September 6, 2013

Centers for Medicaid & Medicare Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number CMS-10476
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medical Loss Ratio (MLR) Report for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)

To Whom It May Concern:

On behalf of the American Academy of Actuaries'[1] Medical Loss Ratio Regulation Work Group, I appreciate this opportunity to provide comments to the Centers for Medicaid & Medicare Services (CMS) on the recently proposed Medicare MLR report and associated instructions based on the May 2013 CMS final rule on the Medicare MLR requirements in Section 1857(e)(4) of the Social Security Act.

We would like to reiterate a comment we made in an April 25, 2013 letter to CMS,[2] regarding the potential applicability of certain aspects of previously-issued commercial MLR sub-regulatory guidance to Medicare MLR reporting. This guidance was in the form of a frequently asked questions (FAQ) document by the Center for Consumer Information and Insurance Oversight (CCIIO).

We recognize that Page 1 of the draft instructions for the proposed Medicare MLR report does mention CCIIO's archive of "commercial MLR regulations, guidance, reporting instructions, and other resources" as an additional resource for Medicare MLR reporting. Nevertheless, for consistency in MLR reporting not only among insurers, but also between the commercial and Medicare markets, we encourage CMS to state explicitly within the instructions for the Medicare MLR report that the following questions apply to Medicare MLR as well. If guidance on any of these items for Medicare MLR is not to remain consistent with the applicable guidance for commercial plans, it would be helpful for CMS to provide an explanation of the differences, possibly through a notice of rulemaking process with an opportunity for public comment.

The specific FAQ items to which we are referring are:

- **Q8**, which states that the entire capitation amount paid to a clinical provider is considered to be claims expense for MLR purposes;

[1] The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

[2] http://www.actuary.org/files/Acad_MA_MLR_comments_042513.pdf

- **Q9**, which confirms that Q8 applies equally with respect to capitations paid to non-physician clinical providers;

- **Q12**, which states that when payments are made to a third-party vendor that provides clinical services to enrollees through its own employees, then the entire payment is treated as claims expense for MLR purposes even though some portion of the payment implicitly covers the vendor's own administrative expenses;

- **Q14**, which states that it is possible for a portion of payments made to a third-party vendor to qualify for treatment as QIA (quality improving activities) expense for MLR purposes;

- **Q19**, which states that when payments are made to a third-party vendor that in turn pays others to provide clinical services to enrollees (i.e., the vendor's own employees are not providing the services), then the portion of the payment that implicitly covers the vendor's own administrative expenses is not considered claims expense for MLR purposes;

- **Q20**, which provides a four-prong test that payments to clinical risk-bearing entities need to satisfy in order for the payment to be treated as claims expense for MLR purposes;

- **Q21**, which confirms that if the four-prong test in Q20 is met, then the portion of the payment that represents administrative expenses performed by the risk-bearing entity on behalf of providers can nonetheless be treated as claims expense for MLR purposes; and

- **Q22**, which states that the portion of a payment to clinical risk-bearing entities that represents administrative expenses performed by the risk-bearing entity on behalf of the insurer (as opposed to providers) cannot be treated as claims expense for MLR purposes.

Thank you for this opportunity to provide input. If you have any questions or would like to discuss these comments in more detail, please contact Heather Jerbi, the Academy's assistant director of public policy, at 202.785.7869 or Jerbi@actuary.org.

Sincerely,

Rowen B. Bell, FSA, MAAA
Chairperson, Medical Loss Ratio Regulation Work Group
American Academy of Actuaries