OFFICE OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

December 15, 2011

The Honorable Kevin M. McCarty
Commissioner
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399-0326

Re: State of Florida's Request for Adjustment to Medical Loss Ratio Standard

Dear Commissioner McCarty:

This letter responds to the request of the Florida Office of Insurance Regulation ("Office"), pursuant to section 2718 of the Public Health Service ("PHS") Act, 42 U.S.C. §300gg-18, for an adjustment to the 80 percent medical loss ratio ("MLR") standard applicable to the individual health insurance market in Florida. The Office has requested an adjustment of that standard to 68 percent, 72 percent, and 76 percent for the reporting years 2011, 2012, and 2013, respectively.

Section 2718 was added to the PHS Act by Section 1001 of the Affordable Care Act and generally requires issuers in the individual market to spend at least 80 percent of premium dollars on reimbursement for clinical services and for activities that improve health care quality for enrollees. Beginning with MLR reporting year 2011, if an issuer does not satisfy the MLR standard, it is required to provide rebates to enrollees.

Section 2718 permits an adjustment to the 80 percent MLR standard for a State's individual health insurance market if it is determined that applying this standard "may destabilize the individual market in such State." The regulation implementing section 2718, 45 CFR Part 158, provides that an adjustment should be granted "only if there is a reasonable likelihood" that application of the 80 percent MLR standard will destabilize the particular State's individual health insurance market. (45 CFR 158.301.) The regulation also provides the criteria the Secretary may consider "in assessing whether application of an 80 percent MLR . . . may destabilize the individual market in a State that has requested an adjustment." (45 CFR 158.330.) These criteria are discussed in Part IV of this letter.

The Center for Consumer Information and Insurance Oversight ("CCIIO") within the Centers for Medicare & Medicaid Services ("CMS") has reviewed the Office's application, as well as the supplemental information provided to us in response to questions raised by the

application and the public comments filed with regard to the application.[1] We have carefully examined all of these materials and considered the criteria set forth in the statute and implementing regulation. Based on this, we have determined that the evidence presented does not establish a reasonable likelihood that the application of the 80 percent MLR standard will destabilize the Florida individual market. Consequently, we have determined not to adjust the MLR standard in the Florida individual market and, thereby, ensure that consumers receive the full benefit of this provision of the Affordable Care Act. This letter explains the basis of our decision.

I. Summary of the Florida Application

CCIIO received the Office's request for an adjustment to the MLR standard on March 11, 2011. Among the information the Office included in support of its request were enrollment and market share numbers for issuers in Florida's individual market, estimated MLRs and rebates for some of these issuers under the 80 percent MLR standard, and a transcript of the public evidentiary hearing held by the Office on September 24, 2010 with regard to the impact of the MLR requirements on the Florida individual market.

On April 4, 2011, CCIIO requested from the Office information needed in order for Florida's application to be deemed complete. This letter included a request for the information missing from the Office's initial submission, including information regarding: issuer withdrawal; enrollee count by issuer; issuer financial data; and a request that the Office revise its proposed adjustment to the MLR standard to be consistent with that permitted by 45 CFR Part 158. On April 4, 2011, CCIIO also requested from the Office follow-up information and clarification regarding matters raised by the Office's application. These matters included the number of issuers the Office expects to exit the market, the Office's concern regarding barriers to entering the market and a potential threat to issuer solvency, and Florida's high risk pool. The Office responded to these requests on June 28, 2011, and on July 20, 2011, CCIIO asked the Office to provide: information on issuers that appeared to be missing from the application; issuer rebate estimates for 2012-2013; explanations for MLR calculation discrepancies found in the application; financial data on new entrants to Florida's individual market; and copies of withdrawal notices for withdrawing issuers. After the Office responded to these requests, the Office's application was deemed complete on October 17, 2011, and the processing period provided for in 45 CFR 158.345 began.

In addition, on October 17, 2011 CCIIO posted notice on its website that any public comments regarding Florida's application were due by October 27, 2011, as provided in 45 CFR 158.342. CCIIO received five public comments, as well as a petition signed by over 3,000 Florida consumers, which we also address in this letter.

On November 16, 2011, CCIIO informed the Office that it would extend the review period for up to an additional 30 days, as provided in 45 CFR 158.345(b).

[1] All of the documents and information described in this letter are posted on CCIIO's website at http://cciio.cms.gov/programs/marketreforms/mlr/mlr_florida.html unless otherwise footnoted.

II. Request for Hearing on Florida's Application

CCIIO has received two requests that we hold a public hearing on Florida's application, pursuant to 45 CFR 158.344. The first, dated May 25, 2011, was submitted on behalf of six groups that advocate for the interests of consumers in the State: Florida CHAIN; Florida PIRG; Florida Center for Fiscal and Economic Policy; Florida Consumer Action Network; Organize Now; and Florida Legal Services. The second, dated October 26, 2011, was submitted by Health Care for America Now ("HCAN"), a national consumer advocacy organization. Both requests note that as part of its application, the Office submitted a transcript of a public hearing it held on September 24, 2010, which focused on the impact the MLR requirements would have on the individual market in the State.[2] As HCAN's request points out, the Office asserts in its application that "the record supports a remarkable unanimity of all interested parties on" the concern that, absent an MLR adjustment, consumer choice would be diminished in the individual market. HCAN goes on to state:

> What the adjustment request fails to note is that the September 24, 2010 event was not a public hearing in any sense of the term. It was held with less than one days' notice. There was no "unanimity of all interested parties" since consumers were not even allowed to speak. Four representatives of insurance companies and one representative of agents and brokers testified at the invitation of the Florida Office of Insurance Regulation (FLOIR). No consumers were invited and the record was closed before the consumers who did attend were given the opportunity to speak.

The request submitted by Florida CHAIN echoes the concerns expressed by HCAN about the hearing held in Florida. It states that the hearings which the Office conducted were "specifically advertised and organized around the interests of insurers and brokers" and "discouraged participation by stakeholders opposed to the MLR adjustment . . . In particular, stakeholders did not have a legitimate opportunity to present information."

Our review of the hearing transcript submitted by the Office confirms that the only testimony that was received came from five representatives of industry who spoke in favor of an adjustment to the MLR. No testimony was taken from consumers or others opposed to an adjustment.

Although we recognize the arguments presented in support of a public hearing on Florida's adjustment request, specifically, the one-sided nature of the hearing that was held by the Office, we will decline to hold a hearing for the following reasons. First, we find the record of the hearing submitted to us by Florida to be of little value in making our determination. The testimony presented did not contain any meaningful discussion of the types of data relevant to a determination of the likelihood of market destabilization. Second, and more importantly, we believe that the public comments submitted by HCAN, Florida CHAIN and others, which are discussed in Part V below, have adequately addressed the testimony given at the September 24, 2010 hearing in Florida, and provide us with a sufficient appreciation for the views of those opposed to our granting this application.

[2] As provided in 45 CFR 158.133, CMS will consider the evidentiary record of any hearing held by a State regarding an application for an adjustment to the MLR.

III. Overview of the Florida Individual Health Insurance Market

According to the Office's application, more than 840,000 Florida residents obtained health insurance coverage through the Florida individual health insurance market as of December 31, 2010. According to the Office's September 2, 2011 letter, the number of enrollees and market shares of these issuers as of December 31, 2010 are:

Table 1: Florida Individual Market Issuers' 2010 Enrollees and Market Share

Issuer ID[3]	Issuer[4]	Enrollees	Market Share
I	BCBS[5]	373,040	44.3%
H	Golden Rule	119,138	14.1%
R	Humana	67,952	8.1%
B	Connecticut General	51,344	6.1%
G	Aetna Health	45,480	5.4%
A	Coventry Health Plan	25,983	3.1%
K	Preferred Medical Plan	24,940	3.0%
J	Time	19,739	2.3%
L	United American	10,922	1.3%
N	Freedom	7,218	0.9%
T	Mid-West	6,088	0.7%
D	Aetna Life	2,665	0.3%
C	MEGA	5,566	0.7%
M	AvMed	5,181	0.6%
Q	Coventry Health & Life	3,627	0.4%
S	American Republic	3,459	0.4%
O	Health Options	2,333	0.3%
F	World	2,457	0.3%
E	Celtic	1,804	0.2%
P	John Alden	1,199	0.1%
	Rest of Market	62,117	7.4%
	TOTAL	842,252	100.0%

According to the Office's application, Rule 69O-149.005 of the Florida Administrative Code generally establishes a minimum loss ratio of 65 percent for guaranteed renewable policies and 70 percent for HMO products sold in the Florida individual market. Unlike the Affordable Care Act MLR standard that applies to each reporting year and is calculated based on data from

[3] The alphabetic identifier was assigned by the Office to each of the 20 issuers included in the Office's initial application.

[4] Although the Office has provided the names of only some of the issuers, all issuers can be identified from other information submitted by the Office, as well as by matching their data to the data on the 2010 Supplemental Health Care Exhibits ("SHCE"s) that issuers file with the National Association of Insurance Commissioners ("NAIC"), provided with the Office's September 2 letter.

[5] According to the Office's September 2 letter, BCBS made an error on its 2010 SHCE. Consequently, the number of enrollees in Table 1 is 36,585 lower than that reported on BCBS' 2010 SHCE. This discrepancy, as well several smaller enrollment figure discrepancies for other issuers are not material to our analysis.

up to three reporting years, Florida's minimum loss ratio is an anticipated lifetime loss ratio standard.

The Office further states that Florida requires guaranteed issue with no pre-existing condition exclusions to enrollees of withdrawing issuers, if such enrollees have 18 months of creditable coverage. Florida's State-operated high-risk pool, however, has been closed to new enrollees since 1991.

According to the Office's application, issuers wishing to withdraw from the Florida individual market must provide at least 180 days notice to their policyholders and the Office, and may not re-enter the Florida individual market for five years.

IV. Application of Regulatory Criteria to the Florida Individual Market

Title 45 CFR 158.330 lists six criteria that the Secretary may consider "in assessing whether application of an 80 percent MLR … may destabilize the individual market in a State." They are:

a) The number of issuers reasonably likely to exit the State or to cease offering coverage in the State absent an adjustment to the 80 percent MLR and the resulting impact on competition in the State;

b) The number of individual market enrollees covered by issuers that are reasonably likely to exit the State absent an adjustment to the 80 percent MLR;

c) Whether absent an adjustment to the 80 percent MLR standard consumers may be unable to access agents and brokers;

d) The alternate coverage options within the State available to individual market enrollees in the event an issuer exits the market;

e) The impact on premiums charged, and on benefits and cost-sharing provided, to consumers by issuers remaining in the market in the event one or more issuers were to withdraw from the market; and

f) Any other relevant information submitted by the State's insurance commissioner, superintendent, or comparable official in the State's request.

The preamble to the regulation provides that 45 CFR 158.330 "does not set forth a single test" for determining whether application of an 80 percent MLR standard may destabilize the individual market in a State, but rather lists the "main criteria" to be considered in assessing such risk. (75 Fed. Reg. 74887 (Dec. 1, 2010).)

A. *Number of issuers reasonably likely to exit the State*

The Office's application asserts that "[t]he MLR requirements will cause a reduction in the number of issuers doing business in the individual market, because the MLR requirements disrupt existing business plans of issuers." The Office explains that "some issuers will have no choice because the prospect of rebates will cause solvency concerns." The Office relates that "one company executive did testify that his company will exit the individual market if there is no

relief from the new MLR requirements." Page 65 of the transcript of the hearing held by the Office reveals that the Chairman and CEO of U.S. Health Group (parent company of Freedom) testified that "[i]f we're faced with an 80 percent medical loss ratio in 2011, … we would have no alternative but to cancel or non-renew our Florida business." The Office further appears to suggest that "106 companies totaling almost 52,000 insureds" may also exit. We note, however, that according to Attachment B to the Office's initial application, only 29 issuers cover at least 1,000 enrollees each in the Florida individual market and could thus be affected by the MLR rebate requirements.[6] We consider 20 of these issuers in making our determination; the Office's September 2 letter indicates that it does not wish us to consider the other nine issuers because eight are not active and one had its business novated to another company.

In its initial application, the Office states that four issuers have informed the Office of their impending withdrawal from the Florida individual market. We have reviewed the circumstances of these withdrawals and do not find them to be relevant to the Office's assertion that the MLR requirements will cause issuers to leave the market. According to Attachment D to the Office's application, these issuers are: Citrus Health Care; Guarantee Trust Life Ins. Co.; Guardian Life Ins. Co. of America; and National Health Ins. Co.[7] According to information provided in the Office's September 2 letter, Citrus and Guardian withdrew for business reasons. We further note that according to Attachment D, all four issuers had fewer than 300 lives in the Florida individual market and thus in 2011-2013 would be presumed to meet or exceed the MLR standard and not be subject to the MLR rebate requirements. Therefore, their withdrawals would be unrelated to the MLR provisions. Additionally, the Office expresses concern that "immediate implementation of the [MLR rebate] requirements will block entry of new products and will even cause issuers to remove existing individual products," reducing consumer choice. In Attachment D, the Office states that BCBS, Golden Rule, and AvMed have discontinued several policy forms. While BCBS and AvMed did not provide reasons for the discontinuance, Golden Rule has informed the Office that the discontinuance of its policy forms "is a part of a continuing effort to streamline its product offerings in the individual health market nationwide" that "allows replacement of obsolete products with plans currently being issued which are more comprehensive." Furthermore, in its June 28 letter, the Office states that it does not have a record of instances of discontinuance of product forms or market withdrawals that have occurred prior to the passage of the Affordable Care Act. The Office indicates, however, that it "is aware of four withdrawals from the market" that have occurred between 2008 and 2010. In sum, evidence presented in the Office's application does not show that the discontinuance of several policy forms and the withdrawals by four small issuers were caused by the MLR rebate provisions.

On October 21, 2011, American Republic and World informed the Office of their intention to exit the Florida individual market. Both issuers are part of the American Enterprise Group. We note that American Enterprise Group has announced the withdrawal of World and American Republic in all States, even though in most States neither company would be subject to rebates. As shown in Table 1 above, in 2010 American Republic and World insured a combined

[6] Experience of issuers with fewer than 1,000 life-years is considered to be non-credible and such issuers are not subject to rebate payments for the first reporting year. (45 CFR 158.230(c) and (d).) Life-years are the total number of months of coverage for enrollees during the year, divided by 12. (45 CFR 158.230(b).)

[7] Attachment D additionally lists Connecticut General Life Ins. Co. and Principal Life Ins. Co. as having provided a notice of exit; however, these issuers withdrew from the group market. Principal has informed the Office that its decision was made due to a decline in business.

total of 5,916 enrollees, or 0.7 percent of the Florida individual market. As of October 2011, this number had declined to 2,615 enrollees. According to these issuers' 2010 SHCEs and information provided by the Office, American Republic and World had credibility-adjusted 2010 MLRs of 59 percent and 85 percent, respectively. American Republic would owe rebates of $2.1 million if it would have had to pay rebates in 2010, while World would not be subject to rebates because its MLR was above the 80 percent standard. Both issuers were unprofitable in the Florida individual market. The fact that American Enterprise Group's decision to withdraw from the Florida individual market was made without taking into account any adjustment to the MLR standard we might make, coupled with the fact that it is withdrawing from markets where it meets the MLR standard and would not be affected by the MLR provisions, suggests that its decision was not related to the risk of paying rebates in Florida and elsewhere.

Under 45 CFR 158.321(d)(2)(iii), applicants requesting an adjustment to the MLR standard are asked to calculate the estimated MLR for issuers in the State using the methodology provided for in the Affordable Care Act and implementing regulation. The Office's application calculates the estimated MLRs using data from calendar year 2010. The 2010 estimated MLRs are an imperfect proxy for the actual results issuers may generate if held to the 80 percent standard in 2011-2013. One reason for this is that the Affordable Care Act was enacted at the close of the first quarter of 2010, presumably after pricing and other business decisions affecting MLRs had largely been made and implemented. Another reason historical data may constitute an imperfect proxy is that there can be year-to-year variability in issuers' claims experience, financial performance, and reported MLRs. Notwithstanding these limitations, the historical data remain the best available basis upon which to estimate the impact of the 80 percent standard in 2011.

Twenty issuers in the Florida individual market are expected to have at least 1,000 life-years each in 2011 and thus to be at least partially credible (as defined in 45 CFR 158.230(c)).[8] Therefore, these issuers could be expected to be subject to rebate payments beginning in 2011 if their MLRs fall below the statutorily mandated 80 percent standard. The chart below shows, for each of these issuers, the estimated 2010 MLR, estimated rebate based on 2010 MLR, estimated 2010 pre-tax net gain in the individual market before payment of rebates, and estimated 2010 pre-tax net gain in the individual market if the issuer would have had to pay rebates in 2010.[9]

[8] Experience of issuers with fewer than 1,000 life-years is considered to be non-credible and such issuers are not subject to rebate payments for the first reporting year. 45 CFR 158.230(d).

[9] "Pre-tax net gain" is the net gain or loss as reported in the SHCE plus any Federal, State, or other taxes and fees paid. The net underwriting gain or loss reported on the SHCE is calculated by subtracting the following from net adjusted premiums earned after reinsurance: net incurred claims after reinsurance; expenses incurred for quality improving activities; claims adjustment expenses; and general and administrative expenses. Unlike the underwriting gain or loss reported on the SHCE, the pre-tax net gain is not reduced by taxes, and is thus consistent with the way underwriting gain is reported on the annual financial statements that issuers file with the NAIC.

Table 2: Estimated 2010 MLRs, Rebates and Pre-Tax Net Gain ($ in millions)[10]

Issuer ID	Issuer	MLR After Credibility Adjustment[11]	Estimated Rebates	Pre-Tax Net Gain Before Rebates	Pre-Tax Net Gain After Rebates
I	BCBS	79.2%	$8.0	$19.5	$11.5
H	Golden Rule	67.5%	$36.8	$51.1	$14.4
R	Humana	62.0%	$27.7	$12.8	($14.9)
B	Connecticut General	65.8%	$11.0	$5.3	($5.6)
G	Aetna Health	81.2%	$0.0	$18.8	$18.8
A	Coventry Health Plan	78.0%	$1.6	$8.6	$7.0
K	Preferred Medical Plan	73.0%	$4.2	$5.1	$0.9
J	Time	66.6%	$7.1	$3.7	($3.3)
L	United American[12]	79.1%	$0.0	$1.2	$1.2
N	Freedom	63.4%	$2.5	$0.4	($2.1)
T	Mid-West	62.5%	$3.1	$5.8	$2.7
D	Aetna Life	85.6%	$0.0	$2.7	$2.7
C	MEGA	67.0%	$2.6	$5.6	$3.0
M	AvMed	114.2%	$0.0	($5.9)	($5.9)
Q	Coventry Health & Life	81.1%	$0.0	($0.6)	($0.6)
S	American Republic	58.6%	$2.1	($0.4)	($2.5)
O	Health Options	105.6%	$0.0	($4.5)	($4.5)
F	World	84.7%	$0.0	($0.3)	($0.3)
E	Celtic	91.6%	$0.0	($1.0)	($1.0)
P	John Alden	67.5%	$0.5	$1.0	$0.5

According to the 2010 MLR data shown above, it appears that six issuers in the Florida individual market – Aetna Health, Aetna Life, AvMed, Coventry Health & Life, Health Options, and Celtic – meet the 80 percent MLR standard.[13] Additionally, according to the Office's application, BCBS is already pricing its products to 80 percent and consequently does not expect to owe rebates for 2011. Time and John Alden expect to achieve an 80 percent MLR beginning in 2012. Consistent with their stated intention to price their products to 80 percent, Time and

[10] The Office's MLR and rebate calculations were based on 2009 data for some issuers, and partial 2010 data for other issuers. The estimates shown in Table 3 are calculated using the data from the 2010 SHCEs provided by the Office with its September 2 letter.

[11] The credibility adjustments used to prepare the MLR estimates shown in Table 2 do not include deductible factors provided under 45 CFR 158.232(c); therefore, the credibility adjustments available to issuers are likely understated.

[12] The Office's September 2 letter indicates that United American only sells policies with total annual limits of $250,000 or less ("mini-med" business) and therefore was not required to file the 2010 SHCE. The 57.4% MLR estimate provided by the Office was based on 2009 data. The MLR shown in Table 2 was estimated based on United American's more recent 2011 quarterly filings submitted to CCIIO pursuant to 45 CFR 158.110(b)(2) and 158.120(d)(3). However, neither the Office's estimate nor CCIIO's MLR estimate shown in Table 2 reflect the fact that pursuant to 45 CFR 158.221(b)(3), for 2011 United American's MLR numerator would be multiplied by two, which would cause both the Office's and CCIIO's MLR estimates for United American to significantly exceed the 80 percent standard. Consequently, CCIIO, as well as United American, estimate United American's 2011 rebates as $0.

[13] As noted previously, World is withdrawing from the Florida individual market.

John Alden indicate that they expect to pay 2011 rebates of $3.9 million and $0.3 million, respectively, much lower than the $7.1 million and $0.5 million suggested by these issuers' 2010 experience. Additionally, at a credibility-adjusted MLR of 78 percent, Coventry Health Plan is also very close to meeting the 80 percent standard. Furthermore, as previously noted, United American is likely to have a 2011 MLR significantly in excess of the 80 percent standard.

Nonetheless, there remain seven issuers with MLRs expected to be below the 80 percent standard in 2011: Golden Rule; Humana; Connecticut General; Preferred Medical Plan; Freedom; Mid-West; and MEGA.[14] These issuers must adjust some combination of their operations and financial targets in order to satisfy an 80 percent MLR standard. In its basic form under the Affordable Care Act and implementing regulation, the MLR is the ratio of monies spent on incurred claims and quality improving activities to premium revenue (adjusted for certain State and Federal taxes and fees). See 45 CFR 158.221. Therefore, all other things being equal, these seven issuers would either need to lower premiums or increase expenditures on claims or quality improving activities, or otherwise risk paying rebates to enrollees. Assuming that these issuers did not reduce their administrative costs, either of these actions could lead to deterioration in profitability, which may be a consideration for each company in assessing whether to remain in the Florida individual market.

Of the seven issuers with MLRs considerably below 80 percent, three would be expected to be unprofitable after payment of rebates in 2011, assuming that their 2011 experience mirrored their 2010 experience: Humana; Connecticut General; and Freedom. However, this analysis presumes certain facts, most notably the continuation of 2010 financial performance and no changes to 2010 business models that likely have changed in 2011. Indeed, according to the Office's application, Freedom projects rebate payment for the 2011 MLR reporting year that is twice lower than the amount estimated based on its 2010 experience. Additionally, Freedom projects no rebate payments under the Office's proposed adjustment to 68 percent in 2011 and 72 percent in 2012, even though Freedom's reported 2010 MLR was 63 percent. This suggests that, notwithstanding the concerns that Freedom has expressed with regard to the MLR rebate requirements during the hearing held by the Office more than a year ago, Freedom is changing its business model to achieve a higher MLR. Similarly, Connecticut General, which had a 66 percent MLR in 2010, expects its MLR to increase to 71 percent in 2011, and its membership to continue to grow significantly in 2011-2013. According to information provided by the Office, Connecticut General is a new entrant that has achieved a rapid expansion into the Florida individual market, becoming the fourth largest issuer in just two years. We further note that Florida is currently Connecticut General's largest individual health insurance market in the country. Based on this, we do not consider it reasonably likely that Connecticut General will abandon that market.

Additionally, although 2010 data suggest that Humana faces rebate payments significantly in excess of its pre-tax net gains, in its annual report to the shareholders, Humana states that "while [Humana] anticipates a challenging near-term profitability environment in the individual market, reform-related provisions are expected to increase the prospect pool by between 23 million and 40 million people in the next six years," and that Humana "expect[s] to

[14] As noted previously, American Republic is withdrawing from the Florida individual market.

be well-positioned to take advantage of this opportunity."[15] Humana's statements suggest that, notwithstanding the near-term impact of Affordable Care Act's provisions on its profitability, Humana intends to stay in the individual market in order to benefit from the influx of new policyholders into the market in 2014. We note that Florida is Humana's largest individual health insurance market in the country, and that Humana is the third largest issuer in that market. Furthermore, according to the information submitted with the Office's September 2 letter, Humana projects rebate payments for the 2011 MLR reporting year of only $11 million, 60 percent lower than the amount estimated based on its 2010 experience.[16] Consequently, it is likely that Humana will remain profitable even after payment of rebates under the 80 percent MLR standard. Humana further projects its rebate liability to fall by two-thirds in 2012, and by another third in 2013. This suggests that Humana is in the process of changing its business model to achieve significantly higher MLRs in 2011-13, and that it will remain in the Florida individual market.

The Office also asserts that "achieving the MLR requirements in the initial years is impossible" and that, consequently, smaller issuers "will not want to enter the individual market, because of the immediate requirements of issuing rebates." The Office explains that "[a]dministrative costs are the highest in the first years of entry into the market, which means [that] for a company wishing to enter the market, the MLR requirements present a significant impediment." According to the Office's application, there are six new entrants in the Florida individual market: Connecticut General; AvMed; Coventry Health & Life; Medica; Florida Health Care Plan; and Humana Medical Plan. With the exception of Connecticut General, which in two years has become the fourth largest issuer in the Florida individual market with more than 50,000 enrollees, all new entrants have a relatively small presence in Florida, with market shares of 0.6 percent or less. We note with respect to the Office's concern that small new entrants would be unable to meet the 80 percent standard, that all five small new entrants currently in the Florida individual market had 2010 MLRs ranging from 81 percent to 116 percent. Therefore, the facts presented do not support the Office's assertion that it is impossible for new entrants to achieve an 80 percent MLR in the initial years of entry. Furthermore, we note that the MLR regulation's provision regarding newer experience, 45 CFR 158.121, allows an issuer with 50 percent or more of its experience during an MLR reporting year resulting from new business to exclude the experience of these policies from MLR calculations for that reporting year. Additionally, we note that a new entrant would not become subject to MLR rebate requirements until it accumulates at least 1,000 life-years in the Florida individual market. According to data presented in the Office's application, with the exception of Connecticut General, all five small new entrants to the Florida individual market had fewer than 1,000 enrollees in the first year of entry. In the second year, three of these issuers still had fewer than 1,000 enrollees, while the other two had more than doubled their membership and thus would have been able to benefit from 45 CFR 158.121 and reduce their rebate liability for that year.

In sum, evidence shows that almost all issuers in the Florida individual market either 1) already meet the 80 percent MLR standard, 2) are sufficiently profitable to absorb the impact of rebate payments under an 80 percent MLR standard, or 3) are adapting their business models in

[15] Humana Inc., 2010 Annual Report, at 6, *available at* http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9ODQ2ODh8Q2hpbGRJRD0tMXxUeXBlPTM=&t=1.

[16] Although Humana's rebate estimates submitted with the Office's initial application were based on 2009 data, the Office's September 2 submission includes updated estimates. Specifically, the 2009-based rebate estimate for 2011 of $5.3 million was revised to $11 million.

order to continue to achieve sustainable financial performance in the individual market. Based on this, we do not expect any issuers to withdraw from the Florida individual market and therefore could not conclude that it is "reasonably likely" that the market will be destabilized if the 80 percent standard is not adjusted.

B. *Number of enrollees covered by issuers that are reasonably likely to exit the State*

As stated previously, the Office expresses concern about the impact of rebate payments on issuers' solvency and existing business plans. As discussed in Part A above, eleven of the eighteen issuers in the Florida individual market that are at least partially credible, including the dominant issuer, either meet the 80 percent MLR standard or intend to price their products to meet the 80 percent standard, and thus would not be likely to leave the market due to MLR rebate requirements. Two other issuers are no longer in the market. Additionally, six of the seven issuers with low MLRs are expected to remain profitable after payment of rebates under an 80 percent MLR standard for 2011. Although one issuer with a low MLR – Freedom – has expressed concern regarding the impact of rebates on its business, this issuer appears to be adjusting its business model to significantly reduce its rebate liability. We further note that an issuer electing to withdraw from the Florida individual health insurance market may not reenter the individual market for five years, which presents a significant disincentive to exiting the market, particularly for an issuer who will remain profitable even after payment of rebates. In light of these circumstances, it appears that all issuers would remain in the market even with an 80 percent MLR standard. If, however, Freedom were to withdraw, this would affect 7,218 enrollees, or less than one percent of the market.

C. *Consumers' ability to access agents and brokers*

The Office expresses concern that the 80 percent MLR standard has "the potential to eliminate the agent … from the transaction between the issuer and the insured" because "[a]gent commissions are presently classified as an administrative expense, and therefore are part of the calculation of the MLR." The Office states that "[b]y delaying the medical loss ratio in the individual market, producers and issuers will be able to adjust to the new market realities over a reasonable period of time and prevent an abrupt loss of services for Florida consumers." The Office goes on to state that by 2014, "[m]ulti-year collateral contracts, including producer compensation arrangements, entered into prior to the enactment of PPACA will have expired, freeing the issuers to enter into contracts that are in accord with … the MLR requirements."

As noted previously, BCBS, the largest issuer, with a 44 percent market share, had a 2010 MLR of 79 percent and, according to the Office's application, is pricing it products to meet the 80 percent MLR standard. The Office has not indicated, nor does it appear likely, that BCBS will need to reduce its commission rates in order to keep its MLR at or above 80 percent. Based upon our analysis of SHCE data, in 2010 BCBS accounted for one third of all agent and broker compensation in the Florida individual market.

As discussed in Part A, based on 2010 data, three issuers would likely require significant adjustments to their business models to meet the 80 percent MLR standard and remain profitable: Humana; Connecticut General; and Freedom. Connecticut General and Freedom reported commissions on their SHCEs that averaged 13 and 19 percent of total earned premium in 2010, respectively, significantly above the market average. We note, however, that notwithstanding

any reductions that the Office believes may occur, the Office has not provided any specific evidence that would lead us to conclude, according to the criterion established by CFR 158.330(c), that "absent an adjustment to the 80 percent MLR standard consumers may be unable to access agents and brokers."

Finally, we also note that four public comments submitted by consumer and patient advocacy organizations relate that "Florida insurance commission data submitted by the National Association of Health Underwriters ["NAHU"] to the NAIC" show that "[n]o insurers reduced commissions between 2010 and 2011." The commenters include the relevant portion of the NAHU report. The commenters additionally relate that "according to an NAIC study, states that already have higher MLR requirements have reported no impact on the availability of agents or brokers."[17] The commenters further note that "[t]he MLR regulations do not guarantee that broker and agent compensation will never be reduced, but rather that consumers must have adequate access to brokers and agents." The commenters' assessment is that "[n]o evidence is provided that implementation of an 80% MLR will reduce that access."

D. *Alternate coverage options*

As discussed in Parts A and B above, all issuers are likely to remain in the Florida individual market without an adjustment to the 80 percent MLR standard. However, even assuming that Freedom were to withdraw, according to the Office's application, Florida requires guaranteed issue with no pre-existing condition exclusions to enrollees of issuers withdrawing from the individual market. Therefore, if Freedom were to withdraw, its policyholders could obtain replacement coverage from the remaining active issuers in the market, and could not be denied coverage due to health status.

According to data submitted by the Office in response to 45 CFR 158.321, Freedom principally offers PPO products, some of which are HSA-compatible, with deductibles ranging from $1,000 to $10,000, and coinsurance of 0% to 50% up to an out-of-pocket maximum of between $0 and $15,000. According to data submitted by the Office and BCBS' website, BCBS, the largest issuer in the market, offers PPO products, including HSA-compatible products, with deductibles ranging from $500 to $10,000, and coinsurance of 0% to 25% up to an out-of-pocket maximum of between $0 and $4,500.[18]

The following comparison displays the monthly premiums a single adult of various ages would pay for either a BCBS or a Freedom policy. The comparison of low-deductible policies is for policies with a deductible of $1,500 and coinsurance of 20 percent up to an out-of-pocket maximum of $3,500 for BCBS, and policies with a deductible of $2,500 and coinsurance of 20 percent up to an out-of-pocket maximum of $2,000 for Freedom. The comparison of high-deductible policies is for policies with a deductible of $10,000 and coinsurance of 20 percent up to an out-of-pocket maximum of $10,000 for BCBS, and policies with a deductible of $10,000 and coinsurance of 20 and 50 percent up to an out-of-pocket maximum of $10,000 for Freedom.

[17] Report of the Health Care Reform Actuarial (B) Working Group to the Health Insurance and Managed Care (B) Committee on Referral from the Professional Health Insurance Advisors (EX) Task Force Regarding Producer Compensation in the PPACA Medical Loss Ratio Calculation (May 26, 2011), *available at* http://www.naic.org/documents/committees_b_exposure_110607_phia_charge_report.pdf.

[18] BCBS Florida, Plans for Individuals and Families, http://consumerdirect.bcbsfl.com/cws/browseplans/individualsandfamilies#Health (*last accessed* Dec. 6, 2011).

While the comparison is not exact, for a Freedom enrollee seeking alternative, comparable coverage, these may be the "most" comparable products based on premiums, benefits, and cost-sharing features. In these examples, the BCBS policies are less expensive than the Freedom policies.

Comparison of the Monthly Rate to Insure a Single Adult – Low Deductible[19]

		BCBS Policy	Freedom Policy	BCBS Policy as a % of Freedom Policy Cost
Age	24	$173	$185	94%
	42	$281	$326	86%
	52	$389	$463	84%

Comparison of the Monthly Rate to Insure a Single Adult – High Deductible

		BCBS Policy 20% coinsurance	Freedom Policy		BCBS Policy as a % of Freedom Policy Cost (20% coins.)
			20% coinsurance	50% coinsurance	
Age	24	$81	$98	$85	83%
	42	$132	$178	$153	74%
	52	$182	$267	$231	68%

Based on our analysis of the premium and benefit level information submitted by the Office, there is no indication that Freedom offers unique products; its products are similar in cost and design to products offered by other issuers in the Florida individual market. Therefore, even if Freedom were to withdraw, its enrollees should be able to obtain comparable coverage at comparable prices from other issuers in the market.

E. *Impact on premiums, benefits, and cost-sharing of remaining issuers*

The Office did not address the impact on premiums charged, or benefits or cost-sharing provided, to consumers by issuers remaining in the Florida individual health insurance market if application of the 80 percent individual market MLR standard causes one or more issuers to leave the market. Based on this, we do not consider the impact of an 80 percent MLR standard on premiums, benefits, and cost-sharing of issuers remaining in the Florida individual market in making our determination.

[19] Rates shown are for a single non-smoking male adult living in the Monroe county (the county for which Freedom provided rate information). Out-of-pocket maximums exclude the deductible. Rate information for Freedom provided by the Office suggests that the rates are for policies with an out-of-pocket maximum of $10,000; however, we assume that the rates for low-deductible products are for an out-of-pocket maximum of $2,000, as described in the product brochure also provided with the Office's application. Freedom rates are for MedComplete, Freedom's most popular product according to the Office's application. BCBS rates are for the BlueOptions Plans 511 and 532, which have the cost-sharing and benefit features most comparable to Freedom's MedComplete features. BCBS rates shown are as quoted on the BCBS website, http://consumerdirect.bcbsfl.com/cws/browseplans/individualsandfamilies#Health (*last accessed* Dec. 6, 2011). BCBS rates provided with the Office's application are lower than the rates shown.

F. *Other relevant information submitted by the State*

According to Exhibit 3 to the Office's application and the Office's July 21, 28, and September 14 letters, the total amount of rebates the Office expects consumers to receive in 2011-2013 if the issuers offering coverage in the Florida individual market had to meet an 80 percent MLR standard in each of those years is $174 million. The total amount of rebates that consumers would receive under the Office's proposed adjustment to the MLR standard is $29 million.[20] The latter amount is somewhat understated because the 2013 rebate projections under the Office's proposed adjustment to the MLR standard for Humana were unavailable. Nonetheless, granting the Office's request could deprive consumers of up to $145 million in rebates.

V. Summary of Public Comments

As part of its application, the Office submitted a transcript of the public evidentiary hearing it conducted on September 24, 2010. The hearing included testimony by four issuers, Aetna, AvMed, Golden Rule, and Freedom, as well as the Florida Association of Health Underwriters ("FAHU"). In addition, Assurant, Coventry, CIGNA, and, according to the Office, more than 100 agents and brokers submitted written affidavits. The issuers expressed concern with the fact that policies priced prior to implementation of the MLR regulation, under Florida's 65 percent (70 percent for HMOs) minimum loss ratio requirement, would make compliance with the Federal 80 percent standard difficult. Additionally, the issuers noted that many issuers had entered into multi-year agent compensation contracts that could not be immediately modified. The issuers also expressed concern with the ability of small new entrants to meet the 80 percent MLR standard, and the possibility that established issuers may discontinue sales. FAHU focused on the importance of agents and brokers in helping consumers make purchasing decisions.

CCIIO received five public comments from consumer groups opposing the Office's request. The commenters assert that the Office has not presented adequate evidence to support its request and has failed to show that the market is likely to be destabilized under any criteria for granting an adjustment. The commenters highlight the fact that Florida has a robust and competitive individual market, and argue that there is no reasonable likelihood that consumer choice will diminish due to implementation of the MLR standard. Instead, the commenters assert that consumers "shouldn't have to waste money on low-quality, inefficient products" and "don't need an endless number of health insurance choices if they are of poor value." The commenters further express concern with the magnitude of rebates that consumers would not receive if the Office's request is granted. A group of 20 consumer and patient advocacy

[20] The rebate projections under the Office's proposed adjustment to the MLR standard were unavailable for Time and John Alden for 2012 and 2013, and for Humana for 2013. However, Time and John Alden are pricing their products to meet the 80 percent MLR standard and do not expect owing rebates for 2012 and 2013 even under the 80 percent MLR standard. Humana estimated only $1,643 for 2012 under the Office's proposed adjustment to the MLR standard and $2 million for 2013 under the 80 percent standard. Therefore, rebates payable by Humana in 2013 would not significantly increase the total amount of rebates that all issuers are expected to pay under the Office's proposed adjustment to the MLR standard.

organizations additionally assert that the Florida Insurance Commissioner lacks authority under Florida law to submit a request for an adjustment to the MLR standard.

More than 3,000 Florida residents signed a petition requesting that the Secretary deny the Office's request. The petitioners state that "implementation of the minimum loss ratio is long overdue in our state, and we urge you to put patients before insurance company profits by rejecting the state of Florida's attempt to delay this rule."

We acknowledge the views and concerns expressed in this comment. They are discussed, many in great detail, in the body of this letter.

VI. Conclusion

As described at the outset of this letter, section 2718 of the PHS Act permits the Secretary to adjust the 80 percent standard in the individual market if it is determined that applying this standard "may destabilize the individual market in [the] . . . State." The regulation implementing section 2718, 45 CFR Part 158, provides that an adjustment should be granted "only if there is a reasonable likelihood" that application of the 80 percent MLR standard will destabilize the particular State's individual health insurance market (45 CFR 158.301).

After applying the standards and criteria set out in section 2718 and 45 CFR Part 158 to the information submitted by the Office, we conclude that the evidence presented does not establish a reasonable likelihood that implementation of an 80 percent MLR standard may destabilize the Florida individual market. We reach this conclusion for the reasons outlined in the analysis under the criteria set out above, and based on the specific characteristics of the Florida individual market addressed in that analysis.

As noted in Part III.A above, eight issuers that are at least partially credible, and would thus be expected to be subject to MLR rebate provisions in 2011 based on 2010 enrollment, would not owe rebates because they have MLRs of 80 percent or higher. One other issuer is very close to meeting the 80 percent standard, while another two expect to meet the 80 percent standard in 2012. Additionally, six of the seven issuers remaining in the market that would be expected to owe rebates beginning in 2011 based on 2010 performance are sufficiently profitable to absorb the impact of rebate payments under the statutory 80 percent MLR standard. As further discussed in Part III.A, one issuer that, based on 2010 data, would be unprofitable after payment of rebates under an 80 percent MLR standard – Freedom – is adapting its business model to significantly reduce its rebate liability, based on information provided in the Office's application. There is no basis to conclude, based on these facts, that there is a reasonable likelihood that any of these issuers may leave the market. As discussed in Part III.D, even if Freedom, which covers less than one percent of the market, were to withdraw, Florida's guaranteed issue requirement and competitive market would ensure that Freedom's enrollees, including those with pre-existing conditions, would be able to obtain alternate coverage at comparable prices from the remaining active issuers in the market.

As discussed in Part III.C above, although the Office expresses concern that the 80 percent MLR standard could eliminate agent participation in the market by putting a downward pressure on commissions, the Office does not provide specific data to support this concern.

Additionally, as discussed in Part III.C, it is not immediately obvious that most issuers would need to reduce commissions in order to meet an 80 percent MLR standard and remain profitable. In sum, there is insufficient evidence to conclude that an 80 percent MLR standard would significantly reduce consumers' ability to access agents and brokers in Florida.

For these reasons, we conclude that an adjustment to the 80 percent MLR standard in the Florida individual market is not appropriate.

Pursuant to 45 CFR 158.346, the Office may request reconsideration of the determination issued in this letter. A request for reconsideration must be submitted in writing within ten days of the date of this letter to MLRAdjustments@hhs.gov, and may include any additional information in support of such request. A determination on a request for reconsideration will be issued within 20 days of the receipt of the request.

Please contact me should you have any questions.

Sincerely,

/Signed, SBL, December 15, 2011/

Steven B. Larsen
Deputy Administrator and Director,
Center for Consumer Information and Insurance Oversight