To: Steven Ostlund, Chair HCRAWG Medical Loss Ratio Working Group

Fr: NAIC Consumer Representatives: Timothy Jost, Marguerite Herman, Adam Linker, Carrie Fitzgerald, Elizabeth Abbott, Barbara Yondorf, Cynthia Zeldin, Joe Dittré, Jen Mishory, Lynn Quincy, Kathleen Gmeiner, Andrea Routh, Sarah Lueck, Stephanie Mohl

Re: Comments on IRD14-017

Date: January 7, 2013

The treatment of prior year rebate payments in calculating medical loss ratios with three-year averaging has proven to be a contentious issue in the Working Group’s consideration of the appropriate methodology to be used in calculating medical loss ratio regulations for reporting years 2015 and later. We are writing to propose a compromise as to how this issue should be handled. The proposed compromise falls between the Consumer’s Representative’s original position that prior rebates should be excluded from these calculations, which is the current proposal of the Working Group, and the insurance industry’s position that prior rebates should always be included in these calculations.

We propose that for 2015 and later years carriers be allowed to claim prior year rebates in the numerator only if they in fact meet the 80/85 percent statutory standard medical loss ratio before paying rebates for the reporting year and for the immediately prior year. For each year beginning in 2015, the carrier would calculate its medical loss ratio for the reporting year and for the prior year without counting rebates from other years. If the loss ratio was 80/85 percent or above for both years, the carrier could add in prior year rebates, if any, in the current year rebate calculation. If the medical loss ratio fell below 80/85 percent for either year, prior year rebates would not be added in. This solution would provide some protection for consumers against carriers that persistently fail to achieve the medical loss ratio target but would allow carriers to reflect their prior rebates in the current rebate calculation when their historical medical loss ratios generally exceeded the 80/85 percent standard. It is a similar solution to that which the NAIC and HHS reached for dealing with credibility adjustments in the current MLR rule.

IRD14-017 currently proposes that prior year rebates not be added to the numerator of the current year in calculating medical loss ratios. AHIP and Aetna are asking that the resolution reached in IRD14-017 be rejected and that prior year rebates always be added to the numerator in calculating medical loss ratios. Nowhere does PHSA 2718 suggest that prior year rebates should be added to the numerator in calculating medical loss ratios. The statute stipulates that the numerator in the medical loss ratio formula for three year averaging must contain only reimbursement for clinical services and health care quality improvement expenses for the three year period. However, for 2013, the first year of three year averaging, the NAIC recommended to HHS that rebates for the prior years should be added to the numerator to avoid double-counting, as full rebates had already been paid for the earlier years included with 2013 in the three-year average rebate calculation. HHS accepted this recommendation, which became section 158.221(b)(2) of the MLR rule for year 2013. HHS explicitly took this approach only to prevent “double
counting” of rebates for years in which rebates had been fully paid. 75 Fed. Reg. 74880 (2010).

Starting in 2015, however, carriers will not have paid a full rebate for any year included in the rebate calculation.¹ Under three year averaging, only one third of the difference between a carrier’s own medical loss ratio and the 80/85 percent target will be paid out in a rebate for any given year. The rest of the difference should be carried forward into subsequent years. However, that will not happen under the insurance industry position. If, as the insurance industry recommends, a carrier is allowed to claim a rebate paid for any given year both as the rebate owed for that year and as a claim to be counted against the numerator for subsequent years, the carrier will be allowed to double or triple count the rebate, once for the year in which it was paid and then again in calculating subsequent rebates in the following two years. It must also be remembered that most carriers will additionally benefit from a credibility adjustment after the basic MLR formula has been applied. This will have the effect of further reducing rebates paid to consumers.

A whole series of simulations provided to this Working Group have demonstrated that if a carrier persistently fails to achieve the 80/85 percent statutory loss ratio target, then allowing the carrier to count prior year rebates in the numerator will permit it to have a combined average medical loss ratio plus rebate ratio below that target. The consumer will never get the full benefit of the medical loss ratio provision contained in the statute. On the other hand, the industry provided simulations which the industry contends show the need to include prior rebates when a carrier consistently meets or exceeds the 80/85 percent threshold. The compromise we are offering will allow carriers that regularly achieve the 80/85 threshold to avoid ever paying rebates, but also provides some protection for consumers insured through carriers that consistently miss the target.

This solution offered by consumers would not be contrary to statutory accounting principles. AHIP and Aetna have referred to the treatment of MLR rebates under SSAP No. 66 as amended as requiring the addition of prior year rebates to the numerator. SSAP No. 66 provides that MLR rebates are to 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 our understanding that this is how returned premiums and policyholder dividends are treated for other lines.

More importantly, however, SSAP 66 simply does not address the question of how rebates should be treated for the calculation of medical loss ratios over multiple years

¹ The 2015 calculation includes the 2013, 2014 and 2015 years. The 2013 year would have only been reflected 2/3 and the 2014 year only 1/3.
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, which would be consistent with the solvency of insurance companies being the main goal of Statutory Accounting. 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 purposes. There are many instances where Statutory Accounting is not used for various other calculations applicable to the insurance industry. For example, federal income taxes are not calculated based upon the income shown in an insurance company’s Annual Statement using statutory accounting principles because the tax laws are intended to serve other purposes than statutory accounting principles. Also, for ratemaking purposes, insurance companies often deviate from the values derived from Statutory Accounting to derive higher profit provisions to include in rates that result in higher premiums.

Neither does current 45 C.F.R. § 158.221(b)(2) address this issue. That rule, as noted earlier, was promulgated only for 2013, when carriers would have been paying full rebates for years prior to three-year averaging and explicitly only applies for 2013. We would note that the example Aetna gives in its comment letter assumes full payment of a prior year rebate for the year in which an MLR of 71 was achieved, which could happen in years prior to 2013 but not in years 2015 or later. Its example, therefore, is not relevant to this discussion.

We recognize that the compromise we recommend is not required by PHSA 2718, which does not require any recognition of prior year rebates in 3-year averaging. It may also result in some carriers not paying the rebates necessary to reach the 80/85 percent statutory target. It should generally protect carriers from paying rebates when the statutory target of 80/85 percent is achieved, however, and thus should be considered an acceptable approach. We urge the Working Group to accept this compromise.