



Comments of Aetna Inc. before the
Joint Public Hearing of the
Florida Office of Insurance Regulation
And the
Florida health Insurance Advisory Board

May 4, 2010

Mark LaBorde
President, Jacksonville/Tampa Markets

Medical Loss Ratio (MLR)

The final regulation should further key goals of health care reform:

I. Quality Improvement and Affordability

- 1) Accurate Quality Definition: The definition of activities that improve health care quality and clinical services must allow for the inclusion of the wide array of insurer functions that provide value for consumers. In addition, the definition should provide a level playing field among different types of insurers and products.
- 2) Scope of Benefits: MLR rules should not apply to HIPAA excepted benefits.
- 3) Exclusion of State and Federal Costs: MLR should be calculated after excluding state and federal assessments, taxes and other costs from revenue.

II. Enhancement of Competition

- 4) Appropriate Aggregation: The large group MLR should be at the aggregated legal entity level for the largest geographic area covered. A combined, state based MLR should be used for the individual and small group markets (at the aggregated legal entity level).
- 5) Market Monitoring: Assure that federal and state regulators have clear direction with established early warning signals to lower MLRs if solvency or competition deteriorates.
- 6) Rolling Averages: Beginning in 2011, insurers should be allowed to calculate MLRs based on three year rolling averages.

III. Administrative Efficiency

- 7) Calendar Years: MLRs should be based on a calendar year basis.
- 8) Rebates: Rebates should take the form of premium credits to current customers. De minimus rebates should be provided to state high risk pools or risk adjustment mechanisms.
- 9) Preemption: Federal MLR rules should preempt state MLR rules.

Legislative Background

The Patient Protection and Affordable Care Act includes the following provisions impacting MLR:

- Insurers are required to submit an MLR report to HHS Secretary
 - MLR requirements are 85% of the large group, 80% for the small group and individual markets
 - Secretary can adjust the 80% MLR in a state if the Secretary determines that such requirements may destabilize the individual market
 - Insurers must provide an annual rebate to enrollees if minimums are not met
 - The NAIC will establish uniform definitions of activities and standardized methodologies for calculation of the MLR, subject to the Secretary's certification
-

I. Quality Improvement and Affordability

Recommendation #1: Accurate Quality Definition

The definitions of activities that improve health care quality and clinical services should include:

Part A: Activities to Improve Health Care Quality

As the purchaser of health care services for more than 170 million Americans, health insurers play a pivotal role in implementing mechanisms to improve care quality. This role has long been recognized by government agencies such as the Agency for Healthcare Research and Quality (AHRQ), independent accreditation bodies such as the National Center for Quality Assurance (NCQA) and the Utilization Review Accreditation Committee (URAC), and an array of public interest initiatives to advance health quality including the National Association for Healthcare Quality, the American Health Quality Association, the Quality Assurance Project, the NYS Health Accountability Association (and many analogous programs in other states), the National Initiative on Children's Health Care Quality, the Institute for Healthcare Improvement, the National Quality Forum, the Leapfrog Group, Bridges to Excellence and the Center for Payment Reform. Most health plans are required to maintain quality assurance and utilization review programs by state law. Similar requirements are reflected in the Federal HMO Act. Most plans also maintain accreditation by either NCQA or URAC and actively participate in quality improvement initiatives sponsored or supported by the other agencies noted above.

Examples of these quality improvement initiatives include, but are not limited to:

- **Health information technology (HIT), including electronic health records EHRs and protocol-driven care review:** Health information tools allow clinical information to be shared in real time among patients and providers, reducing the risk of medical errors and unnecessary/ duplicative services. These record-sharing mechanisms include EHRs, personal health records (PHRs), and regional health information organizations (RHIOs).
 - Aetna's *Care Engine* technology provides a major enhancement to electronic health records by continuously reviewing member health activities against more than 10,000 evidence-based care protocols to identify gaps in care, opportunities for care improvement and potential health risks associated with adverse care interactions. The Care Engine technology provides alerts called "Care Considerations" to doctors and patients about opportunities for care improvement and potentially even life-threatening risks.
 - Aetna's PHR platform allows members to manage their own health information and also links them to clinical quality and cost information on common medical procedures, physician-specific indicators based on adverse events and overall efficiency, and hospital information about specific diagnoses and procedures, empowering them to evaluate the overall value and cost of care before they access services.
- **Clinical pharmacy activities:** Includes therapeutic effectiveness assessments (e.g., P&T committee), drug interaction monitoring and direct pharmacy services (e.g., mail order delivery, specialty pharmacy delivery). These services facilitate the ability to prevent negative drug interactions, provider prescription errors, and other issues that could negatively impact patient health.

- In 1993 medication errors are estimated to have accounted for about 7,000 deaths.¹ Medication errors account for one out of 131 outpatient deaths and one out of 854 inpatient deaths.

Rationale: The activities, of which examples are provided above, are designed to assure that consumers get the best care at the best time -- which leads to higher overall quality of health care. Some of these activities improve quality through information sharing, while others work to reduce medical errors, improve provider services, or protect consumers from problematic services. Ultimately, these functions lead to better outcomes and lower premiums. Many organizations recognize these types of activities as quality enhancing -- such as the NCQA, the National Quality Forum, the Leapfrog Group as well as Statutory Accounting Principle #85.

Part B: Clinical Services

Insurers also conduct several activities associated with the reimbursement of health care providers for clinical services and the arrangement of favorable provider reimbursement rates, including network access fees and payments and other intermediaries who arrange for health care services. Additionally, carriers must conduct contracting, credentialing, quality, cost and satisfaction measurement and reporting, communication, electronic connectivity and appeals. These costs assure an ongoing level of quality within provider networks.

The definition of the terms included as clinical services should be consistent as those used by the NAIC. For example, terms such as Incurred Loss and Loss Adjustment Expense, as included in the legislation, are defined in statutory accounting standards and currently reported annually by insurers. The definition of these items should be consistent with the relevant accounting standards (specifically SAP 50, 54, 55 and 85) and include actual clinical claims paid, claims incurred but not yet reported or paid, estimated claims to be paid pursuant to actuarial standards (i.e., claim and premium reserves) and the cost containment expenses included as component of loss adjustment expenses and enumerated in SAP 85.

Rationale: Different insurers contract with and pay providers in different ways. The type of physician financial arrangement (e.g., staff model HMOs, capitation) determine whether under traditional rules these administrative costs are attributed to the physician or the insurer and, in turn, determine whether those costs are included in the MLR calculation. HMOs with very narrow networks (e.g., staff models) will tend to incur lower administrative expenses under this methodology. To assure a level playing field and support the ability of both models to provide quality health services to consumers, all four items listed above -- provider reimbursements, payments to third parties, incurred loss and other categories of provider payment -- should be considered under the category of clinical services costs.

Recommendation #2: Scope of Benefits

HIPAA excepted benefits are not subject to Minimum Loss Ratio Rules.

These HIPAA excepted benefits include:

- Coverage only for accident, or disability income insurance, or any combination thereof
- Coverage issued as a supplement to liability insurance
- Liability insurance, including general liability insurance and automobile liability insurance
- Workers' compensation or similar insurance
- Automobile medical payment insurance

- Credit-only insurance
- Coverage for on-site medical clinics
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits

Benefits not subject to requirements if offered separately

- Limited scope dental or vision benefits
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof
- Such other similar, limited benefits as are specified in regulations

Benefits not subject to requirements if offered as independent, noncoordinated benefits

- Coverage only for a specified disease or illness
- Hospital indemnity or other fixed indemnity insurance

Benefits not subject to requirements if offered as separate insurance policy

- Medicare supplemental health insurance, coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan

Rationale: PPACA minimum loss ratio rules are part of the overall HIPAA framework that includes a set of products that are not subject to reforms. Subjecting these policies to minimum loss ratio rules could thwart their ability to offer critical products to consumers that allow them to access a quality of health services they could not access without coverage.

Recommendation #3: Exclusion of State and Federal Costs

The formula to calculate the minimum loss ratio should exclude state and federal assessments, taxes and other costs from premium revenue. This should include items such as federal income taxes, federal employer payroll taxes, federal excise taxes and other federal regulatory related costs. In addition, state premium taxes, income taxes, property taxes and other regulatory and licensing fees and assessments, such as guarantee fund assessments, charity care assessments, high risk pool assessments etc., should be excluded from premium revenue. This would include items such as New York's HCRA surcharge or the costs associated with normalizing risks such as NYS regulation 146 insurer funded reinsurance pool.

Rationale: The statute clearly intends to exclude these items from the calculation. If the items are not excluded, then it would reduce – or eliminate – the ability of insurers to invest in important services that further quality improvement such as health information technology.

II. Enhancement of Competition

Recommendation #4: Appropriate Aggregation

For purposes of reporting and calculating MLRs:

- Large group: Measure at the aggregated legal entity for the largest geographic area covered
- Individual and small group market: Combined MLR for individual and small group market at state level for the aggregated legal entity

Rationale: Aggregating the groups in this manner will reflect the fact that consumer needs vary based on market segment.

- Large Group Market: Large groups have membership across many states and often prefer to have a single carrier. Blending large group experience across the legal entity level is the most accurate way to assure reasonable distribution across all group clients—and best conforms to the accounting principle of matching costs to associated premiums.

Economist James Robinson warns of the consequences of too narrowly grouping the product on which MLR calculations are based. Robinson points out that since many insurers operate nationally, breaking up their national administrative expenses into component regional or state markets risks incorrectly attributing administrative expenses to specific markets.

In addition, many groups may not have a credible number of lives in individual states. Any requirement to calculate large group MLRs at the state level would increase administrative costs to employers and would reduce the number of insurers capable of serving this marketplace.

- Individual and Small Group Market: If MLRs are required to be calculated separately for the individual and the small group market, many insurers may find it difficult to comply with this requirement and may lead them to exit the individual market. Such exits would reduce competition in a marketplace where consumers in many states already feel their choice is unfavorably constrained.

Recommendation #5: Market Monitoring

Specify that state and federal regulators identify and monitor for early warning signals of the potential market destabilization from MLR requirements and intervene if they occur. In particular, the federal government should lower MLR requirements in any of the following situations:

- Early Solvency Warning: An early warning trigger should be as follows: if a single insurer has a reduction in the risk based capital level of 20%, or the aggregate market experiences a 10% reduction in risk based capital. If this trigger occurs, the MLR should be lowered to avoid the bankruptcy of insurers – and the harm that would bring to consumers and providers.

- **Product Withdrawal:** This trigger would consist of the withdrawal of 10% of products by market carriers. If this occurs, the market would be considered destabilized and the Secretary must intervene.
- **Market Contraction:** Another trigger should be if at least 10% of enrollees in the marketplace are impacted by one or more insurers exiting the market. In this case the individual market should be considered destabilized and the Secretary should lower the MLR requirements.

Rationale: According to the American Academy of Actuaries, “Imposing unrealistically high medical loss ratio requirements may threaten plan solvency by making it difficult for premiums to cover claims and expenses.” Having an early solvency warning trigger is critical to avoid this. In addition, if the MLR is set too high, carriers will exit the market. This undermines one of the stated goals of reform – to allow consumers to “keep what they have.” In addition, it would reduce consumer choice and competition in many states.

Recommendation #6: Transitional Rules on Rolling Averages

Reporting, calculation and rebating regarding MLRs should be done on a three year rolling average per state. Beginning in 2011, the Secretary should allow insurers to use a three year rolling average when calculating their MLR.

Rationale: The timeframe (e.g., multi-year, lifetime, annual) over which included costs and claims occur will have a significant impact on the MLR, since high cost investments and the savings they generate may not accrue in the same time period. In addition, administrative costs for a product vary over time. For instance, launching a new product may require more administrative costs than in later years when the product is simply being maintained. Basing the allocation on a three year rolling calculation will also help to smooth out fluctuation in smaller blocks of business. If single years are required for MLR calculations, it would reduce the ability of new insurers to enter a marketplace, or to existing insurers to roll out new products. In addition, the use of single year MLRs could hurt insurers with a smaller level of business in a marketplace since their MLRs may experience higher year to year fluctuation.

III. Administrative Efficiency

Recommendation #7: Calendar Years

MLRs should be reported and calculated on a calendar year basis.

Rationale: Most states base MLR calculations on a calendar year basis. Requiring insurers to report these calculations differently would increase administrative costs and create nonsensical results. Each group (even those enrolled in the same product line) have different *plan years*. This could result in thousands of MLR calculations per insurer throughout the year. The individual market traditionally doesn't use the term "plan year." Consumers generally have "renewal dates" -- with thousands of customers renewing every day of the calendar year.

Recommendation #8: Rebates

The regulation should provide for a fair and administratively efficient mechanism to protect consumers from insurers who fail to comply with minimum loss ratio requirements. The rebate or "penalty" process should:

- **Provide Premium Credits:** Currently enrolled individuals and employers would receive premium credits toward their payments.
- **Provide reasonable timing:** For rebates given directly to individuals, premium credits should be issued within four months after the MLR report is submitted
- **For all markets:** If the amount is less than 2% of the annual premium costs or less than \$100 per enrollee, premium credits would not be provided. Instead, an aggregate contribution to the state high risk pool or risk adjustment mechanism would occur.

Rationale: These suggestions are based on states already requiring rebates – where many use premium credits as an administratively efficient way to issue rebates. Issuing rebates to individual members is administratively costly, as insurers must locate former members that have since dropped coverage and changed location as well as perform the administratively costly "cutting of checks." If rebates for small amounts are required to be issued, the administrative cost will exceed the value of the checks to consumers. This would have the paradoxical impact of increasing administrative costs and premiums to consumers. Providing this aggregate rebate amount to a state entity – such as a high risk pool or risk adjustment mechanism – would benefit all consumers in the market, be administratively efficient, and still act as a "penalty" to insurers that would encourage compliance with the MLR rules.

Recommendation #9: Preemption

Federal Minimum Loss Ratio reporting and rebate rules should preempt state minimum loss ratio rules

Rationale: PPACA minimum loss ratio rules are part of the overall HIPAA framework that includes a preemption if state laws prevent the application of the federal law. As a practical matter, if states have different MLR formulas and rebate rules these would conflict with federal rules. Insurers can only rebate a dollar once... you cannot rebate the same dollar twice. In addition, conflicting state MLR rules would create unnecessary administrative costs and increase consumer premiums.

ⁱ Phillips, David P.; Christenfeld, Nicholas; Glynn, Laura M. Increase in US Medication-Error Deaths between 1983 and 1993. *Lancet*. 351:643-644, 1998.



ASSURANT
Health

Joint Public Hearing of Florida Office of Insurance Regulation and
the Florida Health Insurance Advisory Board on Market Impact of
Federal Health Care Legislation
May 4, 2010

Testimony of Steve Dziedzic, Chief Actuary of Assurant
Health, Regarding Market Disruption and the Need for
Transitional Relief.

Good Afternoon, my name is Steve Dziedzic. I am currently the Chief Actuary of Assurant Health, and have been an actuary in the individual market for 18 years. I would like to thank the Florida Office of Insurance Regulation and the Florida Health Insurance Advisory Board for inviting me to participate in today's hearing. It is an important opportunity to explore the effects the new Medical Loss Ratio outlined in the Patient Protection and Affordable Care Act will have on the individual market. In addition to my testimony today, Assurant Health will also submit written comments regarding the Medical Loss Ratio calculation.

The application of an 80% medical loss ratio in the individual market in 2011 will likely significantly disrupt the individual market in the State of Florida and nationally, and in turn, limit choices for consumers. Medical loss ratio regulations must be drafted to provide transitional relief to carriers between 2011 and 2014 to avoid increasing the uninsured population and reducing consumer choice. The NAIC was tasked with proposing the medical loss ratio definitions and methodologies with an eye toward smaller plans being able to remain and allowing newer plans to enter the individual health insurance market. It is important to protect these objectives to ensure a vibrant and thriving health insurance market for all Americans.

It is imperative that carriers receive transitional relief to avoid market disruption. The medical loss ratio requirements should be 70% from 2011 to 2013 and move to 80% in 2014. By providing transitional relief, consumers benefit as they will be able to keep the insurance they have, get the advice they need and find the solutions they want.

Individual policies that are currently in force were priced and sold based on certain assumptions, many of which cannot immediately be changed. Similarly, individual plans currently being sold were priced with assumptions made prior to the new law being passed and the underlying distribution and administrative expenses also cannot be changed quickly. It is these realities that limit insurers' ability to meet a new, higher, medical loss ratio immediately. Individual Medical plans have been priced at the agent commission level currently in place. In addition, the current pricing reflects a complicated set of administrative and distribution costs that cannot be removed from the system overnight. Because insurers have only a limited ability to alter the underlying expense structure on these in force and current plans, requiring rebates on these policies based on an 80% medical loss ratio in 2011 can negatively impact insurers' surplus and, potentially, insurers' solvency.

Where the difference between the priced-for medical loss ratio and that imposed by the new law is significant enough, insurers may be forced to discontinue sales and ultimately withdraw from the individual market. When a carrier withdraws from a market, it results in the cancellation of its individual health plans. The discontinuation of sales or market exit are more likely for smaller insurers as they have fewer products and less in force business upon which to spread any resulting losses. These actions could have a devastating impact on the individual insurance market and could leave many Americans uninsured.

Since the guarantee issue provisions of the law are not effective until 2014, those with existing health conditions who have their coverage canceled would face significantly diminished options. The risk pools contemplated by the law require that individuals with pre-existing conditions be uninsured for six months in order to be eligible for coverage. This unintended consequence would cause many Americans -- especially the most vulnerable -- those with pre-existing health conditions -- to be left without insurance right at the time they need it most. The potential result would be an individual health insurance market dominated by a few large carriers, leaving those consumers who can still purchase -- those without pre-existing conditions -- limited choices.

This is why it is so important that transitional relief be granted in the individual market beginning in 2011 until 2014.

In 2014, when all States are required to provide health insurance exchanges, the individual market is guaranteed issue, and subsidies are provided to ensure access to all, insurers will be able to move some of the acquisition costs out of their pricing. However, in today's individual market the purchase of health insurance is an important and sometimes overwhelming decision for a consumer. It is difficult to make an apples-to-apples comparison of the many plans offered by the various health insurance companies. Independent health insurance agents provide an invaluable service to consumers and act as counselors to provide guidance and advice to individuals as they try to make the best choices for their family.

Agent compensation reflects the important and vital role they play in today's health insurance market.

In addition, individual health insurance companies incur underwriting expenses at the time of issue. Because the individual market is not guaranteed issue, all individual carriers must incur these underwriting expenses to align benefits and price. Once the market becomes guaranteed issue in 2014, some of these expenses will be reduced. However, such a reduction is not possible prior to the market reforms that are to be implemented in 2014.

A market place with limited choices, fewer carriers and cancelation of current coverage is not what the legislature intended when they passed this historic and comprehensive health care reform law. If transitional relief is not granted, it will be more difficult for consumers to keep the insurance they have, get the advice they need and find the solutions they want.

Thank you again for giving me the opportunity to discuss this vitally important topic. Assurant Health stands ready to work with all interested parties as regulations are drafted to help ensure a stable, vibrant individual health insurance market place.

Additional Comments of Assurant Health Regarding the Calculation of the Medical Loss Ratio

Activities that Improve Healthcare Quality

As the NAIC determines what expenses should be included in the definition of activities that improve health care quality in the calculation of the medical loss ratio under section 2718 of the Patient Protection and Affordable Care Act, Assurant Health submits the following for your consideration

“Activities that improve health care quality” should be defined to include activities that: 1) relate directly to an individual patient’s care; 2) provide tools to educate and inform patients about their current or future care; 3) prevent unnecessary and inappropriate care; and 4) ensure a minimum level of health care quality. All of these activities improve the quality of health care and/or enhance access to quality care.

Costs Related to Case Management and Patient Care

Costs related to the involvement in the care of customers bear a clear relationship to improving health care quality. For example, board certified physicians and licensed nurses that are available to our customers. These medical professionals interact with our customers in a variety of ways. To ensure that appropriate care is being delivered, medical staff may evaluate care to ensure it is medically necessary and appropriate. At times, independent review is utilized to determine medical necessity. In addition, we have a dedicated staff of nurses who perform case management duties which help customers manage their chronic and serious illnesses.

These professionals also help patients become more informed about their care and/or condition and understand the health care process, including the ongoing management of chronic conditions. This information allows customers to make better health care choices and avoid unnecessary or inappropriate treatment. It also allows individuals to choose the right level of care for their condition and maintain compliance with the appropriate course of treatment. Moreover, the information and services provided by our medical team spurs discussion between providers and patients, resulting in a more open dialogue about the most effective treatment options. This involvement in patient care and the costs related to this involvement directly improve health care quality.

Costs for Educational and Informational Tools Related to Patient Care

Costs related to certain tools also improve the quality of health care. Tools that provide customers with information on how to best access care are important and effective components of an overall health care strategy. These tools might allow an insured to call and get information on qualified physicians in their area, as well as the costs associated

with each one. This information is valuable in helping individuals find and choose quality health care. Such tools may also aid making determinations about accessing affordable care and educate our customers, allowing for better choices regarding their health care.

Another important tool is the development of the PHR (Personal Health Record). The PHR is a single collection of an individual's health record. This will allow for more prompt and effective treatment. It also allows an insured to be more knowledgeable about his/her own health history, which will produce better health care choices. In addition, a single, complete health record makes it easier and more efficient for providers to evaluate patients, also resulting in better care.

These same quality information tools are linked to cost information. Studies have shown that cost is linked to quality. These tools further the goals of price transparency which will aid in keeping prices down, thereby giving access to more citizens. It will also allow individuals to evaluate their providers to determine the best value for their money. Patients will be able to access and evaluate cost and quality information as they make their healthcare decisions. This is a necessary component to both increase the quality of care through consumer behavior as well as bend the cost curve for that care. As quality and price become more transparent, they will be factored into patients' decisions on the selection of providers. This will result in lower quality providers being driven out of business, thereby increasing the overall quality of care in the health care system.

Costs Related to Prevention of Unnecessary or Inappropriate Health Care

Similarly, costs related to post-treatment review of billings improve health care quality. For example provider fraud investigations are vital to ensuring that care is not being provided by unqualified providers and that treatment is accepted in the medical community and is appropriate. These investigations decrease the number of unnecessary tests/procedures and the inherent health care risks that are related to these unnecessary services. In addition, this information is communicated to the affected individuals and thereby educates him/her about any unnecessary care. This results in a decrease in inappropriate care and more informed consumers that are better able to make quality health care decisions.

Insurers also evaluate billings for compliance with generally accepted coding practices. Reviewing for unnecessary, duplicative, or cumulative billings increases the efficiency and ensures proper care in the future. One example of this kind of evaluation is the conversion to ICD-10, which classifies diseases used for clinical and epidemiological storage and retrieval of diagnostic information, health services payment, standardized health records, and public health assessment. The Department of Health and Human Services has already recognized that ICD-10 "will move the nation toward a more efficient, quality-focused health care system by helping accelerate the widespread adoption of health information technology," January 15, 2009 DHHS Press Release (former DHHS Secretary Mike Leavitt).

Costs Related to Ensuring a Minimum Level of Health Care Quality

Many insurance carriers offer plans with network providers. These networks support the credentialing process and minimum credentialing requirements, which confirm providers' board and DEA certifications, and state licenses, and ensure sufficient education and training. In addition, searches are conducted for any negative actions against providers, including malpractice data queries, CAQH databases, fraud, lawsuits, and any negative actions by a health plan, hospital, Medicaid, Medicare, State Board, or other professional organization. Moreover, network providers are also monitored periodically to ensure they continue to meet credentialing requirements.

Networks also ensure members have access to quality providers who agree to a fair and reasonable rate for services. Networks monitor the adequacy and accessibility of their network physicians: the number of physicians available compared with the population in a geographic area (ensuring a member has adequate selection amongst providers and all specialties represented); the distance a member may need to travel to access available providers (ensuring accessibility according to the standard of their community); and the accessibility of such providers (wait times to get an appointment, wait times in the office). Furthermore, Network representatives act as a liaison for resolving quality issues encountered with network providers. In addition, Networks set policies and procedures which they require their providers to abide by to ensure continuity of care and coordination of care. All of these activities ensure that patients seeking care from a network provider will know their provider meets minimum standards of professionalism and quality of care. Not only do these activities help our customers avoid low quality providers, but they serve as a constant check on provider conduct and thereby improve the overall quality of health care.

Credibility Standards

Lastly, to avoid additional market disruption, the premium amounts upon which the medical loss ratio is based must meet a sufficient level of credibility. Without an appropriate credibility threshold, insurer experience would fluctuate significantly from year to year, which would result in significant variability in the premium rates charged to consumers. In addition, the variability in insurer experience could negatively impact insurer financial results and, potentially, its solvency. This risk may lead carriers to exit certain states, refuse to enter others, and/or refuse to introduce new products. It would also act as a barrier to entry for new insurers looking to enter the individual market.

The credibility threshold is needed since without it, one or two large claims can significantly impact an insurers' loss ratio. In addition to the large claims element, there are numerous items that can fluctuate significantly and thus significantly impact health care costs. These include fluctuations in: medical trend; insured utilization (which can vary based on changes in consumer habits, life or financial situation, media reports, or cost sharing); provider practices (e.g., defensive medicine, billing, and changes resulting

from consumer behaviors); insured anti-selective behavior (e.g., lapses and the relative health of those that lapse); and new medical treatments and technologies. Protections should exist to minimize the market disruption that could result from these fluctuations. We agree with the position that America Health Insurance Plans (“AHIP”) presented in their May 10, 2010 letter to Chair of the NAIC Health Care Reform Solvency Impact (E) Subgroup, Lou Felice. In that letter, AHIP presented a modified version of the credibility adjustment table that is included in the NAIC Annual Medicare Supplement Refund Calculation form. The adjustments would be necessary to account for a non-Medicare population.

May 10, 2010

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

Dear Commissioner McCarty:

Thank you for hosting the recent joint public hearing on the impact of federal health care implementation and particularly as it relates to the medical loss ratio (MLR). AvMed gained important insights by attending and participating in the hearing. We share the concerns you expressed at the hearing about plan solvency and quality of care issues as there has been little conversation about "rate adequacy" and other OIR consumer safeguards since the enactment of the reform legislation.

As you know, Secretary Seblius has raised the issue of the proportion of premium revenues spent on clinical services and quality improvement and requested that the NAIC establish uniform definitions and standardized methodologies for determining what services constitute clinical services, quality improvement and other non-claims costs. Importantly, the Secretary has recognized the special circumstances of smaller plans and different types of plans must be accounted for in the establishment of standardized methodologies relating to such activities.

AvMed is a relatively small, not-for-profit regional health plan and has differentiated itself through robust and unique clinical programs related to improving health care quality that require a significant investment of non-claims costs. We believe that the Secretary is speaking of plans like AvMed in noting the special circumstances of smaller plans and different types of plans. As the NAIC and the states work to develop the MLR, it is critical that definitions and methodologies not be structured in a way that harms consumers by reducing choice among carriers or providers, reducing solvency for carriers, or reducing the ability of carriers to maintain quality standards, or interferes with the provision and promotion of high quality heard care benefits through high quality providers.

AvMed offers numerous quality programs that provide direct benefit to our members called Care Management. AvMed's Care Management programs include nurse call lines, centers of excellence where members can receive specialized services from providers and facilities, case management programs that provide care coordination and education for individuals that require guidance with their complex medical issues, disease management, wellness, e-prescribing and other quality-related programs. AvMed's care management programs are critical to enhancing the quality of care of our members and advancing the knowledge of such programs in the industry. In the clinical coordination area, AvMed's medical directors constantly review data to be sure the care being requested is the proper care and is delivered in the proper setting. Additionally, we review and credential providers to ensure they are in good standing, well-trained, responsive to patient needs and practicing high quality medicine.

AvMed's inpatient case management nurses not only assure appropriate care and utilization, but assure that quality care is delivered by all inpatient care givers. The inpatient case managers are available onsite to monitor the quality of care delivery in real time. Inpatient case managers are instrumental in the coordination of care and care integration in the home setting. Our inpatient case managers coordinate, home health, durable medical equipment (DME), infusion therapy and other treatment modalities to ensure that all the necessary care, the correct care, and the coordination of care are available for the patient.

Complex case management allows for one-on-one clinical guidance to the member. This continual relationship allows the member to develop confidence and trust in the case manager so that the patient is compliant with the treatment and follow-up. Medication compliance or adherence is also supported by complex case management and gives the patient the best chance of avoiding or delaying chronic illness or recovery from episodes of illness. Quality of care embraces the full spectrum of clinical services available to AvMed members and investigates, monitors, reviews and recommends in the areas of medication delivery, care delivery, and care integration

AvMed's maintains a twenty-four hour/seven days a week (24/7) nurse, on demand, call center to provide clinical information within appropriate protocols. Advice is provided depending on the unique clinical situation described by our members. For instance, questions about medication arise, questions about whether to use the emergency room or wait to see their primary care physician, questions about where to get medical advice or additional information all contribute to a higher level of care and the quality associated with the care.

Disease management is an essential component of AvMed's integrated care system. We have an opt-out program which allows our program to manage a greater number of members. The AvMed Healthy Living program (disease management program) provides coordination and assistance to approximately 18% of our commercial population and approximately 45% of our Medicare population. The AvMed Healthy Living program includes CHF, CAD, asthma, COPD, diabetes, osteoarthritis, low back dysfunction, and acid-related stomach disorders. We find that these chronic diseases are very much interrelated. Working directly with patients, advising them of the proper wellness and care guidelines, assuring that they get timely care and remain adherent with their treatment plans are some examples of enhanced care quality. Our Healthy Living program is closely tied and integrated with our Complex Case Management program.

In establishing the continuum of care AvMed makes available to its members, we made certain that each portion of our Care Management program is designed to provide integrated care with the utmost quality and service. Adherence to care guidelines, compliance with medication therapies, arranging care both with providers and at home are integral components of our program. Our goal is to deliver the highest quality of care at the right time, at the right place. Thus, unnecessary and potential harmful care is avoided.

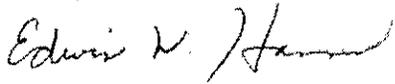
AvMed is greatly concerned that the reform legislation would penalize plans who provide these high quality services to their members. Florida has been very progressive in requiring initiatives that improve the quality of the care that health plans members receive and that provide for a

Page 3

safer, more efficient health care experience for the patient. The medical loss ratio must not be used as a vehicle to remove quality programs and their benefits from health plan members.

Thank you again for your leadership at the NAIC as well as in the implementation of health care reform in Florida. AvMed remains ready to collaborate in any reasonable way to ensure that health care reform has the best chance of succeeding to increase access to coverage, reduce the rates of increase in the cost of health care services and improve its quality. In order to achieve that goal, however, the issues of plan solvency and quality of care that you have raised must not be sacrificed. Furthermore, the special smaller and unique plans such as AvMed must not be lost in a rush to uniformity.

Sincerely,

A handwritten signature in cursive script, appearing to read "Edwin W. Hannum".

Ed Hannum
President
AvMed Health Plans



**BlueCross BlueShield
of Florida**

An Independent Licensee of the
Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Florida
4800 Deerwood Campus Parkway
Jacksonville, FL 32246

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.

I am not quite eligible for Medicare but I have spent a career in health administration and automation. I now volunteer for the FL SHINE (SHIP) program and help seniors with health insurance issues. If the insurance companies were not so profitable to be able to pay their CEO's outrageous sums each year, the ACA spending requirement would not have become part of the reform law. Why should taxpayers pay more for services under MAPD plans than for services under traditional Medicare? Why should the government underwrite the inefficiencies of for profit insurance companies? I say HOORAY for the spending requirements which should put the PCP's and patients back in the healthcare driver's seat where they belong! Seniors don't understand why their CT scans or MRIs are not approved by their HMO's when that had never been the case under traditional Medicare. I do hope this will lead to more efficient marketing, fewer free lunches, tote bags and key chains and more care for the ill for with the Advantage plans. Our seniors deserve better than the MAPD plans currently available.

Linda Bradley

390 Lakeview Dr. Melbourne Beach, FL 32951 321-729-0053



DWYER AND ASSOCIATES, INC.



Michael J. Dwyer, CLU
Investment Advisor Representative

3381 Regal Crest Drive
Longwood, FL 32779
(407) 804-0278
Fax (407) 804-0635
mdwyer@tfamail.com

I am writing to you as a professional benefit specialist with 36 years experience, to urge you to support medical loss ratio definitions that take a broad and flexible view on the many health insurance activities which will serve to further the goals of health care reform.

Medical loss ration (MLR) requirements created by the Patient Protection and Affordability Act (PPACA) should not discourage insurance companies from developing activities aimed at improving quality and containing costs, such as wellness programs, disease management, prevention, and health IT investments, all activities that some may consider administrative costs.

When drafting the definitions and methodologies associated with MLR, it is important that you and your fellow insurance commissioners aim to improve quality and affordability. The definition of clinical services and activities must be inclusive and comprehensive to allow insurance carriers to provide a wide spectrum of activities that contribute to better health outcomes for consumers. Activities by health insurance carriers, such as information sharing on quality providers and work to reduce medical errors, ultimately lead to better outcomes, higher quality and lower premiums.

Similarly, the well established role of agents and brokers in disseminating vital information and performing services which help to reduce costs and improve quality must also be considered.

The goal of PPACA was to provide affordable and quality health care to all Americans, and we must keep these goals in mind as we develop important MLR guidelines. It is important to spend time clearly defining clinical services and administrative costs to allow insurance carriers to provide an array of services that will improve the health of Americans and provide them the health care they deserve. Insurance carriers have an important responsibility to American consumers, to not simply pay claims, but to provide services and systems that help keep them healthy and help keep their insurance affordable. I very much appreciate your efforts in carefully drafting MLR requirements that keep this responsibility in mind and that do not hinder the efforts of health care reform.

Thank you for your consideration on this issue.

Michael J. Dwyer, CLU

*Investment Advisor Representative with securities and
Investment Advisory Services offered through Transamerica Financial Advisors, Inc.,
Member FINRA, SIPC, and Registered Investment Advisor.
Non-securities products and services are not offered through
Transamerica Financial Advisors, Inc.*

FAHU(A.)

Thank you Commissioner Mc Carty, Members of the Office of Insurance Regulation and Florida Health Insurance Advisory Board.

My name is Julian Lago and I am a licensed agent here in Florida and currently serve as President of the Florida Association of Health Underwriters(FAHU).

Our organization is the state affiliate of the National Association of Health Underwriters (NAHU) which represents the agent community involved in the distribution, sale, marketing and servicing of health insurance to both individuals and businesses. Our agents service clients of all sizes from the individuals looking for affordable family coverage to the large employers able to self funded its employees coverage.

Commissioner we thank you for the opportunity to discuss the impact of MLR to both the individual and small group market. Many of our FAHU members are in fact small business owners that have built there businesses servicing their clients and community in which they live and serve many rolls as agents. I would like to share with you the role of an agent in our current market place here in Florida. We serve as advisors to small business and individual seeking to understand insurance. Our products are complex and the purchase of insurance requires one to take many things into consideration.

Individual products currently require medical underwriting which does vary by carrier. The agent will walk the client through this process. Risk tolerance of the clients varies and needs to be explored so that each client can select the right deductible and plan that work for their needs.

Group Products offered to small business require the agent to assist not only with product selection but also with day to day administration, COBRA education, and compliance. New products such as HSA require high level of employee education and ongoing administration support. Many businesses lack the HR infrastructure of larger employers and depend heavily on their broker /agent to support them.

As members of FAHU we support MLR definitions that take into account a board and flexible view on the many health insurance activities that support quality of care. Similarly, well established role of agents and brokers in disseminating vital information and performing services which help reduce cost and improve quality must also be taken into consideration. We are concerned that markets such as New Jersey that have a heavy MLR restriction have seen a reduction in carriers and have seen significant premium increases.

In closing "We are where the tire meets the road " Our phones are already ringing with questions on health Carewe hearHow is this new health reform going to impact me , my family , my employees and my business? The goal of PPACA was to provide affordable and quality health care to all Americans, and we must keep these goals in mind as we develop important MLR guidelines. Agents play an important role in assisting clients not only purchase insurance but also to understand and keep their insurance affordable. An industry without a vibrant agent community will surely suffer. Agents help our clients navigate the complexity of products, enroll , underwrite , handle claims issues, meet compliance requirements, select network providers and access appropriate care.

We believe that today more than ever before the Florida insurance market needs the professional agent and all the serves provided to individuals and businesses.

Thank you

Julian Lago

FAHU State President

FAHU (B.)

May 4, 2010 FHIAB Hearing, Orlando, Florida

Testimony submitted by Joan Galletta, Employee Benefits Consultant

Good afternoon Commissioner, fellow members of the Florida Health Insurance Advisory Board, professional associates, attendees:

My name is Joan Galletta and I am an insurance agent. I am grateful for the opportunity to speak at this hearing regarding enforcement of minimum loss ratios in the individual and small group market in Florida. Much discussion today has focused on the facts and figures surrounding minimum loss ratios. It has been discussed that enforcement of the 80% minimum loss ratio dictated by the healthcare reform law in the individual and small group markets could eliminate the ability of carriers to continue using independent agents to sell health insurance in these markets. For decades, the "agent model" has been the delivery system for insurance products, and people think of the comparison of plans, features, and rates when we discuss the agent's role. I invite anyone who has this limited view of what an insurance agent does to speak to any one of the insureds whose stories you will find in this book, *Brokers Making a Difference*. I am a member of the National Association of Health Underwriters (NAHU). We are an organization of professionals in the health insurance industry; agents, company representatives, third party administrators... professionals whose life's work is to protect the interests of the consumer; to advise our clients on the best choices for them, personally, to finance their healthcare.

Perusing this book of testimonials, assembled by NAHU to help everyone understand the important role an agent fills, you'll read the real life stories of people who needed and received help far beyond the initial "point of sale". This book recounts dozens of stories of how health insurance agents, experienced in this industry and experts in navigating a system that is often complex and confusing, assisted consumers, *families*, in times of extreme need. With your permission Commissioner, I'd like to share one of these stories... I will paraphrase in some instances to be respectful of your time.

An agent from Florida writes: *As 2008 was drawing to an end, my office submitted our last group health case of the year to [a carrier] for processing and would be closing our offices for the New Year holiday. With Underwriting moving very slowly, as it does this time of year, we hoped to have a final approval by the end of the first week of the New Year. On January 2, I received an urgent phone call on my cell phone- a cry for help from a parent. A very rare, very large cancerous tumor had been found in the chest of their son, David. The son was to be flown to Cook's Children's Hospital in Texas for testing and surgery at the beginning of the week. How could I expedite the group's approval? It was New Year's Weekend! We contacted the underwriter, urging the necessity to have the group approved, and within the first few hours of the New Year the case had been approved, issued a group number and the patient was issued his member ID number. That afternoon I received a call that special tests were needed before the Thursday morning surgery. David would be flown to Cook Children's Hospital the next day and tests, requiring the carrier's prior approval needed to begin Wednesday. I arranged a conference call with [the underwriter] who conferenced in a Case Manager. The Case Manager*

was able to expedite the case and approved all tests, including the lifesaving surgery on Thursday, all by the end of the day, while keeping me updated and able to give the family just a bit of peace during this difficult time.

After David had the tests, and the surgery, I received a call from his father thanking me for saving his son's life. The surgeon told David's family that if he had not had the surgery Thursday morning he would likely not have made it. The tumor had begun filling with blood and could have burst at any time, rendering the surgery useless. The agent writes in closing: I no longer see myself as a just a health insurance agent- I am a humanitarian.

I work for JP Perry Insurance, an independent insurance brokerage firm that has been in business in Jacksonville Florida for 55 years. We personally serve our individual, employer group and employee clients and are held to a high standard in doing so. We are trusted advisors. We know our clients by name. They live in our communities. They are our neighbors. They have our cell phone numbers. Yes, we assess their insurance needs and explain their options, and navigate the paperwork and submission requirements to get their coverage issued, but we do so much more than that. We provide guidance and peace of mind; therefore I respectfully submit that a narrow definition and strict enforcement of the 80% minimum loss ratio, resulting in the elimination of the service of health insurance agents does a tremendous disservice to the consumers of Florida.

To obtain a copy of *Brokers Making a Difference*, please e-mail jgalletta@jpperry.com, or contact National Association of Health Underwriters at 703-276-0220 or on-line at www.nahu.org

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

From: **Angela Handa** <Angela.Handa@health-first.org>

Date: Thu, May 20, 2010 at 2:47 PM

Subject: Medical Loss Ratio - Comment

To: edFHIAB@gmail.com

Attn: Torre Grissom, OIR

I understand that the law allows for some flexibility for new or small plans and even addresses system run health plans such as the one I am proud to work for, Health First Health Plans. I am concerned that an additional burden may be placed on health-system owned plans thinking they have an advantage over non health-system run plans. In theory I understand the idea of it but I am here to tell you the advantages one may believe exists are not always in place. For example:

1) Our hospital system does not provide us with preferred pricing. Our rates are targeted to be competitive on par with other large carriers so no significant competitive advantage on this front.

2) We share resources with our system. Candidly we do share resources but the resources are sometimes less in line with a Health Plan's needs so we are forced to pay additional consulting dollars to compensate for the gap. For example, we are contracted with an outside firm for legal services.

3) We are asked to direct members to system resources when sometimes less expensive services are available to our members because we must consider the overall system financial impact. Clearly our competitors have an advantage over a system run plan if they are free to contract with the least expensive qualified provider for a service.

So how do we compete? The answer is by differentiating ourselves on quality, service and value as evidenced by our rankings, therefore I applaud the government on implementing payments tied to performance via the star program.

Lastly I am concerned about the role of the agent. I do believe they provide a good service but at the same time I question the amount of commission we have been forced to pay to be competitive with the national payers. So while I would like to preserve their role, I do think there is room to look at and redefine reasonable compensation rather than allowing their salaries to increase by a percentage of the underlying costs of healthcare. Transparency would help resolve this issue.

Thank you for the opportunity to provide input for Commissioner McCarty's consideration.

Sincerely,

Angela

Angela Handa
Vice President, Sales & Service
Health First Health Plans, Inc.
Office Number: (321) 434-5627
Fax Number: (321) 434-4362
angela.handa@health-first.org
www.healthfirsthealthplans.org

#####

This message is for the named person's use only. It may contain private, proprietary, or legally privileged information. No privilege is waived or lost by any mistransmission. If you receive this message in error, please immediately delete it and all copies of it from your system, destroy any hard copies of it, and notify the sender. You must not, directly or indirectly, use, disclose, distribute, print, or copy any part of this message if you are not the intended recipient. Health First reserves the right to monitor all e-mail communications through its networks. Any views or opinions expressed in this message are solely those of the individual sender, except (1) where the message states such views or opinions are on behalf of a particular entity; and (2) the sender is authorized by the entity to give such views or opinions.

#####

HUMANA

MLR Outline

We recognize that the lawmakers intended the MLR standards to drive value for consumers by assuring more premium dollars go to care costs and creating incentive to reduce administrative expenses.

No one wants these standards to have the unintended effect of causing volatility in premium rates. This could drive up the cost of health insurance coverage for consumers and reduce their choices in the marketplace.

We believe carefully crafted regulations can both assure consumers of the value lawmakers intended and recognize the uncertainties and risks represented by market selection dynamics.

The MLR standard

- The definition of medical expense must include the valuable investments in care coordination, disease management, health information technology, wellness and fraud and abuse programs. These represent real value to members in terms of the direct benefits to their individual care and the positive impact on overall health care costs.
- Premiums and Claims must be aggregated to levels that are statistically credible. A minimum MLR while guaranteeing consumers a return provides no protection against statistical variation in experience. This variability could cause insurers to experience MLRs higher than the minimum that generate financial losses. These losses could force insurers to face solvency challenges or market exits. There is precedence for addressing credibility issues in the NAIC MLR Medigap Model Act.
- Recognize transitional issues –
 - o Today durational factors associated with underwritten business produce a “natural” curve in loss ratios. Most insurers manage this curve to stabilize rates over a longer period of years. While this may increase initial rates, it serves to generate more consistent rates over time. Stability is important to consumers because it protects them from financial exposure within their family budgets during a down economic time.
 - o Many of the federal law provisions (i.e. guarantee issue) that will allow insurers to reduce their current administrative expenses will not be implemented until 2014, years after the MLR provision take effect. .
- Recognize that state licensure rules often require insurers to align different products, such as HMOs and PPOs, with different legal entities. While those insurers manage these products as a group, statutory accounting by entity reports them separately.
- Everyone recognizes that administrative costs as a percentage of premium are affected by two factors:

- Membership size and the growth trend of the insurer's block of business;
and
- Relative cost of fixed administrative expenses to the actuarial value of benefits.

If MLR requirements force smaller insurers to exit states, the requirement will not achieve another intended goal of the legislation to create greater competition among insurers. This will mean less choices for consumers.

Testimony by the National Association of Insurance and Financial Advisors – Florida (NAIFA – Florida) to the joint public hearing by the Florida Office of Insurance Regulation and the Florida Health Insurance Advisory Board

Tuesday, May 4, 2010

Good afternoon Commissioner McCarty, Deputy Commissioner Senkewicz and members of the Health Insurance Advisory Board.

I am Mark Tiralosi, President of the National Association of Insurance and Financial Advisors – Florida. I am also the Vice-President of Sihle Financial Services and have worked in this industry since 1991. We would like to thank you for holding this hearing on this very important issue to our country and to the people of Florida.

Commissioner McCarty, let me begin by thanking you for your work for Floridians. But let me also thank you for your service as an Officer with the National Association of Insurance Commissioners which will play a crucial role in instituting national health reforms.

In January you spoke at the Florida Health Care Summit that we co-sponsored with the Florida Association of Health Underwriters and discussed your concerns regarding required medical loss ratios. Thank you for continuing to focus on this part of the Patient Protection and Affordable Care Act.

We see this requirement as being problematic in a number of ways. In your remarks to the attendees at the Summit you registered concern for insurer solvency if rate approval authority was transferred to Washington D.C. You said that a potential requirement for medical loss ratios to be 80 percent or higher could further compound such solvency problems. Further you said that many believe that such a loss ratio is simply unattainable, particularly within the small group market.

While, fortunately, rate approval authority has not been transferred to Washington, in some sense we have the federal government mandating rates. Worse, they have instituted a one-size-fits-all approach to 50 different states which have 50 different sets of regulations and mandates by instituting these MLR requirements. And these static ratios are based on a thousand page bill to be instituted over the next four years. Are we to believe that such a monumental piece of legislation will not create additional costs?

This, we feel, is a prescription for disaster. At this time I would like to introduce Terri Seefeldt to discuss a few of our concerns ---- Terri.

Thank you Mark. Commissioner McCarty and members of the Board, I am Terri Seefeldt. I am the sales manager for Rogers Benefit Group. I am the Secretary/Treasurer for NAIFA-Florida where also have served as Health Insurance Chair, and I have been a member of FAHU for 22 years.

The Health Care Reform Law establishes that starting next year, minimum loss ratios for the individual and small group segments will have to be 80 percent and for large group segments they will have to be 85 percent. A review of the Health Maintenance Organization MLRs in the 2009 Annual Report of the Office of Insurance Regulation shows MLRs ranging from the high 70's to the low 90's – with the predominant number being in the mid 80's. This, despite the fact that the Florida Administrative Rule regarding the Reasonableness of Benefits with Relation to Premiums requires minimal MLRs of 45 to 75 percent – surely no H.M.O.s in Florida are threatening to undercut those minimums (690-149.005).

In fact, we have reviewed the MLRs for numerous insurers in the Central Florida area and found them ranging from 79% to 86% - certainly within striking distance of the new requirements. In fact, the Senate Commerce Committee on medical loss ratios – using data from the NAIC - said that the established MLR minimums were determined by CBO data that determined a majority of insurers were meeting those minimums on a national basis.

To explain this further, let's say I am with Healthcare Plan A and I do a really great job of negotiating with the doctors and the hospitals. I get my members to participate in wellness programs. My case managers and disease managers do a terrific job of identifying issues and working them efficiently. I am successful at getting members to switch from more expensive brand name drugs to generic drugs. And, as a result of getting my insured population utilizing health care services in a more cost effective manner, my loss ratios drop to 75%. Should there not be an incentive as a carrier to do what is right in trying to address the spiraling cost of healthcare? Does rebating that amount create such an incentive

One of the agents we work with actually received a call within days of this legislation passing from an employer who employs approximately 70 employees. He wanted to get his claims runs. When the agent asked him why he wanted those - as he didn't renew until November - he stated that he was trying to figure out his loss ratio so he could see about getting his rebate check! This is obviously causing confusion in the marketplace already.

But in many of the aforementioned statistics - we are still bumping up against the new 80 to 85 percent M.L.R. minimums and often exceeding them. Therefore, 15 to 20 cents out of every premium dollar is all that can be devoted to ALL administration costs, overhead and profit – and when medical costs spike there won't even be that much. When we asked one of your former top staffers what he thought would happen if these MLRs are instituted in Florida, the response was *the new required medical loss ratios will drive most private companies out of the market.*

Florida cannot be compared with many other states with regard to health insurance. State law mandates one of the most comprehensive packages of coverage in the nation. The size and breadth of our state is matched only by its ethnic, cultural and geographic diversity. In a perfect world we would mandate that any human malady be covered and that premiums be affordable to all. But we do not live in such a world – so we have to find a balance - a middle ground if you will. That middle ground is going to be different in Florida than it will be in any of the other 50 states.

We met with an aide from Congressman Alan Grayson's office last summer. She was remarking about how upset and emotional people were getting over the health care reform bill, and this was *prior* to the emotionally charged Town Hall meetings we saw take place around the country.

I tried to explain to her that it *is* emotional and it *is* personal. We are not insuring houses or cars. We are insuring people: Their children, their parents, themselves. When people mess with something that affects them that closely and personally, it is the equivalent of life and death.

I told her that is the type of atmosphere that health insurance agents deal in on a daily basis. When someone can't get into to see a doctor or get the medications they want, they feel their health, and potentially their life is being jeopardized and they get quite emotional.

When rates jump and they get that premium hike in the mail who do you think they call? Health insurance agents try to get everything back on track and coordinate the care between the health insurance carriers, the member and their providers. We do it all day long, and I have done it for over 22 years. With all due respect to the folks at GEICO - you can't sell health insurance with a website and a lizard that sounds like Crocodile Dundee.

As agents and advisors our compensation is a small part of the 15 to 20 cents per premium dollar that I mentioned. We are seriously concerned about the downward pressure this loss ratio is going to have on our livelihoods and the

corresponding ability to educate businesses and others about their health insurance options. We hope that in your efforts to correct these issues that you protect this vital relationship.

NAIFA-FL – 4/22/2010
Bob Lotane – draft copy

COMMENTS OF PREFERRED MEDICAL PLANS TO OFFICE OF INSURANCE REGULATION

Comments related to merger of individual and small group markets and definitions of small group markets

- If the merger of individual and small group markets was for the purpose of calculating MLRs under the new health care provisions only, that would be one thing. But combining the two markets for the purposes of offering uniform benefits and insurance products would have a detrimental impact on the products offered individuals relying on the individual market. Many insurers may not participate in the small group market and might therefore exit the market and no longer provide such products. One tenet of the health reform bill was to ensure individuals that were satisfied with existing coverage be allowed to keep their coverage. An absolute merger of the markets would go against this fundamental tenet
- Merging the individual and small group markets at this point would discriminate against insurers that only cover the individual market, where MLRs are generally lower. (See comments below regarding the 80% required threshold.)
- The small group and individual markets are fundamentally different in approach and where costs lie. Individual products have higher costs due to the individual attention paid to each enrollee. Underwriting costs are much higher in the individual markets than with group markets. The approach to underwriting is fundamentally different as well.
- FL OIR should maintain the current definition of small business group as under 50 and not elect to immediately move to the 2014 threshold of under 100. Moving now would have the unintended consequences of impacting both the current large group market and individual market (if merged with the small group market).

Comments related to destabilization of the individual marketplace due to the 80% federal health reform MLR threshold

- The state should aggressively pursue a waiver of the 80% MLR threshold for the individual market. Implementing an 80% MLR threshold in the short and long term would significantly destabilize the individual market here in FL.
- First and foremost, individuals enrolled in the individual market are provided quality care for cost effective prices. The underwritten premiums meet thresholds set by OIR as actuarially sound and reasonable. They represent the risk associated with providing health care to these individuals.
- Underwriting thresholds for individual market products are such that the implicit MLR is well below 80%. Thus, an 80% MLR will necessarily mean a major increase in premiums immediately and annually moving forward.
- As opposed to group markets, administrative costs associated with providing individual coverage are much higher due to individual attention offered enrollees.

Underwriting costs are much higher in the individual markets than with group markets as well. Implementing an 80% MLR threshold on the individual market would discriminate against individual market insurers as these higher administrative costs are not taken into consideration. If the MLR is set for the individual market and small group at 80%, the implicit margin allowed for small group markets would be much greater than the individual market given the higher administrative costs.

- An 80% MLR plus administrative costs for an individual product would create the great potential for insolvency of the product, market exits by insurers, and destabilization of the individual market place. The MLR requirement coupled with the known administrative costs would not support a margin or a financial proposition associated with the risk of providing such individual coverage.
- An 80% MLR coupled with the administrative costs and the potential need for a rebate in a given year based on historic MLR spending could also make it difficult for individual market insurers to meet state solvency requirements (for example the minimum 2% return in FL).
- Because of the limitations on differentials in premiums for age, and other factors, a strict 80% minimum MLR threshold actually would create an environment where all individuals are faced to pay higher premiums.
- An 80% threshold in the individual market also takes away the incentive to build appropriate administrative and quality infrastructure.
- If premiums are forced up due to the 80% MLR and differential limitations, healthier populations will decide to go bare. Given weak penalties, they will use discount cards and other health products and decline comprehensive coverage. Thus, individual market plans could be victim of major adverse selection, where premiums would be forced higher and higher. While MLR might cease to be an issue, premiums might become so high as to make individual market products unaffordable and unviable.
- A strict 80% MLR could also mean market exits because insurers could not obtain relief from a rate increase soon enough.
- Higher MLRs do not necessarily translate to quality. High MLRs could be indicative of a plan that is not running its operation cost-effectively. Those that do and may be below 80% are thus at a competitive disadvantage, forced to increase medical expense (potentially for no valid reason) and increase rates.
- A strict 80% MLR threshold especially between 2011 and 2014 works against the whole concept of encouraging individual coverage in the exchanges. Punitive MLRs on the individual market creates an environment where insurers exit, rather than preparing for the launch of 2014 exchanges.
- In short, an overly restrictive individual market MLR will reduce competition and take away consumer choices.

Comments related to calculation and definitions of MLR

- A fairly liberal definition of MLR is in the best interest of health reform so as to ensure the availability and affordability of health insurance. Case management, disease management, education, utilization review/management, other cost-containment (health-IT, fraud detection, and infrastructure costs) expenditures, etc should not be considered non-claims costs as it does contribute to quality and cost-effectiveness. Including all of these costs is justified because it will lead to lower overall health costs in the future.
- It is essential to include the following in the MLR calculation: (1) Loss Adjustment Expenses or claims adjustment expenses that are associated with administrative expenses associated with the payment of run out claims and ordinarily included as part of the IBNR reserve calculation; (2) Cost Containment Expenses noted above; and (3) Other Adjustment Expenses which include the determining and paying of existing claims. Depending on future treatment of these expenses noted above will directly impact the solvency of the plans.
- State regulatory requirements which set forth methodologies and assumptions defining minimum level of contract reserves would need to be address in order to comply with the new legislation in order to adequately set minimum reserves to maintain solvency.
- When would the actual MLR threshold go into effect given the three-year averaging? Including prior year history in the calculation would not be in the best interest of ensuing availability and affordability of coverage.
- The timing of the calculation of the MLR and rebate is important. Relying on a short claims runout period and estimates of runout post close of calendar year could mean miscalculations. Having a longer claims runout would be more reliable. A minimum six to eight months period for calculation of MLR in a previous year.
- The calculation of the rebate and paying out rebates posses an additional layer of administrative costs to the plans going forward. The calculation of premium rates could be significantly impacted from the potential cyclical cycle of the rolling 3 year average and adjustment of those premiums going forward relative to current year rate setting methodology and the actual realization when the rates take effect is a concern.

ADDITIONAL COMMENT BY PREFERRED MEDICAL PLANS TO FLORIDA OFFICE OF INSURANCE
REGULATION

Comment with regard to definition of Medical Loss Ratios and inclusion in minimum Medical Loss Ratio requirements

It is essential that the definitions of Medical Loss Ratio and what is included in the minimum requirements for any of the various insurance groups include reasonable estimation of various reserves used to ensure solvency and the ability to pay claims.

In general, all groups will have the need to account for the following:

- A claims reserve or claims runout reserve. This reserve is used to ensure that plans have adequately reserved for the cost of claims payout and unpaid claims adjustment expenses associated with settling of unpaid claims.
- A premium deficiency reserve. This reserve may be used by a health plan if it needs to meet solvency requirements under state insurance regulations, is at risk of not meeting such requirements at various periods of time, but especially at year end, or indeed must make contributions to remain solvent.

The reserves above are vital to the health of the plan and insurance industry in each state and therefore reasonable estimations of such reserves, as certified by independent auditors/actuaries, must be included in the medical loss ratio definitions and in the minimum requirements.

Individually under-written policies generally have an Active Life Reserve. In general, individual policies are written and such premiums are set over a durational period of enrollment through the use of lifetime medical loss ratios. Therefore, unlike other insurance vehicles, there is no true concept of a benefit year for most individual policies. These policies generally see lower medical loss ratios in the early years and higher loss ratios in later years. Such policies and premiums are written to “smooth out” the premium and the Active Life Reserve taken on such policies from year to year have the effect of smoothing out the medical expenses of such policies. In effect, the reserve acts as a pre-funding mechanism whereby higher claims in the later periods are paid for by the reserve (which is paid for by available premium) in earlier periods. This is made possible by the lower initial medical expenses. This practice is standard and not only recognized but required by state regulatory authorities and in is compliance with NAIC requirements.

The issue described above is mentioned in Section 2718(a) of the Public Health Services 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. The section reads in part: “A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, *with respect to each plan year*, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (*or change in contract reserves*) to earned premiums. ... (emphasis added). The Section is ambiguous in that it is unclear exactly how Active Life Reserves in general, and changes in such reserves from year to year,

are treated for the purposes of the definition and minimum requirements in Section 2718(b). Further, the language speaks to “with respect to each plan year,” which would lead one to believe that adequate Active Life Reserves for individual policies might not be factored into the definitions or minimum requirements.

In general, the definitions cannot exclude such reserves as it would be extremely discriminatory against individual market insurance vehicles. Not recognizing the durational factor or Active Life Reserves for individual policies and, thus, requiring a rebate because a medical loss ratio may be below 80% in a given year would result in underfunding of the individual policies thereby resulting in the insolvency or non-viability of the product or major rate increases in later years for these policyholders. The Active Life Reserve is sound policy and is in the best interest of furthering predictable and affordable health insurance premiums moving forward. This is especially important at times that insurers are growing individual policy business, which is very likely as we lead up to and the first few years after January 1, 2014.

At the same time, a negative change in such reserve from year to year could also have a negative financial impact on plans offering individual insurance products. There could be any number of reasons for the negative change in such reserves, including declining membership or re-estimates. Including negative changes in the definitions and minimum requirements could result in insurers paying out rebates on historical experience in a future year and create solvency and other financial hardship issues.

While we advocate for the general inclusion of all reserves, especially Active Life Reserves, in the MLR definitions and minimum requirements, we do believe that flexibility should be included for negative changes to reserves, or that state regulatory officials should be given regulatory authority to take circumstances surrounding such negative changes in such reserves into consideration when considering MLR and rebate calculations in a given year.

RUTLEDGE, ECENIA & PURNELL

PROFESSIONAL ASSOCIATION
ATTORNEYS AND COUNSELORS AT LAW

STEPHEN A. ECENIA
RICHARD M. ELLIS
JOHN M. LOCKWOOD
MARTIN P. McDONNELL
J. STEPHEN MENTON

POST OFFICE BOX 551, 32302-0551
119 SOUTH MONROE STREET, SUITE 202
TALLAHASSEE, FLORIDA 32301-1841

TELEPHONE (850) 681-6788
TELECOPIER (850) 681-6515

April 30, 2010

R. DAVID PRESCOTT
HAROLD F. X. PURNELL
MARSHA E. RULE
GARY R. RUTLEDGE
MAGGIE M. SCHULTZ
GOVERNMENTAL CONSULTANTS
JONATHAN M. COSTELLO
MARGARET A. MENDUNI

By Hand Delivery and e-mail

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

Torre Grissom, Executive Director
Florida Health Insurance Advisory Board
200 East Gaines Street
Tallahassee, Florida 32399

Re: Federal health care reform
Medical Loss Ratio

Dear Mr. McCarty and Mr. Grissom:

Our firm represents HCA Inc.'s affiliated hospitals, ambulatory surgical centers, diagnostic imaging providers, and related outpatient services providers in Florida. On their behalf, this letter is to provide comments on the issue of the calculation and annual reporting of Medical Loss Ratio ("MLR") data by the healthcare insurance industry under Section 2718 of the Public Health Service Act (the "PHS Act"). We are responding to the invitation to comment that was contained in the April 16, 2010 Media Release issued by the Florida Office of Insurance Regulation (the "Office").

Background

The Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, was enacted on March 23, 2010. Sections 1001 and 10101 of the PPACA add Section 2718 of the PHS Act ("Section 2718"), which is entitled "Bringing Down the Cost of Health Care Coverage." In pertinent part, Section 2718 requires a "health insurance issuer" offering individual or group coverage to submit annual reports to the Secretary of the Department of Health and Human Services concerning the ratio of loss and loss adjustment expense from medical claims to earned premiums. Further, the report must include the percentage of total premium revenue (after accounting for collections or receipts for risk adjustment, risk corridors, and payments for reinsurance) for health coverage spent on the following:

- (1) reimbursement for clinical services provided to enrollees under such coverage;
- (2) activities that improve health care quality; and

Mr. Kevin McCarty
Mr. Torre Grissom
Page 2 of 8
April 30, 2010

- (3) all other non-claims costs, including an explanation of such costs, and excluding federal and state taxes and licensing or regulatory fees.

Section 2718 goes on to provide minimum MLR requirements which, if not met, require the Insurer to rebate premium revenue to enrollees on a pro rata basis. Specifically, Section 2718 states that beginning not later than January 1, 2011, a health insurance issuer offering group or individual coverage shall provide such rebates if the amount of premium revenue expended on categories "(1)" and "(2)" above is less than the following:

- (1) 85 percent, or such higher percentage as a State may by regulation determine, of the total amount of premium revenue for coverage in the large group market (excluding federal and state taxes, licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance); and
- (2) 80 percent, or such higher percentage as a State may by regulation determine, of the total amount of premium revenue for coverage in the small group market or individual market (excluding federal and state taxes, licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance). This part of Section 2718 also provides 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.

Although the term "health insurance issuer" is not defined in Section 2718, the term is used elsewhere in federal health statutes to include health maintenance organizations ("HMOs") as well as indemnity health plans. See, e.g., 42 U.S.C. section 300gg-91(b)(2) (defining "health insurance issuer"). It is clear that Congress intended the term as used in Section 2718 to include HMOs. For purposes of these comments, a "health insurance issuer" will be referred to by the shorthand, "Insurer."

Section 2718 adds that "The Secretary, in consultation with the National Association of Insurance Commissions [sic], shall establish uniform definitions for the activities reported under subsection (a)." This is a reference to the National Association of Insurance Commissioners (NAIC), an association of the insurance regulators of all 50 states, and to the "activities that improve health care quality" component of the minimum MLR requirement.¹ Ultimately,

¹ For the sake of clarity, it should be noted that the term "MLR" is used as a shorthand to describe the 85% and 80% ratios required by Section 2718 to avoid the rebate requirement. The term is not used in the stricter sense commonly found in regulatory insurance law, which does not include subjective concepts such as "activities that improve health care quality."

Mr. Kevin McCarty
Mr. Torre Grissom
Page 3 of 8
April 30, 2010

therefore, "activities that improve health care quality" will be determined by the Secretary in consultation with NAIC.

In the April 14, 2010 *Federal Register*, the Departments of Health and Human Services ("HHS"), Treasury, and Labor (collectively, "Departments") jointly issued a request for comments on the definitions and standards to be used in implementing the MLR provisions of Section 2718, as described above. Through the comment process, the Departments are seeking information on a variety of issues, including the following:

- How the new MLR minimums compare to health insurers' current MLRs;
- The definitions and methodologies currently in place to calculate MLRs;
- Current practices at the state level for calculating/reviewing MLRs;
- Definitions for activities that improve health care quality;
- Whether any states require MLR-related rebates similar to the new law; and
- Any terms or provisions that require further definition to facilitate compliance with the new law.

We appreciate the efforts of the Office and FHIAB to facilitate this dialogue at the State level in Florida. Our comments will give particular emphasis to Section 2718's reference to "activities that improve health care quality," as that aspect of the law has already generated, and is expected to continue to generate, considerable discussion.

Lack of Existing Criteria for "Activities That Improve Health Care Quality"

Section 2718's inclusion of "activities that improve health care quality" will necessarily be the subject of considerable debate. The phrase is not found in Florida's insurance laws, or the insurance laws of any of the fifty states. The regulatory term "medical loss ratio" is an actuarial term of art, with the general meaning of incurred losses and loss adjustment expenses due to medical claims in relation to earned premium. Several states have that definition in their insurance laws.²

Florida law requires a minimum MLR (using the traditional regulatory insurance definition) for health insurers and Medicare Supplement insurers. Sections 627.410, 627.411; Section 627.6745, Florida Statutes. Notably, Florida law does not require a minimum MLR for commercial HMOs. Pursuant to Section 641.23(6), Florida Statutes, the Office's only duty with

² See, e.g., Ct.Stat. s. 38A-478L; Pa.Stat. 40 P.S. S 981-2; Wa.Stat. 48.43.049.

Mr. Kevin McCarty
Mr. Torre Grissom
Page 4 of 8
April 30, 2010

regard to MLR for commercial HMOs is to "publish at least annually the medical loss ratios of all licensed health maintenance organizations." The Office accordingly publishes MLR for HMOs in the Office's "Annual Reports," available for review online at www.flor.com/AnnualReport. Review of the Annual Reports indicates that MLR for Florida-licensed HMOs is given as a "global" number, rather than specifically for large group, small group, or individual health maintenance products. The 2009 Annual Report provides HMO MLR for calendar years 2007 and 2008. Some of the larger HMOs have a "global" MLR of less than 85% for calendar year 2008. For example, Aetna's 2008 MLR was 82%; Humana's 2008 MLR was also 82%.

Significantly, there have been recent media reports indicating that Insurers will seek to "reclassify" various administrative expenses for purposes of meeting the 85% and 80% MLR minimums required by Section 2718. That is, expenses that would be considered "administrative" under the traditional MLR definition will, for purposes of Section 2718 MLR, be reclassified as "activities that improve health care quality." This would effectively defeat the intent of Section 2718. In general, we submit that expenses for "activities that improve health care quality" should be expenses for the actual provision of health care and health services. The Office (both under its current name, and formerly as the Florida Department of Insurance) has historically had great credibility nationally and as a member of the NAIC, and we would urge you to express this position on behalf of Florida.

Insurers Are Not Providers

First and foremost, we believe it is important to understand that Insurers do not *provide* medical care to patients. Rather, they *administer* health benefit coverage plans, and their costs associated with doing so should not be confused with the actual delivery of healthcare services.

Institutional health care providers (such as hospitals) and individual health care providers (such as physicians) share a number of key commonalities: they are licensed by applicable governing bodies to provide healthcare services and are subject to government regulations regarding the healthcare services that they provide; they deliver healthcare services directly to patients via the rendition of diagnostic and treatment modalities; their services are codified via nationally-adopted healthcare provider coding standards (e.g., HCPCS, CPT-IV, ICD-9, NDC, etc.); and all generate "claims" that are billed on standard healthcare provider billing forms (e.g., UB-04, CMS-1500, DWC-66, etc.).

Conversely, none of those key characteristics are shared by Insurers. Rather, the functions that Insurers perform are administrative in nature, generating administrative expenses. These include general administration; sales (including broker fees); marketing, advertising and public relations; underwriting, finance, accounting and auditing; regulatory affairs; network

Mr. Kevin McCarty
Mr. Torre Grissom
Page 5 of 8
April 30, 2010

management and provider contracting; medical policy-setting and utilization/case management (including administration of notification, prior authorization and concurrent review activities); demand management (i.e., referral hot-lines); claims adjudication; and regulatory affairs. In other words, what an Insurer does cannot be classified as "delivery of medical care," nor does it generate "claims".

In this regard, it is also noteworthy that Insurers have historically sought to classify as *few* of their costs/functions as possible on the "claims" side of the MLR equation. To the contrary, they have typically categorized all of these costs/functions as "administrative" in nature. Therefore, section 2718's inclusion of "activities that improve health care quality" should not be construed as enabling new "creative accounting" practices to reclassify historic administrative expenses as medical costs. Doing so would enable Insurers to circumvent the intent of Section 2718 and to retain premium dollars that should be paid out to legitimate healthcare providers for services directly provided to diagnose and treat patients.

Accordingly, and consistent with the traditionally-accepted definition of MLR ("the ratio of incurred loss and loss adjustment expenses to earned premiums"), only those claims payments made to licensed healthcare providers should qualify toward meeting the 85% and 80% thresholds (i.e., "Medical Costs") for the purposes of Insurers' Section 2718 MLR calculations.

Addressing Likely Areas of Confusion and/or Contention

More specifically, there are several areas of administrative expenses that Insurers may seek to "reclassify" for purposes of meeting Section 2718 MLR, and which we would like to bring to your attention. These are as follows:

Capitation Payments. These are non-encounter/non-claim based payments to healthcare providers in exchange for providing a defined set of services to a defined set of patients (typically \$X per-member-per-month for Y services) – i.e., a way to reimburse providers on a risk-transference basis for population management functions (e.g., primary care physicians for managing their assigned enrollees, reference laboratory for providing all lab services to a defined population of insureds, disease management vendors for managing patients' chronic disease states, etc.). To the extent that such Capitation Payments compensate licensed healthcare providers for their services relative to the diagnosis and treatment of patients, these should qualify as Medical Costs in the MLR calculation.

However, this is not to say that all Capitation Payments for all purposes should be so qualified. Insurers are increasingly "carving out" certain services to be managed by other entities that are neither licensed as healthcare providers nor do they directly provide medical care to insureds; and often such carve-out entities are actually wholly-owned subsidiaries of the Insurers

Mr. Kevin McCarty
Mr. Torre Grissom
Page 6 of 8
April 30, 2010

(e.g., behavioral health plans), which have their own administration costs and profit retention objectives in addition to those of the upstream Insurer.

Irrespective of how Capitation Payments are deployed by Insurers, we believe that only the portion of such payments that reimburses licensed healthcare providers for direct patient care should be allowed as Medical Costs in the MLR formula – and that any remaining portion must be considered as Administrative Expense.

Rebates to Insurers. Whether in the form of retrospective payments to Insurers (e.g., by pharmaceutical companies) or the retention/non-distribution of “withholding” or “risk pool” fund balances, the calculation of Medical Costs for the purposes of inclusion in the Medical Loss component of an Insurer’s MLR needs to be reduced by any such rebates.

Activities That Improve Healthcare Quality. Although we agree that some functions performed by Insurers should qualify for inclusion in the MLR formula as “clinical services provided to enrollees” under the Act, we caution that (a) only a minute fraction of such activities should be deemed to so qualify, and (b) this is an undefined element of the Act that we suspect will create the greatest amount of contention – and potential for “gamesmanship” – as Insurers may seek to include more of their functions/costs in this category than we believe the Act was intended to allow.

Examples of such activities that *should* qualify include disease management and health/wellness promotion programs – but again, only to the extent that such activities involve direct patient contact and care delivery (and not the administration/profit components of same).

Examples of Insurer activities that *should not* be permitted to qualify include basically everything else: quality assurance, credentialing, case management, medical policy-making, referral authorization programs, healthplan accreditation, provider contracting and network management. Ultimately all of these activities are administrative in nature and – while some of them may serve to *track or report on* quality – they do not in and of themselves serve to *improve* healthcare quality; only healthcare providers can do that. As such, they should not be considered as Medical Costs in the MLR equation.

The hospital industry is currently subject to dozens upon dozens of different licensing, governance, regulation, reporting requirements and other forms of oversight, such that the additional healthcare provider scrutiny that Insurers seek to apply is effectively redundant – and again, these are quality *reporting* activities and not activities that *improve* quality.

Relatedly, many healthcare Insurers have adopted Pay For Performance (“P4P”) programs, under which healthcare providers may be paid “bonuses” for meeting certain performance criteria. While at first blush these programs might appear to qualify as Medical

Mr. Kevin McCarty
Mr. Torre Grissom
Page 7 of 8
April 30, 2010

Costs in the MLR calculation, we caution that many of these programs' criteria are based on *cost* performance measures. We believe that only the portion of P4P program payouts that is specifically attributed to *quality* measures should be considered as Medical Costs for MLR calculation purposes; all other P4P payout portions are financially based and are thus Administrative Expense in nature.

The Closed Panel HMO Anomaly

We recognize that a comparatively small subset of Insurers operate significantly differently from traditional Insurers – those that are “Closed Panel” (staff and group model HMO) programs that have integrated many aspects of the healthcare provider delivery system (via the employment of a large number of their in-network physicians and, in a few cases, ownership of their own hospitals and other healthcare facilities) with a health insurance vehicle – and we suspect that these entities will seek a correspondingly different formulation and application of MLR requirements than their traditional Insurer counterparts.

Without going into too much detail relative to their comparatively complex hybrid configuration, from an MLR perspective we believe that the same requirements as set forth above should also apply to Closed Panel provider/Insurer systems – but with some additional considerations, including for example:

- * Not all “provider expenses” and “physician salaries” should qualify as Medical Costs for MLR calculation purposes. Costs of any office space and corresponding personnel (and their time) dedicated to healthplan operations (and not to the direct delivery of patient care) need to be tracked, quantified and separated from clinical services, and must be considered as non-qualifying Administrative Expense.
- * In order to be considered as a Closed Panel model, the Insurer must have “internalized” (i.e., via ownership or employment) the vast majority of its in-network healthcare providers; an entity merely owning/operating a few physician practices (but in all other respects operating like a traditional health Insurer) would not satisfy that threshold, and thus should not be considered any differently from a traditional health Insurer for MLR calculation purposes.

Summary

As a healthcare provider system with hospitals, diagnostic imaging centers, ambulatory surgery centers and physician practices, HCA could give many more examples of Insurers' policies, procedures and practices have served to add costs and inefficiencies to the healthcare financing/delivery equation – and to actually impede healthcare providers' efforts to operate more efficiently. Yet ironically, these have been misguidedly undertaken in the name of quality

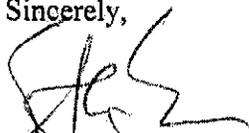
RUTLEDGE, ECENIA & PURNELL

Mr. Kevin McCarty
Mr. Torre Grissom
Page 8 of 8
April 30, 2010

and efficiency. If you would like more details and examples of same, we would be more than happy to provide them.

Thank you for the opportunity to comment on this complicated issue, and for consolidating all of the other comments received from the provider community on this important matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'S. Ecenia', written over a horizontal line.

Stephen A. Ecenia

I am writing to comment on the issue of health plans being able to comply with the 85% MLR requirement as required under full implementation of ACA.

I fail to see how, under current regulatory conditions, MLR can accurately be tracked, when health plans often downstream risk to provider groups, IPA's MSO's and the like. If the intent of the legislation is to ensure that 85% of premium is spent on direct provision of care, the administrative, general, selling and profits of the companies involved in these percentage of premium, risk-assigning arrangements should be fully reported as expenses of the insurer. In many instances, the health plan and risk bearing entity are affiliated through common ownership interests, if not owned outright by the same individual.

In these arrangements, common in Medicare Advantage plans, a percentage of premium is paid to an unregulated, downstream entity to provide for care. Many expenses typically paid by the insurer are assumed by the downstream entity, including disease management, case management, risk adjustment chart review, etc.

One example is the relationship between Humana and MetCare. Both are publicly traded companies, allowing for a reasonable degree of transparency. Let's say that Humana reports a MLR of 85%. Compliant. But follow the cash flow downstream and you will see that MetCare reports a MLR of 85% as well... meaning that only 70% of premium could possibly be used for actual direct provision of beneficiary care. Is this compliant with the intent and spirit of the legislation?

There is far more that I could speak to on the topic. If I can be of further assistance, please feel free to contact me.

Michael Seaman

3205 S. Washington Ave

Suite 801B

Titusville, FL 32780

(407) 875-0120

(407) 252-5500 (cell)

May 7, 2010

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

Re: Medical Loss Ratios Under the Federal Patient Protection and Affordable Care Act (PPACA)

Dear Commissioner McCarty:

We are writing on behalf of the tens of thousands of Floridians that UnitedHealthcare is privileged to serve. We share your belief that thoughtful and measured implementation of the MLR provisions of the PPACA is essential for an orderly market transition. We want to commend you for holding a public hearing on this subject.

As you know, Medical Loss Ratios (MLRs) measure the ratio of a premium dollar that is used for medical services versus administrative services. Many look to this data point as an indication that consumers are getting the full benefit or value of the premiums they pay to health insurers; others look to it as an indication of a health insurer's operating efficiency and solvency. In fact, how MLR is measured and constructed is a complex and nuanced area of actuarial science with many variables. We have significant concerns of the use of MLRs by consumers as a comparative measure of health, especially if used in isolation of other quality indicators.

- As CBO said, "... a loss ratio is not always indicative of a plan's efficiency or value... a health plan that devotes more resources to managing the use of health care services might have a relatively low loss ratio but also a lower overall premium... and...may well be preferable because of its lower overall premium for the package of services that it provides... a loss ratio provides just one way of evaluating a health plan's administrative expenses."
- In addition, the American Academy of Actuaries notes, "Minimum loss ratios do not help contain health care spending growth, ensure that health care services are appropriate and accurately billed, or address directly the quality and efficiency of health care services . . . while a well-designed MLR requirement may be an appropriate component of a federal health reform package, such requirements should not be viewed as a panacea." (American Academy of Actuaries, *Critical Issues in Health Reform – Minimum Loss Ratios*, February 2010).
- As *Health Affairs* wrote, "[N]either premiums nor expenditures by themselves indicate quality of care. More direct measures of quality are available, including patient satisfaction surveys, preventive services use, and severity-adjusted clinical outcomes. Although each of

these is limited in scope, they at least shed light on quality of care. The medical loss ratio does not.”

UnitedHealth Group supports the need for health care consumers to obtain a broad array of information about their coverage options as a core part of our approach to modernize the health care system. MLR is just one measure. While we have concerns with the limited usefulness of MLRs as a proxy for health plan efficiency and consumer value, we support efforts to establish uniform, consistently applied, MLR definitions and calculations as they will ensure a level playing field for all health insurers and facilitate appropriate comparisons.

We believe that, depending on the regulatory interpretation and definition of the PPACA MLR provisions, Florida consumers could face significant risk of losing current coverage offerings as the MLR requirements are implemented. In particular, rapid implementation in Florida’s individual market could lead to market destabilization and significant changes in current coverage options. In general, the individual market features average premiums that are roughly half the level of average group insurance premiums. Therefore equivalent administrative expenses and commissions relative to the group market take a much higher percentage of premiums in the individual market. If the MLR requirements for individual and small group markets are abruptly equalized, insurers may be required to take drastic steps to protect their solvency. These steps could result in unintended consequences, such as: a reduction in the number of competitors and individual insurance plans offered in the State, changes to the engagement (and payment) of independent brokers and agents, and the elimination of various programs designed to help members navigate the health care system and enhance the affordability of health care.

Both the NAIC and American Academy of Actuaries have identified several issues as critically important to the stability of the individual market. Additionally, the Academy has identified other elements critical to all market segments in defining MLR, including data credibility and premium and medical cost definitions. The American Academy of Actuaries recently recommended that the NAIC “explore alternatives to a straight-forward application of an annual MLR threshold to the individual market” as the stringent requirement could result in plans leaving the individual market, and, “if some companies do exit the individual market, then those companies’ former policyholders may find themselves unable to find new coverage in the individual market for a period of years (noting that guaranteed issue requirements do not take effect until 2014) and would not be eligible for the new high risk pools created by PPACA.” To prevent consumer disruptions we recommend a phase in of the loss ratio requirements.

As an overview, we recommend that you work with the NAIC to urge them to consider the following core elements in developing federal MLR standards:

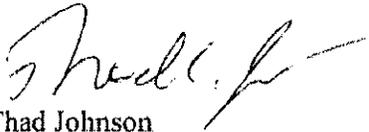
- **Aggregation:** To ensure that MLR calculations and comparisons are statistically valid and non-volatile, they should be calculated and reported over the largest possible experience base within designated lines of business (i.e., individual, small group, and large group).
- **Definition of “Quality Improvement” and “Clinical” Expenses:** To allow – and encourage – health plans to continually advance consumer health improvement programs as well as affordability initiatives, ensure that the required MLR categories appropriately separate them

from pure business / administrative expenses. These definitions also need to allow for new, emerging health plan designs and programs as insurers and employers continue to innovate in this area.

- **Uniformity:** To maintain robust competition in the market, ensure that MLR calculation methodologies and definitions are applied consistently and uniformly to all health insurers (within market categories: individual, small group, and large group) across the country regardless of health plan design or structure (for profit or not-for-profit; staff model or integrated delivery model).
- **Time Period for Calculation:** To ensure accurate MLR reporting and minimize year-to-year pricing fluctuation and volatility, calculate MLRs over a multi-year period (on a calendar year basis) or, alternatively, prior to 2014, utilize a “tolerance” allowance for a single calendar year similar to Medigap rules.
- **Minimizing Consumer Disruption in the Individual Market:** To maintain viable and sustainable individual coverage options for those without access to employer-based and government coverage, consider phasing-in the new MLR standards over the next 3 years or complete deferral of implementation until 2014 when premiums in the individual and small group market will converge.

In closing, we look forward to working with you as we continue to modernize the health care system. UnitedHealthcare appreciates this opportunity to provide you with our recommendations for how to achieve these objectives. Should you have any questions regarding the information set forth in these comments please do not hesitate to contact us. Thank you again for your time and thoughtful consideration of the enclosed comments.

Sincerely,



Thad Johnson
General Counsel,
UnitedHealthcare

VISTA/COVENTRY

Good afternoon Commissioner McCarty, Deputy Commissioner Mary Beth Senkewicz and members of the Florida Health Insurance Advisory Board. Thank you for the opportunity to be here today. I am John Cantillo, Executive Vice President for Coventry Health Care of Florida. Coventry appreciates the invitation by the OIR and the Advisory board to solicit input from the industry. My company is committed to being a part of developing meaningful, broad-based solutions in support of the goals of the Patient Protection and Affordable Care Act (PPACA).

As members of this panel consider their recommendation to the Department of Health and Human Services (HHS) regarding the definition and implementation of the minimum medical loss ratio, or MLR's, Coventry wishes to highlight it's current support of NAIC's existing accounting standards for claim adjustment expenses defined in SSAP No. 55 and equally asks the members of the panel to consider MLR calculation rules that support the following goals:

1. Maintain or increase choice of insurers and product diversity for all Floridians.
 - a. Smaller insurer's and/or potential new entrants to markets could be negatively affected if there is no recognition of the large fixed expenses required to enter a new market or maintain small, but growing, blocks of business. An allowance, or waiver that would phase-in, exempt or amortize start-up expenses or permit the pooling of benefit expenses across state lines will support the goal of maintain or increasing the choice of insurers to all Floridians.
 - b. Minimum MLR's by market segment (Individual, Small Group and Large Group) should also take into consideration the credibility of these blocks of business. Smaller blocks of business tend to be more volatile in terms of projection of claims expenses, credibility addresses this volatility.
 - c. Coventry recommends that MLR calculations should be determined by distinct market segment: Individual, Small Group and Large Group MLR's should be calculated separately. Calculations should be aggregated by legal entity and not solely by regulated entity.
 - d. Claims expenses should be determined on an incurred-basis allowing for several months to pass between payment of premium payment and the calculation of the minimum MLR. Claims expenses should include policy reserves and reinsurance. This is consistent with the American Academy of Actuaries position.
 - e. Claims expenses should include costs for all benefits provided under a uniform policy, certificate of coverage or summary plan document. Consumers are always seeking value for their health care related needs. Product innovation seeks to answer consumer's demand for value and affordability. Health care services, or benefits not only includes medical and pharmacy services but also include chiropractic, dental, vision, behavioral health, alternative medicine and wellness programs such as incentives for fitness clubs, weight loss programs or smoking cessation programs. The value offered by these programs should be included in the claims expense calculation.

2. Quality improvement and Affordability. Incentives should be created for insurers to invest in systems, protocols and tools to reduce costs of health care services, improve health care quality, reduce medical errors, optimize patient care and lower premiums. This includes investment in health information technology, case management and disease management.
 - a. **Case Management, Disease Management and Wellness Programs.** Efforts to optimize patient care and improve outcome should be encouraged. Our chairman, Allen Wise, recently told the story of one of our members, Margaret Anderson, who has several chronic medical conditions including diabetes and congestive heart failure. To support her, she is assigned a specific case manager, Ed Havrila. Ed wears several hats for Margaret. He is a nurse, educator, cheerleader, and personal medical administrator reminding her of doctor's visits and questions to ask her physicians. Margaret and Ed speak at least once a week, frequently more often. Such programs provide value in both medical and human terms. It is difficult to label such as an "expense", but such programs and the personnel required to support such programs should be encouraged. Also, continued support and incentives for wellness programs and initiatives such as on-site health fairs for employers. Many of our clients have benefited from the resources and opportunities provided during the on-site employer health fairs that Coventry conducts for them.
 - b. **Cost containment expenses.** It is important to include as part of claims, investments in technology to support and improve access to or the exchange of health information. Technology such as electronic medical records should be encouraged. In addition, investments in technology that improves the efficiency and/or reduces the burden of administration processes on providers should also be encouraged as these investment help to reduce premiums and maintain affordability.
3. Minimize Disruption to existing insureds. One specific area of concern regarding the impact of implementing MLR's and rebate provisions of the PPACA is the individual market. Coventry is in agreement with the concern of the American Academy of Actuaries expressed in its April 28, 2010 letter to NAIC working groups. In brief, the Academy expressed concern regarding the application of annual MLR calculation to individual business priced to lifetime MLR targets.
 - a. Coventry encourages proposals that incorporate the following recommendations:
 - i. Provide for a transition period. The time frames required by PPACA are aggressive and the sudden implementation of such new rules on business that was priced, marketed and issued under different assumptions could have a negative and disruptive impact on the Individual market. A phasing-in of the minimum MLR's requirements for the Individual market segment to help the insurer transition in a measured way to minimize disruption to insureds and maintain competition/choice is strongly encouraged.
 - ii. Individual and Small Group MLR's should be determined as separate pools. Coventry's position is that these market segments

are distinct and separate. In addition, maintaining separate pools in the calculation of minimum MLR's supports the public policy goal of providing choice of insurers. Smaller insurers or insurers focused strictly on one market segment could be placed at a competitive disadvantage if larger insurers are permitted to cross subsidize market segments.

- iii. Considers credibility for smaller blocks of business.
 - iv. Grandfathering of business underwritten and issued prior to implementation of guaranteed issue requirements in 2014. This business will continue to exhibit patterns consistent with policy duration and the MLR requirements could potentially unfairly penalize insurers with younger durational blocks of business. Alternatively, the MLR calculation for Individual market segments should consider lifetime loss ratio calculations and active life reserves, in lieu of annual MLR calculations. Coventry's position is consistent with the American Academy of Actuaries position.
4. Calculation of minimum MLR's should be determined on a calendar year basis, using a methodology consistent with SSAP No. 55 and the recommendations stated above.
 5. Rebates should be dispersed to policyholders. For the Individual market it would be the subscriber. For the group market it would be the employer.

Once again thank you for the invitation and opportunity to be here today.