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January 6, 2012

Attention: CMS-9998-FC
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Final Rule – Medical Loss Ratio Requirements (CMS-9998-FC)
Submitted via www.regulations.gov

Dear Sir or Madam:

We appreciate the opportunity to provide comments on the Final Rule entitled "Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act" ("the Rule") published on December 7, 2011 in the *Federal Register*, especially regarding the treatment of ICD-10 conversion implementation costs, and the process for providing rebates to group enrollees. Our specific comments follow.

ICD-10 Conversion Implementation Costs as Quality Improving Activities

In *§158.150(b)(2)(i)(A)(6) and (c)(5)* of the Rule, the Centers for Medicare and Medicaid Services (CMS) added a recognition of ICD-10 conversion implementation costs as quality improvement activities. This is a positive change that we strongly support. We agree with recognizing the importance of these codes in allowing practitioners to identify and report conditions and condition management in more specific ways that lead to more effective measurements of quality and outcomes.

However, the rule proposes to limit the amount of ICD-10 conversion costs to only those incurred in 2012 and 2013, without recognizing the significant costs health plans have incurred and tracked in 2011, and which they will be required to report on the NAIC Supplemental Health Care Exhibit (the same form on which the proposed federal MLR Reporting form is based). This significant oversight should be corrected by recognition of the conversion costs incurred in reporting year 2011.

Recommendation: We recommend expenses for ICD-10 conversion implementation costs incurred in 2011 also be included in the MLR calculations for 2011.

We also recommend that if CMS delays implementation of the ICD-10 code sets, as some health care providers are recommending, there should be recognition of implementation costs incurred after 2013, consistent with any extension of the implementation timeframe. This is a reasonable consideration, since health insurers would incur additional implementation costs to bridge and maintain dual processing modes and reporting in such a scenario. To be penalized for timely implementation by being prohibited from reporting additional costs (incurred from delays due to other health care systems) would be both unreasonable and unfair.

> **Recommendation: We recommend the timeframe for permitted reporting of ICD-10 conversion implementation costs be consistent with the timeframe CMS sets if there are extensions to the implementation timeframe.**

The Rule also limits – or caps – the amount of ICD-10 conversion implementation costs to 0.3 percent of earned premium in the relevant state market but does not provide a compelling rationale for such a cap. This artificial cap could disadvantage smaller insurers that have significant implementation costs to spread across smaller blocks of business or in fewer states. The cap appears arbitrary and counterproductive at a time when CMS is requiring insurers to lead the implementation process. We thus recommend that the cap be removed.

> **Recommendation: We recommend removal of the 0.3 percent of earned premium cap. In its place we recommend allowing the actual ICD-10 conversion costs to be allocated across the coverage issued in the relevant state markets for years 2011 through 2013 – with extensions past 2013 if CMS's implementation timeframe is extended.**

Distribution of Rebates in Group Markets and Reporting of those Rebates

In *§158.242(b)* "Recipients of Rebates", and *§158.260(c)* "Reporting of Rebates", the Rule permits distribution of rebates owed to those covered under a group health plan through issuing the rebate to the group policyholder. This distribution is subject to certain stipulations as outlined in the rule in *§158.242(b) 1-4*, and through other related guidance such as the Technical Release 2011-04 from the Department of Labor (DOL) and the CMS Interim Final Rule on nonfederal governmental health plans. Allowing for the group policyholder to distribute the rebate to persons covered under the group health plan is a very positive change, for the reasons outlined in the preamble, and as employers have indicated. We support that change. We also recommend that this reliance on the group policyholder – where permitted to distribute rebates to persons covered under the group health plan – should be carried through consistently in *§158.250* "Notice of Rebates".

CMS also provides guidance in *§158.243 (a) (1)* on the determination for *de minimis* rebates when the rebate is provided to the policyholder, which we support.

Recommendation: We recommend that the reliance on the group policyholder to distribute rebates also be reflected in *§158.250* "Notice of Rebates". In addition, we support the provisions for the determination of *de minimis* rebates.

Notice Requirements to Recipients of Rebates

In *§158.250* "Notice of Rebates", the Rule provides guidance on the notice requirements when the rebate is provided to the group policyholder. We note that terminology used in this section at the bottom of page FR76593 could be read in a way that conflicts with the intent stated in the preamble and in the opening paragraph of *§158.250 (a)* "Notice of Rebates".

The terminology that we recommend be modified is the language that states "an issuer must provide to each policyholder who receives a rebate and subscribers whose policyholder receives a rebate….the following information in a form prescribed by the Secretary:" We recommend this notice requirement be met by the issuer providing that information to the policyholder, and the policyholder including it with the rebate issued – or description of how the rebate is used - to the group's covered enrollees.

We thus recommend the phrase read "an issuer must provide each policyholder who receives a rebate ~~and subscribers whose policyholder receives a rebate~~, or each subscriber who receives a rebate directly from an issuer, the following information in a form prescribed by the Secretary:" This would be consistent with the requirements outlined in *§158.242(b),* with the latter reference to each subscriber only in the cases of the exceptions in *§158.242(b) (3) and (4)* – where the notice and rebate would go to the subscriber.

Requiring health plans to issue those notices separately would require the group policyholder to provide reports to the insurer so that the insurer could subsequently issue notices, increasing the administrative costs on both groups and insurers. This requirement would also be very difficult to administer in those cases where the insurer owing the rebate (insurer of reporting year 2011) is not the current (year 2012) group health plan insurer. The 2011 insurer would not have information related to all current (2012) enrollees. Thus, reliance on the group health plan policyholder would be necessary for that information, further illustrating the rationale for the policyholder to provide notice of rebate to employees or group health plan enrollees.

Recommendation: We recommend the Final Rule language in *§158.250(a)* remove the conflicting phrase "*and subscribers whose policyholder receives a rebate*" from the section, as found on the bottom of FR 76593 and top of page FR 76594.

The preamble to the Rule [FR76580] also notes that the Secretary of Health and Human Services (HHS), in consultation with the Secretary of Labor will prescribe the notice of rebates to policyholders and subscribers of group health plans. We respectfully request that HHS and DOL release the proposed language of such notices at the earliest opportunity, to allow public review

and input in January. We also recommend that HHS and DOL provide for flexibility in the method in which the notice of rebate language is delivered to rebate recipients. Health insurers have many channels of communication with enrollees, and will provide the notice via the communication channel most appropriate for the enrollee.

> **Recommendation: We recommend the proposed language for notice of rebate to group policyholders or rebate recipients be released for comment as soon as possible. We further recommend that insurers be permitted flexibility regarding the means by which they issue the notice of rebates.**

Other Comments

Notice of MLRs to Non-Recipients of Rebates

In the preamble to the Rule [FR 76580-76581], CMS considers proposing a Notice of MLR be sent to policyholders *not* receiving rebates, suggesting that showing MLRs for the current reporting year and *the prior year* could be useful to subscribers in predicting what might be expected to happen the next year, and in making plan choices.

There are several significant reasons why the newly proposed reporting requirement would not be helpful to subscribers as suggested in the preamble, but would instead lead to confusion, and have unintended consequences that would add administrative costs and complexity to a process for MLR calculations and reporting that is already onerous. And, this additional red-tape would be imposed on insurers who are already in compliance with the MLR standards. For example, if required to mail out a notice of MLR, insurers would see increased calls in their customer service departments, since sending information that requires no action often results in subscriber confusion. Insurers would also have to incur additional costs to identify the relevant MLR from prior years for coverage for individuals, which is not an element of the MLR calculation on which the current reporting year is based.

The main reason suggested in the preamble for such notice of MLRs is for a predictor of year-to-year premiums or MLRs. Insurers are concerned with this proposal because the MLR for each year is based on the claims in that year and would not necessarily be relevant to another year nor be helpful for consumers for a number of possible reasons:

- MLR values can vary significantly from year to year based on claims and adjustments.
- MLRs are not a predictor of claims experience or premiums.
- Rebates are based on an average MLR adjusted for cumulative credibility. The MLR itself could be below the MLR required value without requiring any rebate. If this is the case for the prior year, showing the prior year MLR will create questions about why no rebate was paid in that year.

- Premium rates may be based on expected results from the experience in a group of states, not just a single state (especially if the business is not credible), so prior MLRs are not an indicator of expected MLRs in that case, either.
- Premium rates for the next year are unlikely to be based on MLRs from two years prior.
- For reporting year 2011, the prior MLR would not have been calculated using the new federal MLR methodology, thus there is no accurate comparison MLR number to provide.
- In reporting year 2013, the three year averaging would affect the prior year comparison number.

Requiring such a notice would add to the administrative burden on insurers and policyholders, creating an unnecessary and overly burdensome regulation. To provide an estimate of the cost and complexity, we reached out to a number of large and small insurers for examples of the impact. The graphic provided in the attached exhibit demonstrates the depth and scope of activities required for this proposed additional requirement. Depending on insurer size, the net cost per notice was between $2.00 and $3.00, which arrived at an estimated impact of $200 - $300 million dollars[1] for this activity.

There is no requirement in the Affordable Care Act that such a notice be provided, and requiring one would create a significant new administrative burden on insurers with no related benefit to consumers. For these reasons, we oppose a new mandate that would require insurers issue to non-recipients of rebates a new Notice of MLR.

> **Recommendation: We strongly recommend that the proposed requirement in the preamble that a Notice of MLR be sent to policyholders *not* receiving rebates should not be adopted.**

Fraud Prevention Expenses as Quality Improvement Activities

We view the non-inclusion of costs related to fraud prevention and detection as a missed opportunity in the MLR Final Rule that should be revisited, and subject to a new notice and comment period in a revision to the rule. We remain concerned that the Rule only allows recoveries from fraud programs to be counted toward the MLR, while capping expenses to prevent or detect fraud – in other words, rewarding and encouraging only the "pay and chase" system that Congress has moved public programs away from. Health insurance plans devote significant resources to fraud prevention and detection programs as part of a broad-based strategy for improving health outcomes and achieving the optimal use of health care dollars. Recognizing that fraud has far-reaching implications both for health care costs and quality,

[1] *Assuming that the U.S. population is about 300 million individuals – excluding individuals with Medicare and Medicaid (about 95 million individuals), individuals receiving rebates, and dependents – we conservatively estimate that there could be upward of 100 million MLR notices sent.*

health plans have developed cutting-edge techniques to identify fraud and halt practices that lead to substandard care – including the delivery of inappropriate or unnecessary services that may harm patients.

These health plan anti-fraud initiatives are strongly focused on preventing fraud before it takes place, rather than "paying and chasing" after the fact. This approach serves as a powerful deterrent in preventing not only inappropriate billings, but more importantly, preventing inappropriate delivery of unnecessary or inappropriate services from occurring in the first place. The success of health plans' fraud prevention initiatives is evidenced by the fact that government programs now are incorporating these innovative private sector practices.

By taking this approach, the MLR Rule's treatment of fraud prevention expenses works at cross purposes with CMS's efforts to emulate successful private sector programs, and it is at odds with the broad recognition by leaders in the private and public sectors that there is a direct link between fraud prevention activities and improved health care quality and outcomes.

Recommendation: We recommend fraud prevention and detection expenses be included as quality improving activities in the MLR methodology of the rule.

We appreciate the opportunity to provide these comments on the Final Rule, and look forward to working with you in constructive approaches to implementation of the requirements of the ACA.

Sincerely,

Daniel T. Durham
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Policy and Regulatory Affairs

Colleen M. (Candy) Gallaher
Senior Vice President
State Policy

Mass Mailing Process