CMS Response to Public Comments Received for CMS-10526
January 2016

The Centers for Medicare and Medicaid Services (CMS) received comments from two insurance companies and two industry associations related to CMS-10526.

Comment:

Please limit new data requirements to the PRA since issuers need stability to finalize the data collection.

Response:

We consolidated summary, plan, and policy reporting for all issuers regardless of methodology and eliminated a number of data elements in this revised collection; however, since this data collection requires issuers to file separate reports in the event of a merger with or acquisition of an issuer with a different methodology, we are adding data elements to allow said issuers to cross reference their HIOS IDs with those of the acquired issuer(s) or merger partner(s).

Comment:

Please move the data collection to June 1, as proposed in the original PRA, since this collection is for two years of data and issuers will be submitting EDGE data at the same time.

Response:

To complete CSR reconciliation on time, CMS must begin to collect data April 1.

Comment:

Please release the file structure as soon as possible.

Response:

We will release the file specifications shortly. CSR reconciliation data will be collected in a pipe de-limited file.

Comment:

Three commentators asked CMS not to require collection of annual and monthly premium amounts and, if CMS does collect this data, to explain why it is needed and, further, to explain and define a) how issuers would report monthly premium for a policy

whose premium changes over the year because of life events, (b) the point of time premium data should be reported, and (c) whether premium is billed or earned. One commenter noted that 2014 advance payments in 2014 were not tied to premium, therefore premium data is not necessary for 2014, and 2015 premium is already included on monthly submission templates, making this collection redundant. Another commenter said premium is out of scope of CSR reconciliation and collecting premium data will add a significant level of unnecessary complexity to the CSR reconciliation data submission. In addition, premium is difficult to report without specifications on when data should be pulled and for what point in time, because retroactive adjustments to enrollment can result in premium changes months after the enrollment period. The commenter said that if CMS requires issuers to average premium over 12 months, it is not clear that average premium data would be useful.

Response:

CMS requires billed premium data to help validate cost-sharing reduction payments. Premium collected at the plan level on monthly payment submission templates varies according to changes in enrollment; for this data element, CMS asks issuers to report the average policy level premium over the months the policy was in effect during the benefit year. For partial-year policies, we require issuers to divide the total premium billed for the benefit year by the number of months in which the policy was in effect. Premium amounts cover the benefit year, January 1 – December 21 and include retroactive adjustments up to April 30, 2016.

Here is the expanded definition for this data collection:

- **TOTAL MONTHLY PREMIUM**: The monthly premium amount billed for this policy for the applicable benefit year. If the policy changed to self-only or other than self-only during the benefit year, or if the monthly premium amount changed during the benefit period as the result of other changes in circumstance, enter the average monthly premium for this policy over the months in which it was in effect. Issuers should include retroactive adjustments to premium for the applicable benefit year that were made after the close of the applicable benefit year but before or on April 30, 2016.

Comment:

For the standard methodology policy level report, CMS should revise the description of "Amount the Issuer Paid" to read as follows: the amount paid for EHB or the amount paid under the cost sharing variation for EHB

Response:

We agree. "Amount the Issuer Paid" is the total allowed costs for EHB for the plan variation, as described at 156.430(c)(1).

Comment: Several commenters asked CMS to revise language for "Amount Paid by the Issuer" and "Amount the enrollee would have paid under the standard plan," to recognize that capitated or bundled payment arrangements are included. Commenters also asked CMS to clarify that this amount is the amount less enrollee liability, and that the amount should be the amount owed rather than paid by the enrollee.

Response:
We did not intend to exclude recovery of cost-sharing reductions for allowed costs for capitated or bundled payments. Here is the new language.

- **TOTAL ACTUAL AMOUNT THE ISSUER PAID FOR EHB**: The amount the issuer paid providers for EHB for all services to enrollees in this plan. This includes cost-sharing reduction reimbursement amounts to fee-for-service providers to the extent the issuer reimbursed fee-for-service providers. Issuers that provide for essential health benefits on a partially or fully capitated basis should enter all amounts paid by the issuer for those services. This value does not include enrollee liability.

- **TOTAL ACTUAL AMOUNT PAID FOR EHB BY ENROLLEES**: Total amount all enrollees in this plan paid (or are liable for) in cost sharing for all EHB services

- **AMOUNT THE ENROLLEE(S) WOULD HAVE PAID FOR EHB UNDER THE STANDARD PLAN**: The amount the enrollee(s) would have paid for the same EHB claims had he/she/they been enrolled in the standard plan without cost-sharing reductions**.** *For the standard methodology*, dollar amounts entered here must be calculated in accordance with HHS guidance on re-adjudication of claims. Issuers should first equate all claims to zero and adjudicate claims as if the enrollee had been in the standard plan from the beginning of the year. (See discussion of claims re-adjudication on page 9, above.) *For the simplified methodology*, dollar amounts entered here must be calculated in accord with CFR 156.430(c)(4).

Comment:
What time period should be covered when submitting data for the "CSR amount advanced to the issuer?"?

Response:
This is the amount the issuer believes it received from the federal government for the entire benefit year – covering January 1 to December 31. Issuers should include retroactive adjustments to advance payments for the applicable benefit year that were made after the close of the applicable benefit year but before or by April 30, 2016.

Comment:
One commenter asked CMS to allow issuers to claim CSRs provided during a grace period when the enrollee does not pay the premium, since issuers should not be penalized for acting in good faith, and whether this would be affected by the length of the grace period.

Response:
Under 45 CFR 156.430(f), CMS will not reimburse issuers for CSRs following a termination of coverage effective date with respect to a grace period as described in 45 CFR 155.430. The termination date for an enrollee who does not pay premium is the last day of the first month of the three-month grace period (see 45 CFR 155.430(d)(4)). As discussed in 45 CFR 156.270, issuers may pend claims for medical services in the second and third months of a grace period and notify providers that they may not be paid.

Comment:

One commenter asked CMS to clarify how to report multiple policies for a single subscriber in a benefit year, and which Plan Benefit Start and End dates to use when there are gaps in coverage for the same policy. The commenter also asked about paid claims dates, since past CMS filings include the calendar year for the benefit year and a three-month run-out period thereafter.

Response:

Standard methodology:
In the case of a policy that switches from self-only to other than self-only or vice versa after a change in circumstances, such as marriage or death, and remains in the same QHP plan variation, or in the case of other changes of circumstance that result in multiple policies for the same subscriber in the same plan variation during the benefit year, an issuer using the standard methodology may aggregate the policies into one policy report as long as the issuer calculates cost-sharing reductions provided separately, as necessary, under the appropriate parameters for each policy for the period the policy was in effect.

Simplified methodology:
In the case of a policy that switches from self-only to other than self-only or vice versa after a change in circumstances, such as marriage or death, and remains in the same QHP plan variation, an issuer may aggregate the two policies into one report if the issuer calculates separate effective cost-sharing parameters for self-only coverage and other than self-only coverage for the plan variation. In such a case, when a plan variation policy is self-only for part of the year, and then becomes other than self-only (or vice versa), the issuer should apply the set of effective cost-sharing parameters (or the AV method, one minus the actuarial value of the standard plan) for the type of coverage for which the plan variation policy was for the greatest number of coverage months. If the type of coverage of the policy was evenly split, the QHP issuer should default to the other than self-only coverage effective cost-sharing parameters. See FAQ 11901 (August 8, 2015) [1]

[1] https://www.regtap.info/faq_viewu.php?id=11901

When there are gaps in the same plan variation policy, issuers should use the first start data and the last end date the policy is in effect.

In the case of a subscriber who changed plan variations during the year, issuers must reconcile cost-sharing reductions provided to that subscriber separately, using the applicable Start and End dates for each plan variation.

CMS will allow issuers to submit claims for the applicable benefit year that are paid after the close of the year as long as the claims have been re-adjudicated by April 30, 2016. Claims incurred during the benefit year but which have not been paid and re-adjudicated by April 30, 2016 must be submitted in the subsequent reconciliation cycle. We will provide guidance on the process for submitting cost-sharing reduction data for claims that could not be re-adjudicated by April 30, 2016 at a later date.

Comment:

One commenter asked CMS to explain "Record Code."

Response:

Record codes are technical specifications that indicate whether the information is at the issuer, plan, or policy level. For this data collection, 01 will always be the issuer summary report, 02 will always be the plan level report, and 03 will always be the policy level.

Comment:

Commenter asked how plan-level data elements are mapped to policy-level data elements since there is no 16-digit HIOS ID required at the policy level that could be tied to the plan-level data.

Response:

We will require issuers to provide the 16-digit HIOS ID at both the plan and policy level reports so that the reports can be linked.

Comment:

On the issuer attestation of allowed costs for essential health benefits, commenter said CMS should revise language stating that "CSR amounts represent only EHB cost-sharing amounts for which Federal reimbursement is permitted, and amounts paid to fee-for-service FFS providers" to reflect both FFS provider and payments to providers under other arrangements.

Response:

Issuers must attest that cost-sharing reduction amounts represent only EHB cost-sharing for which Federal reimbursement is permitted, excluding certain benefits for which Federal funds may not be used, as described in Section 1303 of the Affordable Care Act and excluding amounts paid by enrollees, but including amounts reimbursed by issuers to fee-for-service providers.[2] (The federal government reimburses issuers that compensate issuers in part or in whole on a fee-for-service basis for cost-sharing reductions reimbursed to providers and provided to enrollees.)

We revised the language on the attestation to indicate that reimbursement payments to fee-for-service providers who accepted reduced cost sharing from enrollees could be included only to the extent they were passed through to providers. This provision does not apply to capitated arrangements. As discussed in the HHS Notice of Benefits and Parameters 2014 final rule (78 FR 15849 March 11, 2013), we expect issuers of non-fee-for-service arrangements to compensate their providers for cost-sharing reductions through other payment processes and, therefore, we reconcile advance payments to issuers of capitated and other alternative payment arrangements only on the basis of actual cost-sharing reductions provided to enrollees.

Here is the new language:

> All issuers must attest that cost-sharing reduction amounts provided to enrollees and submitted for reimbursement represent only cost sharing for essential health benefits for which Federal reimbursement is permitted (in the case of fee-for-service providers, these amounts must have been passed through by the issuer to such providers, pursuant to 45 CFR 156.430(c)(5).)

Comment:
How should issuers report HMO-like plans if the plan qualifies (as an HMO-plan) for self-only medical (> 80% of total allowed costs for EHB for the benefit year under the standard plan is not subject to a deductible) but not for other than self-only medical?

Response:
Space is provided for issuers to report both these and other parameters on "Attestation Form C: Simplified Methodology Effective Parameters and Formulas," in the forthcoming "CMS Draft Manual for Reconciliation of Advance Payment of Cost-Sharing Reductions for Benefit Years 2014 and 2015."

Comment:

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[2] See 45 CFR 156.430(c)(5) *Reimbursement of providers.* In the case of a benefit for which the QHP issuer compensates an applicable provider in whole or in part on a fee-for-service basis, allowed costs associated with the benefit may be included in the calculation of the amount that an enrollee(s) would have paid under the standard plan without cost-sharing reductions only to the extent the amount was either payable by the enrollee(s) as cost sharing under the plan variation or was reimbursed to the provider by the QHP issuer.

Clarify definition of subgroups for "Total CSR provided for this policy."

Response:

For the simplified methodology, CSR provided is the sum of actual CSR amounts provided for all subgroups on this policy; for example, if a policy has separate medical and pharmaceutical parameters, actual CSR provided must be calculated separately and added together.

Comment:
Please clarify claims run out for 2014 benefit year, clarify flexibility in order and batching that issuers apply for re-adjudication of claims, clarify calculations for reporting criteria. Commenter asks CMS to provide CPT codes and diagnostic codes for specific claims that should be excluded by law from EHB.

Response:
We clarify claims run out, order of re-adjudication of claims, and calculations for the simplified methodology in the forthcoming "CMS Draft Manual for Reconciliation of Advance Payment of Cost-Sharing Reductions for Benefit Years 2014 and 2015."

CMS will allow issuers to submit paid claims for the applicable benefit year that have been re-adjudicated as of April 30, 2016. Claims incurred during the benefit year but which have not yet been re-adjudicated by April 30, 2016 must be submitted in the subsequent reconciliation cycle. We will provide guidance on the process for submitting cost-sharing reduction data for claims that could not be re-adjudicated by the applicable benefit year data submission deadline at a later date.

In regard to re-adjudication of claims, on November 17, 2014 HHS published guidance on the re-adjudication of claims which stated that when issuers re-adjudicate allowed costs[3] against the standard plan, issuers using the standard methodology are required to first set all accumulators to zero and then reprocess individual claims for each policy in their original order. [4]

Issuers using a third-party administrator (TPA) – which makes re-adjudication of claims in their natural order complex—may, after setting claims to zero, first adjudicate all medical claims and then all pharmaceutical claims in a policy against the standard plan. These issuers may not process claims in any other order other than their original order.

The process described in the November 17, 2014 guidance also applies to TPAs for other subsets of benefits. As applicable, a TPA should first process medical claims, followed by pharmaceutical claims, and then any other subset of benefits, for example vision,

[3] Allowed costs refer to the total allowed costs for benefits on a policy.
[4] HHS guidance on the re-adjudication of claims may be found at https://www.regtap.info/uploads/library/APTC_Claims_Readjudication_Guidance_110314_5CR_111714.pdf

dental, and substance use disorder benefits.[5] These additional categories of claims should be re-adjudicated in the order that best approximates the natural order in which they were incurred, so that, for example, if a preponderance of vision claims pre-date claims for dental care, the vision claims group should be re-adjudicated before the dental claims.

Finally, to ensure consistency for all enrollees from the claims re-adjudication process, when re-adjudicating claims under the standard methodology, issuers must re-adjudicate all of the enrollee's claims against a standard plan's total allowed costs and then determine the amount of cost sharing for EHB, rather than re-adjudicate cost sharing solely for EHB claims.

Whether a CPT is an essential health benefit is a function of State rules governing benchmark plans. We expect insurance companies to be aware of the CPT codes and diagnostic codes for specific claims described in Section 1303 of the Affordable Care Act that should be excluded from EHB and are not reimbursable under federal law.

Comment:
Commenter asked CMS to allow capitated plans to use an alternative method to calculate total allowed costs for EHB.

Response: Issuers, including issuers of capitated plans, may use plan-specific percentage estimates of non-EHB claims submitted on the Uniform Rate Review Template (URRT) or any other reasonable method to determine total allowed costs for EHB.

[5] HHS guidance on third-party administration of additional benefit groups may be found at

https://www.regtap.info/uploads/library/FT_CSR_FAQStandardMethodReadjudication_5CR__082415.pdf