

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