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The Medicare Advantage and Prescription Drug Program: Part C Explanation of Benefits CFR 422.111(b)(12) (CMS-10453)

Comment On: CMS-2013-0005-0001
The Medicare Advantage and Prescription Drug Program: Part C Explanation of Benefits CFR 422.111(b)(12) (CMS-10453)

Document: CMS-2013-0005-DRAFT-0004
TX

Submitter Information

Address:
TX, 78251

General Comment

In the instance that a claim has been rejected due to the provider billing incorrectly (CPT's, service description does not match the coding), these rejects are sent back to the provider and members are held harmless. Has CMS considered clarifying this scenario?

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Comment On: CMS-2013-0005-0001
The Medicare Advantage and Prescription Drug Program: Part C Explanation of Benefits CFR 422.111(b)(12) (CMS-10453)

Document: CMS-2013-0005-DRAFT-0003
NY

Submitter Information

Name: Jeremy Laubacker
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Organization: Independent Health

General Comment

Introducing beneficiaries to a monumentally new document like the C EOB during the annual enrollment/marketing period would add to the volume of information that beneficiaries would have to digest and adjust to. Introducing something new like this during an important decision making period could cause distraction when they should be focused on making a plan decision. The last thing beneficiaries need is more burden and possible confusion during the annual enrollment/marketing period.

It would be much better to hold-off the introduction of the C EOB until a later date, January 2014 or later. This would allow beneficiaries to make the adjustment of seeing this new document until after the annual enrollment/marketing period and allow them to get accustomed to the document after a decision has been made on their plan. They will be better focused for something new and the document will have more value since they will be able to see the deductible and out-of-pocket accumulators throughout the entire year, from start to finish, rather than seeing these for a very short period at the end of year and then having these completely re-set at the beginning of a new year.

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The Medicare Advantage and Prescription Drug Program: Part C Explanation of Benefits CFR 422.111(b)(12) (CMS-10453)

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The Medicare Advantage and Prescription Drug Program: Part C Explanation of Benefits CFR 422.111(b)(12) (CMS-10453)

Document: CMS-2013-0005-DRAFT-0002
PA

Submitter Information

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Organization: Aetna

General Comment

Aetna is submitting two questions related to EOBs:

1) Would CMS please clarify the timing of the expected release of plans' Annual EOB summary to members? The guidance on the timing of the releases for quarterly EOB summaries is clear, but we are unsure when the Annual EOB summary is due to be released by plans to their members. 2) Would CMS please advise whether MA plans should use the Quarterly EOB template for the Annual EOB summary or is there is a separate template we should use for the Annual summary?

Thank you for your time and attention and the opportunity to submit these questions.

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

February 1, 2013

The Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development

Attention: Document Identifier CMS-10453 (OCN: 0938-New)

Filed: www.regulations.gov

Dear Sir/Madam:

The BlueCross and BlueShield Association ("BCBSA") would like to take this opportunity to comment on the supporting documents to the Paperwork Reduction Act review of the CMS proposal to revise the Medicare Advantage and Prescription Drug Program: Part C Explanation of Benefits CFR 422.111(b)(12).

BCBSA represents the 38 Independent Blue Cross and Blue Shield Plans that provide health coverage to approximately 100 million Americans today. Many of our Plans participate in the Medicare Advantage (MA) Program and collectively serve several million beneficiaries in this important program.

BCBSA submitted comments directly to CMS on November 16, 2012 on the initiative to revise the current requirements related to the Explanation of Benefits (EOB) for Medicare Advantage members. We have reviewed the supporting documents associated with the compliance aspects of the Paperwork Reduction Act of 1995 and we have continued significant concerns with this collection that would require all Medicare Advantage plans to furnish to their members a revised EOB specified by CMS within the next year or so.

On October 18, 2012 CMS issued an HPMS memo outlining their final Part C EOB Model documents and their implementation plans for the Part C EOB. Comments were solicited. BCBSA responded to that memo with the attached comments which serve as the basis for our continued objection to this initiative today.

The revised models pose costly new requirements for MA Plans at a time when MA Plans will face new Medical Loss Ratio (MLR) provisions resulting from the Affordable Care Act; provisions which are designed to pressure MA Plans to maintain a specific medical loss ratio and lower their administrative costs. Failure to maintain this specific MLR threshold can result in an MA Plan not being able to enroll new members and, over time, could result in an MA plan being terminated from the Medicare program. While we await a proposed rule or guidance in how MLRs will be calculated for MA

plans, Plans are acutely aware of the need to maintain reasonable administrative costs. Revised EOBs for Plan members will pose new and significant administrative costs for Plans. Any extensive changes from current practices will involve new design costs, as internal and external technology adjustments, system changes, possible new business associate agreements, and postal mailings that are costly for Plans.

EOBs should be used when appropriate to document received medical services that show what the provider charged, what the plan paid, and what member liability there might be applicable to a specific claim. One could argue that EOBs are not even necessary when the member has no liability remaining from their received service and pays, for example, a simple copayment at the time of service. Medicare Advantage is an alternative to traditional Medicare where EOBs are routinely sent to beneficiaries so the EOB process in FFS Medicare need not be the same for Medicare Advantage. Plans would prefer to keep their current notification processes in place, which seems to be working well for their members, and Plans prefer not have to adopt new proposed formats which are excessive in length and stray off of the common purpose of an EOB. There is no justification to include information in the EOB that may be found in the "Medicare and You Handbook" sent annually to all Medicare beneficiaries by CMS or in the Plan's Evidence of Coverage sent to the MA members. An EOB need not contain lengthy "membership services" information that can be obtained elsewhere. Since many Medicare beneficiaries also receive numerous EOBs annually, to require a detailed "booklet" as an EOB with information not related to the medical services received can cause unnecessary communications or telephone calls to the Plan, create confusion among the beneficiaries, and add little to no value to the member's experience with their Plan as a patient as well as a Medicare beneficiary.

Consumer research from our Plans conclude that EOBs should be simple in format and content, easy to understand, and address a medical claim for a covered service, showing the name of the provider and a general description of the service received. EOBs need not have reminders on available preventive services, definitions applicable to certain benefits such a deductibles etc., and a lot of "text" not related to the medical claim.

The anticipated EOB models proposed by CMS contain five sections. We believe that only Section I is needed on a routine basis and that is the section that shows the detailed claims information for medical and hospital services received. Sections on reminders about preventives services and discussion of deductibles are relayed to the Plan member either in the CMS general "Medicare and You Handbook" and the Plan's Evidence of Coverage and is therefore duplicative information. This should have been noted in the agency's supporting documentation on this proposal.

As we wrote in the attached memo of November 16, 2012, adopting the model templates for the MA EOBs is costly. One Plan with just 25,000 MA members estimates that adopting the models as proposed would result in a $2,000,000 expenditure for the initial implementation. Another Plan with a slightly higher membership estimates $3,500,000 for their implementation costs. These costs would be incurred at a time when it is still uncertain as to how these costs would be factored in any Medical Loss Ratio (MLR) methodology for MA Plans in 2014.

Also BCBSA takes issue with the fact that the "Burden Estimates" in the supporting documentation is based on stand-alone Part D EOBs. Part D EOBs are drastically different from those generally generated in Medicare Advantage Plans as MA EOBs often include hospital, physician and other services not covered under Part D. Part D is essentially a retail benefit with a member paying a fixed copayment or cost sharing amount for a single medication and this information generates a PDE (Prescription Drug Event) transaction that is common to all Part D plans. So we disagree with the stand-alone Part D program serving as the basis for the cost estimates for implementing this new MA requirement. As stated above, Plans with small enrollment levels (under 100,000 members) see this new requirement as adding millions of dollars in start up costs to their administrative costs.

In addition to cost concerns, Plans have a concern with an effective date that could be on or before 2014 that would not allow for sufficient time for design, testing and implementation of any new formats. Additional mailing costs also need to be factored given the new increases for mail just announced by the US Postal Service.

An additional concern is if the HCPCS and CPT Code Descriptions, which have been proposed as a required component of the revised EOB are adopted. Using these codes would be a new function for most Plans and inclusion of this information on the EOB, as stated in our previous comments, raises privacy concerns and can also be confusing to the beneficiary who may not be familiar with such codes and their relationship to the medical service received. We would ask that your review page 2, # 3 in our November 16th comments to fully understand our concerns with including such codes on an EOB. Although the agency does allow some flexibility in that if an MA plan chooses to send a per claim EOB developing their own format, the claim information must still include the American Medical Association (AMAs) HCPCS code descriptors and CPT consumer descriptors, followed by the HCPCS or CPT billing code shows in parentheses (General Instructions for the Model C Explanation of Benefits).

Another challenge is to be able to send EOBs regarding optional supplemental benefits as many MA Plans use external vendors to provide services, such as dental, vision, and hearing aids etc to MA members. These benefits are arranged for Plan members by their MA Plan and are not covered Medicare benefits. We have outlined our concerns

on page 3, # 4 on this issue and would like to agency to understand the complexity of having to do EOBs for such services. New business agreements would have to be set in place and new systems created to report the delivery of these supplemental benefits, most often provided by external vendors, in a prescribed EOB format.

We hope these comments are helpful. We would hope that the agency would again review our comments of November 16, 2012 as the issues outlined in those comments remain significant to Plans. In a spirit of partnership we have been sharing current sample EOBs with the agency that are used in the marketplace today so that the agency can review current templates. These current EOBs serve Plan members well in understanding payments made on their behalf when covered physician and hospital services are received. Plans report that their members are use to these communications and might not be receptive (or confused) by new communications that are greater in length than those used today, with additional information that is not applicable to their medical claim. And if members receive numerous copies of the same lengthy document, such as the proposed EOB, over the course of their membership, the members themselves might begin to question whether the plan's resources and their member premiums (if any) were being appropriately used.

Thank you for the opportunity to provide comment. Questions on these comments may be directed to Jane.Galvin@bcbsa.com

Sincerely,

Jane Galvin
Managing Director
Regulatory Affairs

Attachment

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

To: **Danielle Moon, J.D., M.P.A. Director**
Medicare Drug and Health Plan Contract Administration

From: **Jane Galvin, Managing Director, Regulatory Affairs**

Date: **November 16, 2012**

Re: **Comments on the HPMS Memo of October 18th Regarding Medicare Advantage EOBs**

Thank you for the opportunity to provide comments on the final Part C EOB models and implementation of the Part C EOB initiative as outlined in your HPMS memo of October 18, 2012.

BCBSA asked its member plans for comments and we received a number of concerns, questions and recommendations. Readiness among Plans as to implementation of these new requirements varies.

Because of variation in readiness and the costly investments Plans have to make to comply with the anticipated start date of late fall 2013, we recommend a new start date and that Plans be allowed to phase in these new requirements over a period of time. Those ready to start should be allowed to go forward with a start date of January 1, 2014. Those that need more time should be allowed to implement these new documents at a later date, perhaps no later than January 1, 2015. Many Plans may not have factored these costly new requirements and mailings into their 2013 bids so a delay to January 1, 2014 at a minimum is reasonable.

As you are aware, there are many pressing priorities within all Plans stemming from passage of the Affordable Care Act (ACA). In addition, Plans await new MLR rules for Medicare Advantage for 2014 as well as a new health insurance tax that directly affects MA bids and member premiums. Plans also face a continued phase-in of reductions in plan payments as a result of provisions in the ACA. There is also uncertainty as to how the Congress will deal with the fiscal issues facing the nation and how their actions might result in additional cuts in Medicare that will affect Medicare Advantage payments.

So while we understand this initiative has been underway as to its design, pilot testing and focus group testing, implementation will be costly for all Plans at a time when other financial pressures as well as system changes are being imposed on Plans. It would also be beneficial for CMS to share its findings of "lessons learned" from the pilot programs using these new EOBs.

The following are BCBSA significant observations on this initiative.

1. Initial observations are that the changes will be costly and complex to implement. Some plans have payment systems that reside outside of their claim engines making changes even more complicated. As an example, one plan shared with BCBSA its assessment as to implementation. This Plan has committed to and invested significant dollars in simplifying their current commercial EOB; estimated at approximately $2,000,000. This simplification effort is the result of their desire to enhance their members' experience and provide clarity in the services and benefits they provide. This simplification project is actively in process and planned for implementation in 2013. In general, this Plan feels that departing from their corporate standard EOB for only Medicare Advantage members is an unnecessary, costly endeavor. This Plan estimates the additional cost to be approximately $3,500,000. As the largest insurer in their state, many of their members are aging into Medicare and choosing a Part C plan and Plan wants to maintain a consistent message and format with regards to the EOB for those members.

2. Some Plans have concluded that 10/1/13 as an effective date that does not allow for adequate time to execute and test the changes especially in light of everything else plans have to do in the same time frame, e.g. implement ICD-10, Health Care Reform, etc. We recommend a January 1, 2014 start date. Plans also believe the cost of producing the EOBs will increase due to the additional information required and the additional mailing costs resulting from these new documents. The model documents need to be streamlined.

3. Requirements to include the AMA code descriptors and CPT descriptors followed by the codes are a significant concern. Many Plans do not currently provide this information. Plans also wonder how they will be able to achieve the required reading levels if they include the medical terminology. One Plan offered a viable alternative approach that should be considered which is described below:

   HCPCS & CPT Code Descriptors: This component of the model EOB is a major departure from the EOB the Plan currently uses and would require significant investment in order to make these codes and descriptors available through their settlement process in order for them to be displayed on the EOB. Part of the issue with their commercial business, aside from implementation cost, is the privacy concern of placing sensitive treatment information on the EOB, including mental health treatment information. Based on the number of codes and descriptors that exist today, these codes can be confusing and difficult for the average beneficiary to understand.

   This Plan would like to point out that a similar approach was considered by HHS when developing the ACA regulation for internal claim appeals and the external review process. HHS received a significant amount of feedback regarding the July 2010 regulations and as a result, amended the final interim regulation to

eliminate certain similar requirements. The proposed ACA requirement was replaced with a requirement that the plan provide notification of the opportunity to request treatment codes and their meanings. Therefore, the Plan recommends that CMS consider following the approach taken by HHS, requiring that plans must include notification to members of the opportunity to receive the HCPCS & CPT codes associated with the claims in question, along with descriptions of what the codes mean. They feel this level of direct interaction is a more consumer-centric approach, while effectively controlling the cost of what would be a significant change and departure from their corporate approach concerning the EOB. We think CMS should consider this same approach as adopted by HHS in its ACA implementation rules.

4. Section 2 regarding optional supplemental services may be challenging for plans that use vendors to provide dental, vision and hearing, or if supplemental services are not currently identified as such on the EOBs. Including these optional benefits that are provided though vendors could result in costly new systems integrations as now many of the vendors, not the Plan, communicate with the beneficiary. New requirements in this area could mean system changes that will be costly and require sufficient lead time.

   One Plan specifically focused in their comments on mandatory supplemental benefits and requests that mandatory supplemental benefits be deleted from the EOB requirements as the Plan has three mandatory supplementary benefit vendors and each of these vendors provide billing information to their members. For the plan to have to send this information directly would be a substantial burden and require extensive system changes that would be required with creating connectivity with these vendors. Some Plans asked that mandatory supplemental benefits and the notifications to members be allowed to continue as the practice is today within the plan.

   5. As to accommodations for dual eligible and Integrated Care Delivery Plans, we have specific comments. For members who are enrolled in a Plan that offers an integrated care delivery model and members who are dually eligible for Medicare and Medicaid, there should be exceptions.

   In the case of the Plan that utilizes an integrated care delivery model, we encourage CMS to consider the unintended consequences that may result from mandating use of a standardized EOB. For these integrated health plans that interact directly with their members and do so on a regular basis, such a communication may have a contrary result, as these members are high utilizers of benefits but pay very little, if anything, when accessing the preventive and routine benefits offered by their plan. As a result, members in these integrated Plans will typically receive a voluminous EOB that may be overwhelming to the member and not meaningful, as there is little for the member to pay out of pocket. Likewise, to supply these EOBs to members on a monthly or quarterly basis would be very costly to the health plan.

In the case of dual-eligibles, we support CMS' recognition that the dual eligible population warrants special and additional consideration to ensure that any model Part C EOB template includes both meaningful and timely information. For this especially vulnerable population that has a higher-than-average benefit utilization rate, it is critical that communications be clear and not overly confusing, and we applaud CMS for taking additional time to evaluate comments and consumer testing results already received before requiring plans to implement a standardized EOB for this population. To that end, we encourage CMS to offer a separate comment period for the dual eligible model Part C EOB and sufficient lead time to implement any additional accommodations that may be built into the EOB design for this population.

6. As to the timing of this initiative, if CMS elects to move forward with the Part C model EOB, we encourage CMS to consider the lead time that will be required in order for Plans to make the appropriate IT and system programming modifications. These changes will be implemented on roughly the same timetable as several administrative simplification provisions from the Affordable Care Act and perhaps even the revised Form 1500 for which comments were solicited in the September 21, 2012 Federal Register (77FR58558, Form Number CMS-1500(02/12), CMS-1490-S (OMB#0938—New).

   For this reason, we request that CMS make available the final templates and implementation guidance by no later than January 15, 2013 to ensure plans have sufficient time to budget, plan for and implement the standardized Part C EOB. We also support, as mentioned above, a phase in for Plans with a minimum start date of January 1, 2014, not the fall of 2013.

7. We appreciate CMS' willingness to give plans flexibility in implementing the model Part C EOB by offering both a monthly and quarterly EOB option. This flexibility allows Plans to adopt the model EOB that aligns most closely with their current claims processing and member communications practices. Most plans seem to favor the monthly EOB option, and BCBSA offers the following questions to CMS for clarification:

   - Use of Supplemental Per-Claim EOBs: The template instructions are clear that if the quarterly template is used, Plans must supplement the quarterly EOB with per-claim EOBs. However, the guidance is not clear whether Plans utilizing a monthly EOB would similarly be required or permitted to provide a per-claim EOB. Currently, many Plans utilize a per-claim EOB to provide members with information about how their claims were paid, but also to provide notice of appeal rights when appropriate. To ensure that members receive timely notice of appeal rights, we request that CMS revise the monthly template to clarify or require that per-claim EOBs may still be sent, particularly in instances where the claim is wholly or partially denied, and for member-paid claims, which require the member to pay out of pocket for the services rendered.

- Template Length: The implementation of uniform Part C EOB models as designed pose a very large cost increase to Plans as the program is described. Each Monthly EOB will require significantly more pages to print the EOB and postage costs will increase significantly as well due to envelop size and weight. We request that efforts be made to look at options that will reduce the size of the EOB. For example, the introductory text which fills page 1 will be repeated with each EOB. We recommend the detail about benefit plans be left to the Evidence of Coverage presented to the member each year and only a brief reference be made advising the member to consult their EOC or Summary of Benefits for detailed information about their benefits. We recommend the cautions for Fraud and Abuse of Medicare services be discussed once at the beginning of the EOB and not be addressed in both section 1 and 2 of the EOB. We also specifically request that the list of preventive services be deleted as there are other mechanisms in place to present this information to Plan members. These edits would reduce the page count while still providing members with more detail than they currently have in their medical EOB.
- Accommodations for EOBs Supplied to Employer Sponsored Retiree Plans: On page 1 of the HMO and PPO monthly templates, under the section "Member Services", we note that the instruction includes a statement indicating "*Benefits, formulary, pharmacy network, premium, copayments, and coinsurance may change on January 1 of each year.* " In light of the fact that employer group plans can be based on a fiscal year and not a calendar year, the reference to January 1 may be inaccurate and confusing. For this reason, we recommend that CMS bracket the term "January 1" so that the MAO may insert the applicable renewal date for the individual or group MA plan.
- Allowance for Differences in the Benefit Year: Similar to the prior comment, we note that the templates refer to a benefit year beginning January 1 in the heading titled "Totals for 2013" for both the medical/hospital and optional supplemental benefits sections. To account for differences in benefit year between individual MAOs plans and employer-sponsored plans, we recommend the language in these sections be revised so that the plan year is reflected in brackets: "*TOTALS for [insert plan benefit year],*" *"(Yearly total so far for all claims for medical and hospital services that were processed from [insert beginning date of plan benefit year] to [insert ending date of the current reporting period],*" and *"(Yearly total so far for all claims for optional supplemental services that were processed from [insert beginning date of plan benefit year] to [insert ending date of the current reporting period].)*" Similarly, the benefit years listed in Section 3 should also be bracketed to read: "*In [insert plan benefit year],*" rather than "In 2013."
- Inclusion of American Medical Association's and CPT Consumer Descriptors: If CMS does not accept the recommendation offered earlier in our comments to have members be able to request codes as needed, then we offer these additional technical comments on this issue. On page 5 of the monthly template (for medical/hospital care) and again on page 13 (for optional supplemental

benefits), in the claim-by-claim breakdown, the instructive language indicates that Plans are to insert a description of the service or item that was provided, using the AMA's HCPCS code descriptors and CPT consumer descriptors. Because these descriptors can be very high-level and non-specific, we encourage CMS to allow MAOs the flexibility to use custom service descriptors that are at least as descriptive as the AMA HCPCS descriptors and CPT code descriptors yet are written in a more consumer-friendly manner. In addition, we ask CMS to consider allowing use of revenue codes for facility claim services. To effectuate this flexibility, we recommend that the instructive language be revised to read: "*Insert description of the service or item that was provided, using the American Medical Association (AMA)'s HCPCS code descriptors, CPT consumer descriptors, revenue code descriptors, or the plan's custom descriptors, followed by the HCPCS or CPT billing code shown in parentheses.*"

- Notice of Denial of Payment: On pages 5-7 of the HMO and PPO templates, CMS instructs Plans to include approved language from the Notice of Denial of Payment in a landscape layout. Currently, some plans supply a Notice of Denial of Payment and appeal rights in portrait layout as part of their per-claim EOBs. To minimize the amount of system reprogramming that will be required to accommodate a landscape layout, we recommend the template be modified so that the Notice of Denial of Payment and appeal rights are moved to a separate page (preferably at the end of the claims total) with the portrait layout retained.
- Duplication of Service Descriptions: On the HMO and PPO templates in both the sections on medical/hospital care and optional supplemental benefits, CMS includes the following instruction under the "Your Share" heading: "*You pay [insert percentage]% of the total amount for [insert brief description of service, (e.g., "a primary care office visit")] [POS plans insert: from an [insert as applicable: in-network OR out-of-network] provider].*" Because the model EOB already calls for a description of the service or item provided using the AMA's HCPCS descriptors or CPT consumer descriptors, this additional description of the service under "Your Share" is duplicative. For this reason, we recommend the instructive language in the "Your Share" section be revised to read as follows: "*You pay [insert percentage]% of the total amount for this service.*"
- Clarification on Value to Enter under "Billed Amount" for a Bundled Item or Service: The instructions on pages 5 and 13 of the HMO and PPO templates advise to *"[Insert amount billed by the provider for this service or item]."* As written, this language does not take into account items for which payment may be bundled with another item or service; therefore we recommend the instruction be revised to read *"[Insert amount billed by the provider for this service or item; including items or services that may be bundled.]"*
- Clarification on Value to Enter under "Approved Amount" for Denied Claims: On the HMO and PPO templates in both the sections on medical/hospital care and optional supplemental benefits claims totals, CMS includes the instruction for plans to include the "Approved Amount" per claim, in total, and year-to-date. To ensure MAOs are entering the correct value in situations where a claim is denied,

we recommend that CMS include the following additional language in each section where this instruction is reflected: "*[Insert total approved amount for this claim. If claim is denied, insert '0'.]*"

- "Approved Amounts" for Out-of-Network Providers: On the HMO and PPO templates in both the sections on medical/hospital care and optional supplemental benefits, plans are to include the following notation: *"[Note: if service or item is approved, use amount approved by the plan for the total amount. If service or item is denied use the contracted amount.]"* As written, this instruction does not account for claims submitted by out-of-network providers that are subsequently denied or services that are not covered by the plan, therefore, we recommend the note be revised to read as follows: *"[Note: if service or item is approved, use amount approved by the plan for the total amount. If service or item is denied use the charged amount for the item or service, the contracted amount for contracted providers or the Medicare allowed amount for non-contracted providers.]"*
- Considerations for Optional Supplemental Benefits in Individual Plans: On the HMO and PPO templates, in the section regarding optional supplement benefits, CMS includes instruction to insert the member's monthly premium. We recommend this language be revised to read as follows: "You pay an extra premium for your optional supplemental benefits."
- Considerations for Optional Supplemental Benefits in Employer/Union Sponsored Plans: Optional Supplemental style benefits are not optional at the member level with our employer/union sponsored plans. If the group purchases these benefits, they apply to all members. We recommend that section two be modified to have alternative text for employer/union sponsored plans to call the benefits "Supplemental Benefits". We also recommend deleting any reference to payment of extra premium since the premium is usually paid partially or fully by the past employer/union rather than solely by the member. For employer/union sponsored plans, it is common for many employers to pay the full share of the premium for their retiree. Accordingly, we recommend the text be moved to section 2 which is dedicated for OSB services and altered to read: "*If the claim is for optional supplemental benefits, insert: NOTE: This claim is for services that are covered as part of your optional supplemental benefits. You may pay an extra premium for these benefits.*"

8. Clarifications to Per-Claim (Quarterly) EOB Summary; while most Plans seem to favor the monthly EOB template, we also had questions regarding the model per-claim EOB summary and whether a similar version is to be used as a supplement to the monthly EOB or whether the monthly EOB is intended to replace the per-claim EOBs Plans may be utilizing currently. As noted previously, we believe that Plans should be allowed to continue supplying per-claim EOBs (whether their own version or a CMS model), at least in the instance where a claim is wholly or partially denied, or for member-paid claims, to ensure that members receive timely notice of their appeal rights when they are required to pay out of pocket for the services rendered.

If CMS intends to require use of the per-claim EOB summary as a supplement to the monthly EOB template, we offer the following comments for consideration:

- Additional Detail Needed Per-Claim: Our review of the per-claim EOB summary revealed that the template does not include a section for the per-claim detail, therefore it is unclear where or how that information is to be communicated to members, or whether plans are to continue using their current per-claim EOB in whatever format they choose. If CMS seeks to standardize the per-claim EOB as well as the EOB supplied quarterly, we recommend that the current quarterly template be revised to add a new section detailing per-claim information or create a separate template to use on a per-claim basis. In this new section or per-claim template, CMS should clarify:
    - What language, if any, should be included regarding the Notice of Denial of Payment and notice of appeal rights that would otherwise be included in a per-claim EOB currently supplied by a Plan? For example, the same language that appears in the monthly EOB model could be used for the Notice of Denial of Payment and the notice of appeal rights.
    - Whether the per-claim detail should be formatted in the same fashion as the sections titled "Totals For This Quarter" and "Totals for 2013", or whether an alternate format should be used for the per-claim detail, compared to the aggregated information provided in the quarterly and year-to-date snapshots.

If CMS does not intend for the per-claim EOB to be used as a supplement to the monthly EOB, we offer the following additional comment:

- "Approved Amounts" for Out-of-Network Providers: In several places on the HMO and PPO per-claim template, under the "Approved Amounts" heading, CMS provides the following instruction: "*$[insert total approved amount for the reporting period],*" but does not specify whether the approved amount is to include only approved amounts paid to in-network providers or whether amounts paid to out-of-network providers should also included. The term "approved amount" is sometimes interpreted to mean the approved or allowed amount that a participating provider has agreed to receive as reimbursement for a particular item or service, therefore we recommend the template language be revised to clarify that the approved amount should reflect any amounts paid to participant and non-participating providers during the applicable quarter, if that is CMS' intent.

We also had some of the same observations regarding the per-claim EOB summary as were previously noted in the monthly EOB summary. These observations are reiterated here, so the modifications we have recommended, if adopted by CMS, may be reflected on the appropriate pages of the per-claim EOB summary as well:

- Accommodations for EOBs Supplied to Employer Sponsored Retiree Plans: On page 1 of the HMO and PPO monthly templates, under the section "Member Services", we note that the instruction includes a statement indicating "*Benefits, formulary, pharmacy network, premium, copayments, and coinsurance may change on January 1 of each year.* " In light of the fact that employer group plans can be based on a fiscal year and

not a calendar year, the reference to January 1 may be inaccurate and confusing. For this reason, we recommend that CMS bracket the term "January 1" so that the MAO may insert the applicable renewal date for the individual or group MA plan.

- Allowance for Differences in the Benefit Year: Similar to the prior comment, we note that the templates refer to a benefit year beginning January 1 in the heading titled "Totals for 2013" for both the medical/hospital and optional supplemental benefits sections. To account for differences in benefit year between individual MAOs plans and employer-sponsored plans, we recommend the language in these sections be revised so that the plan year is reflected in brackets: "*TOTALS for [insert plan benefit year],*" "*(Yearly total so far for all claims for medical and hospital services that were processed from [insert beginning date of plan benefit year] to [insert ending date of the current reporting period],*" and "*(Yearly total so far for all claims for optional supplemental services that were processed from [insert beginning date of plan benefit year] to [insert ending date of the current reporting period].)*" Similarly, the benefit years listed in Section 3 should also be bracketed to read: "*In [insert plan benefit year],*" rather

9.Please note that these additional observations are based on the approach of submitting monthly EOBs, as opposed to the Per Claim EOB & Quarterly Summary option.

- Annual Cumulative Claim Totals: The model EOB contains a component involving the display of yearly totals of all claims processed in four categories: Billed Amount, Approved Amount, Plan's Share and Your Share. This component of the model EOB is also a major departure from how BCBSSC produces EOBs today, and would require significant investment in order to accommodate this need. We currently take two approaches to generating an EOB: (1) we generate an individual claim report that details claim adjudication results for a single claim, and (2) we generate a summary claim report that details claim adjudication results for a 21-day period of claim activity. Neither approach involves passing yearly cumulative claims data to our settlement programs that create the EOB. There are significant core infrastructure changes involved with being able to meet this requirement. We recommend that the CMS considers removing this component of the model EOB and emphasizing the inclusion of the deductible and out-of-pocket accumulators. A plan stated that its own market research has found that beneficiaries are primarily concerned with the cumulative data associated with these accumulators.
  - Coverage Period Considerations & Maximum Out-Of-Pocket (MOOP): In an effort to provide clarity to members with regards to the EOB and claim accumulations towards deductibles and MOOP, Plans have had to consider member confusion surrounding processed claims and the overlap of coverage periods. For example, in February, beneficiary claims may process with dates of service for the current coverage period (i.e. 2012) as well as the prior coverage period (i.e. 2011). These claims only contribute to their respective deductible and MOOP accumulators. We found it important to separate EOBs and their corresponding claims by coverage period in order to properly display the accumulators. So in our example, the member would receive two EOBs in the month of February, one for each coverage period. The CMS needs to provide clarity around the issue of reporting claims for conflicting coverage periods within the same month.

- Implementation Effective Date: The October 18, 2012 memorandum issued by the CMS stipulates a mandated implementation date of October 1, 2013. This timeline would involve implementing a new EOB in the middle of a coverage period. We feel this will add unnecessary risk and potential beneficiary disruption with regards to the potential differences in the contents of the EOB compared to a beneficiary's current EOB. This reinforces our previous recommendation of implementing these new requirements as of January 1, 2014 and not have them go into effect in 2013. CMS should consider mandating the implementation date for the new model EOB in line with the start of the new coverage period; for claims with dates of service on or after January 1, 2014.

Thank you for the opportunity to provide comments on this initiative. We hope they are helpful. Questions on these comments may be directed to Jane.Galvin@bcbsa.com or by phone at 202 626 8651.

Thank you.

Michael Breher
MN006-W800
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Minnetonka, MN 55343
Phone: 952.931.5121
Email: Michael.Breher@uhc.com

To: Submitted Electronically: www.regulations.gov
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

From: Michael Breher
UnitedHealthcare Medicare & Retirement
UnitedHealth Group

Date: 2/1/2013

Re: Part C Explanation of Benefits

In response to CMS' request for feedback regarding the Part C Explanation of Benefits CFR 422.111(b)(12), UnitedHealthcare is providing the attached comments. These comments are provided on behalf of UnitedHealthcare Medicare & Retirement and other UnitedHealth Group affiliates, including UnitedHealthcare Community & State and XLHealth, that manage Medicare Advantage and Part D business (collectively "United").

We greatly appreciate the opportunity to comment, and we look forward to continuing to work with CMS to develop successful products and services for Medicare beneficiaries. If there are any questions or concerns about our comments, please contact me at 952-931-5121 or via email at Michael.Breher@uhc.com.

Part C Explanation of Benefits CFR 422.111(b)(12)

Comments Submitted by
UnitedHealthcare
2/1/2013

General Comments

1. CMS has proposed that the new EOB templates are to be implemented as of October 1, 2013, which would require plans to begin issuing monthly summaries no later than November 30, 2013 and quarterly summaries no later than January 31, 2014. We recommend that CMS defer implementation of the Part C EOB until January 2015, to ensure that organizations are afforded the necessary time for planning, appropriate resource allocation and systems development.

   Given the scope of the proposed requirements, as well the operational and design-related challenges, we believe a longer implementation timeline will be critical to allow plans sufficient time to develop or make changes to their systems and to conduct testing to produce the new EOBs. Additional time to implement the new Part C EOB also will provide CMS the opportunity to evaluate and address the concerns and challenges plans have identified before moving forward. Plans are currently engaging in other major systems modifications and development in order to implement MA encounter data reporting and ICD-10. These major initiatives depend heavily upon the same systems resources necessary to carry out development and implementation of the Part C EOB, and it will be highly disruptive and particularly challenging for an additional project on the scale of the new EOB to be incorporated into plan system work flow.

   We also have concerns that the implementation of the Part C EOB will result in the significant expansion of the scope of duties with delegated entities. This would result in the need for contractual renegotiations and possible plan contractual liability.

   Additionally, from the member standpoint, the amount of information received during the 4th quarter of the year is already voluminous. These materials include lengthy, complex documents such as the ANOC, EOC, Part D formulary, directories, etc. Adding a new document of this length and complexity, evidenced by the fact that the CMS provided example is twelve pages, would become overwhelming. If implementing during the 1st quarter of the year, the member would not be overwhelmed with the volume of plan documents such as they receive during the 4th quarter.

2. We request CMS provide a date that the final model EOB templates will be released. Given the changes required, plans need to develop programming and perform quality checks before implementation of the EOB and for planning purposes, need to know the timeframe to do so. In addition, we are seeking confirmation that CMS will provide a checklist of "required" elements for the development of a non-model EOB template.

Monthly HMO Template, PPO and PFFS Template

1. In Section 1, under the "Approved Amount" and "Plan's Share", what is CMS' expectation with respect to completing information for paid claims when the provider is paid on a capitated basis regardless of the service? For example, Dr. X receives $100 per

month/per member (pm/pm) and is not paid on a claim by claim basis. Any allocation to a particular service would not be reflective of any actual cost/payment to the provider.

We recommend that plans be allowed to enter "$0" for both fields and then enter the applicable member cost share represented in the "Your Share" column with a "NOTE" in the "Claim Number" column explaining why there may not be an approved/plan share amount.

2. In Section 1, the monthly template states that if the plan chooses the monthly summary, plans may include the "NDP language" or reference that it was sent separately. Plans are required to process denials for non-contracted providers within 60 calendar days of receipt of the claim, this includes providing the appropriate member notification and their appeal rights (either via NDP or the electronic equivalent of an EOB). However, if the plan chooses the monthly summary option, there is potential that the notification of appeal rights will not be timely if provided on the EOB.

    - Example 1: Claim is received on 8/15/12 and denied on 10/2/12, the monthly summary is not mailed until 11/28/12, which is after the required timeframe.
    - Example 2: Claim is received 10/12/12, does not require any development and subsequently denied on 10/28/12. If a monthly EOB is provided and mailed by 11/30/2012, the member will receive the EOB and NDP language (assuming it is included in the EOB template) before the expiration of the 60 calendar day timeframe.

    In the case of Example 1, as a result of timing, would the plan be required to send a separate NDP notice to satisfy the notification requirements and timeframes? In the case of Example 2, as a result of timing, the plan could include the NDP language in the monthly EOB as the plan would have until the 60th day to notify the member of their rights.

    We are seeking confirmation that this interpretation is correct and clarification of whether or not a separate NDP notice is required in Example 1.

3. If the plan chooses the monthly summary, the current template allows for including the "NDP language" or to reference that it was sent separately. If sent separately, are plans limited to the CMS issued NDP format or may plans develop a separate plan generated statement as provided for in Chapter 13?

4. There are cases in which a claim submitted by a contracted provider may result in member liability. These scenarios would include when the in network provider has notified the member in advance that a particular service is not covered (i.e., process similar to the Original Medicare ABN or for a service that is clearly excluded in the member's Evidence of Coverage).

    We recommend that CMS add a scenario to address denials for claims submitted by in network providers that could result in member liability. In these cases the in-network provider could appeal on behalf of the member if a properly executed Appointment Of Representative (AOR) is submitted.

5. While CMS does provide language for describing a claim that is reprocessed as a result of an appeal, the language does not address provider disputes that may affect the member's cost share or a plan discovered error in which the plan needed to pay or alter the payment of the claim, including overpayment situations.

    - Example: A non-contracted provider files a dispute and upon review additional dollars are due to the provider. This adjusted claim would be included on the monthly EOB statement for the month in which the adjustment occurred.

    We recommend that CMS add language to address provider disputes and other claims adjustments that might occur outside of the appeals process.

6. In the populated template, it appears that CMS uses the "consumer friendly descriptor" rather than the long/short technical definition to describe the service provided. We have found that many of the consumer friendly descriptors are rather technical and would not be easily understood by beneficiaries.

    - Example 1, CPT code 92557:
      Short Description: "Comprehensive hearing test;"
      Long Description: "Compare audiometry threshold eval sp recegni;"
      Consumer Friendly Descriptor: "Air and bone conduction assessment of hearing loss and speech recognition."

    In this case, the short descriptor is more consumer friendly.

    - Example 2, CPT code 92550:
      Short Description: "Tympanometry & reflex thresh;"
      Long Description: Tympanometry and reflex threshold measurements;"
      Consumer Friendly Descriptor: "Assessment of eardrum and muscle function."

    In this case, the consumer friendly descriptor is more consumer friendly.

    We recommend allowing plans the flexibility of choosing to use the short description and to develop more beneficiary language when necessary.

7. Section 3, which provides education to the member regarding their out-of-pocket costs (deductible and MOOP), currently does not include any language to explain to the member that there may be adjustments month to month, whether they be decreases in amounts paid or perhaps an overage. These changes may occur as a result of adjusted claims or a delay in receiving data from an external entity. We recommend that CMS add language to section 3 to explain the changes in totals to the member. For example:

    - If the member's out-of-pocket amount has gone down from the month prior, then include:
      "Your amount paid in out-of-pocket costs has gone down since last month due to an adjustment in the claims paid. Please see (page X/section X) for more details."

    - If the member paid over the MOOP/Deductible:
      "You have paid more than the maximum [deductible/out-of-pocket] for this year. Please watch for a separate letter from us soon."

8. Section 3 reflects services received within a given "benefit year" not within the "processing" year. However, Sections 1 and 2 reflect claims for the given "processing" year and not limited to the "benefit year." The "benefit year" would be dates of service January 1 through December 31. For the initial October 2013 summary through December 2013 summary, Section 3 will reflect the 2013 benefit year (January 1 through December 31, 2013). Upon issuance of the January 2014 monthly summary, is the plan only obligated to provide the new 2014 benefit year (January 1 through December 31, 2014) information?

9. We recommend that plans be given flexibility to design Section 4 to mirror Original Medicare's "Preventive Services" messaging in the Medicare Summary Notice as effort to reduce the overall size of the document and provide a more streamlined, user friendly document. Plans can supplement the messaging with additional reminders in Section 5.

10. The instructions indicate that plans are not required to send the monthly EOB if there is no claims activity. Would it be permissible to mail a monthly summary even when the member may not have any claims activity for a given month? If permissible, this would provide members with a regular mailing and the educational information provided in Sections 3, 4 and 5.

Per Claim Template

1. The current "Per Claim Summary" template is not truly a template for a per claim EOB. We recommend that CMS rename this template to "Quarterly Summary Version" to more accurately reflect the purpose of the template.

2. Within the instructions of the "Per Claim Summary" template, the second bullet references that plans may continue to send "per claim EOBs" via the plan's own EOB template. Please define "per claim." Does every claim event require an EOB to be sent to the member? For example, do plans need to send an EOB if a claim is denied and there is no member liability? Do plans need to send an EOB If a claim is denied as a duplicate claim?

America's Health
Insurance Plans

February 1, 2013

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS–10453 (OMB# 0938–New)
Room C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS–10453 (OMB# 0938–New)

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) in response to the notice under the Paperwork Reduction Act concerning the "Medicare Advantage and Prescription Drug Program: Part C Explanation of Benefits" that was published in the Federal Register (77 FR 70445) on November 26, 2012. The proposed Part C EOB is of significant interest to AHIP's member organizations, many of which participate in the Medicare Advantage (MA) program.

AHIP shares CMS' interest in pursuing, on an ongoing basis, opportunities for providing beneficiaries with additional information that permits them to make the best use of their Medicare health plans and benefits. However, the approach reflected in the proposed templates continues to raise concerns that the length of the resulting Part C EOB could be daunting for many beneficiaries and hinder its utility despite significant plan investment in producing and disseminating it. Our comments below address these and several other issues we have highlighted previously. We urge CMS to consider these issues further, as well as several additional issues that we have identified that are also discussed below.

COMMENTS

Cover Memorandum

- *Implementation Timeline.* Page 1 of the CMS memorandum indicates that the agency expects to require use of the model Part C Explanation of Benefits (EOB) by October 1, 2013. The agency believes this will provide MA organizations "adequate programming time needed to accommodate the EOB requirements." However, as we have previously commented, given the scope of the proposed requirements, as well the operational and design-related challenges discussed below that organizations have identified related to implementing the new Part C EOB, we believe a longer implementation timeline will be critical to allow MA organizations sufficient time to develop or make changes to their systems and to conduct testing to produce the new EOBs. Additional time to implement

the new Part C EOB also will provide CMS the opportunity to evaluate and address the concerns and challenges MA organizations have identified before moving forward.

In addition, we urge CMS to take into consideration that MA organizations are currently engaging in other major systems modifications and development in order to implement MA encounter data reporting and ICD-10. These major initiatives depend heavily upon the same systems resources necessary to carry out development and implementation of the Part C EOB, and it will be highly disruptive and particularly challenging for an additional project on the scale of the new EOB to be incorporated into plan system work flow. Accordingly, we reiterate our recommendation that CMS defer implementation of the Part C EOB until January 2015, to ensure that organizations are afforded the time necessary for orderly planning, appropriate resource allocation and extensive systems development.

- ***Structure and Content.*** The CMS memorandum, on page 1, states that the agency has developed an EOB for Part C benefits that is "modeled on the Part D EOB." As discussed in our previous comments, since the Part C program differs from the Part D program in numerous respects, we believe that using the Part D EOB as a basis for the Part C model does not provide the best platform for presenting information to beneficiaries about their medical benefits. Part C benefit designs are similar to private sector coverage offered to younger consumers, rather than reflecting a unique prescription drug benefit, and we believe experience with EOB requirements for Part D cannot be easily extrapolated to Part C, given the differences between the two programs.

  We remain concerned that the proposed draft EOB templates are too lengthy and could be confusing and intimidating for beneficiaries, especially in comparison to the format beneficiaries may be accustomed to seeing if they are enrolled in MA organizations that provide EOBs of this type to their members. We think the draft templates could be streamlined in a number of areas. For example, Section 4 of the draft MA EOB templates includes detailed descriptive information about Medicare preventive services, which is duplicative of information provided to members in other materials, including the Evidence of Coverage (EOC) that MA organizations are required to provide to all enrollees. We recognize the value in reminding enrollees about preventive care, and we note that page 2 of the recently revised Medicare Summary Notice (MSN) includes a brief section on Medicare Preventive Services that we believe accomplishes this goal, but in a more streamlined and efficient manner. We reiterate our recommendation that CMS consider revising Section 4 of the draft MA EOB templates in a similar way.

  We also reiterate our recommendation that CMS re-evaluate the overall structure and scope of the proposed MA EOB and consider modifying it to build upon elements of EOBs for medical benefits with which beneficiaries are already familiar. Such an approach could provide a simpler, shorter, and more streamlined document that would be

more user friendly for beneficiaries, in contrast to adapting the Part D EOB which is less suited to the proposed content.

- ***Denials***. Page 2 of the memorandum indicates that CMS is proposing that MA organizations will be able to choose between two options for providing Part C EOBs to their members. Organizations may choose to send members a monthly EOB that reflect members' claims for medical and supplemental benefits that were processed in the previous month or send members an EOB for each claim as well as quarterly and annual summary EOBs. In the case of denied claims, the monthly EOB templates provide the flexibility for organizations to either include the standardized CMS appeals language or specify that a "Notice of Denial of Payment" letter has been sent separately explaining the rationale for the denial and how to appeal. It is our understanding that CMS' Part C EOB initiative is not intended to signal changes to the existing requirements for the timing or content of denial notices, except as specifically indicated in the instructions. To promote consistent understanding that this is the case, we recommend that CMS include an explicit statement in any final Part C EOB instructions regarding ongoing application of appeals rules. We also recommend that, consistent with the approach reflected in the monthly EOB templates, the agency confirm that MA organizations continue to have the flexibility to provide separate notice of appeals in formats that they develop (whether claims-based or otherwise) in combination with either the monthly or per claim quarterly/annual EOB options, as long as these notices otherwise comply with CMS appeals rules in Chapter 13 of the Medicare Managed Care Manual (e.g., Section 40.2.1).

- ***Annual Summary EOB.*** The CMS memorandum, on page 2, states that organizations that choose the per claim/quarterly option for sending the Part C EOB must also send an annual summary EOB. However, CMS has not released draft templates for the annual summary or instructions addressing the timing for sending the annual summary to enrollees. To provide an opportunity for review and comment in coordination with the related templates, we recommend that CMS make available draft templates and instructions for the annual summary Part C EOB.

- ***Checklist***. On page 3 of the memorandum, CMS indicates that plans have the option of either using the model EOB or developing their own format. Plans that elect to use their own format must ensure that all elements and/or information provided in the model template are included in their non-model document. As noted in our previous comments, we appreciate CMS' efforts to provide this flexibility. We continue to believe that development by CMS of a checklist that details the specific elements the agency will require plans to include in their non-model EOBs would assist plans in developing EOB formats that meet CMS' requirements, as well as serve as a tool to promote consistent evaluation of non-model EOBs by CMS reviewers. We reiterate our recommendation that CMS issue such a checklist along with the final EOB templates and instructions.

Model Part C Explanation of Benefits Templates
(Comments are applicable to the HMO Version, PPO Version, and PFFS Version)

- ***Providing EOBs to Enrollees with no Liability in the Reporting Period.*** On the cover pages of the draft model Part C EOB templates, CMS states that organizations must send the EOB "to all members who had a claim processed during the reporting period." As discussed in our previous comments, we believe it is unclear whether CMS expects MA organizations to provide an EOB to enrollees in instances where the enrollee does not incur liability for any services or items during the reporting period in question. We recommendation that, for clarity, CMS specify the agency's expectations regarding this issue.

- ***Medical Service Descriptions.*** Under Section 1 and Section 2 (when applicable) of the draft templates, CMS is requiring MA organizations to use the American Medical Association (AMA) HCPCS code descriptors and CPT consumer descriptors, followed by the HCPCS or CPT billing code shown in parentheses to describe the services received by the enrollee for the applicable reporting period. As noted in our previous comments, it is our understanding that in instances where plans currently provide EOBs to their MA members, they have developed simplified service descriptions that correspond to the CPT codes that are easier for enrollees to understand and with which they are already familiar. We believe requiring plans to use the AMA descriptors rather than the beneficiary-friendly descriptions that are currently in use will cause beneficiary confusion and potentially dissatisfaction. We reiterate our recommendation that CMS provide plans the flexibility to utilize either their own service descriptions that correspond to CPT codes or utilize the AMA descriptors.

- ***Capitated Arrangements.*** In the draft templates under Section 1 (total claims processed for the reporting period) and when applicable, Section 2 (total claims processed for optional supplemental benefits for the reporting period), CMS requires MA organizations to provide specific information for each claim including, the amount billed by the provider for the service or item, the approved amount for the service or item, and the plan's share amount for the service or item. However, providers paid under capitated arrangements with MA organizations do not submit claims, but are paid on a per member per month basis, so that MA organizations cannot provide claims-specific amounts. MA organizations may also utilize other payment arrangements under which they do not pay claims (e.g., bundled payments for specific services or case rates). To adapt the template for these payment arrangements, we recommend that CMS permit MA organizations to populate the "Billed Amount," "Approved Amount," and "Plan's Share" fields with a placeholder of "$0.00" and include in the "Claim Number" field a brief explanation for enrollees. No special guidance would be needed for the "Your Share" fields that reflect beneficiary out-of-pocket costs (which are typically in the form of copayments).

- ***Supplemental Benefits.*** The instructions for the draft Part C EOB templates indicate that if the member has claims for optional supplemental benefits that were processed during the reporting period, these claims must be included within the Part C EOB in either Section 1 or Section 2, as appropriate. It is our understanding that some supplemental benefits may be administered by Third Party Administrators (TPAs) (e.g., vision benefits or hearing aids), and under these arrangements multiple TPAs may provide EOBs directly to the enrollee for covered items and services, if an EOB is appropriate depending on the nature of the benefit. For example, an EOB may not be provided when a plan member attends a fitness class. MA organizations may not currently receive from TPAs the information necessary to populate a Part C EOB and would need sufficient time to modify their contracts. In addition, similar to the issue discussed above regarding arrangements with capitated providers, due to the payment structure for some TPA arrangements, information necessary to populate fields for "Billed Amount," "Approved Amount," and "Plan's Share" fields may not be available. Consequently, in this circumstance as well, we recommend that CMS permit MA organizations to use a placeholder of "$0.00" and include in the "Claim Number" field a brief explanation for enrollees.

  In addition, we note that while the instructions to the draft templates specifically address reporting on optional supplemental benefits depending upon whether the plan does or does not count the benefits toward MOOP, the instructions do not reference mandatory supplemental benefits. It is our understanding that depending upon the plan's benefit design, a benefit (e.g., vision coverage or hearing aids) could be either a mandatory or optional supplemental benefit. Therefore, for clarity, we recommend that CMS revise the instructions that reference optional supplemental benefits to clarify that they also apply to mandatory supplemental benefits. We also recommend that CMS revise the title for Section 2. of the Part C EOB template to provide greater clarity for beneficiaries about the services that it will include.

- ***Mailing with Part D EOB.*** On page 2 of the draft templates, CMS instructs MA-PD plans to include language that informs the enrollee that information about their Part D prescription drugs is not provided in this document, but sent in a separate summary of Part D drug costs. For individuals enrolled in an MA-PD plan, as discussed in our previous comments, we believe it could be beneficial for enrollees to receive their Part C EOB and Part D EOB in a single mailing, and we reiterate our recommendation that CMS confirm in the final Part C EOB instructions that providing these documents together is permissible, should the MA-PD plan elect to do so. We note that on page 2 of the CMS memorandum, the agency acknowledges that some plans currently provide a monthly EOB-type document "in combination with the Part D EOB to their enrollees."

- ***Fraud Language.*** On page 3 of the draft templates, CMS is proposing to include language addressing Medicare fraud. As we have previously commented, we note that the proposed language is different than the language that appears in the comparable section of the Part D EOB (Section 5., page 32), and we recommend that CMS evaluate the draft Part C EOB and Part D EOB for consistency and align the language on this topic as appropriate. We believe that better alignment would benefit individuals enrolled in MA-PD plans who may receive an EOB for Part C as well as an EOB for Part D.

- ***Out-of-Pocket Costs.*** Under the "Your Share (what you pay out-of-pocket)" column in Sections 1 and 2 of the draft Part C EOB templates, CMS includes various scenarios that could be applicable based on member cost sharing, whether the service provided was preventive, or whether the service provided was denied by the plan. For clarity, AHIP continues to recommend that CMS provide a populated sample EOB that addresses each scenario.

- ***Coinsurance.*** In Section 1 and Section 2 under the "Your Share" column, CMS includes an instruction directing plans to insert the percentage of the total amount for a service that the enrollee must pay if their cost sharing is a coinsurance. As discussed in our previous comments, it is our understanding that the systems logic required to populate the coinsurance percentage from plan claims systems is very complicated, and it could be challenging to provide this information in a beneficiary-friendly manner. We believe a more efficient approach would be to refer the enrollee to the Evidence of Coverage for specific details on how coinsurance is calculated, and we reiterate our recommendation that CMS revise these sections of the drafts accordingly.

- ***Summary of Yearly Deductible and Yearly Out-of-Pocket Costs.*** In Section 3 of the draft Part C EOB templates, CMS is proposing to require plans to indicate the amount the enrollee has paid, as of the reporting period, toward satisfying the yearly deductible and Maximum Out-of-Pocket (MOOP) costs. In addition, CMS is proposing to require plans to provide a chart that displays the member's progress toward the deductible and MOOP. As discussed in our previous comments, while we recognize the value in providing a graphic along these lines to enrollees, we are concerned that this approach could be confusing to beneficiaries, particularly in instances where claims reversals may occur in subsequent months that require an adjustment to the MOOP amount and therefore a negative change to progress reflected in the chart. In addition, it is our understanding that complex systems programming would be required to allow MA organizations to display in graphic form an enrollee's progression through the benefit throughout the year.

  For clarity for beneficiaries and to simplify necessary programming, we reiterate our recommendation that CMS revise this section of the draft to remove the graphic, but retain inclusion of the dollar amounts the enrollee has paid toward satisfying the MOOP and deductible. We believe this approach is consistent with the approach the agency has

in place for the comparable section of the Part D EOB (Section 3 "Your Out-of-Pocket Costs and Total Drug Costs").

- ***Preventive Services.*** As noted above and included in our previous comments, Section 4 of the draft Part C EOB templates includes detailed descriptive information about Medicare preventive services, which is duplicative of information provided to members in other materials, including the Evidence of Coverage (EOC) that MA organizations are required to provide to all enrollees. We recognize the value in reminding enrollees about preventive care and note that page 2 of the recently revised Medicare Summary Notice (MSN) includes a brief section on Medicare Preventive Services that we believe accomplishes this goal, but in a more streamlined and efficient manner. We reiterate our recommendation that CMS revise this section of the draft Part C EOB in a manner similar to the MSN for clarity and in an effort to provide a more streamlined and user-friendly document to enrollees.

We have appreciated the opportunity to comment. Please contact me if additional information would be helpful or if you have questions about the issues we have raised. I can be reached at (202) 778-3209 or cschaller@ahip.org.

Sincerely,

Candace Schaller
Senior Vice President, Federal Programs

1121 L Street
Suite 500
Sacramento, CA 95814

Anthony Mader
Vice President
Public Policy

Submitted Electronically via www.regulations.gov

February 1, 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Re: WellPoint Comments on the November 26, 2012 Federal Register, Information Collection Request: The Medicare Advantage and Prescription Drug Program: Part C Explanation of Benefits CFR 422.111(b)(12) [Form Number CMS-10453]

To Whom It May Concern:

WellPoint appreciates the opportunity to submit comments on the proposed Part C explanation of benefits (EOB) model templates issued for public comment on November 26, 2012 via the Paperwork Reduction Act (PRA) Information Collection Request: Medicare Advantage and Prescription Drug Program: Part C Explanation of Benefits.

We note that the comments presented today are largely consistent with feedback we provided to CMS regarding the October 18, 2012 HPMS memo titled "Final Part C EOB Models and Implementation of the Part C EOB". To the extent this comment letter identifies new issues or modified concerns from our previous feedback, we have so indicated.

At WellPoint, we believe there is an important connection between our members' health and well-being—and the value we bring our customers and shareholders. So each day we work to improve the health of our members and their communities. And, we can make a real difference since we have approximately 36 million people in our affiliated health plans, and approximately 66 million people served through our subsidiaries. As an independent licensee of the Blue Cross and Blue Shield Association, WellPoint serves members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as the Blue Cross Blue Shield licensee in 10 New York City metropolitan and surrounding counties and as the Blue Cross or Blue Cross Blue Shield licensee in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin. In a majority of these service areas, WellPoint's plans do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia and Empire Blue Cross Blue Shield, or Empire Blue Cross (in the New York service areas). WellPoint also serves customers throughout the country as UniCare and in certain markets through our Amerigroup and CareMore subsidiaries. Our 1-800 CONTACTS, Inc. subsidiary offers customers online sales of contact lenses, eyeglasses and other ocular products. Additional information about WellPoint is available at www.wellpoint.com.

WellPoint makes the following recommendations in regards to implementing the Part C EOB model templates:

Accommodations for Dual Eligible and Integrated Care Delivery Medicare Advantage Organizations (MAOs)

WellPoint appreciates CMS' motivation for establishing a model Part C EOB. We believe the model EOB will streamline member communications, thereby reducing confusion for most members. In the long-term, we believe this standardized communication will also reduce complaints filed with 1-800-MEDICARE.

Two exceptions, though, would be members who are enrolled in an MAO that offers an integrated care delivery model and members who are dually eligible for Medicare and Medicaid.

In the case of MAOs that utilize an integrated care delivery model, we encourage CMS to consider the unintended consequences that may result from mandating use of a standardized EOB. For these integrated health plans that interact directly with their members and do so on a regular basis, such a communication may have a contrary result, as these members are high utilizers of benefits but pay very little, if anything, when accessing the preventive and routine benefits offered by their plan. As a result, members in these integrated MAOs will typically receive a voluminous EOB that may be overwhelming to the member and not meaningful, as there is little for the member to pay out of pocket. Likewise, to supply these EOBs to members on a monthly or quarterly basis would be costly and detract from funds available to cover services.

In the case of dual eligibles, we applaud CMS' recognition that the dual eligible population warrants special and additional consideration to ensure that any model Part C EOB template includes both meaningful and timely information. For this especially vulnerable population that has a higher-than-average benefit utilization rate, it is critical that communications be clear and not overly confusing, and we applaud CMS for taking additional time to evaluate comments and consumer testing results already received before requiring plans to implement a standardized EOB for this population. To that end, we encourage CMS to offer a separate comment period and consumer testing for the dual eligible model Part C EOB and sufficient lead time to implement any additional accommodations that may be built into the EOB design for this population.

AMENDED - Timing of Final Guidance --- Request to Delay Implementation

If CMS elects to move forward with the Part C model EOB, we encourage CMS to consider the lead time that will be required in order for MAOs to make the appropriate IT and system programming modifications. These changes will be implemented at roughly the same time as the annual enrollment process and on roughly the same timetable as several administrative simplification provisions from the Affordable Care Act and perhaps even the revised Form 1500 for which comments were solicited in the September 21, 2012 Federal Register (77FR58558, Form Number CMS-1500(02/12), CMS-1490-S (OMB#0938—New).

For this reason, we request that CMS make available the final templates and implementation guidance by March 1, 2013 to ensure plans have sufficient time to budget, plan for and implement the standardized Part C EOB. We also strongly recommend that CMS adopt an effective date of January 1, 2014, (based on DOS January 1, 2014 forward not date of receipt of the claim), rather than the current implementation date of October 1, 2013, so that plans have adequate time for implementation of the final requirements.

NEW - Applicability to Claims Processed in 2013 and Forward

The PRA for the Standardized Part C EOB maintains the Agency's original implementation date of October 1, 2013. As noted above, WellPoint continues to strongly recommend that this deadline be delayed to January 1, 2014. In addition, we have identified a new concern that could create additional difficulties for plans in meeting the implementation deadline.

Section 3 of the EOB Template requires plans to display the amount a member has paid towards the yearly deductible and limits on out-of-pocket costs. WellPoint notes that the timely filing deadline for claims is one year from the date of service, meaning that it is very likely that plans will process claims for a plan year well into the following year. In these instances, Section 3 could be interpreted to require plans to display information for the previous plan year, in addition to the current year on the EOB.

Such an interpretation would create a new and added burden on the time and resources of plans, as it would require us to retroactively update our systems in order to provide information from the previous plan year on the EOB. Due to the complexities already involved with developing and implementing the new Part C EOB, we strongly recommend that CMS clarify that Section 3 applies to current plan year data only.

NEW - Explanation for Duplicate Claims

In Section 2, plans are limited to displaying one of two denial explanation messages. However, WellPoint observes that neither of these message choices is appropriate for duplicate claim denials. Thus, utilizing either of the existing explanations could cause member confusion and abrasion by leading them to believe that they are responsible for cost-sharing when indeed they are not, or that perhaps the provider is responsible for the full amount. To provide a clear message to the member, WellPoint recommends adding the following claim denial explanation for duplicate claim denials: *This service is a duplicate claim to a previously processed claim submitted by your provider. Please refer to the original claim that was processed to determine your level of cost-sharing or copayment, if any.*

NEW – Definition of "Member Liability"

In Sections 1 and 2 of the PPO and HMO templates, CMS makes references to "member liability". In order to ensure consistency and avoid confusion, WellPoint recommends that CMS provide a specific definition of "member liability" as it relates to claim denials for Medicare Advantage members. On page 5 of the monthly Part C EOB template, CMS provides template language that addresses claim denials for plan providers. We believe that this language will help members understand that denials of network provider claims do not necessarily correspond to a financial liability. We suggest that CMS further clarify that only claim denials issued for the following reasons may have associated member liability: 1) the service was provided by a non-plan provider without prior plan approval or referral from a plan

provider; 2) the service is an excluded benefit; or 3) the member has exceeded his/her benefit limit. Providing a written definition of member liability would ensure that all plans across the industry are operating under the same definition.

Considerations for Claims that do not Count toward a Member's Out-of-Pocket Expense

From a policy standpoint, we understand and support CMS' rationale for moving toward a standardized Part C EOB for members. This communication will help members better understand their out-of-pocket costs for the benefits provided under Medicare Part C, much in the same way the standardized Part D EOB communicates member out-of-pocket costs for prescription drug benefits. However, we encourage CMS to consider the differences in how Part C and Part D claims are paid and to make accommodations on the Part C EOB to reflect the fact that Part C claims can be paid several days or months after the date of service, whereas Part D claims are typically adjudicated at point of sale. To that end, we encourage CMS to give MAOs flexibility to exclude from any per-claim, monthly or quarterly EOBs sent to members those claims which result in no member liability (for example no co-payment or coinsurance) because these claims do not contribute to a member's overall out-of-pocket costs. We similarly request that plan sponsors be given flexibility to exclude from EOBs claims with a minimal, fixed-dollar co-payment, or to allow plans to aggregate these claims in a single line item on an EOB so that plans may provide detail about how these claims contribute to a member's total out-of-pocket costs without overwhelming members with data.

NEW – Mandatory Supplemental Benefits

There are several issues that WellPoint has identified with respect to mandatory supplemental benefits. First, it is unclear whether or not CMS intends to require plans to include these benefits (e.g., routine dental, non-emergency transportation) in Section 1 or Section 2 of the EOB. We request clarification on whether mandatory supplemental benefits are to be included in the EOB, and note that if it is the Agency's intent that plans include these benefits, this creates operational and member abrasion concerns. With respect to operations, many plans contract with vendors to administer mandatory supplemental benefits through capitated arrangements. In such cases, encounter data is not generated and claims for these services will not contain traditional CPT or HCPCS codes. Regarding the potential for member abrasion, some mandatory supplemental benefits have dollar allowances associated with them. For example, many plans offer an allowance for certain over-the-counter items under the Part C benefit. As another example, some plans offer an annual dollar allowance for eyewear. In general, the items and services offered under these benefits do not have co-payments and do not generate traditional claims. We are concerned that, because the usage detail tied to these types of benefits would not fit into the EOB tables cleanly, beneficiaries may confuse the dollar amounts listed in the EOB with a payable balance. For these operational and member abrasion reasons, WellPoint suggests that mandatory supplemental benefits be excluded from the Part C EOB.

NEW – Impact of Part C EOB Pilot on Appeals Volume

WellPoint would appreciate CMS's feedback on how issuance of the Part C EOB in the pilot program affected the volume of claim appeals submitted by beneficiaries and providers. In addition, we are looking for information for the volume of cases submitted to Maximus for Dismissal as a result of non-member liability appeals. We anticipate that beneficiaries will share the EOB with their provider(s), especially when it contains claim denials, which may trigger a higher volume of appeals. We are

concerned that some of the claim appeals triggered by the Part C EOBs will ultimately require dismissal due to a lack of member liability, as we have seen with the Notice of Denial of Payment.

Clarifications to Monthly EOB Requirement

We appreciate CMS' willingness to give plans flexibility in implementing the model Part C EOB by offering both a monthly and quarterly EOB option. This flexibility allows MAOs to adopt the model EOB that aligns most closely with their current claims processing and member communications practices. For WellPoint, we favor the monthly EOB option, and offer the following questions to CMS for clarification:

- Template Length: The implementation of uniform Part C EOB models as designed pose a very large cost increase to MAOs as the program is described. Each Monthly EOB will require significantly more pages to print the EOB and postage costs will increase significantly as well due to envelope size and weight. We request that efforts be made to look at options that will reduce the size of the EOB. For example, the introductory text which fills page 1 will be repeated with each EOB. We recommend the detail about benefit plans be left to the Evidence of Coverage presented to the member each year and only a brief reference be made advising the member to consult their EOC or Summary of Benefits for detailed information about their benefits. We recommend the cautions for Fraud and Abuse of Medicare services be discussed once (rather than in both sections 1 and 2), and that plans be given discretion to determine placement of this information in the EOB. Lastly, CMS could adopt our prior recommendation to exclude from the EOB any claims that have no cost-sharing for a member (because these claims do not count toward a member's out-of-pocket costs) as well as claims with a fixed-dollar co-payment. Together, these recommended edits would reduce the page count while still providing members with more detail than they currently have in their medical EOB.

- Accommodations for EOBs Supplied to Employer Sponsored Retiree Plans: On page 1 of the HMO and PPO monthly templates, under the section "Member Services", we note that the instruction includes a statement indicating *"Benefits, formulary, pharmacy network, premium, copayments, and coinsurance may change on January 1 of each year."* In light of the fact that employer group plans can be based on a fiscal year and not a calendar year, the reference to January 1 may be inaccurate and confusing for employer group members. For this reason, we recommend that CMS bracket the term "January 1" so that the MAO may insert the applicable renewal date for the employer group members.

- Allowance for Differences in the Benefit Year: Similar to the prior comment, we note that the templates refer to a benefit year beginning January 1 in the heading titled "Totals for 2013" for both the medical/hospital and optional supplemental benefits sections. To account for differences in benefit year between individual MAOs plans and employer group-sponsored plans, we recommend the language in these sections be revised so that the plan year is reflected in brackets: "TOTALS for *[insert plan benefit year],"* "(Yearly total so far for all claims for medical and hospital services that were processed from *[insert beginning date of plan benefit year] to [insert ending date of the current reporting period],"* and "(Yearly total so far for all claims for optional supplemental services that were processed from *[insert beginning date of plan benefit year] to [insert ending date of the current reporting period].)"* Similarly, the benefit

years listed in Section 3 should also be bracketed to read: "In *[insert plan benefit year],"* rather than "In 2013."

- Inclusion of American Medical Association's and CPT Consumer Descriptors: On page 5 of the monthly template (for medical/hospital care) and again on page 13 (for optional supplemental benefits), in the claim-by-claim breakdown, the instructive language indicates that MAOs are to insert a description of the service or item that was provided, using the AMA's HCPCS code descriptors and CPT consumer descriptors. Because these descriptors can be very high-level and non-specific, we encourage CMS to allow MAOs the flexibility to use custom service descriptors that are at least as descriptive as the AMA HCPCS descriptors and CPT code descriptors yet are written in a more consumer-friendly manner. In addition, we ask CMS to consider allowing use of revenue codes for facility claim services. To effectuate this flexibility, we recommend that the instructive language be revised to read: *"Insert description of the service or item that was provided, using the American Medical Association (AMA)'s HCPCS code descriptors, CPT consumer descriptors, revenue code descriptors, or the plan's custom descriptors, followed by the HCPCS or CPT billing code shown in parentheses."*

- Notice of Denial of Payment: On pages 5-7 of the HMO and PPO templates, CMS instructs MAOs to include approved language from the Notice of Denial of Payment in a landscape layout. Currently, some plans supply a Notice of Denial of Payment and appeal rights in portrait layout as part of their per-claim EOBs. To minimize the amount of system reprogramming that will be required to accommodate a landscape layout, we recommend the template be modified so that the Notice of Denial of Payment and appeal rights be moved to a separate page (preferably at the end of the claims total) with the portrait layout retained [at the individual MAO's option?].

- Duplication of Service Descriptions: On the HMO and PPO templates in both the sections on medical/hospital care and optional supplemental benefits, CMS includes the following instruction under the "Your Share" heading: *"You pay [insert percentage]% of the total amount for [insert brief description of service, (e.g., "a primary care office visit")] [POS plans insert: from an [insert as applicable: in-network OR out-of-network] provider]."* Because the model EOB already calls for a description of the service or item provided using the AMA's HCPCS descriptors or CPT consumer descriptors, this additional description of the service under "Your Share" is duplicative. For this reason, we recommend the instructive language in the "Your Share" section be revised to read as follows: *"You pay [insert percentage]% of the total amount for this service."*

- Clarification on Value to Enter under "Billed Amount" for a Bundled Item or Service: The instructions on pages 5 and 13 of the HMO and PPO templates advise to *"[Insert amount billed by the provider for this service or item]."* As written, this language does not take into account items for which payment may be bundled with another item or service; therefore we recommend the instruction be revised to read *"[Insert amount billed by the provider for this service or item; including items or services that may be bundled.]"*

- Clarification on Value to Enter under "Approved Amount" for Denied Claims: On the HMO and PPO templates in both the sections on medical/hospital care and optional supplemental benefits claims totals, CMS includes the instruction for plans to include the "Approved Amount" per claim, in total, and year-to-date. To ensure MAOs are entering the correct value in situations where a claim is denied, we recommend that CMS include the following additional language in

each section where this instruction is reflected: *"[Insert total approved amount for this claim. If claim is denied, insert '0'.]"*

- "Approved Amounts" for Out-of-Network Providers: On the HMO and PPO templates in both the sections on medical/hospital care and optional supplemental benefits, plans are to include the following notation: *"[Note: if service or item is approved, use amount approved by the plan for the total amount. If service or item is denied use the contracted amount.]"* As written, this instruction does not account for claims submitted by out-of-network providers that are subsequently denied or services that are not covered by the plan, therefore, we recommend the note be revised to read as follows: *"[Note: if service or item is approved, use amount approved by the plan for the total amount. If service or item is denied use the charged amount for the item or service, the contracted amount for contracted providers or the Medicare allowed amount for non-contracted providers.]"*

- Considerations for Optional Supplemental Benefits in Individual Plans: On the HMO and PPO templates, in the section regarding optional supplement benefits, CMS includes instruction to insert the member's monthly premium. We recommend this language be revised to read as follows: *"You pay an extra premium for your optional supplemental benefits."*

- Considerations for Optional Supplemental Benefits in Employer/Union Sponsored Plans: Optional Supplemental style benefits are not optional at the member level with our employer/union sponsored plans. If the group purchases these benefits, they apply to all members. We recommend that section two be modified to have alternative text for employer/union sponsored plans to call the benefits "Supplemental Benefits". We also recommend deleting any reference to payment of extra premium since the premium is usually paid partially or fully by the past employer/union rather than solely by the member. For employer/union sponsored plans, it is common for many employers to pay the full share of the premium for their retiree. Accordingly, we recommend the text be moved to section 2 which is dedicated for OSB services and altered to read: *"If the claim is for optional supplemental benefits, insert: NOTE: This claim is for services that are covered as part of your optional supplemental benefits. You may pay an extra premium for these benefits."*

Clarifications to Per-Claim (Quarterly) EOB Summary

While WellPoint favors the monthly EOB template, we also had a few questions regarding the model per-claim EOB summary:

- Additional Detail Needed Per-Claim: CMS has issued two versions of the HMO Part C EOB template, a per-claim EOB option and a monthly EOB option. Plans opting to issue the per-claim EOB are instructed to develop their own EOB template, but must then issue a quarterly summary using the template entitled *Part C_EOB_HMO_per_claim_summary_template*. Our review of the per-claim EOB summary revealed that the template does not include a section for the per-claim detail, therefore it is unclear where or how that information is to be communicated to members, or whether plans are to continue using their current per-claim EOB in whatever format they choose.

  If CMS seeks to standardize the per-claim EOB as well as the EOB supplied quarterly, we recommend that the current quarterly template be revised to add a new section detailing per-

claim information or create a separate template to use on a per-claim basis. In this new section or per-claim template, CMS should clarify:

- What language, if any, should be included regarding the Notice of Denial of Payment and notice of appeal rights that would otherwise be included in a per-claim EOB currently supplied by an MAO? Consistent with the flexibility afforded for the monthly EOB model, WellPoint recommends that CMS allow plans the flexibility to combine the NDP language and the EOB in one document when the claim is denied. Specifically, we recommend that CMS require MAOs to use the same language that appears in the monthly EOB model for the Notice of Denial of Payment and the notice of appeal rights.

- Whether the per-claim detail should be formatted in the same fashion as the sections titled "Totals For This Quarter" and "Totals for 2013", or whether an alternate format should be used for the per-claim detail, compared to the aggregated information provided in the quarterly.

- Approved Amounts" for Out-of-Network Providers: In several places on the HMO and PPO per-claim template, under the "Approved Amounts" heading, CMS provides the following instruction: *"$[insert total approved amount for the reporting period],"* but does not specify whether the approved amount is to include only approved amounts paid to in-network providers or whether amounts paid to out-of-network providers should also included. The term "approved amount" is sometimes interpreted to mean the approved or allowed amount that a participating provider has agreed to receive as reimbursement for a particular item or service, therefore we recommend the template language be revised to clarify that the approved amount should reflect any amounts paid to participant and non-participating providers during the applicable quarter, if that is CMS' intent.

Finally, we also had some of the same observations regarding the per-claim EOB summary as were previously noted in the monthly EOB summary. These observations are reiterated here, so the modifications we have recommended, if adopted by CMS, may be reflected on the appropriate pages of the per-claim EOB summary as well:

- Accommodations for EOBs Supplied to Employer Sponsored Retiree Plans: On page 1 of the HMO and PPO monthly templates, under the section "Member Services", we note that the instruction includes a statement indicating *"Benefits, formulary, pharmacy network, premium, copayments, and coinsurance may change on January 1 of each year."* In light of the fact that employer group plans can be based on a fiscal year and not a calendar year, the reference to January 1 may be inaccurate and confusing for employer group members. For this reason, we recommend that CMS bracket the term "January 1" so that the MAO may insert the applicable renewal date for the employer group members.

- Allowance for Differences in the Benefit Year: Similar to the prior comment, we note that the templates refer to a benefit year beginning January 1 in the heading titled "Totals for 2013" for both the medical/hospital and optional supplemental benefits sections. To account for differences in benefit year between individual MAOs plans and employer group-sponsored plans, we recommend the language in these sections be revised so that the plan year is reflected in brackets: *"TOTALS for [insert plan benefit year],"* *"(Yearly total so far for all claims for*

medical and hospital services that were processed from [insert beginning date of plan benefit year] to [insert ending date of the current reporting period]," and *"(Yearly total so far for all claims for optional supplemental services that were processed from [insert beginning date of plan benefit year] to [insert ending date of the current reporting period].)"* Similarly, the benefit years listed in Section 3 should also be bracketed to read: *"In [insert plan benefit year],"* rather than "In 2013."

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WellPoint appreciates this opportunity to offer our suggestions on the CMS' proposed Part C EOB model templates. Should you have any questions or wish to discuss our comments further, please contact Alison Anway at (850) 320-6975 or Alison.Anway@wellpoint.com.

Sincerely,

Tony Mader
Vice President, Public Policy