October 2, 2012

To: Steve Ostlund, Chair, HCRAWG Medical Loss Ratio Subgroup

Re: Comments on IRD14-002

America’s Health Insurance Plans (AHIP) appreciates the opportunity to provide these comments regarding the issue discussed in IRD14-002. AHIP is the nation’s trade association representing member companies providing health, long-term care, dental, disability and supplemental coverage to more than 200 million Americans.

IRD14-002 addresses the potential interplay between Risk Adjustment payments and the rebate calculations for all years starting in 2014. In looking at the applicable CMS publications dealing with Risk Adjustments, it would appear necessary to more exactly spell out terms to be used. Amounts due to or paid to CMS under the Risk Adjustment provisions are defined as “charges” while amounts due to or paid by CMS to a QHP are defined as “payments.”

The current issue is stated as “Should Risk Adjustment payments increase MLR rebates?” a one-sided question. We do not support looking at only one side of the Risk Adjustment issue. We recommend the issue be rephrased as:

Should Risk Adjustment payments (to high risk plans) and charges (from low risk plans) be reflected in MLR calculations?

For the Evaluation section, we propose the following:

Section 2718 of the ACA provides clear direction that they should be included:

“(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

“(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

“(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or
“(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State. [Emphasis added]

The ACA appears to provide that the effect is to be included in the denominator.

Unless insurers are notified of the amounts of payments and charges for each cell sufficiently in advance of the due date of the MLR forms so that actual amounts are transferred, it is likely that accruals will need to be recognized in the MLR spreadsheet and instructions. Instructions should address reflecting the difference between reported accruals and actual payment/charges as well. This suggests including changes to Part 2 of the MLR spreadsheet and instructions.

Sincerely,

William C. Weller,
Omega Squared – consultant to AHIP

cc: Candy Gallaher SVP State Policy - AHIP
   Eric King, NAIC staff to HATF