLR will be much lower. Conversely, for a block of policies no longer being issued, all of the policies will be in their later years and have higher loss ratios. This effect should lessen over time after 2014, when medical underwriting will be prohibited.*

**b. To what extent do States have different minimum MLR requirements based on plan size, plan type, number of years of operation, or other factors?**

*Response to be completed based on survey of states See General Comment above and the spreadsheet submitted with this document.*

**2. What criteria do States and other entities consider when determining if a given minimum MLR standard would potentially destabilize the individual market? What other criteria could be considered?**

*The primary factor is the extent to which issuers would be unable or unwilling to meet the standards and would therefore withdraw from the market and terminate existing policies. In the worst case, this could lead to a lack of available coverage, but even if coverage remains available, those with health conditions who are terminated by withdrawing issuers could be left with no access for up to six months because in most states, issuers will be permitted to medically underwrite until 2014. ~~In that case, they may have to remain uninsured for~~ After six months, ~~when~~ they would qualify for the new federal high risk pools.*

The American Academy of Actuaries has noted three ways in which the MLR standard could cause disruption to consumers in the individual market:

- “1. Applying an 80 percent MLR requirement to existing individual business that had originally been priced under different (lower) MLR expectations may require a company to reduce the premiums it ultimately retains (i.e., collected premiums less rebates) to levels that create losses, with little to no ability to recover those losses. Materially reducing the non-claims costs associated with existing business in order to reduce financial losses is unlikely to be feasible. Such a situation might lead some companies currently active in the individual market to terminate the existing blocks of business and leave the market, in an effort to avoid those future losses and the potential solvency concerns associated with those future losses. If some companies do exit the individual market, then those companies’ former policyholders may find themselves unable to find new coverage in the individual market for a period of years (noting that guaranteed issue requirements do not take effect until 2014), and would not be eligible for the new high risk pools created by PPACA §1101 during the first six months after cessation of coverage.
- “2. Individual policies underwritten and issued prior to the introduction of guaranteed issue requirements in 2014 will continue to exhibit traditional patterns of having loss ratios that increase by policy duration. Issuing new underwritten policies over the next few years would therefore tend to make it more difficult for an insurer to achieve an 80 percent annual MLR across its entire block of individual medical business. This could serve as an incentive for carriers who remain in the individual market to minimize their marketing activity prior to 2014, creating a potential lack of product availability in the individual market over the next few years.
- “3. Since the MLR for underwritten individual products typically increases with policy duration, a company whose individual book of business has a higher proportion of recently-sold business may find it more difficult to achieve an 80 percent annual MLR in the near future than a company having a more mature book of business (and a correspondingly higher MLR). As such, the application of uniform annual MLR requirements could have a

disproportionate impact across companies, which could lead to additional volatility in premium and rate change levels in the individual market.”<sup>1</sup>

We note that most of these issues arise only during the period prior to 2014. It may be desirable to reduce the minimum MLR in the individual market in many states during this initial period.

## B. Uniform Definitions and Calculation Methodologies

The statute requires health insurance issuers offering group or individual health insurance coverage to annually submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums – including the percentage of premiums spent on reimbursement for clinical services provided to enrollees, activities that improve health care quality, and on all other non-claims costs. PPACA also directs NAIC to develop uniform definitions and methodologies for calculating these statistics (subject to certification by the Secretary).

### **1. What definitions and methodologies do States and other entities currently require when calculating MLR-related statistics?**

Response to be completed based on survey of states See General Comment above and the spreadsheet submitted with this document.

#### **a. What assumptions and methodologies do issuers use when calculating MLR-related statistics? What are some of the major differences that exist, as well as pros and cons of these various methods?**

*Issuers may use different methodologies for different purposes, such as internal monitoring, financial statements, and rate filings. For financial statements, the loss ratio in the NAIC A&H (Accident & Health) Policy Experience Exhibit includes incurred claims plus the increase in contract reserves in the numerator and earned premiums in the denominator. No administrative expenses are included in the numerator and no reductions to earned premium are made for taxes and fees. Because the statement must be completed soon after the end of the year, incurred claims reflect an estimate of the “runout” – that is the amount that will be paid after the end of the year on claims incurred during the year.*

*For rate filings, the methodology will depend on the requirements of the each state. Typically, incurred claims for past years are restated to reflect actual runout. Some states include cost containment expenses in the numerator, while others do not. Still others do not specify, in which case the issuer may include these expenses.*

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<sup>1</sup> Letter from the American Academy of Actuaries Medical Loss Ratio Regulation Work Group to Lou Felice, Chair, Health Care Reform Solvency Impact Subgroup, NAIC and Steven Ostlund, Chair, Accident & Health Working Group, NAIC

*For purposes of the new federal requirement, the extent to which actual runout can be reflected rather than an estimate will depend on how soon the loss ratios must be reported after the end of the year. The advantage to allowing more time is that the incurred claims will be more accurate and less dependent on assumptions. The trade-off would be the delay in determining and paying rebates. One possibility would be to include the increase in the estimated liability for unpaid or unreported claims over the prior year. In that way, an inaccurate estimate will to some extent be corrected the following year. However, that would not be the case if the liability were consistently over- or under-estimated.*

*The administrative expenses to be included in the numerator will depend on interpretation of the statute, as discussed under question (c) below.*

**b. What kinds of assumptions and methodologies do issuers currently use for allocating administrative overhead by product, geographic area, etc.? What are the pros and cons of these various methods?**

*[Do we have anything to say here?]*

**c. What kinds of assumptions and methodologies do issuers currently use when calculating the loss adjustment expense (or change in contract reserves)? What are the pros and cons of these various methods?**

*~~This language in the law is confusing, as~~ Loss adjustment expense and the change in contract reserves (as the terms are generally used) are very different things. Loss adjustment expenses (or claim adjustment expenses) are administrative expenses associated with the payment of claims. For financial reporting purposes, the specific expenses to be included are spelled out by the NAIC<sup>2</sup> and are subdivided into two categories: cost containment expenses such as case management, utilization review, fraud prevention, and network access fees, and other claim adjustment expenses, such as determining and paying claims, record-keeping, office expenses, and supervisory and executive duties. It is unclear whether these are the types of expenses intended by the term “loss adjustment expense” in PPACA or whether the parenthetical indicates that in this context “loss adjustment expense” is intended to mean the change in contract reserves.*

*Contract reserves are liabilities shown in the issuer’s financial statement to reflect the extent to which future premiums are not expected to be adequate to pay future ~~claims~~ benefits. Contract reserves are not ~~usually held with respect to~~ as common for medical insurance because each year’s premiums are usually intended to cover all claims for the year. For ~~as for~~ other types of insurance, such as long-term care insurance, contract reserves are needed because ~~where~~ premiums are usually based on the age of the insured at the time the policy was issued, while claims increase each year as the person ages.*

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<sup>2</sup> Statement of Statutory Accounting Principle (SSAP) 85.

*It is appropriate to reflect the change in contract reserves to the extent it reflects ~~claims-benefits~~ to be paid in the future that must be funded by the current year's premiums. State regulatory requirements set forth methodologies and assumptions define a minimum level for contract reserves when needed. Adequate reserves are essential to assure solvency. However, for purposes of minimum loss ratios, it is also important that reserves are not overstated. ~~While it may be appropriate in some circumstance to hold r~~Reserves larger than the minimum standard, ~~they~~ should not be based on unrealistic assumptions that would inflate the loss ratio. **[Question for those with more experience than I have with financial exams: Do they typically look at whether reserves are overstated or do they only ensure they are not understated?]***

*Similarly, if loss adjustment expenses are to be included in the loss ratio, it is important that reasonable allocation methods be used to separate these expenses from other administrative expenses.*

**d. To what extent do States and other entities receive detailed information about the distribution of non-claims costs by function (for example, claims processing and marketing)? To what extent do they set standards as to which administrative overhead costs may be allocated to processing claims, or providing health improvements?**

*See General Comment above and the spreadsheet submitted with this document.*

*The NAIC Annual Statement, which must be completed by all licensed insurers, includes an exhibit with a detailed breakdown of expenses. A copy of the exhibit for health insurers is appended to this response to show the specific product types appended (Appendix ~~BA~~). **[I used the 2009 version because it was what I could find easily. Are there any changes for 2010?]** Life insurers also offer health insurance and the annual statement for life companies contains a similar exhibit but with some differences in the categories shown. Most notably, with the exception of cost containment expenses, the life company exhibit does not separate claim adjustment expenses from other administrative expenses. For both health and life companies, the data may include types of policies other than those to which the new federal MLR requirements apply. The data is on a national basis and is not split by state. As noted in the response above, the specific expenses to be included in claim adjustment (claims processing) expenses are spelled out in Statement of Statutory Accounting Principle (SSAP) 85. **[Should we append this?]***

*~~[Additional response to be added based on survey of states.]~~*

**e. What kinds of criteria do States and other entities use in determining if a given company has credible experience for purposes of calculating MLR-related statistics?**

*Response to be completed based on survey of states See General Comment above and the spreadsheet submitted with this document. **[Should we include a description of how credibility is addressed in the Medicare supplement refund calculation? If so, can someone provide this?]***

**f. What kinds of special considerations, definitions,**

and methodologies do States and other entities currently use relating to calculating MLR-related statistics for newer plans, smaller plans, different types of plans or coverage?

*~~Response to be completed based on survey of states~~ See General Comment above and the spreadsheet submitted with this document.*

2. What are the similarities and differences between the requirements in Section 2718 compared to current practices in States?

*~~Response to be completed based on survey of states~~ See General Comment above and the spreadsheet submitted with this document.*

a. What MLR-related data elements that are required by PPACA do issuers currently capture in their financial accounting systems, and how are they defined? What elements are likely to require systems changes in order to be captured?

*~~{Do we have anything to say here?}~~*

b. What MLR-related data elements that are required by PPACA do States or other entities currently require issuers to submit, and how are they defined? What elements are not currently submitted?

*~~Response to be completed based on survey of states~~ See General Comment above and the spreadsheet submitted with this document.*

3. What definitions currently exist for identifying and defining activities that improve health care quality?

*~~Response to be completed based on survey of states~~ See General Comment above and the spreadsheet submitted with this document.*

a. What criteria do States and other entities currently use in identifying activities that improve health care quality?

*~~Response to be completed based on survey of states~~ See General Comment above and the spreadsheet submitted with this document.*

b. What, if any, lists of activities that improve health care quality currently exist? What are the pros and cons associated with including various kinds of activities on these lists (for example disease management and case management)?

*~~Response to be completed based on survey of states~~ See General Comment above and the spreadsheet submitted with this document.*

Including quality expenses in the numerator of the MLR for rebate purposes will create a strong incentive for issuers to classify as many expenses as possible in this category. Therefore it is important not only to specify the types of activities to be included by name, but to distinguish between different activities that may have the same name. For example, a “case management” program typically includes activities intended to improve continuity and quality of care, but it is not difficult to imagine a utilization review program being renamed a case management program. States can monitor the actual operation of quality improvement programs through market conduct reviews.

It also may be advisable to distinguish between activities that improve quality and those that only reduce costs. While both may be desirable, the statute only refers to improving quality. Quality improvement expenses would include things such as nurse hotlines and statistical measurement systems such as HEDIS. Cost reduction activities would include things such as utilization review and statistical activities to ensure correct coding.

One area that may need careful consideration is IT (information technology) spending. This is a broad category, some of which may improve quality and some of which may be unrelated to quality.

**c. To what extent do current calculations of medical loss ratios include the amount spent on improving health care quality? Is there any data available relating to how much this amount is?**

Response to be completed based on survey of states See General Comment above and the spreadsheet submitted with this document.

**4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?**

Rebates are based on the "plan year." It is not clear whether this means the plan year for each employer (as defined by ERISA) or a calendar year or some other 12-month period applicable to all of an issuer's policies. Insurers report financial results on a calendar-year basis. These could not be used as a basis for loss ratio reporting if loss ratios are to be reported for a different period. Also, if plan year is determined at the employer level, a method would need to be a specified for combining the results for plans with differing plan years, such as combining all plan years that end during a given calendar year ~~would be problematic~~. In addition, if plan year is determined at the employer level, some other ~~method~~ definition would be needed for the individual market.

### C. Level of Aggregation

Depending on the context, insurance-related data may be aggregated at the policy form level, by plan type, by line of business, by company, by State.

**1. What are the pros and cons associated with using various possible level(s) of aggregation for different contexts**

relating to implementation of the provisions in Section 2718 (that is, submitting medical loss ratio-related statistics to the Secretary, publicly reporting this information, determining if rebates are owed, and paying out rebates)?

*Submitting medical loss ratio-related statistics: The extent to which experience should be separated for reporting purposes should be determined by how the data will be used. Specifically, it will have to be reported separately to the extent needed The desired level of aggregation may be different for public reporting and versus determination of rebates. These are discussed below. If a different level of aggregation is used for rebate determination, it may be desirable to make that report publicly available as well so that consumers can determine whether they are eligible for a rebate.*

*Publicly reporting: This may depend on the intended audience. Some cConsumers may find higher levels of aggregation easier to understand and might be overwhelmed by detailed breakdown. The More detail may be of interest to ~~some, such~~ others and to ~~as~~ policy analysts. One option would be to offer more than one configuration of the data.*

*Determining if rebates are owed: At a minimum, business subject to different loss ratio standards must be treated separately. Therefore, large group business must be treated separately because it is subject to a higher standard (unless a state requires the same standard for small groups). It would also be preferable to treat the small group and individual markets separately except in states that combine the two markets. It is generally more difficult to meet the 80% minimum standard in the individual market due to the higher administrative expenses associated with marketing and servicing policies at the individual level. If the two markets are treated together for purposes of determining rebates, an issuer with business in both markets could use higher small group loss ratios to offset lower individual loss ratios. This would create an unlevel playing field for issuers in only the individual market. Also it would mean individual policyholders might not get rebates to which they are arguably entitled.*

*The question of further disaggregation within a market is a more difficult one. One key consideration is credibility. If a block of business is too small, the experience will not be credible, meaning it is subject to random statistical fluctuation resulting in a very low loss ratio in some years and a very high one in other years, perhaps due to one or two large claims. We note that beginning in 2014, three-years of experience will be used, which will improve credibility. For sufficiently large blocks of business, it may make sense to treat different types of products separately if they are rated on different bases. One possibility would be to separate HMO, PPO, and indemnity business. Further breakdown, such as by policy form might be feasible if the block is large enough.*

*~~[I'm not sure what to say about the pros and cons here.]~~ There are good arguments for and against more granularity (less aggregation) for rebating purposes. It might prevent a carrier from charging excessive rates on one segment of its business and offsetting the low loss ratios with lower rates on a segment where the market is more competitive. On the other hand, it could have the unintended consequence of higher premiums. Currently a carrier can offset losses due to unfavorable experience on one product with gains from favorable experience on another. If the gains must be paid out in rebates, higher rates may be needed to build in more risk margin.*

As a general principle, it might be desirable to combine blocks if they are intended to produce similar profit margins (but may not due to unexpected variations in experience) and to separate blocks if they are intended to offset competitive rates on one block with excessive rates on another. The catch is that it may be difficult to distinguish between the two.

Also, more granularity could be problematic for a new product, particularly in the medically underwritten individual market, because loss ratios are low at the early durations. (This could be a problem even with more aggregation if all of the company's business is in early durations.)

In any event, if blocks within a market within a state are to be treated separately, there should be provisions for combining smaller blocks based on some standard of credibility.

*Paying out rebates: Although section 2718 specifies that rebates are to be provided to each enrollee, this may be unreasonable in cases where all or some of the premium was paid by the employer or some other entity. If possible, it would be more equitable to pay the rebate to those who paid the premium. In the common situation where both the employer and the employee contribute toward the premium, the rebate should be prorated.*

**2. What are the pros and cons associated with using various possible geographic level(s) of aggregation (e.g., State-level, national, etc.) for medical loss ratio-related statistics in these same contexts (i.e., submitting medical loss ratio-related statistics to the Secretary, publicly reporting this information, determining if rebates are owed, and paying out rebates)?**

*Submitting medical loss ratio-related statistics: The extent to which experience should be geographically separated for reporting purposes should be determined by how the data will be used. Specifically, it will have to be reported separately to the extent needed for public reporting and determination of rebates. These are discussed below.*

*Publicly reporting: It would be reasonable to report loss ratios at the same level of geographic aggregation used for determining rebates, discussed below.*

*Determining if rebates are owed: At a minimum, business subject to different loss ratio standards must be treated separately. Since states can establish different MLR standards, each state should probably be treated separately, except perhaps in the case of states that have combined their markets through an interstate compact. Although it might be possible to combine non-compacting states that have the same MLR standard, it would not be equitable since rating standards may vary. For example, if rates are higher in State A than in State B because State B regulates rates more tightly, and as a result the loss ratio is below the minimum in State A, combining the experience for both states would result either in no rebates (if the combined experience met the minimum standard) or in smaller rebates in State A and unwarranted rebates in State B.*

*–Business in different geographic regions within a state should not be separated unless there is a compelling reason to do so. For example if rates are more competitive in one area of a state, perhaps because there is a low-cost HMO operating there but not in other parts of the state,*

ratepayers in other areas may not get rebates to which they are arguably entitled unless each area is treated separately. If areas are treated separately, it may be desirable to have an exception whereby the areas can be combined for an issuer with insufficient business in one area to be credible.

*Paying out rebates: [It is unclear to me what geographic aggregation means in the context of paying out rebates.]*

#### D. Data Submission and Public Reporting

PPACA requires health insurance issuers offering group or individual health insurance coverage to annually submit data to the Secretary relating to several medical loss ratio-related statistics (including the percentage of premiums spent on reimbursement for clinical services provided to enrollees, activities that improve health care quality, and on all other non-claims costs) for posting on the Department's Internet web site.

**1. To what extent do States or other entities currently require annual submission of actual medical loss ratio-related statistics for the individual, small group, and large group markets? How do these current requirements compare with the requirements in PPACA?**

*See General Comment above and the spreadsheet submitted with this document.*

*The NAIC Annual Statement, which must be completed by all licensed insurers, includes the "A&H Policy Experience Exhibit." This exhibit shows, separately for a variety of product types: (1) Premiums Earned, (2) Incurred Claims Amount, (3) Change in Contract Reserves, (4) Loss Ratio, (5) Number of Policies or Certificates as of Dec. 31, and (6) Number of Covered Lives as of Dec. 31. A copy of the exhibit is appended to this response to show the specific product types (Appendix ~~CB~~). [I used the 2009 version because it was what I could find easily. Are there any changes for 2010?] The data is on a national basis and is not split by state. As noted above under question B.1.a, the definition of the loss ratio in this exhibit includes only incurred claims plus the increase in contract reserves in the numerator and unadjusted earned premiums in the denominator.*

*[Additional response to be added based on survey of states.]*

**2. How soon after the end of the plan year do States and other entities typically require issuers to submit the required MLR-related statistics? What are the pros and cons associated with various timeframes?**

*See General Comment above and the spreadsheet submitted with this document.*

*The NAIC Annual Statement, including the A&H Policy Experience Exhibit, is due March 1 of each year. Extensions may be granted in some cases.*

*[Additional response to be added based on survey of states.]*

*Some of the claims incurred during a year will not be paid until after the end of the year. Amounts paid after the end of the year are sometimes referred to as “runout.” Depending on when the MLR is calculated, some or all of the runout will be estimated. The longer the lag between the end of the year and the date the MLR is calculated, the greater the accuracy, because more of the runout will reflect actual experience and less will need to be estimated. Although some payments (or recovery of excess payments) may occur a year or more after the end of the year, the bulk of the runout will occur in the first month or two. Some lag will be needed between the time the MLR is calculated and the time it is reported to allow for checking and review. Therefore a reporting date in the range of three or four months after the end of the year may represent a reasonable trade-off between accuracy and timeliness. Alternatively, as discussed under question B.1.a, inaccuracies resulting from an early reporting date could to some extent be corrected the following year by including the increase in the estimated liability for unpaid or unreported claims over the prior year.*

**3. What kinds of supporting documentation are necessary for interpreting these kinds of statistics? What data elements and format are typically used for submitting this information?**

*See General Comment above and the spreadsheet submitted with this document.*

*The data elements and format of the NAIC A&H Policy Experience Exhibit are shown in Appendix B.*

*[Additional response to be added based on survey of states.]*

***[Do we have anything to say about what kinds of supporting documentation are necessary for interpreting these kinds of statistics? Perhaps something relating to how the claims runout is estimated?]***

**4. What methods do issuers use for purposes of submitting medical loss ratio-related data to these entities (for example, electronic filing and paper filing)?**

*Some states may require a particular method while others do not. Methods include completing online forms, submitting spreadsheets, text, or PDF documents by email, fax submissions, or paper filings.*

**5. To what extent is MLR-related information submitted to States or other entities currently made available to the public, and how is it made available (for example, level of aggregation, and mechanism for public reporting)? What are the pros and cons associated with these various methods?**

*Response to be completed based on survey of states See General Comment above and the spreadsheet submitted with this document.*

***[Do we have anything to say about the pros and cons associated with these various methods?]***

**6. Are there any industry standards or best practices relating to submission, interpretation, and communication of MLR-related statistics?**

*[Do we have anything to say here?]*

**7. What, if any, special considerations are needed for noncalendar year plans?**

*This question relates to the definition of “plan year” discussed above under question B.4. If plan year is determined at the employer level, either the cohort of plans beginning in each month of the year must be treated separately or some methodology must be determined to combine experience for varying plan years. Treating each separately would be likely to result in credibility issues because an issuer may have very few plans with plan years beginning in some months. Combining them would result in long delays between the end of some plan years and the date the MLR is reported. For example if all plan years ending during a given calendar year are combined and the MLR is reported three months after the end of the year, then for plan years beginning in February 1, there will be 14 months between the end of the plan year and the reporting date.*

**E. Rebates**

PPACA requires health insurance issuers whose coverage does not meet the applicable minimum standard for a given plan year to provide rebates to enrollees on a pro rata or proportional basis. The rebate is to be calculated based on the product of: (1) the amount by which the applicable minimum standard exceeds the percentage that the coverage spent on clinical services and quality improvement for a given plan year; and (2) the total amount of premium revenue for that plan year (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of PPACA).

**1. To what extent do States and other entities currently require MLR-related rebates for the individual, small group, large group, and/or other insurance markets, and how are these rebates calculated and distributed?**

*~~Response to be completed based on survey of states~~ See General Comment above and the spreadsheet submitted with this document.*

**2. How soon after the end of the plan year do States and other entities currently require issuers to determine if rebates are owed?**

*~~Response to be completed based on survey of states~~ See General Comment above and the spreadsheet submitted with this document.*

**3. What are the pros and cons of various timeframes and methodologies for calculating rebates?**

*As discussed above under question D.2, there is a tradeoff between allowing time for claims runoff to achieve more accuracy and timely reporting and payment of rebates. A rebate*

determination date in the range of three or four months after the end of the year may represent a reasonable balance. Elements of the methodology include the level of aggregation, discussed above, and the items to be included in the numerator and the denominator. The latter is set forth in statute, but the language appears to be subject to interpretation. The language in section 2718(b) seems to say that the numerator includes only amounts expended for “reimbursement for clinical services provided to enrollees” and “activities that improve health care quality.” However, section 2718(a) indicates that the numerator includes “incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves),” although it is unclear whether this definition relates to rebates or only to reporting. These terms are discussed above under question B.1.c.

**4. How do States and other entities currently determine which enrollees should receive medical loss ratio-related rebates?<sup>3</sup> What are the pros and cons associated with these approaches?**

*Response to be completed based on survey of states* See General Comment above and the spreadsheet submitted with this document.

~~**[Do we have anything to say about pros and cons?]**~~ The advantage to providing rebates to current policyholders would be administrative simplicity. Rebates could be deducted from current premiums, avoiding the need to issue checks. The disadvantage would be that those receiving the rebates would not always be the same as those who paid the premiums that generated the rebates. Paying rebates only to current policyholders who were enrolled in the coverage during the applicable time period would introduce some administrative complexity but would avoid paying rebates to those who did not pay the premiums. Paying rebates to all policyholders who were enrolled in the coverage during the applicable time period, regardless of whether currently enrolled, would be the most equitable and the most administratively complex, as the issuer may not have current addresses for those who are no longer enrolled.

**5. What method(s) do States and other entities currently require issuers to use when notifying enrollees if rebates are owed, and paying the rebates? What are the pros and cons associated with these approaches?**

*Response to be completed based on survey of states* See General Comment above and the spreadsheet submitted with this document.

~~**[Do we have anything to say about pros and cons?]**~~

**6. Are there any important technical issues that may affect the processes for determining if rebates are owed, and calculating the amount of rebates to be paid to each enrollee?**

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<sup>3</sup> For example: current policyholders, current policyholders who were enrolled in the coverage during the applicable time period, or all policyholders who were enrolled in the coverage during the applicable time period (regardless of whether they are still active policyholders).

*The law provides that beginning in 2014, rebates will be determined each year based on a three-year average. It is not clear how rebates paid in one year will affect the rebate calculation in subsequent years. If they are not reflected, a low loss ratio in one year could result in double or triple payment of rebates, as that year's experience will be included in the three-year average in three different years. If they are reflected as a policy benefit in the numerator (or perhaps as a reduction to earned premiums in the denominator), ~~(or perhaps as an addition to the numerator)~~, it will make a difference whether the rebate is reflected in the year it is paid or allocated among the year or years for which the experience gave rise to the rebate. If it is reflected in the year paid, it will be fully reflected in each of the next three three-year averages, resulting in a higher calculated MLR. If it is allocated to the year or years for which the experience gave rise to the rebate, amounts allocated to the period before the three-year average currently being calculated will not be considered. If the MLR was below the target in only one of the three years or in all three years, the allocation would be relatively straight-forward. However, if the MLR was higher than the target in one year and lower in the other two, some thought would need to be given to how to allocate the rebate between the two low years.*

***[Do we have other technical issues?]***

#### F. Federal Income Tax

Under Section 9016 of the PPACA, the amendment to Section 833 of the Code applies to taxable years beginning after December 31, 2009. Under Section 2718(c) of the PHS Act, the NAIC is directed to establish uniform definitions for purposes of the reporting required under Section 2718(a) not later than December 31, 2010.

**What guidance, if any, is needed for purposes of applying Section 833 of the Code for the first taxable year beginning after December 31, 2009?**

***[Do we have anything to say here?]***

#### G. Enforcement

PPACA requires the Secretary to publish regulations for enforcing the provisions of this section, and specifies that the Secretary may provide for appropriate penalties.

**1. What methods do States and other entities currently use in enforcing medical loss ratio-related requirements for the individual, small group, large group, and other insurance markets (for example, oversight and audit requirements)? What other methods could be used?**

~~*Response to be completed based on survey of states*~~ *See General Comment above and the spreadsheet submitted with this document.*

***[Do we have anything to say about other methods that could be use?]***

**2. What, if any, penalties do these entities currently apply relating to noncompliance with medical loss ratio-related requirements? What, if any, related appeals processes are currently available to issuers?**

*Response to be completed based on survey of states See General Comment above and the spreadsheet submitted with this document.*

#### H. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Executive Order 12866 requires an assessment of the anticipated costs and benefits of a significant rulemaking action and the alternatives considered, using the guidance provided by the Office of Management and Budget. These costs and benefits are not limited to the Federal government, but pertain to the affected public as a whole. Under Executive Order 12866, a determination must be made whether implementation of Section 2718 of the PHS Act will be economically significant. A rule that has an annual effect on the economy of \$100 million or more is considered economically significant.

In addition, the Regulatory Flexibility Act may require the preparation of an analysis of the economic impact on small entities of proposed rules and regulatory alternatives. An analysis under the Regulatory Flexibility Act must generally include, among other things, an estimate of the number of small entities subject to the regulations (for this purpose, plans, employers, and issuers and, in some contexts small governmental entities), the expense of the reporting, recordkeeping, and other compliance requirements (including the expense of using professional expertise), and a description of any significant regulatory alternatives considered that would accomplish the stated objectives of the statute and minimize the impact on small entities.

The Paperwork Reduction Act requires an estimate of how many "respondents" will be required to comply with any "collection of information" requirements contained in regulations and how much time and cost will be incurred as a result. A collection of information includes recordkeeping, reporting to governmental agencies, and third-party disclosures.

Furthermore, Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$135 million. The Departments are requesting comments that may contribute to the analyses that will be performed under these requirements, both generally and with respect to the following specific areas:

**1. What policies, procedures, or practices of group health plans, health insurance issuers, and States may be impacted by Section 2718 of the PHS Act?**

~~Response to be completed based on survey of states~~See General Comment above and the spreadsheet submitted with this document.

**a. What direct or indirect costs and benefits would result?**

~~Response to be completed based on survey of states~~See General Comment above and the spreadsheet submitted with this document.

**b. Which stakeholders will be impacted by such benefits and costs?**

~~Response to be completed based on survey of states~~See General Comment above and the spreadsheet submitted with this document.

**c. Are these impacts likely to vary by insurance market, plan type, or geographic area?**

~~Response to be completed based on survey of states~~See General Comment above and the spreadsheet submitted with this document.

**2. Are there unique costs and benefits for small entities subject to Section 2718 of the PHS Act?**

*[Do we have anything to say here?]*

**a. What special consideration, if any, is needed for these health insurance issuers or plans?**

*[Do we have anything to say here?]*

**b. What costs and benefits have issuers experienced in implementing requirements relating to minimum medical loss ratio standards, reporting and rebates under State insurance laws or otherwise?**

*[Do we have anything to say here?]*

**3. Are there additional paperwork burdens related to Section 2718 of the PHS Act, and, if so, what estimated hours and costs are associated with those additional burdens?**

*[Do we have anything to say here?]*

~~Appendix A~~

~~Summary of Responses to Survey of States~~

~~To be added.~~

# Appendix BA

## 2009 EXHIBIT ANALYSIS OF EXPENSES - 014

DSSPROD

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04/25/2010

Line	Cost Containment Expenses	Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
01	Rent (\$3000000 for occupancy of own building)				
02	Salaries, wages and other benefits				
03	Commissions (less \$0 ceded plus \$0 assumed)				
04	Legal fees and expenses				
05	Certifications and accreditation fees				
06	Auditing, actuarial and other consulting services				
07	Traveling expenses				
08	Marketing and advertising				
09	Postage, express and telephone				
10	Printing and office supplies				
11	Occupancy, depreciation and amortization				
12	Equipment				
13	Cost or depreciation of EDP equipment and software				
14	Outsourced services including EDP, claims, and other services				
15	Boards, bureaus and association fees				
16	Insurance, except on real estate				
17	Collection and bank service charges				
18	Group service and administration fees				
19	Reimbursements by uninsured plans				
20	Reimbursements from fiscal intermediaries				
21	Real estate expenses				
22	Real estate taxes				
23.1	State and local insurance taxes (taxes, licenses and fees)				
23.2	State premium taxes (taxes, licenses and fees)				
23.3	Regulatory authority licenses and fees (taxes, licenses and fees)				
23.4	Payroll taxes (taxes, licenses and fees)				
23.5	Other (excluding federal income and real estate taxes) (taxes, licenses and fees)				
24	Investment expenses not included elsewhere				
25	Aggregate write-ins for expenses				
26	Total expenses incurred				
27	Less expenses unpaid December 31, current year				
28	Add expenses unpaid December 31, prior year				
29	Amounts receivable relating to uninsured plans, prior year				
30	Amounts receivable relating to uninsured plans, current year				
31	Total expenses paid				

# Appendix €B

## 2009 A&H POLICY EXPERIENCE EXHIBIT - 210

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04/25/2010

	Line	Premiums Earned	Incurred Claims Amount	Change in Contract Reserves	Loss Ratio	Number of Policies or Certificates as of Dec. 31	Number of Covered Lives as of Dec. 31	Member Months
A01.1	With contract reserves (individual business comprehensive major medical)							
A01.2	Without contract reserves (individual business comprehensive major medical)							
A01.3	Subtotal (individual business comprehensive major medical)							
A02.1	With contract reserves (individual business short-term medical)							
A02.2	Without contract reserves (individual business short-term medical)							
A02.3	Subtotal (individual business short-term medical)							
A03.1	With contract reserves (individual business other medical (non-comprehensive))							
A03.2	Without contract reserves (individual business other medical (non-comprehensive))							
A03.3	Subtotal (individual business other medical (non-comprehensive))							
A04.1	With contract reserves (individual business specified/named disease)							
A04.2	Without contract reserves (individual business specified/named disease)							
A04.3	Subtotal (individual business specified/named disease)							
A05.1	With contract reserves (individual business limited benefit)							
A05.2	Without contract reserves (individual business limited benefit)							
A05.3	Subtotal (individual business limited benefit)							
A06.1	With contract reserves (individual business student)							
A06.2	Without contract reserves (individual business student)							
A06.3	Subtotal (individual business student)							
A07.1	With contract reserves (individual business accident only or AD&D)							
A07.2	Without contract reserves (individual business accident only or AD&D)							
A07.3	Subtotal (individual business accident only or AD&D)							
A08.1	With contract reserves (individual business disability income - short-term)							
A08.2	Without contract reserves (individual business disability income - short-term)							
A08.3	Subtotal (individual business disability income - short-term)							

A09.1	With contract reserves (individual business disability income - long-term)								
A09.2	Without contract reserves (individual business disability income - long-term)								
A09.3	Subtotal (individual business disability income - long-term)								
A10.1	With contract reserves (individual business long-term care)								
A10.2	Without contract reserves (individual business long-term care)								
A10.3	Subtotal (individual business long-term care)								
A11.1	With contract reserves (individual business medicare supplement (medigap))								
A11.2	Without contract reserves (individual business medicare supplement (medigap))								
A11.3	Subtotal (individual business medicare supplement (medigap))								
A12.1	With contract reserves (individual business dental)								
A12.2	Without contract reserves (individual business dental)								
A12.3	Subtotal (individual business dental)								
A13.1	With contract reserves (individual business State Children's Health Insurance Program)								
A13.2	Without contract reserves (individual business State Children's Health Insurance Program)								
A13.3	Subtotal (individual business State Children's Health Insurance Program)								
A14.1	With contract reserves (individual business medicare)								
A14.2	Without contract reserves (individual business medicare)								
A14.3	Subtotal (individual business medicare)								
A15.1	With contract reserves (individual business medicaid)								
A15.2	Without contract reserves (individual business medicaid)								
A15.3	Subtotal (individual business medicaid)								
A16.1	With contract reserves (Medicare Part D - stand-alone)								
A16.2	Without contract reserves (Medicare Part D - stand-alone)								
A16.3	Subtotal (Medicare Part D - stand-alone)								
A17.1	With contract reserves (individual business - other individual business)								
A17.2	Without contract reserves (individual business - other individual business)								
A17.3	Subtotal (individual business - other individual business)								
A18.1	With contract reserves (total individual business)								
A18.2	Without contract reserves (total individual business)								
A19	Grand total individual (individual business)								
B01.1	Small employer (single employer) (group business comprehensive major medical)								
B01.2	Other Employer (single employer) (group business comprehensive major medical)								
B01.3	Single employer subtotal (single employer) (group business comprehensive major medical)								
B02	Multiple employer assns and trusts (group business comprehensive major medical)								

B03	Other associations and discretionary trusts (group business comprehensive major medical)							
B04	Other comprehensive major medical (group business comprehensive major medical)							
B05	Comprehensive/major medical subtotal (group business comprehensive major medical)							
B06	Specified/named disease (group business other medical) (non-comprehensive)							
B07	Limited benefit (group business other medical) (non-comprehensive)							
B08	Student (group business other medical) (non-comprehensive)							
B09	Accident only or AD&D (group business other medical) (non-comprehensive)							
B10	Disability income - short-term (group business other medical) (non-comprehensive)							
B11	Disability income - long-term (group business other medical) (non-comprehensive)							
B12	Long-term care (group business other medical) (non-comprehensive)							
B13	Medicare supplement (medigap) (group business other medical) (non-comprehensive)							
B14	Federal Employees Health Benefit Plans (group business other medical) (non-comprehensive)							
B15	Tricare (group business other medical) (non-comprehensive)							
B16	Dental (group business other medical) (non-comprehensive)							
B17	Medicare							
B18	Medicare Part D - stand-alone							
B19	Other group care (group business other medical) (non-comprehensive)							
B20	Grand total group business (group business)							
C01	Credit (individual and group) (other business)							
C02	Stop loss/excess loss (other business)							
C03	Administrative Services Only (other business)							
C04	Administrative Services Contracts (other business)							
C05	Grand total other business (other business)							
D01	Total non U.S. policy forms (total business)							
D02	Grand total individual, group and other business (total business)							