Responses to Comments Received
Federal Register Notice on Revised CMS-10418

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Introduction

CMS received 27 public comments regarding the Medical Loss Ratio (MLR) PRA package published in the Federal Register on December 16, 2012 (76 FR 78265), and amended on February 16, 2012 (77 FR 9931). The original comment period closed on February 14, 2012, but on February 16 was reopened until March 2, 2012 to accommodate comments on amendments to the PRA package.

The PRA package contained two different collections of information: the MLR Annual Reporting Form that issuers must file with CMS each year on June 1, beginning June 1, 2012; and Notices of rebates that issuers must send to subscribers and policyholders each year no later than August 1, beginning August 1, 2012. In addition, the PRA package contained a sample notice and instructions for what a notice might contain if CMS were to issue a rule requiring notice of MLR information when an issuer meets or exceeds the MLR standard.

The comments CMS received regarding the MLR Annual Reporting Form and Instructions are summarized immediately below. Following that is a summary of the comments CMS received regarding the MLR Notices to consumers. Most of the comments addressed multiple issues within the MLR Annual Reporting Form and Instructions, or within the Notices to consumers and Instructions. The summary below sets forth the comment regarding each issue addressed, rather than summarizing each public comment in total.

Comments and Responses Regarding the MLR Annual Reporting Form

Comment 1

CMS received numerous comments pertaining to technical formula errors, typographical errors, minor inconsistencies, and improper cell references in the MLR Form (an Excel spreadsheet) and in the accompanying Instructions.

Response 1

Corrections related to such comments do not change the data nor the substance of what is being reported, but will make it easier for health insurance issuers to complete the MLR Form. Due to the abundance and nature of these comments, CMS will not provide an individual response to each of these comments. However, CMS did accept most of these comments and made the appropriate changes to the MLR Form.

Comment 2

Several issuers suggest clarification regarding the years for which the Instructions are applicable.

Response 2

The Instructions are being revised to indicate that they apply only to an issuer's 2011 MLR experience. Instructions for 2012 and beyond will be issued at a later date.

Comment 3

Commenters support allowing issuers to allocate administrative costs on a pro-rata basis to affiliated entities. However, the commenters assert that the instruction is unclear.

Response 3

The instruction is being revised to clarify that an entity may allocate administrative costs to only those affiliated entities that benefit from the allocated expenses.

Comment 4

Regarding MLR experience in States that have been granted an adjustment to the MLR standard in the individual market, commenters request clarification for how MLR experience will be calculated for reporting years beyond 2011 when an issuer's MLR experience will be based on a multi-year average. Specifically, commenters request that that a weighted average used for those years.

Response 4

The Instructions are being revised to clarify that the Instructions apply only to the reporting of 2011 MLR experience. Guidance on this comment is required only for future MLR reporting years. Instructions for 2012 and beyond will be issued at a later date.

Comment 5

On Part 1 of the MLR Form, commenters propose eliminating reporting the experience not subject to the MLR standard. This experience is captured in columns 32-35: Government Programs Plans, Other Health Business, Aggregate 2% Rule, and Uninsured Plans.

Response 5

A change is not required. This data is required to validate the issuer's submission. This submission is consistent with the National Association of Insurance Commissioners (NAIC) Supplemental HealthCare Exhibit (SHCE), which the NAIC developed in conjunction with its model MLR recommendations to the Secretary, pursuant to section 2718 of the Public Health Service Act (PHS Act).

Comment 6

A commenter suggests that an issuer be allowed to make an adjustment to premium to reflect retroactive adjustments made after December 31 of the MLR reporting year.

Response 6

A change is not required. Any adjustments to premium will be captured in the subsequent MLR reporting year, as reported in Part 2 Line 1.9 (Premium Balances Written Off). This method is consistent with the SHCE.

Comment 7

A commenter suggests that with respect to "employer business issued through an association," the instruction pertaining to the determination of the appropriate market is potentially inconsistent with guidance that is contained in the September 1, 2011, CMS Insurance Standards Bulletin. The commenter states that while the Bulletin provides for specific treatment of "business issued through an association," where the association itself is deemed to be employer, the instruction is silent on this issue.

Response 7

The instruction is consistent with the September 1 Bulletin. The September 1 CMS Bulletin provides guidance to issuers regarding how to properly report the experience from policies issued through an association, even in the rare instance where the association of employers is sponsoring the group health plan and the association itself is deemed the employer. The Bulletin states:

CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules. In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the "employer," the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules.

Comment 8

A commenter notes that page 2 of the Instructions does not elaborate on how the minimum three-year reporting of "dual contract group health coverage" would operate beyond 2011. Specifically, the commenter suggests that CMS clarify that the "three year reporting requirement" is not a requirement that permanently locks the issuer into this method.

Response 8

The Instructions are being revised to clarify that the "three year reporting requirement" begins with the year the issuer adopts the method. The "three year reporting requirement" is not permanent and may be discontinued upon completion of three consecutive years of reporting.

Comment 9

Regarding the aggregation of business through a multiple employer welfare arrangement (MEWA), a commenter states that the instruction (page 3) is inconsistent with guidance contained in the September 1, 2011, CMS Insurance Standards Bulletin. The commenter states that while the instruction treats MEWA business differently from association business, the bulletin treats MEWAs as associations.

Response 9

The MLR regulation, at 45 CFR §158.120, does not address reporting for group associations other than a "multiple employer welfare arrangement" (MEWA). The MLR regulation permits issuers to report MEWA experience either where the MEWA has its principal place of business or where each member employer is located. The September 1, 2011 CMS Insurance Bulletin states that private group health plan coverage, including group health coverage provided through MEWAs, is subject to the Employee Retirement Income Security Act (ERISA). Therefore, if a group association meets ERISA's MEWA requirements, then issuers should file as indicated in the regulation. But, if a group association is not a MEWA pursuant to ERISA, then each employer should be issued a policy and the September 1, 2011 CMS Insurance Bulletin directs issuers to look beyond the association to determine the size of each employer. CCIIO expects issuers to file MLR reports for each State and market where each employer-member of the association is located.

Comment 10

A commenter notes that the method used for calculating average family deductibles contained in the MLR Interim Final Rule (IFR) at section 158.232(c) is actuarially flawed.

Response 10

The Instructions are being revised to clarify the methodology to be used in the calculation of the average family deductible. The average deductible for a policy that covers a subscriber and the subscriber's dependents shall be the lesser of the deductible applicable to each of the individual family members or the overall family deductible for the subscriber and subscriber's family divided by two (regardless of the total number of individuals covered through the subscriber).

Comment 11

Regarding the instructions for Line 2.15 (Blended Rate Adjustment), a commenter suggests that CMS clarify that the blended rates for multi-option coverage should be aggregated for all dual-choice groups together rather than performed on a group-by-group basis.

Response 11

The instruction for Line 2.15 is being revised to state that "affiliated issuers that choose to make such an adjustment must do so for all policies with blended rates in the applicable market." This method is consistent with 45 CFR § 158.140(b)(5)(i) and with the SHCE.

Comment 12

Regarding page 4 of the Instructions (Business as of 12/31 of Current MLR Reporting Year), a commenter suggests that CMS clarify whether the experience that is to be reported in the 12/31 column should include experience for the current MLR reporting year regardless of incurred date, or whether it should include experience with incurral dates only within the MLR reporting year.

Response 12

The Instructions are being revised to indicate that the information to be reported in the 12/31 columns should represent issuer experience for each of the relevant markets for the MLR reporting year regardless of incurred date as reported to the department of insurance in the issuer's State of domicile or as filed on the SHCE.

Comment 13

Regarding page 4 of the Instructions (Business as of 3/31 of Subsequent MLR Reporting Year), a commenter suggested that CMS clarify whether the paragraph that references "actuarial elements" applies only to subsequent claims activity or whether it also applies to premium fields.

Response 13

The instruction for this item is being revised to reference "actuarial elements related to claims."

Comment 14

Regarding page 18 of the Instructions (Claims Paid Line 2.1), two commenters suggest that CMS indicate which expenses should be added or subtracted from claims paid.

Response 14

The instruction for this item is being clarified.

Comment 15

Regarding page 18 of the Instructions, a commenter suggests that CMS revise the instruction for "Claims Paid Line 2.1" to indicate that incentive and bonus payments to providers should only be included in Line 2.11. As published, the instructions for both lines 2.1 and 2.11 allow incentives and bonuses payments to be included.

Response 15

The instruction for this item is being revised to reflect that incentive and bonus payments to providers should only be included in Line 2.11.

Comment 16

Regarding page 18 of the Instructions (Claims Paid Line 2.1), a commenter requests that CMS remove "ex gratia" payments from the list of items excluded from claims paid.

Response 16

To remain consistent with 45 CFR § 158.140, the instruction for Line 2.1 is being revised to remove the reference to "ex-gratia" payments.

Comment 17

Regarding the first paragraph of page 19 of the Instructions, a commenter requests that CMS clarify whether "payments to and from unsubsidized State programs designed to address the distribution of health risks across issuers via charges to low risk issuers that are distributed to high risk issuers" must be included in or deducted from incurred claims.

Response 17

We have used the term "adjustments that must be either included in or deducted from" because payments to such State programs would be included in incurred claims and payments from such State programs would be deducted from incurred claims. We have clarified this instruction to make this clear.

Comment 18

Regarding page 19 of the Instructions, several commenters suggest that CMS clarify whether premium deductions for community benefit expenditures (CBE) are limited to not-for-profit health issuers for the 2011 MLR reporting year. The instruction for Line 3.2c indicates that the deduction of CBE from premium is limited to not-for-profit health issuers for the 2011 MLR Reporting year.

Response 18

The MLR Interim Final Rule (IFR), published December 1, 2010, applies to an issuer's 2011 MLR experience and allows only not-for-profit health issuers to deduct community benefit expenditures from premium. The provision in the MLR Final Rule (FR), published December 7, 2011, which allows all issuers to deduct either State premium taxes or community benefit expenditures from premium, applies to an issuer's 2012 MLR experience and beyond. The Instructions are being revised to clarify that the Instructions apply only to the reporting of 2011 MLR experience. Instructions for 2012 and beyond will be issued at a later date.

Comment 19

Several commenters note that the Instructions use the terms "comprehensive major medical" and "comprehensive health coverage" interchangeably. The commenters suggest that CMS clarify its intent as these terms might have different meanings in different contexts.

Response 19

The Instructions are being revised to replace "comprehensive major medical" and "comprehensive health coverage" with the term "health insurance coverage." The term "health insurance coverage" is the term used in the Public Health Service (PHS) Act and means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. The definition includes any insurance product, such as drug, chiropractic, or mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, unless specifically identified as "excepted benefits" by section 2791 of the PHS Act.

Comment 20

Regarding page 20 of the Instructions (Direct Contract Reserve Line 2.6), several commenters oppose limiting contract reserves to only age-related prefunding expenses. They suggest that doing so is contrary to industry practice and the NAIC intention.

Response 20

The instructions are being revised to delete this limitation if an issuer's contract reserves were not limited in this way prior to 2011.

Comment 21

Regarding page 4 of the Instructions (Deferred Newer Business), a commenter notes that the amounts reported here would not be the exact amount as those of the prior reporting year, due to the allowed claims run-out of the policies to the current year's 3/31 reporting timeframe.

Response 21

A change is not required. Guidance on this comment is only required for future MLR reporting years beyond 2011. Instructions for the 2012 MLR reporting year and beyond will be issued at a later date.

Comment 22

Several commenters request that Line 2.13 (Contingent Benefit and Lawsuit Reserves) be removed from Part 2 of the MLR Form. The commenters suggest that publication of litigation reserves could provide litigants an undue advantage by providing them the amounts an issuer is setting aside for potential settlements.

Response 22

No policy change is required. Line 2.13 includes reserves for both the policy claims portion of the lawsuit in addition to reserves of the policy claims for contingent benefits. In addition, Line 2.13 does not include reserves for other expenses related to lawsuits such as legal fees and damages other than claims. Therefore, we think that it is unlikely that a litigant could ascertain from Line 2.13 the amount set aside for a potential settlement. The instruction for this item is being revised to clarify the that issuers should include only the claims-related portion of reserves for both contingent benefits and lawsuits and that issuers should exclude all reserves related to other costs associated with lawsuits such as legal fees, court costs, pain and suffering damages, and punitive damages, etc.

Comment 23

Regarding Part 2, Line 2.9 (Reserve for Experience Rating Refunds), a commenter suggests that the amounts should be automatically calculated based on data that is entered in other MLR Form cells.

Response 23

A change to the MLR Form is not required. Auto-populating this information increases the potential for data validation issues due to different issuer methodologies in calculating this amount. Therefore, manual entry of this field is required.

Comment 24

Regarding the Instructions for Line 2.10 (Part 2 Reserve for Experience Rating Refunds - Prior Year), a commenter suggests that CMS clarify that this information is applicable only to "staff model HMOs."

Response 24

The instruction for Line 2.10, Part 2, is being revised to indicate that it is applicable to only staff model HMOs.

Comment 25

Regarding the Instructions for Line 2.8, Part 2 (Experience Rating Refunds Paid), one commenter suggests that CMS clarify that this amount should include State refunds.

Response 25

To remain consistent with the MLR regulations, the instruction for Line 2.8, Part 2, is being revised to indicate that this amount should include State refunds.

Comment 26

A commenter notes that regarding the Federal Employee Health Benefits Program (FEHBP), a reserve is held each year for prior year settlements related to audits of the premium calculation. The commenter requests that CMS clarify how an issuer would report revenue related to these reserves.

Response 26

A change is not required. The Instructions permit MLR calculations to include only the reserves described in the MLR regulation.

Comment 27

One commenter requests that CMS extend the MLR Annual Report filing deadline for the 2011 reporting year and communicate the method by which issuers are to file the report for the 2011 reporting year by March 1, 2012.

Response 27

A change is not required. The MLR regulations provide that the deadline for the MLR Form to be filed is June 1 of the year following the MLR reporting year.

Comment 28

Regarding page 3 of the Instructions, two commenters suggest that CMS allow issuers to use individual State rules to determine how to report the experience related to sole proprietors. The commenters state that because some States require health plans to cover sole proprietors in their small group business, it would be administratively burdensome to require the experience for sole proprietors to be removed from the small group experience for MLR purposes.

Response 28

A change is not required. PHS Act §2791 defines the "individual market," the "large group market," and the "small group market" and it applies these definitions to the MLR regulations. To be considered a group health plan, the health plan must have "employees" among its participants. For the purpose of determining whether a group health plan exists, federal law does not classify an individual and his or her spouse as employees when the trade or business is wholly owned by the individual or by the individual and his or her spouse. Thus, where a sole proprietor and/or a spouse-employee are the only enrolled employees, the health plan would not be considered to be a group health plan. Its experience would be aggregated with the issuer's individual market experience and not with the issuer's small group market experience. However, if a sole proprietor enrolls a non-spouse employee, the experience of that plan may be considered part of the small group market for MLR purposes. Even if the only enrollee is one employee who is not an owner or spouse, the plan could still be considered part of the small group market for MLR purposes.

Comment 29

Several issuers suggest that CMS allow ICD-10 conversion costs to be included as an expense related to activities that improve health care quality. The commenters also request that Instructions leave latitude for issuers to report ICD-10 expenses for years other than 2012 and 2013.

Response 29

The MLR regulation applicable to an issuer's 2011 MLR experience does not allow ICD-10 conversion costs to be included as an expense related to activities that improve health care quality. The MLR Final Rule (FR), published December 7, 2011, provides that for the 2012 and 2013 MLR reporting years, an issuer may include ICD-10 conversion costs as an expense related to the improvement of health care quality. The Instructions are being revised to clarify that the Instructions apply only to the reporting of 2011 MLR experience. Instructions for 2012 and beyond will be issued at a later date.

Comment 30

One commenter requests that CMS clarify that issuers providing only HIPAA-excepted benefits are not required to report their MLR experience.

Response 30

The Instructions are being revised to indicate that the MLR Form is required of all issuers offering "health insurance coverage." All terms used in the Instructions that are not defined have the meaning used in 45 CFR Part 158 and are further defined within PHS Act §2791. The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. The definition includes any insurance product, such as drug, chiropractic, or mental

health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, unless specifically identified as "excepted benefits" by §2791 of the PHS Act.

Comment 31

Several commenters request that CMS revise the MLR Form so that issuers are not required to separately report "mini-med" experience.

Response 31

A change is not required. For the 2011 MLR reporting year, 45 CFR §158.120(d)(3) requires issuers of policies that have a total limit of $250,000 or less to report the experience of such policies separately from that of other policies.

Comment 32

Two commenters note that page 3 of the Instructions states that:

> an issuer must report … only the business issued by the reporting entity. Business that is written by an unaffiliated entity as part of a package provided to the enrollee (e.g., inpatient coverage written by the reporting entity, outpatient coverage written by an unaffiliated separate entity) must not be included in this MLR Form.

The commenters suggests that CMS revise this policy and allow the reporting of the out-of-network portion to be treated as reinsurance assumed that is to be reported by the assuming carrier only.

Response 32

A change is not required. The Instructions conform to 45 CFR §158.120(c), which provides that "where a group health plan involves health insurance coverage obtained from two affiliated issuers, one providing in-network coverage only and another providing out-of-network coverage only … experience may be treated as if it were all related to the contract provided by the in-network issuer." The IFR does not provide that an entity may report the claims expenses of an unaffiliated entity and does not provide that such expenses may be treated as 100% assumed reinsurance (which must be reported by the assuming carrier only).

Comment 33

Regarding page 2 of the Instructions for reporting of reinsurance, a commenter requests CMS to clarify treatment of assumption reinsurance that occurs after 2011.

Response 33

The instructions for reinsurance, page 2, are being revised to state:

Experience under a 100% assumption reinsurance agreement (treated as novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.

Reporting of 100% indemnity reinsurance and administrative agreements is limited to only those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business. Experience under those indemnity reinsurance and administrative agreements must be reported by the assuming issuer and must not be reported by the ceding issuer.

Comment 34

Regarding page 17 of the Instructions, Part 2 Lines 1.12 and 1.13 (Premiums Ceded and Assumed Under 100% Reinsurance), a commenter suggests these lines be removed because this is information related to novated contracts and therefore, the "ceding" company will not have access to this data.

Response 34

A change is not required. Lines 1.12 and 1.13 require issuers to report the amount of business ceded (Line 1.12) and assumed (Line 1.13) under a 100% assumptive agreement with novation and/or under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business. Issuers will have this information as it is required to calculate the value of Line 1.1 (Direct Premiums).

Comment 35

Regarding the Instructions for Part 3, Improving Health Care Quality Expenses (General Definition), several commenters note that the Instructions closely follow 45 CFR §158.150 and organize the allowable and non-allowable Quality Improvement (QI) activities into a list that is easy to understand and use in completing the MLR Form. However, the commenters suggest adding specific instructions to the General Definition instructions for reporting and demonstrating measurable improvements in health care quality.

Response 35

A change is not required. As noted by the commenters, the instructions for this section comport with 45 CFR §158.150 and organize the allowable and non-allowable Quality Improvement (QI) activities into a list format that is easy to understand and use in completing the MLR Form.

Comment 36

Regarding page 25 of the Instructions, two commenters note the cost of any activity that is not approved by the Secretary must be excluded from QI, unless, as indicated in 45 CFR §158.150(b), the costs relate to an activity that improve health outcomes, prevent hospital

readmissions, improve patient safety, promote wellness, or are considered HIT expenses. The commenters suggest that this instruction is inconsistent with CMS guidance issued on May 13, 2011.

Response 36

A change is not required. The Instructions are consistent with CMS guidance issued on May 13, 2011. Referencing 45 CFR §158.150(b)(2), the guidance states:

> in order to be reported as a QIA, the activity must be primarily designed to do one of four things: (i) improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations; (ii) prevent hospital readmission through a comprehensive program for hospital discharge; (iii) improve patient safety, reduce medical errors, and lower infection and mortality rates; or (iv) implement, promote, and increase wellness and health activities. Section 158.150(b)(2) provides a list of examples following each of these four things. Each list of examples is intended to be illustrative and not exhaustive.

So long as a QI activity's costs support the definitions and purposes defined under §158.150(b) or the activity is otherwise approved by the Secretary, it need not be explicitly listed in §158.150(b)(2).

Comment 37

A commenter suggests that the Instructions do not address how to handle rate credit receivables. The commenter states that there is no place to report any type of receivable related to rate credits. As a result, the calculation does not actually arrive at an incurred amount if there are any amounts receivable.

Response 37

The Instructions are being revised to clarify that rate credit receivables should be reflected in the reserves for rate credits.

Comment 38

A commenter suggests that CMS revise its policy and not require an issuer with zero premium in a State, even if it offers health insurance coverage in that State, to complete the MLR Form. The commenter also asserts that Parts 3 through 6 of the MLR Form and reporting of information related to lines of business that are not subject to the MLR standard, such as government programs (Medicare and Medicaid) and self-funded plans, should not be required.

Response 38

A change is not required. The reporting requirements and Parts 3 through 6 of the MLR Form conform to the MLR regulations. Information related to business lines not subject to the MLR standard, such as government programs (Medicare and Medicaid) and self-funded plans, is

required to ensure the reasonableness and validity of the data reported that relates to business lines that are subject to the MLR standard. In addition, this information conforms to the information requested by the NAIC on the 2011 SHCE.

Comment 39

Two commenters suggest that CMS delay until September 15, the reporting of: the number of policyholders and subscribers owed a rebate; the number of policyholders and subscribers whose rebates would be de minimis; the amount of de minimis rebates; the amount of rebates paid via premium credit; and the amount of rebates paid via lump sum reimbursement.

Response 39

No change is required. Section 158.260 of the MLR regulation requires that the information described above must be reported by June 1 of the year following the end of the MLR reporting year.

Comment 40

Regarding the instruction for Part 2, Lines 1.5 through 1.7 (relating to experience rated refunds), one commenter suggests that it would not be administratively possible for all issuers to separate their experience refund reserve and payments by MLR reporting year. The commenter suggests that CMS allow the use of the "paid plus change in reserve" approach during each calendar year. The commenter suggests that this approach would allow for reasonable reporting of the impact of experience refunds, especially because as time passes, the calculation includes experience from multiple years.

Response 40

No change is required. Consistent NAIC recommendations, the MLR regulation provides for claims to be reported using the "paid on incurred" approach, allowing only for a change in contract reserves to be reported.

Comment 41

One commenter requests CMS to clarify if it is CMS' intention that when elements of the MLR Form reference values in the SCHE that such values should be equal?

Response 41

The MLR Form contains references to parts of the SHCE to assist issuers with the completion of the 12/31 columns of the filing. An issuer should rely on the MLR Form Instructions and the MLR regulation for reporting their 2011 MLR experience.

Comment 42

One commenter suggests that CMS clarify the Instructions to indicate that Part 6, Lines 5, 5a, and 5b (unclaimed rebates from prior reporting year) are not required for the 2011 MLR reporting year.

Response 42

Part 6, Lines 5, 5a, and 5b of the Instructions are being revised to indicate that these lines do not apply to the 2011 MLR reporting year because the data references unclaimed rebates from the prior MLR reporting year. However, for an issuer's 2011 MLR experience, there will be no prior MLR reporting year.

Comment 43

A commenter suggests that the Part 5 Lines 1.6 and 1.5 ("mini-med" numerator) incorrectly calculate the numerator for mini-med and expatriate plans. The commenter suggests that for 2012 and 2013, rebates paid by these plans should be added to the numerator after the numerator is multiplied by the mini-med or expatriate adjustment factor.

Response 43

A change is not required. Guidance on this comment is only required for future MLR reporting years beyond 2011. Instructions for the 2012 MLR reporting year and beyond will be issued at a later date.

Comment 44

One commenter suggests that the due date for Part 6 of the MLR reporting form should be delayed until October 1 to enhance accuracy. Section 4 Part 6 requires issuers to report amounts of rebates paid by premium credit and/or lump sum reimbursement. They state that this information will not be known until June 1.

Response 45

Most of the information required by Part 6 of the MLR reporting form will be known by June 1. Some of the information required by Part 6 of the MLR reporting form will not be known until later, and such information is not required to be reported until the subsequent MLR reporting year. Thus, those portions that will not be known are grayed out (i.e. no input is permitted) on the reporting form for 2011 experience, and will be available for input on future years' forms.

Comments and Responses Regarding MLR Rebate Notices and MLR Information Notice

COMMENTS REGARDING MLR REBATE NOTICES

Comment 1

Three commenters assert that in the final paragraph of the rebate Notices, providing the refund amount for each subscriber or group policyholder should not be optional for issuers.

Response 1

CMS appreciates the suggestion from commenters but the regulation (§158.250) does not require that issuers include the refund amount. Therefore, CMS is making no changes based on this comment.

Comment 2

One consumer group suggests that the Notices should include more specific information that explains how premiums dollars are being spent, not just whether the MLR was being met.

Response 2

CMS is making no change based on this comment. The regulation (§158.250) does not require that the Notices include specific information on how premium dollars are being spent.

Comment 3

One health plan requests that CMS not require issuers to report premium dollar amounts.

Response 3

Reporting the total premium dollar amount is a requirement in the MLR regulation under §158.250, therefore, CMS is not making a change to the Notices based on this comment.

Comment 4

Two commenters assert that Notices should refer to “rebates” rather than “refunds,” as “rebates” is the term used by the statute and regulation.

Response 4

CMS is revising the language in the Notices and Instructions from “refund” to “rebate” to correspond with the language in the statute and regulation, as commenters suggest.

Comment 5

Two consumer groups assert that the Notices should be translated into the primary language of the policyholder.

Response 5

CMS appreciates the suggestion and will consider this as it determines the form of the Notices beyond 2011.

Comment 6

One health plan requests that CMS allow plans to specify the State for which the Notice pertains to reduce the potential for confusion among subscribers.

Response 6

In response to the comment, CMS is clarifying the Instructions to allow issuers the option of specifying the State in which they reside or to use a generic reference to the subscriber's State.

Comment 7

One commenter suggests we change all "ACA" references to "the law".

Response 7

CMS is not making a change pursuant to this request. We think that specifically referring to the Affordable Care Act will cause less confusion among consumers.

Comment 8

One issuer notes that if CMS requires these Notices to be used, they should include additional examples of administrative costs that are reflective of consumer-focused administrative initiatives such as developing provider networks and combating fraud, which constitute a large component of issuers' administrative costs.

Response 8

Based on the issuer's comment, CMS is adding language to the Notices by including the example "sales" to reflect additional administrative costs.

Comment 9

Several commenters assert that in the Notices "Salaries and advertising" are given as examples of administrative costs. "Salaries" might lead some consumers to confuse it with doctors' fees. They recommend substituting the following: "No more than 20 [15] percent of premiums may be spent on non-medical costs, such as administration and marketing."

Response 9

While CMS appreciates the concern of commenters, we are not making any changes based on this comment due to the fact that some non-medical costs, such as quality improving activities, are not included in the 20% or 15% cap on an issuer's administration costs in the MLR formula.

Furthermore, CMS thinks the letter makes clear that amounts spent on medical care are not an administrative cost.

Comment 10

Several commenters state that the Notices cite wellness programs as an example of a quality improvement activity. However, they assert that wellness activities are not the best example, given that some premiums and cost-sharing vary based on enrollees' compliance with certain wellness programs. They recommend that the example be dropped altogether to shorten the sentence and make it more readable. Some commenters suggested that using "efforts to improve patient safety" would be a better example of a quality improvement activity.

Response 10

Based on these comments, CMS is revising the language in the Notices. Instead of using wellness programs as an example of a quality improving activity, CMS is using "efforts to improve patient safety" as an example.

Comment 11

Two consumer groups suggest that we change the sentence regarding higher State MLR standards to read: "States may require health insurers to meet a higher standard."

Response 11

CMS is revising the Notices to reflect the change suggested by the commenters. The sentence that previously stated "The Affordable Care Act allows States to require health insurers to meet a higher ratio" will now read "States may require health insurers to meet a higher standard".

Comment 12

Two consumer groups note that the current templates do not address non-credible issuers, which are "presumed" to meet or exceed the 80% or 85% MLR standard. They recommend providing Notices that state the issuer's MLR and that no rebate will be paid because of the plan's size, or alternatively, that non-credible issuers need not provide notice.

Response 12

Since non-credible issuers are presumed to meet or exceed the MLR standard, they do not pay rebates. CMS has clarified the Instructions to reflect that Notices #1 - #3 do not apply to non-credible issuers.

Comment 13

Three consumer groups recommend that "mini-med" issuers should be required to provide information about the multiplier that is applied to the numerator of mini-med experience. They also recommend that information regarding MLR be added to Notices regarding the Affordable Care Act's annual benefit limit rules.

Response 13

CMS is not making a change to the Notices based on these comments. We appreciate the concerns of commenters; however, we think that the burden on issuers would exceed the benefits received by consumers. We think that consumers will have the information necessary to understand how their plan achieved their MLR standard.

Comment 14

One issuer association suggests that CMS require general toll-free numbers on the Notices.

Response 14

CMS is not making a change based on this comment. We think that the toll-free numbers we are asking issuers to provide will assist consumers when contacting the issuer with questions.

Comment 15

One consumer group states that in addition to phone numbers, a website or email address should be provided.

Response 15

CMS is revising the language of the Notices to add a website or email address of the issuer for consumers to contact with questions.

Comment 16

Two commenters suggest that a generic salutation, rather than a specific salutation, be required on the Notices.

Response 16

Based on these comments, CMS is revising the Instructions so that issuers may use a generic salutation on the Notices.

Comment 17

Several commenters request that the President's (of the issuer) signature not be the only signature allowed on the Notices because other officers of a corporation typically sign informational Notices to subscribers and group policyholders.

Response 17

Based on the comments, CMS will be revising the language to allow any executive who is authorized to attest to the data submitted through the MLR Annual Reporting Form to sign for the Notices to allow more flexibility.

Comment 18

Several commenters opposed the overly prescriptive format of the Notices. They state that the final rule already specifies the content of the rebate Notices. They recommend that a flexible approach be adopted for MLR rebate Notices, allowing the information to be issued by health plans in their own form, format and method of distribution.

Response 18

CMS appreciates the concerns of the commenters but is not making any changes to the Notices themselves based on the comments. The regulation provides that the notice shall be on a form provided by the Secretary. CMS thinks there is significant benefit to consumers in receiving consistent notices, and the burden on issuers in providing these notices is the same whether they are required to use the form notice or send one they have drafted. With respect to the method of distribution, the Instructions do allow flexibility for issuers to provide the notices electronically or by mail.

Comment 19

Several commenters assert that the Notices are written above an 8th grade reading level and should be revised to be more readable.

Response 19

While we appreciate the concerns of commenters, CMS is not revising the Notices that must be provided in 2012 based on this comment. Medical loss ratio is a complex concept and we have tried to simplify it as much as possible while still making sure that the notices incorporate the regulatory requirements of 45 CFR §158.250. CMS will revisit the readability level for future years' notices.

Comment 20

One health plan asks that we permit State Departments of Insurance to develop alternative language for States whose MLR standards exceed the federal MLR requirement.

Response 20

States that have a higher MLR standard are welcome to develop notices for issuers to provide in compliance with their State law. However, all issuers who owe rebates must provide the notice required by 45 CFR Part 158, with the specific information required in the MLR regulation. Therefore, CMS is making no change based on this comment.

Comment 21

One health plan requests clarification that Notices may be sent prior to or after payment of rebates so long as notice is provided by Aug 1.

Response 21

CMS is clarifying the Instructions to note that Notices may be sent prior to or after payment of rebates as long as the notice is provided by August 1, as stated in the regulation (§158.250).

Comment 22

Three consumer groups ask that CMS place key information regarding the Notices in a stand-alone box at the top of the Notices.

Response 22

CMS is making no change based on this comment. We think the information provided in the title and throughout the Notices is sufficient for consumers to gain a clear understanding of the purpose of the MLR rebate.

Comment 23

Three consumer groups recommend that the Notices should note the MLR standard that will be enforced in the State in 2012 and 2013 and that the minimum 80 percent standard will apply in 2014. They recommend providing a second URL to link consumers to information specific to adjustments being used in their State.

Response 23

The Notices are only applicable for one year, thus CMS is not making a change based on this comment.

Comment 24

Three commenters suggest that the URLs should be shortened to make them more readable. They suggest: www.healthcare.gov/MLR and using an HTML "redirect" to link consumers to the final landing page.

Response 24

Due to timing issues in creating an HTML redirect to link consumers to the final landing page, CMS is making no change based on this comment.

Comment 25

One consumer group asks for clarification of the definition of "group policyholder" in Notice 2.

Response 25

CMS is making no changes based on this comment. We think "policyholder" is clearly defined in §158.103 of the MLR regulation and the meaning of group policyholder is clear.

Comment 26

One commenter states that in Notice 2, the last paragraph on page one lists two ways in which a non-Federal governmental plan may distribute the subscriber portion of any rebate to subscribers. The second bullet does not identify the additional other potential recipients identified in subsection (i) of 158.242(b)(1). The commenter suggests that the notice should be amended to embrace all categories of individuals identified in section 158.242(b)(1).

Response 26

CMS is making no change based on this comment. This language comports with §158.242 and we think adequately references all recipients who will be receiving rebates.

Comment 27

One commenter states that page 2 of the MLR Rebate Notice Instructions notes that issuers may run an eligibility report of subscribers to identify who must be provided rebate Notices. This language appears to apply only to group policyholders and subscribers who will receive Notice 2, but that is not clear in the Instructions. This language should be revised to clarify this issue.

Response 27

Based on the comment received, CMS is updating the Instructions to clarify that an eligibility report may be used for all Notices.

Comment 28

Two commenters note that Notice 2 is applicable to both group policyholders and subscribers in group plans that will receive a rebate. However, the 1st sentence is written for only the group policyholder. They recommend that it be made clear that the rebate is being paid only to the group policyholder – otherwise subscribers receiving the notice would be looking for a rebate from health plans.

Response 28

CMS is revising the Notice 2 to clarify that the rebate is being sent to the employer or group policyholder, based on the comments received.

Comment 29

One commenter suggests that Notice 2 to group policyholders does not address the common situation where an employer group may have two different types of plan offerings and it receives a rebate for one but not the other. For example, the commenter states that if an employer receives a rebate on its HMO offering but not its PPO offering, Notice # 2 will not inform an employer of that fact.

Response 29

No change is required. According to the MLR regulation, each issuer will notify each subscriber or group policy holder of their MLR rebate status. In the instance where an employer offers two different plans from two different issuers who file separate MLR reports, each issuer will be required to separately notify the subscribers or group policy holder if it owes rebates.

Comment 30

One commenter requests that CMS clarify that premium rebates provided in the form of premium credits should be applied to the next premium payment due on or after August 1 following the MLR reporting year. While many health plans have a monthly billing cycle for premium payments, some provide for quarterly or even annual premium payments. Requiring that rebates be applied no later than the next premium payment due on or after the August 1 date will provide flexibility for the full range of premium billing approaches. The commenter notes that the first sample notice states that all rebates must be paid by August 1.

Response 30

The MLR regulation, at 45 CFR §158.241, requires that any rebate that is provided in the form of a premium credit must be provided by applying the full amount due to the first month's premium that is due on or after August 1 following the MLR Reporting year. The regulation also provides that any overage premium credit must be applied to succeeding premium payments until the full amount of the rebate has been credited. CMS is revising the notices to address rebates that are paid by premium credit.

Comment 31

One commenter notes that in Notice 2, the first sentence of the second paragraph describing the "Ways in Which an Employer Can Distribute the Refund," the reference to ERISA as the Employee Retirement Income Security Income Act of 1974 is incorrect – the second "Income" should be removed.

Response 31

Based on this comment, CMS is revising the sentence in the notice to correctly reference ERISA as "Employee Retirement Income Security Act of 1974".

Comment 32

One commenter states that the sample Notices 2 and 3 should allow for a distinction to be made for whether the MLR rebate notice is for a small group or a large group, since there is a material difference in the MLR threshold of 80 percent for small group and 85 percent for large group.

Response 32

CMS is not making a change based on this comment. Each of the notices is a template for issuers to use, and provides the choices of 80 percent for the small group market or 85 percent

for the large group market. The instructions make clear that the issuer is to insert the appropriate standard for the relevant market.

Comment 33

One commenter states that they oppose the two-step process of requiring health plans to issue rebates to the group policyholder, and Notices to subscribers of the group (the scenario in Sample Notice 2). They recommend that the group policyholder be permitted to issue the Notice of rebate to employees.

Response 33

CMS is not making a change based on this comment. The MLR requirements generally apply to issuers and not to policyholders, thus it is issuers that must provide the notices. In addition, we make clear in the Instructions that the rebate may be issued with the Notice that is provided to the group policyholder, if the issuer chooses to do so, thus avoiding a two-step process.

Comment 34

One health plan asserts that if issuers are required to mail out Notices to non-recipients of rebates, then the model Notices should include language to address subscribers not receiving rebates due to the de minimis regulation.

Response 34

The regulation requires that notices be sent to each enrollee who receives a rebate. If a rebate is de minimis, the enrollee would not be receiving a rebate and therefore would not be receiving a notice.

COMMENTS REGARDING MLR INFORMATION NOTICE

Comment 35

Regarding the instance where an issuer meets the MLR standard, several commenters note that the final paragraph of the MLR Information Notice indicates that consumers are "receiving the required value for [their] health care dollars." The commenters suggest that an issuer's MLR is one of many metrics that are used to measure value and that meeting the MLR standard does not necessarily mean consumers are "receiving the required value." For instance, if a plan also requested or implemented a rate increase that was determined to be unreasonable, the commenter suggests that the statement that the plan meets the "required value" may be untrue.

Response 35

No change is required. The MLR Information Notice is only intended to inform consumers about their issuer's MLR experience. As referenced in section 2718(b) of the Public Health Services Act, the MLR standard helps "ensure that consumers receive value for their premium payments." Furthermore, if a rate increase was prospectively determined to be unreasonable,

that same issuer could still meet the applicable MLR standard, which is a retrospective calculation and the statement about receiving the required value would still be accurate.

Comment 36

One commenter asserts that there are other alternatives to issuing further regulation requiring Notices to customers not receiving rebates. One is for CMS to post on its CCIIO website, and/or on the Web Portal, a notice similar to Notice # 4.

Response 36

Currently, the MLR Information Notice is a sample and we are not requiring issuers to send them out. CMS will address this concern if we issue a rule requiring Notice of MLR Information.

Comment 37

One commenter suggests that CMS allow an issuer to classify the cost of providing a notice that the issuer has met the MLR standard as either an incurred claim or a Federal tax.

Response 37

The MLR Regulation, 45 CFR Part 158, describes which expenses are to be considered incurred claims or Federal taxes. The regulation does not allow for the cost of providing notices to be considered an incurred claim or a Federal tax. In addition, this specific notice is currently a sample notice only, and as such, is not currently required to be sent to policyholders and/or subscribers.