BlueCross BlueShield Association

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OMB
Office of Information and Regulatory Affairs

Attention: CMS Desk Officer. Document Identifier/OMB Control No. 0938-NEW (Form Number CMS-10379)

Submitted via e-mail: OIRA_submission@omb.eop.gov

Re: Agency Information Collection Activities; Submission for OMB Review; Comment Request – Rate Increase Disclosure and Review Reporting Requirements; Form Number CMS 10379, OCN 0938-NEW

Dear Sir or Madam:

The Blue Cross Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services (CMS) collection request for "Rate Increase Disclosure and Review Reporting Requirements (45 CFR Part 154)" issued in the Federal Register on June 1, 2011. 76 Fed. Reg. 31613.

BCBSA represents the 39 independent Blue Cross Blue Shield Plans ("Plans") that provide health coverage for more than 99 million members – 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.

We provide general comments, one key recommendation, and detailed comments and recommendations on the Preliminary Justification Forms, Rate Summary Worksheet and Instructions below.

General Comments on the Rate Summary Worksheet, Instructions and Consumer Disclosure Form

Overall, we believe that CMS has made helpful changes to the Rate Summary Worksheet, the Instructions, and the Consumer Disclosure Form. We appreciate these changes and believe the Consumer Disclosure, as revised, will provide useful information to the consumer regarding the reasons for health insurance premium increases.

We applaud the revisions made in the instructions related to the following items:

- Validation that the process is intended to measure changes in the underlying rate structure;
- Instructions for using an identical population when calculating immediately before and after the rate increase to capture the magnitude of the rate change; and
- Clarification that determination of whether a rate increase is subject to review would be based on using the Rate Summary Worksheet methodology.

These three revisions have answered many of our Plans' questions related to this process. In addition, other changes have provided clarification which we believe will help to make the information more consistent across issuers.

Key Recommendation on the Rate Summary Worksheet, Instructions, and Consumer Disclosure

We offer the following key recommendation for your consideration in order to further improve the various components of the Preliminary Justification. This recommendation is consistent with the recommendation included in our May 2, 2011 comment letter regarding the previous version of these forms.

To minimize consumer confusion, set the expectation that the information in Parts I, II, and III and the Consumer Disclosure are not intended to be consistent with the medical loss ratio ("MLR") rebate calculation by including a disclaimer as such on the appropriate forms.

Summary: The information presented on the Consumer Disclosure and on Parts I and II of the Preliminary Justification does not include information on several elements that are part of the MLR rebate calculation, including quality improvement expenses, provider incentives and federal and state taxes and licensing or regulatory fees. We do appreciate the revision made to the instructions regarding Part III on page 11 under item 7 noting that the projected future loss ratio requested is "not the 'adjusted' federal loss ratio."

Issue: Consumers who are viewing the Consumer Disclosure are also likely to be aware of the MLR rebate calculation requirements of the ACA. Presenting the information without a disclaimer that the information is presented in a manner that does not correlate with the MLR rebate calculation will lead to consumer confusion. For example, federal and state taxes along with licensing and regulatory fees are included in the administrative expenses in the Rate Summary Worksheet and in the Consumer Disclosure which is how they are typically presented in a rate filing with a state. However, in the Federal MLR rebate calculation these values are excluded from premium, and thus, excluded in the denominator. A savvy consumer who looks at the chart on page 5 of the Consumer Disclosure, which reflects medical services as a percentage of premium (76.2% in the example), and sees this value on the Rate Summary Worksheet will think this "MLR" is below the federal MLR rebate calculation requirement of 80% and believe a rebate will be due. The calculations for the two different "MLRs" are not the same, for numerous reasons, but without pointing this out to the consumer, confusion will likely result.

Recommendation: Even with the additional clarification in the instructions to Part III, additional disclaimers would be valuable if added to the Rate Summary Worksheet, the instructions and in the Consumer Disclosure. We recommend that disclaimers be provided at the top of the Rate Summary Worksheet, in the "Overview" section of the instructions, and on page 1 of the Consumer Disclosure.

Language such as the following would provide valuable clarification: "The values presented on these forms do not and are not meant to be consistent with the federal Medical Loss Ratio rebate reporting, as the methodologies, time periods, and aggregations are different."

Detailed Comments and Recommendations

Tables 1 through 3 below provide BCBSA's more detailed comments, clarifications and recommendations for changes to the Consumer Disclosure (Table 1), the Rate Summary Worksheet (Table 2), and the Instructions (Table 3). In addition, after Table 3 we include a section entitled, "Clarification Request Related to Examples on Page 2 of the Instructions" with questions related to interpreting the examples included in the instructions, and a section entitled, "Clarification Request Related to 'Product' Definition" with questions related to interpreting the definition of the term "Product."

Table 1
Consumer Disclosure Issues and Recommendations

Page / Section	Issue	Recommendation
General – throughout document	We believe that the values included on the Consumer Disclosure are meant to be populated from the Rate Summary Worksheet. However, many of the values in the revised Consumer Disclosure released June 1 do not match the values in the Rate Summary Worksheet released June 1.	We recommend that whenever these forms are released with example values which reflect how the documents relate to each other, that the forms be released with all values matching. This helps validate the functioning of the various forms.
Page 1	Without a disclaimer that the values presented on this disclosure are not meant to be consistent with the federal Medical Loss Ratio rebate reporting, consumers could be confused (see Key Recommendation above).	We recommend that CMS include a disclaimer at the bottom of Page 1 of the Consumer Disclosure. We suggest the following language: "The values presented on these forms do not and are not meant to be consistent with the federal Medical Loss Ratio rebate reporting, as the methodologies, time periods, and aggregations are different."
Page 2, second bullet under the section, "How will	This sentence reads, "The premiums may be higher, based on an individual's rating factors,	We recommend that CMS change the language to something more general, such

this rate increase affect the premiums people pay?"	or in an employer group plan, based on ages, family structure, and health experience of the group members." This language seems to imply some factors are not used for individual market business that may be used for small group business, when in reality, many items affect both individual business and small group business. We recognize this language allows for flexibility in rating rules by state and appreciate the revision made. However, it may be confusing to consumers.	as, "The premiums may be higher or lower based on rating factors allowed by a particular state or other considerations, such as age, family structure, duration, benefit configuration, employer contributions, and health experience."
Page 3, in the 1st chart, under the row titled, "Medical Services"	The term "policyholders" is used in this table, where everywhere else in the document this was changed this to "groups and covered individuals."	We recommend that CMS change "policyholders" here to "groups and covered individuals" to be consistent throughout the document.
Page 4, in the first chart, "Ancillary Services"	The service category called "Ancillary Services" is not the same name as the service category from the Rate Summary Worksheet where the values are derived. The name of this category on the Rate Summary Worksheet is "Other." This can create confusion for the consumer, if they also review the Rate Summary Worksheet, if this will be publicly available.	Due to potential confusion with the "Other" category on the Rate Summary Worksheet, we recommend that CMS rename the "Other" category on the Rate Summary Worksheet to "Ancillary Services." This will result in consistency in naming between the two forms.
Page 4, second table (new) entitled, "What's Causing These Medical Service Costs to Increase"	We believe this table is meant to be populated using values from Section B3, "Medical Trend Breakout," of the Rate Summary Worksheet. The term "Other Costs" in the new table uses the same definition footnote as for the "Other Costs" in the service category table. "Other Costs" in the service category table reflects various categories of care, whereas the "Other Factors" in section B3 of the Rate Summary worksheet reflects various drivers of trend not specifically related to any service category.	We recommend that the "Other Costs" column of the second table be renamed to "Other Factors" to match the Rate Summary Worksheet. In addition, we recommend that a new footnote for the "Other Factors" column be provided, using language such as, "Other Factors reflect mix, severity, deductible and cost sharing leveraging, and other trend items affecting medical service costs."

	This will cause confusion for the consumer.	
Page 5, 1st chart	This chart shows the breakout of the premium into "Cost of Medical Services," "Administrative Expenses," and "Profit or Retained Earnings." The category "Profit and Retained Earnings" has been renamed on previous pages of the Consumer Disclosure, and could cause confusion to the consumer. In addition, some issuers may have values for underwriting gain/loss that are negative, reflecting a loss. A pie chart does not reflect negative values in a way that is easily understood.	We recommend renaming the category currently entitled, "Profit or Retained Earnings" to "Underwriting Gain/Loss" to be consistent throughout the Consumer Disclosure.. We recommend that this chart be changed from a pie chart to a table of PMPM values and percentages, to allow for situations where some elements, in particular underwriting gain/loss, may be filed as a negative value (e.g., loss).

Table 2
Rate Summary Worksheet

Page / Section	Issue	Recommendation
General	The revised Rate Summary Worksheet was released as a PDF version, which does not allow for validation of the formulas in the worksheet.	We recommend that CMS release a working spreadsheet, so calculations can be validated rather than assumed.
General	We believe that the values included on the Consumer Disclosure are meant to be populated from the Rate Summary Worksheet. However, many of the values in the revised Consumer Disclosure released June 1 do not match the values in the Rate Summary Worksheet released June 1.	We recommend that whenever these forms are released with example values which reflect how the documents relate to each other, that the forms be released with all values matching. This helps validate the functioning of the various forms.
General	There are many titles or headers on the instructions that do not match the titles or headers on the Rate Summary Worksheet to which the instructions refer.	We recommend that the instructions be re-released with all headers and titles matching the Rate Summary Worksheet. Appendix A is attached identifying the list of naming convention differences between the Instructions and the Rate Summary Worksheet.
Section B1 and B2 of Rate Summary Worksheet, and Pages 4 and 5 of Instructions, instructions for inputting "Overall Medical Trend"	The values for "Overall Medical Trend" are requested to be inputted in sections B1 and B2 in the format "1.xxx," or three decimal places, on the Instructions. However, the Rate Summary Worksheet shows four decimal places, or "1.xxxx."	We recommend that CMS change the Rate Summary Worksheet decimal places to three places, as noted in the instructions.
Sections B1 and B2 of Rate Summary Worksheet, and Page 5 of Instructions, instructions for inputting "Cost Share" percentages	"Cost Share" percentage values are requested to be input in Sections B1 and B2 "in the decimal format ".xxx," or three decimal places. However, the values reflected on the Rate Summary Worksheet example only shows two decimal places in the format ".xx."	We recommend that CMS expand these cost share columns to reflect the instructed 3 decimal place input ".xxx." This should help with validating the value for the Net Claims for the prescription drugs service category, which currently cannot be calculated as $44.79 when using 0.26 as the cost share, as presented in the example.
Section B2 of Rate	The instructions include the	We recommend that to be

Summary Worksheet, and Page 5 of Instructions, instructions for "Cost Share" under section B2	following comment for "Cost Share" under Section B2, "If the issuer believes that not all cost sharing has been captured (a situation that can easily arise in a number of situations including but not limited to capitation), an estimate of missing cost sharing should be used to provide insureds a good estimate of their cost sharing." The example included in the Rate Summary Worksheet shows $0 and 0% for capitation cost sharing. In addition, there may not be a good way to estimate these "missing" cost share values.	consistent with the instructions, that the example included in the Rate Summary Worksheet include a value for cost sharing for capitation. We also recommend that CMS change the Instructions to note that in those situations where values cannot be readily estimated, that the cost share shown can be reflected as zero, and an explanation be provided in Part II.
Section B2	The Rate Summary Worksheet provides values reflected in the Consumer Disclosure. However, there are some values reflected on page 5 of the Consumer Disclosure which are not reflected on the Rate Summary Worksheet. These values are percentages of the medical services by service category, which can be easily calculated on the Rate Summary Worksheet by adding an additional column in Section B2 to reflect the percentages of the net claims PMPM by service category.	We recommend that these values be included on the Rate Summary Worksheet such that all values reflected on the Consumer Disclosure can be validated back to the Rate Summary Worksheet, and do not have to be hand calculated by someone reviewing the two forms together.
Section D of Rate Summary Worksheet, and Pages 7 and 8, Instructions of new line items for "Non-Claims Components – PMPM"	The instructions include descriptions of new line items for non-claims components of the rate increase. However, these were not reflected in the Rate Summary Worksheet example.	We recommend that CMS expand the PDF version of the Rate Summary Worksheet (or release a working version of the worksheet) so it shows the additional lines in Section D, Components of Rate Increase, "Non-Claims Components – PMPM" for line items 9 through 13, and "Claims and Non-Claims Components – Percent Change" that were described in instructions.

		In addition, the instructions may also need to be fixed, because line “9. Total” already exists. Thus, the new line items may need to start with item 10 and go to 14, rather than 9 to 13.
Sections A, B1, B2 and D of the rate Summary Worksheet, and pages 4 and 5 of the Consumer Disclosure	The Consumer Disclosure uses the term “Ancillary Services” on pages 4 and 5 when reflecting the values for the “Other” service category from the Rate Summary Worksheet.	In order to decrease confusion, we recommend that CMS change the name of the “Other” service category on the Rate Summary Worksheet to “Ancillary Services.”

Table 3
Instructions for Completing the Preliminary Justification

Page / Section	Issue	Recommendation
General	There are many titles or headers on the instructions that do not match the titles or headers on the Rate Summary Worksheet to which the instructions refer.	We recommend that the instructions be re-released with all headers and titles matching the Rate Summary Worksheet. Appendix A is attached identifying the list of naming convention differences between the Instructions and the Rate Summary Worksheet.
Page 1, third from last paragraph	On page 1 of the instructions, the third from last paragraph states, "The information reported on the preliminary justification form for a reportable rate increase is the same basis that is used to determine whether an increase exceeds the 10% threshold, making it subject to review." The final rule in Section 154.200(a)(1) and (2) states "(1) The rate increase is 10 percent or more…" and "(2) The rate increase meets or exceeds a State-specific threshold…"	We recommend that CMS change the language in the instructions to state, "The information reported on the preliminary justification form for a reportable rate increase is the same basis that is used to determine whether an increase meets or exceeds the 10% threshold, making it subject to review." In addition, the language should be adjusted to allow for a change to state specific thresholds beginning on September 1, 2012.
Page 2, "Overview" section, examples	There are a number of examples explaining the "annual window" and the "cumulative effect" of rate increases. These are very helpful in explaining the cumulative effect of a "one year period from the effective date of any increase." We believe the examples are meant to reflect one year periods on a forward looking basis, rather than a look back basis, and would like clarification on this interpretation.	We request that CMS comment on our interpretations itemized in the section of this letter below Table 3 entitled, "Clarification Request Related to Examples on Page 2 of the Instructions" related to the examples on page 2 of the Instructions. We recommend expanding the examples to help clarify "annual window" and "cumulative effect."
Page 4, "Member Months" definition	The definition of "Member Months" does not include a discussion regarding how to reflect riders or members who purchase optional benefits. In	We recommend that CMS provide further clarification as to how they intend to handle/display varying member months by type of

	these situations, the number of members is typically lower than the total members in a product grouping. However, the Rate Summary Worksheet reflects aggregate analysis only, and does not have a structure to account for these differences.	service (for example, should the drug benefit of a product have differing membership than the Medical benefit). One option is to use the total membership of the pool of products for which the rate filing refers for all service categories for purposes of Parts 1 and 2 and the Consumer Disclosure when inputting values. However, this could pose problems in tying to the overall claim costs PMPM when membership varies by type of service.
Page 4, "Total Allowed Cost" definition	The definition of "Total Allowed Cost" includes an estimate of unpaid claims by service category, which not all issuers will have available, particularly for allowed claims. Unpaid claim values are typically only developed for paid claims and for major service categories only, such as Medical and Drug, or possibly as detailed as Inpatient, Drug and all other. The ability to calculate and spread unpaid claims estimates back to service level detail is extremely difficult mathematically when deductibles and coinsurance amounts are prevalent in a portfolio of benefit designs. Claims payment is generally performed on a "first-in-first-out" basis. As such, distributing unpaid claims estimates into inpatient, outpatient, and other service categories does not work when claims payment does not happen in a neat linear fashion, such as applying deductible only to inpatient claims and coinsurance to professional claims. In most situations, claims are not processed this way.	We recommend that CMS recognize in the instructions that many issuers do not develop unpaid claim values on an allowed basis or on a service category basis, and that the company can adjust their data and provide a description in Part 2.
Page 4, "Total	The definition of "Total Allowed	We recommend that CMS

Allowed Cost" definition, and Section A of the Rate Summary Worksheet.	Cost" does not include a discussion regarding coordination of benefit adjustments. If coordination of benefit values are not adjusted out of the "Total Allowed Costs", but are reflected as removed from the "Net Claims", the values for cost share as calculated from these amounts in Section A of the Rate Summary Worksheet would not reflect member payments, but rather a higher value including coordination of benefit adjustments. We believe the intent is that cost shares reflect the member payments, based on the instructions on page 5 under Cost Share, stating that "If the issuer believes that not all cost sharing has been captured (a situation that can easily arise in a number of situations including but not limited to capitation), an estimate of missing cost sharing should be used to provide insureds a good estimate of their cost sharing." Coordination of Benefits adjustments are not cost sharing paid for by the members. Therefore, in order that "cost sharing" reflect reasonable estimates of an insured's cost sharing, coordination of benefit values must be adjusted out of the Total Allowed Costs prior to inputting these values in the Rate Summary Worksheet.	provide instructions that recommend that "Total Allowed Costs" be the values after adjustment for coordination of benefits.
Page 4, Section A, "Member's Cost Sharing" definition	In the description of worksheet data elements, Section A definition for "Member's Cost Sharing," the phrase "net claims (dollars)" was removed changing the phrase from "Calculated… from total allowed dollars and net claims (dollars)" to "Calculated…from total allowed claims." This phrase should not have been removed, since the cost sharing value is calculated as the difference between total	We recommend that CMS add back the phrase, "net claims (dollars)" to the definition so that it reads, "Calculated…from total allowed dollars and net claims (dollars)".

	allowed and net claims.	
Page 4 and 5, "Overall Medical Trend" definitions, Sections B1 and B2 of Rate Summary Worksheet	The values for "Overall Medical Trend" are requested to be input in Sections B1 and B2 in the format "1.xxx," or three decimal places. However, the Rate Summary Worksheet shows four decimal places, or "1.xxxx."	We recommend that CMS change the Rate Summary Worksheet decimal places to three places, as noted in the instructions.
Page 5, "Net Claims PMPM" definitions, and Section B1 and B2 of Rate Summary Worksheet	In the description of worksheet data elements, Sections B1 and B2 definition of "Net Claims PMPM" states, "Calculated automatically…allowed PMPM and member's cost sharing PMPM." However, there is no member's cost sharing PMPM in Sections B1 or B2; there is only member's cost sharing percentage.	We recommend that CMS change the definitions to reflect the calculation based on the cost sharing percentage rather than the cost sharing PMPM.
Page 5, Section B3, "Medical Trend Breakout" definition, and Section B3 of Rate Summary Worksheet	In the new Section B3, "Medical Trend Breakout," the instructions state that this is to reflect an "estimate of the proportions of trend attributable to each of (1) unit cost changes, (2) utilization changes, and (3) all other components of trend combined." However, the Rate Summary Worksheet lists utilization first, unit cost second, and other factors third. In addition, it is unclear based on the instructions which trend value should be broken out. The possibilities include, but are not limited to: • Overall Medical Trend aggregated for all service categories from Section B2 (trend from B1 to B2) • Overall Medical Trend aggregated for all service categories from Section B1 multiplied by the Overall Medical Trend aggregated for all service categories in Section B2 (trend from A to B2 – longer than 12 months, however)	We recommend that CMS change the order in the instructions to match that in the Rate Summary Worksheet. We recommend that additional instructions be provided to clarify which trend CMS would like to have broken out. Ideally this will reflect the methodology in the American Academy of Actuary's Practice Notes.

	• Total trend reflected in the trend in the Projected Net Claims (line 1) in Section C between the Prior Estimate of Current Trend and the Future Rate (portion of medical trend buried in the rate increase – not shown in Rate Summary Worksheet) It is important to recognize that issuers may calculate each of the various elements of trend differently, and in a different order, such that the breakdown may not be comparable between issuers. However, the American Academy of Actuaries will address guidance on "how" to calculate this in their Practice Note they are developing related to these forms.	
Page 6, "Projected Net Claims" definition, "Prior Estimate of Current Rate" section, Section C of Rate Summary Worksheet	Under the section, "Prior Estimate of Current Rate," for Section C line 1, "Projected Net Claims," the instructions state, "Enter prior estimate of net claims from prior rate filing." It would be helpful if this instruction would be clarified, because, as noted in the instructions on page 3, "the populations must be identical immediately before and immediately after the rate increases."	We recommend that CMS add clarifying language on page 6 in this section to something like, "Enter prior estimate of net claims from prior rate filing using enrollment and product mix that will be affected by the increase."
Page 7, "Capitation" definition, line 6 of Section D, Section D of Rate Summary Worksheet	The definition for line 6, Capitation, states, "Calculated automatically as the product of the overall trend for other entered in B2 (projection period for future rate) minus 1 and the other net claims amount in B1 (the projection period for the current rate)." The term "other" is used twice where "capitation" should be used.	We recommend CMS change the definition to read, "Calculated automatically as the product of the overall trend for capitation entered in B2 (projection period for future rate) minus 1 and the capitation net claims amount in B1 (the projection period for the current rate)."
Pages 7 and 8, "Non-Claims Components – PMPM" definition, Section D of Rate	The Section D instructions now contain additional instructions for "Non-Claims Components – PMPM" for line items 9 through 13, and "Claims and Non-Claims	We recommend that CMS expand the PDF version of the Rate Summary Worksheet (or release a working version of the

Summary Worksheet	Components – Percent Change" which have not been included in the PDF version of the Rate Summary Worksheet. It is difficult to analyze the additional lines when they have not been presented. In addition, the instructions for these new lines start with line item 9, "Administrative Costs." However, line 9 already exists on the rate Summary Worksheet as "Total."	worksheet) so it shows the additional lines in Section D, Components of Rate Increase, Non-Claims Components – PMPM" for line items 9 through 13, and "Claims and Non-Claims Components – Percent Change" that were described in instructions. We recommend that CMS change the instructions such that the new line items described start with item 10 and go to 14, rather than 9 to 13.
Page 8, Section E instructions, first sub-bullet under "For the past three calendar years"	The Section E instructions state to "input "yes," "no,",or "new," with "new" indicating that the product did not exist in that year or the product was in its first year and there were no rate increases." The instructions are confusing related to the use of "yes" and "new." The answers "yes" and "new" seem to mean the same thing.	We recommend that CMS change the instructions to recommend "input "yes" or "no," with "yes" indicating that the product did not exist in that year or the product was in its first year and there were no rate increases." If our interpretation of what CMS is trying to capture is incorrect we recommend CMS provide the definitions to clarify the instructions.
Page 8, Section F of Rate Summary Worksheet, definition of "Minimum and Maximum Rate Increases"	The Section F instructions have been updated to reflect the new table inputs on the Rate Summary Worksheet. Language in the instructions for the definition of "Minimum and Maximum Rate Increases" could be clarified noting that these reflect rate table increases.	We recommend that CMS update the language in the new definition of "Minimum and Maximum Rate Increases" by adding at the end of the first sentence, the phrase, "as calculated by rating cell in the rate table." The new sentence would read, "Enter the minimum and maximum percentage rate increases as calculated by rating cell in the rate table."
Page 9, Part II instructions, "Administrative Costs and anticipated profits" definition	Listed on page 9, for the Part II instructions, is an item called "Administrative costs and anticipated profits." However, in both the Rate Summary Worksheet and the Consumer Disclosure, to which Part II relates, there is no item called	We recommend that CMS change the name of this item to "Administrative Costs and anticipated underwriting gain/loss."

	"anticipated profits." Rather, underwriting gain/loss is the term used.	
Page 10, Part III instructions, item 1.l.vi definition	Item 1.l.vi appears to include item 1.l.vii, for" Issue Age or Attained Age Rating, Issue Age Range" which was a separate section in the prior version.	We recommend that "Issue Age or Attained Age Rating Structure, Issue Age Range" be a separate item, as it was in the prior version.
Page 11, Part III instructions, item 6, "cumulative loss ratio" definition	In item 6, the definition for "The cumulative loss ratio …(for individual business only)" was changed to note this was for individual business only. However, item 4.e.i, "Cumulative Loss Ratio (Historical/Past)" did not note this was only for individual business.	We recommend that CMS add this note in item 4.e.i. on page 11 to reflect that cumulative loss ratio is for individual business only.
Page 12, Part III instructions, item 8, "projected lifetime loss ratio" definition	On page 12, in the instructions for completing Part III, item 8, projected lifetime loss ratio, has a parenthetical phrase which is confusing. The phrase is as follows: "The projected lifetime (a projection of the kind normally used in calculating a state level lifetime loss ratio, and the future loss ratio included is not the same as the future loss ratio in (7) above – the future loss ratio is not "adjusted" and is not under the federal standard) loss ratio that combines cumulative and future experience, and a description of how it was calculated." On page 11, the definition for Item 7, "projected future loss ratio" includes the sentence, "This is not the "adjusted" federal loss ratio." In trying to understand the parenthetical phrase in item 8 on page 12, does this mean that a different "future loss ratio" (not the one reflected in item 7) that ***is*** "adjusted" under the federal standard is to be used to calculate the "Projected lifetime loss ratio?" Does it mean that a different "future loss ratio" (not the one reflected in item 7) that also ***is not***	We recommend that CMS clarify the parenthetical phrase in the definition for item 8 of Part III, such that issuers understand more clearly the appropriate "future loss ratio" that CMS desires to be included in the "projected lifetime loss ratio" calculation. We believe the "future loss ratio" to be used in the calculation of lifetime loss ratio in item 8 should not be "adjusted" under the federal standard, and recommend that CMS change the language in item 8 to read, "The projected lifetime loss ratio (a projection of the kind normally used in calculating a state level lifetime loss ratio, which should not be "adjusted" under the federal standard) that combines cumulative and future experience, and a description of how it was calculated."

	"adjusted" under the federal standard is to be used? Guidance on how the future loss ratio to be included in item 8 differs from the future loss ratio included in item 7 would be helpful.	

Clarification Request Related to Examples on Page 2 of the Instructions

There are a number of examples explaining the "annual window" and the "cumulative effect" of rate increases. These are very helpful in explaining the cumulative effect of a "one year period from the effective date of any increase."

However, the language in the Final Rule and in the Instructions for Completing the Preliminary Justification related to the "annual frame of reference" leaves ambiguity on how to present information for specific situations. The rate summary worksheet shows a 12 month period of time starting with the effective date of the increase, which is prospective. However, the Final Rule has the following sentence, "Rate increases during the 12 month period that precedes the date on which a rate increase is effective are aggregated to determine whether the specified threshold is met or exceeded." 76 Fed. Reg 29967. This implies a retrospective period.

In the Instructions on page 1, Overview, the second to last paragraph states, "The frame of reference for the preliminary justification submission is the effective date of the rate increase seen on an annual window of time." This doesn't say forward or backward. The Instructions go on to say, "If multiple increases are implemented within the annual window, their cumulative effect will be considered. Thus, the threshold test that determines whether an increase is subject to review would include the cumulative effect of any increases implemented within a year of the increase being considered." Again, that doesn't say on a prospective basis or a retrospective basis. The instructions then say, "The frames of reference are each increase effective date within a one year period from the effective date of any increase." This could be interpreted as retrospective or prospective. However, on page 5 of the Instructions for the Rate Summary Worksheet, Part I of the Preliminary Justification, the definition of "start and end dates" state, "Enter the effective date of the proposed rates, for example, 1/1/2012. The end date should be exactly one year after the start date."

We are very concerned that a retrospective review may cause a problem with "already approved as reasonable" rate increases from prior periods. For example, does this mean that if a plan has a new increase effective date that is less than one year after a previous one, they have to re-estimate the previous increase's actual annual increase, on a retrospective basis, such that previously approved rate increases could later be determined to be "unreasonable?"

On a prospective basis, as noted in example 3 on page 2 of the instructions, in a situation where 2 increases occur in the next 12 months, the initial increase would be considered as a single increase for part of the membership, whose renewals occur prior to the implementation of the second increase, and the second increase would be considered as a multiple increase for the remaining portion of renewals occurring on or after the second increase effective date. The effect uses a 12 month window, but

looking at how members are affected by the known rate increase going forward over the next 12 months.

Example number 4 on page 2 of the Instructions describes a 6% increase on January 1, then another 6% increase on July 1. It states, "The second semi-annual increase when combined with the 6% increase (on January 1) would result in a combined 9.18% average annual increase…from the point of reference of the effective date of the first increase. However, the second increase when combined with the first would exceed the threshold since it would comprise a 12.36% annual increase at the point of reference of the second increase."

The 12.36% does not seem to reflect an average annual increase over the membership affected for the next 12 months or even the last 12 months. Assuming members have renewal dates, for example, either on January 1 or July 1, and there are the same number of members with renewal dates on January 1 as are on July 1, the second increase of 12.36% is only for half the membership, so the annual average revenue increase at the point of reference of the second increase will be 12.36% for half of the membership for a full year, but will only be 6% for the other half of the membership starting the next January 1. Assuming the calculation of the average is how much the increase affects the membership for a 12 month period, performing that calculation would be the same if you did it in reference to either the effective date of the first increase or the effective date of the second increase, and would be, assuming the calculations in the example are correct, 9.18% ((½ x 1.06 + ½ x1.1236) – 1 using the first increase effective date) or ((½ x 1.1236 + ½ x 1.06) – 1 using the second increase effective date).

The discussion above shows that the result in example 4 of the Instructions would be the same on both a prospective (12 months of members affected by the rate increases going forward) or on a retrospective basis (12 months of members affected by the rate increases looking back to the last rate increase within 12 months, using a 12 month period).

Another example would be to use the counts of members and their renewal rates: January 1, 2011 - $100 PMPM rate in place, 100 members enroll. July 1, 2011 – still at $100 PMPM rate, 100 more members enroll. On January 1, 2012, the rate changes to $109 for a 9% increase based on a rate filing expected to be effective for 12 months. Thus, since the rate increase is below 10%, no preliminary justification forms need to be filed. On July 1, 2012, however, an additional rate increase is needed, and a new rate filing changes the rate to $112, based on a new rate filing effective July 1, 2012. This increase is not expected to trigger filing the preliminary justification forms assuming a prospective analysis, as the increase percentage depends on what it means for all members on a prospective basis over the next 12 months. In this case, 100 members are getting a 12% effective increase and the other 100 members are getting a 2.8% (112/109) increase. This increase will thus weight to less than 10% [{(100 members *112/100) + (100 members *112/109)}/200 members = 1.074], assuming rates increase on anniversary dates], so no filing would be necessary.

On a retrospective basis, however, this second increase would be estimated on average as being 10.5% [{(100 members x 109/100) + (100 members x 112/100)} -1]. If it was known at the time of the initial 9% filing that the 12% increase would be needed, they would have been filed together at the 10.5% average. However, in this case, it was not

known that the 12% increase would be needed on July 1.Thus, the problems in looking back in this situation rather than forward, at a rate increase that originally did not need a preliminary justification to be filed, to one that now does, could be dramatic.

These examples show the differences between a prospective and a retrospective difference which can be very different. We recommend that the instructions be clarified and use a 12 month prospective approach such that previous rate increases would not need to be re-reviewed and potentially cause a problem with changing a reasonable, approved rate to change to an "unreasonable" rate determination. This approach also seems to be what is intended in the Rate Summary Worksheet, Part I of the Preliminary Justification, with the "start and end dates" being defined on page 5 of the Instructions as, "Enter the effective date of the proposed rates, for example, 1/1/2012. The end date should be exactly one year after the start date."

We would also like CMS to provide updated examples to better understand the intent. In those examples, we would appreciate the following information be included so we can better understand the examples:

1. The rates that were in place prior to those shown in the examples so that the rate increases presented can be clearly calculated.
2. Clarification for the January/July rate increases. For example, to what population does CMS specifically intend for these to apply? Does CMS mean the January rates apply to the cohort renewing (and new business written) between January 1 and June 30 while the July rates apply to the cohort renewing (and new business written) between July 1 and December 31? Does this vary with the examples? This is critical to understanding these examples and thus further clarification is needed.
3. Information on how long each rate increase is in effect for a given population before rates are increased again. For example, when January rates are developed for those renewing (or new business written) between January 1 and June 30, those rates are valid for 12 months and will not change again until the following year upon renewal (and will tie to the rate increase developed and filed for January 1 of that year).
4. Provide an Excel spreadsheet with detailed assumptions and calculations provided for each example so insurers can verify their understanding of what is being proposed.

Clarification Request Related to "Product" Definition

It would help greatly if the definition of "Product" could be clarified. "Product" is defined in section 154.102 of the revised Rule as "a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a state." The preamble states that "the definition is sufficiently flexible to accommodate existing State definitions, and that, as a practical matter, issuers will not have to reclassify their products to comply with the rate review process."

The Instructions for completing the preliminary justification, on Page 1 in the Overview, state that "The information on the preliminary justification form for a reportable rate increase is the same basis that is used to determine whether an increase exceeds the 10% threshold, making it subject to review." The information on the form is aggregated across all combinations of coverage benefits ("benefit designs") within the product, so is an aggregate or average increase. Section 154.200(c) of the revised Rule states that,

"A rate increase meets or exceeds the applicable threshold set forth in paragraph (a) of this section if the average increase for all enrollees weighted by premium volume meets or exceeds the threshold." Part I of the Preliminary Justification also includes in the Rate Summary Worksheet section F asking for the range of the rate increase, with a minimum % increase and a maximum % increase.

Based on this information, we are interpreting a "product" to be the combination of the various benefit designs within the filing that uses a discrete set of rating and pricing methodologies, as defined by a state for rate filing requirements. We are also interpreting this to mean that CMS recognizes that increases will likely be different by benefit design even if the benefit levels do not change, due to deductible and fixed cost leveraging, and that if other benefit levels, benefit differences or cost shares change within any of the benefit designs within the product, that rate increases will also vary by benefit design. We do not see anything in the rule or the preliminary justification that requires all benefit designs, all combinations of coverage benefits, to be the same as the average increase used to determine whether an increase is subject to review. Can CMS validate our interpretation of how to treat a "product" for purposes of the Rate Summary Worksheet.

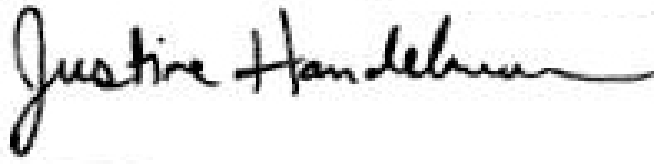
Closing

It is important to note that the approach presented in the Rate Summary Worksheet, related to presentation of a rate increase, is not typically the way most issuers develop premium rates. Many do not use Allowed Cost values as a starting point, for example, nor do they develop unpaid claim estimates by service category. However, we also recognize that CMS is attempting to reflect information that can be presented to consumers in a simple format. We hope that CMS understands that the presentation of information in the Rate Summary Worksheet is for presentation only, and not a prescribed method of developing appropriate rates.

On a final note, we recommend that CMS issue these forms and instructions in a manner that provides regulatory flexibility to update the forms as necessary given the complexities and the changes that will be necessary in preparation for 2014, when the major Affordable Care Act (ACA) reforms become effective.

We appreciate your consideration of our comments on the Rate Increase Disclosure and Review Reporting Requirement, Form Number CMS 10379, OCN 0938-NEW. We look forward to continuing to work with CMS on implementation issues related to ACA. 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 Blue Shield Association

Attachment: Appendix A

Appendix A

List of Naming Convention Differences between Instructions and Rate Summary Worksheet

Rate Summary Worksheet Section compared to Instructions:

- Section A, “Start Period” and “End Period” are called “Start and End Dates” in Instructions
- Section A, “Total Allowed” column is called “Total Allowed Cost” in Instructions
- Section A, “Cost Sharing” column is called “Member’s Cost Sharing” in Instructions
- Section A, “Cost Sharing PMPM” column is called “Cost Share PMPM” in Instructions
- Section A, “Net PMPM” column is called “Net Claims PMPM” in Instructions
- Section A, “Allowed PMPM” column is called “Allowed Claims PMPM” in Instructions
- Section B1 and B2, “Start Period” and “End Period” are called “Start and End Dates” in Instructions
- Section B1 and B2, “Projected Allowed PMPM” columns are called “Projected Allowed Claims PMPM” in Instructions
- Sections B1 and B2, “Net Claims” columns are called “Net Claims PMPM” in Instructions
- Sections B1 and B2, “Cost Sharing” columns are called “Cost Share” in Instructions
- Section D title, “Components of Rate Increase” is called “Components of Medical Claims Changes” in Instructions
- Section D, line 8.a. “Prior Net Claims Estimate for Current Rate Period” is called “Prior Net Claims Estimate for Current Premium Period” on page 7 of Instructions
- Section D, line 8.b., “Re-Estimate of Net Claims PMPM for Current Rate Period” is called “Re-Estimate of Net Claims PMPM for Current Premium Period” on page 7 of Instructions
- Section E title, “List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years” is called “List of the Annual Average Rate Chang Proposed and Implemented in the Past Three Calendar Years” in Instructions
- Section F title, “Range and Scope of Proposed Increase” is called “Range and Scope of the Rate Increase” in Instructions