October 2, 2012

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

Re: Comments on IRD14-003

America’s Health Insurance Plans (AHIP) appreciates the opportunity to provide these comments regarding the issue discussed in IRD14-003. 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.

IRD14-003 addresses the potential interplay between ACA Reinsurance provisions and the rebate calculations for 2014-2016.

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

 Should contributions and payments under ACA’s reinsurance programs be included in MLR calculations?

For the Description Section, we propose the following:

There are two elements to the ACA’s Reinsurance Program:

Contributions: All health insurance issuers, and third-party administrators (TPAs) on behalf of self-insured group health plans, will submit contributions to support reinsurance payments to issuers that cover high-cost individuals in non-grandfathered individual market plans. By statute, the aggregate national contributions for reinsurance payments are $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016.¹

Payments: Reinsurance payments are based on a coinsurance rate or proportion of an issuer’s claims costs that are above an attachment point and below a reinsurance cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for reinsurance payments, while the reinsurance cap is the dollar limit at which point an issuer is no longer eligible for reinsurance payments. The attachment point, coinsurance rate, and reinsurance cap are calculated based on an issuer’s total costs for an individual enrollee in a given calendar year.²

For the Evaluation section, we propose the following:

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² Ibid page 2
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 effects of both payments and receipts are to be included in the denominator.

Contributions should be reflected in the denominator. There should be a revision to the instruction for Section 3 of Part 1 in the 2014 HHS spreadsheet for Parts 1 and 2 for inclusion of the Reinsurance Contribution.

Payments appear to be offsets to claims. The phrase “after accounting for” may allow the payments to be reflected in the numerator but should not be read as permitting exclusion. Whichever choice is made, Part 2 of the MLR spreadsheet and instructions should be revised to include payments. Given the expectation that all payments may not be made by March 31 of the following year\(^3\), it will be necessary for the MLR calculation forms and instructions to allow for differences between paid and incurred.

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\(^3\) *Ibid*, page 8: “HHS intends to ensure payments do not exceed available contributions by prorating payments based on available funds. As the reinsurance program is a State-based program, this proration will be calculated at the State level, using funds collected in each State.” and page 9: “An issuer’s payment for a given quarter will be based on the calculated reinsurance payment for the quarter minus the amount withheld for an annual reconciliation. These amounts will be prorated based on the amount of funds available in each State’s individual reinsurance fund. If an issuer’s calculated reinsurance payments for that quarter cannot be paid in full due to fund availability, HHS is considering including the unpaid amount either at the close of the following quarter or at the end of the benefit year as part of the annual payment reconciliation. We seek comments regarding the quarterly reinsurance payments process.”
Sincerely,

William C. Weller,
Omega Squared – consultant to AHIP

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