BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

January 6, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted via the Federal Rulemaking Portal: http://www.regulations.gov

Re: Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act; Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans (CMS-9998-FC; CMS-9998-IFC2)

Dear Secretary Sebelius:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to submit comments on the Final Rule (the "Final Rule") on Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act and the Interim Final Rule (the "Interim Final Rule") on Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans.

BCBSA is a national federation of 38 independent, community-based, and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for more than 99 million – one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"), and the Federal Employees Health Benefits Program.

BCBSA commends HHS for recognizing the logistical and tax problems inherent in the original Interim Final Rule's approach for providing rebates in the group market. We believe that the changes to the rebate process in the Final Rule that allow rebates in the group market to be provided to the policyholder greatly simplify the process for employers and subscribers. In addition, the changes made to the accounting treatment of costs related to ICD-10 properly recognize that this new coding system can be used for quality improvement activities.

We are, however, concerned that HHS states in the Preamble of the Final Rule that they are considering imposing a MLR notice requirement for issuers that do not owe rebates. Such a notice requirement unnecessarily adds significant administrative costs to issuers that are complying with the MLR requirements and in many cases have medical loss ratios far above the minimum requirements. This notice requirement ultimately would result in an increase in costs for health care coverage, while being of little value to the vast majority of consumers and, in fact, will likely result in increased confusion.

To ensure that the MLR regulation achieves its objectives in the most efficient manner, our key recommendations are as follows:

- Maintain the process outlined in the Final Rule and Interim Final Rule for providing rebates to group subscribers by distributing the rebate to the employer, who then distributes it to subscribers. Only technical, process-related enhancements such as those noted below should be made.

- Do not expand the MLR notice requirements to include policyholders or subscribers of Plans which are not receiving rebates.

- Provide employers with the latitude to reduce premiums or enhance benefits in the plan year following receipt of the rebate.

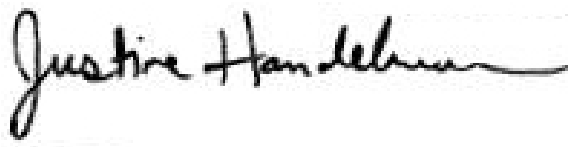
- Permit the MLR notice to group subscribers to include only the percentage of rebate and not the actual dollar amount.

- Do not require the MLR notice to include information on the prior year MLR.

- Permit costs related to ICD-10 conversion to be categorized as a quality improvement activity in the MLR calculation for 2011 consistent with the treatment for 2012 and 2013 and eliminate the 0.3 percent limit.

Attached are BCBSA's detailed comments and recommendations on the Final Rule and the Interim Rule. We appreciate your consideration of our comments. We look forward to continuing to work with HHS on implementation issues related to the Affordable Care Act. If you have any questions, please contact Richard White at (202) 626-8613 or at richard.white@bcbsa.com.

Sincerely,



Justine Handelman
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association

The following are BCBSA's detailed comments and recommendations on the Final Rule and Interim Final Rule addressing Medical Loss Ratio Requirements under the ACA:

I. Recipient of Rebates (§158.242) and Notice of Rebates (§158.250)

A. Rebates in the Group Market Should Generally be Provided to the Employer

Issue: The original Interim Final Rule would have resulted in significant logistical and tax issues associated with the approach in the group market of requiring the issuer to be responsible for providing a proportionate share of the rebates to subscribers, along with the reporting related to these rebates. Issuers would not have the information on the amounts specific subscribers contributed towards coverage, and the logistics associated with obtaining that information and the tax treatment of these contributions would have been extremely challenging and resulted in incomplete information.

Recommendation: BCBSA strongly supports the process outlined in the Final Rule and Interim Final Rule for providing rebates to group subscribers by generally providing the rebate check to the policyholder/employer. We recommend that this process be maintained and only technical, process-related enhancements, such as those below, should be made.

Rationale: The approach in the Final Rule and Interim Final Rule significantly reduces the administrative complexity associated with providing rebates to the policyholder and their enrollees and addresses the tax issues associated with returning rebates that potentially were paid with pre-tax dollars. The old process required issuers to pay rebates to both the group policyholder and individual subscribers in amounts proportionate to the amounts the policyholder and subscriber paid. The issuer could enter into an agreement with the group policyholder for the policyholder to distribute the rebates to subscribers. Even with such an agreement, however, the insurer remained liable if the group policyholder did not distribute the rebates to enrollees accurately and on a timely basis, or did not provide the insurer with documentation detailing such distribution of the rebates.

Holding the health insurance issuer liable for distributing rebates proportionally between the policyholder and the subscriber was problematic because in almost all cases the issuer did not know the amount the subscriber contributed towards the coverage. Requiring employers to provide detailed information regarding the employer/employee contribution split on a prospective basis as part of the renewal process is not a solution to this problem, as employers can and do change contribution levels without notice to issuers.

The new process allows the employer to integrate the return of premium into their payroll process, greatly simplifying both the administration and any tax reporting.

B. Issuers Should not be Required to Send Notices to Persons not Receiving a Rebate

Issue: HHS states in the Preamble of the Final Rule that they are considering imposing a MLR notice requirement for issuers that do not owe rebates. Requiring insurers to send a MLR notice to all consumers in situations where a rebate is not being issued imposes an additional and unnecessary administrative and financial burden on insurers and provides no additional reliable, valid or useful information to the consumer.

Recommendation: HHS should not require issuers to provide an MLR notice to policyholders and subscribers not receiving a rebate.

Rationale: MLR data is unrelated to consumer health plan decision-making criteria and will be of little value to members in making healthcare choices. Provision of this information may actually result in confusion for consumers and prompt additional calls to health plan customer support lines, resulting in additional costs. Consumers typically make health plan purchasing decisions based on premium, out-of-pocket costs, healthcare benefits and quality of provider networks.

When comparing two plans that are equivalent in areas such as premiums, a low MLR may appear to indicate less efficiency. However, MLRs can be a misleading indicator of a plan's efficiency or value. For example, a health plan that devotes more resources to obtaining high quality and lower cost providers might have a relatively lower MLR and still provide the best value to the consumer. The concept of consumers purchasing a health plan based on MLR is analogous to making a purchase decision for a car based on the manufacturer's cost of goods sold. As a result, providing information on MLRs may be misinterpreted by consumers as they compare plans. In addition, MLRs are reported at the market segment level and not the plan level so they are not necessarily relevant to a specific purchase decision.

This requirement would also impose an additional unlegislated mandate on health plans that increases administrative costs that are ultimately borne by customers in the form of higher premiums. Based on 2010 data, the incremental cost associated with mailing notices to subscribers whose issuer met the MLR requirement could total over $27 million dollars annually to subscribers alone. This does not include the additional cost of mailing to group and individual policyholders or the cost associated with the inevitable phone inquiries.

Estimated Incremental Mailing Cost if MLR Notice is Sent to All Policyholders and Subscribers

Market	Number of Lives (2010)[1]	Number of Subscribers[2]	Percent of Lives Meeting MLR Requirement (2010)[3]	Cost of Business Letter[4]	Additional Cost Incurred by Insurers Meeting MLR Requirement[5]
Small Group	17,905,130	8,952,565	97%	$1.00	$ 8,683,988
Large Group	39,102,469	19,551,234	98%	$1.00	$ 19,160,210
Total	**57,007,599**	**28,503,800**			**$ 27,844,198**

Furthermore, in the group market, employers and/or their human resource personnel, not subscribers, usually make decisions regarding which issuers are available to subscribers. As a result, providing group subscribers data on MLRs does not give them actionable or relevant information on which to base health plan decisions.

Given the significant cost of this burdensome administrative requirement and its limited value, CMS should not require issuers to provide the MLR notice to policyholders and subscribers who are not receiving a rebate. An issuer's full report of their MLR for a market segment in a state will already be available on healthcare.gov and the full report provides sufficient detail so as to reduce confusion for policyholders and subscribers who are not due a rebate and who may be interested.

[1] The number of covered lives is based on GAO analyses of NAIC data.
Source: The United States Government Accountability Office. Private Health Insurance: Early Indicators Show That Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards. October 31, 2011.

[2] The number of covered lives includes all subscribers and their dependents. Based on the Employee Benefit Research Institute, we estimate that there are approximately two members per subscriber in the small and large group employer market.
Source: Fronstin, Paul. "Sources of Health Insurance and Characteristics of the Uninsured. Analysis of the March 2011 Data Current Population Survey" EBRI Notes, no. 362 (Employee Benefit Research Institute, September 2011).

[3] Percentage of lives meeting MLR requirement for the small and large group markets are based on HHS medium-range estimates of lives not meeting the minimum MLR threshold for that market.
Source: 45 CFR Part 158 Table VI.8 and Table VI.9 (2010).

[4] Estimated cost of sending a notice of rebate is based on HHS estimates stated in Table VI.12 of the Medical Loss Ratio Requirements Interim Final Rule. Cost is based on 2010 dollars.
Source: 45 CFR Part 158 Table VI.12 (2010).

[5] We calculated the additional cost associated with mailing MLR notices to customers not receiving rebates by multiplying the number of subscribers in plans meeting MLR requirement in each market segment by the cost of developing and mailing a notice of rebate form.

C. Employers Should be Allowed Additional Time to Use Rebates for the Benefit of Plan Members

Issue: The Interim Final Rule and the Department of Labor ("DOL") Guidance on Rebates for Group Health Plans Paid Pursuant to the Medical Loss Ratio Requirements are unclear as to the timeframe in which a group health plan ("GHP") or a non-Federal governmental plan ("NFGP") must use the rebate to benefit subscribers.

In the case of a NFGP, the Interim Final Rule uses the term "subsequent year". It is unclear if this means the subsequent year to the year in which the NFGP receives the rebate or the subsequent year to the year for which the rebate was payable. If it is the latter, a NFGP whose plan year begins in September or October has virtually no chance to select the options outlined in §158.242(b)(1)(i) and (ii) that allow the NFGP to reduce the premiums for what appears to be an entire plan year since those NFGP's plan years end one after two months of receiving the rebate.

The DOL guidance also is unclear and appears to require certain types of GHPs to use the rebates within 3 months. This eliminates the option of reducing premiums for an entire plan year, which many employers would have elected as it reduces the administrative effort.

Recommendation: Clarify that employers can reduce premium or enhance benefits in the plan year following receipt of the rebate.

Rationale: The current requirements for GHPs and NFGPs could be interpreted to significantly limit the ability of many employers to use the rebate to reduce premiums or, in the case of certain GHPs, enhance benefits. Many GHPs, NFGPs and subscribers would prefer to receive the benefit of the rebate over the entire year. In addition, the time frames that some GHPs and NFGPs will face will be challenging and do not appear to allow a reasonable amount of time for them to determine who is due a rebate, how much each person receives and then issue the rebate.

D. The MLR Notice to Group Subscribers Should Just Include the Percentage of Rebates

Issue: Section 158.250(a)(6) requires issuers to communicate the percentage and the amount owed [emphasis added] to enrollees in the MLR notice. It is unclear what amount the issuer is to communicate to the subscribers. If it is the subscriber's proportionate share of premium paid, this notice requirement would have most of the same logistical issues associated with requiring the issuer to provide the proportionate share of the rebate to the subscriber. If it is the total amount of the rebate being provided to either the policyholder or all policyholders in the market segment in a state, this number is not meaningful.

Recommendation: The MLR notice to group subscribers should just include the percentage of rebate and not the actual dollar amount. We recommend the words "and the amount owed" be deleted from §158.250(a)(6).

Rationale: If issuers are required to include the actual amount of the rebate the subscriber is receiving in the notice, it has most of the same logistical issues for issuers and employers as providing the enrollee with their proportionate share of the rebate. If the amount intended to be

shown is either the amount of the rebate being provided to the policyholder or to all policyholders in a market segment in a state, this number is not meaningful and may confuse subscribers. Providing only the percentage addresses these issues and is much more meaningful since the enrollee can look at their yearend payroll information to see how much they paid for health insurance and approximate how much they may receive from their employer in the form of a refund, reduced employee contributions or enhanced benefits.

E. HHS Should not Include Prior Year MLR Information on the MLR Notices

Issue: HHS is seeking comments on whether they should include prior year MLR information on the MLR notice. The following rationale is included in the preamble: "Information showing a less favorable MLR in the current year than that from the year before could be useful to policyholders and subscribers in predicting what might be expected to happen the next year, and thus in making plan choices." Unfortunately, this logic does not consider the volatility associated with health care claims, particularly for smaller, less credible blocks of business.

Recommendation: HHS should not include prior year MLR information on the MLR notice. If HHS wants to provide this information it can be disclosed on the healthcare.gov website along with proper disclosures so consumers do not misinterpret the information.

Rationale: Health insurance claims fluctuate from year to year for a variety of reasons and these fluctuations could be misinterpreted by consumers. Examples include changes in seasonality or an unusual amount of large claims:

- The peak of the normal flu season could occur in February and December of the same year resulting in a higher MLR for that particular year. The following year might have an unusually low MLR if it does not experience a peak flu season.

- Large claims can also cause unexpected fluctuations in MLR. For instance, a block of business may have several premature infants in one year that cost millions of dollars and not have this phenomenon again for many years.

The variability of these fluctuations is greater in smaller, less credible blocks of business. Depending on the size of the block of business, MLRs could be expected to fluctuate from one MLR percentage point to ten or more percentage points in any given year. Section 158.232 of the Final Rule recognizes this normal, expected fluctuation and allows for credibility adjustments in the MLR rebate calculations if there is less than 75,000 "life years" of experience. Many issuers in a given market segment of a state do not have 75,000 "life years" and their claims experience would not be considered credible according to this standard.

Given the above issues, including the prior year MLR in the MLR notice clearly does not accomplish the policy goals HHS has outlined in the preamble.

II. ICD-10 Conversion Costs (§158.150)

A. 2011 ICD-10 Conversion Cost Should also be Categorized as a Quality Improvement Activity

Issue: In the Final Rule, HHS changed the treatment of ICD-10 conversion cost for 2012 and 2013. For those years ICD-10 is now categorized as a quality improvement cost. Many issuers have also incurred ICD-10 conversion cost in 2011 and the treatment is inconsistent.

Furthermore, there is no rationale for limiting the ICD-10 conversion expenses, which are classified as a quality improvement activity to 0.3% of total premiums

Recommendation: HHS should permit carriers to classify 2011 ICD-10 conversion expenses as a quality improvement activity in the MLR calculation and the ceiling of 0.3% of total premiums should be eliminated.

Rationale: BCBSA strongly supports the change made by HHS in the Final Rule to allow issuers to receive credit for certain ICD-10-related expenses as a quality improvement activity in the MLR calculation. As we have previously stated in comments and as HHS made clear in the Preamble to the ICD-10 Final Rule, a major reason behind HHS' requirement for HIPAA covered entities to transition to the ICD-10 code set was to improve quality.

Following this logic, we believe ICD-10 conversion expenses should also be categorized as a quality improvement activity in the MLR calculation for 2011. This would provide for consistent treatment across the years in which plans are incurring the vast majority of their ICD-10 implementation cost. Not having consistent treatment across years is inequitable as it penalizes those issuers who started their ICD-10 implementation efforts earlier. Issuers who incur the vast majority of their ICD-10 conversion expenses in 2012 and 2013 will receive almost full MLR credit for their ICD-10 compliance expenses, while the issuers who started their implementation earlier will not receive credit.

In addition, there is no basis for limiting the ICD-10 expenses for which credit can be taken to 0.3% of total premium. The final rule restricts ICD-10 quality improvement expenses to conversion costs and limiting the amount could result in inequitable treatment for issuers who incur all or most of their conversion costs in one year or for smaller issuers whose conversion costs on a percentage basis are higher.

III. Additional Requested Clarifications

A. Written Assurance from Nongovernmental, Non-ERISA Group Policyholders on Use of MLR Rebates

Issue: Clarification is needed regarding the required written assurance provided to non-governmental, non-ERISA group policyholders. The preamble to the Final Rule (76 Fed. Reg. 76580, December 7, 2011) says that the written assurance as to use of MLR rebates to benefit subscribers from a non-governmental, non-ERISA group policyholder should include the options for use of MLR rebates made available for NFGPs. However, in Section 158.242(b)(3) of the Final Rule, it merely says that the written assurance must state that rebates will be used to benefit subscribers. It does not specifically refer to the options available to NFGPs. The Final Rule simply says that (b)(1) and (2) are "reserved."

The Interim Final Rule (76 Fed. Reg. 76599-76600), (b)(1) and (2) describe the options for the use of rebates to benefit enrollees that are available to NFGPs. In (b)(3), a nongovernmental, non-ERISA group policyholder is required to provide a written assurance that includes the options for use of MLR rebates made available for NFGPs.

Recommendation: HHS should clarify that the written assurance as to use of MLR rebates to benefit enrollees from a nongovernmental, non-ERISA group policyholder should include the options for use of MLR rebates made available for NFGPs.

Rationale: Clarification is needed regarding the required written assurance provided to non-governmental, non-ERISA group policyholders so issuers know whether to reference the rebate distribution alternatives contained in the Interim Final Rule for NFGPs in the required agreement with non-governmental, non-ERISA plans.