April 25, 2011

Submitted via www.regulations.gov

Office of Strategic Operations and Regulatory Affairs
Center for Medicare and Medicaid Services
Attention: Document ID No./OMB Control Number CMS-10373
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Request for Comments Regarding the Quarterly MLR Reporting Form for Expatriate and Limited Benefit Plans

Dear Sir or Madam:

Aetna welcomes the opportunity to respond to the Department of Health and Human Services' ("HHS's" or the "Department's") Request for Comments Regarding the Quarterly Reporting Form for Medical Loss Ratios ("MLRs") of Expatriate and Limited Benefit Plans (76 Fed. Reg. 16789 (March 25, 2011), issued pursuant to § 2718 of the Patient Protection and Affordable Care Act (the "ACA" or the "Act"), and the Department's Interim Final Rule ("IFR") governing the reporting and calculation of MLR (75 Fed. Reg. 74864 (December 1, 2010)).

Aetna is one of the nation's leading diversified health care benefits companies, providing members with information and resources to help them make better informed decisions about their health care. Aetna is committed to working with HHS in developing standards relating to the reporting of MLR for expatriate and limited benefit plans that will avoid unintended consequences for insurers, consumers, and employers. Accordingly, we submit the comments below for HHS's consideration.

1. Expatriate and Limited Benefit Plan Coverage Should Be Reported On a National Basis

As currently drafted, the quarterly reporting form requires that insurers report the MLR experience of their expatriate and limited benefit plan coverage on a state-by-state basis. We respectfully submit, however, that this state-by-state reporting system for such coverage is inappropriate.

With respect to expatriate coverage, the individuals covered by such policies do not reside in the United States (let alone any particular state), and expatriate coverage has a number of unique characteristics that do not lend themselves to state-by-state reporting. Indeed, the IFR itself provides that "[f]or the 2011 reporting year, an issuer of [expatriate coverage] must *aggregate* the experience for these policies but report the experience from such policies separately from other policies." 45 CFR § 158.120(d)(4) (emphasis added). Accordingly, we recommend that HHS modify the quarterly reporting form to permit national aggregation of expatriate coverage.

By definition, expatriates are not residents of any state, so the concept of a state-based MLR has no relevance for expatriate coverage. *See* 45 CFR 158.120(d)(4) (describing expatriate plans as those covering "employees working *outside* their country of citizenship, employees working *outside* of their country of citizenship and *outside* the employer's country of domicile, and non-U.S. citizens working in their home country[.]" (Emphasis added). In the IFR, the Department recognized that expatriate plans have unique features that are not comparable to any domestic plans, which makes an annual MLR assessment subject to large fluctuation. *See* 75 Fed. Reg. at 74871. Among other things, expatriate plans have substantially higher administrative costs than domestic plans, given that insurers offering such plans must provide customer support 24 hours a day, year round, and must engage in an exceedingly complex claims administration process involving non-standardized claims submission systems and multiple currencies and languages.

Additionally, insurers offering expatriate plans must hire employees who can speak multiple languages, and must establish a global network of contracted, qualified foreign health care providers, while maintaining online databases that allow members to understand, access, and navigate health care services in countries all over the world. Moreover, expatriate plans must provide highly specialized (and costly) benefits such as emergency evacuation services, to ensure that their members have access to quality health care wherever they may be assigned in the world. *See* 75 Fed. Reg. at 74871 (detailing what HHS recognized as the "special circumstances" of expatriate plans that require an MLR adjustment).

Further, the claims experience of expatriate plans is likely to vary significantly based on the locations in which participants are living, which makes the concept of a state-based MLR reporting system all the more inappropriate. Indeed, the claims experience of expatriate plans tends to be significantly more volatile than the experience of similarly-sized groups resident in the United States. For example, a single large claim, such as the evacuation of a critically-ill worker in a remote location, can make a meaningful difference in the experience of an expatriate group in a year. And given that many expatriate plans are also relatively small, there are additional difficulties with respect to the pricing of a predictable annual MLR, which further makes the concept of a state-based MLR reporting system inappropriate for expatriate plans.

Applying a state-based MLR reporting system on expatriate plans imposes a significant burden on insurers that provide such coverage, which could penalize expatriate employees in the form of reduced support services. Further, the global aspect of expatriate plans means that U.S. insurers are competing with foreign-based insurers to provide such coverage. The application of a state-based MLR reporting system to expatriate coverage would subject U.S. insurers to significant administrative burdens that would not be imposed on foreign insurers, who are exempt from the ACA's MLR requirements entirely (*see* 75 Fed. Reg. at 74871), placing American insurers at a further disadvantage to foreign insurers.

With respect to limited benefit plans, a state-by-state MLR reporting system is also inappropriate. The Department has recognized that the cost of administering benefits for a limited benefit plan is far greater, as a percentage of premium collected, than is the case for an insurer that is administering a more robust health plan. *See* 75 Fed. Reg. at 74872. And limited benefit plans often serve small employers that employ individuals with higher employee turnover rates. *Id.* Insurers offering limited benefit plan coverage

could have just a few group customers in a given state that comprise a relatively small number of covered lives, and the credibility adjustment in the MLR regulation is generally insufficient to address this issue. Similarly, because the number of covered lives in a particular state may be so small, and subject to such high turnover, claims experience and loss ratios for limited benefit plans could be subject to wide swings from year to year. Further, the IFR's requirement that limited benefit plan insurers disaggregate their expenses on a state-by-state basis is administratively complex and expensive, and will require these insurers to spend significant amounts on systems changes, which will have to be passed onto group customers, which are generally small businesses that are least able to absorb such cost increases.

Recommendation: Given the unique characteristics of expatriate and limited benefit plan coverage, we recommend that the Department modify the quarterly reporting form to permit an insurer to report the MLR experience of its expatriate and limited benefit coverage on a national basis.

2. Information Reported on the Quarterly Form Should Be Exempt from FOIA Disclosure

We appreciate the Department's statement that it "does not intend to publish the quarterly reports on HHS' website or otherwise." *See* HHS Supporting Statement for Emergency PRA – Quarterly Reporting for Mini-Med Plans and Expatriate Plans," at p. 3 (March 25, 2011). Indeed, much of the information detailed on the draft quarterly reporting form is highly sensitive commercial and financial information that is treated as proprietary and confidential by insurers, such as premium earnings, direct premiums written, salary and benefit expenses, and underwriting gains and losses. Additionally, given that the form requires data to be reported state-by-state on a legal entity basis – and further broken down by individual, small group, and large group coverage – there will be circumstances in which only one customer's data will be reported on the form, thereby exposing sensitive commercial and financial information about that customer to HHS.

As such, public disclosure of the data reported by an insurer on the quarterly reporting form could cause significant harm to the insurer, and could potentially have anti-competitive effects if such information is available to other insurers.

Recommendation: HHS should clarify that the data reported by an insurer on the quarterly reporting form will be treated as exempt from disclosure under the Freedom of Information Act ("FOIA"), pursuant to FOIA Exemption No. 4 (5 U.S.C. § 552(b)(4)), which permits a federal agency to refuse disclosure of information that constitutes "trade secrets and commercial or financial information obtained from a person [that is] privileged or confidential." Additionally, the form should have a place on which an insurer may designate the reported data as being "Confidential Commercial and Financial Information Exempt From FOIA Dislosure."

Alternatively, consistent with Executive Order No. 12600, we recommend that HHS provide insurers with copies of any FOIA requests that cover the insurers' respective quaterly reports, and afford the insurer at least five business days to advise HHS as to any specific data that the insurer believes is exempt from FOIA disclosure.

3. The Form Should Be Available In Excel Format, and Modified In Several Respects

HHS has stated that insurers will be required to submit the quarterly reporting form electronically, but to date, only a pdf version of the form is available. Electronic submission would be greatly facilitated if HHS made the final version of the form available as an Excel spreadsheet.

Additionally, HHS should designate an email address (or other web-based filing address) to which the form is to be sent or uploaded. We also recommend that HHS modify the form in several respects, as described below.

Recommendation: HHS should:

a. Make the quarterly reporting form available in Excel format;

b. Publish an email (or other) address to which the form will be sent for filing/uploading;

c. Modify the form to allow insurers to designate a contact person that HHS may contact with any questions about data reported on the filing; and

d. Modify the form to allow insurers to identify the reported data as "Confidential Commercial or Financial Information Exempt From FOIA Disclosure."

4. Data Reported On the Form Should be Modified For Consistency with Financial Statement Reporting and the April 1, 2011 Health Care Supplemental Exhibits

The quarterly reporting form seeks detailed financial information and other indicators for an insurer's limited benefit and expatriate plans, but as currently drafted the form is, in several critical respects, inconsistent with financial statement reporting and the Health Care Supplemental Exhibits that were filed on April 1, 2011 with the National Association of Insurance Commissioners (the "NAIC") by Aetna and other insurers. These inconsistencies could have a material impact on the MLR experience reported for expatriate and limited benefit plans.

For example, Part I of the Form requires insurers to report their *tax* on net investment income and capital gains, without reporting the insurer's actual net investment income and capital gains, which is inconsistent with the April 1st Health Care Supplemental Exhibits and standard financial statement reporting. And Part II of the form omits reporting of critical data about incurred claims, direct claim reserves, and healthcare receivables that could potentially cause an overstatement of the insurer's claims expenses for the quarter. In calculating the incurred claims amounts, the form only collects data regarding claims liability, direct claim reserves, and healthcare receivables for the quarter at issue, *without* gathering data as to the insurer's prior year-end balance in such categories, from which changes to such categories may be measured. Similarly, the form's instruction that insurers exclude pharmacy rebates means that that insurers will be reporting their healthcare receivables without taking into account the income-

side, which will result in an understatement of the insurer's rebates. Additionally, claims based assessments are excluded from the quarterly report.

The proposed form's inconsistencies with existing financial reporting standards not only raises the possibility of quarterly reports that could inaccurately reflect the insurer's MLR experience for expatriate and limited benefit plans, but it also imposes very significant financial and administrative burdens on insurers. Specifically, given that the form seeks non-standardized data concerning a significant number of issues, insurers must engage in a manual process to populate the form's data fields. This manual process is laborious and time-consuming. In fact, Aetna has already expended in excess of $100,000 in staff hours just to initiate preparations for the first quarterly MLR report – which is far in excess of the Department's estimate that it would cost only $3,100 for an insurer to prepare a quarterly filing. Such a significant expense is due in part to the form's request for non-standardized data elements, and we note that such expenses are unlikely to decrease as filings continue, if HHS continues to require such non-standardized data on the quarterly reporting form.

Recommendation: We recommend that HHS modify the form as follows:

a. Part I, Line 6.6 ("Other Federal Taxes"): **Add** [new Line 6.5] to report "*Income from net investment income and capital gains*;"

b. Part II, Line 2.2: **Add** [new Line 2.3] to report "*Direct claims liability, as of end of prior year*." **Add** [new Line 2.4] to report "*Change in direct claims liability (Lines 2.4 - 2.3)*;"

c. Part II, (current) Line 2.3: **Re-designate** current Line 2.3 as "Line 2.5." **Add** [new Line 2.6] to report "*Direct claim reserves, as of end of prior year*." **Add** [new Line 2.7] to report "*Change in direct claim reserves (Lines 2.7 - 2.6)*;"

d. Part II, Line 2.8: **Add** [new Line 2.9] to report "*Healthcare receivables as of end of prior year*." **Add** [new line 2.10] to report "*Change in healthcare receivables (Lines 2.9 – 2.8)*;"

e. Modify the instructions to Part II, to ***include*** pharmacy rebates and claims-based assessments.

5. HHS Should Issue Guidance Regarding the 2012 MLR Treatment of Expatriate and Limited Benefit Plans By No Later Than August 1, 2011 and Extend the Current MLR Treatment of Expatriate and Limited Benefit Plans

The current MLR treatment of expatriate and limited benefit plans is applicable for 2011 only. To ensure employers that such coverage will be available in 2012 and to allow for the effective management of coverage renewals, we respectfully request that HHS issue guidance in the near future detailing the MLR treatment that will apply to expatriate and limited benefit plans in 2012, and we urge that such guidance be issued by August 1, 2011.

Additionally, we recommend that HHS extend the IFR's MLR calculation method permanently for expatriate plans and for limited benefit plans through 2014, given that

such plans will continue to bear the same proportionately higher administrative costs beyond as they did in 2010-2011.

Approximately 1.4 million workers nationwide have group healthcare coverage under limited benefit plans that cover accident- and sickness- related medical expenses. The individuals covered by these plans typically work for employers on a part-time, seasonal, or temporary basis and are ineligible for coverage under the employer's regular group health plan, or are in an eligibility waiting period for an employer's regular health plan. HHS has recognized that in the absence of the annual limits waiver program that it established and the MLR adjustment that it provided for 2011, these individuals would be at significant risk of losing coverage entirely. *See* 75 Fed. Reg. at 74872 (in which HHS expressed its concern that over one million people could lose coverage without appropriate regulatory relief from HHS). Importantly, these workers would not be eligible for guaranteed issue coverage in the individual market, or federal subsidies available through Exchanges, until 2014. Similarly, in the absence of the MLR adjustment that HHS provided to expatriate plans, many insurers would have been forced to discontinue expatriate coverage.

Aetna appreciates that HHS recognized the special circumstances of limited benefit and expatriate plans, and provided an MLR adjustment for 2011. We note, however, that such relief was not announced until late 2010 – well after employers began their renewal discussions with insurers – and some employers were concerned that in the absence of appropriate MLR relief, insurers would not be able to offer these products in 2011, and therefore terminated coverage. To provide certainty to employers and workers as to the continued availability of limited benefit and expatriate coverage, it is critical that HHS announce the MLR treatment of such coverage for 2012 in time for employers and insurers to effectively manage their renewal discussions, without the risk that employers may terminate coverage altogether due to uncertainty as to the availability of such coverage.

Recommendation: We urge the Department to announce the MLR treatment of limited benefit and expatriate plans for 2012 by August 1, 2011.

We further recommend that HHS extend the current MLR calculation method for expatriate plans permanently and for limited benefit plans until 2014. With such an extension – and the certainty it brings – employers will be able to plan and make reasonable benefit decisions during the bridge to 2014, when state exchanges will provide access to benefits for the population currently covered by limited benefit plans. Employers will be less likely to discontinue coverage if there is greater certainty that these plans will be allowed to continue during this span of time. Without such an extension, employers may use the 2011 plan year to transition employees off of any employer-sponsored group limited benefit medical coverage. An early extension will also be helpful to insurers, given that insurers generally need notice of any change to the MLR calculation at least 12 months prior to the start of any calendar year of coverage to appropriately price the cost of plan coverage, and to determine whether the insurer will offer renewal quotes to employers seeking to renew such coverage.

6. HHS Should Extend the First Filing Date For the Quarterly Reporting Form

HHS has requested "emergency clearance" from the Office of Management and Budget ("OMB") for the proposed quarterly form, asking OMB to approve the form by May 1,

2011 – the *same* day that insurers would be required to file their quarterly report with HHS. *See* 76 Fed. Reg. at 16789. The request for OMB clearance provides that the public comment period on the form will close April 25, 2011 – just five days before the requested clearance date and the date by which insurers would be required to file the form.

Aetna and other insurers have only just completed their review of the proposed form and submitted recommendations for changes to the form. Requiring insurers to complete the form for the first time in less than one day after its clearance by OMB is simply not possible, especially if HHS changes the form in response to public comments (as we hope it does). This is especially so given that (as discussed above) gathering and analyzing the non-standardized data necessary to complete the proposed form and verify its accuracy will consume significant administrative resources – which cannot be provided in just one day – assuming OMB approves the form on May 1st, as HHS proposes.

Recommendation: We recommend that HHS allow insurers until July 1, 2011 to submit the first quarterly reporting form. We note, however, that this delayed filing date should *not* delay HHS's announcement of the 2012 MLR treatment of expatriate and limited benefit plans, given that HHS will still have at least 30 days to review the data reported by insurers.

HHS has ample authority to issue Technical Guidance (or another form of sub-regulatory guidance) adopting a non-enforcement policy whereby the quarterly MLR reporting requirement for expatriate and limited benefit plans under 45 CFR §158.110(b)(2) will not be enforced until July 1, 2011. Such guidance would be consistent with HHS's clear regulatory authority, as well as its prior practice with respect to ACA requirements.

Specifically, HHS has inherent discretionary authority to determine its enforcement priorities, and it is settled law that "[a]n agency's decision not to prosecute or enforce . . . is a decision generally committed to an agency's absolute discretion." *Heckler v. Chaney*, 470 U.S. 821, 831 (1985). Accordingly, an agency's adoption of a non-enforcement policy is presumptively exempt from judicial review under § 702 of the Administrative Procedures Act ("APA"). *Id.* ("An agency's decision not to take enforcement action should be presumed immune from judicial review under [APA] § 701(a)(2)"). For this reason, HHS's adoption of a temporary non-enforcement policy with respect to quarterly MLR reporting for expatriate and limited benefit plan coverage (which would last only until August 2011) should be presumptively immune from challenge. *Heckler*, 470 U.S. at 831.

Indeed, HHS, along with the Department of Labor ("DOL") and the Internal Revenue Service ("IRS"), have already exercised this type of authority in adopting a number of non-enforcement policies in connection with the ACA. *See* DOL Technical Release 2011-01 (March 18, 2011) (in which DOL, HHS, and IRS jointly extended (and in certain respects, expanded) DOL Technical Release 2010-02, which adopted a non-enforcement policy for policies and plans with respect to numerous aspects of the claims and appeals IFR; IRS Notice 2011-1 (stating that compliance with ACA § 2716's non-discrimination provisions with respect to highly compensated employees "should *not* be required (and thus, any sanctions for failure to comply do *not* apply) until after regulations or other administrative guidance of general applicability has been issued under § 2716") (emphasis added); HHS Interim Procedure for Internal Claims and

Appeals Under the ACA (September 20, 2010) (adopting non-enforcement policy for health insurance issuers with respect to the claims and appeals IFR); IRS Notice 2010-69 (October 12, 2010) (providing that "an employer will not be treated as failing to meet the requirements of [the ACA's amendments to the Internal Revenue Code] for 2011, and will not be subject to any penalties for failing to meet such requirements, merely because it does not report the aggregate cost of employer-sponsored coverage . . . on Forms W-2 issued in 2011;" Frequently Asked Questions About the Affordable Care Implementation, Part I (September 20, 2010), FAQ-1 (announcing the intention of HHS, DOL, and the IRS to adopt transition provisions, grace periods, and safe harbors to achieve compliance, rather than the assessment of penalties); IFR Relating to Status as a Grandfathered Plan, 75 Fed. Reg. 34538, 34539-40 (June 17, 2010) (noting that HHS will not enforce the ACA's requirements with respect to insured retiree-only plans or non-federal governmental retiree-only plans).

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Aetna is pleased to have the opportunity to provide comments regarding the MLR regulation. Thank you for considering our comments. Should you have any questions, please feel free to contact me.

Sincerely,

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