May 11, 2010

Department of Health and Human Services,
Attention: DHHS-2010-MLR
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: 45 CFR Parts 146 and 148: Medical Loss Ratios: Public Comment

Dear Secretary Sebelius:

We are writing to provide public comment relative to the Request for Information published April 14, 2010 on proposed rules under 45 CFR parts 146 and 148.

1. **It is unclear under the proposed rules at what point in time the MLR calculation would be made.** We would recommend that the calculation be performed at least six (6) months following the end of each calendar year to allow for claims run-out to provide a more accurate calculation of medical expenses relative to the previous calendar year. This would be especially important for catastrophic claims that arrive after the close of the year.

2. **The proposed rules do not define “plan” or what groups, or individuals, would be included in the plan.** “Plan” could be defined as the segment of the insured population subject to the provision (Large Group, Small Group, Individual), or by type of coverage within the segment (HMO, PPO, POS, EPO, etc.). Further, no determination is made with respect to how long a group, or individual, must be enrolled during a plan year to be included in the calculation. To eliminate some of the year to year volatility that could occur, we recommend that populations be aggregated into the largest pools possible, which would be at the segment level (Large Group, Small Group, or Individual) without regard to benefit plan. Also, the calculation should only include those groups, or individuals, that have been continuously enrolled for the entire plan year.

3. **Individual policies should be evaluated on a durational basis.** In the individual market, the loss ratios for new policies tend to start out low and increase over time. The MLR would likely be well below 80% in the early years post implementation of a new plan. While an insurer would rate the product targeting an MLR above 80% over the estimated average time that an individual would keep the policy, the application of a simply MLR calculation, done on an annual basis, could potentially place the insurer in a position where it would have to issue rebates in the early years and then suffer losses as the product matures.
4. *To what extent will the calculation be subject to audit?* We would recommend that the final regulations define to what extent the calculations will need to be certified or audited and the timeliness of any audits. The filings will be made to the Department on an annual basis and, presumably, the Department will bear responsibility for ensuring accuracy from a regulatory perspective. There will likely need to be some independent, actuarial certification of the calculation prior to its submission to the Department and a process put in place related to audits by a regulatory body. Plans selected for audit by the Department should receive notification of audit prior to any established rebate payment deadline. Those plans selected would not be required to issue rebates until the audit has been completed. As audits could increase, as well as reduce, the amount of rebates that would need to be issued, delaying payment until after the audit has been completed would avoid potential collectibility issues should the audit actually reduce the amount of rebates. Delaying payment until that audit has been completed would also help to ensure that audits be conducted in a timely fashion.

5. *To whom are rebates paid?* The proposed rule states that rebates would have to be provided to enrollees when the loss ratio for a plan year falls below the minimum threshold. For the individual market segment it is clear that this means that the rebate is paid directly to the individual who purchased the policy. However, this is less clear for group policies. For these policies, the group is the actual contract holder and bears the responsibility for the payment of premiums. The term enrollee, for group policies, generally refers to those individuals that select the insurer’s coverage that is offered to them by their employer. The way that the proposed rule is written would suggest that any rebates would be payable directly to the individuals that have been enrolled through their employers plan even though the employer is the body that bears the majority of the cost for that coverage. For the purposes of issuing rebates, the term enrollee should be defined as the contract holder and rules must be established for instances when then the employer group is no longer contracted with the original insurer, or has dissolved, when a rebate finding is made at a later date. Further, rebates should only be issued to individuals, or employer groups, net of any outstanding receivable balances beyond the amount due for the current month’s premiums. The potential does exist for a group, or individual, to be due a rebate where that group, or individual, has been terminated by the insurer for non-payment of premiums. In those circumstances where groups, or individuals, are in arrears, the insurer should have the ability to net the arrearage against any rebate that would be due.

Thank you in advance for the opportunity to share our comments with you. Please contact me with any questions you may have.

Daniel B. Vukmer, Esquire  
V.P. & General Counsel

Cc:  Lou Felice, Chair Health Reform Solvency Impact Subgroup  
     Joel Ario, Pennsylvania Insurance Commissioner