



**BlueCross BlueShield
of Florida**

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Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Florida
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May 7, 2010

To: Kevin McCarty
Commissioner, Florida Office of Insurance Regulation
Chairman, Florida Health Insurance Advisory Board

From: Douglas Lynch, FSA, MAAA
Director and Senior Actuary, BlueCross BlueShield of Florida

Subject: Written Testimony for OIR & FHIAB Joint Public Hearing

The Florida Office of Insurance Regulation (OIR) and the Florida Health Insurance Advisory Board (FHIAB) have jointly requested information in the form of the following two questions:

1. *What considerations should be made in determining the most appropriate approach for the calculation of the Medical Loss Ratio (MLR)?*
2. *What is the potential impact of the MLR requirements to the health insurance market in the state of Florida, with a specific focus on the individual health insurance market?*

As you are well aware, there are many variables and many unknowns regarding these topics so we have done our best to present our thoughts based on our current understanding of the intent of the legislation and direction of the regulations. Our view of the intent of the MLR requirements in the legislation was to ensure that a reasonable portion of the revenue collected for health care is spent on claims and claim related expenses. In addition to the questions discussed below, BCBSFL would support consistent definitions nationwide as well as consistency between the MLR definitions in Section 2718 of the Public Health Service Act created by the Patient Protection and Affordable Care Act Section 1001 and Section 833 of the Internal Revenue Code as modified by Section 9016 of the Patient Protection and Affordable Care Act.

BlueCross BlueShield of Florida (BCBSFL) has considered the questions posed by the OIR and the FHIAB and our responses are outlined below.

1. What considerations should be made in determining the most appropriate approach for the calculation of the MLR?

a. Change in Contract Reserves (Active Life Reserves)

Considerations:

- A contract reserve represents a liability for future claims that is funded by prior premium.
- A medically underwritten policy experiences low claims in the early years after the policy is issued as the individual must be relatively healthy to pass medical underwriting. Over time, these individuals will tend to experience higher claims.
- Section 2718(a) mentions the “change in contract reserves” but it is unclear whether or not this is included in the numerator of the MLR calculation in Section 2718(b).
- Including the absolute change in contract reserves could effectively cause insurers to pay rebates on historical experience due to this new MLR requirement. We do not believe that this was the intent of the legislation and this could create significant financial ramifications for certain insurers.
- For existing business, including the change in contract reserves as it appears in the annual statement could reduce incurred claims for insurers that have contract reserves. This will make it more difficult for insurers that have contract reserves to achieve the minimum MLR. This is especially true in an environment where membership is declining as the contract reserve for those members is released if the members leave, reducing the numerator in the calculation.
- Excluding the change in contract reserves as it appears in the annual statement will artificially penalize growing blocks of business as the favorable early experience will not be offset with the contribution to contract reserves.
- The lock-in principle for GAAP assumptions may make GAAP contract reserves a less desirable option as assumptions may need to change now that health care reform has passed.
- The change in statutory contract reserves is reflected in the Analysis of Operation by Lines of Business exhibit in the annual statement.
- Contract reserves will not likely be needed for non-grandfathered individual business due to the lack of medical underwriting beginning in 2014. Due to this, the

definition of grandfathered business will potentially impact the level of contract reserves that an insurer would be required to hold.

Recommendation:

- If some insurers do not hold contract reserves for durational business and others do, including the change in contract reserves funded by future premium (premium for periods beginning with the effective date of the mandate) and excluding the change in contract reserves funded by historical premium would result in an equitable application of the MLR requirement for all insurers.
- If all insurers hold contract reserves, we would recommend using the change in contract reserves reflected in the Analysis of Operation by Lines of Business exhibit in the annual statement.

b. Activities that improve healthcare quality

Considerations:

- SSAP 85 is somewhat dated and may not appropriately reflect current cost categories.
- Historically insurers and regulators have not calculated MLRs how they are defined in this legislation. MLR definitions will have to change to be consistent with the legislation.
- Excluding any activity that truly does improve healthcare quality may force organizations to eliminate those activities and members may suffer from reduced quality.

Recommendation:

- Define activities that improve healthcare quality consistent with America's Health Insurance Plan's (AHIP) recommendation to include, but not be limited to, the following:
 - Case management
 - Care coordination
 - Disease management
 - Consumer education programs
 - Nurse call lines
 - Quality review and assurance
 - Patient monitoring programs

- Investments in upgrades to claims systems
- Wellness programs
- Costs associated with maintaining a quality network including access fees to quality networks for plans that do not maintain their own
- Pay-for-performance initiatives
- Formulary management (MTM)
- Transparency initiatives
- Internal and external review
- Health IT initiatives including electronic prescribing electronic medical records and electronic personal patient records
- Administrative cost of paying claims
- Clinical quality research
- Drug safety programs
- Quality data reporting and quality measurement activities
- Fraud and abuse programs
- Health risk assessments

c. Time Period for MLR Calculation

Considerations:

- Lifetime loss ratio requirements are typically used in the medically underwritten individual health insurance market due to the variation in the level of claims over the duration of an individual policy. Using a shorter timeframe requires the appropriate consideration of contract reserves.
- Section 2718 uses the phrase “with respect to each plan year.” It is unclear what this means for individual business where there is no plan year concept. Group business has a plan year, but it is unclear which plan years should be aggregated for the calculation since groups’ renewal dates are distributed throughout the year giving them different plan years.
- Calendar year would be consistent with most financial reports that organizations complete, including the annual statement.

Recommendation:

- Use a calendar year time period to be consistent with the annual statement.

d. Level of Aggregation

Considerations:

- Larger blocks of business will have less volatility in claims and will therefore be more consistent indicators of MLR levels.
- Insurers may not have all expenses explicitly split between individual and small group so there may need to be allocations of expenses if individual and small group are tested separately.
- Combining multiple states will allow certain states to subsidize other states. This would allow one state to be below the minimum MLR and another state offsetting that by being above the minimum MLR.
- Insurers often sell products from two different affiliated companies side by side in the small group environment.
- The Florida market is large enough to be a credible market on its own.

Recommendation:

- Combine Individual and Small Group business for the purpose of determining conformity to the MLR standard and perform the calculation at the state level combining affiliated companies.

e. Credibility

Considerations:

- Smaller blocks of business have much higher volatility and will more likely breach the MLR thresholds due to randomness as opposed to the presence of unreasonable premium rates in relation to the benefits provided.
- Smaller blocks of business may have a higher proportion of their expenses that are fixed costs.
- Florida Administrative Code Rule 690-149.0025(6)(a) states “Credible Data: Except as provided in paragraph (b), if a policy form has 2,000 or more policies in force, then full (100%) credibility is given to the experience; if fewer than 500 policies are in force, then zero (0 percent) credibility is given.”

Recommendation:

Use the requirement of the state of Florida of 2,000 contracts, or some higher minimum, for the MLR calculation. Plans that do not meet the minimum credibility threshold should not be held to the MLR standards.

f. Payment of Rebates

Considerations:

- Paying rebates will be administratively complex and costly.
- Excess premiums can be returned through reduced future rate increases very efficiently, although this may cause some disconnect between the members who “earned” the rebate and the members who “receive” the rebate.
- Payment to the contract holder for individual business and to the employer for group business is considerably more efficient than making a payment to each enrollee as mentioned in Section 2718(b)(1)(A).

Recommendation:

- Allow for rebates to be paid through reduced future premium increases.

2. *What is the potential impact of the MLR requirements to the health insurance market in the state of Florida, with a specific focus on the individual health insurance market?*

Considerations:

- Section 2718(b)(1)(A)(ii) states that “the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.”
- Insurers may be incented to eliminate lower benefit plans that are typically focused on the uninsured. Lower benefit plans generate lower revenue, sometimes as low as 20% or less of a comprehensive medical plan. Costs often do not scale down proportionately with the premium requiring lower MLRs to cover costs. Using an example, if a comprehensive plan is \$300 per month and a low benefit plan is \$60 per month, an 80% MLR means the insurer will have \$60 for a comprehensive plan (20% of \$300) and only \$12 for a low benefit plan (20% of \$60) to cover often substantially similar administrative costs .
- Insurers that are currently below the minimum MLR may not be able to collect enough revenue to cover medical and administrative expenses and therefore may be forced to exit the individual market in the state.

- Insurers that are currently below the minimum MLR may not be able to collect enough revenue to earn sufficient profit to cover their risks and therefore may choose to exit the individual market in the state.
- Insurers that are currently below the minimum MLR and decide to remain in the individual market may be incented to reduce commissions, which may adversely impact the availability of individuals to get insurance as agents look to sell higher commission products. It may also steer individuals to direct methods of obtaining insurance, which may provide them less guidance to make important financial and health decisions.
- Insurers that are currently below the minimum MLR and decide to remain in the individual market may be incented to reduce administrative costs, which could result in lower levels of quality and service and increased medical costs for individuals. This would be impacted by the specific definitions decided upon for activities that improve health care quality.

Recommendation:

- Consider requesting a lower MLR than the prescribed 80% for the individual market to avoid potential market disruption.

Please feel free to contact us if you should have any questions or require any additional information and we will assist in any way we can.