To: Steve Ostlund, Chair Medical Loss Ratio Subgroup

Fr: Timothy Jost, Bonnie Burns, Carrie Fitzgerald, Stephen Finan, Marguerite Herman, Birny Birnbaum, Cynthia Zeldin, Stephanie Mohl, Barbara Yondorf, Adam Linker, Elizabeth Abbott, Andrea Routh, Joe Ditre, Kathleen Gmeiner, Lynn Quincy, NAIC Consumer Representatives

Date 10/9/2012

Re: IRD14-017

We continue to believe that the Subgroup’s preliminary resolution of IRD14-017 is required by the language of the Affordable Care Act. This resolution is: “rebate payments incurred in any prior year should not be included in the numerator for any plan year after 2014.” We urge you to reject the “compromise” offered by AHIP and leave the resolution of IRD14-017 as proposed.

Section 2718 of the Public Health Services Act is entitled “Bringing down the cost of health care coverage.” Subsection 2718(b), which specifically establishes the rebate program, is entitled “Ensuring that consumers receive value for their premium payments.” The subsection requires insurers that fail to spend 80 (85) percent of their adjusted insurance premiums on health care claims and quality improvement expenses to pay a rebate. Section 2718 does not in so many words require insurers to set their aggregate premiums so as to reach the minimum medical loss ratio target (although HHS has interpreted section 2794 to require this), but this is the obvious meaning of “ensuring that consumers receive value for their premium payments.”

Section 2718(a)(1) and (2) state that the only costs that can be included in the numerator for calculating the medical loss ratio are reimbursement for clinical services and activities to improve health care quality. The provision of 2718 that allows for three-year averaging clearly allows only these costs to be included in the 3-year average. Section 2718(b)(1)(B)(ii) states: “Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be made based on the averages of the premiums expended on the costs described in such subparagraph and the total premium revenue for each of the previous 3 years for the plan.” Subparagraph A refers to the costs described in section 2718(a)(1) and (2) stated above. There are no other costs allowed – including the cost of a rebate to the company.

The preliminary resolution that the subgroup has proposed for three-year averaging is consistent with the statute and ensures that carriers that do not achieve the 80 (85) percent threshold pay a rebate, as required by the law. As demonstrated by the analysis of AIS Consulting that we submitted on October 3, proposals that allow insurers to count rebates from prior years in the numerator do not achieve that goal, and in fact undercompensate consumers and encourage carriers to price below the minimum medical loss ratio threshold. Proposals that add prior year rebates to claims are inconsistent with the law.
and should be rejected. We support, therefore, the preliminary resolution of IRD14-017 reached by the subgroup.