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Comments Submitted Electronically at: *http://www.regulations.gov*

Center for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development,
Room C4–26–05,
7500 Security Boulevard, Baltimore,
Maryland 21244–1850.

Attention: Document Identifier/OMB Control Number CMS-10418

Re: Annual MLR and Rebate Calculation Report and MLR Rebate Notices
Form Number**: CMS–10418**
AHIP Comments on the Draft 2013 Instructions and Forms

Dear Ms. McCune,

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments on the materials in the PRA Information Collection Request published in the Federal Register November 22, 2013. AHIP is the national trade association representing the health insurance industry, with members providing health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the group and individual insurance markets, and public programs such as Medicare and Medicaid.

Based on discussion with our member plan experts, we have the following detailed comments and recommendations:

1) Part 2 – Section 1 Premiums – Line 1.1 – 3/31 Column - We recommend the instruction for all 3/31 columns for this line be the same as it was for 2012. The 2012 instruction permitted companies to report premium collected through 3/31 of the year following the MLR reporting year for coverage in the MLR reporting year, or simply report amounts on the same basis as in the 12/31 columns. This second option appears to have been eliminated for 2013 MLR calculations. This will require administrative system changes for some companies. Given the fact that health insurance premium does not restate significantly subsequent to the reporting year, requiring these changes would not produce much change in the MLR values.

   Requiring companies to incur administrative costs to change their reporting process, which produces an insignificant change in MLR values that would only be of value for one year,

seems an unnecessary burden. ***We recommend the continuation of 2012 Instructions approach - permitting each company the option of utilizing the approach they utilized with their 2012 reports.***

Substantial changes to systems and reporting will be required for 2014 MLR calculations to reflect the reinsurance, risk corridor and risk adjustment impact; and these changes will require changes to issuers' administrative systems to allow for premium adjustments incurred during the entire first half of 2015. We therefore urge that changes that create additional administrative changes and costs for such de minimis value for such a limited period be eliminated.

2) Part 2 – Section 1 Premiums – Line 1.3 – 3/31 Column - The instruction says that with respect to the unearned premium reserve for 12/31/2013 after adjusting for 3/31 information, companies are to "report zero." This is incorrect, as the adjustment from 12/31 to 3/31 is not to "earn" additional premium, but to reflect changes in enrollment or to adjust for premiums reported as due as of 12/31 that were ultimately not paid. While we did not catch this error in the 2012 MLR instructions, we note that companies would have reported the actual correct amounts if "zero" was not the correct amount. ***We recommend the change from "report zero" to "report the adjusted amount, and if there was no adjustment, report the value from 12/31/2013."***

3) ACA Fees Collected in 2013 - We note the request for comment about these fees and the proposed new sentence with respect to not reporting ACA fees collected as unearned premium reserves in Part 2, Line 1.3.

It is critical that the 2013 MLR calculations allow for the reduction to the denominator for the amounts of fees collected with premiums that are earned in 2013 (on fiscal year group policies). Otherwise, the MLR requirement would require the rebate of these amounts for 2013 while not eliminating the requirement to pay them again in 2014 as the ACA fee.

We continue to recommend that these amounts be permitted to be reported as unearned premium reserves held as of 12/31, as the most logical and consistent approach for treating amounts collected for a future commitment. If, from a policy basis, you cannot agree to the unearned premium reserve method of reporting these amounts, we offer two alternatives for use in the 2013 MLR calculation, and recommend that this approach be used in subsequent MLR reporting years as well:

I. It would be appropriate to reflect the collected ACA fees as an adjustment to the experience rating refunds Part 2 – Section 1 Premiums – Line 1.5. The NAIC

recognizes that the requirements with respect to rebates makes these contracts retrospectively rated contracts; or

II. It would be possible to include the collected ACA fees as an amount in Part 1 – Section 1 Premiums – Line 1.5 as "amounts excluded from premium for MLR calculation purposes that are normally included in premiums for financial statement purposes" in the 3/31 columns. This would be a unique entry as these cells are currently marked as "gray." This would also require a modification to the instruction for Part 4 – Section 2 MLR Denominator – Line 2.1 – CY Column to include this as a reduction to the sum of Part 1 Lines 1.1 + 1.2 + 1.3 Columns 3/31.

4) Part 2 – Section 2 Claims - Line 2.6b - 3/31 Column - We are concerned with a lack of clarity in this section that can be remedied with the inclusion of the phrase "*shall exclude the amount of contract reserves accrued prior to 2011"* in the second sentence. In response to comments on the CY2012 reporting materials, CMS replied to this concern stating that "*Policies issued prior to 2011 are not subject to the MLR provisions."*

We appreciated that response, and ask that the instructions be more specific on the applicability of MLR to those plans issued prior to 2011, which may include grandfathered plans. The revision below would make it clear that *line 2.6b – 3/31 column* is intended to recognize any increase or release of contract reserves on a year-to-year basis following the effective date of the MLR provision.

We recommend it should read:
2.6b - 3/31 Column – 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 shall exclude the amount of contract reserves held on December 31, 2010 (as reported in the 2011 MLR report for line 2.7) and may not exceed contract reserves calculated using the applicable product pricing assumptions. Calculate as of 12/31 of the MLR reporting year.

5) Part 4 – Opening Instructions – We believe that there should be more specific instructions on the reporting of Student Health plans for 2013, especially given the limitations to the credibility adjustment based on 2011 and 2012.

We recommend that the 2011 and 2012 reported values for Sections 1 and 2 be the results reported on the Grand Total (GT) spreadsheet for those years. This would include in Line

1.4 rebates paid for either of these years. Assuming a company paid some actual amounts in either of those years, that company would be allowed full credibility adjustment for 2013.

We also recommend that companies be given the options to either recalculate the average deductible for 2011 and 2012 from the entire Student Health plan exposure or use the average deductible already calculated for each state and use earned premiums to determine the weighted average of these reported values.

6) Part 4 – Section 1 – Line 1.3 – PY2 and PY1 Columns– We believe that the instructions should allow for allocation of additional Improving Health Care Quality Expenses to these accounting periods since there is recognition that claims may be reported and paid beyond 3/31 following the calendar year represented by these columns.

7) Part 4 – Section 1 – Line 1.6 – Instructions – Similar to the above recommendation, the adjustment factors for Mini-Med were changed from 2011 through 2013.

We recommend that the first paragraph of the instructions should include the adjustment factors for all three years (2.00 for 2011, 1.75 for 2012 and 1.50 for 2013) so it is clear these three factors are to be used in completing this line. This is important for the determination of the appropriate base credibility factor in line 3.2.

We recommend that the instructions then clarify that the adjustment factor to be used in the Total column is the 2013 factor times the sum of the values in lines 1.2 + 1.3 + 1.4 from the Total column.

8) Aggregating Multiple Years of MLR Experience Subject to Different MLR Standards – On April 5, 2013, HHS issued CCIIO Technical Guidance (CCIIO 2013-0001) Q&A #58 permitting issuers in state markets with MLR standards that change over time to scale the prior year experience included in the current MLR numerator, to account for the higher MLR standard of the current reporting year.

Q&A #58 defined the scaling adjustment as: "the reporting year standard minus the applicable prior year standard, multiplied by the applicable prior year adjusted premium. The amount is then added to the experience from the applicable prior year that is included in the current MLR numerator."

The numerator section of Part 4 of the 2012 MLR rebate form was not revised to allow issuers to properly report this numerator scaling adjustment. Following CCIIO verbal guidance, issuers were advised to "plug" this numerator scaling adjustment into the Part 4, Line 1.5 total column only. This resulted in HIOS validation warnings and confusion since

the sum of the current year and prior year columns did not equal the total column for this line.

The 2013 MLR draft instructions do not include guidance related to aggregating multiple years of MLR experience subject to different MLR standards. In addition, the 2013 MLR rebate form Part 4 has not been revised to accommodate the proper reporting of the numerator scaling adjustment.

We recommend adding clear instruction for 2013 related to the numerator scaling adjustment allowed when aggregating multiple years of MLR experience subject to different MLR standards. We recommend the instructions include an actual example, similar to the Q&A #58 example provided in the April 5, 2013 technical guidance, but reflecting the calculation using three years' of experience.

Example (using Iowa's MLR standards):

2011 MLR Standard: 67%
2012 MLR Standard: 75%
2013 MLR Standard: 80%

2011 MLR Standard Change: 80% - 67% = 13%
2012 MLR Standard Change: 80% - 75% = 5%

2011 Premiums: 1,000,000
2012 Premiums: 1,000,000

2011 MLR Standard adjustment: 13% X $1,000,000 = $130,000
2012 MLR Standard adjustment: 5% X $1,000,000 = $50,000
Total amount added to 2013 numerator is $180,000 (numerator scaling adjustment)

In addition, ***we recommend the 2013 MLR reporting form be revised to include a line in the numerator section of Part 4 to allow issuers to properly reflect the scaling adjustment on the form.*** Adding clear instruction and revising the form to reflect CCIIO issued guidance, would result in the elimination of unnecessary validation warnings and would eliminate the potential for inaccurate or inconsistent reporting across the industry.

9) Validation Warning Formulas – In the prior year, validation warnings were not communicated to issuers until after the MLR rebate form was uploaded to HIOS. This resulted in preparer and attester confusion, avoidable re-work and risky last-minute adjustments to the reported data.

We recommend HHS include the validation expectations in the instructions or provide the validation expectations in a separate communication well in advance of the MLR rebate form filing deadline. Providing the validation expectations in the instructions would allow issuers to pro-actively verify the accuracy of the programmed data prior to filing and would promote clear understanding of how reported amounts are expected to cross-reference with other data within and outside of the MLR reporting form. We believe providing this transparency would mutually benefit both issuers and HHS.

10) Part 1 – Section 5 – 3/31 Columns – Due to the fact that non-claims costs have no impact on the MLR calculations and the fact that SG&A expenses generally are not attributable to a particular claims incurral date, ***we recommend the 3/31 column for this section be grayed out and the data in Part 1 Section 5 be required to be reported for the 12/31 columns only.***

11) Closed Blocks of Business – We appreciate HHS' efforts to reduce the reporting burden for companies with only grand-fathered plans in closed blocks of business. However, the instructions do not provide guidance for companies that have no active policies or membership in the MLR reporting year, but have only reported premium adjustments and claims run-out related to policies that were active in previous years.

We recommend HHS make it clear in the instructions that companies in this situation are exempt from filing the MLR rebate form and also exempt from following the closed blocks of business reporting requirements.

12) Additional Clarification needed on Page 2 - Introductory Section. - Finally, we recommend additional language be added to the introduction of the reporting instructions to provide guidance consistent with the May 30, 2013 sub-regulatory guidance issued by CCIIO on the treatment of hospital indemnity and fixed indemnity products for purposes of reporting the medical loss ratio experience for 2012. The "purpose of this FAQ is to provide guidance on the effective date of Affordable Care Act Implementation FAQs, Set 11, Question and Answer #7, issued in February 2013 by the Departments of Health and Human Services (HHS), Labor and Treasury (collectively, the Departments) related to the Medical Loss Ratio reporting and rebate requirements set forth at 45 CFR Part 158." The text of the MLR FAQ follows:

Question #61: Must an issuer of plans that the issuer had categorized as "fixed indemnity" policies, but which in fact fail to satisfy the criteria for fixed indemnity policies described in the Affordable Care Act Implementation FAQs, Set 11, Question and Answer #7 (January 24, 2013), report the medical loss ratio (MLR) experience of those plans to the Secretary for the 2012 reporting year?

Answer #61: No. Issuers do not need to report the experience of these policies for the 2012 MLR reporting year.

We thus recommend this clarification be included introductory language on page 1 of the 2013 Instructions, at the end of the paragraph that begins "The term "health insurance coverage": "Fixed Indemnity policies, as HIPAA "excepted benefits" also need not be reported for the 2013 MLR Reporting year, per CMS CCIIO MLR FAQ of May 2013."

(http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mlr-guidance-5-30-2013.pdf)

We strongly urge that these comments be considered, and the recommendations incorporated in the instructions for the 2013 MLR Reporting and Rebate Calculation, as they provide further clarification on areas to assure more consistency in the reporting of health insurance issuers offering group or individual health insurance coverage who are required to report information pursuant to Section 2718 of the Affordable Care Act and implementing regulation at 45 CFR Part 158.

We also note that we were unable to provide robust comments on the spreadsheet provided, as it did not include the formulas/macros, (as was provided for the 2012 reporting). We hope that will be made available, and will be happy to review it for consistency with the MLR and Rebate Report Draft Instructions

We would be happy to discuss any of these comments with you, or provide further information as needed.

Thank you.

Sincerely,

Colleen M. (Candy) Gallaher
Senior Vice President - State Policy

cc: William Weller, OmegaSquared - Consultant to AHIP