Article from

The ACA@5

August 2015
Issue 1

The ACA's Medical Loss Ratio Provisions: Looking Back

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In the first months following the enactment of the Patient Protection and Affordable Care Act (ACA), one of the most significant statutory provisions drawing the immediate attention of the actuarial community was the newly created Section 2718 of the Public Health Service Act. Titled "Bringing Down the Cost of Health Care Coverage," Section 2718 created a new requirement, effective as of 2011, where insurers would rebate a portion of premiums for individual and group medical coverage in the event that the insurer were to report a medical loss ratio (MLR) below a certain threshold. As such, although the term "MLR" does not itself appear in Section 2718, the reporting and rebate requirements created therein are usually referred to (in industry circles, at least) as the ACA's MLR provisions.

While the majority of this article will focus on Section 2718, toward the end we will discuss two other sections of the ACA where MLR calculations play a role. One is Section 1103 of the ACA's companion bill, the Health Care and Education Reconciliation Act of 2010 (HCERA); it creates a similar MLR threshold and remittance process for Medicare Advantage (MA) plans, effective for 2014. The other is ACA Section 9016, which created ties between the tax benefits enjoyed by some health insurers (primarily, Blue Cross Blue Shield [BCBS] plans) under Section 833 of the Internal Revenue Code and Section 2718 MLR reporting.

SECTION 2718 AND THE ROLE OF STATUTE VERSUS REGULATION

As these words are being written, insurers are getting ready to file their fourth year of federal MLR reports under Section 2718 and preparing for their fourth annual cycle of administering rebates of premiums to policyholders based on those federal MLR calculations. When compared with so many of the other facets of the ACA, MLR reporting and rebate administration feels like a mature and well-understood process.

In that light, it's interesting to step back and look at which portions of the now-familiar construct were actually pre-ordained by the statutory language, and which were the creation of an intensive and consultative regulatory process in 2010 and 2011—a process in which actuarial participation, both nonpartisan (via the American Academy of Actuaries' MLR Regulation Work Group, which I had the honor of chairing) and partisan (via actuaries directly advising regulators and participating in insurance industry lobbying efforts), was critical.

If we step back to review the bare statute itself, shorn of the light in which we are now accustomed to interpreting it, here's what we see:

- Insurers offering individual or group health insurance coverage need to submit, for each "plan year," a report about "the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums."
- In this report, earned premiums shall be adjusted for payments or receipts relating to the 3Rs, and shall also be adjusted for "Federal and State taxes and licensing or regulatory fees."

- The report would show how the adjusted earned premiums are split between three major categories: "reimbursement for clinical services provided to enrollees," "activities that improve health care quality," and "all other non-claim costs."
- For purposes of determining whether rebates might be owed, the relevant MLR ratio involves earned premiums adjusted for the 3Rs and for taxes and fees in the denominator, and the sum of reimbursement for clinical services and amounts spent on quality-improving activities in the numerator.
- Rebates are to be provided "with respect to each plan year" and "to each enrollee under such coverage, on a pro rata basis."
- For purposes of determining whether rebates might be owed, the MLR as determined above is to be compared against an MLR threshold of either 80% or 85%, depending in some fashion (see discussion below) on whether the individual or small group markets are involved.
- There is no discussion in the statute about the level of granularity at which these MLR calculations are to be made. However, the statute does provide that a state could by regulation impose a higher MLR threshold than the standard 80%/85%, and does give the Department of Health and Human Services (HHS) the ability to downwardly adjust the 80% threshold for a particular state to address concerns about the stability of the individual market in that state. These references suggest that MLR calculations would, at the least, be state-specific.
- If the MLR is below the threshold, then the amount of rebates owed is equal to the adjusted earned premiums multiplied by the difference between the applicable MLR threshold and the reported MLR (which, arithmetically, treats the rebates as though they were a claim—the rebates are the additional amount of claims that the insurer would have needed in order to report an MLR equal to the threshold).
- Starting in 2014, for rebate calculation purposes the MLR is to be determined using three-year average values, rather than one-year values.
- The National Association of Insurance Commissioners (NAIC) was given a specific role to develop technical recommendations, subject to the certification of HHS, about how to define the methodologies for these MLR calculations. Particular mention was made that the methodologies ought to consider "the special circumstances of smaller plans, different types of plans, and newer plans."

As this recitation demonstrates, certain aspects of today's federal MLR construct—the fact that the federal MLR would differ from the traditional ratio of incurred claims to earned premiums, or the fact that expenses on quality-improving activities would be highlighted for special treatment—are inherent in the statute, while others—the concept of credibility adjustments, or the separation of an insurer's book of business into state/market cells for rebate purposes—are the pure product of the regulatory process. This highlights the notion that different regulatory choices could have led to fundamentally different implementations of Section 2718.

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To that end, I wanted to take the opportunity as we look backwards on the first five years of the ACA to talk about two very plausible interpretations of the MLR statute that weren't made—two of the many paths not taken, in the process of breathing life into the statutory MLR provisions via the issuance of implementing regulations.

The first topic relates to when the 80% MLR threshold applies for rebate purposes versus when the 85% threshold applies. Of course, it is well known that the 80% threshold applies to coverage in the individual and small group markets while the 85% threshold applies to coverage in the large group market. One might think I'm mad to suggest that this could have been a debatable point.

However, the statutory language is far from clear-cut. What the statute actually says is that the 80% threshold pertains "with respect to a *health insurance issuer* offering coverage in the small group market or the individual market" (emphasis added). It does not say, for instance, that the 80% threshold pertains "with respect to *coverage offered* in the small group market or the individual market by a health insurance issuer"—which would be a far more natural way of tying the threshold to the type of coverage. Instead, by focusing the sentence around the word "issuer" the enacted language leaves open an alternate, and arguably more natural, interpretation: Namely, that the MLR threshold is supposed to be an attribute of the issuer based on the markets in which it chooses to participate, rather than an attribute of the market.

Moreover, one can imagine reasons why the framers might have wanted to structure the MLR statute in such a way—to incent issuers to offer products in the more highly regulated individual and small group markets. Under this alternate, issuer-centric reading of Section 2718, an issuer that only

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participates in the large group market in a given state would use the 85% threshold—whereas, an issuer that elected to participate in the individual and/or small group markets in that state would get to apply the 80% threshold across all of its business in that state, *including its large group business*. This could serve as a strong incentive for an issuer with a profitable large group block in a particular state to participate in that state's individual or small group markets—and encouraging broad participation in those markets by issuers was, surely, a legislative objective.

As much sense as this interpretation of the statute may make in a vacuum, it is pretty clear that, at the time of enactment, nobody in government believed that this is how Section 2718 was intended to operate. Although some of the comment letters to the government's April 2010 request for information (RFI) on Section 2718 pointed out that having the MLR threshold be an attribute of the issuer rather than of the market was a very plausible interpretation of the statute, it was already quite clear within the RFI document itself that the government believed the intent was for a market-based threshold—and all of the subsequent development of regulations assumed that implicitly. Readers are welcome to draw their own parallels between this situation and the controversy, brewing furiously as of this writing, over whether tax subsidies apply with respect to a federally-facilitated exchange.

There were a number of key areas in which regulators made important and intelligent decisions to create something highly operational out of the statutory language.

The second path not taken involves how to wrap one's head around the specific reference in the first sentence of Section 2718 to "loss adjustment expenses (or change in contract reserves)."

Many people in industry believed that the intent behind these words' inclusion in the statute was for both loss adjustment expense (LAE) and the change in contract reserves to be included in the numerator of the federal MLR. And on technical grounds, there are sound reasons why you might want to include both amounts when defining an MLR used to determine premium rebates.

Taking the latter concept first: In the pre-ACA individual market, products were typically priced to achieve a particular lifetime loss ratio, and it was quite common for an issuer to expect to see radically different loss ratios at different policy durations, in light of the intersection of the impact of medical underwriting at policy issuance and the issuer's renewal rate increase strategy. Many issuers would hold contract reserves in order to achieve a more level emergence of expected profit by policy duration over the lifecycle of a policy, rather than front-load profits into the earlier durations where the effect of underwriting was still dampening morbidity. In this context, if the annual change in contract reserves was not taken into account in the federal MLR calculation, then an issuer with a relatively new block of individual insurance might find itself obliged in a particular year to rebate premiums that were intended to fund contract reserves. In addition to seeming unfair on general principles, this in particular could have served as a significant disincentive for issuers to keep offering new policies in the individual market during the period between enactment and 2014.

The argument for why one might want to include LAE in a rebate-oriented MLR calculation is perhaps more subtle, and has two main thrusts. One thrust is maintaining equity across "different types of plans" (a relevant consideration under the statute). Here the key observation is that the per member per month (PMPM) cost of claims adjudication for a health insurance policy is more or less independent of that policy's actuarial value (AV), because the issuer adjudicates all health care services including those for which the issuer's responsibility is zero due to member cost-sharing features of the policy. As a result, if you look just at the ratio of claims to premiums, low-AV policies will naturally experience lower ratios than high-AV policies, because the fixed PMPM cost of claims adjudication represents more in percentage-of-premium terms for low-AV policies than it does for high-AV policies. This phenomenon would make low-AV policies more likely to require rebates and thereby less attractive to issuers. Having the ability to include LAE in the numerator of the federal MLR would be one way of making the playing field more level between high-AV and low-AV plans. The other thrust is also an equity play, but between different types of health insurance issuers. All else being equal, issuers employing capitated or staff models will report higher claims and lower amounts of LAE than issuers employing other managed care models. Allowing all issuers to calculate rebates based on the ratio of claims + LAE to premiums would avoid tipping the playing field in one particular direction.

Divining the real statutory intent, however, was clouded by two aspects of the statute's construction. The first was the awkward parentheses in the phrase "loss adjustment expenses (or change in contract reserves)"—awkward because when one sees the phrase "A (or B)" one typically expects that A and B are either synonyms, or mutually exclusive concepts—but neither is true here. This created doubt in some minds as to whether the framers really understood what they were trying to say when they wrote this sentence. The second was

the fact that the remaining text in Section 2718 uses completely different jargon than what is used in the first sentence: For instance, the first sentence talks about "incurred loss (or incurred claims)" while the remainder of the section talks about "reimbursement for clinical services." As a result, there was no explicit reference to either LAE or the change in contract reserves in the portion of Section 2718 that discussed how rebates would be calculated.

In the end, regulators split the baby, allowing the change in contract reserves to be included in the numerator of the federal MLR calculation, but not allowing LAE to be included. Obviously if LAE had been included, then reported federal MLRs would have been much higher, and rebates would have been significantly less likely. Interestingly, the November 2009 draft of Section 2718 did not include the "loss adjustment expenses (or change in contract reserves)" language, and instead used rebate thresholds of 75%/80% instead of 80%/85%—and, furthermore, that language was added to the draft bill at the same time that the thresholds were increased to 80%/85%, in December 2009. This anecdotal piece of legislative history certainly lends credence to the notion that somebody involved in the development of the statute had once envisioned that LAE would be included in the MLR numerator; but in the end, that's not the way the cookie crumbled.

KEY REGULATORY CHOICES IN IMPLEMENTING SECTION 2718

Notwithstanding the discussion above about possible alternative interpretations of the statute, it is clear that there were a number of key areas in which regulators made important and intelligent decisions to create something highly operational out of the statutory language. I will highlight six such areas.

"Plan Year"

As noted earlier, the statute talks about having issuers submit an MLR report for each "plan year" and having issuers provide premium rebates "with respect to each plan year."

The use of the term "plan year" as the temporal unit was of some initial concern among industry circles because, if taken literally, it could lead to a regime where the issuer is continually submitting MLR reports and administering rebates—one report for every cohort of policies sharing the same policy anniversary date. Such a regime could also have been confusing for consumers: imagine a person with a March anniversary contract from a particular issuer getting a rebate while his neighbor with an April anniversary contract from the same issuer did not get a rebate, because the two policies were in different cohorts, reporting different MLRs to federal regulators.

Instead, the regulators took a very pragmatic view, deeming that for purposes of Section 2718 the term "plan year" meant "calendar year," notwithstanding the fact that "plan year" was given a different meaning in other ACA provisions. This had the considerable practical advantage of aligning the annual MLR reporting to federal regulators with issuers' annual financial reporting to state regulators, and making MLR reporting and rebate administration a once-per-year event for issuers.

It also had the curious effect of making Section 2718 a retroactive provision of the law, in the following limited sense. The statute said that rebates would be owed for plan years starting January 1, 2011 or later. By deeming that plan year equals calendar year for this purpose, the implication was that all of an issuer's premiums earned in 2011 would be potentially subject to rebates. Some of those 2011 earned premiums pertained to policy years that started prior to the ACA's enactment, e.g., the January and February 2011 premiums for a contract effective March 1, 2010; while some other premiums earned in 2011 pertained to policy years that started post-enactment but where rates were set pre-enactment. As a result, an issuer's ability to adjust its pricing in order to achieve the 80%/85% MLR thresholds for calendar year 2011 was somewhat limited by the fact that, by the time the ACA was enacted (let alone by the time the technical details of MLR calculations were hashed out), it had already set its premiums for a material fraction of its calendar year 2011 business. This phenomenon is one of the reasons why total rebates paid out in mid-2012 based on calendar year 2011 experience were much higher than those for subsequent years.

"Reimbursement for Clinical Services"

As discussed above, while the first sentence of Section 2718 used the familiar language "incurred claims," the later and more substantive portions of the section instead used a term, "reimbursement for clinical services provided to enrollees," that was not heretofore part of standard industry jargon.

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Once again, regulators took a pragmatic approach, deeming that "reimbursement for clinical services" and "incurred claims" were synonyms, but then making a few modifications from traditional statutory accounting definitions of incurred claims. One such modification I alluded to above, namely the inclusion of the change in contract reserves as part of reimbursement for clinical services.

Other important modifications related to situations where regulators wanted to forestall the possibility that administrative expenses could be transformed into claims by bundling them within amounts paid to third-party vendors for certain types of outsourced services. In the end, important supplemental technical guidance was offered by HHS via a series of question & answer documents—technically, an example of something called "sub-regulatory guidance," as it did not go through the normal federal rulemaking process. Of particular interest in this regard was Q&A #20 from February 2012, which established a four-prong test under which an issuer's payments to a clinical risk-bearing entity would be deemed to be incurred claims for MLR purposes. Ultimately, each issuer has needed to go through a process to evaluate whether there are items the issuer routinely included in incurred claims but that need to be excluded from the federal MLR numerator; however, those excluded amounts have generally not been material.

Granularity

Insurance is, at its core, a risk-pooling mechanism. When thinking about a scheme where a portion of premiums collected may be refunded to policyholders based on experience, the level of granularity at which those calculations are made is of paramount importance. There is an entire spectrum of possible choices for MLR granularity, from the policyholder level at the one extreme, to the holding company level at the other. Where ought regulators draw the line?

This was clearly one of the more serious questions faced during the regulatory process. As noted above, the statute provides a couple of tiny clues regarding intent: First, by saying that MLR reports are to be submitted by each health insurance issuer (i.e., by each regulated legal entity rather than by a holding company); and second, by noting that a state could impose MLR thresholds higher than the federal 80%/85% standard, which seems to require state-specific MLR reporting. When you couple this with the statutory interpretation that the MLR threshold is market-specific, you get pretty quickly to a conclusion that a logical minimum granularity level would involve distinct combinations of legal entity, state, and market.

One could certainly imagine going more granular than entity/state/market; for example, one could require separate MLR reporting and rebate calculations for on-exchange versus off-exchange products, or for different metallic tiers, or for different product filings. One could also imagine going less granular, particularly in the large group market, where industry lobbied for greater latitude to mix business across states and entities in recognition of prevailing industry practices (a typical example cited by industry involved a large national account where nationwide PPO coverage is offered by one legal entity, HMO coverage is offered in various cities by various other affiliated legal entities, and premiums are socialized across the entire case). But, different granularity levels create trade-offs: Rebates based on lower granularity levels could threaten the notion of insurance as risk-pooling, while higher granularity in calculating rebates may lead to undesirable opportunities for cross-subsidization.

In the end, entity/state/market is where the regulators ended up. A minor exception was put in place to allow commingling across entities in the not-uncommon situation where an HMO legal entity writes in-network coverage while an affiliated PPO entity writes the corresponding out-of-area coverage.

While reasonable on paper, this framework nevertheless created a number of administrative challenges for issuers, particularly with respect to the precise definitions of how to determine the "state" and "market" for each policy. Some insurers had previously built their financial reporting systems around a very different notion of geography than the one adopted in the federal MLR regulation, which was based on the state in which the contract was issued and delivered. Other insurers did not have clear delineation of small group versus large group in their financial reporting systems—and even if they did, the insurer's definition of the boundary between small versus large was generally aligned with state-level definitions that differed from the federal definition applicable for MLR purposes. Insurers typically found themselves needing to ask many of their group customers for supplemental information about employee counts in order to determine whether the group ought to be considered "small" or "large" for federal MLR reporting.

Credibility Adjustments

Historically, health insurers have borne full exposure in both directions to the impact of random variation of actual experience relative to pricing assumptions. If morbidity was lower than expected due to statistical fluctuation, the insurer enjoyed better-than-expected gains; and, conversely, the insurer experienced worse-than-expected gains if statistical fluctuation led to higher morbidity.

The imposition of rebate requirements fundamentally changed that equation. It remains the case that insurers are exposed to the downside from statistical fluctuation; however, the upside from statistical fluctuation may now accrue to the benefit of policyholders rather than insurers, via increased rebates. And since the potential impact that statistical fluctuation has on the MLR of a block of business decreases as the size of the block increases, left unchecked this phenomenon

could create a sustained competitive advantage for larger issuers over smaller issuers.

Recognizing this, the regulators adopted a mechanism known as the credibility adjustment, in an effort to address "the special circumstances of small plans" as required by the statute. In the MLR regulation, the credibility adjustment takes the form of an additional amount that the issuer gets to add to the numerator of an MLR calculation, based on the size of the entity/state/market pool as well as on the average deductible level within that pool. Equivalently, one could think of the credibility adjustment as being a reduction in the applicable MLR threshold; for instance, if the credibility adjustment for a particular issuer's small group pool in a particular state is 3%, then in effect the MLR threshold for that particular pool is not 80%, but rather 80% - 3% = 77%.

An analogous credibility adjustment had existed for some time in the regulatory Medicare Supplement refund calculation (which is based on cumulative lifetime loss ratios). In the commercial MLR context, the Academy work group that I chaired played a role in raising the concept with regulators, based on some statistical fluctuation modeling that actuaries from one major insurer (Humana) serving on the work group had done using their company's own experience and brought to the work group's broader attention. The Academy was certainly not in a position to vouch for the technical accuracy of those calculations or the applicability of the underlying company-specific dataset to the industry as a whole, but we did feel like the concept was meritorious and that the results of the company's modeling were worth sharing with regulators for illustrative purposes. Ultimately, the NAIC commissioned an actuarial report from Milliman, using a similar methodology applied to a broader industry dataset in Milliman's possession, and that report formed the basis for the credibility adjustment in the MLR regulation.

While there was widespread recognition that some form of credibility adjustment was technically appropriate, there was considerable disagreement as to how large the adjustments ought to be. The issue at hand (quoting from the preamble to the federal regulation) was how to "equitably balance the consumers' interest in requiring plans that should pay rebates to pay rebates against the issuers' interest in minimizing the risk of paying rebates as a result of chance variations." The regulators selected an approach where the theoretical chance of a "false positive"—payment of rebates due to random chance even though the unobservable "true underlying MLR" was equal to the stated threshold before credibility adjustment—was 1 in 4; industry had advocated for larger credibility adjustments intended to reduce the chance of such a false positive to 1 in 10.

Treatment of Taxes

As noted above, the statute specifically states that for rebate calculation purposes, the MLR shall be calculated after removing "Federal and state taxes and regulatory fees" from premiums.

Qualitatively, there are several distinct types of taxes/fees that could fall under the auspices of "Federal and state taxes and regulatory fees," such as:

1. State premium taxes
2. Income taxes (both federal and state)
3. New federal taxes and fees created by the ACA, e.g., health insurer fee, exchange fees
4. Regulatory assessments, e.g., high-risk pool assessments
5. Other general federal and/or state taxes, e.g., payroll taxes.

On policy grounds, there are two distinct reasons why it makes perfect sense, in the context of an MLR calculation used to determine rebates, to exclude many types of taxes from the denominator.

The first reason relates to achieving equity across different types of issuers. Some issuers are exempt from federal income taxes, while most are not, and others may pay federal income taxes as a reduced tax rate (see subsequent discussion about ACA Section 9016). There may also be reasons why the rates of certain non-income taxes, such as premium taxes and the ACA health insurer fee, differ among distinct classes of issuers. If all issuers were held to the same MLR thresholds, and the MLR calculation didn't adjust for these types of tax differences, then the issuers with more preferential tax treatment would get a competitive advantage, because they wouldn't need to fund (as much) taxes out of the retained portion of premiums. Allowing these taxes to be excluded from the MLR denominator makes it more equitable to apply a single common MLR threshold for rebate purposes to all types of issuers across all geographies.

The second reason relates to thinking about where the MLR thresholds ought to be set. Presumably, the legislative decision to set the thresholds at 80%/85% was based at least in part on issuers' historically reported experience. To the extent that the ACA created a number of new taxes and fees that issuers would need to incorporate into their rate structure, it was reasonable for the framers of the statute to expect that, under the traditional claims-over-premiums definition of MLR, post-ACA MLRs would be lower than pre-ACA MLRs due to these new taxes and fees. Rather than attempt to anticipate the impact of those fees on future MLRs in selecting the statutory MLR thresholds, it would be cleaner and more flexible to simply exclude those new fees from the MLR denominator.

These policy considerations make it attractive to include, at the least, the first three categories listed above as part of the regulatory definition of "Federal and state taxes and regulatory fees." However, during the regulatory process there were parties arguing for both a more expansive and

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less expansive reading of that phrase. Arguing for a less expansive reading were six of the key Congressional Democrats involved in the passage of the ACA, who signed a letter sent to HHS in August 2010 opining that the sole intent of this wording was to allow the new taxes and fees created by the ACA to be removed from the MLR denominator. On the other side, industry argued that the words needed to be taken at face value, implying that every type of federal or state tax or fee could be removed from the denominator, including items in the last category above like payroll taxes.

Back in late 2010, regulators took the more literal view, allowing all forms of taxes and regulatory fees to be removed from the MLR denominator. More recently, a February 2015 regulation backtracked very slightly on this: Effective in 2016, issuers will no longer be allowed to exclude payroll taxes from the MLR denominator. (According to HHS, most issuers had not been excluding payroll taxes.)

Once it was decided that issuers would get to exclude federal income taxes from premiums for federal MLR reporting purposes, a key question remained unaddressed in the regulation: How exactly should an issuer allocate income taxes to rebate pools? The central (but not only) problem here is how the issuer should, or should not, think about the interaction between rebates and income taxes.

To start, consider an issuer whose entire business consists of individual medical policies written in one state, so that it has one pool for MLR reporting purposes and no other business. That issuer's reported federal income taxes will be derived from the underwriting gain of its sole block of business; so, it would seem natural to allocate all of the issuer's income taxes, whatever they might be, to this pool in that pool's MLR report. But, any rebates owed to customers in that pool would be a tax-deductible expense to the issuer, and hence would impact the issuer's income taxes. The income taxes in turn impact the issuer's reported federal MLR, and hence the rebate. So, we're in an intrinsically circular situation: The income taxes impact the rebate, which impacts the income taxes, et cetera.

Similar considerations hold for any issuer. But as it turns out, if you assume that the issuer's income tax rate is known, then this circular situation actually has a closed-form solution: One can derive a formula that calculates the rebate for a pool as a function of the MLR threshold as well as the issuer's premiums, claims, tax rate, and allocated expenses.[1] (In practice, the income tax rate would depend on the rebates rather than be known for certain in advance, but iteration of the calculations would allow convergence to an answer.)

This may be clever, and goodness knows that as actuaries we gravitate toward the clever; but is it practical? Many in industry felt that it was not, and that the only practical course was to allow issuers to allocate income taxes to blocks of business based on underwriting gain before rebates. This would eliminate any circularity between the allocation of income taxes to rebate pools and the calculation of MLRs and rebates for those pools. As it happens, this noncircular approach to income tax allocation also leads, as a matter of math, to lower rebate levels than the circular approach.[2]

Remarkably, to my knowledge there is nothing in all of the regulatory and sub-regulatory guidance issued by HHS in 2010 and 2011 that touches on whether the circular or noncircular approach to income tax allocations ought to be used in MLR reporting. However, two things have become clear over time, with the effect that by now the circular approach to income tax allocation is purely of academic interest.

The first is that, prior to year-end 2011 MLR reporting, industry had coalesced around using the noncircular approach, citing as their support a single sentence that was included in the NAIC's October 2010 Model Regulation providing its technical recommendations on federal MLR: "All terms defined in this Regulation, whether in this Section or elsewhere, shall be construed, and all calculations provided for by this Regulation shall be performed, as to exclude the financial impact of any of the rebates…"

The second is that, by no later than March 2013, HHS had recognized the legitimacy of the noncircular approach to income tax allocations for federal MLR reporting purposes. The preamble to a regulation issued that month specifically cited the NAIC sentence quoted above in explaining why the noncircular approach was used in MLR calculations, in the context of justifying why a similar noncircular approach was being adopted with respect to risk corridor calculations.

Rebate Administration

As noted earlier, the statutory language calls for issuers to provide rebates to "each enrollee." This specific reference to the "enrollee" rather than the "policyholder" as the intended rebate recipient caused quite a bit of concern within the industry, from an administrative implementation standpoint.

In draft regulations issued in late 2010, HHS put forward a proposal where if an issuer owed a rebate for a pool of group business, then the issuer would need to take each employer group's rebate and apportion it between an amount that the group would get to retain versus amounts that would need to be sent to each employee that had coverage during the year in question, based on their relative contributions to the premiums received by the issuer.

This proposal may have seemed equitable to regulators as a matter of policy, but it reflected an apparent lack of understanding of normal operating procedures in the health insurance industry. The proposal seemed to presume that, as a matter of course, issuers would have ready access to accurate employee-level

information regarding how the premiums paid by the employer group had been funded; whereas in reality, issuers had never needed to collect that information, since from the issuer's standpoint the entirety of the group's premium is provided directly by the employer and the internal funding thereof is not relevant (except, possibly, in broad strokes as an underwriting criterion). It also turned out that unintended tax consequences could arise if the issuer were to directly rebate premiums to employees, to the extent that a Section 125 cafeteria plan had been used to allow employees to pay their share of premiums using pretax dollars.

As a result, during 2011 industry started going down two paths simultaneously. One path involved trying to build the operational capability to collect and store information about all of its group customers' premium contribution formulas, so that in the event rebates were owed the apportionment proposed in the draft regulations could be performed. The other path involved trying to convince federal regulators that the proposed approach was unworkable and that they ought to allow the issuer to give the entire rebate to the employer and let the employer figure out what to do with it, in a manner consistent with the employer's obligations as a benefit plan fiduciary under ERISA.

In the end, regulators responded to industry's concerns, thereby avoiding some significant administrative challenges for industry. The final MLR regulations issued in December 2011 created a framework whereby issuers would turn the entire rebate over to the group policyholder, who would then need to abide by certain regulatory constraints on what to do with that rebate.

LIVING UNDER SECTION 2718

In light of the various practical interpretations discussed above, I think most parties would acknowledge that the final MLR regulations struck a suitable balance between the interests of consumers and the interests of issuers. Left unresolved in the regulations themselves, however, were some questions about how various stakeholders would behave in a world where all commercial insurance is now subject to MLR-based rebate requirements.

As a matter of theory, the introduction of rebate requirements transforms the risk/return environment for issuers. Think of an issuer as being a portfolio of different blocks of health insurance business, serving different markets and different geographies. Historically, each block within the portfolio was subject to both upside and downside risk, and the issuer enjoyed risk diversification benefits by having assembled a portfolio, to the extent that some of the risk factors inherent in the blocks were not perfectly correlated across markets and geographies; poor experience in some blocks was often offset by better-than-expected experience in others. As such, in the past it would have been reasonable to think of an issuer's portfolio of health insurance blocks as being analogous to an investor's portfolio of stocks. With the introduction of rebate requirements, however, the issuer remains fully exposed to downside risk but now enjoys only limited exposure to upside risk, because past a certain point excess gains need to be returned to policyholders via rebates. This suggests that, in the post-ACA environment, a better analogy would be to liken an issuer's portfolio of health insurance blocks to an investor that has written naked put options on a variety of stocks, capturing a capped return in upside scenarios while remaining exposed to large losses in downside scenarios. Viewed in financial economics terms, rebate requirements have made health insurance a somewhat different, and arguably less attractive, business than it once was.

This can be seen from a pricing perspective, in slightly different terms. Suppose you're pricing a product with best estimate assumptions so as to achieve a federal MLR that is exactly equal to the applicable threshold (e.g., 80% for individual business in a fully credible pool). Deterministically, your expected rebates to customers

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under those best estimate assumptions are zero. But probabilistically, the expected value of customer rebates is surely nonzero, because you're averaging across upside scenarios (where rebates are zero) and downside scenarios (where rebates are nonzero). The expected value of rebates in the situation where the issuer is pricing right at the MLR threshold might be equal, say, to 70 basis points of premium. This "cost" is probably not an explicit component of the issuer's pricing, but instead is implicitly buried within the issuer's desired pricing margin target.

This line of reasoning suggests that an economically rational issuer might prefer to embrace rebates rather than seek to avoid them. Suppose that instead of pricing to achieve a federal MLR equal to the rebate threshold, the issuer priced to achieve a federal MLR 300 basis points below the threshold (e.g., 77% instead of 80%). (Returning to the financial economics analogy, it's like writing deep-in-the-money naked puts instead of at-the-money naked puts.) Now, the issuer would be expecting to issue rebates in the vast majority of scenarios, and so the asymmetry of the situation is largely mitigated. The expected value of rebates in this situation might be, say, 320 basis points; so, relative to the hypothetical of the previous paragraph, on average the issuer has been able to preserve an additional 50 basis points of premium as margin.

Four or five years ago, one could have imagined that this might be how the health insurance industry would naturally evolve in response to the introduction of ACA rebate requirements: Intentionally conservative initial pricing, so that rebates were very much an expected event, with a failure to pay out rebates only occurring in exceptionally adverse circumstances—not unlike what one sees with mutual life insurers, with respect to nonguaranteed policyholder dividends.

Of course, that didn't happen. And certainly one (necessary but not sufficient) reason it didn't happen was stances taken by regulators in the rate review process. Nothing in Section 2718 indicates issuers need, or even ought, to price their products under the assumption that federal MLRs will meet or exceed the rebate threshold. However, for the most part regulators chose to treat the rebate MLR thresholds as if they were pricing standards.

Since issuers were in practice unable to consider implementing a pricing philosophy under which rebates became a routine expectation, it is wholly unsurprising that total industry rebate levels have consistently fallen since enactment. Rebates paid in 2012 based on 2011 experience were in excess of $1.1 billion; of course, as noted earlier, many of the premiums collected in 2011 were priced before MLR requirements were enacted. Rebates paid in 2013 dropped to $504 million, reflecting not only that issuers had additional time to adjust their pricing so as to achieve the MLR threshold, but also that 2011 happened to be a year in which the industry in general overestimated actual trend, which is precisely the type of scenario that leads to larger rebate payments. Payments under the third year of rebate requirements declined even further, to $334 million. Another factor that may have influenced the decline in rebate payments over this period is the phase-in of multiyear MLR averaging from 2011 through 2013.

Another concern that some people had circa 2011, but does not appear to have materialized, was the risk that customers and/or regulators would challenge issuers' calculations of rebate amounts after the fact. As we've discussed, in determining the amount of rebates owed to a particular pool of customers, the issuer has needed to do a lot of things that it wasn't already doing: allocating groups as small versus large based on federal definitions; allocating customers to states using federal rules; allocating income taxes across blocks of business; et cetera. Surely, one thought, in the fullness of time there would be lawsuits alleging that certain classes of customers ought to have received rebates but didn't, or alleging that rebates had been calculated incorrectly. However, if there has been that sort of activity, it has not made its way onto my personal radar screen. Federal audits of issuers' MLR filings could, in principle, lead to astronomical fines: the statutory cap for monetary penalties is $100 per day for each individual impacted by an entity's violation, which in principle could eat through even the healthiest issuer's surplus. In practice, even though three annual filing cycles have elapsed, we're still in the early innings when it comes to regulatory audits of MLR filings and understanding the consequences thereof.

> Viewed in financial economics terms, rebate requirements have made health insurance a somewhat different, and arguably less attractive, business than it once was.

Similarly, another common concern in the immediate wake of Section 2718's enactment was from the producer community, who was very nervous that issuers might squeeze producer compensation in an effort to meet the new MLR thresholds. This led to a wave of lobbying activities from producers, a politically potent constituency in many states. A 2011 House bill that would have amended Section 2718 to allow issuers to exclude producer commissions from the MLR denominator attracted 221 co-sponsors but died in committee.

In the end, looking back after five years one might conclude that the introduction of commercial MLR rebates did not turn out to be a particularly transformative event for the health insurance industry. Reg-

ulators took reasonable stances in implementation; adjustments have been made; and no "parade of horribles" has materialized.

Yes, the industry needed to make considerable administrative investment in order to facilitate rebate calculations and payments; and yes, there have been material amounts of money returned to consumers that in the absence of the ACA would have been retained by the industry; and yes, on the margins the introduction of MLR thresholds may have had a negative impact on some issuers' ability to remain competitive; and yes, there may have been some compression of broker compensation by issuers seeking to rationalize their expense structure in light of MLR thresholds. But all in all, I think it is fair to conclude that the industry has adapted to this new aspect of the regulatory landscape with minimal adverse consequences—a result that is a testament to the care taken by regulators to achieve a balanced implementation of an ambiguous statute.

SECTION 1103: MLR AND MEDICARE ADVANTAGE

HCERA Section 1103, titled "Savings from Limits on MA Plan Administrative Costs," added new language to Title XVIII of the Social Security Act, which governs the Medicare Advantage (MA) program.

The main thrust of this new language is that, starting with contract year 2014, any MA plan that reports an MLR below 85% needs to return a portion of its revenues to HHS. Note that there are no rebates to policyholders contemplated in the MA MLR statute; the potential payments to HHS are referred to as "remittances" rather than rebates. There are secondary clauses in the statute that impact repeat offenders: An MA plan that reports an MLR below 85% for five straight years would see its contract terminated, while one reporting an MLR below 85 percent for three straight years would face marketing restrictions.

Of course, the statutory language neglects to define the term "medical loss ratio," so naturally there was a need for regulatory guidance. For the most part, the draft regulations on MA MLR issued by HHS in 2013 intentionally mirrored the regulatory framework described above for commercial MLR—another example of a pragmatic regulatory decision. Below I highlight three areas where the MA MLR regulations deviate slightly from those developed for commercial MLR.

Granularity

There was some confusion at first as to whether the statutory language really applied only to MA plans, or whether it ought to be construed as applying also to stand-alone Medicare Part D prescription plans. Ultimately HHS concluded that, as a matter of law, the minimum MLR requirements would also apply to stand-alone Part D because they had been incorporated into Section 1857(e) of the Social Security Act, a subsection with which Part D plans were already required to comply.

Having made that determination, the question still remained as to the level of granularity at which MLR reporting and potential remittances to the Centers for Medicare & Medicaid Services (CMS) should be calculated. Here the regulators concluded that, given the existing regulatory framework of MA, the most natural level of granularity was the H-contract (for MA) or S-contract (for PDP) level. This level of granularity has some conceptual similarities to the entity/state/market framework used in commercial MLR, although there are certainly some situations in which this approach will end up being less granular (e.g., a national MA PPO contract) or more granular (e.g., an HMO entity that has multiple H-contracts within the same state) than what entity/state/market would have produced.

Credibility Adjustments

The credibility adjustment concept from commercial MLR was also adopted as part of the MA MLR regulations. One difference was that the actuarial study used to justify the magnitude of the credibility estimates was not performed by a consulting firm (and made publicly available), but rather was performed by CMS' Office of the Actuary (OACT) (and kept private).

Curiously, the OACT study concluded that the impact of block size on statistical fluctuation was more pronounced for MA plans than it was for standalone Part D plans: An H-contract was deemed to have fully credible experience at 15,000 members, whereas an S-contract was not deemed to have fully credible experience until 30,000 members. This conclusion seemed counterintuitive, to the extent that one normally thinks of medical claims as being subject to greater variability than drug claims. With the OACT study not having been made public, however, interested parties were not well-posi-

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tioned to second-guess regulators' judgment.

Treatment of Part D Reinsurance

One of the principles underlying the development of the commercial MLR regulations was fidelity to existing statutory accounting guidance on what constitutes revenues and claims, albeit with some defined exceptions.

In an MA context, adherence to that principle would have implied that neither low-income cost sharing (LICS) subsidies nor Part D reinsurance would be included in the MLR numerator or denominator, as under statutory accounting both are considered to be self-insured elements of a partially insured plan and therefore are excluded from earned premiums and incurred claims.

However, the regulators concluded that for federal MLR reporting purposes, Part D reinsurance amounts would be included in both the numerator and denominator, whereas LICS amounts would be omitted from both. The preamble to the draft MA MLR regulations contains relatively little discussion as to why CMS reached this conclusion, other than the following terse statement: "Part D reinsurance is more appropriately classified as a cost-based reimbursement methodology than reinsurance, per se, and as such is appropriately treated as revenue."

The fact that Part D sponsors get to include an S-contract's Part D reinsurance amounts in both the MLR numerator and denominator creates a significant upward boost to the federal MLR compared against the MLR reported in statutory financial reports, and seems to make it exceedingly unlikely that remittances would ever be owed on S-contracts. The same issue helps boost the federal MLR reported for H-contracts too, of course, but in a less material way. Having said that, the first round of MLR reports for MA plans will not be submitted until later in 2015, so as of yet there is no actual data on the actual impact to industry of the MA MLR requirements.

SECTION 9016: MLR AND BCBS PLANS' TAX BENEFITS

ACA Section 9016 added language to Section 833 of the Internal Revenue Code, a section that was added as part of the Tax Reform Act of 1986 in order to make Blue Cross Blue Shield (BCBS) plans subject to federal income tax for the first time.

As enacted, the new language stated that, starting in 2010, "this section [i.e., Section 833] shall not apply to any organization unless such organization's percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85%."

Although this language obviously only impacts a subset of health insurance issuers, it was of deep interest to those impacted organizations. Ultimately, and very recently, those organizations' lobbying efforts were successful in achieving an exceedingly rare feat: an amendment to an ACA provision that was passed by the Republican-controlled Congress and signed into law by President Obama.

To understand why this statute was so important to certain companies and why a technical amendment was sought, there are two separate themes we need to explore: the benefits that BCBS plans receive from Section 833; and the ambiguities inherent in the Section 9016 language.

First, let's talk about the benefits that BCBS plans may receive from being taxed under Section 833—although I should emphasize that I am not a tax professional! At the risk of over-simplifying, there are two particularly important provisions. One, known colloquially as "deemed status," is that a BCBS organization is automatically deemed to be a stock insurance company for federal taxation purposes, even if it wouldn't qualify under the normal rules to determine whether or not a company gets to use the special tax rules for insurers. Being taxed as an insurer is important in that it allows a company to take deductions for claims expenses on an incurred basis rather than on a cash basis. The other is that a BCBS organization may be eligible for something called the "833(b) special deduction," which insurers not falling under Section 833 do not get. In practice, the effect of the 833(b) special deduction has been that, even as

we approach the three-decade mark since BCBS plans first became taxable, many BCBS plans get to pay federal taxes at the 20% corporate alternative minimum tax (AMT) rate rather than at the normal 35% corporate rate.

With this in mind, a BCBS plan could face two significant adverse consequences if it were to fail the Section 9016 MLR test and thereby lose the benefits of Section 833. One is that it could lose its special deduction, and hence its tax rate might increase from 20% to 35%. The other is that it could lose deemed status, and hence it would need to demonstrate that it qualifies for tax treatment as an insurance company on other grounds. Some BCBS plans, particularly those who have more administrative services only (ASO) customers than they do fully-insured customers, were uncertain as to whether they would qualify as an insurance company in the absence of deemed status. And if you've been taxed as an insurance company for many years, but one day you wake up and it's determined that you're no longer an insurance company for tax purposes, then all of the deductions that you've taken over many years for your claim reserves might need to be unwound all at once, resulting in a massive tax bill—not a pleasant thought.

Next, let's talk about the specific language used within Section 9016. On the one hand, there is an explicit reference to the amounts that the organization reports under Section 2718, creating some type of tie between this MLR test and the commercial MLR reporting discussed above. On the other hand, a BCBS plan would typically be filing a single tax return covering one or more health insurance issuers, and therefore covering multiple entity/state/market combinations for which separate MLR reports were filed under Section 2718, as well as other types of health insurance business (e.g., Medicare Supplement) not covered under Section 2718. So, there was clearly a need for regulatory guidance to explain how the various MLR reports submitted under Section 2718 would be used to determine whether or not the overall taxable entity passes the 85% MLR threshold of Section 9016. In addition, notwithstanding the reference to Section 2718, the language found in Section 9016 was not in perfect alignment with Section 2718. For instance, there's no reference in Section 9016 to expenses on quality-improving activities, nor is there a reference to taxes, fees, and amounts related to the 3Rs as items that would be excluded from premiums.

As a result, there was tremendous uncertainty about the impact in practice of Section 9016, and large dollar amounts potentially at stake depending on the interpretation. Senior executives at one large BCBS plan told me, circa 2011, that minimizing the uncertainty relative to Section 9016 implementation and achieving a desirable outcome—via either regulation or legislation—was their company's top ACA-related lobbying priority.

In the end, the IRS regulations finalized in January 2014 gave the impacted organizations much, but not all, of what they had hoped to achieve. Under the regulations, the MLR test for Section 9016 purposes is a single calculation summing across all relevant entity/state/market combinations filing MLR reports under Section 2718 (and hence ignoring other lines of business like Medicare Supplement); the numerator and denominator are the same as in the Section 2718 reports, except that for Section 9016 purposes the regulations stipulated that the numerator could not include expenses on quality-improving activities. Also, the regulations concluded that if an entity failed to meet the test in one year but then met it the next year, then it could re-qualify as a Section 833 organization; that is, failing the test did not imply permanent loss of Section 833 benefits. However, the regulations did contain a significant defeat for the impacted organizations, as they stated that deemed status was indeed one of the Section 833 benefits that an organization would lose if it failed to meet the test in a given year.

With the IRS regulations in final form, the impacted organizations appear to have refocused their efforts on achieving a legislative fix. Which they did, in December 2014, via Section 102 of the so-called "Cromnibus" bill—the Consolidated and Further Continuing Appropriations Act, 2015. The relevant provision, representing less than half a page buried within a 1,600-page bill, amends the language that had been added to the Internal Revenue Code via ACA Section 9016.

Now, instead of saying that "this section shall not apply" if the 85% MLR is not achieved, the amended language says that "paragraphs (2) and (3) of subsection (a) shall not apply." Since the concept of deemed status is found in Section 833(a)(1), the implication of this amendment is that a BCBS organization is always entitled to deemed status, even if it does not achieve an 85% MLR in a given year. Consequently, and after four-and-a-half years of concerted effort, the impacted organizations have permanently mitigated a significant source of income tax uncertainty emanating from the ACA and its MLR reporting requirements. In addition, the amendments also added language implying that this MLR numerator does include expenses on quality-improving activities, thus fully aligning the MLR metric with Section 2718. ■

ENDNOTES

1. See slides 31-32 of a presentation the author made in 2011 at a meeting of the Chicago Actuarial Association: *http://chicagoactuarialassociation.org/archives/A1_CAA2011_MLR.pdf.*
2. For an illustration, see the author's 2011 Valuation Actuary Symposium slides, available from the SOA website.

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