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Comments Submitted Electronically at: *OIRA_submission@omb.eop.gov*

OMB, Office of
Information and Regulatory Affairs,
Attention: CMS Desk Officer

Attention: Document Identifier/OMB Control Number CMS-10418 (OCN: 0938–1164)
Revised Annual MLR and Rebate Calculation Report and MLR Rebate Notices
Instructions and Reporting Template

AHIP Comments on the revised Draft 2013 Instructions and Forms

Dear CMS Desk Officer,

We appreciate the updates that were made to the MLR Calculation and Rebate Reporting Form and Instructions (the "Instructions"), and the reporting template form (the "Form"), which assist in making clearer the reporting of some of the complex items required in the Form. We provide these comments on the revised Instructions to fine tune two of the changes made, to clarify and request consideration of recommendations we'd previously made, and to request technical supplements at the earliest opportunity, since issuers will be working on these reports once they finalize their annual financial reports. We submit these for your reconsideration and action.

Technical Instructions - Supplements

Formula Tool Needed: We ask that CCIIO release, at the earliest opportunity, or at least no later than April 1, the "*Formula Tool* " for the Form. Unlike normal spreadsheets, the Form does not include any formulas or macros. The 2012 Form also did not include formulas, but CCIIO released a *Formula Tool* for issuers to use in checking their work and submissions. This is very important for timely and accurate submissions, as it provides the necessary full instructions. Without this tool issuers can see pages and pages of "validation errors" simply because they do not have the detailed instructions related to what level of data a cell (or spreadsheet field) will accept, or the actions that will result from the formula in a given cell.

Validation Expectations and Warnings Needed: In the previous year, when the spreadsheet macros were removed, validation warnings were not communicated to issuers until after the

MLR rebate form was uploaded to HIOS. This resulted in preparer and attester confusion, and created avoidable re-work and risky last-minute adjustments to the reported data. For example failing to round in a given cell, or even one cent placed in the wrong cell, could generate validation warnings that were pages and pages long.

Previously we recommended that HHS include the validation expectations in the instructions or provide the validation expectations in a separate communication well in advance of the MLR calculation and 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 continue to request this, believing this transparency would mutually benefit both issuers and HHS, improve accuracy and reduce needless re-work that could have been avoided.

Recommendations to Further Clarify the Instructions

Part 2 (Premiums and Claims) Section 1 – Health Premiums Earned.: (Crosswalk Item #1).

We appreciate the bolded information, and suggest that the additional information added after the BOLDED language should be re-positioned. It should be moved up into the main paragraph, before the bolded information, as it relates to the 3/31 references.

Thus we recommend:

> Revised line 1.1- Direct Premium written, to read "3/31 Column (premium for coverage in MLR reporting year only) – report premium collected from 1/01 of the MLR reporting year through 3/31 of the year following the MLR reporting year for coverage in the MLR reporting year only, plus uncollected (due and unpaid) premium for coverage in the MLR reporting year only as of 3/31 of the year following the MLR reporting year. Premium should include all amounts collected toward ACA fees, regardless of whether the fees were included in premium or billed as a separate line item. Premium should reflect retroactive eligibility adjustments related to coverage in the MLR reporting year. PLEASE NOTE that this methodology differs from NAIC SHCE methodology. ***However, issuers may choose to report amounts on the same basis as in the 12/31 columns."***
> ~~Premium should include all amounts collected toward ACA fees, regardless of whether the fees were included in premium or billed as a separate line item. Premium should reflect retroactive eligibility adjustments related to coverage in the MLR reporting year~~.

Part 4- Section 1-Line 1.3 (PY2 and PY1 Columns): The instructions should provide for updating the amounts in PY1Column and PY2 Column to allow for allocation of expenses to those accounting periods to recognize that claims may be reported and paid beyond 3/31 following the calendar year represented in those columns.

Thus we recommend:

> The addition of this sentence to that section will improve the instructions and allow for accurate allocation - "***issuers may also allocate expenses to those expenses if the claims were reported and paid beyond 3/31***".

Part 4 (Medical Loss Ratio Numerator) Line 1.5- The Proper Treatment of Aggregating Multiple Years of MLR Experience Subject to Different (State Required) MLR Standards: The language in this section was not revised to address the comments we had submitted to address the proper treatment of reporting the aggregating of multiple years of MLR experience subject to different MLR standards.

CIIOO had previously addressed this in CCIIO Technical Guidance (CCIIO 2013-001), where Q&A #58 defined the scaling adjustment as "*the reporting year standard minus the applicable 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 and now the 2013 reporting forms were not revised to allow issuers to properly report this numerator scaling adjustment. In 2012 issuers were verbally advised to follow CCIIO verbal guidance to "plug" the scaling adjustment into the Part 4 Line 1.5 total column only. This resulted in HIOS spreadsheet validation warnings. Unfortunately, the adjustments made to the language in Part 4 Line 1.5 (Crosswalk Item # 5) do not address this particular concern.

Thus we recommend:

> 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 suggest the Instructions could 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.
>
> <u>Example (using Iowa's varied MLR standards):</u>

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)

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.

Part 4 (Medical Loss Ratio Numerator) Line 1.6: (Crosswalk item #6) - The added language assists in illustrating the methodology on page 36, which we appreciate. However, the instructions (on page 37) still require the use of the 2013 adjustment value to the three-year earned premium. This has the effect of reducing the value of the 2011 and 2012 adjustments. We ask where it was stated that this was the intended approach when these adjustments were first agreed to. We do not believe that is a reasonable or valid approach.

Thus we recommend:

The instructions should clarify that the adjustment factor to be used in the Mini-Med Current Year column is the 2013 factor times the sum of the values in lines 1.2 + 1.3 + 1.4. Then the Total column is the sum of the adjusted values for PY2 + PY1 + CY.

New Section 4 (MLR Rebate and Calculation) Section 6 and- Optional Temporary Adjustment for Non-calendar Year Policies: (Cross Walk Item #3). We appreciate that the Instructions provide for the option for issuers with non-calendar year policies to defer including in their MLR and rebate calculations the portion of premiums collected for the following years' ACA issuer fee, which would be added back into the calculation in the following year.

We appreciate that you have recognized this issue, and are allowing that adjustment as optional, since this amount may be significant for some companies, and not as material for others, depending on the size of the companies' block of group business with non-calendar year policies. This is especially true for issuers with a large number of groups renewing in April, or July.

We do however, ask that this new section be added as a part of the standard instructions moving forward, rather than as a temporary section. To the extent that small or large group business continues to renew throughout the year, issuers will need to collect a portion of the ACA issuer fee in the prior year. Thus, this recognition would be necessary moving forward.

Thus we recommend:

> The title of this new section should be revised to remove the word "Temporary";
> **Section 4 (MLR Rebate and Calculation) Section 6 and- Optional ~~Temporary~~ Adjustment for Non-calendar Year Policies.** The remainder of the language is fine for 2013. In future years, the language would be adjusted to reflect the correct years.

We appreciate the opportunity to provide these comments. These comments are intended to improve the consistency and accuracy of reporting, and appreciate the serious consideration our prior comments have been given. We would be happy to discuss further, if needed.

Thank you.

Sincerely,

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

cc: William Weller, OmegaSquared - Consultant to AHIP
Julie McCune - CCIIO MLR Unit - Director