Office of Consumer Information and Insurance Oversight

Interim Final Rule for Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act (OCIIO-9998-IFC)

REGULATORY IMPACT ANALYSIS
TECHNICAL APPENDIX

NOVEMBER 22, 2010

I. INTRODUCTION

This document serves as a technical appendix to the regulatory impact analysis presented as part of the medical loss ratio (MLR) interim final regulation published by the Office of Consumer Information and Insurance Oversight (OCIIO-9998-IFC). This regulation implements sections 2718 (a) through (c) of the Public Health Service (PHS) Act enacted as part of the Patient Protection and Affordable Care Act (the Affordable Care Act). The complete text of the interim final regulation can be found on OCIIO's website at http://www.hhs.gov/ociio/regulations/index.html.

The regulatory impact assessment (RIA) technical appendix provides more detailed documentation on the data and methods used by the Department for its analysis of the impacts of the MLR rebate and reporting provisions set forth under the interim final regulation. It is divided into three main sections: Section II describes the data sources used for the analysis, their limitations, and the imputation methods the Department used to address these limitations; Section III describes the methods and modeling assumptions used to estimate the impact of the rebate requirements; and Section IV describes the methods and assumptions used to estimate the administrative cost of the regulation's MLR reporting, record retention, and rebate notification and payment requirements.

II. DESCRIPTION OF DATA SOURCES, LIMITATIONS, AND IMPUTATION METHODS

A. Data Sources and Limitations

Data for the regulatory impact analysis come from the 2009 National Association of Insurance Commissioners (NAIC) annual financial statements, also known as "Blanks", where insurers report information about their various lines of business. These statements are typically submitted to NAIC through State insurance regulators approximately three months after the end of the reporting year. The NAIC has four types of Blanks: Health, Life, Property & Casualty (P&C), and Fraternal Blanks. If a company's premiums and reserve ratios for its health insurance products equal 95 percent or more of their total business for both the current and prior reporting years, a company files its annual statement using the Health Blank. Otherwise, a company files the annual statement associated with the type of license held in its domiciliary State. The NAIC Blanks include a mix of State- and company-level data on earned premiums, incurred claims, life years[1], and expenses that can be used to estimate the MLR provisions of the Affordable Care Act.

As shown in Table 1, a total of 618 insurers offering fully insured, commercial comprehensive major medical coverage (CMM) in the individual and group markets filed NAIC annual financial statements in 2009. For these companies, CMM coverage accounted for approximately 47.8 percent of all their Accident and Health (A&H) premiums.[2] Since the Health and Life Blank filers accounted for approximately 99 percent of all

[1] Life years represent the total number of member months divided by 12.

[2] This estimate of the number of issuers reporting CMM business to the NAIC reflects companies that report positive earned premiums and incurred claims for this type of coverage. Data for mini-med and expatriate plans are not broken out separately from other data that issuers reported to NAIC in 2009. Therefore, the regulatory impact analysis does not include separate estimates for these types of plans. Accident and health lines of business include coverage for private comprehensive major medical coverage as well as short-term medical coverage; specified disease coverage; limited benefit coverage; student coverage; accident-only coverage; short- and long-term disability coverage; long-term care coverage; Medicare Supplement, Medicare Advantage, and Medicare prescription drug coverage; dental coverage; Children's Health Insurance Program and Medicaid coverage; and other non-private and/or non-comprehensive major medical coverage.

premiums earned in the CMM market, the Department decided to restrict the regulatory impact analysis to Health and Life Blank companies.

Table 1. Description of insurance companies in the NAIC data reporting comprehensive major medical business, 2009

NAIC Blank Filers	Companies		Comprehensive Major Medical Life Years		Comprehensive Major Medical Premiums Earned		Comprehensive Major Medical Coverage as a % of Total A&H Premiums Earned
	N	Percent of total	N (Millions)	Percent of total	N (Millions)	Percent of total	
Health	415	67.2%	58.3	76.9%	$211,122	81.6%	58.3%
Life	181	29.3%	17.3	22.9%	$46,730	18.1%	27.1%
P&C	19	3.1%	0.2	0.3%	$933	0.4%	14.1%
Fraternal	3	0.5%	0.01	0.01%	$19	0.0%	2.7%
Total	618	100.0%	75.8	100.0%	$258,804	100.0%	47.8%

Source: 2009 NAIC A&H Policy Experience Exhibit data and 2009 NAIC Health Blank annual statement.

Note: The primary data source for these estimates is the 2009 NAIC A&H Policy Experience Exhibit. However, there are 39 companies on the NAIC Health Blank statement that are not on the A&H Policy Experience Exhibit data. Since the Health Blank annual statement is the basis for the state-level estimates, these companies are included in the description of the comprehensive major medical market. The estimates are restricted to companies that report positive earned premiums and incurred claims for CMM coverage. Totals reported here may differ from totals reported in the RIA due to differences in data sources. The RIA uses state-level data from the Health and Life Blank annual statements, which uses a different collection procedure to collect data than the A&H Policy Experience Exhibit. The NAIC data exclude issuers regulated by California's Department of Managed Health Care as well as small, single-State insurers that are not required by State regulators to submit NAIC annual financial Statements.

Although the NAIC data represent the best available data source with which to estimate impacts of the MLR regulation, the data contain certain limitations that should be noted. Specifically, the NAIC data do not include issuers regulated by California's Department of Managed Health Care (DMHC) as well as small, single-State insurers that are not required by State regulators to submit NAIC annual financial statements. When we compare the NAIC enrollment data to InterStudy data, we estimate that these limitations lead the NAIC data to exclude approximately 9 percent of the total fully insured, commercial CMM market.[3]

As Table 2 demonstrates, another limitation of the NAIC data is that the Life Blank State data do not directly capture information on comprehensive major medical policies for the individual or group markets. State-level data are needed for the RIA in order to model the level of aggregation required by the interim final regulation which instructs issuers to report MLRs by company and state or what the Department refers to as licensed entities. The Life Blank annual statement only reports earned premiums and incurred claims for all A&H group and individual policies sold in a State. These data capture information for health insurance policies that do not provide comprehensive major medical benefits, including dental, disability, and Medicare supplemental coverage. The Life Blank data also do not report any information on life years at

[3] This estimate is based on a comparison of 2008 NAIC and HealthLeaders-InterStudy (InterStudy) data. Interstudy data report 79.7 million enrollees for comprehensive major medical coverage in 2008 whereas NAIC data report approximately 72.9 million enrollees, which represent 91 percent of the Interstudy total enrollment figure. HealthLeaders-InterStudy is a health care business information company that produces several proprietary data sources on the managed care business of various insurers. The numbers cited here come from their Managed Market Surveyor data. For more information about the HealthLeaders-InterStudy data, see http://home.healthleaders-interstudy.com/ .

the State-level. By contrast, the Health Blank State data capture CMM earned premiums, incurred claims, and life years by State separately for individual and group markets (Table 3).

Companies that use the Life Blank represent nearly 20 percent of premiums in the comprehensive major medical market, and they represent an even larger share of premiums for major companies. For example, three of the top five for-profit carriers report between 60 and 70 percent of their comprehensive major medical premiums through companies that use the Life Blank. Therefore, it is important to include imputed Life Blank data for the analysis rather than excluding these filers altogether. The imputation methods described below modify the Life Blank data so that it matches the structure of the Health Blank State data.

While the Health Blank State data are the most complete, they are limited in that they do not distinguish between small and large group comprehensive major medical policies. Since this distinction is necessary to estimate different statutory minimum MLR standards for the small (80 percent) and large (85 percent) group markets, the Department developed an imputation method to estimate the split of small versus large group business at the State level for both the Health Blank and the edited Life Blank data.

Both the Health and the Life Blank annual statements report policies sold through associations and discretionary trusts as group market coverage, but the PHS Act considers this type of insurance to be individual coverage. The Department created an imputation method to reassign this business from group to individual market coverage. Both data sources also do not capture expenses that are used to adjust MLRs (e.g., federal and State taxes) by State for the individual and group comprehensive major medical markets. They only report company level expenses for all A&H policies. We use an allocation formula to estimate these expenses by market and State. Finally, both Health and Life Blank State-level data include records that are beyond the scope of the regulation or have data that would produce extreme or undefined MLR values. We apply certain sample restrictions to eliminate these records from the RIA estimates.

Despite these limitations, the Department believes that the 2009 NAIC data provide a reasonable basis for developing a model to be used for estimating the impacts of the MLR requirements.[4] To address many of these limitations, we use an additional NAIC data source known as the A&H Policy Experience Exhibit (AHPE). These data include all NAIC filers and provide national totals for companies' premiums, claims, and member months by detailed lines of business, including individual, small group, and large group comprehensive major medical. Table 4 describes the data elements that are used from this data source. The Department did not use these data for the analysis since they only report information at the national-level for each company whereas the MLR regulation requires issuers to use the company-State level of aggregation. The next section describes the imputation methods used to address the data limitations of the Health and Life Blank data.

[4] The NAIC has developed a "Supplemental Blank" that will be used to collect 2010 comprehensive major medical data by company, State and market that are consistent with the uniform definitions and standardized calculation methodologies that NAIC was required to develop under Section 2718(c) of the PHS Act (subject to certification by the Secretary). However, this information will not be available until the Spring of 2011.

Table 2. Description of MLR components available on the 2009 NAIC Life Blank Annual Statement

Measure	NAIC Health Blank data source		Level of aggregation for company data	
	Exhibit name	Location	Area	Product
Incurred claims[1]	State Page - Accident and health insurance	p.24, line 25.1, col 5	State	Individual A&H non-cancelable policies
		p.24, line 25.2, col 5	State	Individual A&H guranteed renewable policies
		p.24, line 25.3, col 5	State	Individual A&H non-renewable policies
		p.24, line 25.5, col 5	State	Individual A&H other policies
		p.24, line 24, col 5	State	Group A&H policies
		p.24, line 24.1, col 5	State	FEHB A&H policies[2]
		p.24, line 26, col 5	State	Total A&H policies
Earned premiums[1]	State Page - Accident and health insurance	p.24, line 25.1, col 2	State	Individual A&H non-cancelable policies
		p.24, line 25.2, col 2	State	Individual A&H guranteed renewable policies
		p.24, line 25.3, col 2	State	Individual A&H non-renewable policies
		p.24, line 25.5, col 2	State	Individual A&H other policies
		p.24, line 24, col 2	State	Group A&H policies
		p.24, line 24.1, col 2	State	FEHB A&H policies[2]
		p.24, line 26, col 2	State	Total A&H policies
Number of member months	--	--	--	--
Federal and foreign taxes[3]	Life - Summary of Operations	p.4, line 32, col. 1	National	Accident &Health policies
State premium taxes	Taxes, Licenses, and Fees - Exhbit 3	p.11, line 3, col. 2	National	Accident &Health policies
Social security taxes		p.11, line 5, col. 2	National	Accident &Health policies
Other state taxes		p.11, line 5, col. 2	National	Accident &Health policies
Licensing and regulatory fees		p.11, line 2, col. 2	National	Accident &Health policies

Source: 2009 NAIC Life Blank annual statement documentation.

[1] Both incurred claims and earned premiums are reported on a direct basis, gross of reinsurance. Incurred claims does not include changes in contract reservers as defined in the NAIC recommendations.

[2] FEHB policies are covered under the MLR regulation and are therefore combined with the group A&H policies to make up the total group market for Life Blank filers. However, the FEHB category may include data on non-comprehensive major medical policies such as dental and vision coverage.

[3] Federal and foreign income taxes do not include taxes related to investment income, payroll, or social security taxes.

Table 3. Description of MLR components available on the 2009 NAIC Health Blank Annual Statement

Measure	NAIC Health Blank data source		Level of aggregation for company data	
	Exhibit name	Location	Area	Product
Incurred claims[1]	Exhibits of premiums, enrollment, and utilization	p.29, line 15. col 2	State	Individual comprehensive major medical policies
		p.29, line 15. col 3	State	Group comprehensive major medical policies
		p.29, line 15. col 7	State	FEHB policies[2]
		p.29, line 15. col 1	State	Total A&H policies
Earned premiums[1]	Exhibits of premiums, enrollment, and utilization	p.29, line 15. col 2	State	Individual comprehensive major medical policies
		p.29, line 15. col 3	State	Group comprehensive major medical policies
		p.29, line 15. col 7	State	FEHB policies[2]
		p.29, line 15. col 1	State	Total A&H policies
Member months	Exhibits of premiums, enrollment, and utilization	p.29, line 15. col 2	State	Individual comprehensive major medical policies
		p.29, line 15. col 3	State	Group comprehensive major medical policies
		p.29, line 15. col 7	State	FEHB policies[2]
		p.29, line 15. col 1	State	Total A&H policies
Federal and foreign taxes[3]	Statement of revenue and expenses	p.4, line 31, col. 2	National	Total A&H policies
State premium taxes	Underwriting & investment exhibit, Part 3	p.14, line 23.2, col 5	National	Total A&H policies
State and local insurance taxes		p.14, line 23.1 , col 5	National	Total A&H policies
Payroll taxes		p.14, line 23.4 , col 5	National	Total A&H policies
Other taxes [4]		p.14, line 23.5 , col 5	National	Total A&H policies
Licensing and regulatory fees		p.14, line 23.3, col 5	National	Total A&H policies

Source: 2009 NAIC Health Blank annual statement documentation.

[1] Both incurred claims and earned premiums are reported on a direct basis, gross of reinsurance. Incurred claims does not include changes in contract reservers as defined in the NAIC recommendations.

[2] FEHB policies are covered under the MLR regulation and are therefore combined with the group comprehensive major medical policies to make up the total group market for Health Blank filers. However, the FEHB category may include data on non-comprehensive major medical policies such as dental and vision coverage.

[3] Federal and foreign income taxes do not include taxes related to investment income, payroll, or social security taxes.

[4] Other taxes excludes federal income and real estate taxes

Table 4. Description of MLR components available on the 2009 NAIC Accident & Health Policy Experience Exhibit

Measure	NAIC A&H Policy Experience Exhibit Data Source	Level of aggregation for company data	
		Area	Product
Incurred claims	Line A01.3, col. 2	National	Individual comprehensive major medical
	Line B01.1, col. 2	National	Small group single employer comprehensive major medical
	Line B01.2, col. 2	National	Other group, single employer (i.e. large group) comprehensive major medical
	Line B02, col. 2	National	Multiple employer association & trusts
	Line B03, col. 2	National	Other association & discretionary trusts
	Line B04, col. 2	National	Other group comprehensive major medical
	Line B05, col. 2	National	Total group comprehensive major medical
	Line B14, col. 2	National	FEHB[1]
Earned premiums	Line A01.3, col. 1	National	Individual comprehensive major medical
	Line B01.1, col. 1	National	Small group single employer comprehensive major medical
	Line B01.2, col. 1	National	Other group, single employer (i.e. large group) comprehensive major medical
	Line B02, col. 1	National	Multiple employer association & trusts
	Line B03, col. 1	National	Other association & discretionary trusts
	Line B04, col. 1	National	Other group comprehensive major medical
	Line B05, col. 1	National	Total group comprehensive major medical
	Line B14, col. 1	National	FEHB[1]
Member months	Line A01.3, col. 7	National	Individual comprehensive major medical
	Line B01.1, col. 7	National	Small group single employer comprehensive major medical
	Line B01.2, col. 7	National	Other group, single employer (i.e. large group) comprehensive major medical
	Line B02, col. 7	National	Multiple employer association & trusts
	Line B03, col. 7	National	Other association & discretionary trusts
	Line B04, col. 7	National	Other group comprehensive major medical
	Line B05, col. 7	National	Total group comprehensive major medical
	Line B14, col. 7	National	FEHB[1]

Source: 2009 NAIC A&H Policy Experience Exhibit data documentation.

[1] FEHB policies are covered under the MLR regulation and are therefore combined with the other group comprehensive major medical policies to make up the total group market for the AHPE company-level data. However, the FEHB category may include data on non-comprehensive major medical policies such as dental and vision coverage.

B. Data Imputation Methods

There are five major data imputation steps that the Department developed in order to better estimate the impacts of the MLR regulations. These steps:

- Edit the Life Blank State data to estimate earned premiums, incurred claims, and life years for comprehensive major medical products, by State, for the individual and group markets;
- Reassign insurance sold to associations and trusts from group to individual markets for both the Health and Life Blank State data;
- Estimate the division of small versus large group business for both State-level data sources;
- Allocate company-level A&H expenses to the State-level for individual, small group, and large group comprehensive major medical markets; and
- Apply sample restrictions to ensure that the analytical sample does not include data from company-State records that are out of scope of the regulation or that would produce extreme or undefined MLRs.

Edit Life Blank State data to resemble the structure of the Health Blank State data. The purpose of this edit is to make the Life Blank State data match the structure of the Health Blank State data, i.e., estimate comprehensive major medical earned premiums, incurred claims, and life years for individual and group markets by State. To estimate these data, we first use the AHPE data to identify Life Blank companies that report positive earned premiums and incurred claims for either individual or total group CMM policies. For these companies, we calculate the ratio of AHPE total comprehensive major medical premiums in each market to total premiums for the comparable company-level A&H individual or group market from the Life Blank State data. We calculate the same ratio for total incurred claims.

For the group market, there is only one category on the Life Blank State data that captures A&H group premiums and claims. If both a company's premium and claims ratios fall between 0.7 and 1.3, then that Life Blank company is included in the group market analytical sample. For the individual market, there are four separate categories in the Life Blank State data that could capture A&H individual market data: guaranteed renewable, non-renewable, non-cancelable, and other individual coverage. Therefore, we calculate four individual market ratios for both premiums and claims. A Life Blank company's State data are included in the individual market analysis if at least one of these ratios for both premiums and claims falls between 0.7 and 1.3. If more than one ratio falls within this range, the category with the premium ratio that is closest to 1 is selected for inclusion as the Life Blank company's individual market data.

The individual market is not particularly sensitive to the ratio range chosen as part of the selection criteria, but the group market sample is, driven by a couple of large companies that have premium and claims ratios that are less than 0.8. Going from a range of [0.7, 1.3] to [0.8, 1.2] reduces the amount of Life Blank group CMM premiums that are captured from 93.8 percent to 49.2 percent (Table 5).

Table 5. Sensitivity of ratio ranges used to identify Life Blank companies for inclusion in the analytical sample, 2009

Premium and claims ratio range used to identify Life Blank companies	Individual Market				Group Market			
	Number of Life Blank companies included				Number of Life Blank companies included			
	N	Percent of total	N (millions)	Percent of total	N	Percent of total	N (millions)	Percent of total
[0.7,1.3]	44	37.9%	$3,642	98.4%	57	49.1%	$40,027	93.8%
[0.8,1.2]	38	32.8%	$3,365	90.9%	52	44.8%	$20,986	49.2%
[0.9,1.1]	34	29.3%	$3,126	84.5%	49	42.2%	$13,109	30.7%

Source: 2009 NAIC A&H Policy Experience Exhibit data and 2009 NAIC Life Blank annual statement.

Note: The ratio ranges reflect the range of the earned premium and incurred claims ratios of company-level CMM AHPE data to company-level data from the comparable A&H individual or group market category in the Life Blank state data. Totals used to calculate percentages represent the total number of companies, and their associated earned premiums, that report individual or group CMM business on the A&H Policy Experience Exhibit. The NAIC data exclude issuers regulated by California's Department of Managed Health Care as well as small, single-State insurers that are not required by State regulators to submit NAIC annual financial Statements.

For both the individual and group markets, the company ratios for the selected Life Blank State data categories are applied as weights to the Life Blank State premiums and claims so that the edited State data matches the company totals reported on the AHPE data.

The last part of the imputation allocates the Life Blank AHPE company-level CMM data on life years to the individual and group markets by State. These data are assigned to an issuer's business in a State in proportion to the percentage of a company's total individual or group CMM premiums that is represented by that State using the State premium data that has been weighted to align with the AHPE premium data for a market.

Reassign association business from group to individual market. As previously mentioned, the Health and Life Blank State group market data include policies sold through associations which the PHS Act defines as individual market coverage. We use the AHPE data, which isolates association business ("other association and discretionary trusts" category on Table 4), to reallocate some of the State data to the individual market. First, we calculate the percent of a company's total group CMM premiums and claims that is represented by association lines of business. If this percentage is greater than or equal to 90 percent for both premiums and claims, then all of the State data for the group market is reassigned to the individual market. The sample of companies that are selected for this imputation does not change when lower thresholds (e.g., 80 percent or 70 percent) are used.

Second, for a company that only operates in one State, the AHPE record is essentially a State-level record. Therefore, we subtract the association-related premiums, claims, and life years reported on the AHPE from the State-level group market data and add them to the State-level individual market data. After this imputation, some association business may still be captured as group coverage if it is reported by companies that operate in multiple States and that do not have association lines of business representing an overwhelming majority of their total group CMM business. Through this edit, approximately $10.7 billion, or 4 percent of Health and Life Blank group CMM premiums, were reallocated to the individual market.

Estimate small and large group market data. By this point in the imputation process, both the Health Blank and the edited Life Blank State data report information for the total group CMM market by State. However, the impact estimates require the data to delineate between the small and large group market in order to measure the effect of different MLR requirements. The Department uses the AHPE data to estimate the division of the total group market into small group and large group business at the State level. Specifically, we estimate unadjusted and fully adjusted MLRs, including credibility adjustments, at the company level using the AHPE for the total group, small group, and large group CMM markets. We then calculate the difference between the large group and total group market company MLRs and the small group and total group market company MLRs. These company-level MLR differences are then applied to the total group market MLRs calculated at the State-level to estimate MLRs for the small group and large group markets for a company in a particular State. In order to estimate the number of licensed entities that are subject to the rebate requirement and total rebate amounts, we also allocate a company's total group market State data on life years and premiums in proportion to the percentage of a company's total group CMM life years or premiums on the AHPE that is represented by the small and large group markets.

It is important to note two major caveats relating to this imputation method. As Table 4 shows, the AHPE data include 5 categories that make up the total group CMM market. However, the AHPE only reports data by small and large group markets for single employers. In order to incorporate companies' total group CMM business for this imputation, we categorized data for multiple employer associations and trusts, other association and discretionary trusts (i.e. what remains after the reassignment to individual market), and other group comprehensive major medical policies as small group since it would likely produce a conservative estimate of the size of rebates.[5] Additionally, the categorization of small versus large group business for single employer coverage is determined by States and, therefore, may vary across companies' group CMM business in different States.[6]

Allocate company-level expenses to States. For both the Health and Life Blank State data, the expenses used to adjust licensed entities' MLRs are reported for all A&H business at the company level (Tables 2 and 3). We allocated these expenses to a company's State business in the individual and group CMM markets in proportion to the percent of a company's total A&H premiums that is represented by the individual, small group, large group, and total group market premiums reported for a particular State. This allocation is done for the entire group market in order to calculate the State-level group CMM MLRs that are then used to estimate MLRs for the small and large group market separately.

[5] "Multiple employer association and trusts" and "Other group" lines of business tend on average to have higher unadjusted MLRs (88 percent and 89 percent) than either single employer small or large group (81 percent and 83 percent), whereas "Other association and discretionary trusts" tend to have substantially lower unadjusted MLRs (67 percent). Categorizing these lines of business as small group would mean that they would be compared to the lower minimum MLR standard of 80 percent, which would reduce the potential size of rebates. However, to the extent that these lines of business increase the number of life years, which in turn reduces the credibility adjustment for companies below the small group MLR minimum, the addition of these lines of business could increase the size of rebates.

[6] According to a report by the Association for Health Insurance Plans (AHIP): "Small groups generally consist of firms with 2-50 employees, although some States allow self-employed people -- so-called "groups of one" -- to purchase in the small group market." (*Small Group Health Insurance in 2008: A Comprehensive Survey of Premiums, Consumer Choices, and Benefits*, AHIP Center for Policy and Research, March 2009.)

Table 6 present summary statistics for taxes and fees as a percent of companies' total A&H earned premiums. On average, all taxes combined represent 2.5 percent of total premiums, with federal taxes representing 1.3 percent of this total. However, the average reflects a distribution that is skewed, with the median percentage value for taxes standing at 1.5 percent.

Table 6. Summary statistics for expenses as a percent of total A&H premiums earned, 2009

Expenses as a percent of total A&H premiums earned	Mean	Minimum	5th Percentile	25th Percentile	Median	75th Percentile	95th Percentile	Maximum
State taxes	0.83%	0.00%	0.00%	0.11%	0.71%	1.29%	2.02%	16.03%
Federal and foreign taxes	1.26%	0.00%	0.00%	0.00%	0.52%	2.50%	3.68%	84.60%
Payroll/social security taxes	0.35%	0.00%	0.00%	0.22%	0.34%	0.44%	0.90%	9.64%
Other taxes	0.08%	0.00%	0.00%	0.00%	0.01%	0.02%	0.42%	12.67%
Licensing and regulatory fees	0.17%	0.00%	0.00%	0.00%	0.04%	0.20%	0.92%	14.86%

Source: 2009 Health and Life Blank annual statement.

Notes: Summary statistics are weighted by total A&H premiums earned. The sample for these estimates is restricted to the 442 companies included in the RIA. The criteria used to restrict the RIA sample is discussed in the next section. The NAIC data exclude issuers regulated by California's Department of Managed Health Care as well as small, single-State insurers that are not required by State regulators to submit NAIC annual financial Statements.

Apply additional analytical sample restrictions. Table 1 shows the number of companies that report comprehensive major medical coverage in the NAIC data. However, given the resource constraints and data limitations faced by the Department, we do not use all these companies in the RIA. Table 7 describes how data restrictions affected the final analytical sample, which used 442 of the 618 companies reporting CMM business to the NAIC.

Table 7. Description of how NAIC data restrictions affect the analytical sample of insurance companies reporting comprehensive major medical business, 2009

Sample Restrictions	Companies		Comprehensive major medical life years		Comprehensive major medical premiums earned	
	N	Percent of total	N (Millions)	Percent of total	N (Millions)	Percent of total
Total	618	100.0%	75.8	100.0%	$258,804	100.0%
Fraternal & PC companies	22	3.6%	0.2	0.3%	$952	0.4%
Not in Life Blank edit	103	16.7%	1.1	1.5%	$2,584	1.0%
Not in Health Blank state data	9	1.5%	0.2	0.3%	$412	0.2%
Not in any market sample	42	6.8%	0.5	0.6%	$1,921	0.7%
In sample	442	71.5%	73.8	97.4%	$252,934	97.7%

Source: 2009 NAIC A&H Policy Experience Exhibit data and 2009 NAIC Health Blank annual statement.

Note: The primary data source for these estimates is the 2009 NAIC A&H Policy Experience Exhibit. However, there are 39 companies reporting CMM business on the NAIC Health Blank statement that are not on the A&H Policy Experience Exhibit data. Since the Health Blank annual statement is the basis for the state-level estimates used for the analysis, these companies are included in the description of the total comprehensive major medical market. Totals reported here may differ from totals reported in the RIA due to differences in data sources. The RIA uses state-level data from the Health and Life Blank annual statements, which uses a different collection procedure to collect premiums and life year information than the A&H Policy Experience Exhibit. The NAIC data exclude issuers regulated by California's Department of Managed Health Care as well as small, single-State insurers that are not required by State regulators to submit NAIC annual financial Statements.

We exclude Fraternal and P&C companies, which represent less than 1 percent of the market, to minimize the burden of data processing tasks. The Life Blank exclusion, which excludes 103 CMM companies, is due to those companies not satisfying the conditions of the Life Blank imputation method described above, i.e. they do not have premium and claims ratios that fall between 0.7 and 1.3. Although the number of companies excluded is large, these companies represent only 1 percent of total CMM premiums. As Table 8 shows, most of the excluded premium from these companies comes from the small group market. The second largest exclusion in terms of life years and premiums is due to companies not meeting the following sample restrictions that the Department applied to the State-level data as a way of excluding observations that are outside the scope of the regulation or observations that would have extreme or undefined MLRs or observations:

- Company-State records for U.S. territories.
- Company-State records that report all zeros for premiums and claims in the market. Company-State records that report anomalous combinations of premiums and claims (e.g. zero premiums and positive claims or negative claims and positive premiums).
- Company-State records that are missing expenses.
- Company-State records where the allocated expenses for the individual and group State markets are greater than the State-level premiums, which would lead to a negative denominator for the MLR.
- Company-State records that are missing data on life years.
- Company-State records that have premiums per life years that are less than $100 or greater than $60,000.

All of these exclusions are market-specific such that if a company's State record were to meet a criterion for exclusion in one market but not in the other markets, it would be excluded only from the market

where it satisfied the sample restriction criteria. The 42 companies that were excluded from the analysis, which represent less than 1 percent of CMM premiums, did not meet these criteria in any of the three markets. Overall, excluded companies represent a small fraction of the CMM market – 3 percent of life years and 2 percent of premiums (Table 7) -- and this pattern is consistent across the individual, small group, and large group markets (Table 8).

Table 8. Description of how NAIC data restrictions affect the analytical sample of insurance companies reporting comprehensive major medical business by market, 2009

Sample Restrictions	Individual comprehensive major medical market			Small group comprehensive major medical market			Large group comprehensive major medical market		
	Companies	Life years (millions)	Premiums earned (millions)	Companies	Life years (millions)	Premiums earned (millions)	Companies	Life years (millions)	Premiums earned (millions)
Total	419	10.30	$25,366	436	25.28	$86,628	385	40.06	$146,226
Fraternal & PC companies	11	0.05	$136	10	0.11	$446	6	0.06	$370
Not in Life Blank edit	68	0.04	$59	48	0.73	$2,310	15	0.32	$208
Not in Health Blank state data	--	--	--	7	0.10	$144	5	0.09	$268
Not in market sample	29	0.25	$585	29	0.45	$1,041	21	0.63	$712
In sample	**311**	**9.96**	**$24,585**	**342**	**23.89**	**$82,687**	**338**	**38.95**	**$144,668**
Percent of total that is in sample	**74.2%**	**96.7%**	**96.9%**	**78.4%**	**94.5%**	**95.5%**	**87.8%**	**97.2%**	**98.9%**

Source: 2009 NAIC A&H Policy Experience Exhibit data and 2009 NAIC Health Blank annual statement.

Note: The primary data source for these estimates is the 2009 NAIC A&H Policy Experience Exhibit. However, there are 39 companies reporting CMM business on the NAIC Health Blank statement that are not on the A&H Policy Experience Exhibit data. Since the Health Blank annual statement is the basis for the state-level estimates used for the analysis, these companies are included in the description of the total comprehensive major medical market. Totals reported here may differ from totals reported in the RIA due to differences in data sources. The RIA uses state-level data from the Health and Life Blank annual statements, which uses a different collection procedure to collect premiums and life year information than the A&H Policy Experience Exhibit. Multiple employer association and trusts, other association and discretionary trusts, and other group comprehensive major medical policies have been allocated across individual, small group, and large group markets according to the method described in the appendix. Finally, the last restriction, "not in market sample" includes all companies that do not meet the sample criteria for that market not just the 42 companies that do not meet the sample criteria for all markets. The NAIC data exclude issuers regulated by California's Department of Managed Health Care as well as small, single-State insurers that are not required by State regulators to submit NAIC annual financial Statements.

III. METHODS FOR ESTIMATING MLR REBATE REQUIREMENTS

The RIA includes estimates that are based on both unadjusted and adjusted MLRs. Information on unadjusted MLRs, which are simply incurred claims divided by earned premiums, is included to assess the impact of the adjustments allowed by the regulation on companies' State-level MLRs.

The adjusted MLRs include three sets of adjustments: (1) premium deductions; (2) credibility adjustments; and (3) quality improvements. First, the adjustments deduct Federal and State taxes and licensing and regulatory fees from premiums. These adjustments follow the policy described in the regulation.

Second, they apply estimates of the credibility adjustments for licensed entities that have partially credible experience, i.e., insurers with life years that are greater than or equal to 1,000 life years but less than 75,000 life years. The preamble of the MLR regulation describes the rationale and method for calculating credibility adjustments. As stated in this section, there are two components to the credibility adjustment: a base factor that depends on the number of life years a company has in a particular market and State and a factor that depends on the average per person deductible for the experience reported in the MLR for a particular market and State. The total credibility adjustment to the MLR equals the base factor times the deductible factor. We use linear interpolation to calculate the base credibility adjustment factor for life years that fall between the values in Table 1 of the preamble (Table 9).

Table 9. Formulas used to linearly interpolate the base credibility adjustment factor

Life Year Range	Formula
>1,000 - <2,500	b =(((.052 - .083)/(2,500 - 1,000))*l) + (.083-(((.052 - .083)/(2,500 - 1,000))* 1,000))
>2,500 - <5,000	b =(((.037 - .052)/(5,000 - 2,500))* l) + (.052-(((.037 - .052)/(5,000 - 2,500))* 2,500))
>5,000 - <1,000	b = (((.026 - .037)/(10,000 - 5,000))* l) + (.037-(((.026 - .037)/(10,000 - 5,000))* 5,000))
>10,000 - <25,000	b = (((.016 - .026)/(25,000 - 10,000))* l) + (.026-(((.016 - .026)/(25,000 – 10,000))*10,000))
>25,000 - <50,000	b = (((.012 - .016)/(50,000 - 25,000))* l) + (.016-(((.012 - .016)/(50,000 – 25,000))*25,000))
>50,000 - <75,000	b = (((.000 - .012)/(75,000 - 50,000))* l) + (.012-(((.000 - .012)/(75,000 – 50,000))*50,000))

Note: b = base credibility adjustment factor; l = life years

To calculate the deductible adjustment factor used in the individual market, we use data collected for the Department's health care reform insurance web portal [7] to estimate the average deductible for certain large companies in the individual market. For simplicity, we assume an overall average deductible for the remaining individual market companies using the distribution of deductibles across their products. This average deductible is then mapped to the appropriate deductible credibility adjustment based on the factors presented in Table 2 of the preamble. We then use formulas similar to those used for the base credibility adjustment to linearly interpolate factors for average deductible values that fall between the points included in the table. A limitation of this method is that the web portal data do not report enrollment by deductible categories so the average deductibles calculated are not weighted by life years. Additionally, for ease in calculation, the estimates of the deductible adjustment factor do not vary by State.

[7] For more information on the web portal, see OCIIO's health care reform insurance web portal regulation requirements located at http://www.hhs.gov/ociio/regulations/webportal.html.

For the group market, we assume a deductible adjustment factor of one since the literature shows that the majority of enrollees in the group market face a deductible that is less than $2,500, the threshold above which the deductible credibility adjustment factor begins to increase above one. According to a 2010 report from the Kaiser Family Foundation, only 6 percent of covered workers with single coverage under Preferred Provider Option plans, the most prevalent form of coverage among workers[8] , face a deductible of $2,000 or more. Even among workers with High Deductible Health Plans with a Savings Option (HDHP/SO), who represent just 13 percent of the all workers with employer-sponsored insurance, only 9 percent face a deductible of more than $2,000 or more.[9]

Third, the adjusted MLRs reported in this analysis also incorporate assumptions about the size of expenses for quality improvement activities, as well as assumptions about other actions that insurers might take to increase their reported MLR. Because the definitions of quality improving activities are new to this rule, the NAIC data collected in 2009 cannot be used to directly estimate how much insurers spent on quality improving activities in 2009 or how much they are expected to spend on these activities in 2011. The closest category in the NAIC data is 'cost containment expenses', which averaged approximately 1 percent of premiums in 2009, but the definition of quality improving activities includes many activities that were not included in cost containment expenses.

Discussions with industry experts suggest that quality improving activities are likely to account for an average of approximately 3 percent of premium, but there is substantial uncertainty concerning this estimate. Few observers think that quality improving activities will be greater than 5 percent of premium, and few expect that they will be less than 1 percent of premium. In the mid-range estimate, the Department assumes that quality improving activities will account for 3 percent of premium, and uses the 1 percent and 5 percent estimates as the range in a sensitivity analysis.

In addition to uncertainty about the magnitude of quality improving activities, there are many other sources of uncertainty about how insurers will respond to this interim final regulation, and the effects of these responses on MLRs and rebate amounts.[10] Given the combination of data imperfections and behavioral uncertainties, the Department has chosen to provide a range of estimates, based on a range of assumptions. A reasonable range of assumptions is that, in the mid-range estimate, MLRs will increase by 1 percentage point relative to the data reported in 2009, with a reasonable bound for this assumption being on one end, no change from the 2009 data, and, on the other end, an assumption that MLRs will increase by 2 percentage points relative to the 2009 data.

Combined with the low-rebate assumption that quality improving activities will increase MLRs by 5 percentage points, the assumption that other behavioral changes may increase MLRs by an additional 2 percentage points will result in estimated MLRs in the low-rebate scenario being 7 percentage points higher than they would be with no allowance for either quality improving activities or other behavioral changes. Consultation with industry experts suggests that this is a reasonable upper bound for the low-rebate assumption as an average for the industry. It is possible that some issuers may invest greater than 5 percent of premium in quality improving activities, or change their behavior in ways that result in a greater than 2 percentage point increase in MLR, but the Department thinks it is unlikely that the changes across

[8] 58 percent of workers with employer-sponsored insurance have PPO coverage.

[9] The Kaiser Family Foundation and the Health Research and Education Trust, *Employer Health Benefits 2010 Annual Surve*, September 2010, http://ehbs.kff.org/ (accesed November 2010). We report estimates for single coverage since the regulation calls for calculating the average per person deductible to determine the deductible credibility adjustment factor.

[10] A discussion of the sources of uncertainty can be found in Section VI.A of the RIA.

the industry for quality improving activities and behavioral changes will be greater than 7 percentage points.

The Department further assumes that issuers with an MLR that is already above the minimum threshold (80 percent in the individual and small group markets, 85 percent in the large group market) will have less incentive to change their behavior in an attempt to increase their MLR than will issuers with lower MLRs that would require them to pay rebates. In the mid-range and low-rebate scenarios, the Department assumes that issuers whose adjusted MLR is above the minimum threshold after an assumed 3 percent increase for quality improving activities will not further increase the MLR with additional quality improving activities or other behavioral changes. Table 10 summarizes the values that are added to the base MLR to adjust for quality improving expenses and other behavioral uncertainties.

Table 10. Assumptions used to estimate MLRs under a range of scenarios

Category	Low estimate for rebates (percentage points)	Medium estimate for rebates (percentage points)	High estimate for rebates (percentage points)
Quality improvement activities	+5	+3	+1
Behavioral uncertainties	+2	+1	+0
Total impact on MLRs	+7	+4	+1

NOTE: In the low and mid-range scenarios, additional adjustments are not made for issuers whose MLR is above the minimum threshold after 3 percentage points are added for quality improving activities.,.

These three sets of adjustments are combined to produce the following formula for estimating companies' adjusted MLRs for the individual, small group, and large group markets by State, rounded to the nearest thousandth decimal place as dictated in the regulation[11]:

Adjusted MLR = (c)/ (p - t - f) + (b*d) + u,

where c = incurred claims
p = earned premiums
t = Federal and State taxes
f = licensing and regulatory fees
b = base credibility adjustment factor
d = deductible credibility adjustment factor
u = low, medium, or high assumptions to account for quality improving activities, unknown behavioral changes and data measurement error

[11] The text states that in the mid-range assumption, quality improving activities will account for 3 percent of premium. In the formula presented here, quality improving (and other behavioral change assumptions) are expressed as percentage point increases in the MLR amount. That is, in the mid-range assumption, we assume that quality improvement expenses will add 3 percentage points to the MLR. As a practical matter, because Federal and State taxes and licensing and regulatory fess are quite small (Table 6), there is virtually no difference between assuming that quality improvement expenses account for 3 percent of premium or assuming that they will add 3 percentage points to the MLR.

We then calculate rebates for a company whose adjusted MLR value in a State falls below the minimum MLR standard in a given market using the following formulas:

Rebates = [(m – a)* (p - t - f)]

where m = minimum MLR standard for a particular market
a = adjusted State MLR for that market

Finally, to estimate impacts for each year covered by the regulation, we assume that the number of issuers, enrollment, and experience are stable over time. The interim final regulation requires that experience be combined across multiple years for issuers that are not fully credible based on a single year of data. Given the assumption that enrollment is stable over time, the Department estimates that issuers which are not fully credible in 2011 will have twice as much enrollment in the combined experience for 2011 and 2012, and three times as much enrollment in the combined 2011 through 2013 data. As a result, the magnitude of the credibility adjustment in 2012 will be smaller than in 2011 and smaller again in 2013.

The Department is unable to model the impact of losing the MLR credibility adjustment beginning in 2013 if licensed entities report partially credible experience for the current year and the two previous years and have MLRs below the minimum standard in all three years. However, the analysis does simulate the impact of doubling life years in 2012 or tripling life years in 2013 for licensed entities that have non-credible or partially credible experience using a single year of data to estimate how this affects the portion of insurers that are deemed to have credible experience as well as their associated MLR values in those years. Additionally, rebates are estimated in 2011 through 2013 by applying the projected growth rate in private health insurance premiums per privately insured from the National Health Expenditures Accounts (NHE) to the 2009 NAIC adjusted premiums.[12]

Table 11 reports the distribution of enrollment (measured in terms of life years) across different MLR ranges for Health and Life Blank filers that the Department estimates will be subject to rebate requirements in 2011. Using unadjusted MLRs, 62 percent of enrollment in the individual market was in licensed entities that were below the 80 percent minimum MLR standard, with 21 percent of enrollment significantly below this standard (i.e., with MLRs less than 70 percent). With adjustments to the MLR, the percent of enrollment below the minimum MLR standard declines, but the size of the decrease depends on the modeling assumptions used to calculate the MLR: 21.5 percent of enrollment is below the minimum under the low rebate assumptions versus 51.1 percent under the high rebate assumptions. For the small and large group markets, licensed entities generally have higher unadjusted MLRs, which translates into approximately 20 percent of enrollment in both markets being in licensed entities that fall below the respective minimum MLR standards for the two markets. Once adjustments are applied to the MLR, only a relatively small portion of both markets remain below the minimum MLR standard regardless of the behavioral assumptions used.

[12] Estimates of projected private health insurance premiums and privately insured enrollees in 2009 and 2011 through 2013 come from the September 2010 National Health Expenditure Projections for 2009 – 2019 developed by the Office of the Actuary in the Centers for Medicare and Medicaid Services (https://www.cms.gov/NationalHealthExpendData/Downloads/NHEProjections2009to2019.pdf, accessed November 2010) . These projections incorporate estimates of the impact of the Affordable Care Act on heath expenditures and insurance coverage.

Table 11. Percent of life years in the market across categories of unadjusted and adjusted MLRs for all filers, by market (2011)

MLR category	Individual Market				Small Group Market				Large Group Market			
	Unadjusted MLRs	Adjusted MLRs			Unadjusted MLRs	Adjusted MLRs			Unadjusted MLRs	Adjusted MLRs		
		Low rebate estimate	Medium rebate estimate	High rebate estimate		Low rebate estimate	Medium rebate estimate	High rebate estimate		Low rebate estimate	Medium rebate estimate	High rebate estimate
0<-<.50	2.1%	0.1%	0.1%	0.3%	0.3%	0.2%	0.2%	0.2%	0.1%	0.05%	0.05%	0.1%
.50-<.60	4.6%	0.7%	1.5%	2.1%	0.3%	0.05%	0.04%	0.2%	0.1%	0.05%	0.05%	0.1%
.60-<.70	14.1%	4.1%	4.9%	10.9%	1.5%	0.3%	0.3%	0.4%	0.4%	0.1%	0.2%	0.1%
.70-<.75	26.3%	7.8%	10.6%	10.1%	4.1%	0.3%	0.3%	1.3%	0.8%	0.1%	0.0%	0.1%
.75-<.80	14.8%	8.8%	13.4%	27.6%	13.5%	0.4%	2.1%	4.8%	4.2%	0.1%	0.2%	0.4%
.80-<.85	10.0%	35.7%	26.7%	11.4%	31.9%	17.7%	15.8%	17.7%	16.2%	0.3%	1.3%	4.2%
.85-<1	21.1%	31.9%	31.9%	27.7%	47.3%	75.0%	75.0%	72.8%	77.7%	92.4%	91.2%	90.9%
1<=	6.9%	10.9%	10.9%	9.8%	1.2%	6.1%	6.1%	2.6%	0.6%	6.9%	6.9%	4.1%
Total <.80	**62.0%**	**21.5%**	**30.4%**	**51.1%**	**19.7%**	**1.2%**	**3.0%**	**6.9%**	--	--	--	--
Total <.85	--	--	--	--	--	--	--	--	**21.7%**	**0.7%**	**1.8%**	**5.1%**

Source: 2009 NAIC Health and Life annual statements and A&H Policy Experience Exhibit data.

Notes: Percent distributions are for all filers that are subject to rebate requirements in 2011, i.e. those with 1,000 life years or more in a single year. The low, medium, and high estimates reflect assumptions for the adjusted MLRs that will give a low to high estimate of rebates. Consequently, the low rebate estimate will have the highest MLRs for insurers and the high rebate estimate will have the lowest MLRs. The NAIC data exclude issuers regulated by California's Department of Managed Health Care as well as small, single-State insurers that are not required by State regulators to submit NAIC annual financial statements.

IV. Description of MLR Reporting Requirement, Record Retention, and Rebate Notification Modeling Assumptions

The Affordable Care Act MLR reporting and rebate requirements will affect health insurance issuers offering coverage in the individual and group markets, including both the small group and large group markets. As discussed earlier, most of the affected issuers currently report similar data to NAIC as part of their annual financial statements. However, this interim final regulation includes requirements related to calculating some additional data elements, and allocating data by company, State and market.

In order to assess the potential administrative burden relating to the requirements in the interim final regulation, the Department consulted with the NAIC and an industry expert to gain insight into the tasks and level of effort required. Based on these discussions, the Department estimates that issuers will incur one-time start-up costs associated with developing teams to review the requirements in this interim final regulation, and developing processes for capturing the necessary data (e.g., automating systems; writing new policies for tracking expenses in the general ledger; developing methodologies for allocating expenses by State, company and market; etc.). The Department estimates that issuers will also incur ongoing annual costs relating to data collection, populating the MLR reporting forms, conducting a final internal review, submitting the reports to the Secretary, internal audit, record retention, and preparing and mailing rebate notifications and checks (where appropriate).

The Department anticipates that the level of effort relating to these activities will vary depending on the scope of an issuer's operations. Specifically, each issuer's estimated reporting burden is likely to be affected by a variety of factors that will affect the level of complexity of its filing – including the number of markets in which it operates (e.g., individual, small group, large group), the number of States and licensed entities through which it offers coverage, the degree to which it currently captures relevant data at the State / company / market level, number of enrollees, whether it offers other types of A&H coverage, whether it is a Health Blank or Life Blank filer, and whether it is a subsidiary of a larger carrier. Table 12 shows that larger issuers (defined based on total individual and group comprehensive earned premiums) tend to have higher levels of complexity based on many of these factors.

Table 12. Description of Issuers Subject to the Medical Loss Ratio (MLR) Reporting Requirements

Total Earned Premiums - Individual and Group Comprehensive Major Medical Coverage	Total Number of Issuers	Average Number of States	Average Number of Markets	Percent of Issuers Part of Larger Carriers	Percent of Issuers Offering Other Types of A&H Coverage	Percent of Issuers That Are Life Blank Filers
Less Than $10 Million	72	4.7	1.2	80.6%	73.6%	30.6%
$10 million to $49 million	71	6.1	1.8	62.0%	62.0%	22.5%
$50 million to $149 million	92	3.0	2.2	80.4%	83.7%	9.8%
$150 million to $999 million	138	3.7	2.6	84.1%	83.3%	7.2%
$1 billion or more	69	6.4	2.8	91.3%	98.6%	13.0%
Total	442	4.5	2.2	80.3%	80.8%	14.9%

Sources: 2009 NAIC A&H Policy Experience Exhibit data and 2009 NAIC Health and Life Blank Annual Statement
Notes: Total issuers represents 2009 NAIC Health and Life Blank filers with valid data. Excludes data for companies that are regulated by the California Department of Managed Health Care and other non-Health and Life Blank filers. Average number of markets represents the average number of lines of business (e.g., individual, small group, large group) in which an issuer offers coverage.

These factors will have implications for the number of reports that must be submitted to the Secretary, the level of effort involved in expense allocation, and available in-house staff resources. For example, issuers

that have multiple companies operating in multiple States for all three markets (individual, small group, and large group) are likely to incur more costs in meeting the MLR reporting requirements than issuers that have a single company operating in a single State and market. However, the Department also anticipates that there will be some economies of scale (e.g., for additional States, markets).

There is some uncertainty relating to the size of the impact that some of these factors will have on administrative burden – for example, relating to the extent to which some issuers may need to automate collection of certain types of data. There are also some uncertainties relating to the degree to which economies of scale exist for companies that are subsidiaries of larger groups, and general data limitations. For these reasons, the Department derived its estimate of the administrative burden associated with the MLR reporting, record retention, and rebate notification and payment requirements by applying a range of assumptions relating to level of complexity and economies of scale to company-level 2009 NAIC data, and aggregating the results at the national level. The following is a summary of the Department's key assumptions relating to administrative burden.

Staffing. Table 13 summarizes the Department's baseline staffing assumptions (e.g., for a single company, State and market). For purposes of the RIA, these assumptions were applied to each issuer in the analytic sample, with various adjustments based on number of States, number of markets, and economies of scale described below.

Table 13. Baseline Staffing Assumptions Relating to Medical Loss Ratio (MLR) Requirements

Description	Type of Activity	Unit of Measure	Smaller Issuers	Medium Issuers	Larger Issuers
MLR REPORTING REQUIREMENTS					
Develop Teams / Review Requirements - Professional	One-Time	Per Issuer	80	120	320
Develop Teams / Review Requirements - Consultants	One-Time	Per Issuer	80	120	0
Develop Process for Capturing Data - Professional	One-Time	Per Issuer	160	320	960
Develop Process for Capturing Data - Consultants	One-Time	Per Issuer	160	320	0
Collect Data and Populate Report Forms	Annual Ongoing	Per Issuer	135.2	216.8	312.8
Final Internal Review	Annual Ongoing	Per Report	8	8	8
Submit Report Forms to HHS	Annual Ongoing	Per Issuer	0.8	0.8	0.8
Internal Audit		Per Issuer	16	24	32
MLR RECORD RETENTION REQUIREMENTS					
MLR Recordkeeping – Professional	Annual Ongoing	Per Issuer	0.08	0.08	0.08
MLR Recordkeeping – Clerical	Annual Ongoing	Per Issuer	0.17	0.17	0.17
MLR REBATE NOTIFICATION AND PAYMENT REQUIREMENTS					
MLR Rebate Notifications – Clerical	Annual Ongoing	Per Notification	0.02	0.02	0.02
MLR Rebate Checks – Professional	Annual Ongoing	Per Check Mailed	0.01	0.01	0.01
MLR Rebate Payments – Clerical	Annual Ongoing	Per Check Mailed	0.02	0.02	0.02

Note: Professional and Clerical represent estimated hours associated with internal company staff.

The Department generally assumes that issuers will use a mixture of professional staff (45 percent accounting, 45 percent information technology, 5 percent financial managers, 5 percent attorneys) to perform all of the one-time and ongoing activities related to MLR reporting. The Department assumes that issuers will use a mixture of professional staff attorneys (33 percent) and clerical staff (67 percent) to perform the ongoing activities related to MLR record retention. Finally the Department assumes that

issuers will use clerical staff to prepare and mail the MLR rebate notifications; and that issuers will use a mixture of clerical staff (50 percent) and professional staff (50 percent) to prepare, review and mail the rebate checks.

Use of Consultants. Since the provisions of this interim final regulation are generally effective beginning on January 1, 2011, issuers will need to quickly develop systems for capturing the necessary data. The Department assumes that larger companies will be able to rely on in-house staff, while smaller and medium-sized companies will use a mix of in-house staff (50%) and consultants (50%) to complete one-time activities relating to start-up.

Labor Costs. The Department used mean hourly wage estimates from the Bureau of Labor Statistics' May 2009 National Occupational Employment and Wage Estimates (accessed at http://www.bls.gov/oes/current/oes_nat.htm#13-0000) for accountants and auditors (Occupation Code 13-2011), computer systems analysts (Occupation Code 15-10), financial managers (Occupation Code 11-3031), lawyers (Occupation Code 23-1011), executive secretaries and administrative assistants (Occupation Code 43-6011), and management analysts (Occupation Code 13-1111) as the basis for estimating labor costs for 2011 through 2013. The Department adjusted the estimated hourly wages for internal company staff to include fringe benefits (at 33 percent), and the Department adjusted the estimated hourly wages for consultants for fringe benefits (at 33 percent) and load (at 76 percent). For purposes of this analysis, the Department used the following hourly labor cost assumptions (stated in 2010 dollars): $50.59 for professional internal company staff, $28.30 for clerical internal company staff, and $95.89 for consultants.

Firm Size. The Department assumes that larger issuers with higher levels of earned premiums are likely to have increased complexity relating to the number of policies, claims, enrollees, quality improvement programs, etc. The median individual and group comprehensive earned premium for issuers that are subject to the MLR requirements was $130.3 million in 2009. For purposes of this analysis, the Department assumes that companies with $1 billion or more in individual and group comprehensive earned premiums are likely to have increased complexity for the low, mid and high-range scenarios. Additionally, the Department assumes that companies with less than $150 million, $50 million, and $25 million in individual and group comprehensive earned premiums are likely to have decreased complexity for the low, mid and high-range scenarios, respectfully.

Economies of Scale for Additional States. The Department assumes that issuers will incur some administrative costs related to MLR reporting for each additional State in which they offer coverage, but that there will be some economies of scale. The Department assumes that administrative costs for the second State will be 50 percent of the comparable costs for the first State. The Department assumes that the incremental costs for each additional State will be smaller because the issuer will be able to replicate the process that was developed to structure it systems to track and allocate the necessary data across multiple States. However, there is some uncertainty regarding the size of the economies of scale that issuers will experience relating to additional States; therefore, the Department has estimated that issuers will incur administrative costs for the third through 51st States that are 15 percent, 25 percent, and 35 percent of the cost of the first State, respectively for the low, mid and high range estimates.

Economies of Scale for Additional Markets. The Department assumes that, consistent with the format of NAIC's 2010 Supplemental Blank, issuers will be able to submit a consolidated filing to the Secretary for each company / State combination that includes data for multiple markets (e.g., individual, small group, and large group). In addition to the administrative costs associated MLR reporting for a single company / State / market combination, the Department assumes that issuers will spend an additional 4 hours reviewing the data for each additional market that is included in a given filing (up to 3 markets total). Table

14 shows the estimated total number of MLR reports (based on company / State / market combinations) that will be submitted by issuers.

Table 14. Estimated Total Number of Reports Submitted By Issuers Subject to the Medical Loss Ratio (MLR) Requirements

Total Earned Premiums - Individual and Group Comprehensive Major Medical Coverage	Total Number of Issuers	Total Number of Licensed Entities	Estimated Total Number of MLR Reports Submitted to the Secretary	Average Number of Reports Per Issuer
Less Than $10 Million	72	339	358	5.0
$10 million to $49 million	71	431	511	7.2
$50 million to $149 million	92	276	427	4.6
$150 million to $999 million	138	517	1,035	7.5
$1 billion or more	69	439	986	14.3
Estimated Total Number of Issuers Subject to the MLR Reporting Requirements	442	2,002	3,317	7.5

Sources: 2009 NAIC A&H Policy Experience Exhibit data and 2009 NAIC Health and Life Blank Annual Statement
Notes: Total issuers represents 2009 NAIC Health and Life Blank filers with valid data. Excludes data for companies that are regulated by the California Department of Managed Health Care and other non-Health and Life Blank filers.Licensed entities represent Company/State combinations. Licensed entities represent Company/State combinations.

Subsidiary Status. The Department assumes that issuers that are subsidiaries of larger carriers may experience economies of scale related to spreading administrative costs across a larger number of companies. However, these issuers may also experience increased costs relating to expense allocation and systems synchronization. Due to uncertainties about the net impact that these factors will have, the Department estimates that subsidiary companies will have one-time and ongoing costs that are -10 percent lower for the low range, and 10 percent higher for the high range, with no change for the mid-range.

Filing Status. The Department assumes that issuers that do not currently file State and Company level individual and group comprehensive major medical data on NAIC's Health Blank will incur some additional costs developing systems to allocate data in this way. The Department estimates that Life Blank filers' one-time start-up costs will be 5 percent higher for the low range, 7 percent higher for the mid range, and 10 percent higher for the high range.

Number of Notifications. The Department assumes that each enrollee in a company / State / market combination that is estimated to owe rebates for a given year will receive a rebate notification. The Department does not make any assumptions about the potential impact that the $5.00 de minimis policy and the option for issuers offering group coverage to enter into agreements with group policyholders to distribute the rebates will have on the estimated number of notifications that issuers will need to distribute.

Use of Premium Credits or Electronic Reimbursement. The Department assumes that some issuers will opt to use the option of paying rebates through premium credits or lump-sum electronic reimbursement, which will reduce the cost associated with mailing lump-sum rebate checks. However, there is uncertainty regarding how many issuers will choose this option nationwide. For purposes of the regulatory impact analysis, the Department assumes that 70 percent, 50 percent, and 30 percent of issuers will pay rebates through premium credits or one-time electronic reimbursement, respectively, for the low-range, mid-range and high-range.

Mailing and Supply Costs. The Department assumes that mailing and supply costs related to the MLR rebate notification and payment requirements are as follows: $0.05 supply cost per notification or check that is mailed, and $0.44 postage cost per mailing (assuming that each mailing will either include a notification and check, or a notification only in cases where an issuer opts to pay rebates through premium credits or one-time electronic reimbursement). The Department believes that this estimate may overstate the mailing costs related to this activity because many issuers are likely to use bulk mailing rates. Issuers may also incur additional costs related to making a good faith effort to locate enrollees in order to distribute the rebates.

Table 15 summarizes the estimated total one-time and ongoing administrative costs related to the MLR reporting, record retention, and rebate notification and payment costs that issuers will incur.

Table 15. Estimated Total Administrative Costs Related to Medical Loss Ratio (MLR) Reporting, Record Retention, and Rebate Notification and Payment Requirements, Year One

Description	Total Number of Issuers	Total Number of Reports	Estimated Total Hours	Estimated Number of Hours Per Issuer	Estimated Total Cost	Estimated Average Cost Per Issuer	Estimated MLR Administrative Costs as a % of Total A&H Premiums
LOW RANGE ASSUMPTIONS							
One-Time Costs	442	3,317	501,640	1,135	$33,157,861	$75,018	0.01%
Ongoing Costs	442	3,317	218,602	495	$11,117,510	$25,153	0.003%
Total Year One Costs	442	3,317	720,242	1,630	$44,275,371	$100,171	0.01%
MID RANGE ASSUMPTIONS							
One-Time Costs	442	3,317	725,497	1,641	$48,109,870	$108,846	0.01%
Ongoing Costs	442	3,317	346,583	784	$17,336,570	$39,223	0.004%
Total Year One Costs	442	3,317	1,072,080	2,426	$65,446,439	$148,069	0.02%
HIGH RANGE ASSUMPTIONS							
One-Time Costs	442	3,317	1,007,078	2,278	$66,965,900	$151,507	0.02%
Ongoing Costs	442	3,317	590,240	1,335	$28,895,102	$65,374	0.01%
Total Year One Costs	442	3,317	1,597,318	3,614	$95,861,002	$216,880	0.02%

Sources: 2009 NAIC Health and Life Annual Statements and A&H Policy Experience Exhibit data.

Notes: Issuers represents companies (e.g., NAIC company codes). Total number of reports represents the estimated total number of MLR reports that will be submitted to the Secretary (e.g., company / State / market combinations). Total costs represent estimated administrative costs incurred by issuers relating to the MLR reporting, record retention, and rebate payment and notification requirements, stated in 2010 dollars. Excludes data for companies that are regulated by the California Department of Managed Health Care and other non-Health and Life Blank filers.