April 25, 2013

Centers for Medicaid & Medicare Services
Department of Health and Human Services
Attention: CMS-4173-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs

To Whom It May Concern:

On behalf of the American Academy of Actuaries[1] Medical Loss Ratio Regulation Work Group, I appreciate this opportunity to provide comments to the Centers for Medicaid & Medicare Services (CMS) on the recently proposed rule implementing the medical loss ratio (MLR) requirements for the Medicare Advantage (MA) and Medicare Prescription Drug (Part D) programs enacted under Section 1857(e)(4) of the Social Security Act.

CMS has made a concerted effort, in developing regulations implementing Section 1857(e)(4) of the Social Security Act, to closely mirror the regulations implementing the commercial health insurance MLR provisions enacted under Section 2718 of the Public Health Service Act. Consistency between the Medicare MLR regulation and the commercial MLR regulation is an appropriate approach.

Our comments focus on a few areas in which further clarification would be helpful or for which we wanted to provide some additional thoughts based on our experience with the commercial MLR regulation.

Timing and Restatements of MLR Reporting

It is important for MLR calculations that have economic consequences to be performed using the most accurate available information. As such, it would be most appropriate for CMS to delay the annual MLR reporting until December, after the annual Part D reconciliations are complete, to minimize the need for estimates in the MLR reporting process. For commercial insurance, a compelling reason to accelerate MLR reporting was to get rebates to customers as soon as possible. For Medicare, by contrast, the remittances are being paid to CMS rather than to customers. In this case, accuracy should outweigh expediency.

As such, we disagree with the concept expressed in the preamble that "the MLR would be reported once and that neither any reopening(s) of any reconciliation processes nor any risk adjustment data validation audits would result in a reopening of the MLR reported for a contract year." For commercial insurance, there are compelling administrative reasons why the MLR reporting and rebate payment for a particular

[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 qualifications, practice, and professionalism standards for actuaries in the United States.

year is not reopened in light of subsequent information. As a practical matter, the issuer may be unable to recover rebates previously paid to customers or locate its former customers if additional rebates were deemed payable years after the fact. For Medicare, however, that concern does not exist since CMS is the only counterparty involved in remittances. Moreover, given the historical magnitude of amounts involved in risk adjustment validation (RADV) audits, it is conceivable that RADV audit results could impact materially what the reported MLR should have been.

As such, we support the notion that MLR calculations and associated remittances in some circumstances should be restated subsequent to the original submission to the extent that more updated information (e.g., RADV audit results) becomes available. We recognize that if CMS were to go down this path, it would need to clarify how the resubmitted MLR results would be viewed for purposes of applying Sections 423.2410(c) and 423.2410(d), in which the issuer faces negative consequences if it repeatedly reports an MLR below 85 percent.

Credibility Adjustment

We are pleased to see that the proposed Medicare MLR regulation includes a credibility adjustment closely modeled after the commercial MLR regulation. We do have a couple of comments about the credibility adjustment, however.

First, we note that Tables 1A and 1B of the Medicare MLR regulation feature "cliffs," in which the credibility adjustment immediately drops from 1 percent to 0 percent on the addition of one member month (i.e., from 180,000 to 180,001 in Table 1A, and from 360,000 to 360,001 in Table 1B). By contrast, in the commercial MLR credibility adjustment (Table 1 of 45 CFR Section 158.232), there is no such cliff, and values are linearly interpolated between the principal credibility thresholds. We recommend that Tables 1A and 1B be modified to avoid this type of cliff.

Second, we would not have expected CMS to find, as stated in the preamble, that "claims for MA-PD contracts have a lower coefficient of less [*sic*] variation around the average than do claims for Part D stand-alone contracts." While we have not had the opportunity to perform a parallel study ourselves, most members of our work group expect that MA-PD claims would have a higher coefficient of variation than Part D claims. As such, we would have expected to see a higher threshold for full credibility in Table 1A (MA) than in Table 1B (Part D). Given this disconnect between what we might have expected and what the data seems to present, we encourage CMS to publicly release the study that its actuaries performed that forms the basis of the Medicare MLR credibility adjustment, just as the National Association of Insurance Commissioners (NAIC) publicly released the report that it commissioned from Milliman in 2011 and that ended up forming the basis of the commercial MLR credibility adjustment.

Issues Addressed in CCIIO Sub-Regulatory Guidance

The Center for Consumer Information and Insurance Oversight (CCIIO) has supplemented the commercial MLR regulation with a series of technical bulletins providing sub-regulatory guidance on commercial MLR issues in form of a frequently asked questions (FAQ) document. As of this writing, this series of CCIIO guidance now addresses 60 separate questions.

Given the consistency between the proposed Medicare MLR regulation and the existing commercial MLR regulation, several of these 60 questions potentially are applicable to the Medicare case. In particular, the items listed below in the commercial MLR guidance provide guidance that also is applicable to Medicare. We would encourage CMS to acknowledge—for example, via sub-regulatory guidance—that the responses to the following specific questions apply to the Medicare MLR as well.

- Q8 states that the entire capitation amount paid to a clinical provider is considered to be claims expense for MLR purposes;

- Q9 confirms that Q8 applies equally with respect to capitations paid to non-physician clinical providers;

- Q12 states that when payments are made to a third-party vendor that provides clinical services to enrollees through its own employees, then the entire payment is treated as claims expense for MLR purposes even though some portion of the payment implicitly covers the vendor's own administrative expenses;

- Q14 states that it is possible for a portion of payments made to a third-party vendor to qualify for treatment as a QIA (quality improving activity) expense for MLR purposes;

- Q19 states that when payments are made to a third-party vendor that in turn pays others to provide clinical services to enrollees (i.e., the vendor's own employees are not providing the services), then the portion of the payment that implicitly covers the vendor's own administrative expenses is not considered claims expense for MLR purposes;

- Q20 provides a four-prong test that payments to clinical risk-bearing entities need to satisfy in order for the payment to be treated as claims expense for MLR purposes;

- Q21 confirms that if the four-prong test in Q20 is met, then the portion of the payment that represents administrative expenses performed by the risk-bearing entity on behalf of providers can nonetheless be treated as claims expense for MLR purposes;

- Q22 states that the portion of a payment to clinical risk-bearing entities that represents administrative expenses performed by the risk-bearing entity on behalf of the insurer (as opposed to providers) cannot be treated as claims expense for MLR purposes.

Treatment of Part D Reinsurance and LICS

In the NAIC discussions that led to its technical recommendations on the commercial MLR regulation, one of the underlying principles that guided the NAIC was a belief that the definitions of revenues and incurred claims in the commercial MLR regulation should follow the NAIC's codified statutory accounting principles as much as possible.

With that as background, we noted that the proposed Medicare MLR regulation deviates from statutory accounting with respect to its treatment of the Part D reinsurance program. Under statutory accounting, as articulated in NAIC INT 05-05, an insurer does not recognize any revenues or claims for amounts associated with the Part D reinsurance benefit. This is based on the perspective that Part D is properly viewed as a partially insured plan, of which the reinsurance benefit represents the uninsured portion. By contrast, the proposed rule specifies that the reporting entity should include amounts associated with Part D reinsurance in revenues and claims, while noting in the preamble that "Part D reinsurance is more appropriately classified as a cost-based reimbursement methodology."

We are not taking a position on whether it is appropriate to include Part D reinsurance as revenues and claims in the MLR calculation. We do note that the inclusion of reinsurance systematically will increase the MLR values reported under Part D contracts, relative to the values that one would derive from

existing published financial statements in which reinsurance amounts do not appear. We also note that to the extent plans offering Part D coverage incur medical management and other administrative expenses associated with the processing of claims for which the reinsurance ultimately applies, then the proposed inclusion of Part D reinsurance as revenues and claims in the MLR calculation may better reflect the administrative cost structure of such plans.

However, given that Part D reinsurance amounts were included in the MLR calculation, we did not expect to see that similar amounts arising from Part D low-income cost sharing (LICS) and/or the Part D coverage gap program were excluded. Statutory accounting, under paragraph 4.a of INT 05-05, notes that the reinsurance and LICS are comparable and treats them similarly. (Note that INT 05-05 does not address the coverage gap program, as it did not yet exist when INT 05-05 was adopted.) As such, it would be helpful for CMS to explain why it has chosen to treat reinsurance differently for MLR purposes from how it treats LICS and/or the coverage gap.

Finally, we note that in the event CMS were to change its position and exclude Part D reinsurance from the MLR calculation—or, alternatively, include Part D LICS and/or the Part D coverage gap program in the calculation—presumably it would need to re-do the actuarial study forming the basis for the Table 1B credibility adjustment. The definition of revenues and claims in the study underlying the credibility adjustment needs to be consistent with the definition of revenues and claims used in the MLR calculation.

100 Percent Indemnity Reinsurance

Sections 423.2420(b)(1)(iv) and 423.2420(c)(4) of the proposed rule indicate that, in a situation in which one entity writes an MA or Part D contract and then uses indemnity reinsurance to cede 100 percent of the risk under that contract to another entity, the assuming entity should report all of the revenues and claims for that contract in its MLR reporting while the ceding entity should report none.

This proposed treatment deviates from the commercial MLR regulation. Under 45 CFR Section 158.130(a)(3), the only instance in which the premiums and claims associated with a 100 percent indemnity reinsurance treaty are reported by the assuming entity instead of by the ceding entity is when the reinsurance treaty was in force prior to the date of enactment of the Affordable Care Act, and in situations in which the assuming entity is also completely responsible for performing administrative functions.

For commercial insurance, our understanding is that the reason for this restriction was a concern that if 100 percent indemnity reinsurance contracts were always reported by the assuming entity, then health insurance issuers might be able to reduce their total customer rebate liabilities by entering into new 100 percent indemnity reinsurance treaties for purposes of changing the MLR of the business reported in a particular MLR cell (typically, a state/market combination). For Medicare, it appears that this concern is not salient, in light of the decision made in the proposed rule to calculate MLR requirements at the contract level. An entity cannot alter its MLR under one contract by agreeing to assume 100 percent of the risk written under another contract.

As such, liberalizing the treatment of 100 percent indemnity reinsurance policies in the Medicare MLR regulation, relative to the treatment in the commercial regulation, may not be inappropriate. Nonetheless, it would be helpful for CMS to explain the deviation from the commercial treatment. We also note that, were CMS to revise its regulation in such a way that MLR requirements applied at a less granular level than the contract, it also should consider revising its treatment of 100 percent indemnity reinsurance contracts.

Finally, we note that the proposed Section 423.2420(c)(4) contains some obvious typographical errors that will need to be corrected (i.e., references to incurred claims should be replaced with references to revenues).

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Thank you for this opportunity to provide input. If you have any questions or would like to discuss these comments in more detail, please contact Heather Jerbi, the Academy's assistant director of public policy, at 202.785.7869 or Jerbi@actuary.org.

Sincerely,

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