America's Health
Insurance Plans

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May 3, 2012

Office of Management and Budget
Office of Information and Regulatory Affairs,
Attention: CMS Desk Officer
Submitted via email to:
OIRA_submission@omb.eop.gov

Subject: Annual Medical Loss Ratio (MLR) Reporting and Rebate Calculation
Document Identifier/Form Number: CMS–10418 (OCN: 0938–New)

Dear Sir or Madam:

We are providing these comments in response to the Information Collection Request (ICR) published in the Federal Register on April 3, 2012 (77 FR 20023) on the Annual Medical Loss Ratio (MLR) and Rebate Calculation forms, instructions, notices and supporting statement and cost estimates.

CMS makes clear in the instructions that the form in this ICR is for use by issuers in reporting for each large group, small group, and individual markets for each state in which the issuer has written direct health insurance coverage. The instructions clarify that the spreadsheet will be used for 2011 data submitted electronically through CMS' Health Insurance Oversight System (HIOS), and the spreadsheet will be revised for calendar year 2012 MLR calculations and beyond. Each issuer is required to submit MLR data by June 1, 2012, including information about any rebates. In addition, each issuer is required to maintain all documents, records and other evidence that support the data included in each issuer's annual report to the Secretary for a period of seven years.

We appreciate the many changes made to the previous draft instructions and forms based on the comments we submitted on February 14, 2012. These revisions have made the form clearer and the instructions more specific to the technical elements required. The crosswalk of changes and clarifications was particularly helpful. While we recognize these improvements, we highlight several remaining concerns with the overall approach and provide the following recommendations that we urge be adopted.

First, we recommend the elimination of any reporting requirement that is not integral to the MLR calculations for which the report is established. As recently noted in Q&A's

released in the **CCIIO Technical Guidance (CCIIO 2012—002)**[1], clarification was made that self-funded plans, Medicaid plans, Medicare Advantage Plans and Medicare prescription drug plans are not subject to the MLR rule, and thus not subject to the MLR reporting requirements. **Therefore, we request that Columns 32-35 – the columns related to reporting of such programs not subject to the MLR rule – be eliminated from the report, as representing an unnecessary and burdensome regulatory reporting requirement that imposes costly and unjustified administrative requirements in insurers.**

Second, we recommend the elimination of the proposed Notice of MLR Information (Notice #4). The sample notice released in the ICR states that it is not required at this time as it was not included in the final MLR issued in December 2011. There is no requirement in the Affordable Care Act for such a notice, and there is no justification for this significant new administrative burden on insurers. Notice #4 provides information that can be made available in other, more administratively efficient and cost effective ways. We thus continue to oppose the requirement that Notice of MLRs be sent to subscribers.

The main reason suggested in the preamble of the final rule for such a notice of MLRs is that it would assist consumers as a predictor of year-to-year premiums or MLRs. We strongly believe that this notice will not serve this purpose and will result in confusion for consumers for the following reasons:

- The MLR for each year is based on the claims in that year and would not be relevant to another year and MLR values can vary significantly from year to year based on claims and adjustments.
- MLRs are not a predictor of claims experience or premiums.
- Premium rates for the next year are unlikely to be based on MLRs from two years prior.
- For reporting year 2011, the prior MLR would not have been calculated using the new federal MLR methodology, thus there is no accurate comparison MLR number to provide.
- And in reporting year 2013, the three year averaging would affect the prior year comparison number.

Requiring such a notice would add an unjustified and costly administrative burden on insurers, with costs in excess of the benefit it provides. To provide an estimate of the cost and complexity, AHIP contacted large and small insurers for examples of the impact. We found that depending on insurer size, the net cost per notice was between $2.00 and $3.00, resulting in an estimated impact of $200 - $300 million dollars[2] for this activity. This estimate is substantially higher than

[1] *http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf*

[2] *Assuming that the U.S. population is about 300 million individuals – excluding individuals with Medicare and Medicaid (about 95 million individuals), individuals receiving rebates, and dependents – we conservatively estimate that there could be upward of 100 million MLR notices sent.*

the regulatory burden estimate in the ICR of only $18.9 million dollars (see Supporting Statement A, Justification, item 12 on page 9). We believe that estimate is completely inadequate, and not based on the reality plans face and the costs they would incur.

In addition to the above recommendations we have other detailed comments and recommendations to offer, which follow.

Annual MLR and Rebate Calculation Forms Detailed Comments

Dual Contracts

We note one area where the proposed documents do not sufficiently address the manner in which the treatment of dual-contracts is to be recorded, where a change to the instructions to the form will significantly improve the comparison of the recorded information with the Statutory statements the companies are required to submit and where no action appears to have been taken on critical issues.

The beginning part of the Instructions under "Aggregation of Experience" provides for an exception from the normal processes for dual contracts which provides that:

> "…the issuer may choose to treat the out-of-network experience of the affiliate that provides the out-of-network coverage as if it were related to the contract providing the in-network coverage."

However, the remainder of the instructions provides no details on how this is to be recorded. To resolve this issue, we provide **Attachment A**, which provides the proposed additional wording to Parts 1 and 2 that would provide these details.

Pre-Tax Underwriting Gain or Loss

Statutory accounting provides for the calculation of a pre-tax (i.e. prior to any reflection of federal income taxes) underwriting gain or loss (i.e. without any recognition of investment income). For purposes of the companies' statements, the pre-tax underwriting gain or loss includes the fees earned from uninsured plans to offset the expenses the company reports related to such plans. The proposed instructions do not include this last item and include part of the federal income tax in Part 1 Line 6.

We recommend revisions, which we provide in **Attachment B**, so that pre-tax underwriting gain or loss is consistent with the Statutory definition. This involves:

- Clarification that allowable fraud expenses that are reflected in MLR incurred claims are a part of the "Other Adjustments" in Part 1, Line 2.6;

- Separation of federal taxes and fees into two parts in Part 1 Line 3.1 so that the federal income tax portion can be backed out of pre-tax underwriting gain or loss;
- A change to the lines in Part 1 section 5 so all other federal taxes and fees are included in pre-tax underwriting gain or loss;
- Reversing Part 1 Lines 6 and 7 with the necessary changes to the calculation instructions.

Note that part of the recommended changes is to include a change to the instructions for Part 1 Line 5.6 to exclude amounts reported in line 5.3 and that Line 9 includes all federal income taxes.

Contingent Benefit and Lawsuit Reserves

In *Part 2, Line 2.13 - Contingent benefit and lawsuit reserves for claims incurred in the current MLR reporting yea*r the instruction retained a breakout for "lawsuit reserves for claims". We strongly recommend removal of this as a separate line item. Similar to the reporting in Lines 2.2, 2.3, 2.4 and 2.5 we ask that no separate line for contingent liability for lawsuit reserves for claims be required. We recommend that and any such claims reserves be included in the total amounts reported in those lines 2.2-2.5. We also note that the NAIC, in the SHCE, had considered this issue, and decided to omit the detailed reporting of litigation reserves in the final SHCE form and instructions.

Judicial and public policy favor settlement, which benefit the judicial system, participants in the system, and society as a whole by providing for fair and relatively expeditious resolution of disputes. Thus steps should be taken to protect and promote the settlement process (e.g., Federal Rule of Civil Procedure 408, treating settlement offers as inadmissible to prove liability). This would be impaired and undermined by distorting the process in the manner as is done by line 2.13. Although a modification was proposed, it is still not adequate to prevent the litigation cost escalation that might occur from breaking out the potential claims costs. Thus, while the entities forced to make the required disclosure are most immediately and directly harmed, ultimately litigants on both sides and the judicial system itself are burdened by the cost of litigation that might otherwise be settled (or might otherwise be settled prior to the unnecessary, time-consuming and expensive discovery).

In addition to the specific implications with respect to individual litigation matters, the disclosure requirements will have long-term implications for companies, as well as their policyholders and investors. By requiring disclosure of the underlying claim analyses, the MLR form creates an environment that will encourage significant increases in plaintiffs' initial litigation demands in aggregate. This could lead to a self-perpetuating escalation in settlement demands, as an individual plaintiff would now have insights not only to the evaluation a company places on the plaintiff's case, but also the company's settlement analyses across matters and across time. CMS should mitigate this negative impact on carriers and policyholders by

removing Line 2.13.

If 2.13 remains as a required element, the spreadsheet should be amended to include an input cell or section in this area for insurers to assert their right of confidentiality and protections from Freedom of Information Act (FOIA) requests. FOIA's Exemption 4 is intended to protect "trade secrets and commercial or financial information obtained from a person [that is] privileged or confidential." Items of the MLR report (alone or in combination) may constitute privileged or confidential commercial or financial information. In accordance with FOIA Exemption 4, insurers should be able to designate certain information as exempt from disclosure under FOIA Exemption 4.

CMS would follow the rules and procedures associated with FOIA Exemption 4 before disclosing designated MLR report information to the public or third parties. We note such HIOS filter or input element has been missing in other template or spreadsheet forms. Absent such protections, and given the potential harm to consumers and insurers, accordingly, we suggest that no the amounts for contingent liability be separately reported, or made public.

Part 3 – Expense Allocation Report

In our prior comments we noted that the instructions were missing details under Column 1 after the word "including." The revised instructions for Column 1 appear to be very limited, as only one specific item was added, thus calling into question what the word 'including' means. As we noted in our prior comments the SHCE provides more detail relating to additional services within the care coordination grouping. We recommend additional wording for the first bullet, which we provide in **Attachment C**.

Part 6 – Rebate Disbursement Form

We note all of the level of detail required in this part of the form may not be available by June 1, when this reporting form is required to be filed - to the extent that it depends not only on the aggregate amount of rebates payable but also on the amounts for specific subscribers, methods of payment, etc. That information would be available by August 1, when the rebates are to be issued.

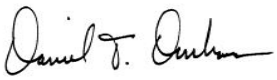
We therefore suggest that insurers be permitted to submit the report in two steps, the first step being the total amounts that can be clearly identified, verified and reported by June 1st, and the second step being the line item roll-ups that can be submitted by August 1. Thus, Lines 3 and 4 can be reported at the total levels by the June 1st reporting deadline. But the break out details, that true up all the elements in 3.a., b., c. and d. – and those in 4.a , b., c. and d, would be reported after all of the insurers' financial reporting systems reports of checks cut, credits to

credit cards issued, and allocation of de minimis rebates, etc. would be made after the payments are made.

Finally, in **Attachment D**, we provide some other comments on spreadsheet formatting or formula items.

We appreciate the opportunity to submit these comments, and welcome the opportunity to discuss any questions you may have regarding them.

Sincerely,



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Attachment A

AHIP Additional Wording for Dual Contract Reporting (new language underlined)

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 1

(Data Development – Summary)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

In addition to the instructions below, the Preliminary Instructions and Column Definitions at the beginning of these Filing Instructions also apply to this Part 1. The Preliminary Instructions and Column Definitions include instructions regarding reporting of reinsurance, assumed and ceded insurance, deferred business, individual business through an association, employer business through a group trust or MEWA, group coverage in multiple states, and dual contract group health coverage.

Where the company has elected the transfer of premiums and claims for out-of-network coverage under Dual Contracts, the instructions are included in Part 2 below. The applicable amounts of taxes and fees related to such out-of-network coverage may also be transferred. The amounts, determined by the affiliate with the out-of-network coverage, are to be included in the appropriate lines 3 through 3.4 for the affiliate with the in-network coverage and excluded for the affiliate with the out-of-network coverage.

Please note that the MLR Form and Filing Instructions implement the requirements of 45 CFR Part 158 and are not identical to the definitions or instructions of the NAIC's SHCE.

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 2

(Data Development - Premium and Claims)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

In addition to the instructions below, the Preliminary Instructions and Column Definitions at the beginning of these Filing Instructions also apply to this Part 2. The Preliminary Instructions and Column Definitions include instructions regarding reporting of reinsurance, assumed and ceded

insurance, deferred business, individual business through an association, employer business through a group trust or MEWA, group coverage in multiple states, and dual contract group health coverage.

Please note that the MLR Form and Filing Instructions implement the requirements of 45 CFR Part 158 and are not identical to the definitions or instructions of the NAIC's SHCE.

SECTION 1 – HEALTH PREMIUMS EARNED

Earned premium means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan and reported on a direct basis.

Line 1.1 – Direct premium written

Include:

- Premium assumed under a 100% assumption reinsurance agreement (treated as a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.
- Premium assumed under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business.
- Premium from affiliated carrier for out-of-network coverage under dual-contract

Exclude:

- Premium ceded under a 100% assumption reinsurance agreement (treated as a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.
- Premium ceded under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business.
- Premium reported in an affiliated carrier for out-of-network coverage under dual-contract.
- Assessments paid to or subsidies received from State and Federal high risk pools;

- Amounts for rate credits paid

Line 1.2 - Unearned premium (year preceding the MLR reporting year)

Report reserves established to account for the portion of the premium paid in the prior MLR reporting year that was intended to provide coverage during the MLR reporting year.

Calculate reserves as of December 31 of the year preceding the MLR reporting year. Reflect any unearned premium related to dual-contract out-of-network coverage.

Line 1.3 - Unearned premium (MLR reporting year)

Report reserves established to account for the portion of the premium paid in the MLR reporting year that was intended to provide coverage during the following MLR reporting year.

Calculate reserves as of December 31 of the MLR reporting year Reflect any unearned premium related to dual-contract out-of-network coverage.

Line 1.4 – Change in unearned premium (Lines 1.2 – 1.3)

[No Further Changes until Section 2 - Claims]

SECTION 2 - CLAIMS

Amounts reported in Section 2 must include direct claims paid to or received by physicians and other non- physician clinical providers, including under capitation contracts with those providers, whose services are covered by the policy for clinical services or supplies covered by the policy. Non-physician clinical providers must be licensed, accredited, or certified to perform clinical health services, consistent with State law, and engaged in the delivery of medical services to enrollees.

Reimbursement for clinical services to enrollees is also referred to as incurred claims.

Line 2.1 – Claims paid

2.1a – 12/31 Column – Claims paid during the MLR reporting year regardless of incurred date.

Report payments net of risk share amount collected.

2.1b – 3/31 Column - Claims paid only on claims incurred during the MLR reporting year, and paid through 3/31 of the following year for those claims incurred during the MLR reporting year.

Include:

- Claims incurred during the MLR reporting year that were either paid during the MLR reporting year or paid through March 31 of the year following the MLR reporting year;
- Any overpayment that has not yet been recovered should be included in paid claims and included in health care receivables.
- Market stabilization payments or receipts by issuers that are directly tied to claims incurred and other claims based or census based assessments.
- State subsidies based on a stop-loss payment methodology.
- Claims assumed under a 100% assumption reinsurance agreement (treated as a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.
- Claims assumed under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into an effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business.
- Payment to unsubsidized State programs designed to address distribution of health risks across issuers via charges to low risk issuers that are distributed to high risk issuers must be included in incurred claims.
- <u>Claims paid by an affiliate for out-of-network coverage under dual-contract.</u>

Exclude:

- Claims ceded under a 100% assumption reinsurance agreement (treated as a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.
- Claims ceded under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into an effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business.
- Amounts paid to third party vendors for secondary network savings;

- Amounts paid to third party vendors for network development, administrative fees and profit, claims processing, and concurrent or post-service utilization management or any other issuer function;
- Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee;
- Incentive and bonus payment made to providers (to be reported in Line 2.11).

Deduct:

- Any overpayment that has already been received from providers should not be reported as a paid claim;
- Prescription drug rebates, refunds, incentive payments, bonuses, discounts charge backs, coupons, grants, direct or indirect subsidies, direct or indirect remuneration, upfront payments, goods in kinds or similar benefits received by the issuer;
- Payment from unsubsidized State programs designed to address distribution of health risks across issuers via charges to low risk issuers that are distributed to high risk issuers must be deducted from incurred claims.
- Claims reported in an affiliated carrier for out-of-network coverage under dual-contract.

Line 2.2 – Direct claim liability (MLR reporting year)

12/31 Column – liability based on all claims unpaid as of 12/31 of the MLR reporting year

3/31 Column – liability based on claims incurred during the MLR reporting year, and unpaid as of

3/31 of the following year for those claims incurred during the MLR reporting year

For the 3/31 Column, calculate as of March 31 of the year following the MLR reporting year, based on claim payments made through March 31 of that year and report in the appropriate column.

Report the outstanding liabilities for healthcare services related to claims in the process of adjustment, incurred but not reported and amounts withheld from paid claims and capitation payments. For dual contract coverage, the affiliate with in-network coverage should report this amount and the affiliate with out-of-network coverage should exclude this amount.

Include:

- Unpaid claims, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation (including third party liability).
- Incurred but not reported - Report the claims incurred but not reported in the MLR reporting year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure.

Line 2.3 – Direct claim liability (year preceding the MLR reporting year)

12/31 Column – Amount reported as of 12/31 of the year preceding the MLR reporting year

Line 2.4 – Direct claim reserves (MLR reporting year)

12/31 Column – based on all claims regardless of the incurred date, calculated as of 12/31 of the MLR reporting year

3/31 Column – based on claims incurred only in the MLR reporting year, calculated as of 3/31 of the following year for those claims incurred during the MLR reporting year

For the 3/31 Column, calculate as of March 31 of the year following the MLR reporting year, based on claim payments made through March 31 of that year related to claims incurred for the MLR reporting year.

Report reserves related to healthcare services for present value of amounts not yet due on claims. <u>For dual contract coverage, the affiliate with in-network coverage should report this amount and the affiliate with out-of-network coverage should exclude this amount.</u>

Line 2.5 – Direct claim reserve (year preceding the MLR reporting year)

12/31 Column – Amount reported as of 12/31 of the year preceding the MLR reporting year

Line 2.6 – Direct contract reserve (MLR reporting year)

Report the amount of reserves required when due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves. For policies issued prior to 2011, contract reserves may only be used in the MLR

calculation if such reserves were held prior to 2011, and may include reserves used for the purpose of leveling policy duration-based variation in claims experience only if durational contract reserves were held for such policies prior to 2011. Reported contract reserves may not exceed contract reserves calculated using the applicable product pricing assumptions.

Include:

- Contract reserves and other claims related reserves.
- Calculate as of December 31 of the MLR reporting year.

Exclude:

- Premium deficiency reserves.
- Reserves for expected MLR rebates

Line 2.7 – Direct contract reserve (year preceding the MLR reporting year)

See instructions for line 2.6.

Calculate as of December 31 of the year preceding the MLR reporting year.

Line 2.8 – Experience rating refunds paid –

2.8a 12/31 Column – based on all payments through 12/31 of the MLR reporting year
2.8b 3/31 Column – based on refunds incurred during the MLR reporting year and paid through 3/31 of the following year for those refunds incurred during the MLR reporting year

Experience rating refunds associated with premium earned during the MLR reporting year, including State premium refunds paid during the MLR reporting year. Experience rating refund is the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium.

Line 2.9 – Reserve for experience rating refunds (rate credits) (MLR reporting year)

12/31 Column – based on all payments through 12/31 of the MLR reporting year

3/31 Column – based on refunds incurred during the MLR reporting year and unpaid through 3/31 of the following year for those refunds incurred during the MLR reporting year

Include:

- Reserves for the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium, plus reserves for State premium refunds incurred during the MLR reporting year.

Exclude:

- Reserves for MLR rebates.

Deduct:

- Amounts receivable under retrospectively rated funding arrangements.

Line 2.10 – Reserve for experience rating refunds (rate credits) (year preceding the MLR reporting year)

12/31 Column – Amount reported as of 12/31 of the year preceding the MLR reporting year

Include:

- Reserves for the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium, plus reserves for State premium refunds incurred during the year preceding the MLR reporting year.

Exclude:

- Reserves for MLR rebates.

Deduct:

- Amounts receivable under retrospectively rated funding arrangements.

Line 2.11 – Incurred medical incentive pools and bonuses

12/31 Column – based on all payments through 12/31 of the MLR reporting year

3/31 Column – payments based on amounts incurred during the MLR reporting year and paid through 3/31 of the following year for the amounts incurred during the MLR reporting year

Include arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments to providers.

2.11a – Paid medical incentive pools and bonuses for the MLR reporting year
2.11b – Accrued medical incentive pools and bonuses for the MLR reporting year.

Exclude amounts recorded on line 2.11a, include only the amount of medical incentive and bonus pool payments that are estimated to be owed but not yet paid for the MLR reporting year.

2.11c – Accrued medical incentive pools and bonuses for the year preceding the MLR reporting year.

Line 2.12 – Net healthcare receivables

12/31 Column – receivables reported as of 12/31 of the MLR reporting year

3/31 Column – receivables incurred during the MLR reporting year and that remain outstanding as of 3/31 of the following year

2.12a – Healthcare receivables (MLR reporting year)
2.12b – Healthcare receivables (prior reporting year)

The amounts on these lines are the gross healthcare receivable assets, not just the admitted portion.

These amounts should not include those healthcare receivables, such as loans or advances to non- related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Line 2.13 – Contingent benefit and lawsuit reserves for claims incurred in the MLR reporting year.

Include:

- The claims-related portion of reserves for contingent benefits and lawsuits.

Exclude:

- Reserves related to costs associated with claims lawsuits within Line 2.13; i.e. legal fees, court costs, pain and suffering damages, punitive damages, etc.

Line 2.14 – Group conversion charges

If there are any group conversion charges for a health plan, the conversion charges must be subtracted from the incurred claims for the aggregation that includes the conversion policies and this same amount must be added to the incurred claims for the aggregation that provides

coverage that is intended to be replaced by the conversion policies.

If an issuer transfers portions of earned premium associated with group conversion privileges between group and individual lines of business in its annual statement accounting, these amounts must be added to or subtracted from incurred claims.

Line 2.15 – Blended rate adjustment

Affiliated issuers that offer group coverage at a blended rate may choose whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer as a whole, according to an objective formula the issuer defined prior to January 1, 2011, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate. From the date an issuer chooses to use such an adjustment, it must be used for a minimum of three consecutive MLR reporting years. Affiliated issuers that choose to make such an adjustment must do so for all policies with blended rates in the applicable State market.

Line 2.16 – Allowable fraud reduction recovery expenses

Report the amount of claims payments recovered through fraud reduction efforts not to exceed the amount of fraud reduction expenses. <u>For dual contract coverage, the affiliate with in-network coverage should report this amount and the affiliate with out-of-network coverage should exclude this amount.</u>

This amount is limited to the lesser of the total fraud reduction expenses reported on Line 2.16a and actual fraud recoveries collected on paid claims on Line 2.16b.

> Line 2.16a – Total Fraud Reduction expense:
> Line 2.16b – Total Fraud Reduction Recoveries that Reduced PAID claims.
> Include collected fraud recoveries on paid claims only.

Line 2.17 – Total adjusted incurred claims - 12/31 Column (Lines 2.1a + 2.2 – 2.3 + 2.4 – 2.5 + 2.6 – 2.7 + 2.8a + 2.9 – 2.10 + 2.11a + 2.11b – 2.11c – 2.12a + 2.12b + 2.13 + 2.14 + 2.15 + 2.16)

Line 2.18 – Total adjusted incurred claims - 3/31 Column (Lines 2.1b + 2.2 + 2.4 + 2.6 – 2.7 + 2.8b + 2.9 + 2.11a + 2.11b – 2.12a + 2.13 + 2.14 + 2.15 + 2.16)

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 3

(Expense Allocation Report)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

In addition to the instructions below, refer to the Preliminary Instructions at the beginning of these Filing Instructions, as well as the Column Definitions which follow the Preliminary Instructions, for the definitions of various markets and business. The MLR Form and Filing Instructions implement the requirements of 45 CF R Part 158 and are not identical to the definitions or instructions of the NAIC's
SHCE.

This Part 3 to the MLR Form is intended to provide disclosure of expenses by major type of activity that improves health care quality, as defined below, as well as the amount of those expenses that is used for other activities, and reported separately for health insurance coverage (individual, small group and large group business), mini-med plans (individual, small group and large group business), and expatriate plans (small group and large group business). This exhibit also shows the amount of qualifying Health Insurance Technology (HIT) expenses, reported separately for each such group of business.

Affiliated issuers that offer group coverage at a blended rate may choose whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer that receives the blended rate as a whole, according to an objective formula that the issuer defined prior to January 1, 2011, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate. Affiliated issuers that offer dual contracts dual-contract coverage may choose to make an adjustment to each affiliate's expenses for activities to improve health care quality, to reflect the manner in which such expenses relate to out-of-network coverage for which premiums and claims are reported with the in-network coverage. From the date an issuer that chooses to use such an adjustment must be used for a minimum of three consecutive MLR reporting years. Affiliated issuers that choose to make such an adjustment must do so for all policies with blended rates or dual contracts in the applicable State market.

[No further changes]

Attachment B

AHIP Comments on Calculation of Pre-Tax Underwriting Gain or Loss (new language is underlined)

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
MEDICAL LOSS RATIO (MLR) ANNUAL REPORTING FORM
FILING INSTRUCTIONS FOR ALL PARTS

INSTRUCTIONS FOR THE 2011 MLR REPORTING YEAR ONLY

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM - PART 1 (Data Development – Summary)

The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011.

[Material without changes not shown]

Line 2.6 – Other Adjustments due to MLR calculation – claims incurred

Add at end of paragraph: Subtract the amount for allowable fraud expenses reported in Part 2 Line 2.16.

Line 3 – Federal and State Taxes and Licensing or Regulatory Fees

Line 3.1 – Federal taxes and assessments incurred by the reporting issuer during the MLR reporting year

Line 3.1a – Federal income taxes deductible from premiums in MLR calculations

Include:

- All federal income taxes allocated to health insurance coverage reported under Section 2718 of the Public Health Service Act.

Exclude:

- Federal income taxes on investment income and capital gains;

Line 3.1b – Federal taxes (other than income taxes) and assessments deductible

from premium in MLR calculations:

Include:

- All federal taxes (other than income taxes) allocated to health insurance coverage reported under Section 2718 of the Public Health Service Act.

Exclude:

- Fines and penalties of regulatory authorities, and fees for examinations by any Federal departments other than as specified in 45 CFR §158.161(a) as other non-claims costs, that are not included as an adjustment to premium revenue.

[No change to Line 3.2 or Line 3.3]

Line 3.4 – Total Federal and State taxes and fees to be deducted ~~excluded~~ from Premium (Lines 3.1a + 3.1b + 3.2a + Max (3.2b or 3.2c) + 3.3)

[No change to Line in Section 4 or Lines 5.1 through 5.4]

Line 5.5 – Other taxes

Line 5.5a - ~~State t~~ Taxes (other than federal income taxes) and assessments not deducted ~~excluded~~ from premium under 45 CFR §158.162(b)(2). (Not included in Line 3.1b or 3.2)

Include:

- Federal taxes (other than income taxes) and assessments not deducted from Premiums in line 3.1b
- State sales taxes if the issuer does not exercise the option of including such taxes with the cost of goods sold and services purchased;
- Any portion of commissions or allowances on reinsurance assumed that represent specific reimbursement of premium taxes;
- Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes;

Line 5.5b – Report fines and penalties of regulatory authorities, and fees for Examinations by any State or Federal departments other than those included in Line 3.3, above.

Line 5.6 – Other general and administrative expenses

General and Administrative Expenses not Included in Line 4.6, Line 5.1, Line 5.2 or

Line 5.3

Line 5.7 – Community benefit expenditures

Report all community benefit expenditures not including those reported in Line 3.2c.

Line 5.8 – Total non-claims costs (Lines 5.1 + 5.2 + 5.3 + 5.4 + 5.5a + 5.5b + 5.6 + 5.7)

Line 5.9 – ICD-10 Implementation expenses (already included in line 5.6; informational for 2011)

[Reverse lines 6 and 7 so pre-tax underwriting gain is consistent with Statutory statements]

Line 6 – Income from fees on uninsured plans

Line 7 – Pre-tax underwriting gain/(loss) as of 12/31/XX (Lines 1.8 – 2.11 – 3.4 + 3.1a - 4.6 – 5.8 + 6)

Line 8 – Net investment income and other gain/ (loss)

Line 9 – ~~Other~~ Federal income taxes ~~not included on line 3.1 above.~~ (Whether included in Line 3.1a or not)

Line 10 – After-tax net gain/(loss) as of 12/31/XX (Lines 7 + 8 – 9)

Attachment C

Recommended Language to Insert to Complete the Section (new language is underlined)

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
MEDICAL LOSS RATIO (MLR) ANNUAL REPORTING FORM
FILING INSTRUCTIONS FOR ALL PARTS

INSTRUCTIONS FOR THE 2011 MLR REPORTING YEAR ONLY

INSTRUCTIONS FOR MLR ANNUAL REPORTING FORM – PART 3
(Expense Allocation Report)
Column 1 – Improve Health Outcomes

Include expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes.

This category can include costs for associated activities such as:

- Effective case management, care coordination, and chronic disease management, including:
  - through the use of the medical homes model as defined in section 3606 of the Affordable Care Act;
  - patient-centered intervention, such as making/verifying appointments, medication and care compliance initiatives, reminding insured of physician appointment, lab test or other appropriate contact with specific providers and activities to prevent avoidable hospital admissions;
  - medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition; and
  - programs to support shared decision-making with patients, their families and the patient's representative such as education and participation in self-management programs, and incorporating feedback from the insured to effectively monitor compliance.
- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1 through 5;

- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;

- Quality reporting and documentation of care in non-electronic format; and

- Health information technology expenses to support these activities (report in Column 5 - see instructions)

Attachment D

Comments on Spreadsheet Formatting or Formulas

- Shaded cells should include cell protections, to avoid unintentional or inadvertent deletions by those filling in the forms.

- In Part 3, the MLR Reporting Year tabs don't show 2011.

NOTE: If the proposed changes in Attachment B are not made, then the following will need to be addressed:

- In Part 1, the cell formulas for AK152, AL152 and AM152 include a reference to K$140 which should be respectively AK$140, AL$140 and AM$140.

- In Part 1 Line 6 should **add** Part 2 Line 2.16 rather than **subtract** it since it has increased Line 2.11 which is a subtraction to get pre-tax underwriting gain[3]. Note that in order to match to statement claims, some companies may already be including this within the Other Adjustments.

- In Part 1 Line 7 should be included in Line 6 as the expenses that are covered by such fees are included in Line 5.8.

- In Part 1 Line 10 the text in the instructions says one thing, but the formula (for column AO) says another:

  Text: Line 1.8- 2.11 – 3.4 – 4.6 – 5.8 + 7 +8 – 9
  Formula: Line 6 – 3.4 – 5.5A – 5.5B

  The correct answer is: Line 1.8 – 2.11 – 3.4 – 4.6 – 5.8 + 7 + 8 – 9 + Part 2 Line 2.16. This last item only if not already reflected in Part 1 Line 2.6.

[3] Without the changes in Attachment B, this is pre-tax - as in before all taxes not allowed as a deduction from premium for MLR calculation purposes.