Crosswalk for Changes to MLR Annual Reporting Form, MLR Rebate Notices, MLR Information Notice, and Instructions CMS 10418

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A. 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. CMS notes that this sample notice is not currently required.

The following charts document the changes made to the MLR Annual Reporting Form, the MLR Rebate Notices and MLR Information Notice, and the accompanying instructions for each of these documents.

B. Changes to MLR Reporting Form and Accompanying Instructions

The following chart contains the list of changes made to the MLR Reporting Form and the accompanying Instructions. These changes were made in response to internal comments and in response to comments received following the 60-day public comment period. Additional minor changes were made to correct excel cell references, typographical errors, and technical errors.

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Document	Section Edited	Revision (Red indicates added language)	Rationale
Instruction	Entire Document	**Instruction Update:** **INSTRUCTIONS FOR THE 2011 MLR REPORTING YEAR ONLY** The annual MLR reporting form filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. The Filing Instructions will be revised for subsequent reporting years to reflect changes made since publication of the MLR Interim Final Rule.	The instructions are clarified throughout to indicate that they are specific to 2011 and that guidance for future MLR reporting years will be issued in the future.
Instruction	Entire Document	The Instructions were revised to replace all references to the term "current MLR reporting year" with "MLR reporting year."	The Instructions were revised to clarify the time period for which the data is sought.
Instruction	Entire Document	The Instructions were revised to replace all references to “prior MLR reporting year” and “prior year” with “the year preceding the MLR reporting year”	The Instructions were revised to clarify the time period for which the data is sought.
Instruction	Entire Document	The Instructions were revised to replace the term “grand total filing” with “grand total page.”	This instruction was revised to correct a technical error.
Reporting Form	Domiciliary State	**Form Update:** I12 Domiciliary State - Drop Down List should be adjusted to include only States and territories CCIIO agrees to remove "Canada" and "Other Territories" from drop down menu.	This item has been revised to ensure all States are available from the drop-down list.
Instruction	Page 1	**Instruction Page 1 Update:** (Note: The experience of expatriate plans is aggregated on a national basis and should be reported on the “Grand Total” MLR Form for each issuer, along with the aggregated lines of business on that form.)	This item has been revised to conform to the regulation and properly capture the data.

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Instruction	Introduction	**Instruction Update:** Note: The MLR Form is an excel workbook that contains many calculated fields based on the information inputted into the data fields by the issuer. Calculated cells or cells not requiring any data input have been shaded and a key provided on each tab within the workbook for further clarification. This workbook includes calculations for any credibility adjustment based on an issuer's life-years and average deductible. The various "Parts" of the MLR Form contain calculated fields, which will assist in reducing data input for the various elements required in the reporting form. Many of the fields within Part 1 of the MLR Form copy over calculated information from data that is entered into Part 2 and Part 3. (Recommendation: Begin inputting data into Part 2 and Part 3, prior to completing Part 1.) Once the information has been inputted into the cells not shaded in Part 2, Part 3, Part 1 and Part 5, the MLR and Rebate Calculation – Part 5 will automatically calculate the issuer's MLR and rebate for each market in each State.	The Instructions were revised to clarify how data is to be entered in the Excel spreadsheet.
Instruction	Introduction	**Instruction Update:** These Filing Instructions are to be used in completing the MLR Form by all issuers offering health insurance coverage. All terms used in these Filing Instructions that are not defined here have the meaning used in 45 CFR Part 158 and further defined within the PHS Act. 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, and mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, unless specifically identified as "excepted" by Federal law.	The Instructions are being revised to clarify that all issuers offering health insurance coverage are required to file the MLR Form.

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Instruction	Introduction - Reinsurance	**Addition to Instructions:** 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 also 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.	This section was revised to clarify the treatment of 100% assumptive reinsurance.
Instruction	Introduction – Allocation of Expenses	**Addition to Instructions:** Allocation of Expenses Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between the two (or more) types of expenses. Expenditures that benefit more than one affiliate may be allocated between the affiliates that benefit from these expenditures on a pro rata basis. Expenditures that benefit all lines of business or products, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata basis.	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
Instruction	Introduction - Aggregation - Dual Contract	**Instruction Update:** Dual-Contract Group Health Coverage: If an issuer has a group health plan which provides coverage for in-network coverage only and an affiliate issuer provides only out-of-network coverage solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits, the issuer may choose to treat the out-of-network experience of the affiliate that provides the out-of-network coverage as if it were related to the contract providing the in-network coverage. If an issuer chooses this method of aggregation, it must do so for a minimum of three consecutive reporting years and the affiliate that provides the out-of-network coverage must not report this experience. After an issuer applies this method for the initial three consecutive reporting years, the issuer may either continue to apply this method for any number of additional consecutive reporting years, or may choose to discontinue applying this method. Affiliated issuers that choose to make such an	The instruction is being revised to clarify that an issuer may discontinue this method after three consecutive years.

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		adjustment must do so for all policies with blended rates in the applicable State market.	
Instruction	Page 4 – Health Insurance Coverage	**Instruction Update:** Health Insurance Coverage: Do not include health insurance coverage specifically not subject to section 2718 of the PHS Act, such as government-sponsored programs, (e.g., Medicare (Title XVIII, including Medicare Advantage), Medicaid (Title XIX), State Children's Health Insurance Program (SCHIP) (Title XXI), and other Federal or State government-sponsored coverage (other than the Federal Employee Health Benefits Program or State government sponsored coverage for State employees or retirees), or uninsured business. Stop (or excess) loss coverage for self insured groups should be reported in Parts 1 and 2 – Other Health Business (business excluded by statute).	The instruction was revised to consistently refer to "health insurance coverage" throughout. This eliminated the use of duplicative and ambiguous terms.
Instruction	Business as of 12/31 of Current Reporting Year	**Instruction Update:** **Page 4** Columns 1, 6, 11, 16, 18, 20, 22, 27, 32, 33, 34, and 35 – Business as of 12/31 of the MLR reporting year Include: Experience of policies in each of the relevant markets (individual market, small group market, large group market, mini-med individual market, mini-med small group market, mini-med large group market, expatriate small group market, or expatriate large group market) for the MLR reporting year, 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. **Part 2** Line 2.1 – Claims paid 2.1a – 12/31 Column – Claims paid during the MLR reporting year regardless of incurred date. Report payments net of risk share amount collected.	The instruction was clarified to specify the time period for which premiums are to be reported.

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Instruction	Business of Subsequent Reporting Year	**Instruction Update:** **Page 4** Columns 2, 7, 12, 17, 19, 21, 23, and 28 – Business as of 3/31 of subsequent MLR reporting year Include: Experience for policies for each market, incurred, paid or received relevant only to the MLR reporting year, reported as of March 31 of the subsequent MLR reporting year. For purposes of actuarial claims elements, the 3/31 column items should generally follow the structure of amounts incurred in the prior year settled through 3/31 of the following year (traditionally described as incurred 12 paid 15), plus any provision remaining as of 3/31 for items properly allocable to the prior period but not yet paid as of 3/31.	The instruction for this item is being revised to specify which actuarial elements are being referenced.
Instruction	Part 1 – Fee for Service and Co-pay revenue - Line 2.10	**Instruction Update:** Include: Revenue recognized by the issuer for collection of co-payments from members and revenue derived from health services rendered by reporting entity providers that are not included in member policies (generally applicable to only staff-model HMOs).	This item has been clarified to add specificity to avoid confusion.
Instruction	Part 1 - Taxes and Regulatory Fees - Lines 3.1 - 3.3	**Instruction Update:** Line 3.1 – Federal taxes and assessments incurred by the reporting issuer Line 3.2 – State insurance, premium and other taxes incurred by the reporting issuer Line 3.3 – Regulatory authority licenses and fees incurred by the reporting issuer	The phrase "owed and paid by" was replaced with the phrase "incurred by" to clarify the meaning.

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Document	Section Edited	Revision (Red indicates added language)	Rationale
Instruction	Part 1 - Community Benefit Expenditures - Line 3.2c	**Instruction Update:** For the 2011 MLR Reporting Year ONLY–Not-for-profit health plans report one of the following types of payments: • Payments by a not-for-profit issuer to a State of premium tax exemption values in lieu of State premium taxes. limited to the State premium tax rate applicable to for-profit entities subject to premium tax multiplied by the allocated premiums earned for individual, small group and large group; • Payments by a not-for-profit issuer for community benefit expenditures** (described below in these Filing Instructions) if made pursuant to a State-based requirement, limited to the State premium tax rate applicable to for-profit entities subject to premium tax multiplied by the allocated premiums earned for individual, small group, and large group; • Payments by an issuer exempt from Federal income tax for community benefit expenditures** (described below in these Filing Instructions), limited to the State premium tax rate applicable to for-profit entities subject to premium tax multiplied by the allocated premiums earned for individual, small group, and large group.	The instructions are clarified for this item to indicate that they are specific to 2011 and that guidance for future MLR reporting years will be issued in the future. This is necessary here as the MLR Final Rule, published December 7, 2011, provides a different rule for 2012 and beyond. Additional changes are made to this section to conform to the controlling regulation.
Instruction	Part 1 – Total Federal Taxes and Fees to be excluded from Premium – Line 3.4	**Instruction Update:** Line 3.4 – Total Federal and State taxes and fees to be excluded from Premium (Lines 3.1 + 3.2a + Max(3.2b or 3.2c) + 3.3)	This instruction was revised to make a technical correction.
Instruction	Part 1 - ICD-10 - Line 5.9	**Instruction Update:** Part 1 Line 5.9 – ICD-10 Implementation expenses (already included in line 5.6; informational for 2011)	The instruction for this item is being revised to note that it is being collected for informational purposes only for the 2011 MLR experience.
Reporting Form	Part 1 - Underwriting Gain / Loss - Line 6	**Form Update:** Pre-tax underwriting gain / (loss) (Lines 1.8 – 2.11 – 4.6 – 5.8 + 5.5a + 5.5b - Part 2 Line 2.16) Formula change: =F$27-F$40-F$57-F$69+F$65+F$66-F$149	This item has been revised to avoid double counting for fraud expenses and to conform to the regulation

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Instruction	Part 1 - Underwriting Gain / Loss - Line 6	**Instruction Update:** Line 6 – Pre-tax underwriting gain/(loss) as of 12/31/XX (Lines 1.8 – 2.11 – 4.6 – 5.7 + 5.5a + 5.5b – Part 2 Line 2.16)	This item has been revised to avoid double counting for fraud expenses and to conform to the regulation
Instruction	Part 2 - Premium - Line 1.1	**Addition to Instructions:** Include: Premium assumed under a 100% assumption reinsurance agreement (treated as a 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. Premium assumed under a 100% indemnity reinsurance and administrative agreements, limited to only those agreements both entered into and also 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. Exclude: Premium ceded under a 100% assumption reinsurance agreement (treated as a 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. Premium ceded under a 100% indemnity reinsurance and administrative agreements, limited to only those agreements both entered into and also 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.	The instruction was revised to clarify the reference to 100% assumptive and indemnity reinsurance in the instruction for determining premium.
Instruction	Part 2 - unearned premium (prior year) - Line 1.2	**Instruction Update:** Line 1.2 - Unearned premium (year preceding the MLR reporting year) Report reserves established to account for the portion of the premium paid in the prior MLR reporting year that was intended to provide coverage during the MLR reporting year.	The instruction for this item was revised to specify that unearned premium for the year preceding the MLR reporting year is to be reported.
Instruction	Part 2 -Reserve for Experience Rating Refunds - Line 1.6	**Instruction Update:** Line 1.6 – Reserve for experience rating refunds (rate credits) (MLR reporting year) unpaid or received 12/31 Columns – Unpaid as of 12/31 of the MLR reporting year. 3/31 Columns – Incurred only in the reporting year and	This section was revised to correct the instruction and conform to the regulation. In addition, the instruction is being revised to clarify treatment of "amounts receivable under retrospectively rated

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		unpaid in the reporting year and through 3/31 of the following year … Deduct: Amounts receivable under retrospectively rated funding arrangements.	funding arrangements."
Instruction	Part 2 – Premium ceded under 100% reinsurance – Line 1.12	**Instruction Update:** Include: • Premium ceded under a 100% assumption reinsurance agreement (treated as a novation) . • Premium ceded 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.	The section was revised to clarify what is to be included in the reporting of this data.
Instruction	Part 2 – Premium assumed under 100% reinsurance – Line 1.13	**Instruction Update:** Include: • Premium assumed under a 100% assumption reinsurance agreement (treated as a novation). • Premium assumed 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.	The section was revised to clarify what is to be included in the reporting of this data.
Instruction	Part 2 - Claims Paid - Line 2.1	**Instruction Update:** Ex gratia payments have been removed from the instructions. Deduct: • Any overpayment that has already been received from providers should not be reported as a paid claim; • Prescription drug rebates, refunds, incentive payments, bonuses, discounts charge backs, coupons, grants, direct or indirect subsidies, direct or indirect remuneration, upfront payments, goods in kinds or similar benefits received by the issuer; • • Payment from unsubsidized State programs designed to address distribution of health risks across issuers via charges to low risk issuers that are distributed to high risk issuers must be deducted from incurred claims	The instruction is being clarified to specify treatment of certain expenditures.
Instruction	Part 2 - Claims Paid - Line 2.1	**Instruction Update:** Removed incentive and bonus payments to providers from Line 2.1. The instruction for line is only for Line	The instruction is being revised to indicate the proper treatment of incentive payments to

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		2.11	conform to the regulation, and to clarify that incentive and bonus payments to providers should only be included in Line 2.11.
Instruction	Part 2 - Claims - Line 2.1	**Addition to Instructions:** Include: Claims assumed under a 100% assumption reinsurance agreement (treated as a 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. Claims assumed under a 100% indemnity reinsurance and administrative agreements, limited to only those agreements both entered into an also 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. Deduct: Claims ceded under a 100% assumption reinsurance agreement (treated as a 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. Claims ceded under a 100% indemnity reinsurance and administrative agreements, limited to only those agreements both entered into an also 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.	The instruction was revised to clarify that "claims assumed and ceded under 100% assumptive and indemnity reinsurance agreements," are to be reported.
Instruction	Part 2, Line 2.6, Contract Reserves	**Instruction Update:** The instruction for this item was revised to state: 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 item was revised to clarify elements that could be included in contract reserves.

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Instruction	Part 2 - Experience Rated Refunds Paid - Line 2.8	**Instruction Update:** Experience rating refunds associated with premium earned during the MLR reporting year, including State premium refunds paid during the MLR reporting year. Experience rating refund is the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium.	This item has been revised to conform to the regulation and properly capture the data.
Instruction	Part 2 – Reserve for Experience Rated Refunds (rate credits) – Line 2.9	**Instruction Update:** Subtract: Amounts receivable under retrospectively rated funding arrangements.	This item has been revised to clarify the treatment of "amounts receivable under retrospectively rated funding arrangements."
Instruction	Part 2 - Net Healthcare Receivables - line 2.12	**Instruction Update:** 3/31 Column – receivables incurred during the MLR reporting year and that remain outstanding as of 3/31 following the MLR reporting year.	The instruction for this item was revised to specify "receivables" that are to be reported
Instruction	Part 2 – Contingent benefit and lawsuit reserves – Line 2.13	**Instruction Update:** Exclude: Reserves related to costs associates with claims lawsuits within Line 2.13; i.e. legal fees, court costs, pain and suffering damages, punitive damages, etc.	This item was revised to clarify treatment of contingent benefit and lawsuit reserves.
Instruction	Part 2 - Blended Rate Adjustment - Line 2.15	**Instruction Update:** Affiliated issuers that offer group coverage at a blended rate *may choose* whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer as a whole, according to an objective formula the issuer defined prior to January 1, 2011, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate. From the date an issuer ***chooses*** to use such an adjustment, it must be used for a minimum of three consecutive MLR reporting years. Affiliated issuers that choose to make such an adjustment must do so for all policies with blended rates in the applicable State market.	The instruction was clarified to conform to the regulation.
Instruction	Part 2 - Fraud - Line 2.16	**Instruction Update:** Line 2.16a – Total Fraud Reduction expense: Line 2.16b – Total Fraud Reduction Recoveries that Reduced PAID claims.	This item has been revised to indicate that the data is used the MLR calculation and to conform to the

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Document	Section Edited	Revision (Red indicates added language)	Rationale
		(Removed reference to informational only)	regulation
Reporting Form	Formula change within Part 2 Line 2.17	**Form Update:** Formula change within Part 2 Line 2.17 =SUM(K$126+K$128-K$129+K$130-K$131+K$132-K$133+K$135+K$137-K$138+K$140+K$141-K$142-K$144+K$145+K$146+K$147+K$148+K$149)	This item was revised to correct a typographical error
Instruction	Part 3 - Improving Health care outcomes - Column 1	**Instruction Update:** • Effective case management, care coordination, and chronic disease management, including through the use of the medical homes model as defined in section 3606 of the Affordable Care Act."	This section was revised to include a list of items mistakenly omitted from the prior version.
Instruction	Part 3 Column 4 Wellness and Health Promotion Activities	**Instruction Update:** • Actual rewards/incentives/bonuses/reductions in co-pays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI for the group market to the extent permitted by section 2705 of the PHS Act.	This item was revised to clarify the classification of "wellness" activities in conformity with the regulation
Instruction	Part 4 - Acceptable Bases for Allocation of Expenses - Instruction	**Instruction Update:** Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses. Expenses that relate to a specific entity or sub-set of entities, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by that specific entity or subset of entities and must not be apportioned to other entities within a group.	The instruction regarding "acceptable bases of allocation" is clarified to more accurately express CMS policy. A comment suggests that the instruction was vague.
Instruction	Part 5 - Instruction	**Instruction Update:** The annual MLR reporting form Filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2011. Part 5 of each State filing is self calculating based on other data elements entered into the other associated tabs. No data information is needed to be completed in any of the shaded cells within the filing.	This section was revised to indicate that this data input is not required for the 2011 MLR reporting. The data field indicates that an issuer is to provide the preceding year's MLR and since 2010 is not an MLR reporting year, the data is not required.

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Document	Section Edited	Revision (Red indicates added language)	Rationale
Instruction	Part 5 - Rebates paid based on experience for the two immediately preceding MLR reporting years - Line 1.4	**Instruction Update:** Line 1.4 – MLR rebates paid based on experience for the two immediately preceding MLR reporting years. (Not applicable to the 2011 MLR Reporting Year).	This item has been revised to conform to the regulation and properly capture the data.
Instruction	Part 5 - Mini-Med - Line 1.6	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. **Instruction Update:** Line 1.6 – Mini-Med / Expatriate numerator after adjustment factor (Line 1.5 x adjustment factor) For the 2011 MLR reporting year, the adjustment factor for mini-med plans and expatriate plans is 2.	This section was revised to clarify that instructions apply for 2011 only.
Reporting Form	Part 5 - Federal & State high risk programs - Line 2.1	**Form Update:** Formula change; ='Pt 1 and 2'!G20,K20, O20, etc should be changed to reference row 23	The formula was edited to correct the calculation and conform to the regulation.
Instruction	Part 5 - Average Deductible - Line 3.3	**Instruction Update:** The per person deductible for a policy that covers a subscriber and the subscriber's dependents shall be calculated as follows: 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).	The calculation instruction is being clarified, as suggested by commenters.
Reporting Form	Part 5 - Deductible factor - Line 3.4	Excel – Part 5, Line 3.4: The cell reference was corrected to properly refer to deductibility factors. Additionally, the formula was modified to correctly interpolate for deductible levels under $2,500 rather than reporting a factor of 1.000.	This item has been revised to conform to the regulation and properly capture the data.
Instruction	Part 5 - Credibility-adjusted MLR -	**Instruction Update:** Line 4.4 – MLR including credibility adjustment if	This item was revised to correct a typographical

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Document	Section Edited	Revision (Red indicates added language)	Rationale
	Line 4.4	applicable (Lines 4.2a or 4.2b + 4.3)	error
Instruction	Part 5 - MLR Standard - Line 5.1	**Instruction Update:** **INSTRUCTIONS FOR THE 2011 MLR REPORTING YEAR ONLY** The annual MLR reporting form filing Instructions only apply to the 2011 MLR Reporting Year and its reporting requirements. The Filing Instructions will be revised for subsequent reporting years to reflect changes made since publication of the MLR Interim Final Rule.	The instructions are clarified throughout to indicate that they are specific to 2011 and that guidance for future MLR reporting years will be issued in the future.
Reporting Form	Part 5 - MLR Standard - Line 5.1	The State-specific MLR standard will be 'pre-coded' in the form.	The State-specific MLR standard will be 'pre-coded' in the form. This will increase data integrity
Instruction	Part 5 - Credibility-adjusted MLR - Line 5.2	**Instruction Update:** Line 5.2 – Credibility-adjusted MLR (MLR Form, Part 5, Line 4.4) (Not applicable to Grand Total page)	This item was revised to correct a typographical error and to clarify that it does not apply to the Grand Total page.
Instruction	Part 6 - Number of policyholders/ subscribers owed rebates - Line 3	**Instruction Update:** Line 1 – Is a rebate being paid? This cell is automatically populated with a “Yes” if Part 5 Line 5.4 is greater than 0, otherwise it will populate with “No”. If no rebate is being paid, do not complete Lines 2 through 5. Line 3 - Number of policyholders/subscribers being paid rebates Line 3.a – Number of group policyholders who are being paid a rebate Include: All group policies within the respective group markets that are due a rebate Exclude: Rebates being paid in the individual market for individual policies. Line 3.b – Number of subscribers who are being paid a rebate.	This section was revised to replace references to the term "owed" with the term "being paid", as a clarification.

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C. Changes to MLR Rebate Notices, MLR Information Notice, and Accompanying Instructions

The following chart contains the list of changes made to the MLR Rebate Notices, the MLR Information Notice, and the accompanying Instructions. These changes were made in response to comments received following the 60-day public comment period. Additional minor changes were made to correct typographical errors.

Document	Item Edited	Type of Revision	Rationale
Notices & Instructions	All throughout Notices and Instructions	Change language to match language in Public Health Service Act.	CMS is revising the language in the Notices and Instructions from "refund" to "rebate" to correspond with the language in the statute and regulation.
Instructions	Notices #1-3	Add clarification for whether non-credible plans are required to send out notices.	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.
Notices	Notices #1-4	Add examples of administrative costs to notices.	CMS is adding language to the Notices by including the example "sales" to reflect additional administrative costs.
Notices	Notices #1-3	In addition to phone #s, website/email should be provided.	CMS is revising the language of the Notices to add a website or email address of the issuer for consumers to contact with questions.
Instructions	Instruction - When Notice of Rebate Must be Provided	Add clarification that notices may be sent prior to or after payment of rebates so long as notice is provided by Aug 1.	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).
Notices	Instructions	Add language to notice regarding de minimis thresholds.	The regulations require 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.

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Document	Item Edited	Type of Revision	Rationale
Notices	Notices #1-3	Re-write the sentence for those States with higher MLR standards.	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". This will ease confusion for consumers.
Instructions	Instructions - Who Must be Provided Notice of Rebate	Clarify language regarding for which notices an eligibility report should be run.	CMS is updating the Instructions to clarify that an eligibility report may be run for all Notices.
Notices	Notice #2	Clarify that Notice 2 is applicable to both group policyholders and subscribers in group plans that will receive a rebates.	CMS is revising Notice 2 to clarify that the rebate is being sent to the employer or group policyholder.
Notices	Notices #1-2	Clarify that the premium rebates should be applied to the next premium payment due on or after August 1st following the MLR reporting year.	CMS is revising the notices to address rebates that are paid by premium credit.
Notices	Notices #1-4, Opening	Change to generic salutation.	Modifying notices to delete the Mr., Ms., Dr., etc., salutation to ease the burden for issuers.
Notices	Notices #1-4, Signature	Allow latitude for executives in addition to the Company President to sign the letter.	CMS will be revising the language to allow an authorized executive to sign for the Notices to allow more flexibility.
Notices & Instructions	Notices #1-4 Instructions - within each applicable field	Allow plans to specify the State for which the notice pertains.	CMS is clarifying the Instructions to allow issuers to specify the State in which they reside, or to use the words "your State", to allow flexibility.
Notices	Notice #2, Ways in Which an Employer Can Distribute the Rebate	Correct acronym for ERISA.	CMS is revising the sentence in the Notice to correctly reference ERISA as "Employee Retirement Income Security Act of 1974".

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Document	Item Edited	Type of Revision	Rationale
Notices	Notices #1-4	Change "wellness program" as the example of activities to improve health care quality. Use “efforts to improve patient safety” as an example of quality improving activities.	CMS is revising the language in the Notices to reflect the variations in “wellness programs” among issuers. Instead, CMS will be using the phrase “efforts to improve patient safety”.