PROJECT HISTORY - 2010

REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED REBATE CALCULATION METHODOLOGY FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718 (b) OF THE PUBLIC HEALTH SERVICE ACT (#190)

1. Description of the Project, Issues Addressed, etc.

The Patient Protection and Affordable Care Act (PPACA) establishes a minimum loss ratio and rebate program that begins January 1, 2011. The law requires the NAIC to develop the uniform definitions and standard methodologies for calculating the medical loss ratio (MLR). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

The MLR is defined as the sum of clinical services and quality improvements divided by the earned premium minus all federal and state taxes and licensing or regulatory fees. The issues considered were 1) aggregation of the business, 2) whether the calculation would be done on a calendar year or a plan year basis, 3) credibility, 4) group conversion charges, 5) claim run out, and 6) reinsurance.

2. Name of Group Responsible for Drafting the Model and States Participating

The 2010 members of the Life and Health Actuarial Task Force are: Kansas (chair), South Carolina (Vice Chair), Alaska, Alabama, California, Connecticut, Florida, Minnesota, Missouri, Nebraska, New York, Ohio, Oklahoma, Texas and Utah.

3. Project Authorized by What Charge and Date First Given to the Group

The initial charge was given to the Task Force in April, 2010, to consider the requirement specified in PPACA and develop a regulation to be delivered to the Secretary of Health and Human Services.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The drafting of the model was done by the PPACA Actuarial Subgroup whose members are: Alabama (Chair), Illinois, Maine, Minnesota, New Jersey, New York, Oklahoma, Oregon, South Carolina, and Washington.

The subgroup began by identifying issues and preparing Issue Resolution Documents (IRDs) on those issues. Each IRD was discussed and posted on the NAIC's home page for comment for at least a week before begin adopted. After all IRDs were adopted by the subgroup, the regulation was written to reflect the issues decided on in the IRDs.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

The subgroup discussed the proposal at 27 public conference calls on this topic from May 24, 2010, to October 4, 2010. Notice of each of these conference calls was posted on the NAIC's home page on the Internet and e-mailed to approximately 400 interested parties. The drafts of the regulation were released for comment on September 23, 2010, and September 29, 2010. The subgroup voted to adopt the regulation on October 5, 2010.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Level of aggregation: The law specifies that the MLR would be calculated by each legal entity for each state for each line of business: individual, small group, and large group. There was some discussion of aggregating the large group line at the national level, but the subgroup decided to reject that concept.

Dual options: An employer may purchase two or more plans of coverage from two or more affiliated carriers, but typically it purchases an HMO product from an HMO and a more flexible product from a non-HMO. Employees are given the option of coverage through either plan (hence the term "dual option"), although the employer may require different employee contributions. The rates paid by the employer are blended rates. For example, while the rates may vary based on benefit differences, the rates do not reflect the selection between the HMO and non-HMO products. The issue is how to determine the premium and claims allocated to each carrier when there is not a contractual premium reallocation agreement in place. The subgroup decided a pre-defined adjustment may be made to the incurred claims in the calculation of the MLR.

Reinsurance: The subgroup decided to require the MLR calculation be done on a gross basis excluding reinsurance.

Credibility: The subgroup discussed making an adjustment to a MLR calculation when the amount of business involved in the calculation is not large enough to be statistically credible. The NAIC requested an actuarial consulting firm to calculate amounts to be added to the unadjusted MLR based on a 50% two-sided confidence level. The credibility factors are based on the level of life years and the average deductible of business in the calculation.

7. Any Other Important Information (e.g., amending an accreditation standard).

This regulation will be submitted to the Secretary of Health and Human Services and is not an accreditation standard.

