Response to Comments Received
Federal Register Notice (77 FR 71801) on Revised CMS-10418

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Introduction

CMS received 4 public comments on 25 specific issues regarding the notice of the revised Medical Loss Ratio (MLR) PRA package published in the Federal Register on December 4, 2012 (77 FR 71801). The comment period closed on February 4, 2013. Comments were received from America's Health Insurance Plans (AHIP), Blue Cross and Blue Shield Association (BCBSA), Cigna, and Prudential.

The PRA package contains the version of the MLR Annual Reporting Form for the 2012 MLR reporting year, which health insurance issuers must file with CMS by June 1, 2013, and the instructions for completing the form. It modifies the MLR Annual Reporting Form approved by OMB, on May 11, 2012, for the 2011 MLR reporting year, OCN 0938-1164.

The comments CMS received regarding the 2012 MLR Annual Reporting Form and Instructions are summarized immediately below. Most of the comments addressed clarifying the instructions or correcting typographical errors, the removal of calculated cells and the issuer's ability to copy and paste data onto the form, and the inclusion of a credibility indicator for small issuers so that small issuers would not need to fill out the complete MLR reporting form. The summary below sets forth each comment and our response.

Comments on the 2012 MLR Annual Reporting Form and Instructions

Requests for Clarification and Typographical Errors

1. One commenter requested that CMS clarify its definition of "prior period" citing that the current context gives way to multiple interpretations.

   CMS Response
   CMS clarified the definition of "prior period" in the instructions to make clear that it does not include years that are not applicable to the MLR regulation.

2. One commenter requested that CMS clarify the instructions regarding the data reported in the "Dual Contract" columns being included in the "3/31" columns.

CMS Response
CMS revised the instructions to clarify that data reported in the "Dual Contract" columns must be included in the "3/31" columns.

3. One commenter expressed appreciation for what the commenter believed to be a change in instructions making reporting of 12/31 data optional.

   CMS Response
   Reporting of 12/31 data is not optional and this requirements has not changed from the 2011 MLR reporting year requirements. CMS revised the instructions to clarify the narrow circumstances under which an issuer is not required to separately report data elements in the 12/31 column of the MLR reporting form.

4. One commenter stated that the premium-based allocation method for reporting experience rating refunds in the instructions for Part 2, Lines 1.4, 1.5 and 2.9, could result in inappropriate allocation.

   CMS Response
   CMS revised the instructions to clarify that experience rating refunds must be allocated to align with the experience being reported.

5. One commenter stated that the reference in Part 2, Line 2.15 in the instructions should read January 1, 2012 rather than January 1, 2011.

   CMS Response
   CMS revised the instructions.

6. One commenter requested that CMS reverse Part 2, Lines 2.16 and 2.17 on the form so that allowable fraud expense is included in incurred claims.

   CMS Response
   Fraud expense is used to calculate Adjusted Incurred Claims in Section 4. CMS revised the instructions for clarity including directing the reader to Section 4 of the form where allowable fraud expense is considered.

7. One commenter requested that the instructions for Part 2, Line 2.17 use calendar year amounts for both collected fraud recoveries in 2012 and fraud reduction recovery expenses in 2012, the two components for this line and its sub-lines.

   CMS Response
   CMS revised the instructions to clarify that the allowable fraud expense attributable to prior years may be restated on Part 4.

8. One commenter stated that, for Part 4, Line 1.2, the parenthetical statement in the instructions is not precisely accurate. The values are incurred claims based on claims

incurred in 12 months and paid in 27 months. The incurred claims from Part 2 include any claim liability or claim reserve still held as of 3/31 for claims incurred on these dates.

CMS Response
CMS revised the instructions for clarity.

9. One commenter requested that on Part 4, Line 2.2 of the form and instructions, CMS remove an incorrect reference to Line 3.1c.

CMS Response
CMS revised the form and instructions as requested.

10. One commenter requested that CMS revise the instructions for Part 4, Line 3.3 to calculate the average per person deductible using a weighted average of the 2011 and 2012 per person deductibles.

CMS Response
CMS revised the instructions as requested.

11. One commenter suggested that the parenthetical in Part 4, Line 5.3 of the form should read: "(Line 2.3 CY only)."

CMS Response
CMS revised the form and instructions as requested.

12. One commenter requested that the definition for the word "paid" in Part 5, Line 4.d be expanded to include situations where rebates are disbursed in the form of premium credit that is applied to billing periods after August 1.

CMS Response
CMS revised the instructions for reporting the percentage of timely disbursed rebates to clarify that "paid" includes disbursements in the form of premium credits that occur after August 1, in accordance with the MLR regulation (45 CFR §158.241(a)).

13. One commenter stated that issuers should not have to report information in Part 6 which pertain only to "Other Health Business" because that business is not subject to Section 2718 of the PHS Act.

CMS Response
CMS revised the instructions for clarity.

14. One commenter requested that the instructions for Part 6, item 4 be revised to read: "If the issuer entered into any 100% reinsurance agreements (with a novation) to assume coverage during the MLR reporting year, provide the name(s) of the entity(ies) with which the agreement was (were) made and the effective date of the novation."

CMS Response
CMS revised the MLR instructions for clarity.

15. One commenter requested that CMS remove the term "with a novation" from Part 6 Item 6.

CMS Response
The term "with a novation" was removed from Part 6 Item 6.

General Comments

16. Four commenters requested that CMS revise the MLR-A template to include formula cells which would automatically calculate required values.

CMS Response
During the 2011 MLR reporting year cycle, issuers stated that the locked cells in the MLR-A template limited the ability to use the "copy and paste" feature of Microsoft Excel. In balancing the need to increase functionality with the need to reduce the risk of inadvertent edits to formulas if all cells were unlocked, CMS removed all formulas and unlocked the input cells of the MLR-A template. In response to this comment and to assist issuers in populating cells that were previously locked and pre-calculated, CMS has created separate tools that will provide the formulas and help users calculate all of the required values in the MLR-A template. The tools will be available for download from CMS' Health Insurance Oversight System (HIOS).

17. One commenter requested that CMS publish the MLR Form and Instructions earlier in the year and allow stakeholders more time to review and provide comments.

CMS Response
CMS will make best efforts to publish future documents with greater lead times.

18. One commenter requested that CMS exercise its authority and adopt State specific definitions of small group and individual markets.

CMS Response
CMS is considering whether to publish additional guidance regarding this issue. However, how to count group size is not addressed as a part of the MLR Form and Instructions.

Claims

19. One commenter requested that the instructions for reporting contract reserves in Part 2, Line 2.6b be amended to exclude contract reserves attributable to policies issued prior to 2011.

CMS Response
CMS made no change based on this comment. Policies issued prior to 2011 are not subject to the MLR provisions. Contract reserves are generally established to set aside a portion of

premium to pay for claims incurred in future years. It is appropriate for the MLR formula to recognize any increase or release of contract reserves in order to correctly reflect the value that policyholders receive for their premium dollar.

MLR Calculation

20. One commenter requested that for Part 4, Line 1.2, the numerator be calculated using the data from the 2011 MLR reporting year and the 2012 MLR reporting year, with run-out through 3/31 of the year following those years, consistent with guidelines provided in the MLR Final Rule.

    CMS Response
    According to 2718 of the Public Health Services Act, the NAIC recommended standardized definitions and methodologies for calculating the MLR for issuers. CMS adopted the recommendations of the NAIC in full. Restatement of adjusted incurred claims for the prior MLR reporting years as of 3/31 of the MLR reporting year ensures that reserves are not improperly inflated. 45 CFR §158.140 describes the derivation of adjusted incurred claims specific to the current MLR reporting year.

21. One commenter requested that for Part 4, Line 5.1, a weighted average MLR standard be used in situations in which MLR standards are different for 2011 and 2012 and an issuer is aggregating 2011 and 2012 experience.

    CMS Response
    CMS is considering issuing guidance on this issue.

22. One commenter requested that CMS test for issuer credibility prior to completion of the MLR-A template and allow non-credible issuers to not file an MLR reporting form.

    CMS Response
    Section 2718 of the Public Service Health Act, as amended by section 1001 of the Affordable Care Act, requires all issuers of health insurance coverage to submit an MLR report, including non-credible issuers. However, CMS will use its enforcement discretion and will not initiate an enforcement action in certain circumstances if an issuer of group or individual health insurance coverage fails to submit a full MLR report and its only health insurance coverage consists of grandfathered plans in small closed blocks. The MLR reporting form instructions were revised accordingly and specify these circumstances.

23. One commenter requested guidance for the treatment of the "mini-med" multiplier in cases where the issuer will aggregate 2011 and 2012 experience.

    CMS Response
    An issuer of "min-med" coverage that aggregates its 2011 and 2012 experience should follow the approach described in the CCIIO Technical Guidance (CCIIO 2012-002), Q&A #36, issued on April 20, 2012, which may be found on the internet at: http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf. The Guidance states, in part:

"45 CFR §158.220(b) provides that, beginning with the 2013 MLR Reporting year, an issuer's MLR is calculated according to the formula in §158.221, aggregating the data reported for three years. On December 7, 2011, the Department issued an MLR Final Rule amending §158.221 and providing mini-med issuers with an adjustment (or multiplier) to the numerator of the MLR (i.e., the total of claims and quality improving activities) as follows: a factor of 1.75 for 2012; 1.50 for 2013; and 1.25 for 2014. The multiplier is applied to the numerator of the issuer's MLR formula…[I]ssuers of mini-med policies should add the reported experience for each MLR year together to obtain the numerator and then apply the multiplier for the current MLR reporting year to the aggregated experience. This is consistent with how other experience is aggregated for purposes of calculating the Federal MLR."

24. One commenter requested that the instructions for Part 2, Section 2, Line 2.1b should be more specific to use calendar year values and not adjust for incurred year. If that is not the intent, then there needs to be some place to address the return of partial risk share amounts collected in 2011 that are returned in 2012.

    CMS Response

    CMS recognizes that some risk share amounts paid or received may be reversed after the three-month run-out period afforded by the instructions. However, CMS does not anticipate the number of such reversals to be significant. Further, similar to other components of incurred claims, actual risk share adjustments occurring after the initial three-month run-out period will be reflected in the following year's MLR calculations.

25. Two commenters requested that the 2011 instructions be used for Part 2, Lines 1.1, 1.2, and 1.3 and allow issuers the option of using either the 12/31 values or values updated as of 3/31 in the 3/31 column for these lines, provided the issuer that elects this option uses it for at least three years.

    CMS Response

    Although the 2011 MLR reporting form and instructions were intended to collect the most accurate premium data, locked cells on the 2011 reporting form prevented issuers from being able to enter premium values updated as of 3/31 in the 3/31 columns. CMS updated the 2012 form to enable issuers to enter premium values updated as of 3/31 in Part 2, Lines 1.1, 1.2 and 1.3. However, in response to commenters' request, CMS revised the instructions to allow issuers an option, for the 2012 reporting year only, of either reporting premium values on the same basis as in the 12/31 column, or reporting updated premium values as of 3/31, in order to afford issuers sufficient time to implement any necessary changes to internal reporting systems.