May 2, 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

Re: Document Identifier CMS-10418
CMS Medical Loss Ratio (MLR) Annual Reporting Form

On behalf of the American Academy of Actuaries'[1] Medical Loss Ratio (MLR) Regulation Work Group, I appreciate the opportunity to provide comments on the April 3, 2012 version of the 2011 Medical Loss Ratio Annual Reporting Form, which will be used by health insurance issuers to fulfill their reporting obligations under Section 2718 of the Public Health Service Act.

The comments below cover three specific topics:

1. Definition of premiums
2. Contract reserves
3. Definition of pre-tax underwriting gain/(loss)

The main points of our comments are as follows:

- The reporting form's treatment of premiums is inconsistent with a statement previously issued by HHS in the preamble to the December 2010 interim final rule on MLR, specifically that "[a]ny premium for a period outside of the MLR reporting year must not be reported in earned premium for the MLR reporting year."

- While the language on contract reserves in the April 2012 version of the reporting form instructions is improved significantly from the language in the original December 2011 version, CMS may wish to offer additional interpretive guidance on contract reserves to assist issuers and actuaries.

- The reporting form's definition of the term "pre-tax underwriting gain/(loss)" is inconsistent with the way this term historically has been used in the insurance industry. While this issue does not affect the calculation of rebates, it could be confusing and/or

[1] The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

misleading to regulators and researchers who will use the data collected in the MLR reporting form to analyze the health insurance marketplace.

1. Definition of Premiums

In the latest version of the 2011 reporting form, the earned premiums used in the denominator of the MLR calculation represent values "as reported as of December 31, to the department of insurance in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year regardless of incurred date."

The language "regardless of incurred date" is newly added and raises a significant concern in light of a statement made by CMS in the preamble of the December 2010 interim final rule on MLR. The preamble's discussion of Section 158.130 of the MLR regulation includes the following sentence:

> "Any premium for a period outside of the MLR reporting year must not be reported in earned premium for the MLR reporting year."

Members of our work group understood this sentence to mean that the earned premiums used for MLR reporting purposes should not be identical with earned premium values reported in the financial statements, but instead should include only those amounts that pertain to the reporting year itself.

It is important to recognize that the amounts reported by issuers as earned premiums in their 2011 NAIC Supplemental Health Care Exhibit (SHCE) filings do not wholly relate to coverage from the 2011 reporting year. Some portion of those earned premiums represents a true-up of the issuer's estimate at year-end 2010 of premiums earned but not yet collected for coverage prior to the 2011 reporting year. (Please see Appendix 1 to this letter for a more thorough technical discussion of this point.) This is directly analogous to what occurs with incurred claims, in which some portion of the incurred claims reported in an issuer's 2011 SHCE represents a true-up of the issuer's previous estimate at year-end 2010 of claims incurred but not yet paid for coverage prior to the 2011 reporting year.

One of the main reasons the MLR reporting form's definition of incurred claims intentionally deviates from the financial statement definition is to exclude the effect in the current year of the true-up of the issuer's previous estimate of unpaid claims. For consistency, it is important that the form's definition of earned premiums be handled in a similar manner. The current instructions imply that the issuer should use a financial statement definition of earned premium. This would mean the MLR calculation was internally inconsistent and also inconsistent with the principle previously articulated by CMS as quoted above.

To rectify this, the instructions and/or the form need to be modified to make it clear that the issuer should report only as earned premiums those premiums earned in the 2011 financial statements for 2011 coverage—and should not report as earned premium any amount that, while included in the issuer's 2011 financial statements, pertains to coverage for years other than 2011. If this change is not made, then some anomalous results may occur in the process of apportioning

an issuer's total rebate liability to the customer level and distributing rebates. (Please see Appendix 2 to this letter for an illustrative example.)

Given time constraints and the existing confusion on this issue, it may be prudent from a practical perspective for CMS to give issuers options with respect to 2011 reporting of earned premiums. Some health insurance issuers, based on the preamble to the interim final rule, may have built MLR reporting capabilities on the assumption that earned premiums not pertaining to 2011 coverage should be excluded. Other health insurance issuers, however, may have expected that financial statement earned premiums would be used in MLR reporting and may not be able to exclude earned premiums not pertaining to 2011 coverage in time to meet the June 1, 2012, reporting deadline. As a result, the most practical course may be to allow issuers to report earned premiums on either basis for 2011 reporting and then seek to transition all issuers to the same basis for 2012 reporting.

2. Contract Reserves

The April 2012 version of the reporting form instructions currently contains the following language regarding contract reserves:

"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."

This language is a significant improvement on the language included in the December 2011 version of the instructions; it reflects the concerns we raised in our February 2012 comment letter.[2]

It is likely that issuers and actuaries will continue to have a number of questions related to the use of contract reserves in the MLR calculation, and that CMS may wish to provide additional guidance. We anticipate questions about contract reserves may arise in the following areas:

- If an issuer's financial statements prior to 2011 included contract reserves for policies issued prior to 2011, is it mandatory for the issuer to include contract reserves for those policies in the MLR calculation? Or, is the inclusion of these reserves at the issuer's option?

- Assuming that an issuer's financial statements prior to 2011 included contract reserves for policies issued before 2011, how much latitude does the issuer have to use one set of methodologies and assumptions in its contract reserves for financial statement purposes and a different set of methodologies and assumptions for MLR reporting purposes? (A variation of this question arises in the situation in which the issuer files financial

[2] Available at http://www.actuary.org/pdf/health/MLRRWG_cmts_MLRreportingForm_120214.pdf.

statements under GAAP, and also under statutory accounting principles, and uses different sets of methodologies and assumptions under the two accounting bases.)

- Assuming that an issuer's financial statements prior to 2011 did not include contract reserves for policies issued prior to 2011, is the issuer allowed to include in the MLR calculation contract reserves for policies issued in 2011 and later? Does the answer depend on whether the issuer's financial statements in 2011 and later include such contract reserves?

- What should happen in a situation in which an issuer makes a material change in its contract reserve methodologies and/or assumptions in the middle of an MLR reporting year? Should MLR reporting include the change from the reserve reported at the end of the prior year to the reserve reported at the end of the MLR reporting year—even though those two numbers may not be internally consistent? Or, as an alternative, should the reserve reported at the end of the prior year be restated, for MLR reporting purposes, to be consistent with the methodologies and assumptions used to compute the reserve at the end of the MLR reporting year?

In addition, it could be made clearer that the newly added language in the reporting form instructions on "applicable product pricing assumptions" refers to assumptions used when policy premiums were most recently repriced, as opposed to assumptions used when the policy was issued originally. One of the most important variables in the type of contract reserve calculations under discussion here is the issuer's estimate of future policyholder lapse rates. For grandfathered policies in particular, the issuer's current estimate of future lapse rates is likely materially different than the estimates made at original policy issuance. This is because of the effect the introduction of exchanges in 2014 is expected to have on policyholders' interest in maintaining their existing grandfathered individual policies. It would be inappropriate to prohibit issuers from reflecting current perspectives on lapse rates and other relevant variables in their MLR contract reserve calculations.

3. Definition of Pre-Tax Underwriting Gain/(Loss)

The MLR reporting form contains, for informational purposes, a metric showing the issuer's pre-tax underwriting gain/(loss). The way in which "pre-tax underwriting gain/(loss)" is defined on the MLR reporting form (Part 1 Line 6) is significantly different from how that term has been used by both regulators and issuers. Pre-tax underwriting gain historically has been computed gross of federal income taxes, but net of a variety of other taxes and assessments paid to state and federal bodies (e.g., state premium taxes). In addition, the issuer's total pre-tax underwriting gain historically has been computed net of fee income from uninsured plans.

This metric does not directly affect the calculation of an issuer's MLR or associated rebates to customers. We expect that the MLR reporting form data submitted by issuers to HHS, however, will become an important source of information about the health insurance industry. It will be utilized by regulators, researchers, and other parties interested in understanding the financial dynamics of the health insurance marketplace. To that end, it is important that all information included on the reporting form, even information that does not affect directly the calculation of

customer rebates, be defined appropriately and in a manner least likely to confuse or mislead users of the submitted data.

To remedy this situation and produce a definition of pre-tax underwriting gain/(loss) that is more consistent with the way in which this term is generally understood, we recommend the following changes to the MLR reporting form:

- Split Part 1 Line 3 into two lines—Line 3.1a, for federal income taxes and Line 3.1b for all other federal taxes and fees (e.g., the ACA Section 9010 health insurer fee effective in 2014).

- Modify the definition of Part 1 Line 3.4 to replace the current Line 3.1 with the new Line 3.1a + Line 3.1b.

- Flip the order of the current Part 1 Line 6 (pre-tax underwriting gain) and Part 1 Line 7 (income from fees of uninsured plans).

- Modify the definition of Part 1 Line 7 (pre-tax underwriting gain) as follows—add Part 1 Line 6 (income from fees of uninsured plans); subtract Part 1 Line 3.4 (total taxes and fees excludable from the MLR denominator); add Part 1 Line 3.1a (federal income taxes excludable from the MLR denominator).

With these changes, pre-tax underwriting gain/(loss) as shown in the MLR reporting form will continue to be gross of federal income taxes, but now will be net of all other taxes and fees, consistent with current usage.

Thank you for your consideration of these comments. If we can be of any further assistance, please contact Heather Jerbi, the Academy's senior federal health policy analyst at Jerbi@actuary.org or (202) 785-7869.

Sincerely,

Rowen B. Bell, MAAA, FSA
Chairperson, Medical Loss Ratio Regulation Work Group
American Academy of Actuaries

Cc: Carol Jimenez (Director, Division of Medical Loss Ratio, Office of Oversight, CCIIO, HHS)

Appendix 1 – Earned Premium Accounting for Health Insurance Issuers

The earned premium reported by a health insurance issuer in its 2011 financial statements (F/S) is composed of many components, in the following manner:

[1a] Cash premiums collected in 2011 for coverage in 2011
[1b] Cash premiums collected in 2011 for coverage prior to 2011
[1c] Cash premiums collected in 2011 for coverage subsequent to 2011

[2a] Due and unpaid premium asset as of 12/31/11 for coverage in 2011
[2b][3] Due and unpaid premium asset as of 12/31/11 for coverage prior to 2011

[3] Due and unpaid premium asset as of 12/31/10 (for coverage prior to 2011)

[4] Unearned premium reserve[4] as of 12/31/11 (for coverage subsequent to 2011)

[5a] Unearned premium reserve as of 12/31/10 for coverage in 2011
[5b][5] Unearned premium reserve as of 12/31/10 for coverage subsequent to 2011

2011 F/S Earned Premium = Cash premiums + Change in D&UP – Change in unearned premium
= {[1a] + [1b] + [1c]} + {[2a] + [2b] – [3]} – {[4] – [5a] – [5b]}

It is instructive to re-organize the above equation into the following equation, also having three terms:

2011 F/S Earned Premium = {[1a] + [2a] + [5a]} + {[1b] + [2b] – [3]} + {[1c] + [5b] – [4]}

In this version of the equation, the meaning of the each of the three terms is as follows:

- The first term, {[1a] + [2a] + [5a]}, represents the portion of the earned premium reported on the 2011 financial statements that pertains to coverage in 2011. This includes the cash collected in 2011 for 2011 coverage, plus the issuer's estimate as of year-end 2011 of premiums due for 2011 coverage but not yet collected, plus the release during 2011 of unearned premium reserves established at year-end 2010 (representing cash collected prior to 2011) for 2011 coverage.

- The second term, {[1b] + [2b] – [3]}, represents premiums that pertain to coverage prior to 2011, but were included as earned premium in the 2011 financial statements. This essentially represents the difference between actual cash collections in 2011 for coverage prior to 2011 and the estimate made at year-end 2010 for expected future cash collections for coverage prior to 2011. This term could be positive or negative; it would be zero only

[3] Included here for completeness. In practice, this almost always should be zero.
[4] For purposes of this discussion, use of the term "unearned premium reserve" is inclusive of what is sometimes separately referred to as the issuer's "advance premium liability."
[5] Included here for completeness. In practice, this almost always should be zero.

if the issuer's estimate at year-end 2010 of expected future cash collections for coverage prior to 2011 was exactly correct. In practice, that is unlikely to happen.

- The third term, {[1c] + [5b] – [4]}, in principle should be zero. It would represent premiums that were recognized in the 2011 financial statements as having been earned but pertain to coverage subsequent to 2011.

In the body of this letter, we propose that the earned premium included in the MLR reporting form should consist only of the first term of this equation (premiums for 2011 coverage reported as earned in 2011 financial statements), and should exclude both the second term (premiums for pre-2011 coverage reported as earned in 2011 financial statements) and the third term (premiums for post-2011 coverage reported as earned in 2011 financial statements). This approach would be consistent with the statement made in the preamble to the MLR interim final rule that "any premium for a period outside of the MLR reporting year must not be reported in earned premium for the MLR reporting year."

Appendix 2 – Illustrative Example of Anomalous Rebate Results

Consider the following situation:

- Customers X and Y obtained coverage from an issuer in 2010.
- Neither X nor Y remitted premiums to the issuer for December 2010 coverage prior to year-end 2010.
- When the issuer prepared its year-end 2010 financial statement, it was under the impression that X intended to terminate its coverage effective Dec. 1, 2010. As a result, the issuer's year-end 2010 due and unpaid premium asset did not include premiums from X for December 2010 coverage. The issuer, however, was under the impression that Y intended to maintain its coverage for December 2010, and therefore its year-end 2010 due and unpaid premium asset did include premiums from Y for December 2010.
- Both X and Y remitted premium for December 2010 in early 2011, and both X and Y formally terminated coverage effective Jan. 1, 2011.
- The issuer owes rebates in 2011 for the state/customer category pertinent to X and Y.

Under the facts stated above, the issuer's financial statement earned premium for 2011 includes the premiums paid by X, but not those paid by Y, for December 2010 coverage. As a result, if financial statement earned premium is used in the denominator of the MLR calculation, then some of the premiums appearing in the denominator of the MLR calculation are attributable to X. Since rebates are calculated by taking the denominator of the MLR calculation and multiplying by a specified percentage, this would suggest that X may be entitled to a rebate for the 2011 reporting year, even though it never was covered during the 2011 reporting year. By contrast, Y would not receive such a rebate, since no amount included in the denominator of the MLR calculation is attributable to Y. From a customer-centric perspective, however, X and Y are similarly situated (i.e., X and Y both terminated coverage effective Jan. 1, 2011, but were late in paying their December 2010 premiums). These results do not make sense.

By contrast, under the approach we believe appropriate for determining earned premium for MLR reporting purposes, neither X's nor Y's December 2010 premiums would be included in the denominator of the issuer's 2011 MLR calculation (even though the issuer did not recognize X's premiums as being earned until its 2011 financial statements). As a result, neither X nor Y would be entitled to a rebate for 2011. We believe this is a more sensible result.