

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

Dear Commissioner McCarty:

On behalf of Florida CHAIN, a statewide network working with and on behalf of uninsured and underinsured Floridians, I am writing today to comment briefly on the Medical Loss Ratio (MLR) requirements that will be imposed on insurers as a result of the passage and implementation of the Patient Protection and Affordable Care Act (PPACA). Thank you for the opportunity to provide this input for your consideration as you prepare to offer your own recommendations to federal HHS representing Florida and Floridians.

However, as consumer advocates who, like most Floridians, are not immersed in all of the technical aspects of the health insurance industry, it is difficult to comment with specificity given our lack of clarity about a number of aspects of the forthcoming proposed regulations. That issue leads directly to our first comment, namely that:

- In drafting regulations, HHS should consider the interests and, to the extent available, the input of consumers when drafting regulations. The hearing recently conducted by OIR was marketed and targeted solely to insurers and agents. Not only was most or all of the content not accessible to the general public, but no background or even an agenda that would have promoted participation by non-industry stakeholders was made available prior to the hearing. You should consider noting that your comments, although ostensibly grounded in findings from a public hearing, exclusively represent the interests of the insurance industry.

We ask that you also consider the following observations and suggestions offered from a consumer advocacy perspective:

- I. Classification of Expenditures

- As we have seen already in the recent case of WellPoint's response to the prospect of the MLR regulations, insurers will predictably (and perhaps even logically) find and exploit whatever loopholes or ambiguity are imbedded in the regulations that are ultimately promulgated. Therefore, HHS should take pains to operationally define all terms and formats involved in the derivation and reporting of MLRs to limit opportunities for undermining Congress intent as expressed in the PPACA.

- The task of precisely defining which types of expenditures should be considered directly related to the provision of care or the improvement of its quality is obviously one of almost infinite complexity. An intensive effort to parse every conceivable category of expenditures at an almost "molecular" level, as well as create a mutually exclusive but exhaustive reporting scheme to capture that parsing will be well worth it. Although the insurance industry will no doubt decry the implementation of such a framework as excessive regulation, it is rather an appropriate safeguarding of taxpayers' investment, particularly with respect to the Health Insurance Exchanges, as well and a much-needed basic consumer protection.

- To the extent that there is ambiguity in the nature of a particular class of expenditures, it should either:

- 1) be classified as administrative in nature by default, or
- 2) be parsed further into two or more unambiguous classifications.

- For types of expenditures that legitimately serve a dual (administrative and non-administrative) purpose, methodology must be developed that uniformly prorates each such expense based on the extent to which it directly, measurably and indispensably impacts care delivery or quality improvement. Expenses that could be eliminated without having any such impact should be classified as fully administrative in nature. The portion of any dual-purpose expense that is classified as administrative in nature should be at least 50%.

- The reporting scheme and the underlying classification of expenses must be assignable and equally binding on any level of contract or subcontract for the provision of any goods or services into which the insurer enters. Furthermore, such reporting by contractors and subcontractors must be folded into the insurer's MLR. The integrity of the MLR concept must not be undermined through the strategic use of contracts and subcontracts.

II. Reporting Requirements

- To the extent that HHS agrees to relaxed enforcement or lower standards during any transition period associated with the fulfillment of obligations imposed by contracts and policies currently in effect, the reporting and publication of MLRs should nevertheless commence without delay. In general, the timetables for allowing MLRs to be used for compliance and enforcement purposes vs. transparency and consumer education purposes should be delinked.
- Regardless of how MLRs are rolled up across distinct geographic regions, time periods, etc. for compliance and enforcement purposes (although such methods should be used sparingly to avoid skewing the true picture), insurers should be required to report and publish MLRs for each plan for each market for each reporting period. Aggregated reports by insurer or region can and should also be readily generated. Lower-level MLRs can easily be further aggregated to produce higher-level MLRs, but that opportunity does not exist in the opposite direction through disaggregation.
- Exceptions to MLR reporting requirements should be granted only in the event that the number of insureds is less than a true de minimis threshold. Thus, the MLRs will aid informed choice on the part of consumers and encourage voluntary actions by insurers to devote more resources to the delivery of health care, even if they do not yet serve any direct regulatory end.
- Recognizing that insurers will object to these and any similar insistence that they report on a complete, frequent and fairly localized basis, the MLR reporting process should make provisions for insurers to provide, in addition to the MLR itself, a brief narrative explanation of the factors that impacted the reported MLR that cannot be inferred from the value alone. The narrative must use only concepts and terms with which the general public is likely to be familiar.
- In the case of large group plans or other plans that may cross state lines as a result of a future interstate compact, no MLR should be based on aggregation of information pertaining to multiple states unless the number of insureds is less than the de minimis threshold. If a plan has sufficient enrollees to reach the threshold in one state but not in another, the MLR should be reported for the former but not aggregated for purposes of combined reporting for the latter.

· An important challenge in the implementation of health care reform will be cementing and optimizing the interface between the Exchanges, Medicaid and CHIP. Extension of any MLR standards and requirements imposed on plans available through the Exchanges to Medicaid and CHIP, while not required by the PPACA, would be beneficial.

I find myself out of time. Thank you in advance for your consideration.

Sincerely,

Greg Mellowe

Policy Director

Florida CHAIN