January 31, 2011

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attn: OCIIO-9988-IFC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

In Re: Interim Final Regulations on Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act

To Whom It May Concern:

New Jersey has a long history of requiring minimum medical loss ratios in the individual and small employer markets, and in overseeing the payment of associated rebates. We know that when done well they can help ensure premiums are reasonable in relation to claims, and incent the design of appropriate cost-structures. On the other hand, we know that burdensome administration and unclear direction can add unnecessary costs to the system and lead to inconsistent administration across insurers.

We note and support the position the Department has taken in following in many regards the Model Regulation promulgated by the National Association of Insurance Commissioners. There are however, areas that go beyond those recommendations in many places in ways that are potentially very problematic.

Recipients of Rebates

As the preamble notes, Section 2718(b) requires an issuer to provide a rebate to each enrollee on a pro rata basis if the issuer has not met the applicable MLR standard. The rebate requirement is found in the section of the law entitled “Bringing Down The Cost Of Health Care Coverage”, and in the Subsection “Requirement To Provide Value For Premium Payments”. Clearly the purpose of the section read in total is to ensure that value is achieved for the premium paid, and it would frustrate the purpose of the section to deprive those who actually paid premiums of the rebate. However, a technical reading of section 2718(b)(1)(A) requires that the rebate be provided “to each enrollee under such coverage, on a pro rata basis.” This creates a potential contradiction when the enrollee, as conventionally defined, is different from the party paying the premium to the issuer.
The regulation at first appears to address this problem through its definition of enrollee. For purposes of the rebate only, the enrollee is defined as the person or entity that paid the premium. This is a perfectly reasonable way to reconcile the otherwise conflicting language of the statute. For employer-based plans, it is the group policyholder legally responsible for the payment of the premiums, regardless of whatever a contribution requirement may apply as between the group and the insured.

The Regulation unfortunately, and unnecessarily, goes on to create a complicated scheme for allocating and reporting rebates between insureds and policyholders, and makes insurers responsible for overseeing and policing the system. Issuers are responsible to provide rebates “in amounts proportionate to the amount of the premium the policyholder and each subscriber paid” at 158.242(b). The payments must be paid separately to the policyholder and enrollee in amounts proportionate to their share of the premium, unless issuers enter into an agreement with the policyholder. In that event, the issuer remains liable for compliance, and must obtain and retain records “evidencing accurate” distribution.

This creates an administrative scheme which is burdensome, costly, confusing, and creates accountability for enrollee-level rebates in the issuer, while the party responsible for paying the rebate is the employer.

Employee contribution arrangements come in many different forms. For example:

- a plan could require no contribution;
- a plan could be paid for entirely by the employees;
- employers and employees may be responsible for a fixed percentage of the actual cost;
- the employer may assume responsibility for a fixed contribution, with the employees liable for the excess;
- the employee may be responsible for a fixed contribution, with the employer liable for the excess; or
- employee contributions may be variable but pegged to a factor unrelated to cost, such as employee salary.

This is a choice made by the employer, and under many of these arrangements the issuer would not have or need direct knowledge of the employee’s specific contribution, a fact the preamble acknowledges (“The Department agrees that group policyholders and subscribers are in a better position than issuers to fairly distribute rebates to individual enrollees given that it is the group policyholders and subscribers, and not the issuers, who know the extent to which the enrollees made the original premium payments.”) Since the issuer may not know the level of employee contribution, the issuer cannot assume responsibility for seeing that rebates, determined as a function of that contribution, have been accurately calculated or returned.
The approach taken in the Interim Final regulation creates a number of problems:

- Many employer-sponsored insurance plans make contribution a function of salary. This trend has been increasing lately as employers attempt to deal with the increasing unaffordability of health insurance. The requirement that an issuer take steps to ensure that each enrollee receives a rebate that is proportional to the amount of premium would require the issuer obtain access to personal financial information on salaries they currently do not have.

- The regulation is unclear on the lengths insurers must go to show compliance. For example, employers may not be willing or able to enter into agreements for distribution of funds, may not be responsive to requests for reports, or may provide incorrect information. The liability of insurers for any of these failures on the part of employers is unclear.

- Fewer employers will be eligible for rebates, due to the calculation of the rebate and de minimis amount being made at the employee rather than the employer level. For example, an employer with 5,000 employees who would otherwise be eligible for a $24,000 rebate would receive nothing, because the per employee share is less than $5.00, even if the plan were entirely contributory. If the reimbursement obligation (and de minimis amount) applied at the employer level, the number of reimbursements falling below the de minimis threshold would be greatly reduced.

Insurance contracts under which refunds are made based on favorable experience are not a new phenomenon, and are not limited to health insurance. Whether or not experience refunds are plan assets is a function of how the employee contribution obligation is described in the plan documents. Employers subject to ERISA have existing obligations to their employees with respect to the disposition of funds representing plan assets, an area in which the Department of Labor has weighed in on in the past. The regulation should provide, as it does, that the enrollee for purpose of distribution is the party that paid the premium to the issuer, and that an employer’s obligation to use rebates for the benefit of enrollees in contributory plans is the same as currently applies to experience rating refunds under ERISA plans.

Enforcement

The Interim Final Regulation gives sole enforcement authority with respect to the reporting and rebate requirements to HHS at 158.401, with a limited ability for HHS to accept audits conducted by states. Some states, including New Jersey, have medical loss ratio and rebate requirements that are stricter than those required by the interim Final Regulation. This creates duplicative and potentially conflicting enforcement authority, and would require HHS to become expert in state law requirements.

The preamble states “The procedure set forth is comparable to the procedures used by HHS when conducting audits of Medicare Advantage plans pursuant to 42 CFR Part 422.” The analogy is inapt, however, because the Medicare Modernization Act clearly delineates the separate authorities of the State and Federal governments over Medicare Advantage plans, preempting state laws other than licensure and solvency. For states with existing MLR and rebate requirements, the regulation should provide for primary enforcement at the state level.
Definition of Incurred Claims

Section 158.140 (b)(3)(iii) would require subtraction from the incurred claim calculation of the portion of amounts paid to providers that represent reimbursement for medical record copying costs, attorneys’ fees, janitors, etc. All medical practices have such overhead, and provider billings for medical services must accordingly consider total expenses of the practice. This should not (and could not practically) be removed from claim dollars.

This section should be revised to exclude amounts paid to providers, so only direct billings of such non-claim amounts would be excluded from the calculation.

Very truly yours,

[Signature]

Thomas B. Considine
Commissioner