Healthcare BUSINESS STRATEGY™

New Health Plan Reporting Requires More Transparency

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Amidst the turmoil of healthcare reform repeal debate, health plans continue to meet the day-to-day regulatory requirements of the business. A key regulatory requirement is the filing of annual financial statements with state regulators and the National Association of Insurance Commissioners (NAIC). In anticipation of future Patient Protection and Affordable Care Act (PPACA) requirements, health insurers will be required to file two new forms. One, the Supplemental Health Care Exhibit, is effective with the Annual 2010 filing. The other form deals with the more controversial MLR rebates and is required under PPACA for plan years beginning on January 1, 2011. It is known as the Rebate Calculation Form for MLR. Both of these forms will be challenging for health plans to complete because they separate financial data by state and, within state, by line of business — including individual, small employer group and large employer group. However, the new forms will not only meet the needs of state regulators to fulfill their duties under PPACA, they will also provide an additional source of benchmark data for the health insurance industry. The purpose of this paper is not to debate the merits or folly of PPACA or to express an opinion on the likelihood of repeal. Rather, it is to discuss the new requirements facing health plans as they struggle to meet regulatory reporting hurdles over the next few months.

New Supplemental Health Care Exhibit

On August 17, 2010, the National Association of Insurance Commissioners (NAIC) approved final implementation of the Supplemental Health Care Exhibit (Supplemental Exhibit). This is a supplemental schedule to the Annual Statutory Financial Statement and is to be filed by April 1st of each year beginning with the 2010 Annual Financial Statement. The purpose of this supplemental exhibit is to assist state and federal regulators in identifying and defining elements that make up the medical loss ratio (MLR). Reports will also be submitted to the U.S. Department of Health and Human Services. The Supplemental Exhibit will also track and compare financial results of health care business as reported in the annual financial statements. The numbers captured in the Supplemental Exhibit are not the same as those used for the rebate purposes although; some of the data elements will apply to the Rebate Calculation Supplemental Form.

The new Supplemental Exhibit is prepared separately for each state in which the company has written direct comprehensive major medical health business. A grand total exhibit is also required. Only insurers that sell individual, small group or large group comprehensive health coverage are required to complete the exhibit. The allocation of membership, premiums and claims between states is clearly defined; however, it does not necessarily match where the member resides. For individual business sold through an association, location is based on the issue state of the certificate of coverage. For employer business it is based on the location mentioned in the employer's contract.

The Supplemental Exhibit reports detailed income statement data based on individual, small group employer, large group employer, government business, other business, other health, and uninsured plans. Small group employer is defined as groups with up to 100 employees, except in states exercising an option under PPACA to define small groups up to 50 employees until 2016. Every state in the U.S. currently defines small group up to 50 employees[1], this may complicate the compilation of these reports, especially for multiple state insurers. Government business includes programs such as Medicare Title XVIII, Medicaid Title XIX, Insurance Program

(SCHIP), Medicaid Program Title XXI risk contracts, and other Federal, State government-sponsored coverage. The large group employer category includes the Federal Employees Health Benefit Program (FEHBP) and state and local fully insured government programs.

The Supplemental Exhibit has three parts: Part 1 summarizes the data from the other parts and includes data on premiums, claims, quality expenses, general and administrative expenses - including agent and broker fees and commissions, and the number of policies, covered lives, number of groups and member months. Part 2 includes a detailed break out of health premiums earned and direct claims incurred. Part 3 includes a detailed break out of expenses related to improving health care quality and claims adjustment expenses.

All types of insurance entities with comprehensive major medical business that currently submit data to the NAIC, including Health; Life, Accident & Health; Property & Casualty; and Fraternal, are required to file this new exhibit. It is uncertain how California HMOs that file annual statements with the California Department of Managed Health Care and small, single-state insurers that are not required by state regulators to submit NAIC Annual Financial Statements will be handled.

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[1] Source: Kaiser Family Foundation, Statehealthfacts.org, "Small Group Health Insurance Market Guaranteed Issue, 2010" provides the definition of Small Group by state.

New Rebate Calculation Form for MLR

As stated earlier, the purpose of the new Supplemental Health Care Exhibit is to assist state and federal regulators in identifying and defining elements that make up the medical loss ratio. PPACA requires health insurance issuers in the individual, small group and large group markets to pay rebates if their medical loss ratio in a plan year (beginning January 1, 2011) is less than the minimum ratio established under the law. The Supplemental Exhibit contributes to a better understanding of MLRs but does not include the MLR or rebate calculations. These calculations will be done on the new Rebate Calculation Form.

The new Rebate Calculation Form for MLR (Rebate Form) is based on the final Medical Loss Ratio Model (Model) regulations adopted by the NAIC on October 21, 2010 for plan years 2011, 2012 and 2013. The federal minimum ratios for the individual and small group markets are 80%; however the Secretary of the U.S. Department of Health and Human Services may adjust such percentage with respect to a State if the Secretary determines that the ratio may destabilize the individual market. The federal minimum ratio for the large group market is 85%. Though, a state may have a higher MLR requirement and its own rebate program as long as it does not prevent the application of the federal program.

The formula for the medical loss ratio, as established in the PPACA, is:

Reimbursement for clinical services + Expenditures to improve health care quality (divided by) Total premium revenue - Federal and State taxes and licensing or regulatory fees (and
accounting for risk adjustment, risk corridors and reinsurance)

The Model only addresses the years 2011 — 2013 because significant reforms are expected to be implemented in 2014, which will impact the medical loss ratio calculation. The Rebate Form is calculated using data as of December 31 of the plan year except for incurred claims which must be restated as of March 31 of the year following the plan year. Medical loss ratios must be reported to the applicable state by May 31 of the year following the plan year on the Rebate Form, and then the rebates are paid annually to the individual or entity that paid the premiums by June 30 of the year following the plan year.

There are two pages to the Rebate Form, The Rebate Calculation Form for each plan year and a Rebate Calculation Supplemental Form. There is a slightly different form for each of the three plan years leading to 2014. The calculations are complex and include credibility adjustments and adjustments for new policies issued each year and during the year. For dual option insurance coverage blended rates are determined. The Rebate Calculation Form looks simple but requires the detail from a separate rebate supplemental exhibit for each experience year. The Rebate Calculation Supplemental Form is supplied by data from the Supplemental Health Care Exhibit and is completed for each company, for each state, for each line of business (Individual, Small Group and Large Group). It includes life years (member months divided by 12), earned premiums, taxes and regulatory fees, expenses to improve health care quality, paid claims, unpaid claims reserve, experience rating refunds, changes in contract reserves, contingent benefit and lawsuit reserves , incurred medical pool incentives and bonuses, and net health care receivables.

From an analytical perspective it will be interesting to see this level of data being reported by plans. It certainly goes a long way toward creating a more transparent industry. From a financial reporting perspective it looks to be extremely challenging. Based on experience with previous adoption of new NAIC exhibits, it is unlikely that compliance and accuracy will be high for submission of data for the 2010 filing year. For some plans, adjustments will need to be made to their accounting systems to capture data in different ways. These changes take time. State regulators and plans may also wait to see if PPACA is repealed before deciding to comply. Nevertheless, as payers are required to disclose more, Mark Farrah Associates stands positioned to capture, interpret and analyze important data elements for inclusion in Health Coverage Portal.

Health Coverage Portal™

Health plans file statutory data on a quarterly and annual basis with state insurance regulators. Financial statements are prepared using statutory accounting rules as defined by the National Association of Insurance Commissioners (NAIC). For companies seeking comprehensive market data, MFA offers the Health Coverage Portal™ (/products/health-coverage-portal.aspx), a unique online application that integrates NAIC statutory and MFA self-insured datasets. The Health Coverage Portal™ provides easy access to financials, PMPM comparisons, ratios, membership and market share. Call MFA at 207.985.8484 to schedule an online demo of the Health Coverage Portal™.

About Mark Farrah Associates (MFA)

Mark Farrah Associates (MFA) is a leading data aggregator and publisher providing health plan market data and analysis tools for the healthcare industry. We are a licensed redistributor of NAIC data. MFA's Health Coverage Portal™ includes both risk-based and administrative services only membership and financial data by plan, parent, state, region and nationally. Committed to simplifying analysis of health insurance business, our products include Medicare Business Online™, Medicare Benefits Analyzer™, Health Coverage Portal™, Health Insurer Insights™ and Health Plans USA™.

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