We are writing to support the preliminary resolution of IRD14-017: “rebate payments incurred in any prior year should not be included in the numerator for any plan year after 2014.” We believe that this preliminary resolution and the evaluation that support it are correct, and urge the Committee not to change them.

AHIP’s comments rely primarily on the treatment of MLR rebates under SSAP No. 66 as amended. SSAP No. 66 requires that MLR rebates be treated like accrued return retrospective premiums under retrospectively rated contracts for purposes of reporting assets and liabilities. It states specifically that “Accrued return retrospective premiums shall be recorded as a liability, as part of Accident and Health Reserves (reserves for rate credits or experience rating refunds), with a corresponding entry to premiums.”

It should be noted that SSAP 66 suggests that rebates should be reflected in an adjustment to premiums (the denominator), rather than that they be added to claims (the numerator) for reporting purposes. Indeed, this is how experience rating premiums are treated under the federal MLR rule. 45 C.F.R. § 158.130(b)(3). It is my understanding that this is how returned premiums and policyholder dividends are treated for other lines.

More importantly, however, SSAP 66 simply does not address how rebates should be treated for calculation of medical loss ratios over multiple years under PHSA § 2718. The question of how rebates should be calculated is a very different question from that of how assets and liabilities should be reported. Obviously accrued MLR rebates are a liability to a company until they are paid and it is sensible to treat them as such for reporting purposes. That is, however, an entirely separate question from how MLR rebates should be handled for calculation of rebates in subsequent years. This is a question of interpreting federal law rather than applying accounting principles developed for other lines.

We agree that PHSA § 2718 does not require health plans to price their plans prospectively to reach the 80/85 percent target. However, the intent of the statute is to ensure that a plan which fails to achieve this target must pay a rebate. At least one insurer recently received approval for a rate increase request that explicitly targeted an MLR lower than the ACA standard of 80%, using instead a target MLR of 76.7 percent.1


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Presumably the insurer will owe a rebate if this MLR is in fact achieved, but if it is allowed to count that rebate in the numerator for the year in which it is paid, and if it consistently prices to this MLR level going forward, consumers will never realize the full medical loss ratio to which they are entitled under law. This particular filing was explicit in targeting a loss ratio below the ACA MLR. However, health insurance companies can also implicitly target a lower ratio through the selection of inflated factors for ratemaking items such as trend or other adjustments made to the loss projections, while contending that the ACA MLR is being targeted.

We recognize that insurers who cycle above and below the MLR threshold level may in the end owe a rebate that would result in a total MLR above 80 percent. We agree with paragraph 6 of the evaluation, however—this is a natural consequence of the one-sided nature of the rebate calculation. Furthermore, this is a result that Congress was aware of and intended.

We agree with paragraph 7 that current accommodations for new plans should address their concerns, but would be open to further consideration of this specific issue.

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2 For example, an insurance company may allege that the projected loss ratio for the rating period is 80%, but if the loss trend factor is overstated by 5%, then the real projected loss ratio is only 76% = 80% X 0.95.

3 As one possibility, the MLR calculation for a new insurance company could include the rebate for the first two years in subsequent years rebate calculations as appropriate, similar to the treatment given to all insurance companies for the 2011 and 2012 rebates.