

**BEFORE THE JOINT MEETING OF THE FLORIDA OFFICE OF INSURANCE REGULATION  
AND THE FLORIDA HEALTH INSURANCE ADVISORY BOARD**

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**Hearing Concerning Implementation of  
Medical Loss Ratios under the Patient  
Protection and Affordable Act ("PPACA")**

**September 24, 2010**

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**Statement of Benjamin M. Cutler, Chairman and Chief Executive Officer of USHEALTH  
Group, Inc., Freedom Life Insurance Company of America, and  
National Foundation Life Insurance Company**

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**AFFIDAVIT OF BENJAMIN M. CUTLER**

BEFORE ME, the undersigned Notary Public, personally appeared Mr. Benjamin M. Cutler, who under oath stated the following:

"Commissioner McCarty, members of the Florida Health Insurance Advisory Board, members of the staff of the Office of Insurance Regulation, and other interested parties, my name is Benjamin M. Cutler. I am the Chairman and Chief Executive Officer of USHEALTH Group, Inc., and its life and health insurance subsidiaries Freedom Life Insurance Company of America and National Foundation Life Insurance Company.

Thank you for the opportunity to appear before you today to address the critical necessity of a phased-in implementation of the medical loss ratio requirements ("MLR") under the Patient Protection and Affordable Care Act ("PPACA") in order to avoid significant disruption in the individual health insurance market in Florida.

I have 40 years of experience in the insurance industry and have served as a President and Chief Executive Officer in three different insurance organizations. Since September 2004, I have served as Chairman and Chief Executive Officer of USHEALTH Group, Inc. and its subsidiaries, where we have been focused on providing individual health insurance in the state of Florida and elsewhere. From September of 2002 through August of 2004 I was Chairman of Assurant Health and Executive Vice President of Assurant, Inc. I originally joined Assurant (previously named Fortis) in 1985 as Chief Financial Officer of the holding company. During my tenure with Fortis, I served as President and Chief Executive Officer of three different Fortis business units, Fortis Life (1991-1994), Fortis Sales (1995-1996), and Fortis Health (1997-2002). Before joining Fortis, I held key executive positions at Sun Life Group of America and USLIFE Corporation.

I have also been very active in the health insurance industry as a whole, including serving as a Director, Vice-Chairman and Chairman of the Health Insurance Association of America ("HIAA"). I was instrumental in the merger of HIAA and AAHP (American Association of Health Plans) to form America's Health Insurance Plans (AHIP) in 2003, and served as a co-chair of AHIP in its inaugural year. I currently serve on AHIP's Executive Committee, serve on AHIP's Board of Directors, and am also the Chairman of AHIP's Membership Committee. I hold a B.S. from Kansas University and an MBA from the Wharton School at the University of Pennsylvania.

Through our life and health insurance subsidiary Freedom Life Insurance Company of America ("Freedom"), our company provides individually underwritten medical expense coverage in Florida and across the country. Florida is a critical market for Freedom and its parent USHEALTH Group, Inc.

Freedom currently provides individual major medical coverage to over 7,500 Florida residents, which represents \$16.5 million of annual premium. Florida accounts for 24% of Freedom's individual major medical inforce and, equally important, 24% of our new business sales.

### **Importance of the Individual Health Insurance Market**

Readily available, affordable individual health insurance coverage is critically important to the state of Florida. Indeed, as this Board noted in its 2007 Florida Health Insurance Market Report, the "individual market is a key indicator of the vitality of a state's commercial health insurance market." <http://www.florir.com/pdf/HealthInsRpt2007.pdf> According to this report, of the approximately 18.1 million residents of Florida, approximately 3.8 million were without health insurance coverage. As of the end of 2006, there were approximately 4.5 million lives covered by private, commercial insurance in Florida. Of this population, approximately 790,000 were covered under individually underwritten in-state and out-of-state policies, roughly 17.5% of the total private health insurance population.

Since almost 20% of Florida's private health insurance coverage is provided under individually underwritten in-state and out-of-state policies, it is clear that a healthy, vibrant individual health insurance market is vitally important to meeting the insurance needs of Floridians. This market serves the backbone of Florida's economy – sole proprietors and small business people who are not eligible for traditional group health insurance through their employer.

Disruption of this market would literally impact almost 1 million insured lives – potentially in the form of losing their valuable health insurance coverage. Disruption will also decrease the availability of this type of coverage in Florida. Unfortunately, that is exactly what will likely happen if a phased-in implementation of PPACA's MLR requirement is not permitted for the individually underwritten insurance market in Florida.

In this regard, it should be noted that most states have historically set minimum required loss ratios for the individual market between 55% and 65%. For its part, Freedom currently prices to a 65% lifetime loss ratio in Florida, and we set our field and home office expense allowable accordingly. It is our belief that other carriers operating in the individual market price their plans similarly. Requiring an immediate and dramatic escalation in the required loss ratio from 65% to

80%, including for coverage written before PPACA was even proposed or became law, will have a dramatic impact on the individual health insurance market in Florida and elsewhere.

The purpose of my testimony today is to address the critical importance of a phased-in implementation of the 80% MLR requirement under PPACA in the individual market so as to avoid any significant market disruptions. Following is a summary of the various considerations that demonstrate why a gradual, phased-in implementation between 2011 and 2014 are essential in order to avoid disrupting the individual market.

### **Unjust, Unfair and Unconstitutional Retroactive Application of PPACA MLR to Policies Issued Prior to Effective Date of PPACA**

From the outset, and separate and apart from the significant constitutional issues raised by the state of Florida and the other states in *State of Florida, et al. v. United States Department of Human Services, et al.*, Civ. Action No. 3:10-cv-99991-RV-EMT, we sincerely believe that any regulations promulgated by HHS which apply the PPACA 80% MLR to individual health insurance policies issued to Florida residents prior to March 23, 2010, (the date PPACA was signed into law by the President) would be unjust, unfair and unconstitutional. More specifically, prior to the PPACA effective date, individual health carriers had existing authority from each state for the sale of individual health insurance coverage in that state under the existing rate and benefit mechanism approved by such state.

The individual health insurance carriers rightfully relied upon the prior state-approved coverage, rate and marketing mechanism to sell and issue such coverage in each state prior to the effective date of PPACA.

In many instances, carriers entered into collateral contracts with third parties in connection with the anticipated sale and issuance of such state-approved coverage prior to the effective date of PPACA. Examples of such third party contracts include (i) PPO network access fees for policyholders' access to network providers (which fees were built into the premium rates approved by the states prior to PPACA), (ii) system consumer tools for use by policyholders for everything from tracking benefits to locating participating providers in real time (which fees were also built into the carrier's general and administrative expenses, and therefore a component of the premium rates approved by each state prior to PPACA), and (iii) vested agent commissions (which commissions were also built into the approved premium rates prior to PPACA).

Therefore, application of the PPACA 80% MLR by any future HHS regulations to health insurance contracts issued to Florida residents prior to the effective date of PPACA is not only patently unjust and unfair, but would also constitute what our counsel believes is a "taking" by the federal government in violation of the due process clause of the Fifth Amendment of the United States Constitution, as well as a violation of the Constitution's reservation of state power and non-encroachment by the federal government upon such state power under the Tenth Amendment.

### **Practical and Financial Impacts of Immediate Application of 80% MLR**

Separate and apart from the fundamental unfairness and serious Constitutional issues raised by changing the laws applicable to business written before PPACA was even proposed, there are

numerous practical and financial issues which require reasonable transition rules for PPACA's 80% for individual health insurers.

First and foremost, PPACA's attempt to immediately apply the same MLR standard on individual health insurance that is applied to small group business is problematic in that the business dynamics of the product lines are significantly different. Second, applying such a standard to existing business written prior to January 1, 2011 creates huge displacement problems, given that existing business has outstanding contractual obligations which will not accommodate an MLR higher than the original product pricing.

The current draft of PPACA's MLR rebate calculation proposed by the NAIC does not take into account the inherent volatility of the individual health insurance business, particularly for smaller insurers. Forcing an MLR standard without a reasonable "confidence interval corridor" that takes into account inherent volatility and statistical credibility will result in disastrous consequence to the individual health insurance market.

If these issues are not appropriately addressed and resolved, it is our belief that most smaller and intermediate insurers, along with possibly some larger national players with diverse books of business, will have no alternative but to cancel existing blocks of business and stop selling new business in the state which will displace a significant number of current insureds.

#### **Reasonable Volatility Adjustments by Carrier Are Required for PPACA MLR Implementation**

As indicated above, there is significant volatility in the year-to-year experience in the individual market which results in volatility in the individual loss ratio. The inherent volatility of an individual health carrier's loss ratio from year to year inevitably will result in a company having to rebate premiums in the good years but having to absorb losses in the unfavorable years.

The smaller the book of business the greater the volatility. This volatility is further magnified when the rebating of premiums and absorption of losses under PPACA has to be done on a state-by-state basis rather than aggregated at the national level. Obviously, this is an untenable situation.

The Accident and Health Working Group (AHWG) of the B Committee of the NAIC have only partly addressed this issue by proposing a set of credibility factors that would result in a company's rebates being undeserved (due to statistical probabilities) 50% of the time.

This is untenable for smaller books of business for two reasons. First, the undeserved rebates that are made 50% of the time are disproportionately higher due to the greater volatility for small books of business versus that for large books of business. Secondly, the AHWG credibility factors do not consider the statistical uncertainty inherent in ratemaking for smaller books lacking credible experience. The Milliman report commissioned by the AHWG mentions other sources of uncertainty that the AHWG chose not to consider. The following is taken directly from the Milliman report:

"There are other source characteristics of any carrier's blocks of business that could also contribute to statistical variability of results for **smaller blocks** such as demographic characteristics (age, gender, family composition), geographic area,

type of health plan, average group size, degree of managed care, underwriting intensity, provider network parameters, average duration of the business, and likely other. Per guidance from the NAIC, these have not been considered in the development of these factors in order to recognize the importance of administrative simplicity and the challenges inherent in being able to appropriately identify the impact of such characteristics. **We expect that the exclusion of these characteristics from the modeling process is likely to lead to an underestimate of the actual variance in MLRs experienced by carriers.** [emphasis added].

There is additional volatility due to the non-pooling of large claims across state lines and the exclusion of stop loss reinsurance from the MLR.

The Milliman report states on page 12 the solvency implications of the credibility factors proposed by the AHWG.

“Note, however, that these events do have other implications, such as for plan solvency. The use of a two-sided 50<sup>th</sup> percentile basis would likely be considered a very low confidence interval for a study concerned with plan solvency implications of the MLR refund requirement. Evaluation of such impacts was outside the scope of our assignment”

Allowing for a phased-in implementation period, with reasonable allowance to account for volatility, particularly within smaller blocks of business, would correct this situation.

### **Inherent Fundamental Differences in the Current Business Models of Small Group and Individual Health Coverage Require Reasonable Transition Rules for the Individual Marketplace in Florida**

Finally, it should be noted that PPACA improperly equates the individual and small group markets, and will require that individual and small employer carriers both meet the 80% MLR requirement beginning in 2011. However, significant and substantive differences exist between the small group market and the individual market that make this untenable in the individual market. While the 80% MLR may be somewhat reasonable in the small group market in 2011, implementation in the individual market is completely unreasonable and disruptive without reasonable transition rules.

In this regard, the small group market is comprised in most states of small businesses with 2 to 50 employees while the individual market is just that – an individual. Following is a summary of the principal differences between the individual and small group market business models:

- Due to economies of scale (2 to 50 vs. 1), the average cost per insured member for sales, marketing and various policy administration functions (i.e. billing) are substantially lower for the small group market than the individual market. In addition, brokerage fees for group business are often billed directly to the employer and excluded from premium.
- Exclusion of pre-existing conditions is typically not permitted for small group business which lowers underwriting/issue costs and substantially increases the average premium per

member (and dollars available for profit and administrative costs) in comparison to the individual market. As an example, under our company's employee group health insurance coverage (purchased from a large third party group carrier), the annual premium is \$11,390 for a \$6,000 deductible and \$11,600 out of pocket maximum. In comparison, our company's annual individual health insurance premium for a family of four that we market and offer in the same zip code with a primary insured age 45 is \$7,378 for a \$5,400 deductible and \$10,000 out of pocket maximum. The group health premium charged for our employees' coverage is 54% higher with a higher out of pocket maximum than the individual premium rate our company charges its customers for individual coverage in the same zip code.

- Small group business is non-renewable on an annual basis, while individual business is guaranteed renewable for life as long as premiums are paid. This provides the small group insurer a significant advantage in managing risk, as groups with the highest risk exposure are simply non-renewed.

In view of the above-referenced differences between individual and small group coverage, which will persist at historical levels through 2013, we believe that a maximum 65% durationally adjusted MLR minimum should be established for the individual market in Florida in 2011. Given our strong belief that an ultimate MLR for individual business should be at least 10% less than that for small group, a reasonable phased-in implementation of the MLR in Florida should start at 65% in 2011, and conclude at 70% in 2014.

Due to the significant additional business risk for the individual market created by PPACA and reduction in return on capital, some carriers will not be able to justify continuing to allocate capital to this line of business, much less expand capacity to meet expected individual market growth as employers exit the small group market unless reasonable transition rules are applied in connection with PPACA's 80% MLR.

For its part, Freedom currently prices to a 65% lifetime loss ratio in Florida, and we set our field and home office expense allowable accordingly. Our year to year loss ratio volatility over the past five (5) years has varied around this expected lifetime average by approximately 10 percentage points. So even with a transition period between 2011 and 2014 we may well be subject to rebates in good years and yet be required to absorb losses in bad years.

## **Conclusion**

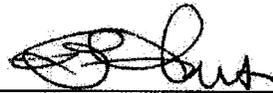
As indicated above, individually underwritten health insurance products serve a critically important function in the overall market for commercial health insurance in Florida. Immediate implementation of the 80% MLR requirement under PPACA, without a gradually phased-in implementation between now and 2014, will cause a significant financial burden on many carriers, and has the potential to significantly disrupt this rapidly growing and important market.

It is undisputed that the 80% MLR requirement will have a significant financial impact on all individual market carriers, many of whom originally priced their products based on a 55-65% loss ratio. Because of the adverse financial effects, and the fact that carriers cannot operate or continue to serve the needs of the existing insureds while incurring significant operating losses, it is likely that immediate implementation of the 80% MLR requirement will cause such carriers to (i) stop offering new policies all together, and/or (ii) non-renew the entirety of their in-force book of business.

This will have a chilling effect on the market for individual health insurance. In addition to reducing the overall availability of insurance, it could also cause hundreds of thousands of insureds to lose their coverage. These individuals, many of whom may have developed uninsured conditions prior to the non-renewal of their policies, would then be required to seek coverage elsewhere, including through risk pools maintained by Florida and/or HHS, in a diminished market for insurance.

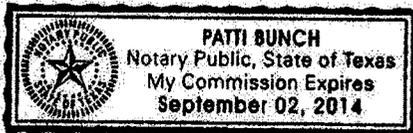
However, this significant disruption of the individual market can be mitigated by adoption of a reasonable, phased-in implementation of the 80% MLR requirement under PPACA.

Thank you for the opportunity to speak with you today about this critically important topic.”



Benjamin M. Cutler  
Chairman and Chief Executive Officer of  
USHEALTH Group, Inc., Freedom Life  
Insurance Company of America and  
National Foundation Life Insurance  
Company.

SUBSCRIBED AND SWORN to before me the undersigned notary public on this 7th day of October 2010, to certify which witness my hand and seal of office.



Notary Public in and for the  
State of Texas

My Commission Expires: 9-2-2014



ASSURANT  
Health

October 7, 2010

Kevin M. McCarty  
Insurance Commissioner  
Office of Insurance Regulation  
200 East Gaines Street  
Tallahassee, FL 32399-0301

Dear Commissioner McCarty:

Assurant Health submits this letter for your consideration regarding the Patient Protection and Affordable Care Act's requirement that individual health insurance carriers meet an 80% medical loss ratio as early as 2011. The immediate application of an 80% medical loss ratio will disrupt the individual market. Transitional relief is necessary to allow carriers selling health insurance in the individual market the time to effectively reduce expenses. Pricing decisions on renewal blocks of business were made prior to the enactment of the Patient Protection and Affordable Care Act. These pricing decisions assumed an administrative expense and sales commission expense that cannot be altered overnight.

Assurant Health has evaluated its business in light of the 80% medical loss ratio and has begun the process of reducing expenses. In an effort to adapt and streamline our organization Assurant Health recently made the difficult decision to reduce our workforce by over 130 employees. In an effort to maintain exceptional service to our customers and to be able to deliver on our promises, these reductions focused on management level did not impact our customer facing employees. Individual medical insurance is sold and serviced one individual at a time. It does not enjoy the economies of scale that exist in the employer market. These administrative costs are ingrained in the systems and the structure of individual medical carriers.

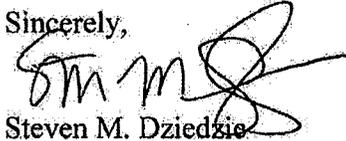
Assurant Health has additional work to do to reduce expenses in order to meet an 80% medical loss ratio. System consolidations and additional workflow streamlining are planned. However, this type of revolutionary systems change takes time. Our customers remain our number one priority and we must ensure that any transition we make does not disrupt or hinder our ability to provide efficient enrollment, exceptional service and accurate and timely claims payments.

If carriers in the individual market are not given transitional relief to carefully and thoughtfully adapt their business to meet the new requirements, their businesses will

suffer and in turn the market will be disrupted. Carriers may choose to discontinue sales while they focus on expense reductions. Already insurers have announced their intention to discontinue sales, if only on a temporary basis, in the individual market in many states. Without allowing carriers the time necessary to transform their business this trend is likely to continue.

Thank you for giving me this opportunity to participate in the dialog regarding these difficult issues. Assurant Health appreciates your involvement and your commitment to a vibrant and competitive individual health insurance market.

Sincerely,

A handwritten signature in black ink, appearing to read 'SM Dziedzic', with a stylized flourish at the end.

Steven M. Dziedzic  
Senior Vice President & Chief Financial Officer

Certification of Steven M. Dziejczak

I, Steven M. Dziejczak, Senior Vice President and Chief Financial Officer of Assurant Health, the marketing name for the health business of Time Insurance Company, John Alden Life Insurance Company and United Security Life Insurance Company hereby certify the following:

1. Pricing decisions were made regarding Assurant Health's individual medical renewal blocks of business prior to March 23, 2010 and included the then current commission and expense structure.
2. Assurant Health reduced its workforce by approximately 130 jobs in its Milwaukee and Plymouth, Minn. offices as of Oct. 1, 2010.
3. In the next three years, Assurant Health is planning additional expense savings via systems consolidation and streamlined processes.

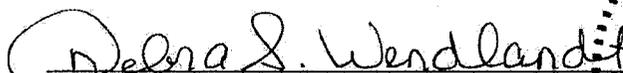


Steven M. Dziejczak

10/7/10

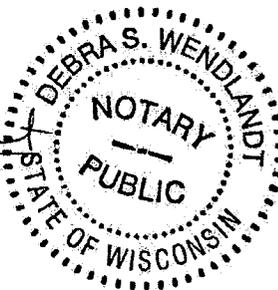
Date

Subscribed to and Sworn before me this 7<sup>th</sup>  
day of October, 2010.



Notary Public

My commission expires 3/3/13





of our under age 65 state population and exceeds the U.S. average of 6.3 percent.<sup>2</sup>

6. Based on the National Association of Insurance Commissioners' (NAIC) database of annual statement filings, almost half of all enrollees covered under the individual plans (from almost 70 insurers) operate below the 80% MLR threshold in the ACA.<sup>3</sup> We do not readily have specific data on individual carriers for Florida. However, current state law and regulations dictate an MLR of no less than 65 % for insurers and 70% for health maintenance organizations.

7. The individual market has unique characteristics that differentiate it from the group or employer-based insurance market. Most individual policies are purchased to provide interim health coverage and protect consumers against catastrophic financial loss until they obtain group coverage through an employer. In the U.S. Department of Health & Human Services' (HHS) interim final rule (IFR) on grandfathered plans, the government cited studies that estimate 40 to 60 percent of individual policies are in effect for less than one year.<sup>4</sup> It is CHC FL's opinion that prior to the establishment of state exchanges in 2014, it is likely that individual plans outside of guaranteed issue markets will continue to exhibit many of the characteristics of the pre-ACA market which are short duration and coverage only for medical conditions that emerge after the purchase of the policy.

8. The new insurance requirements enacted under the ACA have fundamentally changed the market dynamics and economics of individual insurance. Yet, the ACA provides almost no accommodation for these significant market changes and no recognition of the need for an orderly transition period other than the possibility of a "federal adjustment" – presumably through a waiver process – in states where the application of the 80% minimum MLR standard "may stabilize the individual market."<sup>5</sup>

9. CHC FL supports an effort by the State to seek a federal adjustment to the 80% minimum MLR requirement under the ACA. In the absence of a waiver, CHC FL is concerned that the individual market would experience significant upheaval and instability in 2011 through 2014. CHC FL is also concerned that without a thoughtful and well-planned transition period to adjust to the new

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<sup>2</sup> Ibid.

<sup>3</sup> National AAIC: Health Care Reform (PPACA) – Master Issue Resolution Document, IRD041, 15 Sept 2010.

<sup>4</sup> U.S. Department of Health & Human Services: Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule, Federal Register, Vol. 75, No. 116, 17 June 2010.

<sup>5</sup> P.L. 111-148: The Patient Protection and Affordable Care Act, Section 2718.

minimum MLR rules (which are not expected to be issued until December 2010), consumers could face a potential loss of coverage and difficulties finding a replacement policy.

10. Some states have already requested a federal waiver to the new individual MLR requirements. For example, on July 1, 2010, the Superintendent of Insurance for the State of Maine sent a letter to the HHS Secretary that made two specific requests: (1) a waiver of the 80% minimum MLR requirement for the individual health insurance market until 2014; and (2) a federal determination that prior to 2014, implementation of an 80% MLR may destabilize the individual insurance market in that state.<sup>6</sup> More recently, the Commissioner of Insurance for the State of Iowa made similar requests of HHS.<sup>7</sup> While there are important characteristics that distinguish the individual market in Florida from those in Maine and Iowa, it is clear that other states have made a determination that the application of minimum MLR standards will have a deleterious effect on consumers in those states – and the same concepts and logic would apply in Florida.

11. While instability in the market is a critical factor in the decision by the State of Florida to request a federal waiver, there are other key reasons why a waiver and transition period are important to consumers in our State. The reasons are as follows:

1. Impact on Carriers, Jobs, and Competition: From a broad perspective, the application of an 80% MLR to existing individual business without an appropriate state-determined transition period could lead some insurers to exit the market or face unsustainable losses. CHC FL believes that this could result in insolvent carriers, significant job cuts, limited competition and add to our State's economic challenges.
2. Difficulties Finding Replacement Coverage and Limited High Risk Pool Funding: Consumers who rely on individual policies but lose their coverage due to market exits may find it difficult or impossible to find replacement coverage at any price. While the ACA created a high risk temporary health insurance pool program under the now-called "pre-existing coverage insurance program" (PCIP), it

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<sup>6</sup> Letter from Maine Superintendent of Insurance Mila Kofman to Secretary of Health and Human Services Kathleen Sebelius, 1 July 2010 is attached as Exhibit A.

<sup>7</sup> Letter from Iowa Commissioner of Insurance Susan E. Voss to Secretary of Health and Human Services Kathleen Sebelius, 21 September 2010 is attached as Exhibit B.

provided only limited funding. Under the PCIP, Florida's share of federal funding is capped at \$351 million until the program ends on December 31, 2013.<sup>8</sup> The PCIP could eventually be an option for some Floridians, but such individuals would be ineligible for PCIP coverage for at least 6 months, assuming program funding is still available and no waiting list has developed.

3. Discourage New Entrants and Potential Negative Impact on Competition: As noted earlier, the individual market differs from the group market because many Floridians who participate are looking for temporary coverage until employer-based coverage is available. Further, individual policies tend to run at lower MLR levels, especially in the early years of the policy, because coverage is targeted at future medical conditions. Consequently, insurers whose individual book of business has a higher proportion of newer policies will find it very difficult to meet the 80% MLR requirement. The concern is that this could result in an uneven competitive playing field that actually discourages new market entrants and increases premium volatility.
  
4. Eliminate Consumer Choice and Potential Increase in Uninsured: Consumers in the individual market often have preferences for different products compared to the group market. These preferences result in the voluntary selection of plans that tend to run below an 80% MLR, even over the plan's lifetime. For example, individual market plans frequently have higher cost sharing features in exchange for lower monthly premiums. Requiring individual plans to operate at an 80% MLR with no transition period could make policies unaffordable to consumers and lead them to go without coverage—actually increasing the rate of uninsured. The rate of uninsured for the population under age 65 in Florida (26.6% of under 65 Floridians were uninsured at any point during 2009) already exceeds the U.S. average (18.8%) by a significant margin. Adopting an individual market MLR policy that could potentially increase the rate of uninsurance

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<sup>8</sup> HHS Office of Consumer Information & Insurance Oversight (OCIIO): Fact Sheet – Temporary High Risk Pool Program. [http://www.hhs.gov/ociio/initiative/hi\\_risk\\_pool\\_facts.html](http://www.hhs.gov/ociio/initiative/hi_risk_pool_facts.html). Accessed Sept 20, 2010.

would be counterproductive to efforts aimed at reduced the number of the uninsured.<sup>9</sup>

5. Maintaining Brokers as an Important Source of Health Insurance: While some believe that reducing insurer administrative costs by eliminating brokers is an easy solution to attain the minimum MLR, brokers continue to play a valuable role in the individual market in Florida. Brokers help consumers sift through and understand highly complex health information, compare plans, and assist consumers in resolving issues and questions with insurers. Providing a waiver and transition period would allow brokers to maintain their key role in assisting consumers in the purchase of individual insurance plans that best meet their specific needs.

12. CHC FL strongly supports the decision by the State of Florida to seek a waiver of 80% minimum MLR for the individual market in 2011 and the development of an orderly transition period until 2014 to ensure continued and stable access by Floridians to valuable health insurance coverage.

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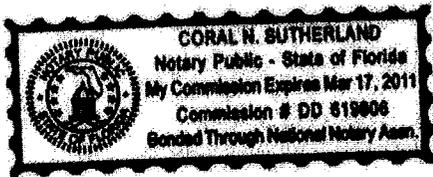
<sup>9</sup> U.S. Census Bureau: Income, Poverty, and Health Insurance Coverage in the United States (2009), Annual Social and Economic Supplement, Table HI05.  
[http://www.census.gov/hhes/www/cpstables/032010/health/h05\\_000.htm](http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm).

FURTHER AFFIANT SAYETH NOT.

*Christopher Ciano*

I HEREBY CERTIFY that on this day personally appeared before me, an officer duly authorized to administer oaths and take acknowledgements, CHRISTOPHER CIANO, who is personally known to me or who has produced \_\_\_\_\_ as identification and who under oath executed the foregoing instrument and acknowledged before me that he executed the same Affidavit freely and voluntarily for the purposes therein expressed.

WITNESS my hand and official seal at said County and State this 29 day of September, 2010.

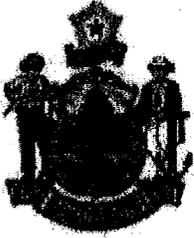


*Coral N. Sutherland*  
Notary Public, State of Florida  
At Large

CORAL N. SUTHERLAND  
Print Name

My Commission Expires: March 17, 2011

## **Exhibits**



JOHN ELIAS BALDACC  
GOVERNOR

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BUREAU OF INSURANCE  
34 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0034

MILA KOFMAN  
SUPERINTENDENT

July 1, 2010

The Honorable Kathleen Sebelius  
Secretary, U.S. Department of Health & Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

*Re: Waiver of Individual Market Medical Loss Ratio*

Dear Secretary Sebelius:

Thank you for your commitment to America's working families and individuals. I have been a strong supporter of health coverage reforms, supporting the Affordable Care Act (ACA), and am fully committed to its implementation. The ACA recognizes that states will face some challenges and allows for individual state waivers to minimize disruptions to coverage that millions of Americans now have.

Pursuant to Section 2718 of the Public Health Service Act, this is a request for a waiver of the 80% minimum medical loss ratio requirement for the individual health insurance market policies in Maine until 2014.

Maine has had a medical loss ratio requirement of 65% in the individual market since 1993. Premium rates are subject to prior approval by the Superintendent and the burden is on the insurer to demonstrate that it will meet the MLR requirement. Maine's MLR, unlike the federal standard, does not allow taxes or other expenses to be deducted nor does it consider quality improvement expenses or any other expenses to be medical. "Medical" expenses are medical claims paid. Functionally, Maine's 65% MLR is somewhat but not substantially lower than the federal standard.

Nonetheless, absent a waiver, I believe that the federal MLR standard may disrupt our individual health insurance market. There are two insurers selling coverage. Although a third insurer sells through a public-private partnership (Dirigo Health), enrollment in that program is currently closed to new individual enrollees. Loss of one of the two insurers would have a serious destabilizing effect in our individual market.



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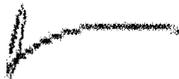
In its filings with the Securities and Exchange Commission, one insurer has indicated its intent to pull out of individual health insurance markets (and has explicitly named one state where that decision has already been made).<sup>1</sup> Based on preliminary discussions I had with the insurer, the company could continue to operate successfully in the Maine market in compliance with our current MLR standard, but would probably need to withdraw from this market if the minimum loss ratio requirement were increased.

This company specializes in catastrophic products, which by their nature have lower claims costs, relative to expenses, than more comprehensive products. In the current market climate, before affordable care subsidies and new coverage guidelines are in place, this is an essential option for our consumers to have available. More than 13,000 Maine residents (approximately one-third of our individual market enrollees) currently depend on this insurer for coverage.

I request a determination that prior to 2014, implementation of an 80% medical loss ratio requirement may destabilize the individual health insurance market in Maine, and an adjustment to the MLR consistent with Maine's current 65% requirement for coverage issued or renewed before 2014.

I look forward to our discussions relating to this request. Please feel free to call me directly at (207) 624-8550 or Bob Wake, General Counsel at (207) 624-8430.

Very truly yours,



MILA KOFMAN  
Superintendent of Insurance

Cc: Jay Angoff, Director, OCIIO

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<sup>1</sup> See 2009 Annual Report of HealthMarkets, Inc., Form 10-K, available online at:  
<http://www.sec.gov/Archives/edgar/data/773660/000095012310025695/d71540e10vk.htm>

EXHIBIT B

CHESTER J. CULVER  
GOVERNOR

PATTY JUDGE  
LT. GOVERNOR

SUSAN E. VOSS  
COMMISSIONER OF INSURANCE

September 21, 2010

The Honorable Kathleen Sebelius  
Secretary, U.S. Department of Health & Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Waiver of Individual Market Medical Loss Ratio

Dear Secretary Sebelius:

Since the passage of the Patient Protection and Affordable Care Act, the state of Iowa has been actively implementing the various provisions of the legislation. Outreach and education to Iowa consumers is at the forefront of our efforts. And, as promised, we want to make sure that Iowans are allowed to maintain the health insurance coverage they currently maintain.

Therefore, this letter will serve as a request for a waiver of the 80% minimum medical loss ratio requirement for the individual health insurance market policies in Iowa until 2014. We are quite concerned that many Iowans who purchase health insurance through smaller carriers will be negatively affected by the medical loss ratio requirement which goes into effect in 2011. We know that one of the goals of the federal law is to ensure that consumers maintain adequate health care coverage. For many Iowans this means allowing them to retain the coverage that they currently have in the private market. These Iowans work closely with their insurance agents to obtain the best possible coverage for their personal needs. And often, this coverage will be through a insurance carrier that maintains a smaller share of the health insurance market.

These smaller carriers will not meet the initial 80% medical loss ratio factor in 2011. They will need a phase-in period. Without such a waiver provision, I believe the federal standard will disrupt our individual health insurance market. This in turn will negatively impact many Iowans who have enjoyed their coverage benefits through these smaller carriers.

Iowa enjoys some of the lowest health insurance rates in the country. And our market provides for not only one very large health insurance carrier, but several small insurance carriers as well in the individual market. Already we are seeing several of our carriers with small numbers of insureds in the individual market announce their intent to cease business in our state. This will impact the choices available to Iowa consumers.

Our first goal as insurance regulators is to protect consumers. Part of that protection is providing "choice" in the market place. Without some form of "phase-in" for these individual carriers, consumers in Iowa will be left with fewer choices. We believe that is not the intent or spirit of the federal law.

Therefore, I respectfully request that prior to 2014, you grant a waiver to the state of Iowa for a phase-in of the medical loss ratio of 80% in the individual market. We would not object if such a waiver was granted to carriers with a limited percentage of the market. But, we believe that consumers will be better served in the long run if they are allowed to maintain their current carrier of choice through this limited waiver provision.

Please feel free to contact me at your convenience to discuss this request. I can be contacted directly at 515-281-5907.

Sincerely,

Susan E. Voss  
Commissioner

**Chris Hocevar**  
President, Individual Segment



**CIGNA HealthCare**

900 Cottage Grove Road  
Hartford, CT 06152  
Christopher.Hocevar@cigna.com

September 30, 2010

Kevin M. McCarty  
Insurance Commissioner  
Florida Office of Insurance Regulation  
200 East Gaines Street  
Tallahassee, FL 32399

Dear Commissioner McCarty:

CIGNA is pleased to respond to the request made by the Florida Office of Insurance Regulation for comments pertaining to the potential destabilizing effect of the new minimum loss ratio standard set forth in the Affordable Care Act (ACA) on the individual insurance market in Florida. The medical loss ratio standard will have a profound impact on the health insurance marketplace and particularly the individual health insurance market. We, therefore, appreciate the opportunity to provide comments on this critically important subject.

We believed that the implementation of the new federal minimum loss ratio standard of 80% may have the following disruptive effects on the individual market in Florida:

1. Reduce competition in the individual market due to insurance carrier withdrawals and consolidation
2. Limit product and plan design availability
3. Disrupt the broker and agent distribution channel
4. Discourage insurance carriers from investing in new capabilities to which improve the customer experience

Each of these items is described below in greater detail:

#### **Impact on Competitive Marketplace**

Individual policies are typically priced to an anticipated lifetime loss ratio rather than an annual loss ratio. Policies currently in force may have been priced to a lower lifetime loss ratio than the new federal standard. In order to meet the annual federal loss ratio standard, insurers may be forced to reduce or rebate premiums such that losses are generated. Rather than incur future losses or generate statutory insolvency concerns, some insurers may find it more prudent to withdraw from the individual market. Such market withdrawals will reduce the number of health coverage options available to individuals and reduce competition in the individual market. In addition, policyholders left without coverage may find that they are unable to obtain alternative coverage until the federal guaranteed issue requirements take affect in 2014. This could result in an increase in the number of uninsured individuals in the state of Florida over the next 3 years.

"CIGNA" or "CIGNA HealthCare" are registered service marks and refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these operating subsidiaries and not by CIGNA Corporation. These operating subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO Plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare of Virginia, Inc. and CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.

Alternatively, insurers may also elect consolidation rather than market withdrawal. While this will ensure policyholders are able to maintain coverage, it will reduce the number of insurers operating in the individual market.

#### **Impact on Product and Plan Design Availability**

Products and plans available in the individual market typically have lower overall medical costs than plans sold in the employer markets as a result of lower actuarial values (higher levels of customer cost sharing) and the impact of medical underwriting. While medical costs tend to be lower in the individual market, non-medical expenses including claim and policy administration costs are not lower. Consequently, non-medical expenses represent a greater percentage of each premium dollar in the individual market.

In an effort to meet federal minimum loss ratio standards, insurers may cease offering plan designs with low actuarial values and lower costs in favor of offering plans with higher actuarial values and higher costs. Such actions would limit the availability of affordable coverage options for individuals. As medical costs continue to escalate, a growing number of Florida consumers may be unable to find health coverage that is affordable until federal subsidies are implemented in 2014.

#### **Impact on Future Service Capabilities**

The federal loss ratio standard limits not only the amount of profit insurers can achieve, but also limits the dollars available to fund necessary operational functions including customer service and claim payment. While CIGNA strongly supports improvements in customer service capabilities and believes they are necessary for a sustainable market, we fear that in the short-term, the new medical loss ratio standard may discourage insurers from making investments in new operational capabilities which enhance the customer experience. In an effort to reduce short term costs, insurers may eliminate value added customer services and migrate to lower level service models.

In addition, the development of operational efficiencies does not occur overnight. Time and resources are necessary to identify opportunities to streamline administrative functions and develop the required technology enhancements, all while ensuring that the customer and provider service experience is not adversely impacted. It is unreasonable to expect insurers to reduce administrative costs in a short time frame without adversely impacting customer and provider services.

#### **Impact on the Broker & Agent Distribution Channel**

CIGNA partners with brokers and agents to provide valuable educational services to consumers and help them select the best health insurance coverage to meet their needs. Broker and agent compensation for these important services represents a material portion of each premium dollar spent in the individual market. In an effort to meet new medical loss ratio standards, insurers may be forced to reduce compensation to agents and brokers or to refrain from selling certain products through this channel. Such actions would lead to significant market disruption as consumer access to brokers and agents will be reduced at a time when the educational services these brokers and agents provide is needed most. In addition, the number of product offerings available to consumers who choose to utilize a broker's or agent's services may become more limited.

As a result of the impacts described above, CIGNA recommends that the state of Florida request a deferral or adjustment to the federal minimum loss ratio standard for individual business until 2014, when Exchanges and other key federal health care reforms are implemented. We believe that many of the negative market consequences may be mitigated through a deferral or gradual phase-in of the loss ratio requirement, or alternatively the development of an adjustment to the loss ratio calculation. Any phase-in approach should be thoughtfully constructed to consider the impact of multi-year averaging which is expected to occur in calendar years 2012 and later.

Thank you for the consideration of these comments. On behalf of CIGNA, we will be available at any time for further discussion.

Respectfully,

A handwritten signature in cursive script, appearing to read "Christopher Hocevar".

Christopher Hocevar  
President, Individual Segment

The following is a sampling of the almost 100 affidavits received from agents and brokers concerned about the impact of the federal medical loss ratio requirements.



Combined Insurance Services  
INCORPORATED

October 07, 2010

Mr. Matt Nowells  
Blank and Mennan, P.A.  
204 South Monroe Steet  
Tallahassee, FL 32301

RE: Health Insurance Agents and Potential Commission Reductions

Dear Mr. Nowells:

Enclosed is my signed, notarized affadavit as requested by the Florida Association of Insurance and Financial Advisors. Additionally, I am enclosing this letter to give some background to enable those involved in the current "Medical Loss Ratio, MLR" discussion a better picture about the services performed by a professional Health Insurance Advisor who has been in the business for over thirty years.

The Health Insurance business in Florida is very complex. Without the services of professional agents/advisors such as myself and my staff; consumers would be lost in trying to find their way through the maze that confronts them in making educated decisions regarding their healthcare choices.

Insurance carriers facing the new "Medical Loss Ratio" standards under Federal Healthcare Legislation are reducing their internal staff and depending more than ever before on agents/brokers to market their products, educate consumers about the choices of plans and options, and making the enrollment process amenable for getting new consumers into the plan they have selected.

There is no Carrier in Florida with a completely foolproof enrollment or claims system. There are problems facing consumers dealing with provider networks, provider claims submission issues and carrier claims decisions.

My staff deals with claims issues on a daily basis. We deal with educating provider staffs on the coverage their patients have and how to properly submit claims.

We provide ongoing support to our clients to keep them knowledgeable in the ever-changing legislative and regulatory landscape which affects their health plan coverage.

We provide human-resource advise for smaller clients who cannot afford their own H.R staff. We provide HIPAA-compliant claims review assistance. We provide

P.O. Box 2438  
Ocala, FL 34478

1701 N.E. 42nd Avenue, #200  
Ocala, FL 34470  
www.combinedinsuranceservices.com  
Phone: 352.237.2181  
Fax: 352.237.2040  
Toll-Free 800.473.2181





**Combined Insurance Services**  
INCORPORATED

patient-advocacy services to assist our clients employees and dependents during conflicts with the medical provider's office staff and insurance carriers' claims staff.

We provide the same level of ongoing service to our clients with three employees that we provide to our clients with 2,500 employees.

We have invested heavily in service personnel and training; having hired our newest client-service associate just this past week.

We have made significant financial investments in technology to keep our client communication lines open and keep our clients informed. For many of our clients; we provide H.R. services which they cannot afford to have in-house.

We are a family-owned small business which has been serving our clients for over thirty years.

Without our firm, our clients would be awash in a sea of legislative, regulatory, and provider-carrier issues they are not trained to understand and able to deal with. We make sure their doctor will see them when their insurance i.d. card has not arrived from the carrier. We explain how their claim was processed and deal with the carrier to get it correctly reprocessed if needed.

Selling the best product to meet the client's needs is only where our work begins,,not where it ends. Our clients need us, the carriers need us and the entire system would become a mass of confusion without us.

I hope this gives a better picture of the part we play in the healthcare system. As insurance carriers struggle to deal with the new "MLR" regulations under healthcare reform, I am hoping that they do not force firms like mine out of business by further cutting our compensation to comply with "MLR". I am already providing many services that carriers once performed, but my compensation is at the lowest level it has been in my thirty-seven years in the health insurance business in Florida.

Sincerely,

Robert E. Taylor  
President & CEO

P.O. Box 2438  
Ocala, FL 34478

1701 N.E. 42nd Avenue, #200  
Ocala, FL 34470

[www.combinedinsuranceservices.com](http://www.combinedinsuranceservices.com)

Phone: 352.237.2181  
Fax: 352.237.2040  
Toll-Free: 800.473.2181



AFFIDAVIT

STATE OF FLORIDA

COUNTY Hillsborough

BEFORE ME, the undersigned authority, personally appeared William F. Daines, II, who, after being first duly sworn, deposes and says:

1. My name is William F. Daines, II
2. I am licensed in Florida as a Life, Health and Annuity agent.
3. I have been licensed as an agent for 20 years.
4. I currently employ 1 non-agent staff.
5. As a result of the Medical Loss Ratio, I expect commissions to be reduced on health insurance policies.
6. I have been notified that in an effort to lower administrative costs carriers may be forced to reduce the number of products available thereby reducing my customer's choices. In addition, I believe that a reduction in administrative cost will lead to increased processing times.

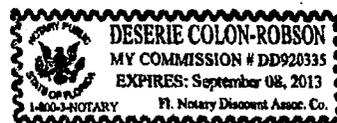
Further affiant sayeth not.

William F. Daines II

NAME

SWORN TO AND SUBSCRIBED before me William Daines who is personally known to me or has produced Florida Driver's license as identification, this 8<sup>th</sup> day of October 2010.

Deserie Colon Robson  
NOTARY PUBLIC  
My commission expires: September 8, 2013



**AFFIDAVIT**

STATE OF FLORIDA

COUNTY Brevard

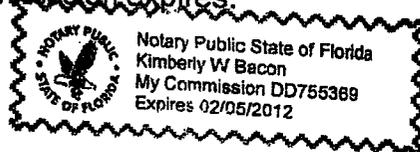
BEFORE ME, the undersigned authority, personally appeared Kristan O'Keefe, who, after being first duly sworn, deposes and says:

1. My name is Kristan O'Keefe.
2. I am licensed in Florida as a Life, Health and Variable Annuities agent.
3. I have been licensed as an agent for almost 4 years.
4. Some carriers have already informed me that my commissions on health insurance policies are going to be reduced, although I do not currently know by how much. Since I am already obligated to a 50/50 split of my commissions with my employer/agency, any decrease in commission will have a significant impact on my ability to meet my family's financial obligations.

Kristan O'Keefe  
NAME

SWORN TO AND SUBSCRIBED before me Kristan O'Keefe who is personally known to me or has produced \_\_\_\_\_ as identification, this 7 day of October 2010.

Kimberly W. Bacon  
NOTARY PUBLIC  
My commission expires:



October 8, 2010

Kevin McCarty  
State of Florida  
Insurance Commissioner  
Tallahassee, FL

Re: Reduction of Health Insurance Commissions

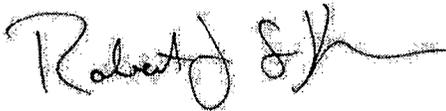
Dear Mr. McCarty,

I wanted to write this letter to express my concern over the possible reduced commissions on health insurance policies. I currently hold a 218 license in the State of Florida and have been in the employee benefits business here for 32 years. I currently employ myself and an assistant and we solely concentrate in the benefits side of the business.

As a result of the healthcare reform Medical Loss Ratio requirements I expect to have my commissions reduced, possibly to a level below sustainability. If the proposed commission reduction is enacted then I would be forced to layoff my assistant, and possibly leave the health insurance industry all together.

I ask that you work to keep the agent a viable part of the insurance process. We provide a valuable service to our clients and must be in a position to receive commissions that support our efforts.

Sincerely,



Robert J. Shafer, Jr., CEBS

# Boca Benefits Consulting Group, Inc.

P.O. Box 4309, Clearwater, FL 33758-4309

Phone: 727.535.6902 | Fax: 727.535.8190 | Cell: 727.510.7138 | Email: [postmaster@bocabenefits.com](mailto:postmaster@bocabenefits.com)

---

[rw\\_murphy@bocabenefits.com](mailto:rw_murphy@bocabenefits.com)

Thursday, October 07, 2010

Dear Commissioner McCarty:

Having been a licensed Life & Health agent for 29 years (i.e., resident Tennessee and Florida and many non-resident licenses in surrounding states), I write with great concern regarding the impact of the MLR requirements of PPACA.

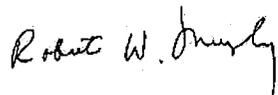
There appears to be little impact for larger groups where the expense component is allowed to be 15%. In fact, as a former underwriter and senior management person for three major health carriers I can state unequivocally that 15-16% was always the target load in premium setting. However, small groups are another matter. Setting the expense component at 20% puts undue pressure on the commission structure required to properly support these type cases.

The implications of agents walking away from small case support due to lack of adequate compensation for their time seems very obvious to me. The question I pose to those setting the MLR requirement regards their interpretation of the agent's role in the new environment and the value/lack of value associated therewith. In a recent webinar with CIGNA held strictly for broker/agent/consultant producers they indicated that philosophically they are opposed to "transactional" selling of product (e.g., web portals with virtually no agent support). When I recently posed a question to a current Florida House candidate about how agents would fit into a Florida "exchange" he could not give me any kind of credible answer. In his defense, I do not believe the impact of diminished agent support has been adequately thought through at the federal or the state level.

In regard to the overall intent of restricting MLR's: I fully support the concept. Having been personally involved in much of the early development of managed care from 1985-1990 I can also unequivocally state that in the last 20 years carriers have built in expenses that are more for product differentiation and marketing than for the delivery of medical management. The expense loads can indeed be squeezed without a substantial change in morbidity (i.e., medical outcomes being the best measure of quality – not which carrier has the fluffiest add-on services). However, allowing carriers to reduce expenses at the expense of support to the buying public via agents is not good policy. CIGNA is sincere in their statements to their producers about how they desire to see this play out. However, ultimately they must respond to market pricing and will shift their focus to "transactional" approaches if that is what the new paradigm becomes.

A waiver of the MLR requirements seems the most plausible solution until the appropriate legislation can be amended to actually more finitely target certain non-productive expense components. I strenuously urge you to seek a waiver as a matter of sound public policy.

Sincerely,



Robert W. Murphy, REBC, ChFC, CLU, RHU, MBA  
President /CEO

**AFFIDAVIT**

STATE OF FLORIDA

COUNTY OF ALACHUA

BEFORE ME, the undersigned authority, personally appeared David W. Ashley, who, after being first duly sworn, deposes and says:

1. My name is David W. Ashley
2. I am licensed in Florida as a 2-18 agent.
3. I have been licensed as an agent for 28 years.
4. I currently employ 1 agent and 1 non-agent staff.
5. As a result of the Medical Loss Ratio:
  - a. I expect carriers to attempt a reduction in agent commissions on health insurance policies as a result of their (the carriers) loss ratios being restricted or limited to a permissible percentage which is less than the carriers historically advertised "breakeven point".
  - b. If "a." becomes reality than I as an agent should not be penalized by having my commissions reduced disproportionately.
6. If commissions are reduced disproportionately I anticipate having to leave the health insurance industry which will be a significant loss for the consumer or my clients.

7. Further affiant sayeth not.

[Signature]  
NAME

SWORN TO AND SUBSCRIBED before me David Ashley, who is personally known to me or has produced Driver License as identification, this 8 day of Oct, 2010.



CAROL ANN CRAWFORD  
NOTARY PUBLIC  
STATE OF FLORIDA  
Comm# DD981519  
Expires 2/15/2014

NOTARY PUBLIC  
My commission expires: