



The Affordable Care Act and Medical Loss Ratios: Federal and State Methodologies

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Acknowledgments

This Policy Brief was prepared by the Center for Health & Pharmaceutical Law & Policy at Seton Hall University School of Law (“SHU”) for the New Jersey Department of Banking and Insurance (“DOBI”), with funding provided by a grant from the United States Department of Health and Human Services (“HHS”). Professors John Jacobi and Kate Greenwood at SHU patiently provided incisive guidance throughout the research and drafting of this Brief. Joel Cantor and Margaret Koller of the Rutgers Center for State Health Policy also shared their knowledge and time to further this project. Special thanks are due to R. Neil Vance and his colleagues in DOBI, who graciously and generously shared their expertise in the area of medical loss ratio regulation in New Jersey. Several current Seton Hall Law students deserve recognition for their contributions to this Brief. Ryan Potente proved to be an exceptionally organized, diligent, and self-motivated research assistant. Jonathan Keller, Joshua Stiers, and Janelle Winters also provided excellent assistance.

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Executive Summary

This Policy Brief focuses on the medical loss ratio (“MLR” or “loss ratio”) provision in the Patient Protection and Affordable Care Act (“ACA,” or “Affordable Care Act”).¹ As part of sweeping health care reform in 2010, Congress established MLR requirements for health insurance issuers offering coverage in the group and individual health insurance markets, including grandfathered but not self-insured plans,² hoping to increase the value consumers receive for their premiums and to improve transparency.³

Medical loss ratio refers to a measure of the percentage of premium dollars that a health insurance company spends on health care as distinguished from administrative expenses and profit, including advertising, marketing, overhead, salaries, and bonuses. The higher a company’s MLR, the greater the proportion of premiums being spent on the consumers’ health care, and thus, in theory, the more value consumers are receiving for their premium dollars. The lower the MLR, the more a company is using premium dollars for administrative overhead and not for consumers’ health care. In calculating MLR, the numerator of the ratio contains the insurance company’s expenses related to health care, and the denominator generally contains the premiums collected by the insurance company. Which expenses may be included in the numerator and what adjustments insurers may or must make to the denominator greatly affect the resulting MLR.⁴ The significance of the MLR calculation depends on these details.

¹ See 42 U.S.C. § 300gg-18.

² See *id.* § 300gg-18(a); 45 C.F.R. § 158.102; Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, 75 Fed. Reg. 74,864, 74,865 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158) [hereinafter IFR Preamble, 75 Fed. Reg. at X]; *CCIIO Technical Guidance (CCIIO 2012-002): Questions and Answers Regarding the Medical Loss Ratio Regulation, 1-2* (Apr. 20, 2012), <http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf> [hereinafter *CCIIO Technical Guidance 2012-002*]; Timothy Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, COMMONWEALTH FUND at 18-19 (Sept. 30, 2010), <http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx>.

³ See 42 U.S.C. § 300gg-18.

⁴ See generally American Academy of Actuaries Loss Ratio Work Group, *Loss Ratios and Health Coverages* (Nov. 1998), <http://www.actuary.org/pdf/health/lossratios.pdf> (cautioning that it can be misleading to compare loss ratios calculated using different methodologies and urging careful examination of the factors influencing the numerator and denominator of the ratio).

Prior to the ACA, some states but not the Federal government regulated loss ratios. The states that adopted MLR requirements employed different definitions and formulae for calculating this ratio and adopted varying minimum MLR requirements. New Jersey, for example, enacted an 80 percent requirement in its individual and small group markets in 2009, which carriers calculate essentially by dividing claims by premiums.⁵ In contrast, approximately nine other states set MLR requirements as low as 55 percent in some segments of their markets.⁶

The new Federal MLR law, which went into effect on January 1, 2011, for the first time established a national MLR standard, which varies from existing state MLR requirements in important ways. First, Congress set the target MLRs above the national trend: insurers will have to pay premium rebates if they fail to achieve a loss ratio of 80 percent in the individual and small group markets and 85 percent in the large group market.⁷ Second, the ACA prescribes components of the MLR formula that differ from those traditionally used by the states in calculating loss ratios. For example, the statute requires insurers to include in the loss ratio numerator the amount of premiums spent on activities that improve health care quality, in addition to the amount spent on reimbursement for clinical services, which traditionally comprises the MLR numerator.⁸ Third, the ACA directs insurers to deduct Federal and state taxes and licensing or regulatory fees from premiums and to account for payments or receipts for risk adjustment, risk corridors, and reinsurance in calculating the MLR.⁹ Each year, issuers must report data on these component parts of the MLR formula as well as on non-claims costs, including broker and agent fees and commissions, that are not included in the Federal MLR calculation.¹⁰ Fourth, the ACA's implementing regulations include additional provisions to account for the special circumstances of smaller plans, different types of plans, and newer plans, including credibility adjustments, which "address the impact of claims variability on the experience of smaller plans"¹¹ by adding additional percentage points to their loss ratios.¹²

This Policy Brief analyzes the new Federal MLR requirements and how they intersect with and affect New Jersey law and its insurance markets. After providing background on medical loss ratios and highlighting the major similarities and differences between the existing Federal and New Jersey MLR regulatory schemes, this Brief examines several requirements and

⁵ N.J. STAT. ANN. § 17B:27A-25(g)(2) (small group market); N.J. STAT. ANN. § 17B:27A-9(e)(2) (individual market).

⁶ See IFR Preamble, 75 Fed. Reg. at 74,899, *supra* note 2.

⁷ See 42 U.S.C. § 300gg-18.

⁸ See *id.* § 300gg-18(b)(1)(A).

⁹ *Id.*

¹⁰ 45 C.F.R. § 158.160(b)(2); see also IFR Preamble, 75 Fed. Reg. at 74,877, *supra* note 2 (itemizing many additional examples of non-claims costs). See *infra* notes 657-675 and accompanying text in Appendix C for discussions of legislative and lobbying efforts to exclude broker commissions from the Federal MLR formula.

¹¹ IFR Preamble, 75 Fed. Reg. at 74,880, *supra* note 2.

¹² *Id.*; cf. Timothy Jost, *Implementing Health Reform: Medical Loss Ratios*, HEALTH AFFAIRS BLOG (Nov. 23, 2010, 8:38 AM), <http://healthaffairs.org/blog/2010/11/23/implementing-health-reform-medical-loss-ratios>.

policy options that New Jersey must consider as it implements the Federal requirements, including:

- Whether to seek an adjustment from the Secretary of Health and Human Services (“HHS”) of the Federal 80 percent minimum MLR percentage in its individual market: New Jersey must evaluate whether there is a reasonable likelihood that application of the Federal 80 percent minimum MLR requirement may destabilize its individual market such that there is a basis for New Jersey to ask the Secretary to adjust its minimum MLR percentage in the individual market for up to three years at a time. It is unlikely that the imposition of Federal standards will result in such instability, since New Jersey already has an 80 percent requirement in its individual market that does not seem to have destabilized the market. This stability is noteworthy because New Jersey’s methodology results in an MLR that appears to be functionally more stringent than that required by the federal methodology. Further analysis would be appropriate, however, to confirm this general conclusion, and to examine the effects of the imposition of Federal law on areas such as access to brokers and agents.
- Whether to exercise its discretion to adopt an MLR percentage higher than that required by the ACA in its individual, small group, or large group markets: New Jersey may wish to adopt a higher, more stringent minimum MLR percentage than is required by Federal law in at least some of its markets to approximate the functional MLR level realized under current New Jersey methodology. New Jersey will need to assess current market conditions to ensure higher MLR percentages will not destabilize its markets. For example, New Jersey does not currently regulate loss ratios in the large group market, and the Federal 85 percent requirement is fairly demanding. Simple adoption of the federally required MLR level may, therefore, be appropriate in that market.
- Whether to adopt its own methodology for calculating MLR: Federal law will likely be determined to preempt any New Jersey methodology for calculating loss ratios that wholly supplants the Federal. New Jersey may be empowered, however, to adopt its own MLR requirements that do not conflict with, and thus do not prevent application of, the Federal requirements and do not stand as obstacles to the accomplishment and execution of the full purposes and objectives of Congress. New Jersey would need to evaluate the feasibility of requiring compliance with both systems. New Jersey will also have to consider whether imposing parallel requirements is a wise policy choice, given the added costs and possible complexity that two systems entail.
- Whether legislative and regulatory changes are necessary and/or desirable: At a minimum, New Jersey will need to update its laws and regulations to ensure they do not prevent the application of Federal law. New Jersey could follow the lead of several states by adopting the Federal requirements *in toto*, which has the advantage of

simplicity but sacrifices aspects of New Jersey law that may be more protective of consumers than the Federal. New Jersey also may choose to adopt the mandatory Federal requirements while preserving some features of its regulatory system that complement and do not frustrate the Federal system. If New Jersey is not preempted from adopting a methodology that differs from the Federal, New Jersey might consider adopting select features of the Federal methodology that it sees as improvements or complements to its MLR rules.

- *New Jersey has a continued role in MLR regulation and enforcement:* Whether New Jersey adopts the Federal requirements or maintains a parallel regulatory system, it has a role in the future regulation of loss ratios, including:
 - Monitoring its markets to determine when it is appropriate to ask the Secretary to defer all or a portion of rebates due from an issuer based on solvency concerns or to seek an adjustment of the Federal MLR requirement in the individual market if carriers are exiting the market or market stability otherwise is in jeopardy.
 - Monitoring if carriers are exiting New Jersey's individual market, in which case, New Jersey has the discretion to determine whether this conduct is related to MLR, and if so to seek an adjustment of the Federal minimum MLR from the Secretary based on threatened market instability.
 - Monitoring the types of expenses plans are labeling as quality improving to ensure insurers are not relabeling administrative expenses that do not bear relevance to improving health standards.
 - Monitoring how carriers are calculating their reserves, which can be manipulated to inflate loss ratios.
 - Conducting audits of issuers' MLR reporting and rebate obligations within parameters set in the Federal implementing regulations.
 - Monitoring consumer access to brokers, as some carriers reduce commissions to minimize their administrative expenses, and reporting back to HHS, which has committed to tracking this concern.

This Brief includes appendices that provide more extensive details regarding the components of the Federal MLR requirements, New Jersey's MLR legal structure, and research regarding experiences with loss ratios nationally and in New Jersey, pre- and post-the ACA.

The Affordable Care Act and Medical Loss Ratios: Federal and State Methodologies

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I. Introduction

A. Purpose and Issue Statement

This Policy Brief focuses on the medical loss ratio (“MLR” or “loss ratio”) provision in the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010) (“ACA” or “Affordable Care Act”), which is intended to improve transparency to inform consumer choice and increase the value consumers receive for their premiums.¹³ Several states, including New Jersey, have preexisting MLR laws. Although these state laws vary in several ways, they generally determine loss ratios by dividing the amount insurers spend on medical claims by their premiums as a way of measuring the value consumers receive. The new Federal MLR law, which went into effect on January 1, 2011, however, calculates loss ratios differently and requires insurers offering coverage in the individual and group markets throughout the country to pay consumers premium rebates if they fail to satisfy the Federal minimum MLR requirements.

This Brief analyzes the new Federal MLR requirements and how they affect New Jersey law. Section II provides a brief background on medical loss ratios, their regulation by states before the ACA, and the recent Federal legislation. Section III then summarizes the major similarities and differences between the existing Federal and New Jersey MLR regulatory schemes. With this foundation, Section IV evaluates various policy issues New Jersey faces as it implements the Federal requirements, including whether Federal law preempts existing New Jersey laws and regulations regulating loss ratios and New Jersey’s continued role in MLR regulation and enforcement. This Brief also includes appendices that provide more details regarding the detailed components of the Federal MLR requirements (Appendix A), New Jersey’s MLR legal structure (Appendix B), and research regarding experiences with loss ratios nationally and in New Jersey (Appendix C).

¹³ See 42 U.S.C. § 300gg-18; Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, 75 Fed. Reg. 74,864, 74,893-94 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158) [hereinafter IFR Preamble, 75 Fed. Reg. at X]; U.S. GOV’T ACCOUNTABILITY OFFICE, GAO 11-711, PRIVATE HEALTH INSURANCE: EARLY EXPERIENCES IMPLEMENTING NEW MEDICAL LOSS RATIO REQUIREMENTS, at 19 & 22 (July 2011), available at www.gao.gov/new.items/d11711.pdf [hereinafter JULY 2011 GAO REPORT].

II. Background on Medical Loss Ratios

Medical loss ratio generally refers to a measure of the percentage of premium dollars that a health insurance company spends on health care, on the one hand, as distinguished from administrative expenses and profit, including advertising, marketing, overhead, salaries, and bonuses, on the other. The higher a company's MLR, the greater the proportion of premiums being spent on consumers' health care, and thus, in theory, the more value consumers receive for their premiums. The lower the MLR, the more a company is using premium dollars for administrative overhead and not for the delivery of health care.

In calculating MLR, the numerator of the ratio contains the insurance company's expenses related to health care, and the denominator contains the premiums collected by the insurance company. Which expenses may be included in the numerator and what adjustments insurers may or must make to the denominator greatly affect the resulting MLR.¹⁴ The significance of the MLR calculation depends on these details. For example, if costs associated with utilization review procedures are considered health care expenditures, the numerator will represent a larger portion of the insurance company's revenue, and the resulting MLR will be larger, even if consumers do not perceive that they are receiving greater value for their premiums. Similarly, if an insurance company is permitted to add its expenditures on broker commissions to its numerator as health care related expenses (or to subtract these amounts from its premiums in the MLR denominator), then its loss ratio will be higher as well. It is critical to understand how MLR is calculated to assess the relative value to consumers represented by this measure.

Prior to the ACA, some states but not the Federal government regulated loss ratios. Not every state required insurance companies to calculate their MLR, and those that did used various definitions and formulae for calculating this ratio. Approximately thirty-two¹⁵ to thirty-four¹⁶ states including New Jersey had established guidelines for or limits on MLRs or administrative expense limits. Frequently these standards applied only to the individual or small group markets and did not apply in the large group markets.¹⁷ Many of these states required

¹⁴ See generally American Academy of Actuaries Loss Ratio Work Group, *Loss Ratios and Health Coverages* (Nov. 1998), <http://www.actuary.org/pdf/health/lossratios.pdf> (cautioning that it can be misleading to compare loss ratios calculated using different methodologies and urging careful examination of the factors influencing the numerator and denominator of the ratio).

¹⁵ See IFR Preamble, 75 Fed. Reg. at 74,899, *supra* note 13.

¹⁶ See Jennifer Haberkorn, *Health Policy Brief: Updated: Medical Loss Ratios*, HEALTH AFFAIRS (Nov. 24, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=33; see also *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations*, AMERICA'S HEALTH INSURANCE PLANS 2 (April 15, 2010), http://www.naic.org/documents/committees_e_hrsi_comdoc_ahip_chart_mlr.pdf.

¹⁷ See Haberkorn, *supra* note 16; Timothy Jost, *Implementing Health Reform: Medical Loss Ratios*, HEALTH AFFAIRS BLOG (Nov. 23, 2010, 8:38 AM), <http://healthaffairs.org/blog/2010/11/23/implementing-health-reform-medical-loss-ratios>.

insurers to file their “anticipated loss ratios” as part of the prospective rate filing process, and some, independent of or in addition to prospective MLR requirements, required retrospective refunds for failing to meet minimum MLR requirements.¹⁸ New Jersey, for example, uses loss ratios both prospectively, as part of rate review, and retrospectively, by requiring rebates to consumers when a company’s MLR fails to meet the statutory targets.¹⁹ Prior to the ACA, approximately nineteen states had not enacted any minimum MLR requirements in any of their markets.²⁰

State MLR requirements historically have “varied widely,” reflecting “differences in rural and urban markets as well as in markets that have different levels of competition.”²¹ Generally, states with more insurers and greater competition have set higher MLR requirements.²² New York, for example, recently enacted an 82 percent requirement in its individual market, small group market, and community rated large group contract forms,²³ and New Jersey enacted an 80 percent requirement in its individual and small group markets in 2009.²⁴ In contrast, North Dakota only requires insurers in its individual market to meet an MLR of 55 percent.²⁵ The United States Department of Health and Human Services (“HHS”) reports that approximately nine other states set MLR requirements as low as 55 percent in some segments of their markets.²⁶

States differ not only in their target MLRs but also in how they define the components of the MLR calculation. While some states like New Jersey restrict the numerator essentially to the medical claims paid out by insurers, New York, for example, counts cost-containment expenditures as medical expenses in the MLR numerator, which increases the insurer’s MLR.²⁷ These variations make it difficult to compare MLRs across states.²⁸

Despite the efforts of various states to regulate loss ratios to increase the amount insurers spend on medical claims for consumers, “high marketing expenses, underwriting, churning on and off coverage, benefit complexity, and brokers’ fees” may explain why “[o]ur country now leads all other industrialized nations in the share of health care expenditures

¹⁸ See IFR Preamble, 75 Fed. Reg. at 74,899, *supra* note 13; Jost, *Implementing Health Reform*, *supra* note 17.

¹⁹ See N.J. STAT. ANN. §§ 17B:27A-9(e)(1) & (2) & 25(g)(1) & (2).

²⁰ See IFR Preamble, 75 Fed. Reg. at 74,899, *supra* note 13.

²¹ Haberkorn, *supra* note 16.

²² *Id.*

²³ See N.Y. INS. LAW §§ 3231, 4308.

²⁴ N.J. STAT. ANN. § 17B:27A-25(g)(2) (small group market); N.J. STAT. ANN. § 17B:27A-9(e)(2) (individual market).

²⁵ See N.D. CENT.CODE. § 26.1-36-37.2.

²⁶ See IFR Preamble, 75 Fed. Reg. at 74,899, *supra* note 13.

²⁷ See *Health Policy Memo, Medical Loss Ratios: Evidence from the States*, FAMILIES USA (June 2008), <http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf> [hereinafter *Evidence from the States*].

²⁸ See generally Haberkorn, *supra* note 16 (“Because states have defined what constitutes medical care differently, their medical loss ratios differ even more than these numbers would suggest.”).

devoted to administration.”²⁹ According to the Federal government, of consumers who purchased health insurance in the individual markets prior to the ACA, 20 percent participated in plans that spent more than thirty cents of each premium dollar on administrative expenses and another 25 percent were in plans that spent between twenty-five and thirty cents of each premium dollar on administrative costs.³⁰ Although administrative costs tend to be higher in the individual market because of the increased costs associated with marketing plans to individuals rather than to employers, some small group insurers also spend thirty cents of every premium dollar on administrative expenses.³¹

Presumably concluding “that higher MLRs were achievable, and warranted,”³² Congress imposed uniform minimum MLR standards that exceeded the existing targets in most states as part of its 2010 health care reform law. Beginning January 1, 2011, Section 10101 of Title X of the ACA, which is captioned “Bringing down the cost of health care coverage” and which created Section 2718 of the Public Health Services Act (“PHSA”), requires all insurance companies offering coverage in the small group and individual health insurance markets, including grandfathered but not self-insured plans,³³ to pay a premium rebate to consumers if their MLR is less than 80 percent; insurers in the large group market will need to have an MLR of at least 85 percent to avoid paying a premium rebate.³⁴ States may establish a higher minimum MLR percentage, subject to various considerations set forth in the statute.³⁵ The

²⁹ Sara R. Collins, *Medical Loss Ratio Regulations Good for Consumers*, THE COMMONWEALTH FUND BLOG (Nov. 23, 2010) <http://www.commonwealthfund.org/Blog/2010/Nov/Medical-Loss-Ratio-Regulations-Good-for-Consumers.aspx>.

³⁰ See *Medical Loss Ratio: Getting Your Money’s Worth on Health Insurance* (Nov. 22, 2010), http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html (last visited Aug. 18, 2011) [hereinafter *Getting Your Money’s Worth on Health Insurance*].

³¹ See Collins, *supra* note 29; see generally *id.* (reporting that an April 2010 report prepared by the Democratic staff of the Senate Committee on Commerce, Science, and Transportation found that the nation’s largest health insurers in 2009 had medical loss ratios ranging from 68 percent to 88 percent in the individual market; 78 percent to 84 percent in the small-group market; and 83 percent to 88 percent in the large-group market).

³² Jost, *Implementing Health Reform*, *supra* note 17.

³³ See 42 U.S.C. § 300gg-18(a); 45 C.F.R. § 158.102; IFR Preamble, 75 Fed. Reg. at 74,865, *supra* note 13; CCIIO *Technical Guidance (CCIIO 2012-002): Questions and Answers Regarding the Medical Loss Ratio Regulation*, 1-2 (Apr. 20, 2012), <http://cciiio.cms.gov/resources/files/mlr-qna-04202012.pdf> [hereinafter *CCIIO Technical Guidance 2012-002*]; Timothy Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, COMMONWEALTH FUND at 18-19 (Sept. 30, 2010), <http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx>. Recent agency guidance confirmed that the Federal MLR requirements also do not apply to Medicaid managed care organization or Medicare contracts, including Medicare Part C (Medicare Advantage) or D (prescription drugs) plans “designed for members of an employer group.” *CCIIO Technical Guidance 2012-002*, *supra* note 33, at 2; see also 42 U.S.C. § 1395w-27(e)(4) (establishing independent medical loss ratio requirements for Medicare Part C plans).

³⁴ See 42 U.S.C. § 300gg-18.

³⁵ See *id.* § 300gg-18(b); 45 C.F.R. § 158.211; see also *CCIIO Technical Guidance 2012-002*, *supra* note 33, at 7 (clarifying that “HHS will only apply a higher MLR to issuers in States that have taken affirmative action since March 23, 2010 indicating that they have exercised their option pursuant to 45 CFR § 158.211 to require issuers to meet a higher MLR standard for Federal MLR purposes”).

Secretary also may adjust the 80 percent minimum MLR in a state's individual market if the 80 percent requirement may destabilize that market.³⁶

The ACA also prescribes components of the MLR formula that differ from those traditionally used by the states in calculating loss ratios. The statute requires insurers to include in the loss ratio numerator the amount of premiums spent on activities that improve health care quality, in addition to the amount spent on reimbursement for clinical services (which traditionally comprises the MLR numerator).³⁷ The ACA also directs insurers to deduct Federal and state taxes and licensing or regulatory fees from premiums and to account for payments or receipts for risk adjustment, risk corridors, and reinsurance in the denominator.³⁸ Beginning January 1, 2014, the reported MLR calculation must be based on the average of three years of data.³⁹ Issuers must report data on these component parts of the MLR formula each year as well as on all other non-claims costs.⁴⁰ HHS must make these reports publicly available on its web site.⁴¹

The Federal MLR statute also required the National Association of Insurance Commissioners ("NAIC")⁴² to establish "uniform definitions of . . . and standardized methodologies for calculating" the components of the MLR formula, subject to HHS certification.⁴³ Following receipt of NAIC's suggestions on October 27, 2010, HHS promulgated detailed implementing regulations in an Interim Final Regulation ("IFR") that was published in the *Federal Register* on December 1, 2010 and was effective January 1, 2011.⁴⁴ The IFR adopted

³⁶ See 42 U.S.C. § 300gg-18(b)(1)(A)(ii); 45 C.F.R. § 158.301; see also 42 U.S.C. § 300gg-18(d) (preserving the Secretary's discretion to adjust the minimum MLR if "appropriate on account of the volatility of the individual market due to the establishment of State Exchanges").

³⁷ See 42 U.S.C. § 300gg-18(b)(1)(A).

³⁸ *Id.*

³⁹ See 42 U.S.C. § 300gg-18(b)(1)(B)(ii); 45 C.F.R. § 158.220(b); see also *CCIIO Technical Guidance 2012-002*, *supra* note 33, at 8 (reminding insurers to calculate the MLR numerator, beginning in the 2013 MLR reporting year, by adding three years of experience together).

⁴⁰ 45 C.F.R. § 158.160(b)(2); see also IFR Preamble, 75 Fed. Reg. at 74,877, *supra* note 13 (itemizing many additional examples of non-claims costs).

⁴¹ See U.S.C. § 300gg-18(a)(3).

⁴² NAIC "is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight." See *About the NAIC*, NAT'L ASS'N OF INS. COMM'RS, http://www.naic.org/index_about.htm (last visited September 15, 2011).

⁴³ 42 U.S.C. § 300gg-18 (emphasis added).

⁴⁴ See *Issuer Use of Premium Revenue: Reporting and Rebate Requirements*, 45 C.F.R. §§ 158.101 *et seq.*; IFR Preamble, 75 Fed. Reg. at 74,864-74,921, *supra* note 13; *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Corrections to the Medical Loss Ratio Interim Final Rule With Request for Comments*, 75 Fed. Reg. 82,277 (Dec. 30, 2010) (to be codified at 45 C.F.R. pt. 158); *Health Insurers Issuers Implementing Medical Loss Ratio (MLR) Under the Patient Protection and Affordable Care Act; Correcting Amendment*, 77 Fed. Reg. 28,788 (May 16, 2012) (to be codified at 45 C.F.R. part 158) [hereinafter *MLR Correcting Amendment*, 77 Fed. Reg. at X]. "When an agency finds that it has good cause to issue a final rule without first publishing a proposed rule, it often characterizes the rule as an "interim final rule," or

the vast majority of NAIC's recommendations, and added some provisions not addressed in NAIC's submission.⁴⁵ After reviewing approximately ninety comments to the IFR, HHS issued a Final Rule on December 7, 2011 that largely finalized the detailed provisions in the IFR with a few revisions ("MLR Final Rule").⁴⁶

As summarized with more specificity in Appendix A, the Federal MLR regulations add specificity to the statutory MLR requirements. For example, they define in great detail the various components of the Federal MLR formula, including which expenditures on activities that improve health care quality will and will not qualify for inclusion in the numerator;⁴⁷ the treatment of different types of reserves in the calculation of incurred claims for the numerator;⁴⁸ various adjustments to claims and premiums;⁴⁹ the treatment of state and Federal taxes in the calculation of the denominator;⁵⁰ and examples of expenses that must be included in non-claims costs in the required Federal MLR report, including agent and broker fees and commissions.⁵¹

In addition, the Federal MLR Regulations standardize the methodology that insurers must follow in calculating their MLRs, including how issuers must aggregate data.⁵² The Federal regulations also impose various additional requirements on insurers, such as filing annual reports with HHS, paying rebates to enrollees, and maintaining records.⁵³ They also flesh out

"interim rule." This type of rule becomes effective immediately upon publication. In most cases, the agency stipulates that it will alter the interim rule if warranted by public comments. If the agency decides not to make changes to the interim rule, it generally will publish a brief final rule in the Federal Register confirming that decision." *A Guide to the Rulemaking Process*, OFFICE OF THE FEDERAL REGISTER, http://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf (last visited Sept. 15, 2011).

⁴⁵ See IFR Preamble, 75 Fed. Reg. at 74,866, *supra* note 13; see also Letter from Kevin M. McCarty, Florida Commissioner of Insurance and NAIC President, et al., to Hon. Fred Upton, Chairman, House Committee on Energy and Commerce, U.S. House of Representatives (Jan. 12, 2012), *available at* http://www.naic.org/documents/committees_ex_grlc_120112_response_energy_commerce_cmte_hhs.pdf (describing communications between NAIC and HHS during NAIC's development of its MLR recommendations).

⁴⁶ See Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 76,574 (Dec. 7, 2011) (to be codified at 45 C.F.R. pt. 158) [hereinafter MLR Final Rule Preamble, 76 Fed. Reg. at X].

⁴⁷ 45 C.F.R. §§ 158.150, 158.151, 158.221(b).

⁴⁸ *Id.* § 158.140(a); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 44; see generally 45 C.F.R. § 158.103 (defining terms); IFR Preamble, 75 Fed. Reg. at 74,874, *supra* note 13 (discussing and defining the terms used to define incurred claims, including unpaid claims reserves and change in contract reserves); Jost, *Implementing Health Reform*, *supra* note 17 ("Clinical services reimbursement include not only direct payments for services and supplies but also changes in contract reserves (where an issuer holds reserves for later years when claims are expected to rise as experience deteriorates) and reserves for contingent benefits and lawsuits.").

⁴⁹ 45 C.F.R. § 158.140(b); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 44.

⁵⁰ See C.F.R. §§ 158.161-162.

⁵¹ See *id.* § 158.160(a). See *infra* notes 657-675 and accompanying text in Appendix C for discussions of legislative and lobbying efforts to exclude broker commissions from the Federal MLR formula.

⁵² See 45 C.F.R. §§ 158.120 & 158.220(a).

⁵³ See, e.g., *id.* §§ 158.110, 158.130-151, 158.160-162, 158.240(a). HHS published the required annual MLR reporting form on April 2, 2012. See Medical Loss Ratio Annual Reporting Form and Instructions, published as part of the MLR Paperwork Reduction Act (PRA) package (CMS-10418) (Apr. 2, 2012), *available at* <http://cciio.cms.gov/resources/other/index.html#mlr>.

the protocol states must follow to seek an adjustment to the minimum MLR requirement in the individual market.⁵⁴ The Federal MLR Regulations also address enforcement of the MLR requirements, including authorizing HHS to impose civil monetary penalties if issuers fail to comply with the Federal law.⁵⁵

As required by the ACA,⁵⁶ the Federal MLR Regulations include additional provisions to account for the special circumstances of smaller plans, different types of plans, and newer plans. First, they provide for credibility adjustments “to address the impact of claims variability on the experience of smaller plans”⁵⁷ that “do not have sufficient experience to be statistically valid for purposes of the rebate provisions.”⁵⁸ Credibility adjustments modify the MLR for qualifying small plans by adding additional percentage points to the ratio “in recognition of the statistical unreliability of the reported number.”⁵⁹ Credibility adjustments also take into consideration the plan’s deductible because the “variability of claims experience is greater under health insurance policies with higher deductibles than under policies with lower deductibles.”⁶⁰ An MLR that is based on at least 1,000 but fewer than 75,000 life-years⁶¹ is considered partially credible and eligible for a credibility adjustment.⁶² Depending on the number of life-years, credibility adjustments can add up to 8.3 percent to an issuer’s reported MLR for partially credible plans, and “issuers with policies that have large deductibles may receive an additional adjustment of up to 6.1 percent on top of the 8.3 percent.”⁶³

Second, the Federal MLR Regulations provide for different treatment of so-called mini-med and expatriate plans, in recognition of the assertion that these plans have higher administrative expenses as a percentage of premiums than other plans, given their special circumstances.⁶⁴ For purposes of Federal MLR calculations and reporting, mini-med plans are

⁵⁴ 45 C.F.R. § 158.301.

⁵⁵ *Id.* §§ 158.401-402, 158.601-610, 158.613-615. *Id.* § 158.606.

⁵⁶ *See* 42 U.S.C. § 300gg-18(c).

⁵⁷ IFR Preamble, 75 Fed. Reg. 74,880, *supra* note 13.

⁵⁸ *Id.* at 74,866. *See* Appendix A, Section E.1 for further explanation of credibility adjustments.

⁵⁹ IFR Preamble, 75 Fed. Reg. at 74,880, *supra* note 13; *cf.* Jost, *Implementing Health Reform*, *supra* note 17.

⁶⁰ IFR Preamble, 75 Fed. Reg. at 74,881, *supra* note 13.

⁶¹ “Life-years means the total number of months of coverage for enrollees whose premiums and claims experience is included [in the MLR report] divided by 12.” 45 C.F.R. § 158.230(b).

⁶² *Id.* § 158.230 (a) & (c)(2). *But see id.* § 158.232(d) (setting forth conditions under which there will be no credibility adjustment for the 2013 MLR reporting year for partially credible experience); IFR Preamble, 75 Fed. Reg. at 74,881-82, *supra* note 13 (explaining that “[t]his exception prevents issuers from receiving a credibility adjustment when the issuer consistently sets its prices to produce an MLR below the statutory 80 percent MLR standard”). Plans with 75,000 or more life-years are deemed fully credible and thus ineligible for a credibility adjustment. *See* 45 C.F.R. § 158.230(a) & (c)(1). Plan with fewer than 1,000 life-years also are not eligible for credibility adjustments, but these non-credible plans will not have to pay any rebate to policyholders because they are “presumed to meet or exceed the minimum” MLR. *Id.* § 158.230(c)(3) & (d); IFR Preamble, 75 Fed. Reg. at 74,881, *supra* note 13.

⁶³ IFR Preamble, 75 Fed. Reg. at 74,886-87, *supra* note 13.

⁶⁴ *See id.* at 74,871-72.

policies with a total annual limit of \$250,000 or less.⁶⁵ Expatriate plans generally refer to group policies providing coverage for employees working abroad.⁶⁶ The IFR directed these plans to multiply their MLR numerator by two and to comply with special aggregating and quarterly reporting requirements for the 2011 reporting year, which would permit HHS to evaluate the impact of the new Federal requirements on these plans.⁶⁷ The MLR Final Rule indefinitely extends the special circumstances treatment of expatriate plans, permits mini-med plans to continue to adjust their MLR numerators for reporting years 2012 through 2014 using graduated adjustments of 1.75 in 2012, 1.50 in 2013, and 1.25 in 2014, and reduces the reporting obligation on these plans to annual.⁶⁸

HHS recently added student health insurance coverage⁶⁹ to this category of plans whose “unique administrative costs” constitute special circumstances warranting different treatment for MLR purposes.⁷⁰ Although the individual market Federal MLR standards and reporting and rebate requirements will apply to these plans beginning in 2013, issuers should separately report this experience from other individual market experience and aggregate it on a national basis.⁷¹ To help student plans adjust to the MLR requirements, HHS directed issuers to multiply the sum “of the incurred claims and expenditures for activities that improve health care quality” in their MLR numerator by 1.15, but only for the 2013 MLR reporting year.⁷²

Third, to encourage new entrants to the market, the Federal MLR Regulations provide for special treatment of plans with substantial blocks of new business.⁷³ If 50 percent or more of an issuer’s total earned premium for any market segment in any state in a given MLR reporting year “is attributable to policies newly issued and with less than 12 months of

⁶⁵ 45 C.F.R. § 158.120(d)(3).

⁶⁶ *Id.* § 158.120(d)(4).

⁶⁷ See *id.* §§ 158.120(d)(3)-(4), 158.221(b)(3); IFR Preamble, 75 Fed. Reg. at 74,871-72, *supra* note 13; see also *CCIIO Technical Guidance (CCIIO 2011-002): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule*, 2 (May 13, 2011), http://cciio.cms.gov/resources/files/2011_05_13_MLR_Q_and_A_Guidance.pdf [hereinafter *CCIIO Technical Guidance 2011-002*] (confirming that the IFR provisions regarding mini-med and expatriate plans are mandatory and not optional); *CCIIO Technical Guidance (CCIIO 2011-003): Submission of 2011 Quarterly Reports of MLR Data by Issuers of “Mini-med” and Expatriate Plans*, at 2 (May 19, 2011), http://cciio.cms.gov/resources/files/20110519_guidance_mlr_1Q_deadline.pdf (adjusting the timeline for quarterly submissions because of delays finalizing the required form).

⁶⁸ See 45 C.F.R. §§ 158.110(b), 120(d)(3)-(4), & 158.221(b)(3)-(4); MLR Final Rule Preamble, 76 Fed. Reg. at 76,575-77, 76,581, *supra* note 46; see also *CCIIO Technical Guidance 2012-002*, *supra* note 33, at 8 (clarifying that “issuers of mini-med policies should add the reported experience for each MLR reporting year together to obtain the numerator and then apply the multiplier for the current MLR reporting year to the aggregated experience”).

⁶⁹ See 45 C.F.R. §§ 144.103, 147.145(a), & 158.103 (defining student health insurance coverage).

⁷⁰ See Student Health Insurance Coverage; Final Rule, 77 Fed. Reg. 16,453, 16,459 (Mar. 21, 2012) (to be codified at 45 C.F.R. parts 144, 147, and 158) [hereinafter Student Health Insurance Coverage Final Rule, 77 Fed. Reg. at X].

⁷¹ 45 C.F.R. § 158.120(d)(5); Student Health Insurance Coverage Final Rule, 77 Fed. Reg. at 16,459, *supra* note 70. Although some states regulate student health insurance coverage as a form of blanket or non-employer group coverage, these plans do not satisfy the Federal definition of group health plans because “they are not employment-based.” Student Health Insurance Coverage; Proposed Rule, 76 Fed. Reg. 7,767, 7,769 (Feb. 11, 2011).

⁷² 45 C.F.R. § 158.221(b)(5); Student Health Insurance Coverage Final Rule, 77 Fed. Reg. at 16,459, *supra* note 70.

⁷³ See *Getting Your Money’s Worth on Health Insurance*, *supra* note 30.

experience in that MLR reporting year,” the issuer may defer reporting this experience until the next MLR reporting year.⁷⁴

As detailed in Appendix B, New Jersey’s 80 percent MLR requirement involves fewer components than the Federal. Carriers⁷⁵ in the individual and small group markets⁷⁶ calculate MLR by dividing claims by premiums and do not consider quality expenditures or taxes.⁷⁷ As New Jersey recently summarized, “[c]laims are amounts paid to providers for covered medical care to covered people. Incurred claims are calculated as paid claims, adjusted for six months of claims run-out and a formula [f]or other residual reserves.”⁷⁸ Generally, only “expenses incurred in the delivery of medical or hospital services or those activities in direct support of the delivery of medical services” may be included in claims paid in the MLR numerator.⁷⁹ Interestingly, however, while the New Jersey MLR numerator “do[es] not include claims administration expenses or expenses associated with loss control (such as utilization management) . . . , [it does] include administrative costs incurred by providers or vendor intermediaries, such as Organized Delivery Systems (ODS’s).”⁸⁰ New Jersey law also requires aggregation pursuant to state-specific plan categories in the small group market.⁸¹

MLR reform, which HHS estimates will apply to plans covering approximately 75 million insured Americans,⁸² raises interesting and challenging policy questions on a national and local level. Consumer advocates, for example, generally contend that the Federal MLR requirements are “needed to check excessive insurer profits.”⁸³ The insurance industry, however, cautions that these requirements could threaten stability in some markets, which, in turn, could limit consumer choice.⁸⁴ Appendix C reviews some experiences with MLR regulation at the national and New Jersey level both pre- and post-the ACA. The following section evaluates how the

⁷⁴ 45 C.F.R. § 158.121; *see also* IFR Preamble, 75 Fed. Reg. at 74,872, *supra* note 13.

⁷⁵ This Policy Brief uses the familiar term, carrier, although New Jersey’s regulation in the individual market uses to term “member,” which is defined as excluding carriers with dominant Medicare, Medicaid, and NJ FamilyCare enrollment. *See* N.J. ADMIN. CODE § 11:20-1.2.

⁷⁶ New Jersey does not have an MLR requirement in its large group market. *NAIC Response to Request for Information Regarding Section 2718 of the Public Health Service Act*, at N.J. Response to Question A.1.b (May 12, 2010), available at http://www.naic.org/documents/committees_e_hrsi_hhs_response_mlr_adopted.pdf [hereinafter *NAIC Response*].

⁷⁷ N.J. ADMIN. CODE §§ 11-20-7.4(a)(4) & 11:21-7A.4(a)(3) & (4).

⁷⁸ *NAIC response*, *supra* note 76, at N.J. Response to Question B.1. Claims run-out refers to the amount that issuers will pay in claims after the end of a year for claims that were incurred but not processed during that year. *See id.* at 3.

⁷⁹ Bulletin No. 98-01, Inclusion of Network Related Costs in Loss Ratio Calculations (DOBI Feb. 18, 1998) (on file with author).

⁸⁰ LIFE & HEALTH, N.J. DEP’T OF BANKING & INS., NJ COMMERCIAL HEALTH MARKET - 2007, ATTACHMENT 3, LOSS RATIOS (revised Nov. 18, 2009), <http://www.state.nj.us/dobi/lifehealthactuarial/commercialhealth2007.html>.

⁸¹ *See* N.J. STAT. ANN. § 17B:27A-25(g)(2); N.J. ADMIN. CODE § 11:21-7A.3(a).

⁸² *See* IFR Preamble, 75 Fed. Reg. at 74,893, *supra* note 13; *Getting Your Money’s Worth on Health Insurance*, *supra* note 30.

⁸³ *See* JULY 2011 GAO REPORT, *supra* note 13, at 2.

⁸⁴ *See id.*

Federal requirements intersect and affect New Jersey's existing MLR laws and regulations, and its insurance markets.

III. Comparing Federal and New Jersey MLR Requirements

Although Federal and New Jersey law require the same numeric minimum loss ratio in their individual and small group markets, there are a variety of differences between the specific ways each system calculates and regulates MLR. This section highlights these similarities and differences.⁸⁵

For example, New Jersey law, unlike the Federal law, does not:⁸⁶

- regulate MLR in the large group market;⁸⁷
- permit claims in the MLR numerator to include amounts spent for health improvement expenditures;⁸⁸
- reduce premiums in the MLR denominator by Federal and state taxes or licensing and regulatory fees;⁸⁹
- account for payments or receipts for risk adjustment, risk corridor, or reinsurance payments in the MLR denominator;⁹⁰
- require issuers to calculate MLR based on three years of data, aggregated in each market in each state;⁹¹
- permit affiliated entities that are offering in and out of network coverage to a single employer to aggregate their MLR data;⁹²
- provide for credibility adjustments for smaller health plans;⁹³
- make any adjustments for newer plans;⁹⁴

⁸⁵ Appendices A and B to this Policy Brief contain more detailed discussions of the Federal and New Jersey MLR regulatory systems.

⁸⁶ The bulleted list that follows is an illustrative sample of differences between the Federal and New Jersey MLR systems and is not meant to be exhaustive. These and other differences are discussed in more detail in the sections that follow.

⁸⁷ *NAIC Response*, *supra* note 76, at N.J. Response to Question A.1.b.

⁸⁸ *Id.* at *New Jersey's Response to Question B.1.*

⁸⁹ *Id.* at *New Jersey's Response to Question B.2.*

⁹⁰ See 42 U.S.C. § 300gg-18(b)(1)(A).

⁹¹ See *id.* § 300gg-18(b)(1)(B)(ii); 45 C.F.R. § 158.220; N.J. STAT. ANN. § 17B:27A-25(g)(2); N.J. ADMIN. CODE § 11:20-7.3.

⁹² See 45 C.F.R. § 158.120(c); IFR Preamble, 75 Fed. Reg. at 74,869-70, *supra* note 13; N.J. STAT. ANN. § 17B:27A-17; *NAIC response*, *supra* note 76, at *New Jersey Response to Question E.1.*

⁹³ See 45 C.F.R. § 158.230 (a) & (c)(2).

- make any exceptions for mini-med,⁹⁵ expatriate,⁹⁶ or student health insurance plans;⁹⁷
- permit the Commissioner of the New Jersey Department of Banking and Insurance (“DOBI”) to adjust minimum MLR requirements in any market;⁹⁸
- permit the State Commissioner to ask the Secretary to defer all or a portion of rebates due from an issuer based on solvency concerns;⁹⁹ and
- require carriers to include detailed information regarding their administrative costs in their loss ratio reports.¹⁰⁰

As reviewed below, and in Appendix C, some of the differences between the two regulatory systems are more significant than others.

For example, most insurers and state regulators interviewed for a July 2011 report from the Government Accountability Office (“GAO”) agreed that deducting taxes and fees from the MLR denominator – which the Federal formula requires but New Jersey’s does not permit – “would constitute the largest change” to the loss ratio calculation.¹⁰¹ While some recognized that the effect will depend on state tax laws, one estimated that reducing premiums by taxes would have more than double the effect on MLR as including quality improving expenses in the numerator.¹⁰² Indeed, when GAO subsequently analyzed 2010 MLR data using the new Federal MLR requirements, it found that the deduction for Federal and state taxes and regulatory fees accounted for the largest percentage point increase in MLR in all three markets compared with other components of the ACA’s MLR formula, including quality improving and fraud and abuse

⁹⁴ See *id.* § 158.121; see also IFR Preamble, 75 Fed. Reg. at 74,872, *supra* note 13.

⁹⁵ New Jersey does not permit carriers to offer mini-med plans.

⁹⁶ See 45 C.F.R. §§ 158.110(b), 120(d)(3)-(5), & 158.221(b)(3)-(4); MLR Final Rule Preamble, 76 Fed. Reg. at 76,575-77, 76,581, *supra* note 46.

⁹⁷ See 45 C.F.R. §§ 158.120(d)(5), 158.220(d), 158.221(b)(5); Student Health Insurance Coverage Final Rule, 77 Fed. Reg. at 16,459, *supra* note 70. Indeed, because student health insurance coverage in New Jersey presently is sold on a large group basis, and New Jersey does not impose MLR requirements on its large group carriers, student health plans in New Jersey are not subject to State MLR requirements. See internal correspondence with DOBI officials (on file with author); see, e.g., N.J. ADMIN. CODE § 11:4-13.1(b) (applying rule prohibiting provisions of group student health insurance policies that are unjust, unfair, inequitable, misleading, contrary to law, or contrary to public policy to all student health insurance policies delivered or issued for delivery after January 1, 1978). *But see* N.J. STAT. ANN. § 18A:62-15(c) (“The State Department of Health shall require all public and private institutions of higher education in this State to offer health insurance coverage on a group *or individual* basis for purchase by students who are required to maintain the coverage” by State law) (emphasis added); N.J. ADMIN. CODE § 8:57-7.4(a) (same).

⁹⁸ See 42 U.S.C. § 300gg-18(b)(1)(A)(ii); 45 C.F.R. § 158.301.

⁹⁹ *Cf.* 45 C.F.R. § 158.270.

¹⁰⁰ See *id.* § 158.160(a).

¹⁰¹ See JULY 2011 GAO REPORT, *supra* note 13, at 15.

¹⁰² See *id.*

detection and recovery expenses.¹⁰³ Deducting taxes and fees from the denominator increased MLR by an average of 2.6 percentage points in the individual market, 2.3 percentage points in the small group market, and 1.3 percentage points in the large group market. The federal treatment of taxes, then, renders a calculation of MLR significantly more favorable than the New Jersey methodology.

Because some taxes in New Jersey are calculated based on net premiums, it is easy to estimate their impact on MLR. For example, HMOs pay 2 percent of premiums to the charity care assessment,¹⁰⁴ while non-HMOs in the group markets pay 1 percent of premiums¹⁰⁵ and non-HMOs in the individual market pay 2 percent of premiums in State taxes.¹⁰⁶ Because these amounts will reduce the MLR denominator, at a minimum, the impact of the tax deduction in New Jersey will inflate the reported MLR by approximately 1.6 percent for HMOs in all markets (individual, small group, and large group); 0.8 percent for any other non-HMO group coverage; and 1.6 percent for non-HMO individual coverage. Although these numbers do not account for all taxes and fees that are relevant for the Federal calculations, such as Federal Income Tax, they provide a ballpark estimate for the minimum impact of the extent to which the Federal treatment of taxes and fees will affect MLR calculations for New Jersey carriers.

According to some estimates, including spending on quality improvements could add 0.5 to 5 percentage points to an issuer's MLR.¹⁰⁷ The October 2011 GAO report found that including quality improving expenses in the numerator accounted for MLR increases of 2.6 percentage points in the individual market, 2.3 percentage points in the small group market, and 1.3 percentage points in the large group market.¹⁰⁸ Although New Jersey does not presently include quality expenditures in its MLR numerator, former Commissioner Considine indicated his support for doing so.¹⁰⁹

¹⁰³ See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 12-90R, PRIVATE HEALTH INSURANCE: EARLY INDICATORS SHOW THAT MOST INSURERS WOULD HAVE MET OR EXCEEDED NEW MEDICAL LOSS RATIO STANDARDS, at 10 & n.18 (Oct. 31, 2011), available at <http://www.gao.gov/new.items/d1290r.pdf> [hereinafter OCTOBER 2011 GAO REPORT]; Appendix C, Section C.

¹⁰⁴ See N.J. STAT. ANN. § 26:2J-47(a)(1).

¹⁰⁵ See *id.* § 54:18A-2(b).

¹⁰⁶ See *id.* § 54:18A-2(a).

¹⁰⁷ See IFR Preamble, 75 Fed. Reg. at 74,900-01, *supra* note 13; JULY 2011 GAO REPORT, *supra* note 13, at 15-16; Jean M. Abraham and Pinar Mandic, *Regulating the Medical Loss Ratio: Implications for the Individual Market*, 17 AM. J. MANAGED CARE 211, 212 (March 2011).

¹⁰⁸ OCTOBER 2011 GAO REPORT, *supra* note 103, at 10.

¹⁰⁹ See Letter from Commissioner Thomas B. Considine, Re: Medical Loss Ratios under Section 2718 of the Public Health Services Act (May 26, 2010), available at http://www.state.nj.us/dobi/division_insurance/pdfs/nj_mlr_comment.pdf [hereinafter May 26, 2010 Considine Letter]; see also Letter from New Jersey Chamber of Commerce, to Mr. Lou Felice, Chair, Health Reform Solvency Impact (E) Subgroup (May 20, 2011), available at http://www.naic.org/documents/committees_e_hrsi_comments_0520exposure_nj_coc.pdf (outlining Chamber's position, which the former Commissioner endorsed in his May 26, 2010 letter, that wellness and prevention programs, case management and disease management, care coordination, quality reporting, incentives to promote evidence based medicine, programs designed to ensure patient safety, and programs that reduce avoidable hospital admissions and readmissions should be deemed medical and not administrative). Despite much

Federal and New Jersey law also vary significantly with respect to how MLR data are aggregated over time and plans. Federal MLR generally is calculated based on three years of data in each state and in each market, and Federal law separately aggregates mini-med, expatriate, and student health insurance plans.¹¹⁰ New Jersey, in contrast, uses only one year of data;¹¹¹ aggregates by certain delineated state-specific plans in the small group market (namely, the standard, open nonstandard, closed nonstandard, and alliance policy forms);¹¹² and does not separately aggregate MLR data for expatriate or student health insurance plans or permit carriers to sell mini-med policies.¹¹³

Another important difference involves aggregation across legal entities under common ownership. Under Federal law, generally there is no aggregation of insurers with common owners. Instead, distinct legal entities calculate separate loss ratios, even if they are owned by a common entity.¹¹⁴ So a distinct legal entity that fails to satisfy the minimum MLR in a market in a state must make rebate payments as required by the ACA. Each legal entity calculates its own MLR in New Jersey's group markets as well, even if it shares common ownership with another legal entity in the market.¹¹⁵

overlap with the activities listed in the IFR, however, the former Commissioner expressed his support for including activities that the IFR declined to include, such as implementation of the new ICD-10 requirements and utilization review generally (and not just prospective utilization review, as in the Federal). As discussed in Appendix A, Section A.1., the MLR Final Rule permits issuers to count as quality improving activities ICD-10 conversion costs (but not claims adjudication systems or maintenance costs) incurred in 2012 and 2013, limited to 0.3 percent of earned premium in each market in a state. 45 C.F.R. §§ 158.150(b)(2)(i)(A)(6) & 150(c)(5); MLR Final Rule Preamble, 76 Fed. Reg. at 76,578, *supra* note 46. *But see* Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Set; Proposed Rule, 77 Fed. Reg. 22,950 (Apr. 17, 2012) (to be codified at 45 C.F.R. pt. 162) (proposing to delay the compliance date for ICD-10 conversion from October 1, 2013 to October 1, 2014).

¹¹⁰ See 45 C.F.R. §§ 158.110(b), 120(d)(3)-(5), & 158.221(b)(3)-(4); MLR Final Rule Preamble, 76 Fed. Reg. at 76,575-77, 76,581, *supra* note 46; Student Health Insurance Coverage Final Rule, 77 Fed. Reg. at 16,459, *supra* note 70; *see also* Appendix A, Section E.2 for further discussion of the Federal treatment of mini-med, expatriate, and student health insurance plans.

¹¹¹ See N.J. ADMIN. CODE §§ 11:20-7.4(a)(3)(i); *id.* § 11:21, Appx. Exh. GG.

¹¹² See N.J. STAT. ANN. § 17B:27A-25(g)(2).

¹¹³ See *NAIC Response*, *supra* note 76, at New Jersey's Responses to Questions A.1.b, B.1.e, & B.1.f.

¹¹⁴ See 45 C.F.R. §§ 158.120 & 158.220(a); IFR Preamble, 75 Fed. Reg. at 74,870, *supra* note 13; *see generally* Jost, *Implementing Health Reform*, *supra* note 17 ("MLRs are calculated separately for each licensed entity within a state by market segment (individual or small or large group)."). The Federal MLR Regulations provide additional instructions for issuers offering group health insurance coverage in multiple states, group health insurance coverage with dual contracts, individual market business sold through an association or trust, and employer business issued through a group trust or multiple employer welfare association. See 45 C.F.R. § 158.120(b)-(d); *see also* MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 44; *CCIIO Technical Guidance 2012-002*, *supra* note 33, at 4-5; Memorandum from Gary Cohen, Acting Director, Office of Oversight, CMS, *Insurance Standards Bulletin Series – Information: Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations* (Sept. 1, 2011), http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.pdf.

¹¹⁵ *NAIC Response*, *supra* note 76, at New Jersey Response to Question E.1.

But in New Jersey’s individual market, separate legal entities under common ownership combine their data when calculating their loss ratio.¹¹⁶ This can mean that a distinct legal entity that would have had to pay a rebate to consumers if its MLR were separately calculated no longer has to pay that rebate when its data are combined with data of separate but commonly owned entities with higher MLRs. As a result, fewer consumers may receive refunds under New Jersey’s individual market aggregation rules. This is an area in which Federal law may be more favorable to consumers than New Jersey’s.

Federal law’s aggregation rules in certain instances, however, can result in lower rebates to consumers, compared to New Jersey. For example, where a group health plan offers only in-network coverage through one issuer and only out-of-network coverage through an affiliated entity, the Federal MLR Regulations create an exception that permits them to aggregate their MLR data – even though these affiliated issuers are distinct legal entities – when the affiliation is solely for the purpose of offering a choice of coverage option to employees of a single employer so that their “experience may be treated as if it were all related to the contract provided by the in-network issuer.”¹¹⁷ Similarly, the Federal MLR regulations permit two or more affiliated issuers that sell insurance to the same employer to reallocate the incurred claims and activities that improve health care quality for that employer among the affiliates for loss ratio purposes so that each affiliate will have “the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as . . . the employer group in the aggregate.”¹¹⁸ Although this formally is treated as an adjustment to incurred claims in the Federal regulations, it effectively aggregates the experience of these separate, though affiliated, legal entities with respect to that employer. New Jersey does not have similar exceptions in its small group market,¹¹⁹ and it does not regulate MLR in its large group market. Thus, it could be easier for affiliated issuers in the group markets to satisfy MLR requirements under Federal rather than New Jersey law, which then would result in fewer rebates to consumers.

Credibility adjustments are another significant difference between the two systems, although more data are needed to estimate the impact they will have in New Jersey. GAO reported that the credibility adjustment accounted for the largest percentage point increase in average MLR in all three markets, with average increases ranging from 2.7 percentage points in

¹¹⁶ N.J. STAT. ANN. § 17B:27A-2.

¹¹⁷ See 45 C.F.R. § 158.120(c); IFR Preamble, 75 Fed. Reg. at 74,869-70, *supra* note 13. HHS explained that this exception “maintains the experience of employees in a single reporting entity.” IFR Preamble, 75 Fed. Reg. at 74,870, *supra* note 13. Issuers choosing to aggregate their MLR data pursuant to this exception must do so for at least three MLR reporting years. See 45 C.F.R. § 158.120(c). Where affiliated issuers cover employees in more than one state, however, each issuer has to attribute its business to “each State based on the situs of the contract.” *Id.* § 158.120(b).

¹¹⁸ See 45 C.F.R. § 158.140(b)(5)(i). If an issuer chooses to make this adjustment, it must do so for a minimum of three MLR reporting years. See *id.*

¹¹⁹ See N.J. STAT. ANN. § 17B:27A-17; NAIC response, *supra* note 76, at New Jersey Response to Question E.1.

the large group market, 3.3 percentage points in the small group market, and 4.2 percentage points in the individual market.¹²⁰ In addition, GAO has estimated that approximately half of all insurers in the nation's small and large group markets and a bit less than one-third of insurers in individual markets would be partially credible (greater than one thousand but less than 75,000 life-years) and thus eligible to apply credibility adjustments to their Federal loss ratio.¹²¹ These numbers do not capture market share, however. Although a small percentage of insurers nationally have more than 75,000 life-years (and thus are fully credible and ineligible for credibility adjustments), these insurers command the majority of total life-years covered nationally.¹²²

It is not clear what impact credibility adjustments will have on New Jersey insurers or markets. A substantial percentage of the insurance companies in New Jersey's markets should qualify to apply a credibility adjustment to their loss ratio. For example, according to preliminary data from DOBI for the 2010 MLR reporting year, nine of sixteen carriers in the large group market would have been partially credible and two would have been non-credible; seven of fourteen carriers in the small group market would have been partially credible and four would have been non-credible; and in the individual market, seven of ten would have been partially credible and three would have been non-credible.¹²³

Like the Federal numbers reported by GAO, however, New Jersey's numbers are misleading without market share as a backdrop. Preliminary data from 2010 reveal that five fully credible carriers controlled 83.8 percent of New Jersey's large group market, leaving nine partially credible carriers (16 percent) and two non-credible carriers (0.2 percent) to split the remainder; three fully credible carriers held 71.8 percent of the small group market, while seven partially credible carriers represented 28 percent of market share and four non-credible carriers nibbled at less than 1 percent of the market; and seven partially credible carriers dominated the individual market with 99.7 percent market share, with the sliver left for three non-credible carriers to share.¹²⁴

It is important to consider market share when evaluating the impact credibility adjustments will have on individual carriers and the market as a whole. If these insurance markets are described in terms of their participating insurers, it could appear that there is a

¹²⁰ See OCTOBER 2011 GAO REPORT, *supra* note 103, at 9-10.

¹²¹ New Jersey does require affiliated carriers to file a report for each carrier as well as a combined report for all affiliated carriers in the individual market. See N.J. ADMIN. CODE § 11:20-7.3(a) and (b). See JULY 2011 GAO REPORT, *supra* note 13, at 7.

¹²² See *id.*

¹²³ Data on file with author. These estimates are based on only one year of data. Although the Federal MLR Regulations instruct that "[t]he life-years used to determine the credibility of an issuer's experience are the life-years for the MLR reporting year plus the life-years for the two prior MLR reporting years," 45 C.F.R. § 158.231(a), the regulations also have special provisions for the first two years of implementation, see 45 C.F.R. § 158.231(b) and (c).

¹²⁴ See Appendix C, Section C for a fuller discussion of credibility adjustments and market share in Federal and New Jersey markets.

high concentration of insurers with less than full credibility. But if the same markets are described in terms of the insured consumers, a large percentage are covered by insurers with fully (or at least partially) credible insurers.

Even where Federal and New Jersey law overlap, material definitional differences affect the resulting MLR calculations. For example, although both Federal and New Jersey law take reserves into account in determining the MLR numerator, they define this term differently. One important difference is how the two systems handle claims reserves for claims incurred but not paid during the reporting year. Federal law provides for a three-month claims run-out,¹²⁵ whereas New Jersey has a six-month claims run-out.¹²⁶ Claims run-out estimates under New Jersey's system are likely to be more accurate than under the Federal because issuers will have to base their claims run-out amount on estimates for a shorter period of time.¹²⁷ These different assumptions well could lead to different numerical components of the loss ratio equation, which in turn would lead to different MLR calculations.

The two systems also differ in how they define residual reserves. New Jersey law, unlike Federal, calculates residual reserves as a fixed percentage of certain claims.¹²⁸ Because "[e]xcessive reserves could result in significantly higher MLRs for several years,"¹²⁹ it may be advisable for New Jersey to analyze these differences to determine their impact on MLR calculations.

New Jersey and the Federal requirements also differ in how they define the insurance markets. Federal law defines the small group as including employers with an average of 1-100 employees, at least one of whom was employed on the first day of the plan year,¹³⁰ while New Jersey's small group employers have an average of 2-50 eligible employees, at least two of whom must have been employed on the first day of the plan year.¹³¹ Although Federal law permits states to substitute 50 for 100 in the small group definition, this discretion only applies to plan years beginning before January 1, 2016,¹³² and it does not reconcile the discrepancy between the bottom number of the range. As a result, Federal law contemplates situations

¹²⁵ See IFR Preamble, 75 Fed. Reg. at 74,839, *supra* note 13; MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 44. Claims run-out refers to the amount that issuers will pay in claims after the end of a year for claims that were incurred but not processed during that year. See *NAIC Response*, *supra* note 76, at 3.

¹²⁶ *NAIC Response*, *supra* note 76, at New Jersey's Response to Question B.1.

¹²⁷ See *id.* at 9.

¹²⁸ N.J. ADMIN. CODE § 11:20-7.4(b); N.J. ADMIN. CODE § 11:21, Appx. Exh. GG.

¹²⁹ See *NAIC Response*, *supra* note 76, at 4.

¹³⁰ See 42 U.S.C. § 18024(b)(2); 45 C.F.R. § 158.103.

¹³¹ N.J. STAT. ANN. § 17B:27A-17.

¹³² See 42 U.S.C. § 18024(b)(3). Guidance from CMS makes clear that a state will be deemed to elect to use fifty employees in its definition of a small employer for MLR purposes until January 1, 2016 if it does so for other purposes and does not indicate a different choice. See *CCIIO Technical Guidance CCIIO 2011-002*, *supra* note 67, at 2.

when a group of one will be deemed part of the small group market whereas New Jersey law does not.¹³³

Federal and New Jersey law also differ regarding which employees are eligible to be included in this count. CMS recently clarified that “employee” under Federal law includes full-time, part-time, and seasonal employees.¹³⁴ But New Jersey law defines an eligible employee as a full-time employee who works a minimum of twenty-five hours per week.¹³⁵ New Jersey also requires that the majority of the employees are employed in New Jersey.¹³⁶

The two systems also classify student health insurance coverage in different markets. Student health coverage presently is sold in New Jersey on a large group basis,¹³⁷ which means that these plans are not subject to State MLR requirements since New Jersey does not regulate MLR in its large group market. As discussed above, however, recent Federal regulations classify student health coverage as a type of individual health insurance coverage and impose modified individual market MLR requirements on these plans beginning in 2013.¹³⁸

Other apparent differences are not, in fact, of major significance. The Federal MLR requirements detail various mandatory adjustments to premium, such as assessments paid to or subsidies received from Federal and state high risk pools, the portions of premiums associated with group conversion charges, and incurred experience rating refunds.¹³⁹ Although New Jersey law does not reference these premium adjustments, these adjustments either are not relevant in New Jersey, where, for example, carriers do not make experience rating refunds,

¹³³ CMS recently provided Guidance regarding when to report a health plan with small group experience as a group of one and when it is reported with individual market experience. See *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 3. Where a sole proprietor and/or a spouse employee are the only employees enrolled in a plan, it is not deemed a group plan because they are not deemed employees under Federal law. But if the sole enrollee of a plan is an employee but neither the owner nor the owner’s spouse, the plan is reported with the issuer’s small group experience. *Id.*

¹³⁴ *CCIIO Technical Guidance (CCIIO 2011-004): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule*, Question and Answer #19 (July 18, 2011), http://cciio.cms.gov/resources/files/20110718_mlr_guidance.pdf. CMS also recently provided Guidance regarding the methods issuers should employ to count the number of employees covered by a group policy that does not cover all of the employer’s employees when the issuer does not have access to information needed to establish the employers’ total number of employees, which information determines whether the plan is bound by the small or large group MLR requirements. See *CCIIO Technical Guidance 2012-002*, *supra* note 33, at 3.

¹³⁵ N.J. STAT. ANN. § 17B:27A-17.

¹³⁶ *Id.*; N.J. ADMIN. CODE § 11:21-1.2.

¹³⁷ See internal correspondence with DOBI officials (on file with author); see, e.g., N.J. ADMIN. CODE § 11:4-13.1(b) (applying rule prohibiting provisions of group student health insurance policies that are unjust, unfair, inequitable, misleading, contrary to law, or contrary to public policy to all student health insurance policies delivered or issued for delivery after January 1, 1978). But see N.J. STAT. ANN. § 18A:62-15(c) (“The State Department of Health shall require all public and private institutions of higher education in this State to offer health insurance coverage on a group or individual basis for purchase by students who are required to maintain the coverage” by State law) (emphasis added); N.J. ADMIN. CODE 8:57-7.4(a) (same).

¹³⁸ See *supra* notes 69 to 72 & accompanying text.

¹³⁹ 45 C.F.R. § 158.140(b); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 44.

or are handled consistent with accounting principles. Thus, at best these differences have a negligible effect on MLR calculation.

There also are a number of technical differences between the two systems, although some have a substantive impact as well. Federal loss ratio reports, for example, generally are due June 1 each year,¹⁴⁰ whereas New Jersey's reports are due August 1 and 15 for the small and individual markets, respectively.¹⁴¹ New Jersey's later due date permits carriers to use a six-month, rather than a three-month, claims run-out, which, as discussed above, tends to lead to more accurate claims data.¹⁴²

The rebate provisions also differ between the two.¹⁴³ Federal rebates are due by August 1,¹⁴⁴ but carriers in New Jersey have until December 31 to provide theirs.¹⁴⁵ While both systems offer carriers some choice of how to pay rebates, Federal law expressly authorizes more options for payment, including credit card refunds.¹⁴⁶ Recent Guidance from CMS also considers whether an issuer may offer its policyholders a "premium holiday" during which it temporarily suspends or reduces premiums during the MLR reporting year to help increase its MLR to the applicable Federal minimum and thus avoid having to pay rebates.¹⁴⁷ Because State law governs whether such a holiday is permissible, CMS directs issuers to ask State regulators. If a State permits an issuer to institute this pricing strategy, however, CMS outlines various expectations it has about any premium holiday, including that it "would be provided in a non-

¹⁴⁰ 45 C.F.R. § 158.110(b).

¹⁴¹ N.J. STAT. ANN. § 17B:27A-25(g)(2); N.J. ADMIN. CODE § 11:21-7A.3(b).

¹⁴² See *NAIC Response*, *supra* note 76, at 9.

¹⁴³ See 42 U.S.C. § 300gg-18(b)(1)(B)(i); see also 45 C.F.R. § 158.240(a). One similarity between the two systems with respect to rebates, however, is that neither achieves the exact minimum MLR required by law after the refund. This is because the refund is treated as an addition to claims (which it is not) rather than a reduction to premium (which it is). To take a simple example based on MLR calculated as claims divided by premium (and not factoring in the Federal reduction of taxes from premiums, for example), if a carrier in the small group market received \$100 in premiums but only spent \$70 on claims, it would have a loss ratio of 70 percent. According to the Federal and New Jersey rebate formulae, it would owe a \$10 rebate. But by returning \$10 of premiums to policyholders, the MLR denominator decreases to \$90 because the carrier received \$10 fewer in premiums (or, put another way, policyholders paid \$10 less in premiums). The numerator remains \$70 because the carrier has not increased its spending on claims (or quality improving activities, in Federal). Thus, the resulting MLR is 70/90, or 77.8 percent, shy of the 80 percent minimum. To achieve the minimum MLR through the rebate process, the rebate calculation methodology would need to be amended to take into consideration that the rebate is a reduction to premium and not an addition to claims. The Federal and New Jersey MLR systems also do not require carriers to pay interest on rebates paid by their due dates, despite the considerable time lag between when policyholders pay their premiums and when carriers must remit rebates.

¹⁴⁴ 45 C.F.R. § 158.240(e) & (f).

¹⁴⁵ N.J. STAT. ANN. § 17B:27A-9(e)(2); *id.* § 17B:27A-25(g)(2); N.J. ADMIN. CODE § 11:21-7A.5(h).

¹⁴⁶ 45 C.F.R. § 158.241. CMS recently indicated that issuers generally may use pre-paid debit or credit cards to distribute rebates to current or former enrollees, as long they comply with a number of requirements, including, but not limited to, that the policyholder or subscriber's name is on the card; that the policyholder or subscriber does not incur any fees by using or not using the card, may convert the card to cash, and may opt-out of the card and request a check; and that the card has no expiration date. See *CCIIO Technical Guidance 2012-002*, *supra* note 33, at 8-9.

¹⁴⁷ *CCIIO Technical Guidance 2012-002*, *supra* note 33, at 5.

discriminatory manner, meaning that it would be offered to every policyholder in a State's market and not based on product type or the experience of a particular policy."¹⁴⁸

Both Federal and New Jersey law have provisions setting a minimum threshold for distributing rebates to consumers. The Federal MLR Regulations do not require issuers to distribute de minimis rebates to enrollees.¹⁴⁹ New Jersey, in turn, requires carriers in its individual market to provide rebates for any refund owed that is \$5 or greater.¹⁵⁰ But the Federal MLR Regulations require issuers to aggregate all de minimis rebates not provided to enrollees by individual, small, and large group markets in a state and then distribute this aggregated amount evenly among the pool of enrollees receiving rebates for the same MLR reporting year.¹⁵¹ New Jersey law says nothing about what issuers may do with de minimis rebates.

The person or entity receiving the rebate under Federal and New Jersey law is different in some respects. Carriers in New Jersey's small group market must provide rebates to employers, as policyholders, and are not required to provide any rebates directly to subscribers.¹⁵² The Federal MLR Final Rule, however, establishes a more complicated rebate system in the small and large group markets to balance the statutory requirement that rebates benefit enrollees with the reality of potential tax consequences (if premiums paid with pre-tax dollars are rebated to enrollees) and logistical concerns involved with requiring issuers rather than policyholders to distribute rebates.¹⁵³ While the Federal Regulations generally permit large

¹⁴⁸ *Id.*

¹⁴⁹ 45 C.F.R. § 158.243; MLR Final Rule Preamble, 76 Fed. Reg. at 76,581, *supra* note 46. In the individual market, a rebate is deemed de minimis if the issuer owes the subscriber less than \$5. *See* 45 C.F.R. § 158.243(a)(2). Similarly, issuers distributing rebates in the group market directly to subscribers are not required to distribute rebates totaling less than \$5 to each subscriber. *See id.* § 158.243(a)(1). But where an issuer distributes a group policy rebate to the policyholder, the rebate is considered de minimis when "the total rebate owed to the policyholder and the subscribers combined is less than \$20 for a given MLR reporting year." *Id.* § 158.243(a)(1).

¹⁵⁰ N.J. ADMIN. CODE § 11:20-7.5(b)(1). The statutes and rules governing New Jersey's small group market do not make any reference to minimum rebate requirements, which suggests that issuers in the small group must provide rebates of any value.

¹⁵¹ 45 C.F.R. § 158.243(b); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 44.

¹⁵² N.J. ADMIN. CODE § 11:21-7A.5(f).

¹⁵³ MLR Final Rule Preamble, 76 Fed. Reg. at 76,579, *supra* note 46. The ACA requires issuers to pay rebates "to each enrollee" on a "pro rata basis." 42 U.S.C. § 300gg-18(b)(1). The Federal MLR Regulations generally define "enrollee" as "an individual who is enrolled . . . in group health insurance coverage, or an individual who is covered by individual insurance coverage, at any time during an MLR reporting year." 45 C.F.R. § 158.103. To avoid requiring issuers to send rebates to each person covered by an insurance plan, such as dependents and spouses, the Federal MLR Regulations define "enrollee," solely when used to identify the person or entity entitled to receive a rebate, as "the subscriber, policyholder, and/or government entity that paid the premium." *Id.* § 158.240(b). In the small and large group markets, "subscriber means the individual, generally the employee, whose eligibility is the basis for the enrollment in the group health plan and who is responsible for the payment of premiums. *Id.* § 158.103. "Policyholder means any entity that has entered into a contract with an issuer to receive health insurance coverage as defined in section 2791(b) of the PHS Act." *Id.* Thus, rebates must "be provided on a pro rata basis to the person or entity that paid the premium on behalf of the enrollee." IFR Preamble, 75 Fed. Reg. at 74,884, *supra* note 13. Appendix A, Section C contains a fuller summary of the Federal MLR rebate requirements.

and small group issuers to provide rebates to policyholders, the rules vary based on the type of entity issuing the rebate and include requirements designed to ensure the amount of any rebate attributable to the premium paid by subscribers (as distinguished from policyholders) is used for the benefit of subscribers.¹⁵⁴ In some circumstances, Federal law requires small and large group issuers to distribute rebates directly to subscribers.¹⁵⁵ In addition, Federal law requires issuers to aggregate the portions of rebates based on former subscribers' contributions to premium and use these funds for the benefit of current subscribers.¹⁵⁶

Federal law also requires issuers that are required to pay rebates to provide notices to policyholders and subscribers of group health plans and subscribers in the individual market at the time rebates are paid each year, which must contain "information about the MLR and its purpose, the MLR standard, the issuer's MLR, and the rebate being provided."¹⁵⁷ In addition, because HHS believes providing MLR information to all policyholders and subscribers, even if they are not receiving rebates, will "further the goals of improving transparency of health insurance markets, supporting more informed purchase decisions, and promoting competition and efficiency,"¹⁵⁸ issuers that meet or exceed the applicable MLR requirements in the 2011 MLR reporting year also must provide notice to each subscriber and policyholder of group plans and each subscriber of individual plans.¹⁵⁹ After considering public comments, however, the agency decided not to require these notices to include information about the issuer's prior or current year MLRs, opting instead to require the notices to refer consumers to HHS' web site,

¹⁵⁴ See 42 U.S.C. § 300gg-18(b)(1)(A); 45 C.F.R. §§ 158.240(b), 158.242(b)(1)-(4); see also MLR Final Rule Preamble, 76 Fed. Reg. at 76,579-81, *supra* note 46; Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans, 76 Fed. Reg. 76,596, 76,596-97 (Dec. 7, 2011) (to be codified at 45 C.F.R. pt. 158) [hereinafter MLR Rebate IFR Preamble, 76 Fed. Reg. at X]; *Guidance on Rebates for Group Health Plans Paid Pursuant to the Medical Loss Ratio Requirements of the Public Health Service Act*, Technical Release No. 2011-04, <http://www.dol.gov/ebsa/newsroom/tr11-04.html> (Dec. 2, 2011).

¹⁵⁵ 45 C.F.R. § 158.242(b)(3)-(4); MLR Final Rule Preamble, 76 Fed. Reg. at 76,580-81, *supra* note 46.

¹⁵⁶ 45 C.F.R. § 158.242(b)(2).

¹⁵⁷ MLR Final Rule Preamble, 76 Fed. Reg. at 76,580, *supra* note 46; see also 45 C.F.R. § 158.250. HHS recently published the required notices to policyholders and subscribers. See Medical Loss Ratio Notices to Policy Holders and Subscribers and Instructions, published as part of the MLR Paperwork Reduction Act (PRA) package (CMS-10418) (Apr. 2, 2012), available at <http://cciio.cms.gov/resources/other/index.html#mlr>.

¹⁵⁸ Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act; Final Rule, 77 Fed. Reg. 28,790, 28,792 (May 16, 2012) (to be codified at 45 C.F.R. pt. 158) [hereinafter MLR Notice Final Rule Preamble].

¹⁵⁹ See 45 C.F.R. § 158.251(a). The final rule specifies the language that issuers must include in their notices, which must be sent "with the first plan document that the issuer provides to enrollees on or after July 1, 2012." 45 C.F.R. § 158.251(a)(2) & (4). The regulation also specifies the mandatory font and permissible placement and transmission of these notices. *Id.* § 158.251(a)(3); MLR Notice Final Rule Preamble, 77 Fed. Reg. at 28,792, *supra* note 158.

healthcare.gov, where MLR data will be available.¹⁶⁰ Mini-med, expatriate, and non-credible plans, however, are exempted from this notice requirement.¹⁶¹

In addition to notice to policyholders and subscribers, Federal law also requires issuers to submit a detailed report to the Secretary concerning the rebates provided in a given MLR reporting year, which is due on June 1, along with the annual Federal MLR report.¹⁶² New Jersey law only requires carriers in the individual market to attest to their compliance with their refund obligations.¹⁶³ New Jersey also does not provide any mechanism to defer rebate payments to avoid insurer insolvency, as Federal law does.¹⁶⁴

Although both systems provide for civil penalties for violations of the various MLR requirements, they authorize different penalty amounts and impose them on a different basis (daily in Federal and per violation in New Jersey).¹⁶⁵ While New Jersey's language suggests that penalties are mandatory, the Federal system identifies various specific mitigating (as well as potentially aggravating) factors to be considered.¹⁶⁶

An important similarity between the Federal and New Jersey requirements is that both generally do not include administrative costs in the numerator (or subtract them from the denominator). Neither, for example, considers broker fees or commissions in their MLR calculations by, for example, adding them to the numerator or subtracting them from premiums.¹⁶⁷ An exception to this rule is that New Jersey includes amounts paid to integrated providers in claims even when some of those amounts are for administrative functions. Under Federal law, in contrast, issuers must "count as administrative rather than claims costs

¹⁶⁰ MLR Notice Final Rule Preamble, 77 Fed. Reg. at 28,792, *supra* note 158; see generally Jay Hancock, *Insurers Push Back on Consumer Rebate Letter*, KAISER HEALTH NEW (Mar. 29, 2012) (summarizing industry objections to notice proposals).

¹⁶¹ See 45 C.F.R. § 158.251(b). The preamble to this regulation also notes that this requirement will not apply to issuers of student health insurance coverage since the Federal MLR requirements generally do not apply to these plans until January 1, 2013. MLR Notice Final Rule Preamble, 77 Fed. Reg. 28,792, *supra* note 158.

¹⁶² 45 C.F.R. § 158.260.

¹⁶³ N.J. ADMIN. CODE § 11:20-7.7.

¹⁶⁴ 45 C.F.R. § 158.270.

¹⁶⁵ Compare *id.* §§ 158.601-615, and IFR Preamble, 75 Fed. Reg. at 74,890, *supra* note 13, with N.J. STAT. ANN. § 17B:27A-43.

¹⁶⁶ Former Commissioner Considine objected to HHS that the Federal MLR Regulations "give[] sole enforcement authority with respect to the reporting and rebate requirements to HHS . . . , with a limited ability for HHS to accept audits conducted by states," arguing that "[t]his creates duplicative and potentially conflicting enforcement authority, and would require HHS to become expert in state law requirements." Letter from Thomas B. Considine, Commissioner, to Office of Consumer Information & Insurance Oversight, to HHS Jan. 31, 2011, *available at* http://www.state.nj.us/dobi/division_insurance/pdfs/nj_mlr_comment_110131.pdf. He further urged that "the regulation should provide for primary enforcement at the state level" in states like New Jersey "with existing MLR and rebate requirements." *Id.*

¹⁶⁷ See 45 C.F.R. § 158.160(b)(2). See *infra* notes 657-675 and accompanying text in Appendix C for discussions of legislative and lobbying efforts to exclude broker commissions from the Federal MLR formula.

payments made to third party vendors (such as behavioral health or pharmacy benefit managers) that are attributable to administrative services.”¹⁶⁸

It also is interesting how the Federal and New Jersey regulatory structures use MLR calculations. Both Federal and New Jersey use MLR in a retrospective manner, meaning that carriers calculate their MLR after the close of the reporting year and pay a rebate if they failed in that prior year to satisfy the minimum loss ratios. Used in this way, “[r]etrospective loss ratio reports and refunds (if necessary) are only a check or correction to the initial rates.”¹⁶⁹

New Jersey also employs MLR calculations as part of its prospective rate review process. To support proposed rate increases, an actuary must certify that the carrier’s anticipated loss ratio will not be less than 80 percent.¹⁷⁰ By using MLR calculations in this prospective manner, New Jersey tries to set initial rates such that carriers will achieve MLR targets without needing a retrospective correction.

The ACA and the Federal MLR Regulations do not discuss prospectively using MLR as part of rate review. Traditionally, the Federal government has left questions of rate review to the states, not all of whom engage in rate review. Under the ACA, however, non-grandfathered insurers in the individual and small group markets must justify any rate increases of 10 percent or more before putting those rates into effect.¹⁷¹ In states without an effective rate review program, HHS must review these proposed premium increases for reasonableness.¹⁷² In determining whether a rate increase is excessive, and therefore unreasonable, HHS will consider “[w]hether the rate increase results in a projected medical loss ratio below the Federal medical loss ratio standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under Federal law.”¹⁷³ Thus, although the Federal MLR law does not require issuers to take loss ratios into account in setting their premiums, issuers in states without effective rate review *de facto* are required to use MLR prospectively. For example, one of the reasons supporting HHS’s determination in January 2012 that Trustmark Life Insurance Company’s proposed premium increases of 13 percent in Alabama, Arizona, Pennsylvania, Virginia, and Wyoming were unreasonable was that “the rate increase

¹⁶⁸ Jost, *Implementing Health Reform*, *supra* note 17.

¹⁶⁹ *MLR State Survey Responses*,

<http://www.nmprc.state.nm.us/insurance/docs/sjmi/MLR%20State%20Survey%20Responses.xls> (available on the web site for the New Mexico Public Regulation Commission, <http://www.nmprc.state.nm.us/insurance/healthcare-reform.html#lossratio>).

¹⁷⁰ See N.J. STAT. ANN. §§ 17B:27A-9(e)(1) & 25(g)(1).

¹⁷¹ See 42 U.S.C. § 300gg-94(a); 45 C.F.R. §§ 154.103, 154.200.

¹⁷² See 45 C.F.R. §§ 154.210, 154.301. Indeed, in determining whether a state’s rate review process is effective, HHS considers whether the state’s rate review process includes an examination of, among other things, an insurer’s MLR. See *id.* § 154.301(a)(4)(xi); see generally *Health Insurance Rate Review: Lowering Costs for American Consumers and Businesses*, http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html (last visited Feb. 15, 2012) (identifying which states have and do not have effective rate review programs).

¹⁷³ 45 C.F.R. § 154.205(b)(1).

would result in a projected medical loss ratio below the applicable Federal standard of 80%.”¹⁷⁴ HHS does not have authority to stop a rate increase that it deems unreasonable. Instead, it is limited to publicizing its finding on its web site along with the issuer’s required justification for the increase and urging the company to rescind its planned increase.¹⁷⁵ In contrast, New Jersey’s Commissioner may disapprove a premium increase that he finds is not in substantial compliance with the State’s insurance laws.¹⁷⁶

Federal and New Jersey MLR Requirements

	Federal	New Jersey
Report Due Date	June 1 st	-August 1 st (Small Group) -Aug. 15 th (Individual)
Rebates Due Date	August 1 st	December 31 st
Minimum MLR Individual	80%	80%
Minimum MLR Small Group	80%	80%
Minimum MLR Large Group	85%	none

¹⁷⁴ *Trustmark Life Insurance Company Rate Review*, http://companyprofiles.healthcare.gov/states/VA/companies/64800/products/64800VA002/rate_reviews/86?search_method=rate_reviews (last visited Feb. 15, 2012) [hereinafter *Trustmark Rate Review*]; see also *News Release*, U.S. DEPT’ OF HEALTH & HUMAN SERVCs., *Affordable Care Act Holding Insurers Accountable for Premium Hikes* (Jan. 12, 2012), <http://www.hhs.gov/news/press/2012pres/01/20120112a.html>.

¹⁷⁵ As of February 15, 2012, HHS has deemed unreasonable premium increases planned by two insurers in six states. See Chris Anderson, HEALTHCARE FINANCE NEWS, *HHS Calls Trustmark’s Health Insurance Increases in Five States “Unreasonable”* (Jan. 13, 2012), <http://www.healthcarefinancenews.com/news/hhs-trustmarks-health-insurance-increases-five-states-unreasonable>. Despite the publicity, both companies have announced their intentions to proceed with the increases as planned. See *Trustmark Rate Review*, *supra* note 174; *Everence Insurance Company Rate Review*, http://companyprofiles.healthcare.gov/states/PA/companies/78080/products/78080PA001/rate_reviews/33.

¹⁷⁶ See N.J. STAT. ANN. § 17B:27A-9(d).

Comparison of Select Features of Federal and New Jersey MLR Requirements

	Federal	State
Aggregation	<ul style="list-style-type: none"> -generally by legal entity, state, and market (individual, small group, and large group) -affiliated entities exceptions in group markets -for past three MLR reporting years -mini-med, expatriate, and student health insurance plans separately aggregated and reported 	<ul style="list-style-type: none"> -small group: by standard, open nonstandard, closed nonstandard, and alliance policy forms -by legal entities in small group market and not by common ownership or by affiliated entities -by common ownership in individual market -for preceding calendar year -mini-med plans are not permitted in NJ -no special rules for expatriate and student health insurance plans
New Plan Flexibility	Issuer may defer reporting experience if $\geq 50\%$ of total earned premium is attributable to policies newly issued and with less than 12 months of experience	no special treatment
Definition of Small Employer	<ul style="list-style-type: none"> -Employed average of 1-100 employees on business days during preceding calendar year and at least one employee on first day of plan year -state may substitute 50 for 100 until January 1, 2016 -“employee” includes full-time, part-time, and seasonal -possible group of one 	<ul style="list-style-type: none"> -Employed average of 2-50 <i>eligible</i> employees on business days during preceding calendar year and employs at least two employees on first day of plan year -eligible means full-time employee who works at least 25 hours/week
Credibility Adjustments	Yes (if $\geq 1,000$ but $< 75,000$ life-years)	No
Adjustments to MLR for Mini-Med, Expatriates, or Student Health Insurance Plans	Yes	No
Federal and State Taxes	Excluded from MLR denominator	Not excluded from MLR denominator
Regulatory and Licensing Fees	Excluded from MLR denominator	Not excluded from MLR denominator

Comparison of Select Features of Federal and New Jersey MLR Requirements (continued)

	Federal	State
Non-Claims Cost	Must be reported in annual report	Not reported
Payments or Receipts for Risk Adjustment, Risk Corridors, and Reinsurance	MLR Denominator adjusted to account for them	Do not affect the MLR denominator
Flexibility in MLR Adjustments	-States may set higher MLR percentage -States may seek adjustment from Secretary for up to 3 years at a time of MLR percentage in individual market if 80% MLR may destabilize individual market	MLR rate set by statute; methodology determined by DOBI
Rebates	-Must be paid by August 1 st -individual market: paid to policyholder who paid premium -small and large group markets: rules vary by type of entity, but generally, issuer may provide rebate to policyholder, with certain requirements; regulations identify instances when issuer must provide rebate directly to subscriber -definition of de minimis rebates: <\$5 per subscriber (in individual market and group market, when rebates are sent directly to the subscriber); <\$20 owed to subscriber and policyholder combined (in group markets when rebate is sent to policyholder) -requires issuers to aggregate and equally distribute de minimis rebates to enrollees receiving rebates in each market for the given reporting year -possibility of “premium holiday,” depending on State law	-Must be paid by December 31 st -small group: to employer -individual: to policy and contract holders when ≥ \$5 -silent regarding what carriers may do with de minimis rebates in individual market that they are not required to distribute to enrollees
Enforcement	-HHS has sole responsibility for enforcing ACA’s reporting and rebate requirements -HHS may accept state audit in certain circumstances	Commissioner of DOBI adopts regulations to implement NJ’s MLR standards

Comparison of Select Features of Federal and New Jersey MLR Requirements (continued)

	Federal	State
Civil Penalties	-May be imposed if issuer fails to comply with MLR requirements -≤ \$100 per day for each entity for each individual affected	-Shall be imposed if issuer fails to comply with MLR requirements -≥ \$2,000 and ≤ \$5,000 per violation
Use of MLR Calculations	-retrospective -de facto prospective use in review of premium increases ≥ 10% in states without effective rate review programs	-prospective and retrospective

IV. Policy Options for New Jersey

A. Whether New Jersey Should Seek an Adjustment from HHS of the Federal 80 Percent Minimum MLR in Its Individual Market

The ACA empowers the Secretary to lower, for up to three years at a time, the MLR applicable in New Jersey’s individual market below the 80 percent minimum if New Jersey demonstrates a reasonable likelihood that application of the Federal 80 percent minimum MLR requirement would destabilize its individual market. It is unlikely, however, that applying the Federal requirement will destabilize New Jersey’s individual market. Importantly, unlike the seventeen states and Guam that have requested adjustments to date, as discussed in Appendix C, New Jersey already requires carriers in its individual market to satisfy an 80 percent MLR requirement.¹⁷⁷ Although some carriers in New Jersey’s individual market have had to pay rebates under New Jersey’s system, there is no evidence these requirements have destabilized that market.¹⁷⁸ Nor does it appear that New Jersey’s 80 percent requirement has adversely affected access to brokers.¹⁷⁹

¹⁷⁷ Indeed, as discussed *infra*, New Jersey’s MLR formula generally results in a lower MLR than the Federal methodology.

¹⁷⁸ Preliminary data from DOBI for the 2009 MLR reporting year, the first in which New Jersey’s 80 percent MLR requirement applied, show that only two of ten carriers in the individual market failed to satisfy this percentage. One had only 177 enrollees and thus was non-credible and not subject to any rebate requirement under the ACA. The other, with enrollment around 50,000, would be eligible for a credibility adjustment under the ACA, which could sufficiently raise its 79.2 percent loss ratio so that it, too, would face no rebate requirement. In 2010, the average MLR in the individual market according to preliminary data was 87.6 percent. Seven of ten carriers met or exceeded the 80 percent MLR requirement. One carrier had a loss ratio of 75.6 percent when calculated as a legal entity. But because New Jersey aggregates loss ratios of affiliated carriers in its individual market, the combined ratio of this carrier and its affiliate, which had an MLR of 164.6 percent, was 150.3 percent, and thus this carrier was not subject to any rebate requirement. Similarly, another carrier that missed the minimum MLR (albeit by only one-tenth of a percent) with an MLR of 79.9 percent did not have to pay a New Jersey rebate because its affiliate had an MLR of 86.6 percent, which gave these carriers a combined MLR of 82.1 percent. The only other New Jersey individual group carrier with an MLR less than 80 percent in 2010 had a loss ratio of only 50.9 percent but

There is little reason to believe the Federal MLR requirements will change this. Many of the components of the Federal methodology, when compared to New Jersey's, tend to increase the resulting percentage, such as including quality improving expenditures in the calculation of claims in the numerator, excluding taxes and regulatory expenses from premiums in the denominator, and applying credibility adjustments to smaller plans.¹⁸⁰ As a consequence, even though Federal and New Jersey law require the same minimum MLR percentage in their small group and individual markets, the Federal MLR formula will result in a higher nominal percentage for many, if not all, carriers. Because insurers likely will report a higher MLR under Federal criteria than they would under New Jersey criteria under the same factual circumstances, the Federal MLR requirement, though nominally the same as New Jersey's, is effectively lower, permitting insurers to retain more of consumers' premiums.

represented less than 0.1 percent of the market with an enrollment of only 44. (Preliminary data on file with author.) The results of the American Journal of Managed Care study discussed below also seem to support the hypothesis that the eighty percent MLR requirement in New Jersey has not destabilized the individual market. See *infra* note 181 and accompanying text.

¹⁷⁹ In a study of broker commission rates in New Jersey's small group market from 2005 to 2011, DOBI found that four of eight carriers paid higher rates in 2011 than in 2005, even though the minimum loss ratio increased from 75 to 80 percent in 2009. The other four carriers for which DOBI had data paid the same rates in 2011 as they had paid in 2005, two of which had raised their rates during the period but then had reduced them to 2005 levels by 2011. No carrier in this study had lowered its 2011 rates below 2005 levels. Indeed, although the range of commissions remained the same (4.75-6.7 percent), the median increased slightly from 5.7 percent in 2008-09 to 6.15 percent in 2011. By February 2012, two of these carriers had reduced their rates by less than 1 percent in 2011, which slightly reduced the range of commissions (4.75-6.6 percent) and the median rate (6.1 percent). Four carriers, however, are paying higher commissions than at the beginning of the study, and the other two are paying the same rates. See R. Neil Vance, FSA, Managing Actuary, Life & Health, DOBI Internal Memo regarding Commissions (Small Employer), at 2 (Apr. 19, 2011, updated Feb. 14, 2012) (on file with author). See also NAIC REPORT OF THE HEALTH CARE REFORM ACTUARIAL (B) WORKING GROUP TO THE HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE ON REFERRAL FROM THE PROFESSIONAL HEALTH INSURANCE ADVISORS (EX) TASK FORCE REGARDING PRODUCER COMPENSATION IN THE PPAC MEDICAL LOSS RATIO CALCULATION, APPENDIX B, AT 19 (May 26, 2011) (reporting "no problem with access" to brokers in the small group market), http://www.naic.org/documents/committees_b_110607_hcrawg_report.pdf; MARK NEWSOM, CONG. RESEARCH SERV., R41439, HEALTH INSURANCE AGENTS AND BROKERS IN THE REFORMED HEALTH INSURANCE MARKET, at 6-7 (May 13, 2011) (noting that the absence of "clear evidence of the [negative] impact" on access to brokers from reductions in commissions and the opinion of some analysts that reductions to commissions "are necessary and can be absorbed by producers"), available at [http://op.bna.com/hl.nsf/id/shad-8gxjkb/\\$File/Health%20Insurance%20Agents%20and%20Brokers%20in%20the%20Reformed%20Health%20Insurance%20Market%20\(CRS,%2005.13.11\).pdf](http://op.bna.com/hl.nsf/id/shad-8gxjkb/$File/Health%20Insurance%20Agents%20and%20Brokers%20in%20the%20Reformed%20Health%20Insurance%20Market%20(CRS,%2005.13.11).pdf); see generally 45 C.F.R. §§ 158.321(d)(2)(iv) & 158.330(c) (noting that HHS will consider impact of minimum MLR requirement on access to brokers as part of state application for adjustment of MLR in individual market, but requiring state to provide data on agents' and brokers' commission expenses on individual health insurance products).

¹⁸⁰ See NAIC Response, *supra* note 76, at 1; OCTOBER 2011 GAO REPORT, *supra* note 103, at 1; see generally Mark A. Hall & Michael J. McCue, Commonwealth Fund, *Estimating the impact of the Medical Loss Ratio Rule: A State-by-State Analysis*, at 1, 4, 6-7 (Apr. 2012), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Mar/1587_Hall_medical_loss_ratio_ib.pdf (opining that including quality improvement and fraud and abuse detection and recovery expenses in the MLR numerator and deducting taxes and assessments from the denominator "result in a higher MLR than a standard financial report, which makes it easier for insurers to meet the minimum MLR requirements").

A recent study in the American Journal of Managed Care seems to support this conclusion. Based on its assumptions regarding the impact the Federal requirements will have on MLR calculations, only one insurer in New Jersey's individual market in 2009 would not have met the Federal MLR minimum, had it been in effect.¹⁸¹ With only 177 member years, this non-credible carrier would not have had to pay rebates under the ACA.¹⁸² Even if it did, it is doubtful that requiring this small carrier to pay rebates would destabilize the market as a whole. Further actuarial analysis could shed more light on this issue, and New Jersey will need to continue to monitor the stability of its individual market and consumer access to brokers as the ACA is implemented.

B. Whether New Jersey Should Adopt a Higher MLR Standard

1. Whether New Jersey Should Exercise Its Discretion to Adopt a Minimum MLR Percentage Higher Than That Required by the ACA in Its Individual, Small Group, or Large Group Markets

New Jersey has a statutory right to adopt an MLR percentage higher than that required by Federal law in its individual, small, or large group markets, as long as it “seek[s] to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.”¹⁸³

Because the Federal requirements generally would result in a lower effective MLR than New Jersey's formula, New Jersey may want to adopt a higher minimum MLR percentage in its individual and small group markets, where Federal and New Jersey both require a nominal MLR of 80 percent, to compensate for this effect and maintain its longstanding regulatory goals. New York, for example, recently announced that although it will use the Federal MLR methodology for purposes of determining whether rebates are required, it will exercise its discretion to increase the Federal minimum MLR in the individual and small group markets from 80 to 82 percent, which is its current State minimum loss ratio percentage.¹⁸⁴ Actuarial analysis can provide a rough estimate of the nominal level at which an MLR would be required to be set

¹⁸¹ See Abraham & Pinar Mandic, *supra* note 107.

¹⁸² See 45 C.F.R. §§ 158.230(c)(3) & (d); IFR Preamble, Fed. Reg. at 74,881, *supra* note 13.

¹⁸³ See 42 U.S.C. § 300gg-18(b)(2); 45 C.F.R. § 158.211(b).

¹⁸⁴ Insurance Circular Letter No. 15 from Louis Felice, Ass't Deputy Sup't & Bureau Chief, Health Bureau, N.Y. State Dep't of Financial Servcs., to All Insurers Authorized to Write Accident and Health Insurance in New York State, *et al.*, at 3 (Dec. 22, 2011), available at http://www.dfs.ny.gov/insurance/circltr/2011/cl2011_15.htm; cf. ALM GL ch. 176J, § 6 (requiring refunds in the individual and small group markets “[i]f the annual aggregate medical loss ratio for all plans offered under this chapter is less than 90 per cent, or less than the medical loss ratio that was not presumptively disapproved by the commissioner for being in excess of 1% of the carrier's prior year base rate, over the applicable 12-month period”) (effective Oct. 1, 2012); N.M. Stat. Ann. § 59A-22-50(A) & (C) (establishing 85 percent minimum MLR requirement “across all health product lines, except [certain] individually underwritten health insurance policies, contracts or plans).

under Federal methodology to achieve the functional equivalent of an 80 percent MLR under New Jersey's methodology. Admittedly, the precision of this estimate will depend on many factors, including the tax situation of the carrier. Adoption of the Federal methodology, even at a higher nominal MLR percentage, would affect some carriers more than others, based on their individual circumstances. While New Jersey would not perfectly replicate the effect and stringency of its current law simply by adopting Federal MLR methodology at a higher-than-federally-required nominal percentage, doing so would come closer to New Jersey's current system than not raising the percentage. New Jersey will have to assess current market conditions to ensure that adopting higher nominal MLR percentages will not destabilize these markets.

It is less likely New Jersey would want to increase the Federal MLR percentage in its large group market, where to date it has not imposed an MLR requirement. Using New Jersey's MLR methodology, seven out of sixteen carriers in New Jersey's large group market, representing nearly 30 percent of large group enrollment, would have reported loss ratios under 85 percent in 2008.¹⁸⁵ Similarly, eight of the sixteen carriers in New Jersey's large group market in 2010, representing approximately 26 percent of the market, would have had to pay rebates.¹⁸⁶ Some of these issuers might reach 85 percent under the Federal methodology, given its tax deductions, credibility adjustments, special aggregation rules, and inclusion of quality improving expenditures, for example. But 85 percent is a fairly demanding standard, and New Jersey may decide, at least in the first instance, to adhere to the Federal requirements for this market.¹⁸⁷

2. Whether New Jersey Should Adopt or Retain Its Own Methodology for Calculating MLR

New Jersey may prefer to maintain a version of its own methodology for calculating MLR instead of adopting the Federal methodology – with or without an increase in the nominal rate. It may wish to do so to continue into the future approximately the effect current State MLR regulations have on New Jersey carriers. But Federal law may preempt New Jersey from requiring insurers to calculate MLR using a methodology that deviates from the Federal. The Supremacy Clause in the Federal Constitution “invalidates laws that ‘interfere with, or are

¹⁸⁵ Commercial Loss Ratio 2008, DEP'T OF BANKING & INS., 2 (Nov. 30, 2010), http://www.state.nj.us/dobi/lifehealthactuarial/2008comhealth_loss.pdf.

¹⁸⁶ Preliminary data from DOBI on file with author.

¹⁸⁷ Note that these numbers regarding MLR in New Jersey's large group market are based on one year of MLR data. Beginning in 2013, Federal MLR calculations for purposes of establishing the amount of any rebate will be based on accumulated data from a three year period. See 42 U.S.C. § 300gg-18(b)(1)(B)(ii); see also 45 C.F.R. § 158.220(b)-(c) (explaining how MLR data for three year periods will be aggregated and how calculations will be made in years 2011 and 2012); IFR Preamble, 75 Fed. Reg. at 74,880, *supra* note 13 (stating that data from a three-year period will be used to calculate an issuer's MLR for the 2013 MLR reporting year “for purposes of determining whether any rebate is owed and, if so, in what amount” and that this data “should consist of the accumulated experience, rather than the average three MLRs”).

contrary to,' federal law."¹⁸⁸ Federal statutes as well as Federal regulations may preempt state laws and regulations.¹⁸⁹

Although commentators often describe preemption doctrine as "muddled,"¹⁹⁰ courts generally identify three main categories of preemption. First, express preemption arises when Congress, subject to constitutional limitations, states in explicit terms that Federal law preempts state law.¹⁹¹ Second, field preemption arises when courts infer Congressional intent to preempt state law in a particular field or area "where the scheme of federal regulation is sufficiently comprehensive to make reasonable the inference that Congress 'left no room' for supplementary state regulation" or "where the field is one in which 'the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject.'"¹⁹²

It is the third branch of preemption law – conflict preemption – that is implicated in MLR discussion. Conflict preemption blocks enforcement of state law "to the extent that it actually conflicts with federal law."¹⁹³ Courts have found that state law actually conflicts with Federal law not only when "compliance with both federal and state regulations is a physical impossibility" ("implied impossibility preemption"), but also "when state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress'" ("implied obstacle preemption").¹⁹⁴ Courts rarely find impossibility preemption, which requires that either state or Federal law require what the other jurisdiction prohibits.¹⁹⁵ Obstacle preemption, however, "can be broad."¹⁹⁶ Courts often consider whether the matter being regulated traditionally is Federal in nature or otherwise requires uniformity, the purposes

¹⁸⁸ *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 712 (1985) (quoting *Gibbons v. Ogden*, 9 Wheat. 1, 211 (1824)).

¹⁸⁹ *See id.* at 713.

¹⁹⁰ Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 234 (Mar. 2000); *see also* Alan Untereiner, *The Defense of Preemption: A View from the Trenches*, 84 TUL. L. REV. 1257, 1257 (May 2010) (describing preemption law as a muddle).

¹⁹¹ *See Automated Med. Labs*, 471 U.S. at 713.

¹⁹² *Id.* (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

¹⁹³ *Id.* (quoting *Gibbons*, 9 Wheat. at 211).

¹⁹⁴ *Id.* (quoting *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963) and *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)). *But see Williamson v. Mazda Moto of Am.*, 131 S. Ct. 1131, 1142 (Feb. 23, 2011) (rejecting "purposes-and-objectives pre-emption as inconsistent with the Constitution because it turns entirely on extratextual 'judicial suppositions'" (Thomas, J., concurring); *Wyeth v. Levine*, 555 U.S. 555, 129 S. Ct. 1187, 1211-17 (2009) (same) (Thomas, J., concurring in judgment); *but see generally Nelson*, *supra* note 190, at 260-61 (urging adoption of a logical-contradiction test for preemption, rather than the three tiers courts presently use, pursuant to which "[c]ourts are required to disregard state law if, but only if, it contradicts a rule validly established by federal law," even if it is physically possible to comply with both).

¹⁹⁵ *See Erika Fisher Lietzan & Sarah E. Pitlyk, Thoughts on Preemption in the Wake of the Levine Decision*, 13 J. HEALTH CARE L. & POL'Y 225, 225 (2010).

¹⁹⁶ Nelson, *supra* note 190, at 228.

animating the Federal law, and whether the Federal law reflects a balance or compromise between competing objectives.”¹⁹⁷

Congressional purpose “‘is the ultimate touchstone’ in every pre-emption case.”¹⁹⁸ It is not always easy, however, to divine Congressional intent from statutory text, which often reflects legislative compromise. Where Congress delegates responsibility for implementing a statute to an administrative agency, courts also may consider the various means by which agencies address problems, “including regulations, preambles, interpretive statements, and responses to comments,” as long as these statements are not “inconsistent with clearly expressed congressional intent” or “subsequent developments.”¹⁹⁹ This is particularly true when the subject matter is technical.²⁰⁰ Absent delegation by Congress, agencies do not have authority to make legal conclusions concerning what state laws are preempted. But their expertise may help them “make informed determinations about how state requirements may pose an ‘obstacle to the accomplishment and execution of the full purposes and objectives of Congress.’”²⁰¹ How much weight courts will give to an agency’s views will depend “on its thoroughness, consistency, and persuasiveness.”²⁰²

A plurality of the Court recently cautioned that “[i]mplied preemption analysis does not justify a freewheeling judicial inquiry into whether a state statute is in tension with federal objectives; such an endeavor would undercut the principle that it is Congress rather than the courts that preempts state law.”²⁰³ Instead, the plurality believed that precedent sets a high threshold that must be satisfied to preempt a state law because it conflicts with the purposes of Federal law.²⁰⁴

Particularly where the matter being regulated is within the traditional police powers of the states, courts employ a presumption against preemption whereby they assume Federal law does not supersede the historic powers of the states “‘unless that was the clear and manifest

¹⁹⁷ Lietzan & Pitlyk, *supra* note 195, at 241.

¹⁹⁸ *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996) (quoting *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963)).

¹⁹⁹ *See, e.g.*, *Automated Med. Labs*, 471 U.S. at 714-15, 718 (quoting *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-45 (1984)); *see generally* Williamson, 131 S. Ct. at 1131 (examining “the regulation, including its history, the promulgating agency’s contemporaneous explanation of its objectives, and the agency’s current views of the regulation’s preemptive effect” in identifying significant objectives for preemption analysis); *Altria Group, Inc. v. Good*, 555 U.S. 70, 87-89 (2008) (reviewing agency guidances, among other things, to identify Federal policy in obstacle preemption analysis). *But see* *Levine*, 555 U.S. 555, 129 S. Ct. at 1201 (finding that preamble to Federal regulations did not merit deference where the agency finalized the rule without opportunity for notice and comment and the preamble was “at odds” with other evidence of Congress’s purposes and reversed the agency’s longstanding position); *but see generally* Nelson, *supra* note 190, at 290-303 (criticizing the presumption against preemption).

²⁰⁰ *See* *Geier v. American Honda Motor Co., Inc.*, 529 U.S. 861, 883 (2000).

²⁰¹ *Levine*, 555 U.S. 555, 129 S. Ct. at 1201 (quoting *Hines*, 312 U.S. at 67).

²⁰² *Id.*

²⁰³ *Chamber of Commerce v. Whiting*, 131 S. Ct. 1968, 1985 (May 26, 2011) (internal citations and quotation marks omitted).

²⁰⁴ *See id.* (internal citations and quotation marks omitted).

purpose of Congress.”²⁰⁵ To rebut this presumption, the party arguing for preemption must make a showing of field or conflict preemption “that is strong enough to overcome the presumption that state and local regulation of [traditional areas of state concern, such as] health and safety matters can constitutionally coexist with federal regulation.”²⁰⁶ Given states’ traditional power to regulate insurance, “[s]tate law governing insurance generally is not displaced, but ‘where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress,’ federal preemption occurs.”²⁰⁷

The Supreme Court has not yet addressed whether the ACA preempts state laws governing medical loss ratios. Section 1321(d) of the ACA provides that “[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.”²⁰⁸ The statute does not define, however, what “prevent the application of” its provisions means in this context. The Eleventh Circuit recently interpreted this language, as it applies to establishing state-run health insurance exchanges, to mean that states enjoy “some flexibility in operations and enforcement, though states must either (1) directly adopt the federal requirements set forth by HHS, or (2) adopt state regulations that effectively implement the federal standards, as determined by HHS.”²⁰⁹

Congress also specifically tasked HHS, based on guidance from NAIC, to adopt regulations to implement the ACA’s MLR requirements,²¹⁰ and thus courts may consider HHS’s comments regarding preemption. In its preamble to the IFR, HHS parroted the statute by recognizing that “States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking.”²¹¹ The preamble also added HHS’s view that “[s]tate insurance laws that are more stringent than the Federal requirements are unlikely to ‘prevent the application of’ the Affordable Care Act, and be preempted,” and that “[s]tates have significant latitude to impose requirements on health with respect to health insurance issuers that are more restrictive than the Federal law.”²¹² Again, though, the Federal MLR Regulations do not define “prevent the application of,” “more stringent than,” or “more restrictive.”²¹³

²⁰⁵ *Levine*, 555 U.S. 555, 129 S. Ct. at 1195 (quoting *Medtronic*, 518 U.S. at 485). *But see Untereiner*, *supra* note 190, at 1265-68 (summarizing recent decisions evidencing that the Supreme Court is divided over the appropriateness of the presumption against preemption).

²⁰⁶ *Automated Med. Labs*, 471 U.S. at 716.

²⁰⁷ *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993).

²⁰⁸ *See* 42 U.S.C. § 18041.

²⁰⁹ *Florida v. United States HHS*, Nos. 11-11021 & 11-11067, 2011 U.S. App. LEXIS 16806, at *58 (11th Cir. Aug. 12, 2011), *cert. granted sub nom.* *Nat’l Fed’n of Indep. Bus. v. Kathleen Sebelius*, No. 11-393, 181 L. Ed. 2d 420; 2011 U.S. LEXIS 8269 (Nov. 14, 2011) (grant of *certiorari* limited to issue of severability).

²¹⁰ *See* 42 U.S.C. § 300gg-18(c).

²¹¹ IFR Preamble, 75 Fed. Reg. at 74,920, *supra* note 13.

²¹² *Id.* at 74,865, 74,920.

²¹³ *Cf.* 45 C.F.R. § 160.202 (defining “contrary” and “more stringent,” as those terms are used to address preemption of state law by HIPAA). In a draft document, NAIC interprets the language in the ACA as “effectively

The ACA's MLR requirements do not implicate express or field preemption. Even though the comprehensive Federal MLR scheme could evidence Congress's intent to regulate exclusively, the statute and implementing regulations make clear that Congress contemplated a role for states in the field of medical loss ratio regulation.²¹⁴ For example, the statute and Federal MLR Regulations specifically permit states to set higher MLR percentages and conduct audits.²¹⁵ Whether either species of implied conflict preemption prevents the states from adopting a different MLR, however, requires more dissection.²¹⁶

New Jersey could take the position that its MLR methodology is more stringent than the Federal methodology because, as discussed earlier, it results in an *effective* MLR that is higher than the one resulting from the Federal formula. Building on HHS's language in the IFR's preamble, New Jersey's more stringent MLR calculation method does not conflict with or otherwise prevent the application of the ACA and therefore is not preempted by the Federal methodology.

This argument has two primary weaknesses. First, it is not clear what defines a more stringent methodology. Each system's methodology includes various components, and it is unclear if New Jersey's must be more demanding with respect to each component or on average.²¹⁷ It appears that it is more difficult to achieve a higher effective MLR under New

allowing states to adopt and enforce laws and regulations that afford greater consumer protections while ensuring a basic level of protections across the country." Preemption and State Flexibility in PPACA (Draft) (NAIC 2010), http://www.naic.org/documents/index_health_reform_general_preemption_and_state_flex_ppaca.pdf. In its view, if a state law does not satisfy the Federal minimum standards required by the ACA, it will be preempted. But "[i]f a state already has a requirement that at least meets the federal standards, or adopts one in the future, then it would retain the authority to enforce it." *Id.* This analysis, even assuming it is an accurate application of preemption law to the ACA, does not answer the critical question whether New Jersey meets the Federal standards if it employs a methodology that differs from the one detailed in the ACA and its implementing regulations, as analyzed below.

²¹⁴ *Cf.* Whiting, 131 S. Ct. at 1987 (finding Arizona immigration law not preempted where Federal law expressly reserved state authority to regulate in the field and state took "the route least likely to cause tension with federal law" by, for example, adopting Federal definitions and relying on Federal determinations of law).

²¹⁵ *See, e.g.,* Automated Med. Labs, 471 U.S. at 714 (rejecting field preemption argument, despite pervasive Federal regulatory scheme, where the agency "explained in a statement accompanying the regulations that '[these] regulations are not intended to usurp the powers of State or local authorities to regulate . . . in their localities'"); *cf.* O'Donnell v. Blue Cross Blue Shield of Wyo., 173 F. Supp. 2d 1176, 1184 (D. WY 2001) (finding that HIPAA's similar preemption language made clear that Congress did not intend "to completely preempt state law in the field").

²¹⁶ *Cf. generally* MMA Ins. Co. v. Blue Cross & Blue Shield of Kan., Inc., 552 F. Supp. 2d 1250, 1257 (D. Kan. 2004) (finding that similar preemption language in HIPAA, albeit "narrow and flexible," would preempt state law that directly conflicts with Federal law "as construed by the agencies responsible for implementing it") (citing 42 U.S.C. § 300gg-23(a)).

²¹⁷ *Cf.* Letter from Steven B. Kelmar, Senior Vice President, Gov't Affairs & Public Policy, Aetna to U.S. Dep't of Health & Human Services 18-19 (Jan. 31, 2011) *available at* www.aetna.com/health-reform-connection/documents/mlr-comment-letter-1-31-11.pdf [hereinafter Jan. 31, 2011 Aetna Letter to HHS, MLR Comments] (expressing concern in comments to IFR that insurers might have "to compare any state MLR rule on a provision by provision basis against the federal MLR rule – to determine which aspects of the state law are less protective of consumers than the federal standard – and to run hybrid MLR calculation and rebate distribution

Jersey's formula than under the Federal because, for example, New Jersey does not permit carriers to count quality improving expenditures in its numerators, subtract taxes or regulatory fees from its denominator, or make credibility adjustments to its MLR. But, as has been discussed, some of New Jersey's aggregation rules can result in fewer or at least lower refunds to consumers, and New Jersey permits carriers to count administrative costs of vendor intermediaries in its numerator.

Even if actuarial analysis demonstrates that New Jersey's calculation nearly always results in a higher effective MLR than the Federal (and thus is more stringent in that respect), there is strong evidence that Congress intended to require states to adopt universal definitions and not to permit states to continue to employ their own formulae in place of the Federal formula. The statute, for example, specifically calls for the establishment of "*uniform definitions of . . . and standardized methodologies for calculating*" the components of the MLR formula.²¹⁸

Consistent with this Congressional requirement of uniformity in the way MLR is calculated, the statute and Federal MLR Regulations require specific ingredients for the loss ratio calculation. The language is mandatory and not permissive: the numerator must include both expenditures on reimbursement for clinical services and activities that improve health care quality; revenue must exclude Federal and state taxes and licensing or regulatory fees and account for payments or receipts for risk adjustment, risk corridors, and reinsurance; and NAIC, subject to certification by HHS, had to establish uniform definitions and standardized methodologies that had to take into account the special circumstances of smaller plans, different types of plans, and newer plans.²¹⁹

Federal law, then, identifies specific areas in which states retain discretion to deviate from the Federal standards. Neither Congress nor HHS has stated, however, that states may adopt a methodology for calculating MLR that is different than the detailed, prescriptive Federal methodology.²²⁰ Rather, the text of the ACA, the Federal MLR Regulations, and the preamble to the IFR repeatedly and specifically reference a state's discretion to set a "higher percentage"²²¹ or "provide for a higher ratio."²²² Although the preamble to the IFR also refers

systems that combine applicable features of federal and state MLR laws, which would be enormously expensive and administratively burdensome").

²¹⁸ 42 U.S.C. § 300gg-18 (emphasis added).

²¹⁹ See *id.*; 45 C.F.R. § 158.221(b).

²²⁰ Cf. *Rowe v. New Hampshire Motor Transp. Assoc'n*, 552 U.S. 364, 374 (2008) (noting that the Federal law had explicitly listed a set of exceptions to preemption in declining to find an additional, non-itemized exception); see generally *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 188 (1978) (applying *expressio unius est exclusio alterius* maxim of statutory construction in finding that Congress did not intend to exempt Federal agencies from the Endangered Species Act because it had not included such an exemption in its itemized list of hardship cases).

²²¹ 42 U.S.C. § 300gg-18(b)(1)(A)(i) & (ii); C.F.R. § 158.211(a).

²²² IFR Preamble, 75 Fed. Reg. at 74,866, 74,870, *supra* note 13; see generally *id.* at 74,886 (after summarizing the 80 and 85 percent minimum MLR requirements, the IFR Preamble says that "if a State sets a higher MLR within its State, that higher MLR must be met").

more generally to the states' ability to "establish a higher MLR standard,"²²³ context strongly suggests that HHS intended "standard" to mean "percentage" in this context. For example, mere words after referring to setting a higher MLR standard, the preamble specifies that "such higher percentage" should "be substituted" for the Federal minimum MLR in that state.²²⁴ The statute and Federal MLR regulations' specific references to percentage strongly indicate that states may adopt a higher percentage than the ACA requires for their minimum MLR while continuing to require insurers to calculate the MLR using the uniform Federal definitions and methodologies.²²⁵

Further evidence that HHS intends to require states to use its methodology for calculating MLR is found in recent Guidance concerning state requests for adjustments of their MLR in the individual market. HHS explicitly instructed that states may only request adjustments to the numerical ratio, may not substitute their own definitions or methods for calculating MLR, and must follow the Federal methodology.²²⁶ Although the adjustment context is distinct from a state's right to adopt a higher standard, this is powerful evidence of HHS's thinking regarding whether states may tinker with the Federal methodology. HHS seems to be executing Congress's direction that states comply with uniform definitions and standards.

This uniformity is important to Congress's goal to increase transparency. If the states were free to adopt their own methodologies, it would be more difficult for consumers to know whether a particular MLR level in New Jersey is effectively higher or lower than the same nominal MLR rate in a neighboring state. If Congress intended to permit carriers to calculate loss ratios differently in different states, and were these differently calculated ratios functionally impossible to compare, there would be no reason to require HHS to publish these numbers on its web site. Relatedly, Federal law requires the loss ratio report to detail non-claims costs that will not be factored into the MLR formula so that consumers can know how insurers have spent premium dollars on various administrative expenses, like salaries, overhead, and brokers fees.²²⁷ Permitting states to adopt their own requirements that do not require such disclosures undermines transparency.

²²³ *Id.* at 74,867, 74,879, 74,889.

²²⁴ *Id.* at 74,879.

²²⁵ *See, e.g.*, Jan. 31, 2011 Aetna Letter to HHS, MLR Comments, *supra* note 217, at 19 ("[U]nlike the other PHSA provisions, Section 2718's MLR rule is comprehensive and reticulated, and expressly delineates the areas in which states are permitted to modify the otherwise applicable federal MLR rule. In issuing the IFR, HHS . . . struck a delicate balance with respect to critical policy matters impacting the calculation of MLR, including the inclusion or exclusion of administrative costs, quality expenditures, credibility adjustments, federal and state taxes, and the methods by which rebates are to be distributed and to whom they must be distributed. The IFR contemplates that these rules are to apply uniformly to all insurers on a national basis. If states are permitted to interpose their own MLR standards beyond the extent permitted by PHSA § 2718, it will contravene both the express statutory limit on their authority to adjust only the MLR percentage, and it will upset the delicate policy judgments that HHS made in developing the IFR.").

²²⁶ *See CCIIO Technical Guidance CCIIO 2011-002, supra* note 67, at 7.

²²⁷ 45 C.F.R. § 158.160.

Even if there were not such strong indications of Congressional intent to limit states to altering the Federal MLR percentage but not its methodology, the numerous ways in which the Federal and New Jersey requirements conflict likely mean that New Jersey is impliedly preempted from wholly supplanting the Federal methodology with its own. For example, New Jersey prohibits insurers from including quality improving expenditures in its numerator while Federal law requires them to be included. Similarly, if New Jersey insurers complied with the State's aggregation or reporting rules, they would be violating the analogous Federal requirements. Thus, requiring adherence to a single MLR methodology that differs from the Federal would prevent application of the ACA, which New Jersey may not do.

It is a much closer question whether New Jersey and Federal requirements may coexist in parallel regulatory systems, in which carriers comply with the Federal MLR requirements as well as different but not conflicting state-specific requirements.²²⁸ The Supreme Court recently emphasized how demanding it is to establish impossibility preemption.²²⁹ If it is feasible to comply with both Federal and New Jersey's MLR requirements, courts likely would not find impossibility preemption.

Were New Jersey to require insurers to comply with both Federal and state MLR requirements, it would be appropriate to consider the burden such a dual system would place on insurers. New Jersey would have to consider, for example, how to set off any rebates required under its methodology to account for rebates paid pursuant to the Federal system. The differences between the two systems highlighted in this Policy Brief complicate the required set-offs. It is not clear how New Jersey would compare rebates calculated under different systems, based on different ingredients, definitions, and timing requirements. New Jersey would need to examine, for example, how it would apply set-offs when Federal law calculates MLR (and thus requires different rebate amounts) for different aggregations than New Jersey law and requires that rebates be paid to different entities (e.g., policyholder versus subscriber), in some circumstances. Similarly, New Jersey must assess how it will handle

²²⁸ DOBI recently suggested that carriers would comply with both Federal and New Jersey MLR requirements when it readopted its regulations without modification, stating that “[i]t is the Department's current understanding that the calculation of medical loss ratios and payment of rebates in accordance with existing New Jersey law does not prevent the application of the Federal law” 43 N.J. REG. 6 (June 6, 2011), *available at* <http://www.state.nj.us/dobi/proposed/re110606ihc.pdf>. *Cf.* John Hancock Mut. Life Ins. Co., 510 U.S. at 98 (finding that “ERISA leaves room for complementary or dual federal and state regulation [of insurance], and calls for federal supremacy when the two regimes cannot be harmonized or accommodated”); *see generally* Nelson, *supra* note 190, at 231 (“[I]f state and federal law can stand together, the Supremacy Clause does not require courts to ignore state law. Courts remain free to apply state law except to the extent that doing so would keep them from obeying the Supremacy Clause’s direction to follow all valid rules of federal law.”).

²²⁹ *Cf.* Levine, 555 U.S. 555, 129 S. Ct. at 1198 (refusing to find it impossible for a pharmaceutical company to comply with Federal and state requirements absent clear evidence that FDA would not have approved a change to a drug’s label that would have been necessary to avoid state tort liability); *see generally* Lietzan & Pitlyk, *supra* note 195, at 234 (noting that the Court in Levine did not make clear what will constitute clear evidence and that lower courts will have to flesh out this standard).

employers who are classified as large in Federal but small in New Jersey (and thus subject to different minimum MLR percentages). Assuming it is feasible for New Jersey to construct a parallel system that accounts for these differences, courts are unlikely to find that it is impossible to comply with both laws, even if the administrative burdens are quite high.

Beyond these feasibility questions, however, New Jersey also should assess whether its law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.²³⁰ The statutory text of the Federal MLR provision, which is entitled, “Bringing down the cost of health care coverage,” suggests that Congress had two main aims: to increase the value consumers receive for their insurance premiums and to increase transparency and accountability regarding how they spend premiums.²³¹ As long as insurers must satisfy the Federal MLR requirements, it should not frustrate the goal of increasing value also to require insurers to satisfy non-conflicting state requirements.

Reasonable courts could differ, however, regarding whether permitting New Jersey to require insurers to calculate a state-specific MLR will frustrate the interrelated goals of uniformity and improving transparency. Courts could find, for example, that the Federal policies are not undermined as long as insurers must report their Federal MLR to HHS for public dissemination and disclosure. Consumers would have access to standardized Federal loss ratio calculations so they could compare how different companies spend premium dollars. But courts also could find that having two sets of MLR numbers increases the risk that consumers will be confused or will not be able to compare different insurers on common grounds, which arguably undermines or at least makes less valuable the goal of greater transparency. The stronger argument seems to be the former, especially in light of the presumption against preemption and because HHS would be reporting only Federal MLR ratios, which minimizes the risk that consumers will be bombarded with numbers they cannot compare.

Improving quality appeared also to be a Congressional purpose in enacting the Federal MLR requirements. The text of the ACA is replete with references to quality, including the titles of Titles I, III, and X and numerous subtitles of the Act that seek through various ways to improve the quality of health care, the validity of quality measures, and the value of quality reporting. The ACA’s MLR provision requires the numerator of the loss ratio equation to include premium dollars spent on quality improving expenditures.

It is possible that Congress included this requirement as part of the statute’s goal of improving the quality of health care, perhaps because Congress believed that encouraging these types of expenditures would improve patient care. Indeed, there is language in the preamble suggesting that HHS thought increased quality improving expenditures “could help to

²³⁰ As cited above, although there are strong voices on the Court who question the validity of obstacle preemption, a majority continues to apply its principles.

²³¹ See 42 U.S.C. § 300gg-18; see also IFR Preamble, 75 Fed. Reg. at 74,865, *supra* note 13.

increase the level of investment in and implementation of effective quality improving activities, which could result in improved quality outcomes and lead to a healthier population.”²³²

It also is possible, however, that Congress included quality expenditures in the numerator as a compromise between consumer advocates and the insurance industry that made it easier for insurance companies to achieve the minimum MLR requirement using expenses that were not traditionally counted in MLR calculations. It is not apparent from the statutory or regulatory text what motivated Congress to include these expenses.

What is clear is that neither the ACA nor the Federal MLR Regulations require insurers to spend a specific amount or percentage of premiums on quality improving activities.²³³ Instead, Federal law permits insurance companies to choose how to achieve the mandatory minimum MLR requirements. Insurers may achieve the minimum through efficiency gains, for example, without spending any dollars on quality improving expenditures. Or they may increase quality improving spending to help raise their MLR. How insurers increase value is up to them, within the confines of the MLR formula. Thus, while Congress clearly wanted to and did *permit* quality expenses to count in the MLR numerator, it did not *require* these expenditures. Had Congress wanted to encourage spending on quality, it might have required a certain amount of such spending or created an incentive to encourage this type of spending.²³⁴ But it did not.

Thus, although there are viable arguments on both sides, it seems that permitting New Jersey to have a parallel formula that does not count quality improvement costs in the MLR numerator will not frustrate Congress’s goals in enacting its MLR requirements. If New Jersey does not permit insurers to count quality expenditures in its State MLR calculations, insurers might focus more on efficiency gains so that it will satisfy both Federal and New Jersey minimums. As a result, New Jersey insurers may have less incentive to invest in quality improving activities. But since quality spending is not required in the Federal system and there is inadequate evidence that Congress wanted to encourage this spending (as opposed to just permitting it to count in loss ratio calculations), no clear Congressional purpose is thwarted by the parallel formula.²³⁵ Because insurance regulation is within the traditional police powers of the states, the presumption against preemption provides further support for finding New Jersey law is not impliedly preempted here based on obstacle preemption.

If New Jersey is not preempted from adopting its own MLR methodology, either to replace or run parallel to the Federal requirements, it also should consider the costs and possible confusion that two systems will bring. Carriers will need to tabulate and report

²³² IFR Preamble, 75 Fed. Reg. at 74,893, *supra* note 13.

²³³ *Id.* at 74,876.

²³⁴ *Cf.* Geier, 529 U.S. at 880 (finding that regulation giving extra credit to car manufacturers that installed air bags evinced intent to ensure at least some made this choice).

²³⁵ *Cf.* Williamson, 131 S. Ct. at 1134 (finding that a regulation giving car manufacturers a choice of the type of seatbelt to install did not preempt state tort action that, if successful, would eliminate that choice, because providing choice was “not a significant objective of the federal regulation”).

different data and pay two sets of rebates, sometimes to different entities. HHS estimates that the Federal requirements alone will include approximately \$33 to \$67 million in one-time administrative costs (less than 0.02 percent of total premiums) and \$11 to \$29 million in annual ongoing administrative costs (less than 0.01 percent of total premiums) from 2011 to 2013.²³⁶ New Jersey will have to consider the impacts on its markets of imposing these costs on carriers, including whether these requirements affect barriers to new entry to New Jersey's markets, and what steps it can take to minimize the administrative burdens of a dual MLR regulatory system.

Thus, there are significant lingering questions of feasibility, conflict, and policy that New Jersey should study before deciding to maintain a parallel MLR regulatory system. Given these practical concerns, it might make more sense for New Jersey, like New York, to adopt the Federal MLR rebate methodology while perhaps upwardly adjusting the Federal minimum MLR percentage, where appropriate, to more closely realize the aims of New Jersey's current regulatory framework.

C. Whether Legislative and Regulatory Changes are Necessary and/or Desirable

Given the differences between Federal and New Jersey MLR laws, at a minimum New Jersey will need to update its laws and regulations to ensure they do not prevent the application of Federal law.

²³⁶ IFR Preamble, 75 Fed. Reg. at 74,893, 74,895, *supra* note 13. These estimates are based on the provisions of the IFR and do not take into account the modifications that the Final MLR Rule made to the IFR, such as reducing mini-med and expatriate plan reporting obligations from quarterly to annually; graduating the mini-med special circumstances numerator adjustment factor from 2.0 in 2011 to 1.75 in 2012, 1.5 in 2013, and 1.25 in 2014; permitting issuers to count some ICD-10 conversion costs as quality improving activities in 2012 and 2013; altering the requirements relating to deducting community benefit expenditures from earned premium in a way that should encourage these expenditures without imposing additional administrative costs on not-for-profit issuers; modifying the rebate distribution process in the group markets in a way that avoids tax consequences for consumers and reduced administrative burdens on issuers, which should more than offset increased administrative costs for policyholders disbursing rebates to group plan subscribers; and adding requirement that issuers provide notice of rebates to subscribers and policyholders. *See* MLR Final Rule Preamble, 76 Fed. Reg. at 76,581, 76,583, 76,586, *supra* note 46. The Regulatory Impact Statement in the preamble to the Final MLR Rule estimates the impacts of these modifications. *See id.* at 76,582-90, *supra* note 46. For example, HHS estimates that the Final Rule will result in a total of approximately \$2.8 million annually in reduced annual reporting costs for mini-med and expatriate plans and approximately \$1.8 million annually in reduced administrative costs for rebate distribution by group plans. *See id.* at 76,586. While graduating the mini-med special circumstances adjustment is estimated to lead to increased rebates of approximately \$1.3 million in 2012 and \$4.1 million in 2013, the changes relating to treatment of ICD-10 conversion costs and community benefit expenditures may reduce rebate payments to some enrollees. *Id.* at 76,583, 76,589-90. *But see* Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Set; Proposed Rule, 77 Fed. Reg. 22,950 (Apr. 17, 2012) (to be codified at 45 C.F.R. pt. 162) (proposing to delay the compliance date for ICD-10 conversion from October 1, 2013 to October 1, 2014).

New Jersey may choose to adopt the Federal requirements *in toto*.²³⁷ This approach has the advantage of simplicity, but it also sacrifices the aspects of New Jersey law that are more protective of consumers than the Federal. If New Jersey exercises its discretion to adopt a higher MLR percentage or obtains an adjustment of its MLR, it could include these variations in its amendment of existing law.

New Jersey also may choose to adopt the mandatory Federal requirements while preserving some features of its regulatory system that complement and do not frustrate the Federal system. For example, like California²³⁸ and Maine,²³⁹ New Jersey might continue to prospectively use MLRs as part of its rate review process.²⁴⁰

If New Jersey is not preempted from adopting a methodology that differs from the Federal, New Jersey might consider adopting select features of the Federal methodology that it sees as improvements or complements to its MLR rules. In particular, there are two ways in which the Federal MLR requirements may provide better protection to consumers than New Jersey's. First, by calculating MLRs by legal entity in all markets, each entity is held responsible for meeting the applicable minimum MLR, and consumers receive refunds when each fails to satisfy this duty. New Jersey's practice of aggregating carriers by common ownership in its individual market, in contrast, can result in fewer refunds to consumers. The Federal requirements also make it more difficult for insurance companies to increase their numerator with administrative costs by carefully teasing which parts of payments to third party vendors may be included as incurred claims. The Federal MLR Regulations and agency Guidance provide models for how New Jersey can eliminate the anomalous practice that permits carriers to include administrative costs incurred by providers or vendor intermediaries, such as ODS's, in incurred claims.

There are a number of other features of the Federal MLR requirements that New Jersey could consider adopting. Former Commissioner Considine indicated his support for including quality improving expenditures in New Jersey's MLR numerator. New Jersey also could consider adding minimum MLR requirements in its large group market to mirror the Federal requirements. Relatedly, New Jersey should consider how it wants to treat student health insurance plans. These plans are currently regulated in the State's large group market and are not subject to State MLR requirements. But, as discussed above, those that come within the

²³⁷ See, e.g., Appendix C, Section F (summarizing legislative and regulatory initiatives in other states).

²³⁸ See CAL. CODE REGS., tit. 10, § 2222.12(a)(2).

²³⁹ See PUBLIC Law, Chapter 90, LD 1333, Sec. D-3. 24-A MRSA § 2736c, 125th Maine State Legislature, 2011 Me. Laws 90, Dx3 (signed into law on May 17, 2011), available at http://www.mainelegislature.org/legis/bills/bills_125th/chappdfs/PUBLIC90.pdf.

²⁴⁰ Because HHS has determined that New Jersey has an effective rate review program, CMS will adopt DOBI's determination of whether a rate increase is unreasonable. See 45 C.F.R. § 154.210; *Health Insurance Rate Review: Lowering Costs for American Consumers and Businesses: List of Effective Rate Review Programs*, supra note 172.

Federal definition²⁴¹ will be subject to modified individual market MLR requirements beginning in 2013.²⁴²

Given the relative concentration of New Jersey's insurance markets, New Jersey might also want to model aspects of the Federal program that could help encourage new entrants into New Jersey's markets. For example, New Jersey could study the effects that credibility adjustments would have in this State. Depending on market composition, credibility adjustments could help new entrants to the markets develop the critical mass necessary to survive. Similarly, New Jersey could evaluate the relative strengths and weaknesses of including new plan flexibility in its regulatory framework, which might support new entry into its markets.

New Jersey also could consider excluding some taxes from its MLR denominator. The ACA includes new taxes or assessments on insurers to help fund its reforms, such as the so-called Cadillac Tax on high-cost employer-sponsored health coverage and the assessments required by the reinsurance, risk adjustment, and risk corridor programs.²⁴³ New Jersey should evaluate whether its calculation of premiums should account for these additional financial obligations.

²⁴¹ See 45 C.F.R. § 147.145(a) (defining student health insurance coverage as "a type of individual health insurance coverage (as defined in § 144.103 of this subchapter) that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets the following conditions: (1) Does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education. (2) Does not condition eligibility for the health insurance coverage on any health status-related factor (as defined in § 146.121(a) of this subchapter) relating to a student (or a dependent of a student). (3) Meets any additional requirement that may be imposed under State law").

²⁴² HHS has recognized that "States may continue to regulate student health insurance coverage as a form of group or blanket health insurance, provided these standards do not prevent the application of the relevant individual market provisions of the PHS Act." Student Health Insurance Coverage Final Rule, 77 Fed. Reg. at 16,458, *supra* note 70; see also *id.* at 16,467 ("Under this final rule, student health insurance coverage will be defined as a type of individual health insurance coverage, and will therefore be subject to the individual market provisions of the PHS Act and the Affordable Care Act, with the exception of certain specific provisions that are identified in the final rule. States would continue to apply State laws regarding student health insurance coverage. However, if any State law or requirement prevents the application of a Federal standard, then that particular State law or requirement would be preempted. Additionally, State requirements that are more stringent than the Federal requirements would be not be preempted by this final rule. Accordingly, States have significant latitude to impose requirements with respect to student health insurance coverage that are more restrictive than the Federal law."). Compare N.J. ADMIN. CODE § 11:22-5.7(a)(6) (permitting group student health insurance plans to have annual dollar benefit maximums lower than \$ 1 million) with 45 C.F.R. § 147.145(b)(2) (requiring phase-in for student health insurance plans of Federal prohibitions of annual dollar benefit maximums set forth in 45 C.F.R. § 147.126 by prohibiting annual dollar limits on essential health benefits lower than \$100,000 for plan years beginning before September 23, 2012 and \$500,000 for plan years on or after September 23, 2012 but before January 1, 2014, before the full limits apply for policy years beginning on or after January 1, 2014).

²⁴³ See 26 U.S.C. § 4980I; 42 U.S.C. §§ 18061-18063.

As CMS recently recognized, New Jersey also has authority to determine whether, and under what conditions, carriers may institute “premium holidays” to avoid having to pay MLR rebates.²⁴⁴

D. New Jersey’s Continued Role in MLR Regulation and Enforcement

Whether New Jersey adopts the Federal requirements or decides to pursue its own MLR system, New Jersey has a role in the future regulation of loss ratios. HHS expressly recognized the states’ continued role in MLR enforcement in the IFR’s Regulatory Impact Analysis, noting that states remain responsible for solvency and may impose higher MLR standards. In addition, many states, like New Jersey, also have a role in rate review.²⁴⁵ NAIC officials warned HHS “about the potential for unintended consequences arising from the medical loss ratio rules” and urged that these rules “will have to be adjusted as medicine and insurance evolves [sic].”²⁴⁶ New Jersey can facilitate the appropriate shaping of the MLR process by monitoring various aspects of its markets as the Federal rules go into effect.²⁴⁷

If New Jersey elects to conduct audits of issuers’ MLR reporting and rebate obligations as a means of exercising its continued oversight role, it should ensure that its audits satisfy the requirements outlined in Section 158.403 of the Federal MLR Regulations. In particular, New Jersey law must permit public release of the audit findings. The audit also must report “on the validity of the data regarding expenses and premiums that the issuer reported . . . [,] the accuracy of rebate calculations[,] and the timeliness and accuracy of rebate payments.” Further, New Jersey has to submit the audit reports to HHS within thirty days of when they are finalized and preliminary or draft audit reports to HHS no later than six months from the completion of audit field work. HHS only has discretion to defer to state audits that comply with these requirements. Notably, HHS expects the States’ role in conducting audits to increase as they develop more expertise.²⁴⁸

As the authors of a recent study in the *American Journal of Managed Care* recommended, New Jersey also can monitor how insurance companies are responding to the Federal requirements.²⁴⁹ Perhaps insurers’ responses will benefit consumers by reducing administrative costs and profits, increasing spending on medical claims or legitimate quality improving activities, or reducing premiums.²⁵⁰ But they also may respond in less consumer-friendly ways, including exiting the market or raising premiums to make room for more profit

²⁴⁴ See CCIIO *Technical Guidance 2012-002*, *supra* note 33, at 5.

²⁴⁵ IFR Preamble, 75 Fed. Reg. at 74,889, *supra* note 13.

²⁴⁶ Haberkorn, *supra* note 16.

²⁴⁷ IFR Preamble, 75 Fed. Reg. at 74,875, *supra* note 13.

²⁴⁸ *Id.* at 74,890.

²⁴⁹ See Abraham & Mandic, *supra* note 107, at 217.

²⁵⁰ See Appendix C for an overview of early evidence some insurers are seeking to increase their MLR by lowering premiums, increasing spending on quality improving activities, and reducing administrative costs.

while adhering to MLR requirements.²⁵¹ If carriers exit the individual market, though, New Jersey has the discretion to seek an adjustment of the minimum MLR from the Secretary based on threatened market instability.²⁵² If carriers are raising premiums, New Jersey will have the ability to evaluate the propriety of these increases as part of the rate review process.²⁵³

New Jersey also retains its responsibility to monitor carrier solvency as the reforms are implemented. If a carrier's solvency is at risk, the Federal MLR Regulations permit the Commissioner to seek a deferment of the carrier's rebate obligations.²⁵⁴

Although not required, New Jersey can monitor other aspects of Federal implementation. Timothy Jost has cautioned that "the flexibility allowed plans in determining how to allocate expenses may lead to abuse."²⁵⁵ A particular area of concern involves expenditures on routine administrative activities, which could be reported in such a way as to appear to be quality improving activities. New Jersey would be well-advised to monitor expenses being claimed as quality improving and determine whether these expenses "actually improve health standards."²⁵⁶ NAIC suggests that states "monitor the actual operation of quality improvement programs through market conduct reviews."²⁵⁷

Although early indications suggest that New Jersey consumers are not losing any access to brokers as some carriers reduce commissions to minimize their administrative expenses,²⁵⁸ New Jersey could continue to monitor consumer access to brokers and report back to HHS, which has committed to tracking this concern.²⁵⁹

²⁵¹ See generally May 26, 2010 Considine Letter, *supra* note 109 ("Viewed in a vacuum, loss ratio requirements create perverse incentives because as premiums increase, permissible expenses and profits increase.") .

²⁵² See 45 C.F.R. § 158.301.

²⁵³ See generally Julie Appleby, *Trade Group, Other Association Health Plans to Face Rate Hike Scrutiny*, CAPSULES: THE KHN BLOG (Sept. 1, 2011 4:10 PM), <http://capsules.kaiserhealthnews.org/index.php/2011/09/trade-group-other-association-health-plans-to-face-rate-hike-scrutiny/> (summarizing Federal law requiring states and the Federal government to scrutinize and publicly post rate increases exceeding 10 percent).

²⁵⁴ See 45 C.F.R. § 158.270.

²⁵⁵ Jost, *Implementing Health Reform*, *supra* note 17.

²⁵⁶ Haberkorn, *supra* note 16.

²⁵⁷ NAIC Response, *supra* note 76, at 5.

²⁵⁸ See *supra* note 179 and accompanying text.

²⁵⁹ See 45 C.F.R. § 158.330; see generally MAJORITY STAFF OF THE COMM. ON COMMERCE, SCIENCE, AND TRANSP., OFFICE OF OVERSIGHT AND INVESTIGATIONS MAJORITY STAFF, CONSUMER HEALTH INSURANCE SAVINGS UNDER THE MEDICAL LOSS RATIO LAW, Exh. 1, (Staff Report for Chairman Rockefeller) (May 24, 2011), *available at* http://commerce.senate.gov/public/index.cfm?p=Reports&ContentRecord_id=e5361268-9f7f-456c-b1ed-097c9cda2943&ContentType_id=6a6fef64-34f1-4348-b965-ec03a1dcadfe&Group_id=a89b0b93-3242-4d2a-82da-5e916a62b6a9 [hereinafter ROCKEFELLER REPORT] (estimating that New Jersey would lose approximately \$21.23 million out of \$28.87 million in estimated consumer rebates if broker fees were excluded from the MLR denominator). Note that there is a dramatic difference between the amount of rebates paid by carriers in New Jersey's small group market in 2008 (approximately \$850,000) and the amount that the Rockefeller Report predicts New Jersey carriers would have owed if the Federal requirements had been in place for 2010 (\$28.87 million). See DOBI Internal Memo regarding SEH Loss Ratio and Refund Reports for 2008, R. Neil Vance, FSA, Managing Actuary, Life & Health Actuarial, and Avnee Parekh, ASA, Actuarial Analyst, Life & Health Actuarial, to Ellen DeRosa, Executive Director, SEH/IHC Boards (Apr. 19, 2010), *available at*

V. Conclusions

Implementing the ACA's MLR requirements in New Jersey will raise challenging legal and policy questions. Initially, the State must evaluate the extent to which the MLR requirements of Federal law preempt New Jersey law in this area. As is described in this Brief, the ACA both demands uniform compliance with some aspects of its MLR requirements and permits state variation to increase consumer protection. The preemption analysis depends in part on the question of whether a state variation is more "stringent" than the Federal model – a question that is not always easily answered.

Preemption aside, the State's approach to implementation will be informed by an analysis of the similarities and differences between the MLR structure in New Jersey and Federal law. Consideration of the implications of including and excluding certain ingredients in one formula but not the other, aggregating data in differing ways, or applying credibility adjustments to recognize the special challenges small plans face, among varied additional differences, will allow the State more accurately to assess how adjustments to the MLR model affect consumers and New Jersey's insurance markets.

As a threshold matter, New Jersey must assess whether the Federal requirements will affect the stability of its individual market; if the imposition of Federal MLR rules could be destabilizing, New Jersey will have the opportunity to seek an adjustment from the Secretary. In addition, the State can assess the effect of the Federal MLR methodology as compared to New Jersey's existing MLR rules. Because it is likely that the use of the proposed Federal methodology will result in a lower effective loss ratio – that is, the Federal MLR system arguably is less "stringent" than New Jersey's – then New Jersey, like New York, could compensate by adopting the Federal methodology with a higher numerical loss ratio than is required by the ACA. The adoption of the Federal loss ratio system with a higher numerical requirement is both simple and clearly permissible under Federal law. More complicated would be a State decision to modify the components of the Federal MLR methodology. New Jersey could consider such tinkering if the result promises to increase consumer protection or market stability. The tinkering could be difficult to assess in advance, and it is far less clear that this "mix and match" approach would be permissible in either Federal regulatory oversight or preemption terms.

http://www.nj.gov/dobi/division_insurance/ihcseh/sehrpts/seh08lossratiopt.pdf. At least some of this discrepancy is explained because the 2008 rebates were paid when New Jersey only required a minimum MLR of 75 percent. Further, the Rockefeller Report estimates the rebates that would be owed to consumers in the individual, small group, and large group markets, whereas the 2008 rebates summarized in the DOBI memorandum concern only the small group market. Based on preliminary MLR data from New Jersey for 2010, carriers in the large group market are responsible for a large portion of the estimated rebates. (Data on file with author.) The difference also could owe, at least to some extent, to differences in loss ratio data in 2008 and 2010. Notably, New Jersey carriers' loss ratios generally were lower in 2010 than in 2008. It could illuminate the preemption analysis to develop and then compare estimates of the rebates that would be required under the Federal and New Jersey methodologies.

The State, then, has several options available to tailor the Federal MLR requirements to New Jersey's own needs. Some of these options are clearly permissible under Federal law and some less so. Fundamentally, however, the State has the opportunity to assess the practical effects of MLR adjustments that adopt all of the Federal requirements as set forth in the ACA and implementing regulations, adjust the Federal system to conform to New Jersey's needs, or even run parallel systems of loss ratio requirements to maximize the effect of this program. As this Brief describes, the most beneficial outcome will require, first, an assessment of the practical effects of a program design, and second, to the extent the most beneficial design differs from the proposed Federal model, the extent to which preemption principles permit such fine tuning.

Appendix A: Overview of Federal MLR Legal Structure

Section 10101 of Title X of the ACA, which is captioned, “Bringing down the cost of health care coverage” and created Section 2718 of the Public Health Services Act (“PHSA”), establishes the Federal MLR requirements for health insurance issuers (“issuers”) offering coverage in the group and individual health insurance markets.²⁶⁰ This provision applies to grandfathered but not self-insured plans.²⁶¹ These Federal requirements vary from existing state MLR requirements in important ways. First, Congress set the target MLRs above the national trend: 80 percent in the individual and small employer markets and 85 percent in the large group market.²⁶² Second, the ACA directed insurance companies to include spending on activities that improve health care quality in the MLR numerator and to exclude various amounts from the denominator, including taxes and licensing fees.²⁶³

Although the MLR statute itself is only a few pages long, its implementing regulations illustrate that the devil indeed is in the details. First, the United States Department of Health and Human Services (“HHS”) issued a comprehensive Interim Final Regulation (“IFR”), which was published in the *Federal Register* on December 1, 2010 and was effective January 1, 2011.²⁶⁴ After reviewing approximately ninety comments to the IFR, HHS then issued a Final Rule on December 7, 2011 that largely finalized the detailed provisions in the IFR with a few revisions (“MLR Final Rule”).²⁶⁵ The terms of the MLR Final Rule were effective January 3, 2012

²⁶⁰ See 42 U.S.C. § 300gg-18.

²⁶¹ See *id.* § 300gg-18(a); 45 C.F.R. § 158.102; Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, 75 Fed. Reg. 74,864, 74,865 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158) [hereinafter IFR Preamble, 75 Fed. Reg. at X]; *CCIIO Technical Guidance (CCIIO 2012-002): Questions and Answers Regarding the Medical Loss Ratio Regulation*, 1-2 (Apr. 20, 2012), <http://ccio.cms.gov/resources/files/mlr-qna-04202012.pdf> [hereinafter *CCIIO Technical Guidance 2012-002*]; Timothy Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, COMMONWEALTH FUND at 18 (Sept. 30, 2010), <http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx>. Recent agency guidance confirmed that the Federal MLR requirements also do not apply to Medicaid managed care organization or Medicare contracts, including Medicare Part C (Medicare Advantage) or D (prescription drugs) plans “designed for members of an employer group.” *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 2; see also 42 U.S.C. § 1395w-27(e)(4) (establishing independent medical loss ratio requirements for Medicare Part C plans).

²⁶² See 42 U.S.C. § 300gg-18.

²⁶³ See *id.*

²⁶⁴ See Issuer Use of Premium Revenue: Reporting and Rebate Requirements, 45 C.F.R. §§ 158.101 *et seq.*; IFR Preamble, 75 Fed. Reg. at 74,864-74,921, *supra* note 261; Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Corrections to the Medical Loss Ratio Interim Final Rule With Request for Comments, 75 Fed. Reg. 82,277 (Dec. 30, 2010) (to be codified at 45 C.F.R. pt. 158); Health Insurers Issuers Implementing Medical Loss Ratio (MLR) Under the Patient Protection and Affordable Care Act; Correcting Amendment, 77 Fed. Reg. 28,788 (May 16, 2012) (to be codified at 45 C.F.R. part 158) [hereinafter MLR Correcting Amendment, 77 Fed. Reg. at X].

²⁶⁵ See Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 76,574 (Dec. 7, 2011) (to be codified at 45 C.F.R. pt. 158) [hereinafter MLR Final Rule Preamble, 76 Fed. Reg. at X].

even though the comment period for certain of its provisions did not close until January 6, 2012.²⁶⁶ On the same day it issued the MLR Final Rule, HHS also issued an Interim Final Rule with request for comments establishing rules for “the distribution of rebates by issuers in group markets for non-Federal governmental plans,” which provisions were effective January 3, 2012 and comment with respect to which closed February 6, 2012.²⁶⁷ The Federal MLR Regulations define in great detail the activities insurers must report, standardizes the methodology that insurers must follow in calculating their MLRs, and sets forth various requirements for insurers, such as filing annual reports with HHS, paying rebates to enrollees, and maintaining records. What follows is an overview of these Federal statutory and regulatory requirements.

A. Formula for Calculating Federal MLR

The ACA establishes the following formula for calculating an issuer’s MLR: the numerator, consisting of the amount of premium revenue spent on reimbursement for clinical services provided to enrollees and activities that improve health care quality, divided by the denominator, consisting of “the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments of receipts for risk adjustment, risk corridors, and reinsurance under sections 18061, 18062, and 18063 of [the ACA]) for the plan year.”²⁶⁸ The Federal MLR Regulations then provide detailed guidance for how to identify and calculate each component of this formula, as discussed below.

1. Federal MLR Numerator

As the statutory language directs, the MLR numerator includes the amount spent by issuers on reimbursement for clinical services provided to enrollees and on activities that improve health care quality. The Federal MLR Regulations refer to the amounts spent by issuers to reimburse for clinical services provided to enrollees as incurred claims.²⁶⁹ These expenses include what one might expect a measure of expenditures on clinical services to include – “direct claims paid to or received by providers, including under capitation contracts with physicians, . . . for clinical services or supplies covered by the policy.”²⁷⁰ Incurred claims, as defined in the Federal MLR

²⁶⁶ *Id.* at 76,574.

²⁶⁷ Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans, 76 Fed. Reg. 76,596 (Dec. 7, 2011) (to be codified at 45 C.F.R. pt. 158) [hereinafter MLR Rebate IFR Preamble, 76 Fed. Reg. at X].

²⁶⁸ See 42 U.S.C. § 300gg-18(b)(1)(A). The Federal MLR regulations also outline exceptions to this formula to account for the special circumstances of smaller plans, different types of plans, and newer plans, as required by the statute, see *id.* § 300gg-18(c), and discussed in subsection E below.

²⁶⁹ 45 C.F.R. § 158.140; MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264.

²⁷⁰ C.F.R. § 158.140(a); see also *CCIIO Technical Guidance (CCIIO 2011-002): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule*, at 4 (May 13, 2011), http://cciio.cms.gov/resources/files/2011_05_13_MLR_Q_and_A_Guidance.pdf (confirming that that generally issuers do not need to take out administrative expenses from payments to clinical providers in a capitation

Regulations, also include “claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the medical portion of lawsuits, and any incurred experience rating refunds.”²⁷¹ The MLR reporting year is defined as a calendar year.²⁷²

The Federal MLR Regulations also itemize a laundry list of adjustments to incurred claims, some of which *must* be subtracted from, some of which *must not* be included in, others that *must* be included in, and still others that *must be either* included in or deducted from incurred claims.²⁷³ For example, incurred claims may not include payments to third party vendors for secondary network savings, network development, administrative fees, claims processing, and utilization management.²⁷⁴ Nor may they include amounts paid “for professional or administrative services that do not represent compensation or reimbursement for covered services,” such as “medical record keeping copying costs, attorneys’ fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks”²⁷⁵ Issuers also must exclude from incurred claims MLR rebates paid in the preceding year.²⁷⁶

Issuers must include in incurred claims, however, “[t]he amount of claims payments recovered through fraud reduction efforts not to exceed the amount of fraud reduction expenses.”²⁷⁷ The Federal MLR Regulations also include instructions for subtracting from and adding group conversion charges to incurred claims, where applicable.²⁷⁸

arrangement but clarifying that “provider” does not include third party vendors) [hereinafter *CCIIO Technical Guidance 2011-002*].

²⁷¹ 45 C.F.R. § 158.140(a); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264; *see generally* 45 C.F.R. § 158.103 (defining terms); IFR Preamble, 75 Fed. Reg. at 74,874, *supra* note 261 (discussing and defining the terms used to define incurred claims, including unpaid claims reserves and change in contract reserves); Timothy Jost, *Implementing Health Reform: Medical Loss Ratios*, HEALTH AFFAIRS BLOG (Nov. 23, 2010, 8:38 AM), <http://healthaffairs.org/blog/2010/11/23/implementing-health-reform-medical-loss-ratios> (“Clinical services reimbursement include not only direct payments for services and supplies but also changes in contract reserves (where an issuer holds reserves for later years when claims are expected to rise as experience deteriorates) and reserves for contingent benefits and lawsuits.”).

²⁷² *See* 45 C.F.R. § 158.103.

²⁷³ *Id.* § 158.140(b); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264.

²⁷⁴ 45 C.F.R. § 158.140(b)(3)(i) & (ii). CMS has issued extensive Guidances regarding the treatment of payments to third party vendors, including how an issuer should report amounts paid to third party vendors who pay others to provide clinical services to enrollees and who perform network development, administrative functions, claims processing, and utilization management compared to how it should report amounts paid to third party vendors who provide clinical services directly to enrollees. *See CCIIO Technical Guidance (CCIIO 2011-004): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule*, Question and Answer #19 (July 18, 2011), http://cciio.cms.gov/resources/files/20110718_mlr_guidance.pdf; *CCIIO Technical Guidance 2011-002*, *supra* note 270, at 4.

²⁷⁵ 45 C.F.R. § 158.140(b)(3)(iii); *see also CCIIO Technical Guidance CCIIO 2011-002*, *supra* note 270, at 4.

²⁷⁶ 45 C.F.R. § 158.140(a)(5); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264. *But see id.* § 158.221(b)(1)-(2) (outlining exceptions to this rule for the 2012 and 2013 reporting years).

²⁷⁷ *Id.* § 158.140(b)(2)(iv); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264. In the preamble to the MLR Final Rule, HHS considered and responded to several comments regarding treatment of fraud reduction

The MLR numerator also includes issuers' expenditures that improve health care quality.²⁷⁹ These expenses have not typically been included in MLR calculations prior to the ACA. This provision may encourage "insurers to maintain programs that help consumers remain healthy and have better health care outcomes, such as a care management program to help a diabetes patient stay on medication."²⁸⁰ But some are concerned that issuers will abuse this provision to pad their numerator to make it easier to satisfy minimum MLR requirements.²⁸¹

To help minimize this risk of abuse, HHS set forth detailed requirements in Section 158.150 of the Federal MLR Regulations to make it more difficult for issuers to masquerade administrative expenses as quality expenditures.

First, the "activity must be designed to" do all of the following:

- i. Improve health quality.
- ii. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
- iii. Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.
- iv. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.²⁸²

Although issuers do not need to "present initial evidence" to designate an activity as quality improving, they "will have to show measurable results stemming from the quality improvement

expenses and decided to maintain the treatment set forth in the IFR. *See* MLR Final Rule Preamble, 76 Fed. Reg. at 76,577, *supra* note 265.

²⁷⁸ 45 C.F.R. § 158.140(a)(1). This regulation addresses additional adjustments to incurred claims not detailed in this overview, such as prescription drug rebates received by issuers, state subsidies based on a stop-loss payment methodology, and optional adjustments available to affiliated issuers that offer group coverage at a blended rate.

²⁷⁹ *Id.* §§ 158.150-151 & 158.221(b).

²⁸⁰ Jennifer Haberkorn, *Health Policy Brief: Updated: Medical Loss Ratios*, HEALTH AFFAIRS (Nov. 24, 2010),

http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=33.

²⁸¹ *See, e.g.*, Letter from John D. Rockefeller IV, Chairman, Comm. on Commerce, Science, & Transp., U.S. Senate, to Comm'r Jane L. Cline, Nat'l Ass'n of Ins. Comm'rs, at 5 (May 7, 2010), <http://rockefeller.senate.gov/press/5.07.10%20Letter%20to%20NAIC%20President%20Commissioner%20Jane%20Cline.pdf> ("The purpose of the provision was to encourage health insurers to spend money on health care services that have been demonstrated to improve the safety, timeliness, and effectiveness of patient care" – and not to let insurance companies "cook their books.").

²⁸² 45 C.F.R. § 158.150(b)(1).

activity in order to continue claiming that it does in fact improve quality.”²⁸³ As Timothy Jost has pointed out, however, the Federal MLR regulations do not explain how this will work in practice.²⁸⁴

In addition to satisfying these four requirements, the activity also “must be primarily designed to” do one of the following:

- i. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
- ii. Prevent hospital readmissions through a comprehensive program for hospital discharge.
- iii. Improve patient safety, reduce medical errors, and lower infection and mortality rates.
- iv. Implement, promote, and increase wellness and health activities.
- v. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with [45 C.F.R. § 158.151].²⁸⁵

Section 158.151 of the Federal MLR Regulations details how expenditures related to health information technology and meaningful use requirements can qualify as quality improvement costs, recognizing that these costs “are required to accomplish the activities allowed in § 158.150 . . . and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible”²⁸⁶ Indeed, the definitions of activities that improve health care quality in Section 158.150 expressly address the role of health information technology.²⁸⁷

The Federal MLR Regulations and agency Guidance list copious examples of activities that may satisfy each of these categories. For example, face-to-face, telephonic, or web-based effective case management, care coordination, chronic disease management (such as blood glucose monitoring programs), and medication and care compliance initiatives (such as medication adherence programs), may constitute activities designed primarily to improve health outcomes.²⁸⁸ Wellness and health activities may include wellness and lifestyle coaching programs, among other initiatives to educate the public and change member behavior.²⁸⁹ The

²⁸³ *Medical Loss Ratio: Getting Your Money's Worth on Health Insurance* (Nov. 22, 2010), http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html (last visited Aug. 18, 2011) [hereinafter *Getting Your Money's Worth on Health Insurance*].

²⁸⁴ See Jost, *Implementing Health Reform*, *supra* note 271.

²⁸⁵ 45 C.F.R. § 158.150(b)(2).

²⁸⁶ *Id.* § 158.151(a); see also *CCIIO Technical Guidance CCIIO 2011-002*, *supra* note 270, at 4.

²⁸⁷ 45 C.F.R. §§ 158.150(b)(2)(i)(A)(4), (b)(2)(ii)(E), (b)(2)(iii)(A)(6), (b)(2)(iv)(A)(8), (b)(2)(v).

²⁸⁸ *Id.* § 158.150(b)(2)(i)(A)(1); *CCIIO Technical Guidance CCIIO 2011-002*, *supra* note 270, at 4.

²⁸⁹ 45 C.F.R. § 158.150(b)(2)(iv)(A).

costs of quality reporting related to improving health outcomes, preventing hospital readmission, improving patient safety, reducing medical errors, and implementing, promoting, and increasing wellness and health activities also may qualify.²⁹⁰ Recent Guidance instructs that if an issuer and third party vendor can demonstrate that the vendor’s “expenses were incurred for performing allowable quality improving activities on behalf of the issuer,” the issuer may include these costs in its MLR numerator as quality improvement expenditures.²⁹¹

The Federal MLR Regulations also provide a lengthy list of activities that may not be considered quality improvement expenditures. For example, issuers may not include in the numerator the costs of activities designed primarily to control or contain costs, fraud prevention activities, provider credentialing, marketing expenses, or retrospective and concurrent utilization review.²⁹² Issuers also may not include the costs associated with “[e]stablishing or maintaining a claims adjudication system.”²⁹³

The IFR defined this exclusion to include the costs associated with converting “International Classification of Disease code sets from ICD-9 to ICD-10” because of the difficulty of “parsing expenses associated with ICD-10 conversions that may be solely ‘development and maintenance of claims adjudication systems’ as opposed to those that are uniquely conversion costs” that “will enhance the provision of quality care through the collection of better and more refined data.”²⁹⁴ After examining recently collected data relating to the conversion, considering public comments, and consulting with the Office of E-Health Standards and Services within CMS, HHS determined in the MLR Final Rule to permit issuers to count as quality improving activities the costs of “implementing ICD-10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer’s earned premium” and incurred in 2012 and 2013, when Federal HIPAA regulations require the conversion to be completed.²⁹⁵ In doing so, HHS recognized that the conversion to ICD-10 can improve “data collection for diagnoses and medical procedure coordination, patient safety, health outcomes, and medical research.”²⁹⁶ But issuers may not include as quality improving activities claims

²⁹⁰ See *id.* §§ 158.150(b)(2)(i)(A)(3), (b)(2)(ii)(D), (b)(2)(iii)(A)(5), (b)(2)(iv)(A)(6).

²⁹¹ *CCIO Technical Guidance CCIO 2011-002*, *supra* note 270, at 4.

²⁹² 45 C.F.R. §§ 158.150(c)(1), (7), (8), (10) & (11); see also Jost, *Implementing Health Reform*, *supra* note 271 (noting that “[t]he ACA does not allow insurers to count fraud prevention costs in the numerator, but the rule does allow insurers to offset their fraud detection and recovery expenses against actual recoveries if fraud recovery activities are successful”). Despite many comments urging the contrary, HHS decided in the MLR Final Rule to “continue to exclude fraud prevention activities from [quality improving activities].” MLR Final Rule Preamble, 76 Fed. Reg. at 76,577, *supra* note 265.

²⁹³ 45 C.F.R. § 158.150(c)(5).

²⁹⁴ IFR Preamble, 75 Fed. Reg. at 74,876-77, *supra* note 261.

²⁹⁵ 45 C.F.R. § 158.150(b)(2)(i)(A)(6); MLR Final Rule Preamble, 76 Fed. Reg. at 76,578, 75,581, *supra* note 265.

²⁹⁶ MLR Final Rule Preamble, 76 Fed. Reg. at 76,578, *supra* note 265.

adjudication systems costs or ICD-10 maintenance costs.²⁹⁷ HHS requested comment on the treatment of ICD-10 conversion costs in the MLR Final Rule.²⁹⁸

Interestingly, the Federal MLR Regulations distinguish retrospective and concurrent utilization review from prospective utilization review. The former may not be counted as a quality expenditure. The latter may, if it satisfies all of the elements of the definition of quality expenditures in the Federal MLR Regulations.²⁹⁹ For example, the rule specifically identifies “[p]rospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions” as an example of a quality improvement activity to improve patient safety, reduce medical errors, and lower infection and mortality rates.³⁰⁰ This illustrates the importance of evaluating expenditures by the factors set forth in the Federal MLR Regulations and not relying on labels that seem quality-oriented.

With these detailed definitions of what constitutes quality expenditures, HHS intended to be specific enough to provide clear guidance without stifling innovation.³⁰¹ The examples provided are illustrative and not exhaustive.³⁰² There is no upper or lower limit on the percentage of expenses an issuer may commit to quality expenditures as long as activities satisfy the criteria in the Federal MLR Regulations.³⁰³

2. Federal MLR Denominator

The MLR denominator includes the issuer’s premium revenue minus the issuer’s Federal and state taxes and licensing and regulatory fees.³⁰⁴

Premium revenue or “earned premium” is defined in Section 158.130 of the Federal MLR Regulations as “all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan.”³⁰⁵ The Federal MLR Regulations and Agency Guidance provide instructions on how to account for and report assumed or ceded policies.³⁰⁶ Issuers also are required to adjust earned premium to account for assessments paid to or subsidies received from Federal and state high risk pools; the portions of premiums associated with group conversion charges; any incurred

²⁹⁷ 45 C.F.R. § 158.150(c)(5); MLR Final Rule Preamble, 76 Fed. Reg. at 76,578, *supra* note 265.

²⁹⁸ MLR Final Rule Preamble, 76 Fed. Reg. at 76,578, *supra* note 265. On April 17, 2012, HHS proposed delaying the compliance date for ICD-10 conversion from October 1, 2013 to October 1, 2014. *See* Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for ICD–10–CM and ICD–10–PCS Medical Data Code Set; Proposed Rule, 77 Fed. Reg. 22,950 (Apr. 17, 2012) (to be codified at 45 C.F.R. pt. 162).

²⁹⁹ IFR Preamble, 75 Fed. Reg. at 74,876, *supra* note 261.

³⁰⁰ 45 C.F.R. § 158.150(b)(2)(iii)(A)(4).

³⁰¹ IFR Preamble, 75 Fed. Reg. at 74,876, *supra* note 261.

³⁰² *See CCIIO Technical Guidance CCIIO 2011-002*, *supra* note 270, at 4.

³⁰³ IFR Preamble, 75 Fed. Reg. at 74,876, *supra* note 261.

³⁰⁴ 45 C.F.R. § 158.221(c).

³⁰⁵ *Id.* § 158.130(a).

³⁰⁶ *See id.* § 158.130(a)(2)-(3); *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 5-6.

experience rating refunds, excluding any rebate paid based on an issuer's MLR, and unearned premium.³⁰⁷ Because the ACA's new risk adjustment, risk corridors, and reinsurance programs do not go into effect until 2014, HHS will issue future Guidance regarding how to treat these payments and receipts as adjustments to premium, as required by the ACA.³⁰⁸

Sections 158.161 and 158.162 detail which Federal and state taxes and licensing and regulatory fees may be deducted from the MLR denominator and which may not be excluded.³⁰⁹ The chairs of the Congressional committees that drafted the ACA penned a letter to HHS indicating that Congress only intended to exclude from the MLR denominator "Federal taxes and fees that relate specifically to revenue derived from the provision of health insurance coverage that were included in the [ACA]" to help fund the reforms but not Federal income or payroll taxes.³¹⁰ Despite this letter, the Federal MLR Regulations exclude all "Federal taxes and assessments allocated to health insurance coverage" from the MLR denominator.³¹¹ Only "Federal income taxes on investment income and capital gains" are not excluded from premium.³¹² The Federal MLR Regulations also itemize a variety of state income taxes and assessments that issuers may and may not exclude from earned premiums in the MLR denominator.³¹³ For example, the Final MLR Rule permits issuers to deduct from earned premiums the greater of the amount they paid in state premium taxes or in community benefit

³⁰⁷ See 45 C.F.R. § 158.130(b)(2)-(4); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264.

"Unearned premium means that portion of the premium paid in the MLR reporting year that is intended to provide coverage during a period which extends beyond the MLR reporting year." *Id.* § 158.103 (also defining group conversion charges and experience rating refunds); IFR Preamble, 75 Fed. Reg. at 74,873, *supra* note 261 (defining high risk pool subsidies, group conversion charges, experience rating refunds, and earned and unearned premium); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264.

³⁰⁸ See IFR Preamble, 75 Fed. Reg. at 74,873, *supra* note 261. As a recent issue brief noted, MLR calculations cannot be finalized without risk adjustment and reinsurance figures. See ROSS WINKELMAN ET AL., WAKELY CONSULTING GROUP (for State Health Reform Assistance Network), RISK ADJUSTMENT AND REINSURANCE: A WORK PLAN FOR STATE OFFICIALS, at 24 (Dec. 2011). As the authors point out, "[i]f HHS intends for MLR and risk corridor provisions to be applied after the effects of [risk adjustment and reinsurance] audits (or be applied before audit and then adjusted after audits) and the three year limit on audit completion is used, then final reconciliation for MLR and risk corridor programs may take several years to complete." *Id.* at 25.

³⁰⁹ See 45 C.F.R. §§ 158.161-162.

³¹⁰ Letter from Max Baucus, Senator, Chairman U.S. Senate Comm. on Finance, et al., to Honorable Kathleen Sebelius, Secretary, Dep't of Health & Human Servs. (Aug. 10, 2010), *available at* http://www.politico.com/static/PPM170_100811_taxes.html. Thus, these Senators and Representatives claimed that only "(1) the annual fee . . . based on each health insurer's market share based on net premiums written; . . . (2) the annual fee . . . on each health insurance policy (based on the average number of people covered under the policy); and (3) the tax imposed . . . on high-cost employer-sponsored health coverage" were to be excluded from premiums. *Id.*

³¹¹ 45 C.F.R. § 158.162(a)(1); see generally NAIC REPORT OF THE HEALTH CARE REFORM ACTUARIAL (B) WORKING GROUP TO THE HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE ON REFERRAL FROM THE PROFESSIONAL HEALTH INSURANCE ADVISORS (EX) TASK FORCE REGARDING PRODUCER COMPENSATION IN THE PPAC MEDICAL LOSS RATIO CALCULATION, at 20 (May 26, 2011), http://www.naic.org/documents/committees_b_110607_hcrawlw_report.pdf; Haberkorn, *supra* note 280.

³¹² Federal income taxes on investment income and capital gains are considered non-claims costs that must be separately reported in the MLR report, as discussed in Section D below. See 45 C.F.R. § 158.162(a)(2).

³¹³ See *id.* § 158.162(b).

expenditures, “limited to the highest premium tax rate in the State.”³¹⁴ Issuers also may exclude from premiums the amounts of “statutory assessments to defray operating expenses of any State or Federal department, and examination fees in lieu of premium taxes as specified by State law.”³¹⁵ CMS recently clarified that this language encompasses user fees paid to a State or Federal Exchange such that these fees constitute regulatory fees that may be deducted from premium in the MLR denominator.³¹⁶

3. Federal Aggregation and Tabulation

Generally, each legal entity licensed in each state must calculate separate MLRs for the individual, small group, and large group markets within each state, unless the state exercises its discretion to require the small group and individual markets to be merged, in which case these markets’ data may be merged for purposes of calculating an issuer’s MLR and any rebates owed.³¹⁷ Federal law, however, permits aggregation where a group health plan offers only in-network coverage through one issuer and only out-of-network coverage through an affiliated entity. Even though these affiliated issuers are distinct legal entities, the Federal MLR Regulations create an exception that permits them to aggregate their MLR data when the affiliation is solely for the purpose of offering a choice of coverage option to employees of a single employer so that their “experience may be treated as if it were all related to the contract provided by the in-network issuer.”³¹⁸

³¹⁴ See *id.* §§ 158.162(b)(1)(vi), (vii), & (c); MLR Final Rule Preamble, 76 Fed. Reg. at 76,579, *supra* note 265.

³¹⁵ 45 C.F.R. § 158.161(a); IFR Preamble, 75 Fed. Reg. at 74,878, *supra* note 261. “[F]ines and penalties of regulatory authorities, and fees for examinations by any State or Federal departments other than as specified in § 158.161(a),” however, are not excluded from premium and are treated as other non-claims costs for purposes of the MLR calculations. See 45 C.F.R. § 158.161(b).

³¹⁶ *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 6-7.

³¹⁷ See 45 C.F.R. §§ 158.120 & 158.220(a). An issuer in a state that requires merger of the small group and individual markets still must report the individual and small group market data separately in its annual MLR report, as discussed below. See *id.*; see generally Jost, *Implementing Health Reform*, *supra* note 271 (“MLRs are calculated separately for each licensed entity within a state by market segment (individual or small or large group).”). The Federal MLR Regulations provide additional instructions for issuers offering group health insurance coverage in multiple states, group health insurance coverage with dual contracts, individual market business sold through an association or trust, and employer business issued through a group trust or multiple employer welfare association. See 45 C.F.R. § 158.120(b)-(d); see also MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264; *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 4-5; Memorandum from Gary Cohen, Acting Director, Office of Oversight, CMS, *Insurance Standards Bulletin Series – Information: Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations* (Sept. 1, 2011), http://ccio.cms.gov/resources/files/association_coverage_9_1_2011.pdf. Section 158.120 also provides for separate aggregation and reporting of mini-med, expatriate, and student health insurance plans, as discussed below. See 45 C.F.R. § 158.120(d)(3)-(5).

³¹⁸ See 45 C.F.R. § 158.120(c); IFR Preamble, 75 Fed. Reg. at 74,869-70, *supra* note 261. HHS explained that this exception “maintains the experience of employees in a single reporting entity.” *Id.* at 74,870. Issuers choosing to aggregate their MLR data pursuant to this exception must do so for at least three MLR reporting years. See 45 C.F.R. § 158.120(c). Where affiliated issuers cover employees in more than one state, however, each issuer has to attribute its business to “each State based on the situs of the contract.” *Id.* § 158.120(b).

Similarly, the Federal MLR regulations permit two or more affiliated issuers that sell insurance to the same employer to reallocate the incurred claims and activities that improve health care quality for that employer among the affiliates for loss ratio purposes so that each affiliate will have “the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as . . . the employer group in the aggregate.”³¹⁹ Although this formally is treated as an adjustment to incurred claims in the Federal regulations, it effectively aggregates the experience of these separate, though affiliated, legal entities with respect to that employer.

Generally, MLR for a given reporting year is calculated using the MLR formula discussed above based on three years of data: the data for the reporting year that is being calculated as well as the data for the two prior MLR reporting years.³²⁰ The Federal MLR Regulations include special rules for calculating MLR for the 2011 and 2012 reporting years, when three years of data will not be available.³²¹ The loss ratio is rounded to three decimal places, so “if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent.”³²²

B. Federal Minimum MLR Requirements

To “[e]nsur[e] that consumers receive value for their premium payments,”³²³ the ACA then establishes the minimum ratios, according to this formula, that issuers offering group or individual health insurance coverage must satisfy beginning no later than January 1, 2011. The minimum MLR that issuers in the large group market must satisfy is 85%; issuers in the individual or small group markets have a minimum MLR of 80%.³²⁴

Under the ACA, the large group market means the health insurance market in which individuals obtain health insurance coverage through a group health plan maintained by a large employer, which is defined as “an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.”³²⁵

The small group market, then, is for group plans offered to individuals by small employers, which are defined as employers “who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who

³¹⁹ See 45 C.F.R. § 158.140(b)(5)(i). If an issuer chooses to make this adjustment, it must do so for a minimum of three MLR reporting years. See *id.*

³²⁰ See 42 U.S.C. § 300gg-18(b)(1)(B)(ii); 45 C.F.R. § 158.220(b); see also *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 8 (reminding insurers to calculate the MLR numerator, beginning in the 2013 MLR reporting year, by adding three years of experience together).

³²¹ See 45 C.F.R. § 158.220(c).

³²² *Id.* § 158.221(a)(2).

³²³ See 42 U.S.C. § 300gg-18(b); IFR Preamble, 75 Fed. Reg. at 74,871, *supra* note 261.

³²⁴ See 42 U.S.C. §§ 300gg-18(b)(1)(A)(i) and (ii).

³²⁵ See *id.* § 18024(a)(3) & (b)(1).

employ[] at least 1 employee on the first day of the plan year.”³²⁶ As a result, Federal law contemplates situations when a group of one will be deemed part of the small group market. CMS recently provided Guidance regarding when to report a health plan with small group experience as a group of one and when it is reported with individual market experience.³²⁷ Where a sole proprietor and/or a spouse employee are the only employees enrolled in a plan, it is not deemed a group plan because they are not deemed employees under Federal law. But if the sole enrollee of a plan is an employee but neither the owner nor the owner’s spouse, the plan is reported with the issuer’s small group experience.³²⁸

Recognizing that some states defined small employer as having no more than an average of fifty employees in a given year, Congress authorized States to substitute “51 employees” for “101 employees” in the definition of large employer and “50 employees” for “100 employees” in the definition of small employer for plan years beginning prior to January 1, 2016.³²⁹ A state will be deemed to elect to use fifty employees in its definition of a small employer for MLR purposes until 2016 if it does so for other purposes and does not indicate a different choice.³³⁰

CMS recently provided Guidance regarding the methods an issuer should employ to count the number of employees covered by a group policy that does not cover all of an employer’s employees, where the issuer does not have access to information needed to establish the employer’s total number of employees, and where this unavailable information determines whether the plan is bound by the small or large group MLR requirements.³³¹ In these circumstances, “issuers should make every attempt to accurately count the number of employees employed by a group policyholder” at the point of sale so that they know whether the group is in the small or large group market.³³² But where an issuer does not have access to, and is not on notice of, this information, it “may determine the group size for MLR reporting purposes and the minimum MLR standard based on the information available to the issuer.”³³³ CMS also recently clarified that “employee” includes full-time, part-time, and seasonal employees.³³⁴

The ACA scripts two possible avenues for a state to have a minimum MLR that varies from its statutorily mandated minimums. First, each state has discretion to enact a regulation setting a higher minimum MLR percentage in the large, small, or individual markets in that

³²⁶ See *id.* § 18024(a)(3) & (b)(2).

³²⁷ See *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 3.

³²⁸ *Id.*

³²⁹ See 42 U.S.C. § 18024(b)(3).

³³⁰ See *CCIIO Technical Guidance CCIIO 2011-002*, *supra* note 270, at 2.

³³¹ See *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 3-4.

³³² *Id.* at 4.

³³³ *Id.*

³³⁴ *CCIIO Technical Guidance CCIIO 2011-04*, *supra* note 274, at Question and Answer #19.

state.³³⁵ If a state elects to set its MLR higher than the minimum set forth in the ACA, it must “seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.”³³⁶

In addition, the Secretary has discretion to adjust a state’s minimum MLR percentage in the individual market if she “determines that application of such 80 percent may destabilize the individual market in such State.”³³⁷ This discretion addresses concerns that the individual markets in some states might need transitional relief to maintain issuer solvency and competition in these markets.³³⁸ The Secretary’s express statutory discretion to adjust a state’s MLR exists only in the individual market.³³⁹

Because this adjustment is not issuer specific and would apply to all issuers in the individual market in a state, the state’s insurance commissioner, superintendant, or comparable official must request an adjustment from the Secretary.³⁴⁰ Section 158.311 of the Federal MLR regulations provides that “[a] State may request that an adjustment to the MLR standard be for up to three MLR reporting years.”³⁴¹ Some have interpreted this language to permit states to seek an adjustment only for reporting years 2011, 2012, and/or 2013.³⁴² But the regulation limits only the number of years that any one request may involve and does not limit future requests for adjustments for up to three years at a time.³⁴³

The Federal MLR Regulations provide detailed requirements for what a state must submit to support its request for an adjustment to help the Secretary assess the risk of market destabilization, including that each state must propose, explain, and justify the specific

³³⁵ See 42 U.S.C. §§ 300gg-18(b)(1)(i)-(ii); 45 C.F.R. § 158.211.

³³⁶ See 42 U.S.C. § 300gg-18(b)(2); 45 C.F.R. § 158.211(b); see also *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 7 (clarifying that “HHS will only apply a higher MLR to issuers in States that have taken affirmative action since March 23, 2010 indicating that they have exercised their option pursuant to 45 CFR § 158.211 to require issuers to meet a higher MLR standard for Federal MLR purposes”).

³³⁷ See 42 U.S.C. § 300gg-18(b)(1)(A)(ii); 45 C.F.R. § 158.301; see also 42 U.S.C. § 300gg-18(d) (preserving the Secretary’s discretion to adjust the minimum MLR if “appropriate on account of the volatility of the individual market due to the establishment of State Exchanges”). Section E of Appendix C reviews the requests for adjustments filed as of February 16, 2012.

³³⁸ IFR Preamble, 75 Fed. Reg. at 74,886, *supra* note 261.

³³⁹ See *id.*

³⁴⁰ See 45 C.F.R. § 158.310; IFR Preamble, 75 Fed. Reg. at 74,887, *supra* note 261.

³⁴¹ 45 C.F.R. § 158.311; see also IFR Preamble, 75 Fed. Reg. at 74,887, *supra* note 261.

³⁴² See, e.g., *Medical Loss Ratios for Health Insurance: Provisions in the Federal Affordable Care Act of 2010 (ACA)*, NATIONAL CONFERENCE OF STATE LEGISLATURES (updated Jan. 4, 2012), <http://www.ncsl.org/issues-research/health/health-insurance-medical-loss-ratios-state-implement.aspx> (“States may apply for waivers to allow a different timetable or percentages on a temporary, annual basis between 2011 and 2014.”).

³⁴³ For example, when Indiana sought an adjustment for MLR reporting years 2011-2014, HHS notified the Commissioner that it would consider the request for 2011-2013 and that the state could “request an adjustment for MLR reporting year 2014 in the future if, at that time, it deems circumstances to so warrant.” Letter from Steven B. Larsen, Deputy Admin’r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Stephen W. Robertson, Comm’r, Indiana Dep’t of Ins., at 2 (Nov. 27, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/indiana/in_mlr_adj_determination_letter.pdf.

adjustment it seeks.³⁴⁴ Recent Guidance from CMS makes plain that while the Secretary may adjust the actual MLR percentage required, “a State may not propose definitions or methods for calculating the MLR that differ from those established by the federal law and regulations.”³⁴⁵

The Federal MLR Regulations also itemize the criteria the Secretary may consider in evaluating a state’s request, including the number of issuers reasonably likely to exit the state and the number of covered lives that would be affected if they did; impact on access to brokers and agents; alternate coverage options in the individual market in that state; and impact on premiums charged.³⁴⁶ Although the Secretary does not need to “find destabilization to a certainty,” she also may not exercise this discretion based merely on a “remote possibility.”³⁴⁷ Rather, as the Federal regulations make clear, there must be a reasonable likelihood that application of the 80 percent MLR requirement will destabilize the individual market in a state to warrant an adjustment.³⁴⁸

A state’s request for an adjustment, including all materials submitted in support of the request, will be deemed public and posted on the Secretary’s web site.³⁴⁹ The public will have an opportunity to comment on a state’s request,³⁵⁰ and the state making the request or the Secretary may hold a public hearing to create an evidentiary record.³⁵¹ After the Secretary determines that she has received all of the material required by the Federal MLR Regulations, she must make a determination on a state’s request within thirty days, unless she exercises her discretion to grant an extension of this time by no more than thirty additional days.³⁵² The Federal regulations impose additional burdens if a state makes a subsequent request for an adjustment.³⁵³

C. Federal Rebate Required

Beginning not later than January 1, 2011, issuers offering group or individual coverage, including grandfathered plans, that fail to meet their respective minimum MLRs (as established

³⁴⁴ See 45 C.F.R. §§ 158.320-323; see also *OCIIO Technical Guidance (OCIIO 2010 – 2A): Process for a State to Submit a Request for Adjustment to the Medical Loss Ratio Standard of PHS Act Section 2718* (Dec. 17, 2010), http://cciio.cms.gov/programs/marketreforms/mlr/12-17-2010ociio_2010-2a_guidance.pdf (detailing how a state must submit its MLR adjustment request to the Secretary).

³⁴⁵ *CCIIO Technical Guidance CCIIO 2011-002*, *supra* note 270, at 7.

³⁴⁶ See 45 C.F.R. § 158.330.

³⁴⁷ IFR Preamble, 75 Fed. Reg. at 74,886, *supra* note 261.

³⁴⁸ 45 C.F.R. § 158.301.

³⁴⁹ See *id.* § 158.341.

³⁵⁰ See *id.* § 158.342.

³⁵¹ See *id.* § 158.343.

³⁵² See *id.* § 158.345. The Federal MLR Regulations also provide a mechanism by which a state may seek reconsideration of a denial of a request for an MLR adjustment. See *id.* § 158.346.

³⁵³ See *id.* § 158.350.

by the statute, set higher by individual states, or set lower by the Secretary in the individual market) must provide an annual rebate to enrollees on a pro rata basis.³⁵⁴

The annual rebate will equal the amount the applicable minimum MLR exceeds the issuer's MLR multiplied by the issuer's "total amount of premium revenue (excluding Federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance)."³⁵⁵ In other words, the rebate will equal the applicable minimum MLR minus the issuer's MLR and then multiplied by the denominator in the MLR calculation.³⁵⁶ As the preamble to the IFR explains, "rebates are essentially a retrospective adjustment or correction to premiums."³⁵⁷

Issuers must provide any rebate owed to an enrollee by August 1 in the year following the end of the MLR reporting year or be subject to interest.³⁵⁸ Thus, the first rebates under the Federal MLR requirements must be paid by August 1, 2012. Section 158.270 of the Federal MLR Regulations establishes a mechanism for a state commissioner, superintendent, or other responsible official to ask the Secretary to defer all or a portion of rebates due from an issuer based on solvency concerns.³⁵⁹

Issuers may provide rebates owed to current enrollees via a premium credit, lump-sum check, or as a lump-sum reimbursement to the credit card or debit account used to pay the premium.³⁶⁰ When issuers owe rebates to former enrollees in the individual market, however,

³⁵⁴ See 42 U.S.C. § 300gg-18(b)(1); see also 45 C.F.R. § 158.240(a).

³⁵⁵ See 42 U.S.C. § 300gg-18(b)(1)(B)(i); see also 45 C.F.R. § 158.240(c).

³⁵⁶ See IFR Preamble, 75 Fed. Reg. at 74,883, *supra* note 261. As discussed above in the MLR Formula Section (A.3), beginning in 2013, MLR calculations for purposes of establishing the amount of any rebate will be based on accumulated data from a three year period. See 42 U.S.C. § 300gg-18(b)(1)(B)(ii); see also 45 C.F.R. § 158.220(b)-(c) (explaining how MLR data for three year periods will be aggregated and how calculations will be made in years 2011 and 2012); IFR Preamble, 75 Fed. Reg. at 74,880, *supra* note 261 (stating that data from a three-year period will be used to calculate an issuer's MLR for the 2013 MLR reporting year "for purposes of determining whether any rebate is owed and, if so, in what amount" and that this data "should consist of the accumulated experience, rather than the average three MLRs").

³⁵⁷ See IFR Preamble, 75 Fed. Reg. at 74,870, *supra* note 261. Note that the Federal formula for determining the rebate amount does not achieve the exact minimum MLR required by law after the refund. This is because the refund is treated as an addition to claims (which it is not) rather than a reduction to premium (which it is). To take a simple example based on MLR calculated as claims divided by premium (and not factoring in the Federal reduction of taxes from premiums, for example), if an issuer in the small group market received \$100 in premiums but only spent \$70 on claims, it would have a loss ratio of 70 percent. According to the Federal rebate formula, it would owe a \$10 rebate. But by returning \$10 of premiums to policyholders, the MLR denominator decreases to \$90 because the issuer received \$10 fewer in premiums (or, put another way, policyholders paid \$10 less in premiums). The numerator remains \$70 because the carrier has not increased its spending on claims or quality improving activities. Thus, the resulting MLR is 70/90, or 77.8 percent, shy of the 80 percent minimum. To achieve the minimum MLR through the rebate process, the rebate calculation methodology would need to be amended to take into consideration that the rebate is a reduction to premium and not an addition to claims.

³⁵⁸ 45 C.F.R. § 158.240(e)-(f). Note that the Federal methodology does not require issuers to pay interest on rebates paid by the due date despite the considerable time lag between when policyholders pay their premiums and when issuers must remit rebates.

³⁵⁹ *Id.* § 158.270.

³⁶⁰ *Id.* § 158.241(a).

there is no premium credit option, but issuers may choose between making a lump-sum check or reimbursement.³⁶¹ CMS recently indicated that issuers generally may use pre-paid debit or credit cards to distribute rebates to current or former enrollees, as long they comply with a number of requirements, including, but not limited to, that the policyholder or subscriber does not incur any fees by using or not using the card, may convert the card to cash, and may opt-out of the card and request a check; and the card includes the policyholder or subscriber's name and has no expiration date.³⁶² Issuers thus have some ability to choose the mechanism for paying rebates that imposes the least administrative burden.³⁶³

The statute requires that rebates be paid "to each enrollee" on a "pro rata basis."³⁶⁴ The Federal MLR Regulations generally define "enrollee" as "an individual who is enrolled . . . in group health insurance coverage, or an individual who is covered by individual insurance coverage, at any time during an MLR reporting year."³⁶⁵ To avoid requiring issuers to send rebates to each person covered by an insurance plan, such as dependents and spouses, the Federal MLR Regulations define "enrollee," solely when used to identify the person or entity entitled to receive a rebate, as "the subscriber, policyholder, and/or government entity that paid the premium."³⁶⁶ In the individual market, subscriber means the individual who purchases an individual policy and who is responsible for the payment of premiums."³⁶⁷ In the small and large group markets, "subscriber means the individual, generally the employee, whose eligibility is the basis for the enrollment in the group health plan and who is responsible for the payment of premiums."³⁶⁸ "Policyholder means any entity that has entered into a contract with an issuer to receive health insurance coverage as defined in section 2791(b) of the PHS Act."³⁶⁹ Thus, rebates must "be provided on a pro rata basis to the person or entity that paid the premium on behalf of the enrollee."³⁷⁰

In the individual market, this means an issuer must provide the rebate to an enrollee, although where individual policies insure more than one person, issuers may provide a lump sum to the subscriber who paid the premium on behalf of all enrollees covered by the policy.³⁷¹

The Federal rules are more complicated in the large and small group markets because of the need to balance the reality of potential tax consequences (if premiums paid with pre-tax dollars are rebated to enrollees) and logistical concerns involved with requiring issuers rather

³⁶¹ *Id.* § 158.241(b).

³⁶² See *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 8-9.

³⁶³ See IFR Preamble, 75 Fed. Reg. at 74,884, *supra* note 261.

³⁶⁴ See 42 U.S.C. § 300gg-18(b)(1).

³⁶⁵ 45 C.F.R. § 158.103.

³⁶⁶ *Id.* § 158.240(b).

³⁶⁷ *Id.* § 158.103.

³⁶⁸ *Id.*

³⁶⁹ *Id.*

³⁷⁰ IFR Preamble, 75 Fed. Reg. at 74,884, *supra* note 261.

³⁷¹ 45 C.F.R. § 158.242(a).

than policyholders to distribute rebates against the statutory obligation to ensure rebates benefit enrollees.³⁷² Thus, the Federal Regulations generally permit large and small group issuers to provide rebates to policyholders but include “protections designed to satisfy, in a practical way, the objective of benefitting subscribers and their related enrollees.”³⁷³

When the policyholder is a “non-Federal governmental group health plan,” the regulations identify three options from which the policyholder must choose for how to use “the amount of the rebate that is proportionate to the total amount of premium paid by all subscribers under the policy” to ensure that it is used “for the benefit of subscribers,” including reducing future premiums and paying a cash refund to subscribers.³⁷⁴ If any portion of the rebate is “based upon former subscribers’ contributions to premium,” policyholders must aggregate these amounts and use them “for the benefit of current subscribers in the group health plan” according to one of these three regulatory options.³⁷⁵

When the policyholder is a group plan but neither a governmental plan nor “subject to the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 et seq.) (ERISA),”³⁷⁶ the issuer may pay the rebate to the policyholder only if it “receives a written assurance from the policyholder that the rebates will be used to benefit enrollees.”³⁷⁷ Absent that written assurance, “the issuer must distribute the rebate directly to the subscribers of the group health plan covered by the policy during the MLR reporting year on which the rebate is based by dividing the entire rebate, including the amount proportionate to the amount of premium paid by the policyholder, in equal amounts to all subscribers entitled to a rebate without regard to how much each subscriber actually paid toward premiums.”³⁷⁸

To further complicate matters, if, at the time of the rebate payment, the group health plan has been terminated, and the issuer is unable to locate the policyholder, despite “reasonable efforts, . . . the issuer must distribute the rebate directly to the subscribers of the terminated group health plan by dividing the entire rebate, including the amount proportionate

³⁷² MLR Final Rule Preamble, 76 Fed. Reg. at 76,579, *supra* note 265.

³⁷³ *Id.*

³⁷⁴ 45 C.F.R. § 158.242(b)(1); *see also* MLR Final Rule Preamble, 76 Fed. Reg. at 76,579-80, *supra* note 265; MLR Rebate IFR Preamble, 76 Fed. Reg. at 76,596-97, *supra* note 267.

³⁷⁵ 45 C.F.R. § 158.242(b)(2).

³⁷⁶ CMS does not have authority to regulate rebates owed by ERISA or non-governmental plans, such as church plans. *See* MLR Final Rule Preamble, 76 Fed. Reg. at 76,579, *supra* note 265. “[R]ebates paid in connection with policies for ERISA-covered employee benefit plans may constitute plan assets that are required to be handled in accordance with the requirements of ERISA.” *Id.* at 76,580. HHS noted that the Department of Labor published a Guidance contemporaneously with the Final MLR Rule “regarding the duties of employers/plan sponsors and other fiduciaries responsible under sections 403, 404 and 406 of ERISA for decisions relating to MLR rebates.” *Id.*; *see Guidance on Rebates for Group Health Plans Paid Pursuant to the Medical Loss Ratio Requirements of the Public Health Service Act*, Technical Release No. 2011-04, <http://www.dol.gov/ebsa/newsroom/tr11-04.html> (Dec. 2, 2011).

³⁷⁷ 45 C.F.R. § 158.242(b)(3); MLR Final Rule Preamble, 76 Fed. Reg. at 76,580, *supra* note 265.

³⁷⁸ 45 C.F.R. § 158.242(b)(3).

to the amount of premium paid by the policyholder, in equal amounts to all subscribers entitled to a rebate without regard to how much each subscriber actually paid toward premiums.”³⁷⁹

The Federal MLR Regulations do not require issuers to distribute de minimis rebates to enrollees.³⁸⁰ In the individual market, a rebate is deemed de minimis if the issuer owes the subscriber less than \$5.³⁸¹ Similarly, issuers distributing rebates in the group market directly to subscribers are not required to distribute rebates totaling less than \$5 to each subscriber.³⁸² But where an issuer distributes a group policy rebate to the policyholder, the rebate is considered de minimis when “the total rebate owed to the policyholder and the subscribers combined is less than \$20 for a given MLR reporting year.”³⁸³ Issuers, however, may not retain these funds. Instead, issuers must aggregate all de minimis rebates not provided to enrollees by individual, small, and large group markets in a state and then distribute this aggregated amount evenly among the pool of enrollees receiving rebates for the same MLR reporting year.³⁸⁴

The Federal MLR Regulations require issuers required to pay rebates to provide notices to policyholders and subscribers of group health plans and subscribers in the individual market at the time rebates are paid each year, which must contain “information about the MLR and its purpose, the MLR standard, the issuer’s MLR, and the rebate being provided.”³⁸⁵ The regulations also include requirements for the various types of group plans to ensure their notices to policyholders and subscribers address how the issuer is complying with the requirement that rebates benefit enrollees.³⁸⁶ HHS recently published the required notices to policyholders and subscribers.³⁸⁷

Originally, only issuers that had to pay a rebate had to provide notice to policyholders and subscribers. But on May 16, 2012, HHS added Section 158.251 to the Federal MLR Regulations that requires issuers that meet or exceed the applicable MLR requirements to provide notice to each subscriber and policyholder of group plans and each subscriber of individual plans.³⁸⁸ HHS believes providing MLR information to all policyholders and subscribers, even if they are not receiving rebates, will “further the goals of improving

³⁷⁹ *Id.* § 158.242(b)(4); *see also* MLR Final Rule Preamble, 76 Fed. Reg. at 76,581, *supra* note 265.

³⁸⁰ *See* 45 C.F.R. § 158.243; MLR Final Rule Preamble, 76 Fed. Reg. at 76,581, *supra* note 265.

³⁸¹ *See* 45 C.F.R. § 158.243(a)(2).

³⁸² *See id.* § 158.243(a)(1).

³⁸³ *Id.* § 158.243(a)(1).

³⁸⁴ *Id.* § 158.243(b); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264.

³⁸⁵ MLR Final Rule Preamble, 76 Fed. Reg. at 76,580, *supra* note 265; *see also* 45 C.F.R. § 158.250. HHS recently published the required notices to policyholders and subscribers. *See* Medical Loss Ratio Notices to Policy Holders and Subscribers and Instructions, published as part of the MLR Paperwork Reduction Act (PRA) package (CMS-10418) (Apr. 2, 2012), *available at* <http://cciio.cms.gov/resources/other/index.html#mlr>.

³⁸⁶ *See* 45 C.F.R. § 158.250; MLR Final Rule Preamble, 76 Fed. Reg. at 76,580, *supra* note 265.

³⁸⁷ *See* Medical Loss Ratio Notices to Policy Holders and Subscribers and Instructions, published as part of the MLR Paperwork Reduction Act (PRA) package (CMS-10418) (Apr. 2, 2012), *available at* <http://cciio.cms.gov/resources/other/index.html#mlr>.

³⁸⁸ *See* 45 C.F.R. § 158.251(a).

transparency of health insurance markets, supporting more informed purchase decisions, and promoting competition and efficiency.”³⁸⁹ After considering public comments, however, the agency decided not to require these notices to include information about the issuer’s prior or current year MLRs, opting instead to require the notices to refer consumers to HHS’ web site, healthcare.gov, where MLR data will be available.³⁹⁰ HHS also opted to limit this notice requirement to the 2011 MLR reporting year, when the agency believes that “consumer knowledge of the MLR is low and the greatest benefit can be achieved by providing enrollees with educational information.”³⁹¹ The regulation also exempts mini-med, expatriate, and non-credible plans from this notice requirement.³⁹² The preamble to this regulation also notes that this requirement will not apply to issuers of student health insurance coverage since the Federal MLR requirements generally do not apply to these plans until January 1, 2013.³⁹³ The final rule specifies the language that issuers must include in their notices, which must be sent “with the first plan document that the issuer provides to enrollees on or after July 1, 2012.”³⁹⁴

Issuers also must submit a detailed report to the Secretary concerning the rebates provided in a given MLR reporting year, which is due on June 1, along with the MLR report discussed below.³⁹⁵ If issuers are unable, after a good faith effort, to locate a former enrollee to pay a required rebate, they “must comply with any applicable State law.”³⁹⁶

Recent Guidance from CMS also considers whether an issuer may offer its policyholders a “premium holiday” during which it temporarily suspends or reduces premiums during the MLR reporting year to help increase its MLR to the applicable Federal minimum and thus avoid having to pay rebates.³⁹⁷ Because State law governs whether such a holiday is permissible, CMS directs issuers to ask State regulators. If a State permits the issuer to institute this pricing strategy, however, CMS outlined various expectations it has about any premium holiday, including that it “would be provided in a non-discriminatory manner, meaning that it would be offered to every policyholder in a State’s market and not based on product type or the experience of a particular policy.”³⁹⁸

³⁸⁹ Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act; Final Rule, 77 Fed. Reg. 28,790, 28,797 (May 16, 2012) (to be codified at 45 C.F.R. pt. 158) [hereinafter MLR Notice Final Rule Preamble].

³⁹⁰ *Id.* at 28,792; see generally Jay Hancock, *Insurers Push Back on Consumer Rebate Letter*, KAISER HEALTH NEW (Mar. 29, 2012) (summarizing industry objections to notice proposals).

³⁹¹ MLR Notice Final Rule Preamble, 77 Fed. Reg. at 28,792, *supra* note 389.

³⁹² See 45 C.F.R. § 158.251(b).

³⁹³ MLR Notice Final Rule Preamble, 77 Fed. Reg. at 28,792, *supra* note 389.

³⁹⁴ 45 C.F.R. § 158.251(a)(2) & (4). The regulation also specifies the mandatory font and permissible placement and transmission of these notices. *Id.* § 158.251(a)(3); MLR Notice Final Rule Preamble, 77 Fed. Reg. at 28,792, *supra* note 389.

³⁹⁵ 45 C.F.R. § 158.260.

³⁹⁶ *Id.* § 158.244.

³⁹⁷ See *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 5.

³⁹⁸ *Id.*

D. Federal Report Required

Each health insurance issuer that offers group or individual health insurance coverage must submit a report to the Secretary with respect to each plan year concerning its MLR for that reporting year.³⁹⁹ The report includes all of the data needed to calculate the issuer's MLR and any required rebates, which were discussed in detail above in the MLR formula and rebate sections of this Appendix, including earned premium, reimbursement for clinical services provided to enrollees, activities that improve health care quality, and Federal and state taxes and licensing and regulatory fees.⁴⁰⁰

In addition to detailing the components of the loss ratio numerator and denominator that must be reported annually, Section 158.160 of the Federal MLR Regulations also require the loss ratio report to include data that will not be used in calculating the MLR. For example, the required report must detail non-claims costs that will not be factored into the MLR formula.⁴⁰¹ By doing so, issuers are itemizing how they have spent premium dollars "other than to provide reimbursement for clinical services covered by the benefit plan, expenditures for activities that improve health care quality, and Federal and State taxes and licensing or regulatory fees" ⁴⁰² By requiring these data, HHS intended "to provide consumers with information needed to better understand how much of the premium paid to an issuer is used to reimburse providers for covered services, to improve health care quality, and to pay for the 'non-claims,' or administrative expenses, incurred by the issuer."⁴⁰³ Section 158.160 itemizes these non-claims or administrative costs as including: cost-containment expenses that are not quality expenditures; loss adjustment expenses that are not classified as cost containment expenses; direct sales salaries, workforce salaries, and benefits; agents and brokers fees and commissions; general and administrative expenses; and community benefit expenditures.⁴⁰⁴

The report also must include the Federal and state taxes and licensing and regulatory fees that may not be excluded from the MLR denominator but are instead considered other non-claims costs.⁴⁰⁵

³⁹⁹ See 42 U.S.C. § 300gg-18(a). HHS interprets "plan year" in the statute to mean the MLR reporting year, which is defined as the calendar year, recognizing that issuers would not be able to collect data across plans in the same market that have different plan years. See IFR Preamble, 75 Fed. Reg. at 74,868, *supra* note 261.

⁴⁰⁰ See generally 45 C.F.R. §§ 158.110, 158.130-151, 158.161-162.

⁴⁰¹ *Id.* § 158.160(a); see also IFR Preamble, 75 Fed. Reg. at 74,877, *supra* note 261 (itemizing many additional examples of non-claims costs).

⁴⁰² 45 C.F.R. § 158.160(a).

⁴⁰³ IFR Preamble, 75 Fed. Reg. at 74,866, *supra* note 261.

⁴⁰⁴ 45 C.F.R. § 158.160(b)(2); see also *id.* § 158.162(c) (defining community benefit expenditures); MLR Final Rule Preamble, 76 Fed. Reg. at 76,578, *supra* note 265 (declining to expand definition of community benefit expenditures); IFR Preamble, 75 Fed. Reg. at 74,877, *supra* note 261 (itemizing many additional examples of non-claims costs). See *infra* notes 657-675 and accompanying text in Appendix C for discussions of legislative and lobbying efforts to exclude broker commissions from the Federal MLR formula.

⁴⁰⁵ See 45 C.F.R. §§ 158.161(b), 158.162(a)(2) & (b)(2).

Section 158.120 of the Federal MLR Regulations requires issuers to submit an MLR report for each state in which it is licensed to issue health insurance.⁴⁰⁶ State level reporting is necessary, given the states' discretion to set higher MLR requirements within their boundaries.⁴⁰⁷ Each report must aggregate data separately for the large group, small group, and individual markets.⁴⁰⁸ The preamble to the IFR explains that HHS considered but decided against disaggregating products by type of coverage, such as high-deductible or preferred provider organization ("PPO") plans.⁴⁰⁹ Generally, the state where a policy was issued determines the report in which that policy will be reported.⁴¹⁰

Section 158.170 of the Federal MLR Regulations provides specific rules for allocating expenses in the report.⁴¹¹ Generally, each expense must be reported under only one type of category, although the Federal regulations provide guidelines for when it is permissible to prorate expenses among and between categories. Issuers must allocate expenses ("including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs") to each health insurance market in each state and include a "detailed description of the methods used" in making such allocations.⁴¹² They also must include in the report "[a] detailed description of each expense element . . . , including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated."⁴¹³ The Federal MLR Regulations further state that allocation "should be based on a generally accepted accounting method that is expected to yield the most accurate results."⁴¹⁴ Issuers must maintain and make available to the Secretary the data used to allocate expenses, "with all supporting information required to determine that the methods identified . . . were accurately implemented in preparing the report"⁴¹⁵

⁴⁰⁶ See *id.* § 158.120(a).

⁴⁰⁷ See IFR Preamble, 75 Fed. Reg. at 74,866, *supra* note 261.

⁴⁰⁸ See 45 C.F.R. § 158.120(a); see also *id.* § 158.220(a) (requiring aggregation by state and by market). As discussed in subsection E.2 of this Appendix, the Federal MLR regulations provide for separate reporting of expatriate and mini-med plans, see *id.* § 158.120(d)(3)-(4), and deferred reporting for plans with newer business, see *id.* § 158.121.

⁴⁰⁹ IFR Preamble, 75 Fed. Reg. at 74,869, *supra* note 261.

⁴¹⁰ See 45 C.F.R. § 158.120(a). The Federal MLR Regulations include specific guidance for group health insurance coverage in multiple states and with dual contracts and for coverage sold through an association, group trust, or multiple employer welfare association. See *id.* § 158.120(b)-(d); see also MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264; *CCIIO Technical Guidance 2012-002*, *supra* note 261, at 4-5; Memorandum from Gary Cohen, Acting Director, Office of Oversight, CMS, *Insurance Standards Bulletin Series – Information: Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations* (Sept. 1, 2011), http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.pdf.

⁴¹¹ See 45 C.F.R. § 158.170.

⁴¹² *Id.* § 158.170(b).

⁴¹³ *Id.* § 158.170(b) and (c).

⁴¹⁴ *Id.* § 158.170(b)(1).

⁴¹⁵ *Id.* § 158.170(d).

These reports generally are due on June 1 of the year following the end of an MLR reporting year and must be submitted on a form prescribed by the Secretary.⁴¹⁶ By making the reports due June 1, issuers may include “claims for services provided during the MLR reporting [that is, calendar] year that are processed and paid in the three months following the end of the MLR reporting year” and still have two months to tabulate the data.⁴¹⁷ The first reports required by the ACA are due June 1, 2012. Consistent with the ACA’s intent to make health insurance issuers’ expenditures more transparent,⁴¹⁸ the Secretary must make these reports available to the public on HHS’s web site,⁴¹⁹ and the proposed exchange regulation seeks to require MLR information on exchange web sites.⁴²⁰

On August 17, 2010, the National Association of Insurance Commissioners (“NAIC”) approved a MLR Blanks Proposal form for issuers to use to comply with the Federal MLR reporting requirements.⁴²¹ Because NAIC’s data collection requirements are very similar, but not identical, to the Federal MLR Regulations’ requirements, HHS developed the required annual MLR reporting and rebate forms and recently published them on its web site.⁴²²

E. Federal Special Circumstances

As required by Section 2718(c) of the PHSA,⁴²³ the Federal MLR methodology accounts for the special circumstances of smaller plans, different types of plans, and newer plans, as discussed below.⁴²⁴

1. Federal Credibility Adjustments

The Federal MLR Regulations apply credibility adjustments as a means of accounting for the special circumstances of small plans. “A credibility adjustment is a method to address the

⁴¹⁶ See *id.* § 158.110(b). As discussed below, issuers of mini-med and expatriate plans have different reporting requirements. See *id.* § 158.120(b)(3)-(4).

⁴¹⁷ See IFR Preamble, 75 Fed. Reg. at 74,869, *supra* note 261. This is referred to as a three-month claims run-out.

⁴¹⁸ See *id.* at 74,865.

⁴¹⁹ See U.S.C. § 300gg-18(a)(3).

⁴²⁰ 45 C.F.R. § 155.205(b)(1)(vi) (proposed); Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Pt. II, 76 FED. REG. 41,866, 41,876 (proposed July 15, 2011) (to be codified at 45 C.F.R. pts. 155 & 156).

⁴²¹ Press Release, NAT’L ASS’N OF INS. COMM’RS, NAIC Approves Form for MLR Financial Reporting Requirements (Aug. 17, 2010), http://www.naic.org/Releases/2010_docs/naic_approves_mlr_reporting_form.htm; Blanks Agenda Item Submission Form, NAIC Blanks (E) Working Group, NA’L ASS’N OF INS. COMM’RS (June 18, 2010), http://www.naic.org/documents/index_health_reform_mlr_blanks_proposal.pdf.

⁴²² See Medical Loss Ratio Annual Reporting Form and Instructions, published as part of the MLR Paperwork Reduction Act (PRA) package (CMS-10418) (Apr. 2, 2012), *available at* <http://cciio.cms.gov/resources/other/index.html#mlr>.

⁴²³ See 42 U.S.C. § 300gg-18(c).

⁴²⁴ See IFR Preamble, 75 Fed. Reg. at 74,865, *supra* note 261.

impact of claims variability on the experience of smaller plans”⁴²⁵ that “do not have sufficient experience to be statistically valid for purposes of the rebate provisions.”⁴²⁶

Despite best efforts to predict the amount of claims insureds will submit each year, claims vary from plan year to plan year for all plans. If a few insureds have particularly high or low claims in a plan year, a large plan often can absorb those fluctuations without substantially impacting its overall MLR because of the size of its premium base. But a plan that covers fewer individuals, or life-years,⁴²⁷ has a harder time absorbing and redistributing these variations because it has a smaller premium base.⁴²⁸ This means that random variations in claims can cause the MLR for a small plan to fluctuate rather dramatically in a given year, even if the issuer made a good faith effort to establish appropriate premiums and comply with minimum MLR requirements.⁴²⁹ The smaller the number of life-years covered by a plan, generally the more variable the MLR will be. Thus, smaller plans are at a greater risk for having to pay rebates due to random fluctuations than are plans with more life-years. This places smaller plans at a competitive disadvantage to larger plans, which is especially troubling if markets want to encourage new entrants to increase competition.

Credibility adjustments modify the MLR for qualifying small plans by adding additional percentage points to the ratio “in recognition of the statistical unreliability of the reported number.”⁴³⁰ Credibility adjustments also take into consideration the plan’s deductible because the “variability of claims experience is greater under health insurance policies with higher deductibles than under policies with lower deductibles.”⁴³¹

Whether an issuer may add a credibility adjustment to its MLR depends on the number of life-years on which the issuer’s MLR was calculated. The Federal MLR Regulations instruct that “[t]he life-years used to determine the credibility of an issuer’s experience are the life-years for the MLR reporting year plus the life-years for the two prior MLR reporting years.”⁴³²

⁴²⁵ *Id.* at 74,880.

⁴²⁶ *Id.* at 74,866.

⁴²⁷ “Life-years means the total number of months of coverage for enrollees whose premiums and claims experience is included [in the MLR report] divided by 12.” 45 C.F.R. § 158.230(b).

⁴²⁸ See generally NAIC Response to Request for Information Regarding Section 2718 of the Public Health Service Act, at 1 (May 12, 2010), available at

http://www.naic.org/documents/committees_e_hrsi_hhs_response_mlr_adopted.pdf [hereinafter *NAIC Response*]

(“The smaller a block of policies is, the more claims will fluctuate due to random variations.”).

⁴²⁹ See IFR Preamble, 75 Fed. Reg. at 74,880, *supra* note 261.

⁴³⁰ *Id.*; cf. Jost, *Implementing Health Reform*, *supra* note 271.

⁴³¹ IFR Preamble, 75 Fed. Reg. at 74,881, *supra* note 261.

⁴³² 45 C.F.R. § 158.231(a). The Federal MLR regulations include specific instructions for which life-years to consider for the 2011 and 2012 MLR reporting years. See *id.* § 158.231(b)(7)(c). See also *id.* §§ 158.220(d), 158.231(d)-(e), & 158.232(e) (outlining how to calculate life-years, credibility, and MLR for student health insurance coverage for the 2013 and 2014 MLR reporting years).

An MLR that is based on at least 1,000 but fewer than 75,000 life-years is considered partially credible and thus eligible for a credibility adjustment.⁴³³ If an MLR is based on the experience of fewer than 1,000 life-years, it is considered non-credible, and “it is presumed to meet or exceed the minimum” MLR.⁴³⁴ Issuers with non-credible MLRs will not have to pay any refund to policyholders because “there is no valid data to determine that the issuer has failed to meet the MLR standard.”⁴³⁵ An MLR is considered fully credible (and thus ineligible for a credibility adjustment) if it is “based on the experience of 75,000 or more life-years.”⁴³⁶

Federal Credibility Adjustments

Number of Life-Years	Credibility Classification	Eligible for Credibility Adjustment?
< 1,000	Non-credible	No (but presumed to satisfy minimum MLR, so no rebate requirement)
≥ 1,000 but < 75,000	Partially Credible	Yes
≥ 75,000	Fully Credible	No

Section 158.232 of the Federal MLR Regulations provides base credibility factors based on the number of aggregated life-years and a deductible factor based on the average per person deductible of policies included in the aggregation.⁴³⁷ The credibility adjustment is calculated by multiplying the applicable base credibility factor by the applicable deductible factor.⁴³⁸ The resulting credibility adjustment then is added to the MLR for the qualifying small plan before determining if any rebates are owed.⁴³⁹ Depending on the number of life-years, credibility adjustments can add up to 8.3 percent to an issuer’s reported MLR for partially credible plans, and “issuers with policies that have large deductibles may receive an additional adjustment of up to 6.1 percent on top of the 8.3 percent.”⁴⁴⁰

While credibility adjustments reduce an issuer’s risk of paying rebates based on random claims variations, they also reduce the amount of rebates to consumers. HHS thus intends “to

⁴³³ *Id.* § 158.230 (a) & (c)(2). *But see id.* § 158.232(d) (setting forth conditions under which there will be no credibility adjustment for the 2013 MLR reporting year for partially credible experience); IFR Preamble, 75 Fed. Reg. at 74,881-82, *supra* note 261 (explaining that “[t]his exception prevents issuers from receiving a credibility adjustment when the issuer consistently sets its prices to produce an MLR below the statutory 80 percent MLR standard”).

⁴³⁴ 45 C.F.R. § 158.230(c)(3) & (d).

⁴³⁵ IFR Preamble, 75 Fed. Reg. at 74,881, *supra* note 261.

⁴³⁶ 45 C.F.R. § 158.230(a) & (c)(1).

⁴³⁷ *Id.* § 158.232(b) & (c); MLR Correcting Amendment, 77 Fed. Reg. at 28,789, *supra* note 264.

⁴³⁸ 45 C.F.R. § 158.232(a).

⁴³⁹ IFR Preamble, 75 Fed. Reg. at 74,881, *supra* note 261.

⁴⁴⁰ *Id.* at 74,886-87.

monitor the effects of the credibility adjustment and, as appropriate, to update the credibility adjustment method.”⁴⁴¹

2. Mini-Med, Expatriate, and Student Health Insurance Plans

The Federal MLR Regulations provide for different treatment of three unique kinds of plans, so-called mini-med, expatriate, and student health insurance plans.

Mini-med plans, which have no statutory basis, generally refer “to policies that often cover the same types of medical services as comprehensive medical plans but have unusually low annual limits.”⁴⁴² For purposes of MLR calculations and reporting, mini-med plans are policies with a total annual limit of \$250,000 or less.⁴⁴³ These plans claim that they experience higher administrative costs because the populations they serve tend to have higher turnover rates,⁴⁴⁴ and higher turnover rates can lead to lower claims costs. These plans also tend to spend less on quality improvement initiatives because of their low annual limits.⁴⁴⁵ As a result, they sought to be excluded from the new Federal minimum MLR requirements.⁴⁴⁶ Absent exclusion, these plans threatened that they would not be able to continue offering this coverage option.⁴⁴⁷

Despite arguments from consumer groups and the Blue Cross and Blue Shield Association that mini-med plans have higher profit margins than traditional plans and should not be exempt from MLR requirements, HHS was concerned that the estimated more than one million individuals currently covered by mini-med plans could lose their coverage and would not be able to afford replacement coverage until 2014.⁴⁴⁸

To provide more data for HHS to assess this risk, the IFR required “an issuer with policies that have a total annual limit of \$250,000 or less [to] report the experiences from such policies separately from other policies”⁴⁴⁹ for the 2011 MLR reporting year.⁴⁵⁰ These reports had to be submitted on a quarterly schedule, as required in the IFR and agency Guidance.⁴⁵¹ While evaluating whether mini-meds should be treated differently for the long-term, HHS directed

⁴⁴¹ Id. at 74,881; see also *Getting Your Money’s Worth on Health Insurance*, *supra* note 283.

⁴⁴² IFR Preamble, 75 Fed. Reg. at 74,872, *supra* note 261.

⁴⁴³ 45 C.F.R. § 158.120(d)(3).

⁴⁴⁴ See IFR Preamble, 75 Fed. Reg. at 74,872, *supra* note 261.

⁴⁴⁵ *Id.*

⁴⁴⁶ *Id.*

⁴⁴⁷ *Id.*

⁴⁴⁸ *Id.*

⁴⁴⁹ 45 C.F.R. § 158.120(d)(3).

⁴⁵⁰ See IFR Preamble, 75 Fed. Reg. at 74,872, *supra* note 261.

⁴⁵¹ See *id.*; *CCIIO Technical Guidance (CCIIO 2011-003): Submission of 2011 Quarterly Reports of MLR Data by Issuers of “Mini-med” and Expatriate Plans*, at 2 (May 19, 2011), http://cciio.cms.gov/resources/files/20110519_guidance_mlr_1Q_deadline.pdf (adjusting the timeline for quarterly submissions because of delays finalizing the required form).

mini-med plans to adjust their reported experiences by multiplying their 2011 reporting year MLR numerator by two.⁴⁵²

The second type of plan receiving special treatment under the ACA for MLR purposes is an expatriate plan, which refers to group policies providing coverage for “employees, substantially all of whom are: Working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country.”⁴⁵³ Similar to mini-med plans, these plans tend to have higher administrative expenses, as a percentage of premiums, than plans that primarily provide coverage in the United States due to the higher costs required, for example, to negotiate foreign provider networks, credential providers abroad, and process claims in different languages.⁴⁵⁴ Issuers also may be less able to provide quality improving activities because the care is provided overseas.⁴⁵⁵

To the extent these plans are covered by the ACA,⁴⁵⁶ HHS recognized that expatriate plans present special circumstances, and thus required issuers to aggregate their experiences from expatriate plans separately from other policies for the 2011 MLR reporting year.⁴⁵⁷ Like mini-med plans, issuers of expatriate plans for the 2011 MLR reporting year had to multiply their MLR numerator by 2 to account for these special circumstances and had to submit quarterly reports to HHS.⁴⁵⁸ Unlike mini-med plans, which still had to be aggregated separately by market in each state, expatriate plans are aggregated on a national level in the large and small group markets.⁴⁵⁹

As promised in the preamble to the IFR,⁴⁶⁰ the Secretary revisited the special treatment of mini-med and expatriate plans for MLR purposes in the MLR Final Rule.⁴⁶¹ After reviewing public comments and data from the first two quarterly mini-med filings, HHS decided to permit mini-med plans to continue to adjust their MLR numerators for reporting years 2012 through 2014 to account for their special circumstances but to do so using graduated adjustments of

⁴⁵² See IFR Preamble, 75 Fed. Reg. at 74,872, *supra* note 261; see also CCIIO Technical Guidance CCIIO 2011-002, *supra* note 270, at 2 (confirming that the IFR provisions regarding mini-med plans are mandatory and not optional).

⁴⁵³ 45 C.F.R. § 158.120(d)(4).

⁴⁵⁴ See IFR Preamble, 75 Fed. Reg. at 74,871, *supra* note 261.

⁴⁵⁵ See *id.*

⁴⁵⁶ See *id.* (noting that “[p]olicies issued by non-U.S. issuers for services rendered outside of the U.S. are not subject to the Affordable Care Act”).

⁴⁵⁷ See *id.*

⁴⁵⁸ See *id.* at 74,871-72; see also CCIIO Technical Guidance CCIIO 2011-002, *supra* note 270, at 2 (confirming that the special adjustment, aggregating, and reporting provisions in the IFR for expatriate plans are mandatory and not optional).

⁴⁵⁹ See CCIIO Technical Guidance CCIIO 2011-002, *supra* note 270, at 3.

⁴⁶⁰ See IFR Preamble, 75 Fed. Reg. at 74,872, *supra* note 261.

⁴⁶¹ See MLR Final Rule Preamble, 76 Fed. Reg. at 76,575-77, 76,581, *supra* note 265.

1.75 in 2012, 1.50 in 2013, and 1.25 in 2014.⁴⁶² By doing so, HHS hopes “to strike a balance that ensures continued access for consumers while ensuring that they receive value for their premium dollar.”⁴⁶³ Mini-med plans must continue to report their experience separately from other policies through 2014, although they need only submit annual and not quarterly reports.⁴⁶⁴ HHS found no need to extend the special treatment past 2014, when “non-grandfathered plans in all markets and grandfathered plans in the large and small group markets will no longer be permitted to have annual dollar limits,” and thus mini-med plans will not exist in those markets.⁴⁶⁵

Because two quarters of data and public comments confirmed their “unique administrative costs”⁴⁶⁶ and that the exception is necessary to ensure “Americans working abroad will still have access to U.S.-based coverage,”⁴⁶⁷ HHS indefinitely extended the special treatment of expatriate plans in the MLR Final Rule.⁴⁶⁸ Specifically, expatriate plans will continue to multiply their MLR numerator by two and aggregate and report their experience separately for the large and small group markets on a national basis.⁴⁶⁹ They no longer need to report quarterly, however, and instead are subject to the same annual reporting requirement as other issuers.⁴⁷⁰

HHS recently added student health insurance coverage⁴⁷¹ to this category of plans whose “unique administrative costs” constitute special circumstances warranting different treatment for MLR purposes.⁴⁷² Although the individual market Federal MLR standards and reporting and rebate requirements will apply to these plans beginning in 2013, issuers should separately report this experience from other individual market experience and aggregate it on a national basis.⁴⁷³ To help student plans adjust to the MLR requirements, HHS directed issuers to

⁴⁶² 45 C.F.R. § 158.221(b)(3); *see also* CCIIO Technical Guidance 2012-002, *supra* note 261, at 8 (clarifying that “issuers of mini-med policies should add the reported experience for each MLR reporting year together to obtain the numerator and then apply the multiplier for the current MLR reporting year to the aggregated experience”).

⁴⁶³ *See* MLR Final Rule Preamble, 76 Fed. Reg. at 76,575, *supra* note 265. Data showed that, absent a multiplier, seven of the twelve individual market mini-med plans and six of the fifteen large group plans would not have achieved their respective minimum MLR targets in 2011. *See id.*

⁴⁶⁴ *See* 45 C.F.R. §§ 158.110(b) & 120(d)(3).

⁴⁶⁵ MLR Final Rule Preamble, 76 Fed. Reg. at 76,575, *supra* note 265.

⁴⁶⁶ *Id.* at 76,576.

⁴⁶⁷ *Id.* at 76,575.

⁴⁶⁸ *See* 45 C.F.R. §§ 158.110(b), 120(d)(4), & 221(b)(4).

⁴⁶⁹ *See id.* §§ 158.120(d)(4) & 221(b)(4).

⁴⁷⁰ *See id.* §§ 158.110(b), 120(d)(4).

⁴⁷¹ *See id.* §§ 144.103, 147.145(a), & 158.103 (defining student health insurance coverage).

⁴⁷² *See* Student Health Insurance Coverage; Final Rule, 77 Fed. Reg. 16,453, 16,459 (Mar. 21, 2012) (to be codified at 45 C.F.R. parts 144, 147, and 158) [hereinafter Student Health Insurance Coverage Final Rule, 77 Fed. Reg. at X].

⁴⁷³ 45 C.F.R. § 158.120(d)(5); Student Health Insurance Coverage Final Rule, 77 Fed. Reg. at 16,459, *supra* note 472. Although some states regulate student health insurance coverage as a form of blanket or non-employer group coverage, these plans do not satisfy the Federal definition of group health plans because “they are not employment-based.” Student Health Insurance Coverage; Proposed Rule, 76 Fed. Reg. 7,767, 7,769 (Feb. 11, 2011).

multiply the sum “of the incurred claims and expenditures for activities that improve health care quality” in their MLR numerator by 1.15, but only for the 2013 MLR reporting year.⁴⁷⁴

3. New Plan Flexibility

The Federal MLR Regulations also provide for special treatment of newer plans. If 50 percent or more of an issuer’s total earned premium for any market segment in any state in a given MLR reporting year “is attributable to policies newly issued and with less than 12 months of experience in that MLR reporting year,” the issuer may defer reporting this experience until the next MLR reporting year.⁴⁷⁵ If an issuer elects this option, however, it must add this newer experience to the experience reported in the next MLR reporting year.⁴⁷⁶

A predominant rationale for this special treatment is to lower barriers to entry into the insurance markets.⁴⁷⁷ As HHS explains, “claims experience is generally expected to be substantially less than the premium revenue from [newly issued] policies during the year in which the coverage is issued.”⁴⁷⁸ As a result, an issuer’s MLR tends to be lower when a large proportion of the block of business consists of new policies “simply because of the new business.”⁴⁷⁹ Indeed, “for a relatively new plan, where all of the policies are in their early years, the MLR in the first year can be as low as half of the ultimate level.”⁴⁸⁰ Absent special treatment, issuers with a substantial volume of new policies would be at increased risk of having to pay rebates because of their lower MLRs.⁴⁸¹ “Applying the rebate requirement to these policies would create a substantial barrier to the entry of new issuers into a market.”⁴⁸² HHS thus treats issuers with substantial amounts of new business differently to encourage new entrants in the markets.

F. Federal Enforcement

HHS is responsible for enforcing the ACA’s MLR reporting and rebate requirements, and the Federal MLR Regulations establish ground rules for audits conducted by the Secretary.⁴⁸³ To this end, issuers report data directly to the Secretary rather than the states, and Federal law does not include “any role for the States in terms of receiving or analyzing the data or enforcing” the MLR requirements.⁴⁸⁴ HHS has discretion, however, to accept the findings of a

⁴⁷⁴ 45 C.F.R. § 158.221(b)(5); Student Health Insurance Coverage Final Rule, 77 Fed. Reg. at 16,459, *supra* note 472.

⁴⁷⁵ *Id.* § 158.121; *see also* IFR Preamble, 75 Fed. Reg. at 74,872, *supra* note 261.

⁴⁷⁶ 45 C.F.R. § 158.121.

⁴⁷⁷ *See Getting Your Money’s Worth on Health Insurance*, *supra* note 283.

⁴⁷⁸ IFR Preamble, 75 Fed. Reg. at 74,872, *supra* note 261.

⁴⁷⁹ *Id.* at 74,873.

⁴⁸⁰ *See NAIC Response*, *supra* note 428, at 2.

⁴⁸¹ IFR Preamble, 75 Fed. Reg. at 74,873, *supra* note 261.

⁴⁸² *Id.* at 74,872.

⁴⁸³ 45 C.F.R. §§ 158.401 & 158.402.

⁴⁸⁴ *See* IFR Preamble, 75 Fed. Reg. at 74,889 & 74,920, *supra* note 261.

state audit of an issuer's MLR reporting and rebate obligations under certain conditions set forth in the Federal regulations.⁴⁸⁵

The Secretary also may impose a civil penalty if an issuer fails to comply with the Federal MLR requirements, including, among others, for failing: to submit a required report in a timely fashion; to submit an accurate and complete report; to timely and accurately pay a required rebate; to respond to HHS inquiries; or to maintain required records.⁴⁸⁶ The penalty for each violation "may not exceed \$100 for each day, for each responsible entity, for each individual affected by the violation" and is in addition to any other penalty allowed by law.⁴⁸⁷ HHS will take into consideration, among other factors, whether a state has assessed a penalty for the violation.⁴⁸⁸

G. Use of MLR in Rate Review

The ACA and the Federal MLR Regulations do not discuss prospectively using MLR as part of rate review. Traditionally, the Federal government has left questions of rate review to the states, not all of whom engage in rate review. Under the ACA, however, non-grandfathered insurers in the individual and small group markets must justify any rate increases of 10 percent or more before putting those rates into effect.⁴⁸⁹ In states without an effective rate review program, HHS must review these proposed premium increases for reasonableness.⁴⁹⁰ In determining whether a rate increase is excessive, and therefore unreasonable, HHS will consider "[w]hether the rate increase results in a projected medical loss ratio below the Federal medical loss ratio standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under Federal law."⁴⁹¹

Thus, although the Federal MLR law does not require issuers to take loss ratios into account in setting their premiums, issuers in states without effective rate review *de facto* are required to use MLR prospectively. For example, one of the reasons supporting HHS's determination in January 2012 that Trustmark Life Insurance Company's proposed premium increases of 13 percent in Alabama, Arizona, Pennsylvania, Virginia, and Wyoming were

⁴⁸⁵ 45 C.F.R. § 158.403.

⁴⁸⁶ *Id.* §§ 158.601 & 158.602. Several sections of the Federal MLR Regulations establish procedural due process relating to civil penalties. *See id.* §§ 158.603-605, 158.613-615.

⁴⁸⁷ *Id.* § 158.606.

⁴⁸⁸ *See* IFR Preamble, 75 Fed. Reg. at 74,890, *supra* note 261; *see also* 45 C.F.R. §§ 158.607-610 (identifying factors and mitigating and aggravating circumstances for the Secretary to consider in determining the penalty; recognizing the Secretary's settlement authority; and imposing limits on the Secretary's ability to impose penalties).

⁴⁸⁹ *See* 42 U.S.C. § 300gg-94(a); 45 C.F.R. §§ 154.103, 154.200.

⁴⁹⁰ *See* 45 C.F.R. §§ 154.210, 154.301. Indeed, in determining whether a state's rate review process is effective, HHS considers whether the state's rate review process includes an examination of, among other things, an insurer's MLR. *See id.* § 154.301(a)(4)(xi); *see generally* *Health Insurance Rate Review: Lowering Costs for American Consumers and Businesses*, http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html (last visited Feb. 15, 2012) (identifying which states have and do not have effective rate review programs).

⁴⁹¹ 45 C.F.R. § 154.205(b)(1).

unreasonable was that “the rate increase would result in a projected medical loss ratio below the applicable Federal standard of 80%.”⁴⁹² HHS does not have authority to stop a rate increase that it deems unreasonable. Instead, it is limited to publicizing its finding on its web site along with the issuer’s required justification for the increase and urging the company to rescind its planned increase.⁴⁹³

⁴⁹² *Trustmark Life Insurance Company Rate Review*, http://companyprofiles.healthcare.gov/states/VA/companies/64800/products/64800VA002/rate_reviews/86?search_method=rate_reviews (last visited Feb. 15, 2012) (hereinafter *Trustmark Rate Review*); see also *News Release*, U.S. DEPT’ OF HEALTH & HUMAN SERVCs., *Affordable Care Act Holding Insurers Accountable for Premium Hikes* (Jan. 12, 2012), <http://www.hhs.gov/news/press/2012pres/01/20120112a.html>.

⁴⁹³ As of February 15, 2012, HHS has deemed unreasonable premium increases planned by two insurers in six states. See Chris Anderson, HEALTHCARE FINANCE NEWS, *HHS Calls Trustmark’s Health Insurance Increases in Five States “Unreasonable”* (Jan. 13, 2012), <http://www.healthcarefinancenews.com/news/hhs-trustmarks-health-insurance-increases-five-states-unreasonable>. Despite the publicity, both companies have announced their intentions to proceed with the increases as planned. See *Trustmark Rate Review*, *supra* note 492; *Everence Insurance Company Rate Review*, http://companyprofiles.healthcare.gov/states/PA/companies/78080/products/78080PA001/rate_reviews/33.

Appendix B: Overview of New Jersey MLR Legal Structure

New Jersey has almost two decades of experience with MLRs. In 1992, New Jersey enacted comprehensive reform of its individual and small group insurance markets. This pioneering reform required insurers in the individual and small group markets to guarantee the issue and renewal of coverage to any willing buyer, and that the policies sold be community rated, have only limited periods of preexisting illness exclusion, and adhere to standard forms of product design.⁴⁹⁴ This reform included MLR limits for individual and small group markets; New Jersey does not, however, have an MLR requirement in its large group market.⁴⁹⁵ Although there have been amendments over the years, the individual and small group markets continue to bear the stamp of the 1992 reform, including the requirement that insurers in these markets adhere to MLR limits.⁴⁹⁶ As is described below, the details of the MLR calculation methodology varies between the two markets.

To understand how MLR is calculated in New Jersey, it first is important to understand the way the individual and small group markets are defined in New Jersey. New Jersey's individual market loss ratio rules apply to standard health benefit plans as well as basic and essential health care services plans.⁴⁹⁷ The small group market in New Jersey includes carriers⁴⁹⁸ offering health benefit plans to eligible employees of employers "that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employed at least two employees on the first day of the plan year, and the majority of the employees are employed in New Jersey."⁴⁹⁹ Eligible employees means a full-time employee who works a minimum of twenty-five hours per week.⁵⁰⁰ The small

⁴⁹⁴ P.L. 1992, c. 161 (codified as amended at N.J. STAT. ANN. § 17B:27A-2 *et seq.*) and 162 (codified as amended at N.J. STAT. ANN. § 17B:27A-17 *et seq.*). See Alan C. Monheit *et al.*, *Community Rating And Sustainable Individual Health Insurance Markets In New Jersey*, 23:4 HEALTH AFFAIRS 167 (2004); Katherine Swartz and Deborah W. Garnick, *Lessons from New Jersey*, 25:1 J. HEALTH POL., POL'Y & LAW 45 (2000).

⁴⁹⁵ NAIC Response to Request for Information Regarding Section 2718 of the Public Health Service Act, at New Jersey's Response to Question A.1.b (May 12, 2010), available at http://www.naic.org/documents/committees_e_hrsi_hhs_response_mlr_adopted.pdf [hereinafter *NAIC Response*].

⁴⁹⁶ See N.J.S.A. 17B:27A-9(e)(2) (individual market); N.J.S.A. 17B:27A-25(g)(2) (small group market).

⁴⁹⁷ N.J. STAT. ANN. § 17B:27A-4.5(e). As the name suggests, a basic and essential health plan is a limited benefits plan that all carriers offering individual health insurance in New Jersey must offer. See *id.* A standard health benefits plan is a health benefits plan that was adopted by New Jersey's Individual Health Coverage Program Board. See N.J. ADMIN. CODE § 11:20-1.2. See generally N.J. DEP'T OF BANKING & INS., INDIVIDUAL PLANS SUMMARY CHART, http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcguide/ihc_plansummary.pdf.

⁴⁹⁸ N.J. STAT. ANN. § 17B:27A-17 (defining carriers).

⁴⁹⁹ *Id.*; N.J. ADMIN. CODE § 11:21-1.2.

⁵⁰⁰ N.J. STAT. ANN. § 17B:27A-17.

group market includes standard health benefits plans, open nonstandard health benefits plans, closed nonstandard health benefits plans, and alliance policy forms.⁵⁰¹

A. Formulae for Calculating New Jersey's MLR

In the individual market in New Jersey, the carrier's⁵⁰² MLR is determined by dividing total losses incurred by net earned premium.⁵⁰³ The law in the small group market simply directs carriers to divide the claims by the premiums.⁵⁰⁴

Although New Jersey law uses different terminology in describing the formulae for calculating MLR in its individual and small group markets, essentially the calculation is the same, as discussed below.

1. New Jersey's MLR Numerator

Total losses incurred, for the New Jersey individual market MLR numerator, are defined as:

- i. Claims paid during the preceding calendar year, regardless of the year incurred;
- ii. Less residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year;
- iii. Less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year's Loss Ratio Report;
- iv. Plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;
- v. Plus residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year.⁵⁰⁵

“Claims paid” means a dollar amount determined in accordance with statutory annual statement reporting⁵⁰⁶ Residual reserve, in turn, is calculated as 3.3 percent of the combination of paragraphs (i), (iii), and (iv) of the total losses incurred definition.⁵⁰⁷

⁵⁰¹ See N.J. STAT. ANN. § 17B:27A-25(g)(2) (defining alliance policy forms); N.J. ADMIN. CODE §§ 11:21-1.2 & 11.2 (defining standard, open non-standard, and closed non-standard health benefits plans); *id.* § 11:21-7A.2 (defining terms relevant to loss ratio reports); see also N.J. STAT. ANN. § 17B:27A-25.2 (providing definitions relative to small employer benefits purchasing alliances).

⁵⁰² This Brief uses the familiar term, carrier, although New Jersey's regulation in the individual market uses to term “member,” which is defined as excluding carriers with dominant Medicare, Medicaid, and NJ FamilyCare enrollment. See N.J. ADMIN. CODE § 11:20-1.2.

⁵⁰³ *Id.* § 11:20-7.4(a)(4).

⁵⁰⁴ *Id.* § 11:21-7A.4(a)(3).

⁵⁰⁵ *Id.* § 11:20-7.4(a)(3).

⁵⁰⁶ *Id.* § 11:20-7.2. This regulation also references N.J. ADMIN. CODE § 11:20-8.5(c), which was repealed effective June 6, 2011. See generally N.J. STAT. ANN. § 17:23-1 (specifying that an insurance company's annual statement

Although claims are not defined in the small group MLR statute or regulation, the instructions for the form that carriers must use to report small group MLR make clear that “claims” for the small group numerator mean functionally the same thing as “total losses incurred” in the individual market.⁵⁰⁸ Thus, the numerator is calculated the same way in the New Jersey individual and small group markets. As New Jersey recently summarized, “[c]laims are amounts paid to providers for covered medical care to covered people. Incurred claims are calculated as paid claims, adjusted for six months of claims run-out and a formula [f]or other residual reserves.”⁵⁰⁹

Generally, only “expenses incurred in the delivery of medical or hospital services or those activities in direct support of the delivery of medical services” may be included in claims paid in the MLR numerator.⁵¹⁰ Carriers may not include “[c]harges for medical directors, utilization review, network development, network contracting, [or] policyholder or provider education”⁵¹¹ Interestingly, however, “amounts paid to integrated providers of services (such as behavioral health or imaging) are counted entirely as claims, even though these integrated providers usually perform (and are being compensated for) other than clinical services such as pre-authorization.”⁵¹² Thus, while the New Jersey MLR numerator “do[es] not include claims administration expenses or expenses associated with loss control (such as utilization management) . . . , [it does] include administrative costs incurred by providers or vendor intermediaries, such as Organized Delivery Systems (ODS’s).”⁵¹³

2. New Jersey’s MLR Denominator

Net earned premium, which is the denominator for the New Jersey individual market MLR calculation, is defined as “the premiums earned in this State on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plan business.”⁵¹⁴ This figure includes “the aggregate premiums earned on the

must “be prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners, and all applicable provisions of law”).

⁵⁰⁷ N.J. ADMIN. CODE § 11:20-7.4(b).

⁵⁰⁸ Compare *id.* § 11:21, Appx. Exh. GG (defining claims for the small group market numerator), with *id.* § 11:20-7.4(a)(3) (defining total losses incurred in the individual market numerator).

⁵⁰⁹ NAIC Response, *supra* note 495, at *New Jersey’s Response to Question B.1*. Claims run-out refers to the amount that issuers will pay in claims after the end of a year for claims that were incurred but not processed during that year. See *id.* at 3.

⁵¹⁰ Bulletin No. 98-01, Inclusion of Network Related Costs in Loss Ratio Calculations (DOBI Feb. 18, 1998) (on file with author).

⁵¹¹ *Id.*

⁵¹² NAIC Response, *supra* note 495, at *New Jersey’s Response to Question B.1*.

⁵¹³ LIFE & HEALTH, N.J. DEP’T OF BANKING & INS., NJ COMMERCIAL HEALTH MARKET - 2007, ATTACHMENT 3, LOSS RATIOS (revised Nov. 18, 2009), <http://www.state.nj.us/dobi/lifehealthactuarial/commercialhealth2007.html>.

⁵¹⁴ N.J. STAT. ANN. § 17B:27A-2; see also N.J. ADMIN. CODE § 11:20-1.2 (“Premium earned’ means premium received, adjusted for the changes in premium due and unpaid, and paid in advance, and unearned premium, net of refunds

carrier's insured group and individual business and health maintenance organization business, including premiums from any Medicare, Medicaid, or NJ FamilyCare contracts with the State or federal government."⁵¹⁵ But the statutory definition expressly excludes from this figure "premiums earned from contracts funded pursuant to the 'Federal Employee Health Benefits Act of 1959,' 5 U.S.C. ss. 8901-8914, any excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan, or Medicare supplement policies or contracts."⁵¹⁶

Although New Jersey's small group MLR statute and regulation do not define premiums, the small group MLR reporting form defines premiums for the small group denominator as "the total earned premiums, on the same earned basis as in the carrier's Annual Statement for the preceding calendar year, before dividends or credits applicable to prior years"⁵¹⁷

3. Aggregation and Tabulation in New Jersey

MLR is calculated as a percentage to one decimal place (for example, 84.2 percent) in both New Jersey's small group and individual markets.⁵¹⁸

Carriers in New Jersey's individual market combine standard health benefits plans and basic and essential health care services plans for purposes of calculating and reporting MLRs.⁵¹⁹ Affiliated carriers in the individual market must file a separate MLR report for each carrier as well as a combined report for all affiliated carriers.⁵²⁰

But carriers in New Jersey's small group market must calculate separate MLRs for their standard (other than alliance) policy forms, open non-standard policy forms, closed nonstandard policy forms, and alliance health benefit plans for the preceding calendar year.⁵²¹ Carriers have the choice to "annually report the loss ratio . . . for all of the alliances in the aggregate or separately for each alliance."⁵²²

The definition of carrier varies between the New Jersey individual and small group markets. In the individual market, carriers that are affiliated companies, even if each carrier is a distinct legal entity, are treated as one carrier.⁵²³ But a health maintenance organization in New Jersey affiliated with an insurance company, health service corporation, hospital service

or dividends paid or credited to policyholders, but not reduced by dividends to stockholders or by active life reserves.").

⁵¹⁵ N.J. STAT. ANN. § 17B:27A-2; *see also* N.J. ADMIN. CODE § 11:20-1.2.

⁵¹⁶ *Id.*

⁵¹⁷ N.J. ADMIN. CODE § 11:21, Appx. Exh. GG.

⁵¹⁸ *Id.* § 11:20-7.4(a)(4) (individual market); *id.* § 11:21, Appx. Exh. GG (small group market).

⁵¹⁹ *Id.* § 11:20-7.3(b).

⁵²⁰ *Id.* § 11:20-7.3(a).

⁵²¹ N.J. STAT. ANN. § 17B:27A-25(g)(2); N.J. ADMIN. CODE § 11:21-7A.3(a).

⁵²² N.J. STAT. ANN. § 17B:27A-25(g)(2).

⁵²³ *Id.* § 17B:27A-2.

corporation, or medical service corporation is treated as a separate carrier in New Jersey's small group market,⁵²⁴ such that MLR calculations are "made at the regulated entity basis."⁵²⁵

B. New Jersey's Minimum MLR Requirements

New Jersey raised its minimum loss ratio requirement in 2009 to require carriers in New Jersey's individual and small group markets to satisfy an MLR of 80 percent each calendar year.⁵²⁶ New Jersey does not have a minimum loss ratio for its large group market, and it does not make any adjustments to MLR.⁵²⁷

C. New Jersey Rebate Required

If a carrier in the individual market fails to satisfy the 80 percent minimum MLR requirement, it must "issue a dividend or credit against future premiums . . . in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits equal 80% of the aggregate premiums collected for the policy or contract forms in the previous calendar year."⁵²⁸ The small group has a similar rebate requirement, which applies when a carrier's MLR "fails to substantially comply with the 80% loss ratio requirement."⁵²⁹ The small group loss ratio report form defines dividends as 80 percent of the premiums minus the claims,⁵³⁰ while the individual group loss ratio report form defines the refund as 80 percent of net earned premium minus total losses incurred.⁵³¹ Rebates must be prorated on the basis of the premium paid per contract or policyholder, or other "practical and equitable" alternative formula or methodology proposed by the carrier and approved by the Commissioner.⁵³²

⁵²⁴ *Id.* § 17B:27A-17.

⁵²⁵ *NAIC response, supra* note 495, at New Jersey Response to Question E.1.

⁵²⁶ N.J. STAT. ANN. § 17B:27A-25(g)(2) (small group market); *id.* § 17B:27A-9(e)(2) (individual market).

⁵²⁷ *NAIC response, supra* note 495, at New Jersey's Response to Questions A.1.b and B.1.f.

⁵²⁸ N.J. STAT. ANN. § 17B:27A-9(e)(2).

⁵²⁹ *Id.* § 17B:27A-25(g)(2).

⁵³⁰ N.J. ADMIN. CODE § 11:21, Appx. Exh. GG.

⁵³¹ *Id.* § 11:20, Appx. Exh. J. Note that neither of New Jersey's formulae results in an exact 80 percent loss ratio after the refund. This is because the refund is treated as an addition to claims (which it is not) rather than a reduction to premium (which it is). For example, if a carrier received \$100 in premiums but only spent \$70 on claims, it would have a loss ratio of 70 percent. According to New Jersey's formulae, it would owe a \$10 rebate. But by returning \$10 of premiums to policyholders, the MLR denominator decreases to \$90 because the carrier received \$10 fewer in premiums (or, put another way, policyholders paid \$10 less in premiums). The numerator remains \$70 because the carrier has not increased its spending on claims. Thus, the resulting MLR is 70/90, or 77.8 percent, shy of the 80 percent minimum. To achieve the minimum MLR through the rebate process, New Jersey would need to amend its formulae for determining rebates to take into consideration that the rebate is a reduction to premium and not an addition to claims. New Jersey also does not require carriers to pay interest on rebates, despite the considerable time lag between when policyholders pay their premiums and when carriers must remit rebates.

⁵³² *See id.* §§ 11:20-7.5(b)(2) & 11:21-7A.5(g).

Carriers must distribute any small group or individual MLR dividend or credit required “by December 31 of the year following the calendar year in which the loss ratio requirements were not satisfied.”⁵³³ The small group MLR refund regulation (but not the individual group) defines a “credit” as reducing a premium currently due and a “dividend” as a payment of cash.⁵³⁴ Rebates in the individual market must be made to “policy and contract holders,”⁵³⁵ but carriers in the small group market must issue dividends or credits “to each small employer who was covered for any period in the preceding calendar year.”⁵³⁶ While carriers in the individual market must make rebates for any refund owed that is \$5 or greater,⁵³⁷ the laws governing rebates in the small group market do not identify a minimum threshold for the required rebates, suggesting that issuers in the small group market must provide rebates of any value.

Refunds must be made within sixty days of when the Commissioner approves the carrier’s individual market refund plan in writing.⁵³⁸ Carriers in the individual market then must provide a certification attesting to their compliance with their refund obligations within thirty days of distributing required refunds.⁵³⁹ If a rebate remains unclaimed two years after the Commissioner approves the dividend plan, it is deemed abandoned and is subject to the Uniform Unclaimed Property Act.⁵⁴⁰ There is no provision for unclaimed refunds in the small group market.

D. New Jersey Report Required

Carriers in the small group market in New Jersey must file their loss ratio reports with the State Department of Banking and Insurance (“DOBI”) no later than August 1st each year.⁵⁴¹ The small group annual loss ratio report must include, among other things, “[t]he carrier’s earned premiums, before dividends or credits applicable to prior years, and claims for the preceding calendar year,” and the carrier’s MLR.⁵⁴² The form carriers must complete is available as Exhibit GG to the small group regulations.⁵⁴³

⁵³³ N.J. STAT. ANN. §§ 17B:27A-9(e)(2) & 17B:27A-25(g)(2); N.J. ADMIN. CODE § 11:21-7A.5(h).

⁵³⁴ N.J. ADMIN. CODE § 11:21-7A.4(a)(4).

⁵³⁵ *Id.* § 11:20-7.5(a).

⁵³⁶ *Id.* § 11:21-7A.5(f).

⁵³⁷ *Id.* § 11:20-7.5(b)(1).

⁵³⁸ *Id.* § 11:20-7.5(b)(3).

⁵³⁹ *Id.* § 11:20-7.7.

⁵⁴⁰ *See id.* § 11:20-7.6.

⁵⁴¹ N.J. STAT. ANN. § 17B:27A-25(g)(2); N.J. ADMIN. CODE § 11:21-7A.3(b). As discussed in the aggregation subsection above (Section A.3), New Jersey’s MLR statute and regulation specify how to aggregate standard, open nonstandard, closed nonstandard, and alliance health benefit plan data in the annual loss ratio report. *See* N.J. STAT. ANN. § 17B:27A-25(g)(2); N.J. ADMIN. CODE § 11:21-7A.3(a).

⁵⁴² N.J. ADMIN. CODE § 11:21-7A.4(a)(2) & (3). Exhibit GG to this regulation, which is the form carriers should use to complete their loss ratio reports, includes instructions for calculating earned premiums and claims. *See id.* § 11:21, Appx. Exh. GG.

⁵⁴³ *Id.* § 11:21, Appx. Exh. GG.

Similarly, carriers in New Jersey’s individual market must complete a Loss Ratio Report by August 15 each year, which must include, among other things, all of the components of the MLR formula, such as the carrier’s net earned premium for the preceding calendar year and total losses incurred, as well as its loss ratio for that reporting year.⁵⁴⁴ A carrier’s report shall combine all of its standard health benefit plans and basic and essential health care services plans written by that carrier, although affiliated carriers must file a separate report for each carrier as well as a combined report for all affiliated carriers.⁵⁴⁵ Exhibit J to the State’s individual market MLR regulations provides the form that carriers must complete each year.⁵⁴⁶

In both markets, carriers that fail to satisfy the minimum MLR must include a refund plan with the loss ratio report required each year, detailing how they plan to distribute all dividends and credits.⁵⁴⁷ A member of the American Academy of Actuaries must certify that the information in the loss ratio report is accurate and complete and that the carrier is in compliance with New Jersey’s MLR requirements.⁵⁴⁸ New Jersey does not require carriers to report “detailed information about the distribution of non-claims costs by function” in their annual loss ratio reports.⁵⁴⁹

E. New Jersey Special Circumstances

The minimum MLR in New Jersey’s small group and individual markets does not vary for any factor, such as plan size, plan type, or number of years of operation.⁵⁵⁰

F. New Jersey Enforcement

The Commissioner of DOBI has authority under New Jersey law to adopt regulations to implement the State’s MLR requirements.⁵⁵¹

⁵⁴⁴ See *id.* § 11:20-7.3; see also *id.* § 11:20, Appx. Exh. J; but see N.J. STAT. ANN. § 17B:27A-9(e)(2) (requiring individual market loss ratio report by August 1).

⁵⁴⁵ N.J. ADMIN. CODE § 11:20-7.3(a) & (b).

⁵⁴⁶ *Id.* §§ 11:20-7.3(a) & 11:20, Appx. Exh. J.

⁵⁴⁷ See N.J. STAT. ANN. § 17B:27A-25(g)(2); N.J. ADMIN. CODE §§ 11:20-7.5 & 11:21-7A.4(a)(4)-(6).

⁵⁴⁸ N.J. ADMIN. CODE §§ 11:20-7.4(a)(5) & 11:21-7A.4(a)(7). The individual group regulation also permits a member of the Society of Actuaries or Casualty Actuarial Society to make the required certification. See *id.* § 11:20-7.4(a)(5).

⁵⁴⁹ When asked, “To what extent do States and other entities receive detailed information about the distribution of non-claims costs by function (for example, processing and marketing)? To what extent do they set standards as to which overhead costs may be allocated to processing claims, or providing health improvements?”, New Jersey responded:

This information is not reported through the MLR report process (which has only premiums and claims). It is reported in the informational rate filing process for small employer (where it is confidential) and individual (where it is public). Other than the minimum loss ratio requirement of 80% which sets an aggregate standard 20% for administrative expenses (including health improvement) and underwriting gain, there are no requirements for any components.

NAIC response, supra note 495, at New Jersey’s Response to Question B.1.d.

⁵⁵⁰ *Id.* at New Jersey’s Responses to Questions A.1.b, B.1.e, & B.1.f.

A carrier that violates New Jersey’s loss ratio provisions “shall be liable to a penalty of not less than \$2,000 and not greater than \$5,000 for each violation,” which the Commissioner shall collect in a summary proceeding in accordance with the State’s penalty enforcement law.⁵⁵²

G. Use of MLR of MLR in Rate Review

New Jersey employs MLR calculations as part of its prospective rate review process. To support proposed rate increases, an actuary must certify that the carrier’s anticipated loss ratio will not be less than 80 percent.⁵⁵³ By using MLR calculations in this prospective manner, New Jersey tries to set initial rates such that carriers will achieve MLR targets without needing a retrospective correction. New Jersey’s Commissioner may disapprove a premium increase that he finds is not in substantial compliance with the State’s insurance laws.⁵⁵⁴

⁵⁵¹ See N.J. STAT. ANN. §§ 17B:27A-9(e)(2) & 25(g)(2).

⁵⁵² *Id.* § 17B:27A-43.

⁵⁵³ See *id.* §§ 17B:27A-9(e)(1) & 25(g)(1).

⁵⁵⁴ See *id.* § 17B:27A-9(d).

Appendix C: Summary of Research Regarding and Experience with Federal and New Jersey MLR Requirements

A. National MLR Experiences Prior to the ACA

A recent analysis of MLR data from 2006 to 2009 revealed that the average MLR for approximately 91 percent of health insurers nationwide exceeded the minimum loss ratio percentages required by the ACA even without applying the various provisions of the ACA that generally will yield higher MLRs, such as including quality expenditures, excluding taxes, and applying credibility adjustments, where appropriate.⁵⁵⁵

All markets showed relative stability over the four years: The mean in the individual market was 84.3 percent in 2006, 83.3 percent in 2007, 81.2 percent in 2008, and 84.7 percent in 2009; the small group mean was 79.5 percent in 2006, 81 percent in 2007, 80.6 percent in 2008, and 83.1 percent in 2009; and the large group mean was 84.9 percent in 2006, 87.3 percent in 2007, 87.3 percent in 2008, and 88.8 percent in 2009.⁵⁵⁶

The individual market, however, had a larger standard deviation than the small and large group markets, which reflects greater variability in that market (64.4-105 percent in the individual compared to 69.4-96.8 percent in the small group and 79-97.9 percent in the large group markets).⁵⁵⁷ MLRs also fluctuated more each year in the individual market. 70 percent of insurers in the individual market experienced annual average changes in their loss ratios of more than 5 percentage points from 2006 to 2009, while only 46 percent of small group insurers and 39 percent of large group insurers had such swings.⁵⁵⁸ Indeed, nearly 12 percent in the individual market had greater than 20 percent average annual changes in MLR during this time period; only 4 percent of insurers in both the small and large group markets saw similar annual fluctuations.⁵⁵⁹

Variation was not limited to the individual market, however. Smaller insurers with more than 1,000 but fewer than 75,000 life years (which are classified as partially credible under the

⁵⁵⁵ See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 11-711, PRIVATE HEALTH INSURANCE: EARLY EXPERIENCES IMPLEMENTING NEW MEDICAL LOSS RATIO REQUIREMENTS, at 3 n.6, 10 (July 2011), available at www.gao.gov/new.items/d11711.pdf [hereinafter JULY 2011 GAO REPORT] Notably, the study excluded, among others, insurers with less than 1,000 life years, which would not be subject to rebate requirements under the ACA. It also calculated data by insurer but across state lines and did not disaggregate data by insurer and by state, as the ACA requires. See *id.* at 11 n.21.

⁵⁵⁶ See *id.* at 10.

⁵⁵⁷ See *id.* at 11-12. See also U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 12-90R, PRIVATE HEALTH INSURANCE: EARLY INDICATORS SHOW THAT MOST INSURERS WOULD HAVE MET OR EXCEEDED NEW MEDICAL LOSS RATIO STANDARDS, at 6-8 (Oct. 31, 2011), available at <http://www.gao.gov/new.items/d1290r.pdf> [hereinafter OCTOBER 2011 GAO REPORT] (reporting, based on 2010 MLR data calculated according to the ACA's MLR methodology, that MLRs varied widely among insurers, especially for partially credible issuers and issuers in the individual market).

⁵⁵⁸ See JULY 2011 GAO REPORT, *supra* note 555, at 12.

⁵⁵⁹ See *id.* The study points out that the ACA's requirement to calculate MLR based on three years of data starting in 2013 could mitigate the impacts of this annual variability. See *id.* at 12-13.

ACA) in all three markets experienced greater variability in their MLRs from 2006 to 2009 than larger insurers with more than 75,000 life years (which are defined as fully credible under the ACA).⁵⁶⁰ Specifically, MLRs within one standard deviation above and below the mean ranged from 64-107.2 percent for smaller insurers but only from 69.1-90.2 percent for larger insurers in the individual market, 68.5-97.9 percent for smaller insurers compared to 73.9-91.5 percent for larger insurers in the small group market, and 78.1-99.5 percent for smaller insurers compared to 84.7-92.9 percent for larger insurers in the large group market.⁵⁶¹ In general, “a higher percentage of smaller insurers generally report[ed] lower MLRs.”⁵⁶²

B. MLR Experience in New Jersey Prior to the ACA

From the Department of Banking and Insurance’s (“DOBI”) reported perspective, New Jersey’s MLR regime has the virtue of relative simplicity, which allows both the State and insurers to have confidence that the result of the methodology matches the intent of the Legislature.⁵⁶³

In 2008, the average MLR in New Jersey’s small group market was 86.1 percent, even though New Jersey law required only a 75 percent MLR that year.⁵⁶⁴ Three carriers paid refunds in the standard small group market totaling approximately \$700,000 because they failed to satisfy the minimum MLR.⁵⁶⁵ Two carriers in the non-standard small group market paid small

⁵⁶⁰ See *id.* at 13-14.

⁵⁶¹ See *id.* at 15.

⁵⁶² See *id.* at 13. These variations may reduce under the ACA because partially credible insurers will be eligible for credibility adjustments. *Id.* In this regard, it is notable that the study aggregated data across state lines. Because the ACA requires issuers to calculate MLR in each market in each state, the number of partially credible issuers eligible for credibility adjustments likely will be higher than the number identified in this study. *Id.*

⁵⁶³ See *Health Policy Memo, Medical Loss Ratios: Evidence from the States*, FAMILIES USA (June 2008), <http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf> [hereinafter *Evidence from the States*].

⁵⁶⁴ Memorandum from R. Neil Vance, FSA, Managing Actuary, Life & Health Actuarial, and Avnee Parekh, ASA, Actuarial Analyst, Life & Health Actuarial, to Ellen DeRosa, Executive Director, SEH/IHC Boards, N.J. Dep’t of Banking & Ins. (Apr. 19, 2010), http://www.nj.gov/dobi/division_insurance/ihcseh/sehrpts/seh08lossratiortpt.pdf [hereinafter Apr. 19, 2010 Memorandum]; Commercial Loss Ratio 2008, DEP’T OF BANKING & INS. (Nov. 30, 2010), http://www.state.nj.us/dobi/lifehealthactuarial/2008comhealth_loss.pdf [hereinafter Commercial Loss Ratio 2008].

⁵⁶⁵ Apr. 19, 2010 Memorandum, *supra* note 564. These rebate amounts are strikingly less than the amounts estimated by a recent report prepared by the staff of the Senate’s Commerce, Science, and Transportation Committee for Chairman Rockefeller. As discussed below, see *infra* note 589 and accompanying text, this Report estimated that New Jersey consumers would have received \$28.87 million in rebates in 2010, if the Federal MLR requirements had been in effect. See MAJORITY STAFF OF THE COMM. ON COMMERCE, SCIENCE, AND TRANSP., OFFICE OF OVERSIGHT AND INVESTIGATIONS MAJORITY STAFF, COMPARE CONSUMER HEALTH INSURANCE SAVINGS UNDER THE MEDICAL LOSS RATIO LAW, Exh. 1 (Staff Report for Chairman Rockefeller) (May 24, 2011), available at http://commerce.senate.gov/public/index.cfm?p=Reports&ContentRecord_id=e5361268-9f7f-456c-b1ed-097c9cda2943&ContentType_id=6a6fef64-34f1-4348-b965-ec03a1dcadfe&Group_id=a89b0b93-3242-4d2a-82da-5e916a62b6a9 [hereinafter ROCKEFELLER REPORT]. At least some of this discrepancy is explained because the 2008 rebates were paid when New Jersey only required a minimum MLR of 75 percent. Further, the Rockefeller Report estimates the rebates that would be owed to consumers in the individual, small group, and large group markets, whereas the 2008 rebates summarized in the text concern only New Jersey’s small group market. Based on

refunds totaling \$150,000 even though the average MLR was higher in this segment of the market that year (89.2 percent after refunds).⁵⁶⁶ Premiums grew very slowly at about 1 percent in the standard small group market but declined in the non-standard small group market in 2008.

New Jersey's individual market has been less competitive than its small group market, and the minimum MLR is credited with helping to control premiums.⁵⁶⁷ Preliminary unpublished MLR data from DOBI show that in 2008, carriers in New Jersey's individual market, aggregated by common ownership, had MLRs ranging from 56.1 percent to 132.2 percent. The carrier with 66.6 percent of enrollment among the combined carriers had a combined MLR of 81.4 percent.⁵⁶⁸ The individual market in 2007 saw loss ratios for the four major carriers range from 72.4 percent to 110.8 percent, with an average MLR of 83 percent.⁵⁶⁹

Raising the minimum MLR in New Jersey to 80 percent in 2009 did not seem to destabilize these markets. Preliminary data from the 2009 MLR reporting year show that eight of ten carriers in the individual market satisfied the 80 percent MLR requirement. One of the carriers that failed to achieve this minimum had only 177 enrollees. The other had an MLR of 79.2 percent, just shy of the requirement.⁵⁷⁰ In 2010, the average MLR in the New Jersey's individual market, according to preliminary data from DOBI, was 87.6 percent. Seven of ten carriers met or exceeded the 80 percent MLR requirement. One carrier had a loss ratio of 75.6 percent when calculated as a legal entity. But because New Jersey aggregates loss ratios of affiliated carriers in its individual market, the combined ratio of this carrier and its affiliate, which had an MLR of 164.6 percent, was 150.3 percent, and thus this carrier was not subject to any rebate requirement. Similarly, another carrier that missed the minimum MLR – albeit by only one-tenth of a percent, with an MLR of 79.9 percent – did not have to pay a New Jersey rebate because its affiliate had an MLR of 86.6 percent, which gave these carriers a combined

preliminary MLR data from New Jersey for 2010, carriers in the large group market are responsible for a large portion of the estimated rebates. (Data on file with author.) The difference also could owe, at least to some extent, to differences in loss ratio data in 2008 and 2010. Notably, New Jersey carriers' loss ratios generally were lower in 2010 than in 2008.

⁵⁶⁶ Apr. 19, 2010 Memorandum, *supra* note 564; *see also* Memorandum from R. Neil Vance, FSA, Managing Actuary, Life & Health Actuarial, and Avnee Parekh, ASA, Actuarial Analyst, Life & Health Actuarial, to Ellen DeRosa, Executive Director, SEH/IHC Boards, N.J. Dep't of Banking & Ins. (Aug. 5, 2009), http://www.nj.gov/dobi/division_insurance/ihcseh/sehrpts/seh07lossratiopt.pdf (reporting that small group standard rebates totaled less than \$1 million in 2007).

⁵⁶⁷ *Evidence from the States*, *supra* note 563; *see generally* NAIC Response to Request for Information Regarding Section 2718 of the Public Health Service Act, at 6 (May 12, 2010), available at http://www.naic.org/documents/committees_e_hrsi_hhs_response_mlr_adopted.pdf ("It is generally more difficult to meet the 80% minimum standard in the individual market, due to the higher administrative expenses associated with marketing and servicing policies at the individual level.").

⁵⁶⁸ Data on file with author.

⁵⁶⁹ LIFE & HEALTH, N.J. DEP'T OF BANKING & INS., NJ COMMERCIAL HEALTH MARKET - 2007, ATTACHMENT 3, LOSS RATIOS (revised Nov. 18, 2009), <http://www.state.nj.us/dobi/lifehealthactuarial/commercialhealth2007.html>.

⁵⁷⁰ Data on file with author.

New Jersey MLR of 82.1 percent. The only other individual group carrier with an MLR less than 80 percent in 2010 had a loss ratio of only 50.9 percent but represented less than 0.1 percent of the market with an enrollment of only 44.⁵⁷¹

Only one of fourteen carriers in New Jersey's small group market in 2009 failed to satisfy the 80 percent minimum, and that carrier missed by 0.1 percent and had enrollment under 2,000. Although the average MLR for New Jersey's small group market was 83.3 percent in 2010, according to preliminary data from DOBI, the number of carriers that had loss ratios less than 80 percent grew to four of fourteen. Two of these carriers, however, were within a few percentage points of the minimum ratios, with loss ratios of 77.6 and 79.6 percent, respectively. Although the other two carriers had significantly lower MLRs (23.9 percent and 66.5 percent), together they accounted for less than 0.4 percent of the small group market.⁵⁷²

Although New Jersey does not presently have minimum MLR requirements in its large group market, data from DOBI reveal that the average MLR in the large group market in 2008 was 85.3 percent, with carriers' individual MLRs ranging from 67.3 percent to 113 percent.⁵⁷³ If New Jersey had had a minimum MLR of 85 percent in the large group in 2008, seven of the sixteen carriers, representing nearly 30 percent of the large group enrollment, would have had to pay rebates to consumers.⁵⁷⁴ Preliminary 2010 data for New Jersey's large group market reflect some slippage, with the average MLR dropping to 84.4% and the range of loss ratios for individual carriers going as low as 36.4 percent and as high as 108 percent. Half of the market's sixteen carriers, with a combined market share of 74 percent, had loss ratios greater than 85 percent. Had New Jersey imposed a minimum MLR of 85 percent in 2010, eight carriers would have had to pay rebates.⁵⁷⁵

C. Predicted Impact of Federal Rule on MLR Calculations

Because the Federal MLR methodology differs from those used by various states and relies on data that has not historically been collected, including quality improvement expenditures and expatriate health plans, it is difficult to calculate the impact Federal law will have on MLR calculations in the states. For example, even if we had data on how much issuers spent last calendar year on quality improving activities that would satisfy the Federal MLR Regulations'

⁵⁷¹ Data on file with author.

⁵⁷² Data on file with author.

⁵⁷³ See Commercial Loss Ratio 2008, *supra* note 564.

⁵⁷⁴ See *id.* This estimate is based on MLRs calculated pursuant to New Jersey's methodology and does not predict the impact of using the Federal MLR methodology in New Jersey's large group market.

⁵⁷⁵ Data on file with author. Again, these estimates assume application of New Jersey's MLR methodology. Several of these eight carriers might not have had to pay rebates if their loss ratios were calculated under the Federal methodology because of the impact of various elements of the Federal formula, such as including quality improving expenditures in the numerator, reducing taxes from premiums, credibility adjustments, and special aggregation rules for certain affiliated entities. In addition, two of the eight carriers with MLRs less than 85 percent no longer offer health insurance policies in New Jersey.

demanding requirements, issuers may well change their behavior, now that these costs are included in the MLR numerator, and spend more on these activities to increase MLR.⁵⁷⁶

Grounded in discussions with industry experts and as summarized in the preamble to the IFR, the United States Department of Health and Human Services (“HHS”) made “a range of estimates, based on a range of assumptions,” of the effects the Federal MLR requirements will have on an issuer’s MLR, based on estimated spending on quality improvements and behavioral changes in response to the rules, such as lowering premiums, improving efficiencies, or increasing spending on health claims or quality.⁵⁷⁷ Specifically, HHS’s mid-range estimate is that including quality improvement activities could increase an issuer’s MLR by 3 percentage points, with a reasonable range of 1 to 5 percentage points. Similarly, the mid-range estimate of the effect on the MLR percentage of the behavioral changes in response to the requirements is 1 percentage point, with a reasonable range from 0 to 2 percentage points. HHS further assumed, however, that issuers whose MLR already is above the applicable minimum MLR will have less incentive to change their behavior (by, for example, increasing spending on quality activities, becoming more efficient, or lowering premiums) to try to raise their MLR to avoid paying rebates. Combining these assumptions, HHS estimated that the new Federal requirements would add somewhere from 1 to 7 percentage points to an issuer’s MLR, with a mid-range estimate of a 4 percentage point increase to MLR.⁵⁷⁸

Based on these assumptions, HHS made the following estimates:

- The Federal MLR requirements will protect up to 74.8 million Americans each year, nine million of whom could be eligible for rebates beginning in 2012 totaling between \$0.6 billion to \$1.4 billion annually.⁵⁷⁹ The mid-range estimate for rebates in each market in 2011 is:
 - \$521 million in the individual market, which:

⁵⁷⁶ See Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, 75 Fed. Reg. 74,864, 74,893 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158) [hereinafter IFR Preamble, 75 Fed. Reg. at X]; see also JULY 2011 GAO REPORT, *supra* note 555, at 10.

⁵⁷⁷ See IFR Preamble, 75 Fed. Reg. at 74,900-01, *supra* note 576. These estimates are based on the provisions in the IFR and do not take into account the modifications that the Final MLR Rule made to the IFR, such as graduating the mini-med special circumstances numerator adjustment factor from 2.0 in 2011 to 1.75 in 2012, 1.5 in 2013, and 1.25 in 2014; permitting issuers to count some ICD-10 conversion costs as quality improving activities in 2012 and 2013; and altering the requirements relating to deducting community benefit expenditures from earned premium. See Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 76,574, 76,581, 76,583, 76,586 (Dec. 7, 2011) (to be codified at 45 C.F.R. pt. 158) [hereinafter MLR Final Rule Preamble, 76 Fed. Reg. at X]. The Regulatory Impact Statement in the preamble to the Final MLR Rule estimates the benefits, costs, and transfers of these modifications. See *id.* at 76,582-90.

⁵⁷⁸ See IFR Preamble, 75 Fed. Reg. at 74,900-01, *supra* note 576.

⁵⁷⁹ See *id.* at 74,893; *Medical Loss Ratio: Getting Your Money’s Worth on Health Insurance* (Nov. 22, 2010), http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html (last visited Aug. 18, 2011).

- Represents 7 percent of premiums at companies required to pay rebates and 2 percent of all premiums written in the market.
 - Affects 28 percent of enrollees (or 3.2 million people), who are estimated to receive an average rebate of \$164 per person.
 - \$226 million in the small group market, which:
 - Represents less than 1 percent of premiums at companies required to pay rebates and 8 percent of all premiums written in the market.
 - Affects 3 percent of enrollees (or 700,000 people), who are estimated to receive an average rebate of \$312 per person.
 - \$121 million in the large group market, which:
 - Represents less than 1 percent of premiums at companies required to pay rebates and 5 percent of all premiums written in the market.
 - Affects 2 percent of enrollees (or 700,000 people), who are estimated to receive an average rebate of \$166 per person.⁵⁸⁰
- The average adjusted MLRs (taking into account the new Federal requirements, such as taxes, licensing and regulatory fees, quality improving activities, and assumed behavioral changes) among fully or partially credible entities in 2011 are estimated to be:
 - 86.5 percent in the individual market, with a range of 84.2 to 87.2 percent.
 - 90.8 percent in the small group market, with a more conservative estimate of 88.7 percent.
 - 94.2 in the large group market, with a more conservative estimate of 92.2 percent.⁵⁸¹
- Of licensed entities selling insurance in the individual market in 2011 throughout the country:
 - 68 percent will have fewer than 1,000 enrollees in at least one state and thus will be deemed non-credible (although these entities account for 1 percent of enrollees and two percent of earned premiums⁵⁸²).
 - 30 percent will be partially credible.

⁵⁸⁰ See IFR Preamble, 75 Fed. Reg. at 74,906-09, *supra* note 576.

⁵⁸¹ See *id.* at 74,904-05.

⁵⁸² See *infra* notes 592-599 and accompanying text, discussing credibility adjustments and market share.

- 2 percent will be fully credible (accounting for 50 percent of enrollees and 40 percent of premiums).⁵⁸³
- Estimated average administrative costs of complying with the Federal MLR requirements include:⁵⁸⁴
 - Estimated costs related to MLR reporting requirements: approximately \$75,018 to \$151,507 per issuer in one-time costs and \$17,261 to \$32,259 per issuer in annual ongoing costs.
 - Estimated costs related to MLR rebate notifications and payments: annual ongoing costs of approximately \$58,010 to \$122,891 per affected issuer.⁵⁸⁵
- If HHS adopted a narrow definition of which taxes to exclude from the Federal denominator by requiring issuers to include payroll and Social Security taxes, the mid-range estimate for increases in the average rebate would be \$31 million in the individual market and \$9 million in both the small and large group markets.⁵⁸⁶

The National Association of Insurance Commissioners (“NAIC”) also has estimated the impact the new MLR law will have.⁵⁸⁷ Assuming the Federal MLR requirements had been in place in 2010, it calculated the following estimates:

- In the individual market:
 - Median MLR would be 73.9 percent.
 - 14.2 percent of issuers would pay rebates to 52.9 percent of subscribers.
 - Rebates would total \$978.3 million, or \$8.09 per person per month.
- In the small group market:
 - Median MLR would be 82.3 percent.
 - 15.7 percent of issuers would pay rebates to 22.8 percent of policyholders.
 - Rebates would \$447.4 million, or \$2.13 per person per month.

⁵⁸³ See *id.* at 74,902-03.

⁵⁸⁴ As noted in *supra* note 577, HHS’s estimates do not factor in the modifications to the Federal MLR methodology made by the Final MLR Rule, including changes that likely will affect the administrative cost of compliance. For example, the Regulatory Impact Statement in the preamble to the Final MLR Rule estimates that the changes in the Final Rule will result in a total of approximately \$2.8 million annually in reduced annual reporting costs for mini-med and expatriate plans and approximately \$1.8 million annually in reduced administrative costs for rebate distribution by group plans. See MLR Final Rule Preamble, 76 Fed. Reg. at 76,586, *supra* note 577.

⁵⁸⁵ See IFR Preamble, 75 Fed. Reg. at 74,910-16, *supra* note 576.

⁵⁸⁶ See *id.* at 74,917.

⁵⁸⁷ Like HHS’s estimates discussed above, the estimates calculated in the NAIC, Rockefeller, and July and October 2011 GAO reports, discussed *infra*, were based on the IFR and did not consider the impact of the modifications made in the Final MLR Rule.

- In the large group market:
 - median MLR would be 89.4 percent.
 - 15 percent of issuers would pay rebates to 14.7 percent of policyholders.
 - Rebates would total \$526.7million, or \$1.13 per person per month.⁵⁸⁸

Based on NAIC data, a Staff Report for the Senate’s Commerce, Science, and Transportation Committee [“Rockefeller Report”] estimated that New Jersey consumers would have received \$28.87 million in rebates in 2010, if the Federal MLR requirements had been in effect.⁵⁸⁹ A recent Commonwealth Fund report prepared by Mark Hall and Michael McCue similarly estimated that insurers would have had to pay almost \$2 billion in rebates nationally and almost \$30 million in New Jersey if the Federal MLR requirements had been in place in 2010.⁵⁹⁰ Interestingly, they also found that “insurers that are privately-owned, nonprofit, and provider-sponsored would be substantially less likely than their counterparts to owe rebates in each of the market segments.”⁵⁹¹

The Government Accountability Office (“GAO”) recently estimated that approximately half of all insurers in the nation’s small and large group markets and a bit less than one-third of insurers in its individual markets will be deemed partially credible (because they have at least one thousand but fewer than 75,000 life-years) and thus will be eligible to apply credibility adjustments to their Federal loss ratio.⁵⁹² These numbers do not capture market share, however. Although a small percentage of insurers nationally have more than 75,000 life-years (and thus are fully credible and ineligible for credibility adjustments), these insurers command the majority of total life-years covered nationally.⁵⁹³

It is not clear what impact credibility adjustments will have on New Jersey insurers or markets. A substantial percentage of the insurance companies in New Jersey’s markets will

⁵⁸⁸ See NAIC REPORT OF THE HEALTH CARE REFORM ACTUARIAL (B) WORKING GROUP TO THE HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE ON REFERRAL FROM THE PROFESSIONAL HEALTH INSURANCE ADVISORS (EX) TASK FORCE REGARDING PRODUCER COMPENSATION IN THE PPAC MEDICAL LOSS RATIO CALCULATION (May 26, 2011), http://www.naic.org/documents/committees_b_110607_hcrawg_report.pdf [hereinafter NAIC REPORT].

⁵⁸⁹ See ROCKEFELLER REPORT, *supra* note 565; As noted in footnote 565 *supra*, these rebate estimates dwarf the rebates carriers in New Jersey’s small group market paid in 2008, although there are substantial reasons why it is inappropriate to compare these varying estimates.

⁵⁹⁰ See Mark A. Hall & Michael J. McCue, Commonwealth Fund, *Estimating the impact of the Medical Loss Ratio Rule: A State-by-State Analysis*, at 1, 4, 6-7 (Apr. 2012), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Mar/1587_Hall_medical_loss_ratio_ib.pdf; cf. Jill S. Herbold, FSA, MAAA, *Medical Loss Ratios and Illustrative Rebates: 2010 Commercial Health Insurance*, Milliman Research Report, at 4, 6 (Feb. 2012), <http://publications.milliman.com/publications/health-published/pdfs/commercial-health-insurance-mlr-2010.pdf> (predicting, based on preliminary 2010 medical loss ratios, that “illustrative rebate amounts totaling nearly \$2 billion, or 0.8% of premium across the large group, small group, and individual insured markets”).

⁵⁹¹ Hall & McCue, *supra* note 590, at 8.

⁵⁹² See JULY 2011 GAO REPORT, *supra* note 555, at 7.

⁵⁹³ See *id.*

qualify to apply a credibility adjustment to their loss ratio. For example, had the Federal requirements been in place in 2008, preliminary data from DOBI suggest that although four of sixteen insurers in New Jersey's large group market would have been fully credible, twelve of sixteen would have been partially credible. Similarly, three of fourteen insurers in the small group market would have been fully credible, but seven would have been partially credible, and four would have been non-credible. No insurers in New Jersey's individual market in 2008 would have been fully credible, whereas six of nine would have been partially credible, and three of nine would have been non-credible. Preliminary data for the 2010 MLR reporting year reveal similar numbers: nine of sixteen carriers in the large group market would have been partially credible and two would have been non-credible; seven of fourteen carriers in the small group market would have been partially credible and four would have been non-credible; and in the individual market, seven of ten would have been partially credible and three would have been non-credible.⁵⁹⁴

Looking at current enrollment data in New Jersey, three carriers in its individual market have fewer than 1,000 enrollees and thus would be deemed non-credible and not responsible for any rebate payments.⁵⁹⁵ Three additional carriers have more than 1,000 but fewer than 75,000 enrollees, and thus would be partially credible and eligible for credibility adjustments to their loss ratio.⁵⁹⁶ Based on this preliminary data, only one carrier in New Jersey's individual market would be ineligible for credibility adjustments in 2011 because its enrollment is equal to or greater than 75,000.⁵⁹⁷

Like the Federal numbers reported by GAO, however, New Jersey's numbers are misleading without market share as a backdrop. In 2011, the apparently sole, fully credible carrier in New Jersey's individual market commands 73.34 percent of that market, whereas the partially credible carriers represent only 26.61 percent of that market.⁵⁹⁸ Similarly, in 2008, four fully credible insurers held 77.3 percent of New Jersey's large group market, compared with 22.7 percent held by twelve partially credible issuers. Three fully credible insurers controlled 71.5 percent of the small group market, whereas seven partially credible companies had 28.3

⁵⁹⁴ Data on file with author.

⁵⁹⁵ See *Individual Health Coverage Program, 2Q11*,

http://www.nj.gov/dobi/division_insurance/ihcseh/enroll/2q11ihccarriers.pdf.

⁵⁹⁶ See *id.* But see 45 C.F.R. § 158.232(d) (setting forth conditions under which there will be no credibility adjustment for the 2013 MLR reporting year for partially credible experience); IFR Preamble, 75 Fed. Reg. at 74,881-82, *supra* note 576 (explaining that "[t]his exception prevents issuers from receiving a credibility adjustment when the issuer consistently sets its prices to produce an MLR below the statutory 80 percent MLR standard").

⁵⁹⁷ See *Individual Health Coverage Program, 2Q11, supra* note 595. These estimates of which New Jersey carriers would be eligible for credibility adjustments are based on one year of data. Although the Federal MLR Regulations instruct that "[t]he life-years used to determine the credibility of an issuer's experience are the life-years for the MLR reporting year plus the life-years for the two prior MLR reporting years," 45 C.F.R. § 158.231(a), the regulations also have special provisions for the first two years of implementation, see *id.* § 158.231(b) and (c).

⁵⁹⁸ See *Individual Health Coverage Program, 2Q11, supra* note 595.

percent and four non-credible had less than 1 percent of the market. Three non-credible issuers in the individual market had less than 1 percent of the market while the six partially credible insurers commanded a whopping 99.4 percent of the market. Preliminary data from DOBI for 2010 are consistent with these numbers: five fully credible carriers controlled 83.8 percent of New Jersey's large group market, leaving nine partially credible carriers (16 percent) and two non-credible carriers (0.2 percent) to split the remainder; three fully credible carriers held 71.8 percent of the small group market, while seven partially credible carriers represented 28 percent of market share and four non-credible carriers nibbled at less than 1 percent of the market; and seven partially credible carriers dominated the individual market with 99.7 percent market share, with the sliver left for three non-credible carriers to share.⁵⁹⁹

It is important to consider market share when evaluating the impact credibility adjustments will have on individual carriers and the market as a whole. If these insurance markets are described in terms of their participating insurers, it could appear that there is a high concentration of insurers with less than full credibility. But if the same markets are described in terms of the insured consumers, a large percentage is covered by insurers with fully (or at least partially) credible insurers.

The GAO issued a report in July 2011 summarizing its interviews of “a judgmental sample of seven insurers – selected to provide a range based on their size, profit status, and the number of states in which they operated” – to learn about their early experiences implementing the new Federal requirements.⁶⁰⁰ Most agreed that deducting taxes and fees from the MLR denominator “would constitute the largest change” to the loss ratio calculation.⁶⁰¹ The state regulators interviewed agreed.⁶⁰² One insurer estimated that reducing premiums by taxes would have more than double the effect on MLR of including quality improving expenses in the numerator.⁶⁰³ Others recognized that the effect will depend on state tax laws.⁶⁰⁴ Another observed that even though excluding taxes will have the biggest impact on

⁵⁹⁹ Data on file with author.

⁶⁰⁰ See JULY 2011 GAO REPORT, *supra* note 555, at 15.

⁶⁰¹ See *id.*; see also OCTOBER 2011 GAO REPORT, *supra* note 557, at 10 (finding, based on 2010 MLR data analyzed according to the ACA's MLR methodology, that the deduction of taxes and fees from the MLR denominator accounted for the greatest increase in average MLR in all three markets).

⁶⁰² See JULY 2011 GAO REPORT, *supra* note 555.

⁶⁰³ See *id.*

⁶⁰⁴ See *id.* Because some taxes in New Jersey are calculated based on net premiums, it is easy to estimate their impact on MLR. For example, HMOs pay 2 percent of premiums to the charity care assessment, see N.J. STAT. ANN. § 26:2J-47(a)(1), while non-HMOs in the group markets pay 1 percent of premiums, see *id.* § 54:18A-2(b), and non-HMOs in the individual market pay 2 percent of premiums in State taxes, see *id.* § 54:18A-2(a). Because these amounts will reduce the MLR denominator, at a minimum, the impact of the tax deduction in New Jersey will increase MLR by approximately 1.6 percent for HMOs in all markets (individual, small group, and large group); 0.8 percent for any other non-HMO group coverage; and 1.6 percent for non-HMO individual coverage. Although these numbers do not account for all taxes and fees that are relevant for the Federal calculations, such as Federal Income Tax, they provide a ballpark estimate for the minimum impact of the extent to which the Federal treatment of taxes and fees will affect MLR calculations for New Jersey carriers.

MLR calculation, if the carrier experiences loss of profits, and thus a reduction in income taxes, this deduction would lower its MLR.⁶⁰⁵

Although the interviewed insurers agreed that excluding taxes and fees likely would have more of an impact on MLR calculations than including quality improvement spending, they differed in their estimation of the impact quality spending would have. Two, for example, estimated that including quality would have “very little impact” on their MLR, while another estimated increases of only 0.5 of its total estimated 2.0-2.5 percent increase in overall MLR as a result of the ACA, and a fourth put the number at less than 2 percent.⁶⁰⁶ Insurers counted disease management programs, wellness activities, 24-hour nurse hotlines, and care coordination as quality improving activities.⁶⁰⁷

The July 2011 GAO report also predicted that the ACA’s aggregation rules will result in variation of MLRs for insurers that provide coverage in more than one state.⁶⁰⁸ After the ACA, companies that offer insurance in more than one state no longer may aggregate their MLRs to help spread out higher administrative costs. Instead, they generally must separately aggregate their MLR data in each market in each state, which will result in lower MLRs in the states where plans have higher administrative costs due, for example, to offering lower benefit plans.⁶⁰⁹ The July 2011 GAO report, however, was based on data that preceded enactment of the ACA and calculated MLR using pre-ACA methodologies, including aggregating data by issuer across state lines.⁶¹⁰

GAO issued another report in October 2011 that evaluated preliminary MLR data that insurers submitted to NAIC based on their 2010 experience.⁶¹¹ Although these data are from a period before the ACA’s MLR provisions went into effect, GAO employed the ACA’s MLR

⁶⁰⁵ See JULY 2011 GAO REPORT, *supra* note 555.

⁶⁰⁶ See *id.* at 15-16.

⁶⁰⁷ See *id.* at 16. A recent Milliman study made similar findings based on preliminary 2010 medical loss ratios: that 83 percent of the large group, 74 percent of the small group, and 48 percent of the individual market would exceed Federal MLR requirements; that the Federal adjustments to MLR increased preliminary MLRs by an average of 2.7 percent in the large group, 3.5 percent in the small group, and 3 percent in the individual group markets; and that the adjustment for taxes and regulatory fees had a greater impact on MLR (2 percent in the large group, 2.8 percent in the small group, and 2.3 percent in the individual markets) than the adjustment for quality improving expenses in the numerator (0.7 percent in each market) or deducting fraud and abuse detection and recovery expenses from the denominator (< 0.2 percent). See Jill S. Herbold, FSA, MAAA, *Medical Loss Ratios and Illustrative Rebates: 2010 Commercial Health Insurance*, Milliman Research Report, at 4, 6 & n.2, 7 (Feb. 2012), <http://publications.milliman.com/publications/health-published/pdfs/commercial-health-insurance-mlr-2010.pdf>.

⁶⁰⁸ JULY 2011 GAO REPORT, *supra* note 555, at 16.

⁶⁰⁹ See *id.*

⁶¹⁰ OCTOBER 2011 GAO REPORT, *supra* note 557, at 5 & n.13.

⁶¹¹ *Id.* at 2. Given that these data predate implementation of the MLR requirements, GAO warned that they “should be considered transitional and may reflect best estimates that will become more precise with data reported for 2011 and future years.” *Id.* For example, some issuers used best estimates to report their quality improving expenses for 2010. See *id.* 9 n.17. Indeed, although 11 percent of issuers did not report any spending on quality improving activities, at least one issuer interviewed indicated that it did not yet have adequate information to report qualified spending but would develop the means for 2011 reporting. *Id.* at 9.

methodology in analyzing them.⁶¹² GAO found that 64 percent of credible insurers⁶¹³ in all markets, covering at least 77 percent of covered lives, would have met or exceeded the ACA's MLR standards.⁶¹⁴ When analyzed by market, 77 percent of the large group market (representing 58 percent of covered lives) and 70 percent of the small group market (representing 27 percent of covered lives) would have satisfied the requirements, compared with only 43 percent of the credible issuers in the individual market (representing 15 percent of covered lives).⁶¹⁵

GAO calculated average MLR as 89.5 percent in the large group market, 85.0 percent in the small group market, and 78.8 percent in the individual market (79.1 percent when GAO excluded the data for the five states granted an adjustment of their MLR).⁶¹⁶ It reasoned that one of the reasons MLR tends to be higher on average in the groups markets than in the individual market is because nonclaims expenses are lower on average in these markets.⁶¹⁷ While nonclaims expenses averaged 13 and 16 percent of earned premiums in the large and small group markets, respectively, they averaged 23 percent in the individual market.⁶¹⁸ Brokers fees explained some of this variation. Issuers in the small and large group markets spent an average of 3 and 5 percent, respectively, of earned premium on broker fees, compared with 7 percent on average in the individual market.⁶¹⁹

Interestingly, GAO found that, on average, MLR increased more in the individual and small group markets than it did in the large group market as a result of the credibility adjustment and the other new components of the ACA's MLR methodology. As GAO reported, "[t]he average adjusted [ACA] MLRs for individual, small group, and large group market insurers in 2010 were 7.5, 6.5, and 4.8 percentage points higher, respectively, than the average MLRs for these markets calculated without the credibility adjustment and using the traditional MLR formula."⁶²⁰ The credibility adjustment, which only applies to partially credible insurers, accounted for the largest percentage point increase in average MLR in all three markets, with

⁶¹² As the GAO warns, the MLRs it calculated in its July 2011 Report are not comparable with the MLRs reported in its October 2011 Report because the latter report used the ACA's methodology. *See id.* at 5 n.13.

⁶¹³ GAO excluded non-credible issuers from the analysis but included partially credible (after applying credibility adjustments) and credible issuers in the analysis. *Id.* at 6 & n.15. Note that because issuers did not have to report data on deductibles in 2010, GAO "applied a 1.0 multiplier for the deductible adjustment factor for the credibility adjustment." *Id.* at 2 n.8. As a result, to the extent insurers had plans with deductibles greater than \$2,500, and thus would be eligible to use a deductible adjustment factor greater than 1.0, GAO's analysis reported in its October 2011 report underestimates the credibility adjustment the issuer would receive. *Id.*

⁶¹⁴ *See id.* at 3, 6.

⁶¹⁵ *Id.* at 6. In calculating MLR in the individual market, GAO used the lower 2011 MLR standard approved by HHS for the individual markets in five states. *Id.* at 6, Table 1 n.b.

⁶¹⁶ OCTOBER 2011 GAO REPORT, *supra* note 557, at 6. *See* Section E, *infra*, for a discussion of requests to adjust MLR in the individual market).

⁶¹⁷ OCTOBER 2011 GAO REPORT, *supra* note 557, at 9.

⁶¹⁸ *Id.* at 9.

⁶¹⁹ *Id.*

⁶²⁰ *Id.* at 3.

average increases ranging from 2.7 percentage points in the large group market, 3.3 percentage points in the small group market, and 4.2 percentage points in the individual market.⁶²¹ When it analyzed the components of the MLR formula, which apply to all issuers, GAO found that the deduction for Federal and state taxes and regulatory fees accounted for the largest percentage point increase in MLR in all three markets compared with other components of the ACA's MLR formula, including quality improving and fraud and abuse detection and recovery expenses.⁶²² Deducting taxes and fees from the denominator increased MLR by an average of 2.6 percentage points in the individual market, 2.3 percentage points in the small group market, and 1.3 percentage points in the large group market. Including quality improving expenses in the numerator accounted for MLR increases of 2.6 percentage points in the individual market, 2.3 percentage points in the small group market, and 1.3 percentage points in the large group market.⁶²³

The October 2011 GAO report also confirmed insurers' prediction regarding the impact of the Federal MLR aggregation requirements on insurers providing coverage in more than one state. Indeed, many of the issuers operating in more than one state, which now must calculate MLR for each market of each state in which they operate, reported 2010 MLRs across a wide range for those states. For example, an issuer's MLR would have been 72 percent if it combined its experience in the twenty states where it operated, as was the practice before the ACA. But when it calculated MLR for each state and market, as the ACA requires, it reported MLRs ranging from 50 to 94 percent.⁶²⁴ Another issuer operating in the small group market in two states had MLRs of 66 percent in one state, 103 percent in another, and an aggregated MLR in both of 84 percent.⁶²⁵ It thus would have to pay a Federal rebate in the state where its MLR failed to reach 80 percent even though its aggregated MLR was greater than 80 percent.

The Kaiser Family Foundation ("KFF") recently analyzed insurers' estimated 2012 rebates, based on 2011 MLR estimates, as reported by insurers to NAIC in the 2011 Supplemental Health Care Exhibit.⁶²⁶ Based on these preliminary reports, insurers reportedly expect to pay a total of approximately \$1.3 billion in rebates for the 2011 MLR reporting year: \$426 million to 3.4 million people in, or 31 percent of, the individual market, with an average rebate of \$127 among those receiving rebates; \$377 million to 4.9 million people in, or 28 percent of, the small group market, with an average rebate of \$76 among those receiving

⁶²¹ See *id.* at 9-10.

⁶²² *Id.* at 10 & n.18.

⁶²³ *Id.* at 10.

⁶²⁴ *Id.*

⁶²⁵ *Id.*

⁶²⁶ See Cynthia Cox *et al.*, Kaiser Family Foundation, *Focus on Health: Insurer Rebates under the Medical Loss Ratio: 2012 Estimates*, at 8 (Apr. 2012), <http://www.kff.org/healthreform/upload/8305.pdf>.

rebates; and \$541 million to 7.5 million people in, or 19 percent of, the large group market, with an average rebate of \$72 among those receiving rebates.⁶²⁷

The KFF report also reports that New Jersey insurers expect to pay more than \$106 million in rebates in 2012 – more than triple the approximately \$30 million estimated by the Rockefeller and Commonwealth Reports based on 2010 MLR data.⁶²⁸ Specifically, it is estimated that two plans in New Jersey’s individual market will pay rebates totally approximately \$6.2 million to 62 percent of the market.⁶²⁹ The analysis further predicts that four plans will pay more than \$41 million to 79 percent of New Jersey’s small group market, while five plans will pay nearly \$59 million to 67 percent of its large group market.⁶³⁰ These estimates are rather surprising, given New Jersey’s historic experience with MLR requirements and rebates.⁶³¹ Without final numbers and more information about the methodology KFF employed, however, it is difficult to evaluate these estimates. For example, it is not clear if insurers factored credibility adjustments into their estimates or otherwise incorporated all of the elements of the Federal formula into their MLR calculations, such as including quality expenses in the numerator or deducting taxes and regulatory fees from the denominator. It will be interesting to analyze insurers’ final numbers this summer.

D. Possible Issuer Response to Federal MLR Requirements

Issuers may respond in a number of ways to the new Federal MLR requirements. While there is risk some insurers will increase premiums, restructure coverage, or even leave markets altogether, proponents hope insurers will raise their MLRs by finding ways to be more efficient by, for example, reducing administrative costs, such as profits or broker fees, reducing premiums, or increasing spending on health care claims or quality improving activities.⁶³²

Some opponents of the Federal reforms have sounded the alarm bell. Witnesses, for example, testified before the House Energy and Commerce Subcommittee that Federal MLR requirements “will ultimately raise costs and reduce options for consumers.”⁶³³ University of Pennsylvania Professor Scott Harrington reportedly opined that the Federal MLR rules “distort insurers’ incentives for legitimate business decisions.”⁶³⁴

⁶²⁷ *Id.* at 1-3.

⁶²⁸ See *supra* notes 565 & 589-590 & accompanying text.

⁶²⁹ See *Cox, supra* note 626, at 5.

⁶³⁰ *Id.* at 6-7

⁶³¹ See *supra* notes 565 & 589 & accompanying text.

⁶³² See Roger Collier, *Could the New Medical Loss Ratio Provisions Increase Premiums?*, HEALTH FIN. NEWS (Sept. 24, 2010), <http://www.healthcarefinancenews.com/blog/could-new-medical-loss-ratio-provisions-increase-premiums>.

⁶³³ Sam Baker, *Insurance Agents Say MLR Rules Create ‘Desperate’ Situation*, HEALTHWATCH: THE HILL’S HEALTHCARE BLOG (June 2, 2011 5:16 PM), <http://thehill.com/blogs/healthwatch/health-reform-implementation/164503-insurane-agents-say-mlr-rules-create-desperate-situation>.

⁶³⁴ *Id.*

Evidence to support these claims is mixed. GAO recently interviewed seven issuers to gauge issuer response to the new Federal requirements.⁶³⁵ Some issuers are responding (or planning to respond) by exiting markets, closing blocks of business, and/or increasing barriers to access. GAO reports, for example, that one large insurer operating in multiple states already has exited the individual market in one state, where it did not have a large market share, at least in part because of the loss ratio requirements, and it is considering whether to leave the individual market in other states where it anticipates difficulty meeting the minimum MLR ratio.⁶³⁶ A for-profit issuer intends to exit or stop issuing new policies in the individual markets in several states and to consolidate some companies that might not meet the standard as distinct legal entities.⁶³⁷

Several insurers, however, said the MLR requirements will not affect their decision about where to conduct business.⁶³⁸ One nonprofit explained that part of its mission is to serve its community and thus would not be exiting any of its markets.⁶³⁹ Another issuer indicated that although it may eliminate some of its high and mid-level deductible plans, it is not planning to exit any markets.⁶⁴⁰

A recent study in the *American Journal of Managed Care* focused on the ACA's threat to individual market stability and access to care in that market.⁶⁴¹ The study aimed to estimate the portion of the individual market "that may be vulnerable to major coverage disruption due to poor health status."⁶⁴² To do so, the authors had to adjust historical MLR data to account for quality improvement expenses, which are not captured in MLR calculations prior to the ACA. Citing unspecified "anecdotal evidence suggest[ing] a possible upward shift on MLRs on the order of 5 percentage points," the authors added 5 percentage points to each issuer's MLR for this study.⁶⁴³

Applying this adjusted Federal MLR calculation to 2009 data, the study estimated that approximately 29 percent of insurers in the individual market, which insure 32 percent of enrollees, would fail to satisfy the Federal 80 percent MLR minimum. If these insurers choose to

⁶³⁵ See JULY 2011 GAO REPORT, *supra* note 555, at 19.

⁶³⁶ See *id.*

⁶³⁷ See *id.*

⁶³⁸ See *id.*

⁶³⁹ See *id.*

⁶⁴⁰ See *id.*

⁶⁴¹ Jean M. Abraham and Pinar Mandic, *Regulating the Medical Loss Ratio: Implications for the Individual Market*, 17 AM. J. MANAGED CARE 211 (March 2011).

⁶⁴² See *id.*

⁶⁴³ See *id.* at 212. *But see supra* note 107 and accompanying text in the main brief (citing estimates as low as 0.5 percentage points for the impact of including spending on quality improvements in MLR calculations); OCTOBER 2011 GAO REPORT, *supra* note 557, at 10 (analyzing 2010 MLR data using the new Federal MLR requirements and finding that including quality improving expenses in the numerator accounted for MLR increases of 2.6 percentage points in the individual market, 2.3 percentage points in the small group market, and 1.3 percentage points in the large group market).

leave the market rather than pay rebates, “major coverage disruption could occur for those in poor health.” The authors estimated that between 104,624 and 158,736 member-years were at risk.⁶⁴⁴

In total, the study estimated that 2.18 million member-years out of 6.7 million nationally were associated with insurers with an estimated adjusted MLR under 80 percent. The threat is particularly palpable in certain states. For example, the authors identified nine states in which at least 50 percent of health insurers would likely fail to meet the Federal MLR minimum requirement. In twelve states, at least one-half of the enrollees were affiliated with health insurers with estimated adjusted MLRs under 80 percent, which represent 1.87 million member years, or 28 percent of total enrollment in this country.⁶⁴⁵

Its estimates concerning New Jersey, however, were far less dramatic. Based on the study’s adjusted MLR data, only one out of ten active health insurers in New Jersey’s individual market in 2009 would not have met the MLR minimum, which insurer was associated with 177 member years. Because this carrier would be deemed non-credible (and thus not liable to pay rebates under the ACA), it is unlikely the Federal MLR requirement will cause it to exit the market or eliminate the product line. Even if this carrier chooses to exit the market or eliminate product lines rather than pay the required rebate, the authors estimated that between 8 and 2,414 enrollees could be vulnerable to coverage disruption.⁶⁴⁶

As the study authors acknowledge, however, insurers may respond in a variety of ways to the Federal requirements, including “cutting administrative expenses related to marketing or distribution, lowering premiums, using less aggressive medical management, dropping product lines that may contribute to lower MLRs, or exiting the market.”⁶⁴⁷ The study did not evaluate the likelihood this carrier would respond by exiting or eliminating product lines rather than pursuing alternatives that would permit it to stay in business. While exit remains a possibility, it is far from a certainty. As the authors suggest, state regulators should monitor MLR implementation to see which path carriers are taking and what impact those choices will have on consumers.⁶⁴⁸

Although it is far too early to draw general conclusions, there are some indications that at least some insurers are taking alternative steps to raise their MLR rather than seeking to exit markets or raise premiums. As an alternative means of raising their MLR by lowering their administrative costs, for example, some issuers already have lowered broker and agent fees and commissions.⁶⁴⁹ Almost all of the companies interviewed for the July 2011 GAO study, for

⁶⁴⁴ See Abraham & Mandic, *supra* note 641, at 211.

⁶⁴⁵ See *id.* at 212, 214, 216.

⁶⁴⁶ See *id.* at 216.

⁶⁴⁷ See *id.*

⁶⁴⁸ See *id.* at 217.

⁶⁴⁹ See ROCKEFELLER REPORT, *supra* note 565; MARK NEWSOM, CONG. RESEARCH SERV., R41439, *HEALTH INSURANCE AGENTS AND BROKERS IN THE REFORMED HEALTH INSURANCE MARKET* (May 13, 2011), available at

example, reported that they were reducing or planned to reduce broker commissions.⁶⁵⁰ The process could take some time to implement because existing contracts limit the changes to new policies or group renewals.⁶⁵¹

According to a recent Congressional Research Service (“CRS”) report, initial broker commissions can equal 3-15 percent of premiums in the individual and small group markets and are second only to staff salaries in an insurance company’s administrative expenses.⁶⁵² It is not surprising that insurers trying to trim their administrative costs would reduce broker fees before their own profits.

But it also is not surprising that brokers, who numbered more than 434,000 in 2008,⁶⁵³ are not happy about this. They argue that they provide an important service to consumers by identifying appropriate health care and that this service warrants compensation and should not be reduced simply to raise MLRs and avoid rebates. In addition, they contend that it makes sense to exclude these sums from insurers’ premiums because insurers do not keep commissions; instead, they are passed along to brokers to benefit consumers.⁶⁵⁴

Despite mounting a strong lobby, brokers failed to persuade HHS to remove commissions from the MLR denominator. HHS did agree, however, to form a working group with NAIC to “ensure that agents and brokers can remain in the market.”⁶⁵⁵ One compromise resulting from that working group was to expressly permit the Secretary to consider the impact on brokers when deciding whether to grant an adjustment to a state’s minimum MLR in the individual market.⁶⁵⁶

Dissatisfied with this compromise, brokers brought their fight back to Congress, where on March 17, 2011, Republican Representative Mike Rogers introduced the Access to Professional Health Insurance Advisors Act of 2011 (H.R. 1206) that would exclude broker commissions from the definition of non-claims costs and from the calculation of premium in an insurer’s MLR denominator.⁶⁵⁷ The bill also would permit states to seek adjustments to MLR in the small group market, in addition to the individual market, and require the Secretary to defer to a state's determination that enforcing the required MLR may destabilize the individual or

[http://op.bna.com/hl.nsf/id/shad-8gxjkb/\\$File/Health%20Insurance%20Agents%20and%20Brokers%20in%20the%20Reformed%20Health%20Insurance%20Market%20\(CRS,%2005.13.11\).pdf](http://op.bna.com/hl.nsf/id/shad-8gxjkb/$File/Health%20Insurance%20Agents%20and%20Brokers%20in%20the%20Reformed%20Health%20Insurance%20Market%20(CRS,%2005.13.11).pdf).

⁶⁵⁰ See JULY 2011 GAO REPORT, *supra* note 555, at 18.

⁶⁵¹ See *id.*

⁶⁵² NEWSOM, *supra* note 649, at 1 & 6.

⁶⁵³ See Jane Norman, *Industry Pushes for Review of ‘Broker Rule’; Supporters Fight Back*, CQ TODAY ONLINE NEWS – HEALTHBEAT MONDAY (June 3, 2011 9:24 PM), www.cq.com/doc/news-3882825 (subscription required).

⁶⁵⁴ NEWSOM, *supra* note 649, at 5-6.

⁶⁵⁵ Jennifer Haberkorn, *Health Policy Brief: Updated: Medical Loss Ratios*, HEALTH AFFAIRS (Nov. 24, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=33.

⁶⁵⁶ See IFR Preamble, 75 Fed. Reg. at 74,877, *supra* note 576.

⁶⁵⁷ Access to Professional Health Insurance Advisors Act of 2011, H.R. 1206, 112th Cong. (2011-12); see *generally* NEWSOM, *supra* note 649, at 8.

small group markets when a state seeks an adjustment of MLR.⁶⁵⁸ As of February 16, 2012, H.R. 1206 has 175 co-sponsors, including some Democrats, and has been referred to the House Subcommittee on Health.⁶⁵⁹

The proposed bill specifically references NAIC in its findings section, remarking that “[t]he National Association of Insurance Commissioners – whose core mission is to protect consumers in all aspects of the business of insurance – strongly advocates for the continuing role of licensed independent insurance producers in health insurance, and has expressed that the ability of insurance agents and brokers to continue assisting health insurance consumers at a time of rapid insurance market changes is more essential than ever.”⁶⁶⁰ NAIC has written to HHS in the past to “underscore[] the importance of making sure insurance agents and brokers are not short-changed as the rules are implemented.”⁶⁶¹ In June 2011, an NAIC task force on broker issues voted to support H.R. 1206, moving it one step closer to a vote by the full NAIC.⁶⁶²

It was thought NAIC’s support might move the bill further along in Congress, where it had not been scheduled for committee mark-up.⁶⁶³ But on July 12, 2011, members of NAIC did not vote on whether to endorse the Act.⁶⁶⁴ Reportedly, interested parties were in discussions that would not involve a statutory fix, given obstacles to passage in Congress.⁶⁶⁵

After months of reportedly behind the scenes negotiations among commissioners in some states,⁶⁶⁶ a divided NAIC on November 22, 2011 passed a resolution that, without specifically referencing H.R. 1206, called on Congress to “expeditiously consider legislation amending the MLR provisions of the PPACA in order to preserve consumer access to agents and brokers.”⁶⁶⁷ In addition to a long-term legislative fix, NAIC’s resolution also called on HHS to “take whatever immediate actions are available to the Department to mitigate the adverse effects the MLR rule is having on the ability of insurance producers to serve the demands and

⁶⁵⁸ See Access to Professional Health Insurance Advisors Act of 2011, H.R. 1206, *supra* note 657. See Section E, *infra* for a discussion of a state’s ability under the ACA to seek an adjustment to MLR in the individual market.

⁶⁵⁹ Bill Summary & Status, H.R. 1206, 112th Cong. (2011-12), <http://thomas.loc.gov/cgi-bin/bdquery/z?d112:HR01206:@@L&summ2=m&> (last visited Feb. 16, 2012).

⁶⁶⁰ Access to Professional Health Insurance Advisors Act of 2011, H.R. 1206, 112th Cong. (2011-12).

⁶⁶¹ Haberkorn, *supra* note 655.

⁶⁶² Jane Norman, *NAIC Takes a Pass on ‘Broker Bill’*, CQ HEALTHBEAT NEWS, (July 12, 2011 5:10 PM), <http://www.cq.com/doc/hbnews-3905799> (subscription required).

⁶⁶³ *Id.*

⁶⁶⁴ *Id.*

⁶⁶⁵ James Gutman, *NAIC Doesn’t Vote on Broker-Bill Support, Eyes Other Forms of Relief*, AIS’S HEALTH REFORM WEEK (July 18, 2011), <http://aishealth.com/archive/nref071811-04>; Norman, *NAIC Takes a Pass on ‘Broker Bill’*, *supra* note 662; Julie Appleby, *Insurance Commissioners Back Away From Broker Bill*, CAPSULES: THE KHN BLOG (July 12, 2011 5:47 PM), <http://capsules.kaiserhealthnews.org/index.php/2011/07/naic-backs-away-from-broker-bill/>.

⁶⁶⁶ See Rebecca Adams, *Insurance Commissioners Embrace Broker Bill in Close Vote*, CQ HEALTHBEAT NEWS (Nov. 22, 2011 5:46 PM), <http://www.cq.com/doc/hbnews-3987755> (subscription required).

⁶⁶⁷ *Resolution Urging the U.S. Department of Health and Human Services to Take Action to Ensure Continued Consumer Access to Professional Health Insurance Producers*, at 2, NAT’L ASS’N OF INS. COMM’RS, http://www.naic.org/documents/committees_ex_php_resolution_11_22.pdf (last visited Jan. 22, 2012).

needs of consumers and to more appropriately classify producer compensation in the final [ACA] MLR rule.”⁶⁶⁸ NAIC identified three potential options available to HHS:

(1) approving state MLR adjustment requests; (2) placing an immediate hold on implementation and enforcement of the MLR requirements relative to agent and broker compensation; and (3) considering the NAIC’s finding that a significant portion of insurance producer activities are [sic] dedicated to consumer advocacy and service and therefore classifying an appropriate portion of producer compensation as a health care quality expense for [MLR calculation] purposes⁶⁶⁹

This resolution caused somewhat of a brouhaha within NAIC and the consumer community.⁶⁷⁰ Some commissioners complained about the lack of transparency in the process that led to the resolution and worried this was a political statement that would undermine NAIC’s credibility.⁶⁷¹ Consumer advocates criticized NAIC for ignoring its own research findings and robbing consumers of rebates.⁶⁷² But the resolution did not seem to influence HHS, which did not alter its provisions relating to broker commissions when it issued its Final MLR Rule on December 7, 2011.⁶⁷³

On February 2, 2012, Senator Mary L. Landrieu, a Republican from Louisiana and Chair of the Senate Small Business Committee, introduced S.2068, the Access to Independent Health Insurance Advisors Act of 2012, as an alternative to H.R. 1206 in the Senate.⁶⁷⁴ This bill, which is co-sponsored by Democratic Senator E. Benjamin Nelson of Nebraska and Republican Senators Johnny Isakson of Georgia and Lisa Murkowski of Alaska, reportedly seeks to appeal to more Democrats than H.R. 1206 by excluding agent and broker commissions from the MLR denominator only in the individual and small group markets, continuing to count bonuses paid

⁶⁶⁸ *Id.*

⁶⁶⁹ *Id.*

⁶⁷⁰ See Adams, *supra* note 666.

⁶⁷¹ *Id.*

⁶⁷² *Id.*

⁶⁷³ MLR Final Rule Preamble, 76 Fed. Reg. at 76,574, *supra* note 577. Interestingly, Republican members of the House Energy and Commerce Committee asked NAIC to explain “the processes behind NAIC’s deliberations on the MLR rule and its decision to recommend the model regulation as drafted,” including why NAIC had not recommended that HHS change definitions used in the MLR regulations despite testimony regarding their negative impact on agents and brokers. Emily Ethridge, *GOP Lawmakers Ask about HHS, Insurers’ Talks on Medical Loss Ratio Rules*, CQ TODAY ONLINE NEWS – HEALTHBEAT (Dec. 8, 2011 2:25 PM), www.cq.com/doc/news-3996528 (subscription required). See also Letter from Kevin M. McCarty, Florida Commissioner of Insurance and NAIC President, et al., to Hon. Fred Upton, Chairman, House Committee on Energy and Commerce, U.S. House of Representatives (Jan. 12, 2012), available at http://www.naic.org/documents/committees_ex_grlc_120112_response_energy_commerce_cmte_hhs.pdf (describing communications between NAIC and HHS during NAIC’s development of its MLR recommendations in response to December 7, 2011 inquiry from Energy and Commerce).

⁶⁷⁴ See Bill Summary & Status, S. 2068, 112th Cong. (2011-12), <http://thomas.loc.gov/cgi-bin/bdquery/z?d112:s.2068>: (last visited Feb. 16, 2012).

by insurers to agents as administrative expenses (and therefore not permitting them to be excluded from the MLR denominator), and not extending a state's ability under the ACA to ask HHS to adjust its individual market MLR requirement to its small group market MLR as well.⁶⁷⁵ The bill has been referred to the Senate Committee on Health, Education, Labor, and Pensions.

Opponents of legislative or regulatory relief targeted at brokers balk at its premise, emphasizing that broker fees historically have been treated as administrative expenses that were neither included in the MLR numerator nor excluded from the MLR denominator.⁶⁷⁶ They also point out that excluding broker fees from MLR calculations will take money away from consumers. The Rockefeller Report, for example, estimates that New Jersey would lose approximately \$21.23 million out of \$28.87 million in estimated consumer rebates if broker fees were excluded from the MLR denominator.⁶⁷⁷

In addition, there is a dearth of evidence that the sky is falling on the broker job market. A recent NAIC report found that although a "significant number" of insurance companies had lowered broker commissions in 2011, especially in the individual market, a "significant number" had not.⁶⁷⁸ More importantly, while some states with higher MLR requirements had seen reduced commissions over several years, the ten states with relatively high MLR requirements, including New Jersey, "have not observed any problems with consumer access to insurance or to producers."⁶⁷⁹ Appendix B to the NAIC Report records that New Jersey specifically informed NAIC there was "no problem with access" to brokers in the small group market (and that most individual insurance is sold directly and not through brokers).⁶⁸⁰ The CRS report similarly noted

⁶⁷⁵ See Access to Independent Health Insurance Advisors Act of 2012, S. 2068, 112th Cong. (2011-12), <http://www.gpo.gov/fdsys/pkg/BILLS-112s2068is/pdf/BILLS-112s2068is.pdf>; see John Reichard, *Insurance Industry Expects Senate Bill to Exempt Brokers' Fees from MLR*, CQ HEALTHBEAT NEWS, (Jan. 25, 2012 5:33 PM), <http://www.cq.com/doc/hbnews-4016410> (subscription required).

⁶⁷⁶ See ROCKEFELLER REPORT, *supra* note 565, at 3; Appleby, *Insurance Commissioners Back Away*, *supra* note 665.

⁶⁷⁷ See ROCKEFELLER REPORT, *supra* note 565, Exh. 1. *But see supra* note 565 and accompanying text (noting dramatic difference between amount of rebates paid by carriers in New Jersey's small group market in 2008 (approximately \$700,000) and the amount of rebates predicted by the Rockefeller Report and suggesting some explanations for this difference).

⁶⁷⁸ NAIC REPORT, *supra* note 588.

⁶⁷⁹ *Id.* at 5.

⁶⁸⁰ *Id.* The NAIC report also calculated the impact on MLR calculations and rebates of various modifications to the Federal MLR rule, including excluding agent and broker fees from the denominator; excluding commissions subject to various caps; and excluding commissions in exchange for including Federal taxes. *See id.* In a study of broker commission rates in New Jersey's small group market from 2005 to 2011, DOBI found that four of eight carriers paid higher rates in 2011 than in 2005, even though the minimum loss ratio increased from 75 to 80 percent in 2009. The other four carriers for which DOBI had data paid the same rates in 2011 as they had paid in 2005, two of which had raised their rates during the period but then had reduced them to 2005 levels by 2011. No carrier in this study had lowered its 2011 rates below 2005 levels. Indeed, although the range of commissions remained the same (4.75-6.7 percent), the median increased slightly from 5.7 percent in 2008-09 to 6.15 percent in 2011. By February 2012, two of these carriers had reduced their rates by less than 1 percent in 2011, which slightly reduced the range of commissions (4.75-6.6 percent) and median (6.1 percent). Four carriers, however, are paying higher commissions than at the beginning of the study, and the other two are paying the same rates. *See* R. Neil Vance,

that brokers have “not provided clear evidence” that reductions in commissions are impacting consumers.⁶⁸¹

To the contrary, CRS quotes Carl McDonald and James Naklicki, equities analysts at Citigroup Global Markets Inc., as opining in an investor note that broker commissions should be reduced, and that brokers can absorb these reductions, because brokers, who often are paid a percentage of premiums, have been benefitting from the unsustainable growth in premiums in recent years.⁶⁸² As a result, some brokers were generating twice as much in commissions in 2010 as they did five years earlier.⁶⁸³ Even if insurers reduce “first year commissions in half, to around 10% of premiums, . . . brokers are still receiving a significant amount of compensation for the duties they are performing.”⁶⁸⁴

It will be important to continue to monitor the issue of broker fee treatment and consumer access to brokers as HHS, NAIC, consumer advocates, and brokers continue to debate these issues.

In addition to reducing broker fees, some issuers are reducing their premiums to raise their MLRs.⁶⁸⁵ In Connecticut, for example, Aetna reportedly was planning to reduce premiums by an average of 10 percent for more than 15,000 policyholders in the individual market to help it satisfy the Federal minimum MLR requirement.⁶⁸⁶ According to the July 2011 GAO study, an insurer reported that it was considering reducing premiums in 2012 at least in part due to the ACA MLR requirements.⁶⁸⁷ In addition, a regulator interviewed in one state said that some insurers have not applied for premium increases and are lowering premiums to increase their loss ratios.⁶⁸⁸ This same regulator also “commented that reducing premiums is the best

FSA, Managing Actuary, Life & Health, DOBI Internal Memo regarding Commissions (Small Employer), at 2 (Apr. 19, 2011, updated Feb. 14, 2012) (on file with author).

⁶⁸¹ NEWSOM, *supra* note 649.

⁶⁸² *Id.* at 7.

⁶⁸³ *Id.* Indeed, the California Insurance Commissioner recently reported that aggregate broker compensation increased from \$5.8 million in 2000 to a whopping \$168 million in 2010, as premiums increased, based on a survey of four of the five largest insurers in California. See Jane Norman, *California Insurance Commissioner Wades into Insurance Broker Fight*, CQ HEALTHBEAT NEWS (June 7, 2011 5:06 PM), <http://www.cq.com/doc/hbnews-3884260> (subscription required).

⁶⁸⁴ NEWSOM, *supra* note 649; see generally OCTOBER 2011 GAO REPORT, *supra* note 557, at 9 (finding that in 2010, issuers in the small and large group markets spent an average of 3 and 5 percent, respectively, of earned premium on broker fees, compared with 7 percent on average in the individual market).

⁶⁸⁵ See generally Cox, *supra* note 626, at 4 (opining that the MLR rebate requirements “have provided an incentive for insurers to seek lower premium increases than they would have otherwise, and in some cases premiums have even decreased” and that “[t]his ‘sentinel’ effect on premiums has likely produced more savings for consumers and employers than the rebates themselves”).

⁶⁸⁶ See Arielle Levin Becker, *As Federal Health Reforms Take Effect, Aetna Proposes Rate Cuts*, THE CONNECTICUT MIRROR (May 11, 2011), <http://ctmirror.org/print/12550>; see also ROCKEFELLER REPORT, *supra* note 565, at 3 (same and quoting Credit Suisse health care analyst Charles Boorady as saying issuers “were cutting policy renewal prices ‘in markets where a rebate would otherwise be paid to meet new minimum loss ratio requirements’”).

⁶⁸⁷ See JULY 2011 GAO REPORT, *supra* note 555, at 18.

⁶⁸⁸ See *id.*

strategy for insurers to improve value for consumers.”⁶⁸⁹ Issuers in the small and large group markets spent an average of 3 and 5 percent, respectively, of earned premium on broker fees, compared with 7 percent on average in the individual market.⁶⁹⁰

While issuers also may try to increase their MLR by increasing their spending on quality improving activities, the evidence is not overwhelming that many are targeting this alternative. One insurer interviewed in the July 2011 GAO study said that it may increase its spending on activities that would satisfy the exacting requirements in the Federal MLR Regulations to count a quality improving expenditure in the MLR numerator, like prospective utilization review, and, conversely, might decrease spending on those that would not, such as retrospective utilization review.⁶⁹¹ Another issuer said that it would stop focusing on preauthorizations for inpatient admissions because the attendant costs could not be included in the numerator.⁶⁹² Yet five insurers said that the ACA’s requirements “are not a factor in decisions about their activities to improve health care quality.”⁶⁹³

In addition, other aspects of health reform should make it easier for insurers to satisfy the minimum MLR requirements by reducing administrative demands, which should relieve pressure to take more negative steps, like raising premiums or exiting markets.⁶⁹⁴ For example, it is hoped that the insurance exchanges, if they function as intended, will lower an issuer’s advertising costs, more efficiently pool risk, and reduce benefit complexity.⁶⁹⁵ Further, rate banding provisions “will significantly reduce insurers’ underwriting costs.”⁶⁹⁶ The Secretary’s discretion to adjust a state’s MLR percentage in the individual market, as discussed in the next subsection, also provides some needed flexibility to states as health reform is fully implemented over the next few years.

⁶⁸⁹ See *id.*

⁶⁹⁰ *Id.* at 9.

⁶⁹¹ See *id.*

⁶⁹² See *id.*

⁶⁹³ See *id.*; see generally *supra* note 107 and accompanying text in the main brief (citing estimates as low as 0.5 percentage points for the impact of including spending on quality improvements in MLR calculations); OCTOBER 2011 GAO REPORT, *supra* note 557, at 10 (analyzing 2010 MLR data using the new Federal MLR requirements and finding that including quality improving expenses in the numerator accounted for MLR increases of 2.6 percentage points in the individual market, 2.3 percentage points in the small group market, and 1.3 percentage points in the large group market).

⁶⁹⁴ See Timothy Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, COMMONWEALTH FUND at 51 (Sept. 30, 2010), <http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx> (identifying ways the ACA should help lower administrative costs).

⁶⁹⁵ Karen Davis *et al.*, *Starting on the Path to a High Performance Health System: Analysis of the Payment and System Reform Provisions in the Patient Protection and Affordable Care Act of 2010*, COMMONWEALTH FUND, 9 (revised Sept. 2010), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1442_Davis_Payment%20and%20System%20Reform_923v2.pdf.

⁶⁹⁶ *Id.* A forthcoming Policy Brief under this grant will analyze the Federal rate banding requirements as they relate to New Jersey’s rate banding restrictions.

E. Requests for Adjustments to MLR

HHS estimated that thirty states would seek an adjustment of the minimum MLR percentage in the individual market, as authorized by the ACA.⁶⁹⁷ As of February 16, 2012, seventeen states and a territory have filed requests: Delaware, Florida, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, New Hampshire, Nevada, North Carolina, North Dakota, Oklahoma, Texas, Wisconsin, and Guam.⁶⁹⁸ Several of these states do not have their own MLR requirement. Of the requesting states that do have their existing own minimum MLR requirement, one has a 70 percent minimum for HMOs, but the majority set their ratio at 65 percent, and a few are set even lower than that.

Given the statutory and regulatory limitations on the Secretary's discretion to grant an adjustment,⁶⁹⁹ it is not surprising that the requests mainly focus on how failure to adjust the minimum MLR threatens to destabilize the individual market. Commonly, states identify insurance companies who have left or are threatening to leave the market. Delaware, for example, expressed its serious concern that, absent an adjustment, two of the three insurers with "an overwhelming majority of the market share" in its individual market would leave and another would reverse plans to enter the market.⁷⁰⁰ Maine indicated that one of "two private insurers with material enrollment in the individual market" had indicated that it "probably would need to withdraw from the individual market" (and had exited the State's small group market in 2004 in response to a 75 percent MLR requirement) absent relief from the 80 percent minimum requirement.⁷⁰¹ Indiana reported that five insurance companies already have left its individual market and another is "closely contemplating a withdrawal."⁷⁰² Georgia also raised concern that policyholders with preexisting conditions would have trouble securing new coverage if issuers left the individual market since the State does not have a guaranteed issue requirement or a State-operated high-risk pool.⁷⁰³

⁶⁹⁷ See IFR Preamble, 75 Fed. Reg. at 74,892, *supra* note 576.

⁶⁹⁸ *Medical Loss Ratio*, The Center for Consumer Information & Insurance Oversight, <http://cciio.cms.gov/programs/marketreforms/mlr/index.html> (last visited Feb. 16, 2012).

⁶⁹⁹ See Appendix A, Section B for a discussion of the statutory and regulatory provisions governing requests for an adjustment of MLR in the individual market.

⁷⁰⁰ See Attachments to Letter from Karen Weldin Stewart, CIR-ML, Delaware Ins. Comm'r, to The Honorable Kathleen Sebelius, Sec'y of Health & Human Servcs., at 2-3, 6 (May 12, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/delaware/sebelius_051211.pdf.

⁷⁰¹ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Mila Kofman, Superintendent of Ins., State of Maine Bureau of Ins., at 5-6, 14 (March 8, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/maine/maine_decision_letter_3_8_11.pdf.

⁷⁰² Letter from Stephen W. Robertson, Indiana Comm'r of Ins., to Honorable Kathleen Sebelius, Sec'y of Health & Human Servcs., at 14 (May 13, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/indiana/mlr_letter_051311.pdf.

⁷⁰³ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ralph T. Hudgens, Georgia Comm'r of Ins., at 1, 2 (Nov. 8, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/georgia/final_ga_ml_r_adj_determination_letter.pdf.

Nearly all state applications for adjustments also address the states' concern that the law adversely affects consumer access to brokers, who play an integral role in helping consumers identify coverage options. They claim that as issuers decrease commissions, consumers will find it harder to find brokers to assist them.⁷⁰⁴ Some states like Indiana also pointed out that they already are bound by multi-year agreements with brokers at set commissions.⁷⁰⁵

In addition to discussing market exit and access to brokers, some states like Florida and North Carolina argued that the Federal requirements will serve as a barrier to entry in the market.⁷⁰⁶ At least Florida and Kansas held hearings as part of their investigation of the expected impact of the Federal requirements on their individual markets, as authorized by the Federal MLR Regulations.⁷⁰⁷

HHS has granted seven of the eighteen requests submitted as of February 16, 2012. In each case, the Secretary has carefully scrutinized the data to be sure any adjustment does not exceed what is necessary to prevent destabilization in the individual market. In six of the seven granted requests, HHS approved smaller adjustments than the states had proposed. Only Maine has gained approval of all of its requested percentages, although the adjustment for 2013 is conditioned on Maine submitting additional data.⁷⁰⁸ The chart that follows summarizes the adjustments requested and granted so far:

⁷⁰⁴ See, e.g., Letter from Theodore K. Nickel, Ins. Comm'r, State of Wisconsin, to Honorable Kathleen Sebelius, Sec'y of Health & Human Servcs., at 2 (Oct. 25, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/Wisconsin/wi_mlr_request_10252011.pdf; Letter from Ralph T. Hudgens, Ins. & Safety Fire Comm'r, State of Georgia, to Honorable Kathleen Sebelius, Sec'y of Health & Human Servcs., at 7-8 & Attachments (Mar. 17, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/georgia/georgia_mlr_waiver_request.pdf. *But see* discussion in Section IV.A. in the main Brief and Appendix C, Section D *supra* of studies reporting that reductions in broker commissions have not affected consumer access to brokers.

⁷⁰⁵ Letter from Stephen W. Robertson, Indiana Comm'r of Ins., to Honorable Kathleen Sebelius, Sec'y of Health & Human Servcs., *supra* note 702, at 24.

⁷⁰⁶ See Petition of the State of Florida for an Adjustment of the Medical Loss Ratio Provisions for the Patient Protection and Affordable Care Act and Regulations Issued Pursuant Thereto, at 2 (Mar. 11, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/Florida/petition_mlr_03112011.pdf; *Medical Loss Ratio Adjustment Request*, at 8, NORTH CAROLINA DEP'T OF INS. (Sept. 6, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/nc_mlr/nc_mlr_request_09062011.pdf.pdf.

⁷⁰⁷ See Petition of the State of Florida for an Adjustment of the Medical Loss Ratio Provisions for the Patient Protection and Affordable Care Act and Regulations Issued Pursuant Thereto, at 1, *supra* note 706; Kansas Request for MLR Waiver Modification, at 5 (Apr. 29, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/kansas/mlr_waiver_request_04292011.pdf. *But see* Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Kevin M. McCarty, Comm'r, Florida Office of Ins. Regulation, at 3 (Dec. 15, 2011), <http://cciio.cms.gov/programs/marketreforms/mlr/states/Florida/2011%201215%20FL%20MLR%20Adj%20Determination%20Letter.pdf> (noting that Florida's "hearing" included only industry supporters of the adjustment request and did not include the perspectives of consumers or others opposed to the application).

⁷⁰⁸ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Mila Kofman, Superintendent of Ins., State of Maine Bureau of Ins., *supra* note 701.

State	Year	MLR Adjustment Sought	MLR Adjustment Approved
Georgia ⁷⁰⁹	2011	65%	70%
	2012	70%	75%
	2013	75%	80%
Iowa ⁷¹⁰	2011	60%	67%
	2012	70%	75%
	2013	75%	80%
Kentucky ⁷¹¹	2011	65%	75%
	2012	70%	80%
	2013	75%	80%
Maine ⁷¹²	2011	65%	65%
	2012	65%	65%
	2013	65%	65%
New Hampshire ⁷¹³	2011	70%	72%
	2012	70%	75%
	2013	70%	80%
Nevada ⁷¹⁴	2011	70%	75%
	2012	80%	80%
	2013	80%	80%
North Carolina ⁷¹⁵	2011	72%	75%
	2012	74%	80%
	2013	76%	80%

⁷⁰⁹ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ralph T. Hudgens, Georgia Comm'r of Ins., at 1, 2 *supra* note 703.

⁷¹⁰ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Susan E. Voss, Iowa Comm'r of Ins., at 1, 2 (July 22, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/iowa/ia_mlr_adj_determination_letter.pdf.

⁷¹¹ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Sharon P. Clark, Kentucky Comm'r of Ins., at 8 (July 22, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/Kentucky/ky_mlr_adj_determination_letter.pdf.

⁷¹² Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Mila Kofman, Superintendent of Ins., State of Maine Bureau of Ins., *supra* note 701.

⁷¹³ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Roger A. Sevigny, Comm'r, State of New Hampshire Ins. Dep't, at 10-11 (May 13, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/nh_mlr_adj_declearter.pdf.

⁷¹⁴ See Letter from Stephen B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Brett J. Barratt, Nevada Comm'r of Ins. (May 13, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/nevada/mlr_adj_decision_letter_5_13_11.pdf.

⁷¹⁵ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Honorable Wayne Goodwin, North Carolina Comm'r of Ins. (Feb. 16, 2012), http://cciio.cms.gov/programs/marketreforms/mlr/states/nc_mlr/2012_0216_nc_determination_letter.pdf.

HHS found that no adjustment was necessary in Guam because all issuers in its individual market are non-credible, and thus they are presumed to satisfy or exceed the 80 percent minimum MLR requirement.⁷¹⁶

HHS has denied adjustment requests from ten states – Delaware,⁷¹⁷ Florida,⁷¹⁸ Indiana,⁷¹⁹ Kansas,⁷²⁰ Louisiana,⁷²¹ Michigan,⁷²² North Dakota,⁷²³ Oklahoma,⁷²⁴ Texas,⁷²⁵ and

⁷¹⁶ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Artemio R. Ilagan, Guam Acting Banking and Insurance Commissioner, at 1 (Aug. 5, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/Guam/2011_0805_guam_ml_r_adjustment_determination_letter.pdf.

⁷¹⁷ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Karen Weldin Stewart, CIR-ML, Comm'r, Delaware Dep't of Ins. (Sept. 9, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/delaware/de_ml_r_adj_determination_letter.pdf.

⁷¹⁸ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Kevin M. McCarty, Comm'r, Florida Office of Ins. Regulation, *supra* note 707.

⁷¹⁹ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Stephen W. Robertson, Comm'r, Indiana Dep't of Ins. (Nov. 27, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/indiana/in_ml_r_adj_determination_letter.pdf; Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Stephen W. Robertson, Comm'r, Indiana Dep't of Ins. (Dec. 28, 2011), <http://cciio.cms.gov/programs/marketreforms/mlr/states/indiana/IN%20Reconsideration%20Letter%201228%202011.pdf>.

⁷²⁰ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Sandy Praeger, Comm'r, Kansas Ins. Dep't (Jan. 4, 2012), http://cciio.cms.gov/programs/marketreforms/mlr/states/kansas/2012_0104_ks_ml_r_adj_determination_letter_final.pdf.

⁷²¹ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to James J. Donelon, Comm'r, Louisiana Dep't of Ins. (Nov. 27, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/louisiana/la_ml_r_det_letter.pdf; Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to James J. Donelon, Comm'r, Louisiana Dep't of Ins. (Dec. 28, 2011), <http://cciio.cms.gov/programs/marketreforms/mlr/states/louisiana/LA%20Reconsideration%20Letter%201228%202011.pdf>.

⁷²² See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to R. Kevin Clinton, Comm'r, Michigan Office of Financial & Ins. Regulation (Dec. 16, 2011), http://cciio.cms.gov/resources/files/Files2/12232011/mi_ml_r_adj_determination_letter.pdf.

⁷²³ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Adam W. Hamm, North Dakota Ins. Comm'r (July 22, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/northdakota/nd_ml_r_adj_determination_letter.pdf; see generally John Reichard, *HHS Denies North Dakota MLR Waiver, Says Yes to Iowa, Kentucky*, CQ HEALTHBEAT (July 22, 2011 5:25 PM), <http://interest.healthcare.thomsonreuters.com/content/CQNewsletter20110729?elq=151fd5e445af42a5896710069a0b17f5#Article2>; Julie Appleby, *Medical Loss Ratio Deadline Extended for Two States*, CAPSULES: THE KHN BLOG (July 22, 2011 5:31 PM), <http://capsules.kaiserhealthnews.org/index.php/2011/07/mlr-deadline-extended-for-two-states/>.

⁷²⁴ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to John D. Doak, Comm'r, Oklahoma Ins. Dep't (Jan. 4, 2012), http://cciio.cms.gov/programs/marketreforms/mlr/states/Oklahoma/2012_0104_ok_ml_r_adj_determination_letter_final.pdf.

Wisconsin.⁷²⁶ In doing so, HHS generally determined that insurers in the individual markets in each state already met the 80 percent MLR standard (after adjusting for credibility determinations, where applicable), were adjusting their business models to raise their MLR to meet this requirement, and/or would still make a profit after paying any required rebates; where there was a likelihood insurers would leave the individual market for reasons related to the MLR requirement, HHS generally determined consumers would have access to alternative comparable coverage at comparable prices.⁷²⁷

North Dakota, for example, whose current MLR minimum is only 55 percent, requested an adjustment to 65 percent in 2011, 70 percent in 2012, and 75 percent in 2013. The Secretary found that there was no reasonable likelihood that implementing the 80 percent MLR would destabilize North Dakota's individual market. Only two insurers are partially credible and thus liable to pay rebates. One had an MLR that exceeded the minimum (and opposed the adjustment application), and the other is on track to comply by 2012 and would still be profitable after paying a rebate for 2011.

Similarly, Delaware had sought an adjustment to 65 percent in 2011, 70 percent in 2012, and 75 percent in 2013. Although estimates suggest that two of the three partially or fully credible insurers would have to pay rebates under an 80 percent minimum MLR requirement, these companies still were expected to realize pre-tax net tax gains of 19 and 12 percent of premium, respectively, even after paying rebates.⁷²⁸ HHS thus denied the request for an adjustment because it did not find a reasonable likelihood that the ACA's 80 percent requirement would destabilize Delaware's individual market.⁷²⁹

HHS also has found that states have not supported their broker access concerns with compelling evidence.⁷³⁰ As commenters have noted, "[t]he MLR regulations do not guarantee

⁷²⁵ See Sam Baker, *Texas Will Not Receive Healthcare Waiver*, HEALTHWATCH: THE HILL'S HEALTHCARE BLOG (Jan. 27, 2012 12:12 PM), <http://thehill.com/blogs/healthwatch/health-reform-implementation/207051-texas-will-not-receive-healthcare-waiver>.

⁷²⁶ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Theodore K. Nickel, Wisconsin Comm'r of Ins. (Feb. 16, 2012), http://cciio.cms.gov/programs/marketreforms/mlr/states/Wisconsin/2012_0216_final_wi_mlr_adj_determination_letter.pdf.

⁷²⁷ See, e.g., Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Kevin M. McCarty, Comm'r, Florida Office of Ins. Regulation, *supra* note 707, at 15.

⁷²⁸ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Karen Weldin Stewart, CIR-ML, Comm'r, Delaware Dep't of Ins., *supra* note 717, at 5.

⁷²⁹ *Id.* at 9.

⁷³⁰ See, e.g., Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ralph T. Hudgens, Georgia Comm'r of Ins., at 10-11, *supra* note 703; Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Roger A. Sevigny, Comm'r, State of New Hampshire Ins. Dep't, at 10-11, *supra* note 713; Letter from Stephen B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Brett J. Barratt, Nevada Comm'r of Ins., at 8, *supra* note 714; see generally NEWSOM, *supra* note 649, at 7. Indeed, HHS reports that the carrier with 83.5 percent of Kentucky's individual market share increased first year commission rates. See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Sharon P. Clark, Kentucky Comm'r of Ins., at 8, *supra* note 711.

that broker and agent compensation will never be reduced, but rather that consumers must have adequate access to brokers and agents.”⁷³¹ While some (but certainly not all) insurers may be reducing commissions, HHS has not seen evidence that consumer access will significantly suffer as a result of implementation of the 80 percent MLR standard in states’ individual markets.⁷³² For example, HHS assessed that the few insurers in Florida that may need to reduce commissions to meet MLR targets were paying commissions in 2010 that “averaged 13 and 19 percent of total earned premium,” which were “significantly above the market average.”⁷³³

States also did not persuade HHS that the MLR requirements would discourage new entrants to individual markets. HHS reminded states that the MLR framework builds in some protection for new entrants. Section 158.121 of the MLR regulations, for example, permits an issuer with 50 percent or more new business in a given MLR reporting year to exclude that experience from MLR calculations for that year. In addition, HHS noted that a new entrant to the market would not be susceptible to rebate obligations until it has 1,000 life-years.⁷³⁴

In considering these applications, HHS has foreclosed certain requests or bases for seeking adjustments. For example, it rejected Maine and Florida’s requests to continue using their own formulae for calculating MLR and required them to follow the methodology set forth in the ACA and the Federal MLR Regulations.⁷³⁵ It also informed Guam and Indiana that it has no authority to grant requests for adjustments in group markets.⁷³⁶ HHS further found that it

⁷³¹ Letter from Steven B. Larsen, Deputy Admin’r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Kevin M. McCarty, Comm’r, Florida Office of Ins. Regulation, at 12, *supra* note 707.

⁷³² See, e.g., Letter from Steven B. Larsen, Deputy Admin’r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Karen Weldin Stewart, CIR-ML, Comm’r, Delaware Dep’t of Ins., *supra* note 717, at 7.

⁷³³ Letter from Steven B. Larsen, Deputy Admin’r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Kevin M. McCarty, Comm’r, Florida Office of Ins. Regulation, *supra* note 707, at 11. Cf. Letter from Steven B. Larsen, Deputy Admin’r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to James J. Donelon, Comm’r, Louisiana Dep’t of Ins., at 8 (Nov. 27, 2011), *supra* note 721 (noting that the two largest issuers in Louisiana, with 73 percent market share and responsible for two-thirds of the broker compensation in the state, had MLRs well above 80 percent and paid commissions averaging 4 percent of total earned premium, which was slightly below the state average, while issuers with MLRs below 80 percent paid commissions ranging from 3 to 13 percent).

⁷³⁴ See, e.g., Letter from Steven B. Larsen, Deputy Admin’r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Sandy Praeger, Comm’r, Kansas Ins. Dep’t, *supra* note 720, at 10. In contrast, in granting a modified adjustment to North Carolina, HHS emphasized its “unusually concentrated market, exacerbated by the recent loss of a third of the credible or partially-credible issuers,” meant that “a decision by any of the remaining issuers. . . to withdraw or curtail marketing would have a significant negative impact on consumer choice and competition in that market.” See Letter from Steven B. Larsen, Deputy Admin’r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Honorable Wayne Goodwin, North Carolina Comm’r of Ins., *supra* note 715, at 8. In addition, implementing the 80 percent requirement in 2011 “would make it more difficult for smaller issuers to compete with the dominant issuer and would likely cause issuers to make business decisions that would result in further drastic reductions to consumer choice.” *Id.*

⁷³⁵ See Letter from Steven B. Larsen, Deputy Admin’r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Mila Kofman, Superintendent of Ins., State of Maine Bureau of Ins., *supra* note 701, at 8; Letter from Gary M. Cohen, Acting Dir., Office of Oversight, CMS, to Mary Beth Senkewicz, Florida Deputy Ins. Comm’r (Apr. 4, 2011), http://cciio.cms.gov/programs/marketreforms/mlr/states/Florida/information_deficiency_letter_04-04-2011.pdf.

⁷³⁶ See Letter from Steven B. Larsen, Deputy Admin’r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Artemio R. Ilagan, Guam Acting Banking and Insurance Commissioner, *supra* note 716, at 1; Letter from Steven B. Larsen,

may not take into consideration possible destabilization of the small group market (from, for example, selection discrimination stemming from market permeability, as New Hampshire argued) in deciding whether to grant an adjustment in the individual market. Only destabilization in the individual market is relevant.⁷³⁷ HHS also found that the ACA does not authorize a waiver or adjustment of the MLR requirement for consumer-driven, or high-deductible, health plans, and thus denied Indiana's request for a permanent waiver for these plans in the individual and small group markets.⁷³⁸ It similarly found that it lacked authority to grant a waiver from the 80 percent MLR requirement for new entrants to Indiana's individual market (although it recognized that Section 158.121 of the Federal MLR Regulations permits deferral of newer experience, in some circumstances).⁷³⁹

In addition, although it found that New Hampshire had not provided enough information to assess the likelihood that it is at risk for anti-selection bias because its neighboring states received MLR adjustments, HHS left open the question of whether it is proper for adjustment decisions to consider this risk.⁷⁴⁰

HHS's response to Indiana's application clarified the temporal scope of the Commissioner's power to grant adjustments to MLR in the individual markets. The regulation provides that "[a] State may request that an adjustment to the MLR standard be for up to three MLR reporting years."⁷⁴¹ Some have interpreted this language to permit states to seek an adjustment only for reporting years 2011, 2012, and/or 2013.⁷⁴² But when Indiana sought an adjustment for MLR reporting years 2011-2014, HHS notified the Commissioner that it would consider the request for 2011-2013 and that the State could "request an adjustment for MLR reporting year 2014 in the future if, at that time, it deems circumstances to so warrant."⁷⁴³

Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Stephen W. Robertson, Comm'r, Indiana Dep't of Ins., at 1 (Nov. 27, 2011), *supra* note 719.

⁷³⁷ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Roger A. Sevigny, Comm'r, State of New Hampshire Ins. Dep't, *supra* note 713, at 14.

⁷³⁸ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Stephen W. Robertson, Comm'r, Indiana Dep't of Ins., at 2 (Nov. 27, 2011), *supra* note 719; Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Stephen W. Robertson, Comm'r, Indiana Dep't of Ins., at 2 (Dec. 28, 2011), *supra* note 719.

⁷³⁹ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Stephen W. Robertson, Comm'r, Indiana Dep't of Ins., at 2 (Nov. 27, 2011), *supra* note 719.

⁷⁴⁰ Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Roger A. Sevigny, Comm'r, State of New Hampshire Ins. Dep't, *supra* note 713, at 15.

⁷⁴¹ 45 C.F.R. § 158.311.

⁷⁴² See, e.g., *Medical Loss Ratios for Health Insurance: Provisions in the Federal Affordable Care Act of 2010 (ACA)*, NATIONAL CONFERENCE OF STATE LEGISLATURES (updated Jan. 4, 2012), <http://www.ncsl.org/issues-research/health/health-insurance-medical-loss-ratios-state-implement.aspx> ("States may apply for waivers to allow a different timetable or percentages on a temporary, annual basis between 2011 and 2014."); *Medical Loss Ratio Adjustment Request*, at 1, NORTH CAROLINA DEP'T OF INS., *supra* note 706 (summarizing the adjustment request process as applying only to calendar years 2011 through 2013).

⁷⁴³ See Letter from Steven B. Larsen, Deputy Admin'r & Dir., Ctr. for Consumer Info. & Ins. Oversight, to Stephen W. Robertson, Comm'r, Indiana Dep't of Ins., at 2 (Nov. 27, 2011), *supra* note 719.

Thus, while issuers may only request adjustments for up to three years at one time, the Federal MLR Regulations do not prohibit adjustment requests in 2014 and beyond.⁷⁴⁴

F. State Legislative and Regulatory Responses to the ACA's MLR Requirements

Some states have initiated statutory and regulatory processes to respond to the MLR requirements in the ACA.

Maryland already has enacted legislation that makes the ACA's minimum loss ratio requirements applicable in its individual, small, and large group markets.⁷⁴⁵ The legislation, which was effective July 1, 2011, does not detail the Federal requirements but instead simply refers to the applicable sections of the ACA. The law notably gives Maryland's Insurance Commissioner authority to enforce the MLR provisions.⁷⁴⁶

Maine also has enacted legislation to adopt the Federal MLR requirements in the individual, small, and large group markets.⁷⁴⁷ This legislation, signed into law on May 17, 2011, also references and adopts the meaning of all terms used in the ACA and Federal MLR Regulations. But it also includes some features that are not part of the ACA, including using prospective loss ratios during rate review and optional guaranteed loss ratios.⁷⁴⁸

California amended its rate review regulation by an emergency measure in January 2011 to add a requirement that an insurance company's projected medical loss ratio in the individual market may not be less than 80 percent.⁷⁴⁹ The emergency amendment specifically adopted and incorporated by reference the methodology for calculating MLR set forth in the IFR.⁷⁵⁰ It did not, however, adopt the Federal requirements in its small or large group markets or require retrospective rebates. California adopted this amendment again as an emergency measure on July 25, 2011, and again did not address the small or large group markets. California Senate Bill No. 51, however, which was introduced on December 15, 2010, passed the State Senate and Assembly on September 9, 2011, and approved by the Governor on October 9, 2011, adopts the Federal MLR requirements in the individual, small, and large group markets.⁷⁵¹ As the

⁷⁴⁴ See generally 45 C.F.R. § 158.311 (requiring a state that made a previous request for an adjustment to submit, in addition to what is required with an initial request, information regarding "what steps the State has taken since its initial and other prior requests, if any, to increase the likelihood that enrollees who have health coverage through issuers that are considered likely to exit the State's individual market will receive coverage at a comparable price and with comparable benefits if the issuer does exit the market").

⁷⁴⁵ MD. CODE ANN., INS. § 15-137.1(a)(12).

⁷⁴⁶ *Id.* § 15-137.1(c).

⁷⁴⁷ PUBLIC Law, Chapter 90, LD 1333, Sec. D-5. 24-A MRSA § 4319, 125th Maine State Legislature, 2011 Me. Laws 90, Dx5 (signed into law on May 17, 2011), available at http://www.mainelegislature.org/legis/bills/bills_125th/chappdfs/PUBLIC90.pdf.

⁷⁴⁸ *Id.*, Dx2 & Dx3.

⁷⁴⁹ See CAL. CODE REGS., tit. 10, § 2222.12 (a)(2).

⁷⁵⁰ See *id.*

⁷⁵¹ See S.B. 51, 2011-2012 Reg. Sess.; S.B. 51, Complete Bill History 2011, http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0051-0100/sb_51_bill_20111009_history.html.

Committee Report summarizes, “[t]he requirements of this bill largely mirror federal law, but the bill provides more specificity about when rebates are to be issued and provides explicit statutory authority [for] state enforcement.”⁷⁵²

Illinois similarly has a bill pending that would adopt the Federal minimum MLR requirements in its individual, small, and large group markets.⁷⁵³ Like California’s S.B. 51, Illinois’s S.B. 1618 essentially just incorporates all of the requirements set out in painstaking detail in the Federal MLR Regulations.

Although this bill was not signed into law, Connecticut H.B. 6323 also proposed to adopt the Federal definition of MLR as set forth in the ACA. In doing so, it sought to add a requirement that insurance companies publish their MLR in the Connecticut Insurance Department’s annual “Consumer Report Card on Health Insurance Carriers in Connecticut.”⁷⁵⁴

Other states have taken legislative action since the ACA that makes no reference to the extensive Federal MLR methodology. As part of its General Appropriations bill, Georgia imposed a minimum MLR (87 percent on care management organizations) that exceeds the Federal requirements after the ACA and without addressing the Federal MLR methodology.⁷⁵⁵

New York, as part of its prior rate review process, increased the minimum MLR in its individual market, small group market, and community rated large group contract forms to 82 percent in June 2010.⁷⁵⁶ Even though this postdates passage of the ACA, the legislation did not require insurers to include quality improving activities in MLR calculations. Rather, after considering whether to maintain its higher MLR minimum or to align its laws with the lower Federal standards,⁷⁵⁷ New York has chosen an administrative rather than a legislative route to comply with the ACA. In a circular dated December 22, 2011, the State notified insurers that it will adopt the Federal MLR methodology for purposes of determining whether rebates are required, although it will exercise its discretion to increase the minimum MLR in the individual and small group markets from 80 to 82 percent.⁷⁵⁸ Thus, insurers in the individual, small group, and large group markets must comply with the Federal MLR requirements with respect to calculating, paying, and reporting rebates, with minimum MLR requirements in the individual

⁷⁵² 2011 Cal. Senate Bill No. 51, Cal. 2011-2012 Reg. Sess., Cal. Committee Report (Aug. 16, 2011).

⁷⁵³ S.B. 1618, 97th Gen. Assemb. (IL 2011), *available at*

<http://www.ilga.gov/legislation/fulltext.asp?DocName=&SessionId=84&GA=97&DocTypeId=SB&DocNum=1618&AID=11&LegID=&SpecSess=&Session=>

⁷⁵⁴ Substitute Raised H.B. 6323, Sec. 10(b), Gen. Assemb.. Jan. Sess. 2011, *available at*

<http://www.cga.ct.gov/2011/FC/2011HB-06323-R000620-FC.htm>.

⁷⁵⁵ H.B. 78, 151st Gen. Assemb., 2011-2012 Reg. Sess., sec. 94.18, 95.7, 2011 Ga. ALS 223.

⁷⁵⁶ See N.Y. INS. LAW §§ 3231, 4308.

⁷⁵⁷ Patricia Boozang *et al.*, *Implementing Health Care Reform: A Roadmap for New York State*, N.Y. STATE HEALTH FOUNDATION, at 48-51 (Aug. 2010),

http://www.healthcarereform.ny.gov/research_and_resources/docs/roadmap_for_nys.pdf.

⁷⁵⁸ Insurance Circular Letter No. 15 from Louis Felice, Ass’t Deputy Sup’t & Bureau Chief, Health Bureau, N.Y. State Dep’t of Financial Servcs., to All Insurers Authorized to Write Accident and Health Insurance in New York State, *et al.*, at 3 (Dec. 22, 2011), *available at* http://www.dfs.ny.gov/insurance/circltr/2011/cl2011_15.htm.

and small group markets of 82 percent and in the large group market of 85 percent.⁷⁵⁹ But, because the Federal MLR requirements “by their terms apply only to the calculation of MLRs for the purposes of determining whether rebates are required” and the “federal standards will generally result in a higher MLR than calculating the MLR as simply the ratio of claims to premiums,” New York will continue to use its methodology and standards when prospectively reviewing rates.⁷⁶⁰ By doing so, New York is retaining “the Superintendent’s maximum discretion to determine whether proposed premiums are unreasonable, excessive, inadequate or unfairly discriminatory.”⁷⁶¹ Thus, for purposes of rate review, “the expected loss ratio of individual, small group and community rated large group contract forms must be at least 82%,” calculated pursuant to New York’s methodology.⁷⁶²

As more states digest the Federal requirements, undoubtedly there will be extensive legislative and regulatory activity.

⁷⁵⁹ *See id.*

⁷⁶⁰ *Id.*

⁷⁶¹ *Id.*

⁷⁶² *Id.* at 4.

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