



State of New Jersey

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*Commissioner*

May 26, 2010

**Re: Medical Loss Ratios Under Section 2718 of the Public Health Services Act**

Dear Colleagues:

New Jersey has a long history of administering medical loss ratios and overseeing the payment of associated rebates. We have seen firsthand the power that they can have in ensuring premiums are reasonable in relation to claims and in incenting the design of appropriate cost-structures. We also know that a too-rigid structure can result in discouraging programs that would benefit the participants of the program.

Insurance companies cannot be given license to re-brand administrative overhead as 'quality initiatives' to evade the minimum loss ratio requirements. Some commenters have suggested that the legislation requires including all loss adjustment expenses including claim payment expenses in the numerator of the calculation, i.e. the "medical" side of the fence. We urge outright rejection of such a position.

On the other hand, the rules cannot define quality initiatives so narrowly that value-added programs that do increase quality and hold down unnecessary costs are discouraged. This is a particular risk in the large group market where the loss ratio requirement is more aggressive at 85%. The statute did clearly make provision for including the cost of quality initiatives with claim costs in the numerator of the ratio as "medical costs." Many of the comments received by the NAIC appear to be aimed at eviscerating the language of the law rather than giving it meaning, as this body has been charged to do.

Viewed in a vacuum, loss ratio requirements create perverse incentives because as premiums increase, permissible expenses and profits increase. Conversely activities that bring down medical costs and therefore premiums add expenses while shrinking the allowable collectible premium. Market demands for cost containment and competition will encourage initiatives to improve quality while holding down unnecessary costs, unless thwarted by regulatory requirements.

To illustrate, assume a carrier is operating at an 84% loss ratio in the large group market, with premiums of \$500 per member per month. Claims expenses are therefore \$420 PMPM, with \$80 available for expenses and profit. A cost containment initiative becomes available that would improve quality while reducing hospital stays and readmissions by \$4 PMPM, at a cost of \$2 PMPM. If this initiative is required to be accounted for as administrative expense, claims expenses are now \$416 PMP (\$420-\$4), leaving \$489 as the maximum permissible premium (\$416/85%). The initiative would cause the carrier's permitted expense and profit amount to go down by \$7 while its expenses would rise by \$2. The carrier therefore must spend \$2 more, of a reduced premium dollar, and would keep \$7 less. If required to be accounted for as expense rather than quality improvement, such a program would likely not be pursued. Utilization review programs do improve quality by limiting the number of potentially risky health interventions to which an insured is otherwise exposed.

While the example is simplified, the dynamic illustrated is very real.

An area of opportunity in which regulators, insurers and health care providers have shared responsibilities to advance is electronic health records. We usually think of premium dollars as composed of two independent buckets – medical costs and administrative costs. Electronic health records represent a unique opportunity to drive down both cost components, while at the same time increasing quality of care. We have to move to a future where duplicate tests are avoided because clinicians have access to a patient's entire health record, where allergic reactions are avoided because emergency rooms have access to the patient's health history, and where the cost and hassle of claim payment is reduced because insurers can get the medical records they require for review without faxing back and forth to the hospital. Investments in Health Information Technology initiatives aimed at improving care and reducing errors should be considered quality initiatives.

Attached is a copy of a May 19 letter sent to Lou Felice on behalf of the New Jersey Chamber of Commerce. I fully support and endorse their recommendations. I would urge the NAIC's proposed definition of quality improvement initiatives incorporate the following concepts:

Quality improvement includes programs to educate members, reduce unnecessary care, improve health outcomes, and incent the delivery of cost-effective care, including:

- Hotlines providing members with access to clinical personnel including RNs;
- Wellness and Disease Management Programs;
- Utilization Review Programs;
- Technology Health Information errors, such initiatives aimed at improving care and reducing as Electronic health records and implementation of ICD-10;
- Provider bonuses;
- Member education, including clinical and cost transparency information;
- On-site clinics and health kiosks; and
- Health risk assessments.

The term should not be defined as a closed list that would preclude the development of future programs.

I look forward to continuing to work on these issues with you.

Very truly yours,

A handwritten signature in black ink, appearing to read "Tom", with a long horizontal flourish above the letters.

Thomas B. Considine  
Commissioner

Attachment