

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.