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STATE OF FLORIDA  
DEPARTMENT OF FINANCIAL SERVICES  
OFFICE OF INSURANCE REGULATION

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PUBLIC EVIDENTIARY HEARING ON  
MEDICAL LOSS RATIO  
BY THE OFFICE OF INSURANCE REGULATION  
IN CONJUNCTION WITH  
THE FLORIDA HEALTH INSURANCE ADVISORY BOARD

DATE HELD: September 24th, 2010  
TIME: 10:00-12:00 P.M. EST  
PLACE: Senate Office Building  
Jim King Committee Room  
Room 401  
Tallahassee, Florida

These proceedings were held at the time and place  
aforesaid, when and where they were reported by:

TRACY A. LEFEBVRE, Court Reporter  
For the Record Reporting, Inc.  
1500 Mahan Drive - Suite 140  
Tallahassee, Florida 32308

PRESENT :

FLORIDA HEALTH INSURANCE ADVISORY BOARD

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DEPUTY COMMISSIONER MARY BETH SENKEWICZ

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RANDY M. KAMMER

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## P R O C E E D I N G S

1  
2 COMMISSIONER MCCARTY: Good morning, ladies  
3 and gentlemen. My name is Kevin McCarty. I'm the  
4 insurance commissioner in the State of Florida.  
5 I'd take this opportunity to call to order a joint  
6 public evidentiary hearing convened by the Florida  
7 Office of Insurance Regulation and the Florida  
8 Health Insurance Advisory Board.

9 We are joined today by our attorney, Bob  
10 Prentiss, who will preside over the hearing after  
11 my introductory remarks. As you recall, May 4th  
12 we had a hearing. We had consultation with HHS,  
13 and with my colleagues at the office, we are now  
14 taking an evidentiary hearing in the hopes of  
15 providing and perfecting the record to present to  
16 the Health and Human Services Secretary Sebelius.

17 I want to welcome the members of the board  
18 and those who are on the phone, and thank you for  
19 taking time to participate in today's hearing. I  
20 want to thank all of you who are here today for  
21 taking time out of your busy schedule to  
22 participate in our hearing as well.

23 The purpose of our hearing today is to  
24 solicit testimony related to the issue of medical  
25 loss ratio in the health insurance market and the

1 particular effect on the individual market. The  
2 Federal Health Care Reform Act titled, Patient's  
3 Protection and Affordable Care Act, requires  
4 health carriers to meet a new minimum loss ratio  
5 beginning in 2011. Those minimum loss ratios are  
6 85 percent in the large group and 80 percent in  
7 the small group and individual markets.

8 The federal law states that the medical loss  
9 ratio calculation has three components: The  
10 reimbursement for medical services; the cost for  
11 activities that are envisioned to improve health  
12 care quality; and, lastly, the cost of all other  
13 non-claims costs, excluding taxes and fees. This  
14 is commonly referred to as an administration cost  
15 for health care.

16 The NAIC, the National Association of  
17 Insurance Commissioners, has recently adopted the  
18 supplemental health exhibit with instructions  
19 delineating these costs. The NAIC, through the  
20 Accident and Health Working Group of the Life and  
21 Health Actuarial Task Force, is continuing with  
22 its related work in the computation of the MLR.  
23 And yesterday they received the first draft for  
24 comment with expecting to complete their work by  
25 the end of September.

1           The specific issue we will hear today regards  
2           the impact of these new minimum loss ratios on the  
3           Florida insurance marketplace, and in particular,  
4           the individual market. The secretary of HHS is  
5           providing in the law the flexibility to adjust the  
6           loss ratio requirements in a state if she  
7           determines that the 80 percent loss ratio may  
8           destabilize the state's individual market. We  
9           look forward to hearing your testimony on the  
10          panels today and provide information regarding  
11          this subject.

12          I'd like to thank the Florida Channel for  
13          recording the meeting today. And I'd like to  
14          remind everyone that is participating to please  
15          speak into the microphones, and please turn off  
16          your cell phones and communication devices as  
17          well. And I want to thank you, and if you want to  
18          look at the meeting and task force, it will be  
19          available at WFSU.org.

20          With that, I'd like to turn the hearing over  
21          to Mr. Prentiss of our legal department. Mr.  
22          Prentiss.

23          MR. PRENTISS: Thank you, commissioner. My  
24          name is Bob Prentiss. I'm assistant general  
25          counsel with the Office of Insurance Regulation.

1 Today's evidentiary hearing is limited in scope.  
2 The focus is on the potential adverse impact of  
3 the federal requirements related to medical loss  
4 ratio, MLR, on the stability of the Florida health  
5 insurance markets, and particularly, the  
6 individual health insurance market.

7 Persons testifying and members of the public  
8 commenting are instructed to limit their comments  
9 on that particular focus and only that focus. We  
10 will not entertain comments on the merits or  
11 problems with the federal legislation, any other  
12 facet of the federal legislation, whether the  
13 legislation will be around in two or four years or  
14 anything other than the potential adverse impact  
15 of the federal law relating to MLR on the  
16 stability of the health insurance market,  
17 especially the individual health insurance market.

18 This is the procedure we will follow today:  
19 Testimony will be given by five people; four  
20 people, each representing a different insurer and  
21 one person representing agents servicing the  
22 individual market.

23 The testimony is being recorded by a court  
24 reporter. The statements will be made under oath.  
25 All persons testifying will be sworn in by the

1 court reporter.

2 After each one delivers a prepared statement,  
3 he will answer questions posed by the panel. When  
4 questioning of one is complete, the next one will  
5 be sworn in, will deliver his prepared statement,  
6 and will undergo questioning by the panel and then  
7 on to the third, fourth, and fifth persons.

8 At that point, the hearing portion of the  
9 meeting will be closed, and the meeting will be  
10 opened for comments from the public. Members of  
11 the public commenting will not be sworn in. If  
12 you wish to be heard, you need to fill out a  
13 request to speak form. I believe they're right  
14 outside in the little entryway. Please fill it  
15 out and bring it up and put it at the end of the  
16 table, please. Speaker Number 1, Mark LaBorde.

17 (WHEREUPON, Mr. LaBorde is placed under oath  
18 by the court reporter.)

19 WHEREUPON,

20 MARK LABORDE

21 having been first duly sworn to tell the truth,  
22 testified as follows:

23 MR. PRENTISS: Sir, please state your name  
24 and your position and your affiliation.

25 MR. LABORDE: My name is Mark LaBorde. I am

1 the president for Aetna in the Jacksonville and  
2 Tampa markets in Florida.

3 MR. PRENTISS: You may speak.

4 MR. LABORDE: Thank you.

5 COMMISSIONER MCCARTY: Welcome, Mr. LaBorde.

6 MR. LABORDE: Thank you, commissioner. I  
7 would like to start by thanking the commissioner,  
8 the deputy commissioner and the FHIB group for  
9 holding this evidentiary hearing today. We  
10 commend you for hearing the critical issue of the  
11 medical loss ratios.

12 Aetna is one of the nation's leaders in  
13 health care, dental, pharmacy and other employer  
14 benefits. We have 18.6 million members nationwide  
15 and cover nearly 1.2 million members here in  
16 Florida and employ 4,200 -- excuse me, 4,271  
17 Floridians who come to work every day with the  
18 mission of improving health care coverage for our  
19 members here and across the country.

20 Our operations in Florida specifically  
21 include provider and member call centers, claim  
22 operations, the processing of complaints,  
23 grievances and appeals and provider relations.

24 While many of these operations may seem  
25 superficially administrative, they represent

1 critical elements of the support we provide to our  
 2 individual customers, employer accounts and  
 3 provider partners. Our employees are proud to  
 4 serve 16,900 Florida employers, including 15,900  
 5 small businesses in partner with over 48,000  
 6 Florida medical providers and more than 3,800  
 7 Florida agents and brokers.

8 The issue of the development of the medical  
 9 loss ratio by the NAIC and its promulgation and  
 10 regulation by the U.S. Department of Health and  
 11 Human Services will have potential impacts in  
 12 communities across the nation as well as here in  
 13 Florida.

14 We appreciated the opportunity to testify  
 15 during the May 4th hearing where we made specific  
 16 recommendations regarding the MLR. There are two  
 17 critical issues that remain outstanding. The two  
 18 I'd like to address today include, number one, the  
 19 importance of preserving competition and choice.

20 To accomplish this, we recommend that the  
 21 NAIC and the Federal Department of Health and  
 22 Human Services do the following: Establish a  
 23 phase-in of the MLR for both the individual and  
 24 small group market; second, recognize the  
 25 interstate nature of large group business by

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allowing for national large group MLR reporting; and facilitate choice of coverage by allowing an aggregation of HMO and PPO coverages.

Secondarily, we will also speak to the necessity of addressing real drivers of health care costs. Medical loss ratios will not improve the affordability of coverage and could actually harm important initiatives that attempt to address real delivery system reform while preserving the quality of care we desire.

With regard to the importance of preserving competition and choice, to assure that Floridians and Americans across the country continue to enjoy competitive markets and choice of products, we recommend three important changes in the NAIC MLR proposals.

First, the MLR should be phased in across the country in the individual and small group markets. In many states, these markets already experience competitive challenges with the Federal General Accounting Office, GAO, reporting the five largest carriers in the small group market represent at least 90 percent of the market in 23 of 39 states surveyed. The NAIC reported that for the individual market, 20 states had less than three

1 carriers in the market.

2 Currently, in Florida, at least 11 insurers  
3 offer small group coverage in the Florida market,  
4 and at least 15 companies are offering one or more  
5 plans in the individual market. We expect  
6 Floridians would want to preserve robust  
7 competition in their market; however, compliance  
8 with the 80 percent federal MLR prior to 2014 is  
9 likely to create competitive issues.

10 It will be difficult for many insurers to  
11 continue to provide coverage in the Florida  
12 individual and small group markets during the  
13 transition because most of these products were  
14 priced and sold prior to the new MLR rules.

15 Current Florida regulation sets MLR's of 65  
16 percent for insurers and 70 percent for HMO's.  
17 These are dramatically different than the new MLR  
18 standards making a cold-turkey conversion  
19 challenging for the market to absorb.

20 These products still carry the same  
21 administrative requirements associated with  
22 underwriting, rating and distribution with many  
23 insurers involved with multi-year contracts with  
24 brokers and other distribution mechanisms that  
25 cannot be modified overnight. A phase-in that

1 gradually raises the current standards every year  
2 would allow time for insurers to adjust to the new  
3 rules and would help assure continued competition.

4 Also, the health care reform transition  
5 years, now through 2014, will see a transformation  
6 of the insurance business as insurers reinvent  
7 their products to come into compliance with the  
8 Affordable Care Act. This includes benefit  
9 redesign to add a hundred percent coverage for  
10 preventative services, new appeals processes,  
11 eligibility expansions and other initiatives  
12 intended to help consumers.

13 While these initiatives add value for  
14 consumers, they will, in the short term, also  
15 require some intensive administrative operations  
16 to implement. Existing law already would have  
17 imposed unusual administrative challenges during  
18 this time period because of the federally-mandated  
19 and previously-scheduled adoption of the new  
20 coding system called ICD-10.

21 Secondly, on our second recommendation,  
22 the NAIC should recognize the interstate nature of  
23 the large group business by allowing for national  
24 large group MLR reporting. We are appreciative  
25 that the associated industries of Florida

1 submitted support for this recommendation as well  
2 as other MLR improvements to the NAIC earlier this  
3 summer.

4 In their letter, they note and I will quote:  
5 Requiring state-by-state reporting would require  
6 millions of dollars in system changes for  
7 insurers. And who pays for these upgrades?  
8 Employer accounts. Large employers don't need or  
9 want to state -- or want state-by-state minimum  
10 loss ratio reporting, and we certainly don't need  
11 the higher premiums they would generate, in their  
12 quote.

13 It is also important to recognize that  
14 state-by-state reporting of large group MLR's  
15 could result in reducing competition in the large  
16 group market. Even in the large group market,  
17 insurers may have relatively small enrollments in  
18 certain states. Volatility in the state-by-state  
19 MLR reporting could cause insurers to exit some  
20 state markets. This may mean that some large  
21 employers and their employees who are happy with  
22 their insurer could lose their option to continue  
23 that coverage.

24 Most consumers and public policymakers view  
25 the large group market as a success story.

1 Coverage is administered efficiently, and 95  
2 percent of large employers offer insurance to  
3 their employees. Policymakers should be cautious  
4 about imposing state-by-state MLR rules in a  
5 market that is working well.

6 The final recommendation: The NAIC should  
7 facilitate choice of coverage by allowing  
8 aggregation of HMO and PPO products in the MLR  
9 calculation. The current NAIC proposal would  
10 require insurers to report separate MLR's for  
11 their HMO versus PPO business in many states.

12 This could cause insurers to decrease the  
13 offering of different products and eliminating  
14 point of service and dual-choice options where  
15 employers allow employees to choose either a PPO  
16 or an HMO. Americans like choice.

17 About 44 percent of employers with more than  
18 200 employees allow their employees to choose  
19 among more than one option. Insurers may  
20 discontinue this popular benefit because these  
21 products are priced in a way that blends the PPO  
22 and HMO options. If the MLR is forced to be  
23 calculated separately, it would not match the  
24 underlying premium assumptions. Choices like this  
25 could disappear.

1           In the small group market nationally,  
2           enrollees are divided between HMO and PPO  
3           enrollment. About 50 percent of enrollees are in  
4           PPO coverage and about 41 percent are in HMO.  
5           Some insurers may not be able to continue to offer  
6           both of these choices if the MLR requirements are  
7           to be administered separately on a state-by-state  
8           basis.

9           Secondarily, as I mentioned, we'd like to  
10          speak to the necessity of addressing real drivers  
11          of health care costs. Medical loss ratios will  
12          not improve affordability of coverage and could  
13          actually harm important initiatives that attempt  
14          to address real delivery system reform while  
15          preserving the quality of care we desire.

16          The NAIC MLR continues to penalize insurers  
17          that invest in quality-enhancing activities such  
18          (indiscernible) review, retrospective utilization  
19          review and the adoption of ICD-10 code sets that  
20          will enhance future medical care studies.

21          The centers for Medicare and Medicaid  
22          services, CMS, quantifies the largest drivers of  
23          cost increases as hospital costs at 32 percent of  
24          spending growth in 2009, physician services at 24  
25          percent of spending and growth in 2009 and

1 pharmaceuticals at 9 percent of spending growth in  
2 2009.

3 Cost shifting by the government also adds to  
4 the private sector premiums. Cost shifting is  
5 where the government underpays providers so that  
6 the providers are forced to charge more to private  
7 insurers. For example, Medicare only covers 91  
8 percent of the hospital cost and pays 89 percent  
9 of the average physician rate.

10 Medicaid pays a far smaller percentage of  
11 those costs. For Medicaid, hospitals receive  
12 payment of only 88 cents for every dollar spent by  
13 hospitals caring for Medicaid patients.

14 Specifically, these underpayments result in a  
15 typical insured family paying almost 11 percent  
16 more in premiums or about \$1,788 in additional  
17 cost per family, \$1,512 in higher premiums and  
18 \$276 in higher out-of-pocket expenses.

19 In conclusion, a common sense, practical  
20 application of health care reform is critical. If  
21 the NAIC MLR is not modified, there will be a  
22 reduction in choice and competition in the  
23 individual, small, and even the large group  
24 markets.

25 We recommend that the MLR be phased in and

1 that the large group market be treated as the  
2 interstate market it is with insurers reporting a  
3 single MLR for their large group market in their  
4 HMO and PPO business. In addition, policymakers  
5 should refocus their efforts on the real  
6 underlying cost drivers of health care.

7 Again, I'd like to thank the commissioner,  
8 the deputy commissioner and the board for hearing  
9 my remarks today.

10 MR. PRENTISS: Thank you, Mr. LaBorde. We  
11 have questions by the board?

12 COMMISSIONER MCCARTY: Thank you again for  
13 your testimony. Would you elaborate a little bit  
14 more. You've gone into some detail as to the  
15 potential disruptions of consumer choice in  
16 products. Can you specify if failure of the  
17 phase-in of the MLR, what specific impact you  
18 believe that has on your company or what reduction  
19 in choices would result?

20 MR. LABORDE: The adoption of the Patient  
21 Protection Act has obviously put a great number of  
22 administrative responsibilities, additional  
23 responsibilities as I might call them, upon all  
24 the insurers.

25 The ability to comply with that in immediate

1 form really places us at a real challenge in being  
 2 able to, as well, offer the robust product  
 3 offerings we currently have in the marketplace to  
 4 remain compliant and to effectively be able to  
 5 afford the administration to undertake those  
 6 changes that are needed.

7 COMMISSIONER MCCARTY: In your professional  
 8 opinion, do you believe that failure to implement  
 9 this over a three-year period would result in  
 10 reduced competition?

11 MR. LABORDE: Yes. It is my professional  
 12 opinion that the challenges that an immediate  
 13 implementation of the MLR would initiate, if you  
 14 will, would be an impediment to potential new  
 15 competitors within the marketplace and also a  
 16 potential challenge for those that are within the  
 17 marketplace at this time.

18 COMMISSIONER MCCARTY: Thank you. Yes, Mr.  
 19 Jackson.

20 MR. JACKSON: I have a question, if I may.  
 21 You had mentioned in your comments that you're  
 22 concerned about the underpayment of providers by  
 23 the federal government for those products and that  
 24 it would adversely have an impact on payments to  
 25 providers but in the private sector, if I

1 understand; is that correct?

2 MR. LABORDE: The item was specifically with  
3 regard to cost shifting.

4 MR. JACKSON: Cost shifting, right.

5 MR. LABORDE: The private sector then bears  
6 the additional cost that the providers must  
7 collect in order to cover their costs.

8 MR. JACKSON: Okay. How does that affect the  
9 insurance industry in terms of their payments to  
10 the providers? Is that not by contract? Is that  
11 already fixed in place, or does that affect the  
12 rates that insurers pay providers when there's  
13 cost shifting by the federal government?

14 MR. LABORDE: It affects the reimbursement  
15 levels that the hospitals and doctors need from  
16 the insurers in order for them to maintain their  
17 businesses, if you will. And so, what it truly  
18 affects in the long run are those folks that pay  
19 for their medical insurance because -- and to  
20 answer your question, Mr. Jackson, they are not  
21 fixed in -- you know, there might be some  
22 multi-year contracts, but those contracts are  
23 constantly up for renegotiation, if you will,  
24 throughout the State of Florida is a good example.

25 And when we face those negotiations as an

1 insurer/payer with those participating hospitals  
2 and physicians, they're under a greater pressure  
3 for greater demands for reimbursement from  
4 companies like Aetna given the continued reduction  
5 in the government reimbursement plans like  
6 Medicare and Medicaid.

7 MS. GALLETA: Hello? Could you elaborate  
8 again, please, on how requiring a separate MLR for  
9 PPO's and HMO'S will limit choice?

10 MR. LABORDE: Sure. Many plan sponsors offer  
11 benefit plans, particularly those in the large  
12 group market, which have HMO and PPO's side by  
13 side.

14 It is the practice of the insurance industry  
15 in our dealings with those plan sponsors to view  
16 those in an aggregate basis. In other words, you  
17 could have, if I might use the example, a scenario  
18 through which an MCR (sic) on a PPO plan is, let's  
19 say, 90 some-odd percent, and yet the MLR on the  
20 HMO is in the 70 area.

21 The aggregate view of that particular risk  
22 from the insurer point of view is that it is an  
23 acceptable medical loss ratio, and based upon the  
24 choices that that employer has made on behalf of  
25 their employees and their dependants, they believe

1 that's an appropriate representation of the  
2 benefit offering they wish to make to their  
3 employees.

4 If we were forced into the position of, then,  
5 having to solve for separate and distinct MLR's  
6 between a PPO and an HMO, many employers will face  
7 the fact of having to eliminate one of those  
8 coverage options because it's more poorly  
9 performing and the increases that would have to be  
10 passed along to it. And, as such, the employees  
11 could potentially lose their choice in that  
12 matter.

13 MS. GALLETA: Thank you.

14 COMMISSIONER MCCARTY: Are there any other  
15 questions?

16 DEPUTY COMMISSIONER SENKEWICZ: Not at this  
17 time.

18 COMMISSIONER MCCARTY: We don't have any  
19 other questions at this time, but just remain  
20 available as we may call you up again as we have  
21 some discussion.

22 MR. LABORDE: Thank you.

23 MR. PRENTISS: Mr. Brad Bentley.

24 (WHEREUPON, Mr. Brad Bentley comes forward  
25 and is placed under oath by the court reporter.)

1 WHEREUPON,

2 BRAD BENTLEY

3 having been first duly sworn to tell the truth,  
4 testified as follows:

5 MR. PRENTISS: Good morning, Mr. Bentley.

6 Please state your name, your affiliation and your  
7 (inaudible).

8 MR. BENTLEY: My name is Brad Bentley. I'm  
9 vice-president of underwriting for AvMed Health  
10 Plans.

11 MR. PRENTISS: You may proceed.

12 MR. BENTLEY: Commissioner McCarty, Deputy  
13 Commissioner Senkewicz, members of the Florida  
14 Health Insurance Advisory Board, good morning and  
15 thank you for the opportunity to speak here today.

16 As I indicated earlier, my name is Brad  
17 Bentley. I'm vice-president of underwriting for  
18 AvMed Health Plans. AvMed is a relatively small,  
19 not-for-profit, regional health plan licensed  
20 solely in the State of Florida.

21 As such, we are concerned with the minimum  
22 medical loss ratio requirement and the potential  
23 unintended consequences of its immediate  
24 implementation, particularly in the individual  
25 market.

1 AvMed has been a participant in the large and  
2 small employer group markets for several decades;  
3 however, we are a relatively recent entrant into  
4 the individual market having launched our first  
5 product line in the early part of 2009.

6 The future holds much uncertainty for  
7 consumers who are currently insured through the  
8 employer market. Our organization has made  
9 substantial investment in individual product line  
10 as we want to have a long-term presence in the  
11 market to serve new members, as well as existing  
12 members who may ultimately transition from the  
13 employer market to the individual market. We  
14 currently have approximately 2,000 members  
15 enrolled in one or more of our individual health  
16 plans.

17 I would like to briefly outline some specific  
18 concerns to companies like AvMed who are small  
19 start-up plans with low enrollment in the  
20 individual market space and specifically why we  
21 need transitional assistance in terms of complying  
22 with the minimum loss ratio requirements.

23 Our first concern as a health plan with low  
24 enrollment is simply with the volatility  
25 associated with low membership volume and the

1 resulting inability to accurately predict what the  
2 medical loss ratio will be over the policy period.

3 The intent of the minimum medical loss ratio  
4 requirement, we believe, is to protect consumers  
5 from being charged premiums that are unreasonable  
6 in relation to the benefits being provided. We  
7 want the same for our customers. We want our  
8 customers to see value associated with the  
9 premiums they pay for health care coverage.

10 For start-up companies with low enrollment,  
11 the ability to meet a medical loss ratio standard  
12 does not necessarily mean that that company's  
13 customers are getting value for their premium  
14 dollar. Conversely, an inability to meet those  
15 requirements does not necessarily mean that its  
16 customers are not getting value.

17 Because of the volatility associated with low  
18 enrollment, meeting the MLR requirement for  
19 smaller health plans such as ours will likely be  
20 influenced by more random events as opposed to  
21 specific actions taken by us. Thus, for small  
22 start-up plans, the MLR calculation result is not  
23 a reliable metric to assess health plan value and  
24 quality. In fact, I would argue that even for  
25 larger plans the MLR metric has limited usefulness

1 to the consumer. Rather, each individual consumer  
2 must make the decision as to what constitutes  
3 value based on his or her own criteria for judging  
4 quality, service, and benefits in relation to  
5 premiums. Competition across a variety of health  
6 plans is what insures that each consumer's own  
7 individual needs can be met through the exercise  
8 of choice.

9 Our second concern has to do with the  
10 misalignment of the time period over which claim  
11 costs are measured for purposes of calculating a  
12 medical loss ratio and the time period for which  
13 claim costs are estimated in the development of  
14 premium rates.

15 As you know, the individual product is  
16 currently a medically-underwritten product. The  
17 value of the medical information gathered at time  
18 of member application declines over a period of  
19 years and significantly so after the first policy  
20 year.

21 This means that claim costs for individuals  
22 are not likely to increase at a steady rate over  
23 the first few years of the policy. Rather, we  
24 expect to see significant escalation in claims  
25 costs over time as the value associated with the

1 medical underwriting wears off.

2 To protect consumers from fluctuations in  
3 premium rates, premiums are developed based on  
4 loss ratios expected to be incurred over the  
5 lifetime of the policy. This provides the  
6 consumer with more predictable changes in premiums  
7 from year to year; however, this results in  
8 medical loss ratios that are low in the early  
9 portion of the policy lifetime and higher as time  
10 progresses.

11 The irony is that the very mechanism that is  
12 designed to protect consumers from significant  
13 increases in premiums from year to year will  
14 generate a lower than required loss ratio in the  
15 first few years of the policy and noncompliance by  
16 the health plan, especially a small start-up  
17 health plan like AvMed.

18 The loss ratio requirement for a new or  
19 start-up plan whose entire membership consists  
20 solely of new policyholders does not serve its  
21 intended purpose on behalf of the consumer. We  
22 need to have some alternate mechanism to  
23 demonstrate to our customers that our premiums are  
24 reasonable in relation to the benefits being  
25 provided.

1           Our third concern deals with the impact of  
2 benefit design on the MLR results. We all know  
3 that increases in the underlying cost of  
4 healthcare are responsible for the level of  
5 premium increases that consumers have been faced  
6 with. This has driven up consumer demand for  
7 policies that have more significant levels of  
8 deductibles and member cost-sharing. These  
9 policies are becoming more and more popular in the  
10 market because of the premium savings that they  
11 generate for the purchasers.

12           This creates a couple of problems with  
13 respect to the MLR calculation. First, as already  
14 noted, lower premiums are generated for the higher  
15 deductible health plans that consumers want;  
16 however, it is not necessarily less costly to  
17 administer these programs than it is to administer  
18 richer benefit designs that carry higher premiums.

19           Our organization invests heavily in quality  
20 improvement activities and other services that our  
21 members value. The cost of some of those  
22 activities and services will be able to be counted  
23 in the numerator of the medical loss ratio  
24 calculation, but the cost of some of those  
25 services may ultimately not be able to be counted.

1           As members migrate to lower cost benefit  
2 designs, health plans will need to spread the same  
3 administrative costs over a much lower premium  
4 base making it more difficult to meet the minimum  
5 loss ratio requirement. In fact, depending upon  
6 the average level of medical benefits being  
7 purchased by the consumer, one company's MLR may  
8 look very differently than another company's MLR  
9 when, in fact, they provide the same level of  
10 service and have the same level of administrative  
11 expense. Again, this points out the flaws  
12 inherent in the MLR calculation as a means through  
13 which to assess the ultimate value being provided  
14 to the consumer.

15           As a start-up plan operating in the  
16 individual market, virtually all of our members  
17 are enrolling in these lower-cost, lower-premium  
18 plan designs. This makes it more challenging for  
19 us to compete in the market because we have not  
20 yet established the economies of scale relative to  
21 other plans.

22           Some plans have expressed the intent to  
23 consider the reduction or elimination of services  
24 that many consumers find valuable. We do not  
25 believe that this is the best result for Florida's

1 consumers.

2 Based on the these concerns and others, we  
3 strongly urge that the final rules and regulations  
4 for implementing the minimum medical loss ratio  
5 requirement provide for some transitional relief  
6 for companies serving the individual market,  
7 especially smaller start-up plans whose own  
8 actions may not be able to directly influence the  
9 outcome of the MLR test.

10 We understand that the NAIC has just released  
11 its draft of the proposed MLR regulations. We're  
12 in the process of reviewing and evaluating that  
13 proposal. We do believe that the transition  
14 period between 2010 and 2014 will be critical to  
15 the success of health care reform and sincerely  
16 hope that regulations provide for an effective  
17 transition so as to avoid potential disruption of  
18 coverage for Floridians.

19 The State of Florida is fortunate to have an  
20 insurance market that has many participants  
21 offering many choices for Florida residents. We  
22 understand the intent of the MLR requirement and  
23 share the same goal of insuring the reasonableness  
24 of premium rates being charged in the market;  
25 however, we firmly believe that it is competition

1 among many market participants that will  
2 ultimately insure that consumers receive value for  
3 their premium dollars.

4 Without addressing the concerns I've  
5 expressed and some transition implementation  
6 relief and the concerns expressed by others, we  
7 are fearful that carriers will be placed in the  
8 untenable position of having to consider reducing  
9 services, eliminating services or exiting the  
10 market altogether. Further, if these issues are  
11 not addressed, they will become significant  
12 barriers to entry for potential new health plans  
13 considering entrance into the market as we did  
14 back in 2009.

15 If these concerns are not addressed, we  
16 believe that the end result would be  
17 destabilization of the market and fewer choices  
18 for the residents of Florida.

19 Again, we urge you to petition the secretary  
20 of HHS to adopt transition rules that phase in  
21 compliance requirements and/or to adjust the  
22 minimum loss ratio percentage as is currently  
23 allowed in the Federal Health Care Reform Law.

24 That concludes my comments. Again, I thank  
25 you very much for the opportunity to speak here

1 today.

2 MR. PRENTISS: Thank you, Mr. Bentley. And  
3 I'd open it up for questions by the board.

4 COMMISSIONER MCCARTY: Thank you, Mr.  
5 Bentley. We appreciate your testimony, and I  
6 think your particular point of view from a small  
7 market is a very important part of our market.  
8 How many members do you have in Florida?

9 MR. BENTLEY: We have approximately 310,000  
10 members statewide currently, but only 2,000 in the  
11 individual market.

12 COMMISSIONER MCCARTY: I appreciate you going  
13 through and providing a background about how the  
14 loss ratio develops over time. I think that's  
15 important, particularly in the consideration that  
16 we give to emerging companies and emerging  
17 markets.

18 Do you believe that the implementation of the  
19 loss ratio of 2011 would destabilize Florida's  
20 market?

21 MR. BENTLEY: Yes, I do. For us, as I had  
22 mentioned and for all the reasons I mentioned,  
23 it's going to be difficult, if not impossible, to  
24 comply because of that disconnect between how the  
25 loss ratio is calculated and how premiums are

1 developed.

2 And, you know, destabilization, in my  
3 opinion, has to do with either a reduction of  
4 services that are currently being provided to  
5 consumers in the market or carriers exiting the  
6 market. And if this is not phased in, I see both  
7 of those things as potential things that can occur  
8 in Florida.

9 COMMISSIONER MCCARTY: Thank you very much.  
10 Further questions? Ms. Senkewicz.

11 DEPUTY COMMISSIONER SENKEWICZ: Thank you,  
12 commissioner. So just to follow up on the  
13 commissioner's point and for the record to really  
14 kind of explore that just fully, as I understand  
15 it, because you have a young -- you're an  
16 immature, let's say, market because you're a new  
17 entrant, you've only got 2,000 people.

18 And the principles of insurance and  
19 durational experience would show that -- and this  
20 is what I believe you were saying -- that in the  
21 early years, you have underwritten these people;  
22 they're less likely to have claims. So,  
23 therefore, in year one, let's say, your medical  
24 loss ratio is going to be much lower.

25 MR. BENTLEY: Correct.

1           DEPUTY COMMISSIONER SENKEWICZ: And you have  
2 much higher administrative costs that you have  
3 expended into setting up your market. But if it  
4 is set on a year-by-year basis without any  
5 transition, you, in fact, might be in the position  
6 of having to do significant rebates, would you  
7 not?

8           MR. BENTLEY: Yes. I think we would be in  
9 that position for that very reason.

10          DEPUTY COMMISSIONER SENKEWICZ: And then to  
11 carry that further, so you've done significant  
12 rebates; you've invested a lot of money  
13 administratively. Year two comes around, year  
14 three, the loss -- the claims start piling up and,  
15 in fact, your -- because of the premium that you  
16 already rebated, would you not be in the position  
17 of potentially taking losses? And, in fact, it's  
18 almost like a vicious circle that you really can't  
19 catch up to the money that you've collected and  
20 rebated when you had such a young market that  
21 didn't have the claims costs because they develop  
22 over time.

23          MR. BENTLEY: That's correct. I mean, we are  
24 in the risk business, and we understand that  
25 there's an upside gain potential and there's a

1 downside gain -- or a downside loss potential.

2 And what this does for a new or start-up plan is  
3 it completely removes the upside gain potential,  
4 leaving essentially losses in future periods. And  
5 that is just an untenable way in which to operate  
6 a market and I think will reduce competition in  
7 the market, which is very badly needed.

8 DEPUTY COMMISSIONER SENKEWICZ: And if, in  
9 fact, that plays out, would you, in fact, have to  
10 consider exiting the market?

11 MR. BENTLEY: We would -- we don't want to  
12 say that.

13 DEPUTY COMMISSIONER SENKEWICZ: I said  
14 consider.

15 MR. BENTLEY: We would have to consider every  
16 option available to us in terms of complying with  
17 this new regulation. And we think the answer lies  
18 in either adjustment of that percentage or some  
19 transition or phase-in, especially with respect to  
20 new plans who have very volatile claims associated  
21 with low enrollment. And, again, whether we  
22 comply or not is going to have little to do with  
23 actions that we have taken specifically as an  
24 organization. They are going to be random events,  
25 and I don't think that that was the intent of the

1 law when it was originally developed.

2 DEPUTY COMMISSIONER SENKEWICZ: And just one  
3 final question, at least for now, the transition  
4 that most people are talking about is through 2014  
5 because the law is clear, I think, that starting  
6 in 2014, it will be calculated on a three-year  
7 rolling basis. So do you think that if we were to  
8 transition to that higher number, 80 percent in  
9 2014, would that make it easier for you, then, to  
10 stay in the market and service your customers and  
11 give them value for their dollar?

12 MR. BENTLEY: It would certainly make it  
13 easier, but it wouldn't necessarily alleviate the  
14 entire set of issues depending on what our  
15 enrollment level is in 2014.

16 DEPUTY COMMISSIONER SENKEWICZ: Thank you.

17 COMMISSIONER MCCARTY: Ms. Kammer.

18 MS. KAMMER: I just had a question on whether  
19 or not the credibility factors being developed by  
20 the NAIC assist you at all because of the size and  
21 maturity of your business or lack of it?

22 MR. BENTLEY: They have that potential, but  
23 we are still reviewing that proposal. I don't  
24 know if what came out last night is 100 percent  
25 consistent with some of what I've seen previously

1 in development. But we have to take a look at  
2 that. Certainly, we would be a proponent of  
3 credibility adjustments as a way of reflecting the  
4 true risk or the true expected losses within that  
5 product line. But it's too early for me to tell  
6 because we have not reviewed what came out last  
7 night.

8 COMMISSIONER MCCARTY: Yes.

9 MS. GOODHUE: Hi. Forgive me because I don't  
10 have a lot of the technical background, but as a  
11 consumer advocate, I'm just trying to understand  
12 the challenge, and I think both of the testimonies  
13 today have helped me understand the challenge that  
14 needs to be met.

15 But I'm -- just for my own information, what  
16 is the current minimum loss ratio or medical loss  
17 ratio for the small and individual groups? I  
18 think the previous speaker mentioned 65 and 70  
19 percent? I guess I'm trying to understand the  
20 challenge of you having to get up to 80 to 85 in  
21 2014. What is the percent of the average are  
22 small groups? What are they looking at now?

23 MR. BENTLEY: The requirements currently in  
24 Florida is 70 percent for entities licensed as  
25 HMO's, which our company is, and it's 65 percent

1 for insurance companies.

2 MS. GOODHUE: And that's following the  
3 current definition of medical loss ratio in  
4 Florida, but not -- because those rules are still  
5 being proposed. So I guess that's following a  
6 definition now, but the definition will also  
7 change in what would make up those?

8 MR. BENTLEY: Yeah. There are two things  
9 happening with the new legislation. Number one,  
10 there is an increase in the percentage from 70 to  
11 80 in our case. But there's also a difference in  
12 terms of how that's determined because under --  
13 barring what comes out in terms of the  
14 transitional relief or multi-year averaging, it's  
15 been expressed as 80 percent on a one-year basis  
16 initially; whereas, the Florida requirement to get  
17 a rate filing approved contemplates a 70 percent  
18 minimum loss ratio over the lifetime of the  
19 contract or the policy, recognizing that you have  
20 low claims cost followed by escalation in claims  
21 over time.

22 And that's what I was trying to point out  
23 earlier from a consumer perspective. That's a  
24 protection for consumers because what you don't  
25 want us doing is rating for the actual risk in

1 each year because those members will then get  
2 very, very high increases as the impact of medical  
3 underwriting wears off.

4 So this is a way of smoothing that out to  
5 make it more palatable to the consumer. But it  
6 makes it darn near impossible, then, to comply  
7 with the one-year calculation of the medical loss  
8 ratio under the federal requirement when your  
9 entire book of business, like ours, is made up of  
10 these new policyholders.

11 MS. GOODHUE: Thank you.

12 COMMISSIONER MCCARTY: Thank you. Yes,  
13 Joan -- Ms. Galleta.

14 MS. GALLETA: Just a follow-up. I understand  
15 you to say that you had 2,000 individual members  
16 at this point have entered the market in 2009.  
17 Would you say that the legislation that has passed  
18 has impacted your business plan at this point to  
19 go forward in other areas of Florida that need  
20 individual market expansion?

21 MR. BENTLEY: It hasn't really impacted it at  
22 this point. Our intent is to develop a block of  
23 business and then expand into other markets. The  
24 new legislation certainly provides one other set  
25 of criteria to evaluate in terms of what we

1 ultimately do in that product line, and it  
2 presents a concern to us in that regard because we  
3 will always have, for quite sometime, even past  
4 2014 if we continue to grow, we're going be  
5 bringing in a lot of people who are at the  
6 beginning level of that claims costs curve. And  
7 they're not going to generate that 80 percent loss  
8 ratio, so that's a consideration for us as we move  
9 forward and consider our future plans.

10 MS. GALLETA: Thank you.

11 MR. PRENTISS: Any other questions by the  
12 board? Thank you, sir.

13 MR. BENTLEY: Thank you.

14 MR. PRENTISS: Speaker Number 3, Mike Corne.

15 COMMISSIONER MCCARTY: Welcome, Mr. Corne.

16 MR. CORNE: Thank you, commissioner.

17 (WHEREUPON, Mr. Corne comes forward and is  
18 placed under oath by the court reporter.)

19 WHEREUPON,

20 MIKE CORNE

21 having been first duly sworn to tell the truth,  
22 testified as follows:

23 MR. PRENTISS: Good Morning. Would you state  
24 your name and your affiliation and what your  
25 position is?

1 MR. CORNE: My name's Mike Corne. I'm  
2 vice-president with Golden Rule Health Insurance  
3 Company, and we are a subsidiary of United Health  
4 Care.

5 MR. PRENTISS: You may proceed.

6 MR. CORNE: Thank you for having me and  
7 inviting our organization. We think this is a  
8 very important issue and we're happy to testify.  
9 For more than 60 years, Golden Rule's offered a  
10 wide range of quality health insurance options for  
11 individuals and families. In addition, we offer  
12 short-term coverage to fill in the gaps for those  
13 that are between jobs, durations of one to six  
14 months.

15 As you know, The Patient Protection and  
16 Affordable Care Act is largely a complex piece of  
17 legislation that requires extensive federal  
18 rulemaking and substantial regulatory and process  
19 changes for states and insurance companies.

20 While we welcome efforts by states and the  
21 federal government to gather detailed information  
22 about the practical application of new MLR  
23 standards that become effective January 1, 2011,  
24 we remain concerned about unintended consequences  
25 and potential disruption for consumers.

1 I'd like to focus on the market in my  
2 testimony today. While the NAIC is carefully and  
3 thoughtfully developing model guidelines for the  
4 MLR regulations that are in effect January 2011,  
5 we in the industry face the practical problem of  
6 having to price insurance policies for 2011.  
7 Those that we'll sell next year, we had to  
8 price -- begin pricing last February, so, what,  
9 eight, nine months ago. Before federal health  
10 care reform even passed, we'd already priced those  
11 policies.

12 With specific regards to the individual  
13 insurance market, we are concerned that the  
14 current MLR requirement of 80 percent effective  
15 2011 could create significant disruption in the  
16 market. There are four points we would like to  
17 make, and, again, I want to focus on the market.

18 First, some carriers may stop selling to new  
19 customers so some newer carriers may conclude that  
20 their small scale -- and I think this goes to the  
21 point the gentleman before me who spoke was  
22 making -- will not allow them to cover the cost of  
23 distribution and administration of new business.

24 As a practical matter, the loss ratio  
25 pattern, which he mentioned, for underwritten

1 medical business is not level over the lifetime of  
2 any given policy. There are lower medical loss  
3 ratios in the first years, and they are higher in  
4 subsequent years.

5 Contrary to that, in the first year, the  
6 acquisition costs, the underwriting costs, the  
7 MIB, the cost necessary to complete medical  
8 underwriting upfront, as opposed to post-claims  
9 underwriting, are higher. We don't have those  
10 costs in the following years.

11 So at the same time, our administration and  
12 commission costs are the highest in the first year  
13 of the new policy. The combination of the high  
14 first-year cost to underwrite new business and the  
15 potential consumer rebates because of low loss  
16 ratios in the early years could lead carriers to  
17 cease new business sales. And I think the AvMed  
18 talked about that.

19 Without a phase-in in the 80 percent  
20 requirement or the latitude to use a rolling  
21 method to calculate loss ratios, there may be  
22 unintended consequences of less competition in the  
23 market. We think it is a barrier to entry. And I  
24 think that was talked about a little bit as well  
25 before my presentation -- before this testimony.

1           You know, it's very difficult to come in  
2           because you have 20 percent to work with in that  
3           first year, so you're putting on all this new  
4           business, and you're probably going to spend more  
5           than 20 percent on commissions and other  
6           acquisition costs. And you know that between the  
7           rebate and the claims paid, you've got to spend  
8           80. So I think you made the point, Ms. Senkewicz,  
9           that you're now already over a hundred and you've  
10          just started to play. So it's not sustainable and  
11          it's a barrier to entry.

12          My second point, carriers could exit the  
13          market rather than maintain a business at a loss.  
14          So I was talking about those that are entering the  
15          market or those that are actively selling in the  
16          market. And now I want to talk a little bit about  
17          those that have an existing book of business and  
18          the challenges that they're going to confront.

19          Nationwide our average individual premium  
20          rates are approximately half the cost of similar  
21          group coverage, so the individual market, half the  
22          cost of the small group market. That is primarily  
23          due to individual underwriting. Administrative  
24          costs and commissions, however, are roughly  
25          equivalent on a per person basis. And I'm talking

1 about dollars now, so it costs us the same.

2 Therefore, as a percentage of premiums, individual  
3 product administration costs are roughly twice as  
4 large as in the small group market.

5 Consequently, compliance with an 80 percent  
6 loss ratio in the individual market will be very  
7 challenging relative to the small group market.  
8 Phasing in the MLR over time will give carriers  
9 time to adjust internal cost structures to meet  
10 these new requirements. So the way we like to  
11 think about it is an adjustment to our business  
12 model.

13 We've had a business model for years that has  
14 evolved or changed in terms of process over time.  
15 And we are an innovative group. We can change  
16 over time, but we would like to have the time to  
17 change because change is, in fact, best  
18 accommodated as a process rather than an event.  
19 So we need time to change our business model.

20 My third point: Consumers could lose  
21 important resources for information if brokers are  
22 forced out of the marketplace. Today, the  
23 significant portion of individual health insurance  
24 in the market is purchased by consumers with the  
25 assistance of a professional, licensed insurance

1 broker. As a result, brokers are vital to the  
2 smooth functioning of the insurance market.

3 Consumers rely on brokers as a single point  
4 of contact to, one, present them with a wide  
5 variety of carriers, plan designs and pricing.  
6 Think about it like one-stop shopping. You know,  
7 I'm a consumer and I want to buy insurance. I  
8 don't want to have to call every insurer and try  
9 to pull together all the pieces of information to  
10 compare all these plans and all these prices to  
11 find the plan that best suits my needs at a price  
12 point I can afford. That's one role that the  
13 trusted advisor plays.

14 Two, they help them select the best plan for  
15 them and navigate the enrollment and underwriting  
16 process. So the application process, as well as  
17 the need to go through the medical underwriting  
18 process, which at times involves gathering medical  
19 records and the like, so, again, we're back to  
20 completing the medical underwriting right up  
21 front.

22 The third thing they do is, of course, they  
23 provide ongoing service after the sale. So as  
24 service needs arise, maybe the first time someone  
25 has a claim or the first time they have a premium

1 problem, they're going to call their broker, and  
2 the broker is going to help navigate through the  
3 company to get those issues resolved, so they play  
4 an important role.

5 As millions of new entrants to the health  
6 insurance market obtain individual insurance  
7 coverage for the first time -- so this law is  
8 supposed to bring in 45 million or 40 million or  
9 however many -- you have all these millions of  
10 people that are now going to come and try to buy  
11 insurance for the first time, the role of the  
12 broker will be even more important than it is  
13 today because of the price of individual health  
14 insurance, which is much lower on average than  
15 group insurance prices.

16 And because of the considerable upfront  
17 investment in servicing new customers, broker  
18 commissions tend to be higher in the first year --  
19 and I talked about this a little bit already --  
20 and lower in subsequent years. For example, a  
21 typical schedule might feature a 20 percent first  
22 year compensation for a broker with a 5 percent or  
23 a 10 percent trailing in subsequent years because  
24 there's not as much start-up service. The  
25 application process is resolved so the first year

1 costs go down.

2 Under an 80 percent MLR, 100 percent of the  
3 first year administrative and profit allowance  
4 will be consumed by the typical broker commission.  
5 So if you've got 80 percent in rebates and claims  
6 costs, plus 20 percent in the commission in  
7 today's business model, the money is gone.  
8 There's no money for administration or anything  
9 else.

10 Clearly, this structure is unsustainable and  
11 will necessitate lower commission percentages than  
12 used today. We notified our brokers in July that  
13 as of January, we were probably going to make some  
14 changes. We don't know what those changes are  
15 because, of course, MLR is not finalized at this  
16 point; even though we've already priced those  
17 policies that we're going to be selling, and we've  
18 already written the business that we're going to  
19 write this year, we have the mix we have, and we  
20 still don't know the answer.

21 Nevertheless, retaining these advisors is  
22 critical for those Floridians who rely on those  
23 services. By phasing in the medical loss ratios  
24 in the individual market, brokers and insurance  
25 companies will be able to adjust to the new market

1 realities over a reasonable period of time and  
2 prevent an abrupt loss of services for Florida  
3 consumers. And, again, we're back to the need to  
4 have time to adjust our business model.

5 The fourth point I want to make is around  
6 younger, healthier consumers, and we believe that  
7 they could be -- or could have fewer choices. As  
8 in the transition periods in the new MLR  
9 requirement, we are concerned that there will be  
10 fewer health insurance options available in the  
11 individual insurance market for one of the largest  
12 segments of the uninsured population, the young  
13 invincibles.

14 There's been a lot of talk about the young  
15 invincibles. They don't think anything's going to  
16 happen. The only thing they're worried about is  
17 the bus (sic), and I think their parents really  
18 worry about that more than they do. So we have a  
19 lot of young invincibles that are uninsured.  
20 They're going to come into the market, and we're  
21 just hopeful that something happens that will  
22 allow insurers to continue to target on that  
23 market for product development and brokers to  
24 continue to serve that market.

25 And we're concerned because at the lower

1 commissions required to meet the new MLR rules,  
2 brokers may be unable to offer these products to  
3 customers, and therefore, leave young, healthier  
4 consumers with fewer health insurance  
5 alternatives.

6 So what do I mean by that? The young  
7 invincible premiums are much lower. You know,  
8 someone who is 22 is going to have a much lower  
9 premium than someone who is 50. So on a  
10 percentage basis, there are fewer dollars. It  
11 becomes very challenging with those fewer dollars  
12 for brokers to focus on serving the needs of the  
13 young invincibles at a time when so many are going  
14 to be entering the system, which is something we  
15 want and we desire.

16 In conclusion, we believe that implementing  
17 the medical loss ratio requirements outlined in  
18 the new reform legislation without an appropriate  
19 transition period to adjust business models could  
20 unintentionally destabilize the Florida individual  
21 health insurance market.

22 We appreciate the time and attention you've  
23 given to this issue. We think it's important and  
24 we thank you for the opportunity to appear before  
25 you today. And I'll take questions and try to

1 answer them.

2 COMMISSIONER MCCARTY: Thank you again. I  
3 appreciate you going into detail about the  
4 distribution channel, particularly as we're  
5 bringing in 30 to 50 million as envisioned by the  
6 federal law of new players in the system, how do  
7 we -- how could we effectively or efficiently get  
8 them into the system without having an agent  
9 force. And I appreciate your testimony with  
10 regard to that. Could you tell me how many  
11 members -- I mean, how many policyholders you have  
12 in Florida?

13 MR. CORNE: You know, I heard that question a  
14 minute ago, and I thought I didn't bring that note  
15 so --

16 DEPUTY COMMISSIONER SENKEWICZ: 118,684.

17 MR. CORNE: You know, one of the things we  
18 do, we talk about the amount of business with  
19 regard to the individual market, and we like to  
20 say that Tampa is our largest state. So we write  
21 a considerable amount of business in Florida.

22 COMMISSIONER MCCARTY: I know you do. And  
23 you're an important player in the individual  
24 market particularly, like you said, addressing the  
25 gaps in the marketplace and the people that are

1 going from job to job, and that's an important  
2 coverage, as well as the young invincibles.

3 And as we're looking at the legislation, and  
4 I know it's intended to get more people in, but I  
5 think one of the unintended consequences is the  
6 costs for these young invincibles are going to go  
7 up substantially, which kind of defeats the  
8 purpose of trying to get them into the market.

9 They already think they don't want the  
10 coverage, and it's just making it more challenging  
11 for them to do so. And then on top of that, the  
12 disruption of the distribution channel, which you  
13 felt was counterintuitive to getting people into  
14 the marketplace.

15 MR. CORNE: Well, it does. Fewer  
16 storefronts, I think it's going to be very  
17 challenging for those who want to come in,  
18 particularly those that are buying for the first  
19 time. Where are they going to go? How are they  
20 going to navigate the system? How are they going  
21 to learn? How are they going to identify all the  
22 various options that are available to them? So I  
23 think it's going to be very challenging for them.

24 COMMISSIONER MCCARTY: Yes, I think you're  
25 right. Any other questions? Mr. Jackson.

1           MR. JACKSON: Thank you, commissioner.  
2           Michael, if you can, can you help me to understand  
3           how much time you think is needed for purposes of  
4           complying with the MLR requirements in terms of  
5           transition?

6           MR. CORNE: Well, I'm not an actuary so -- I  
7           don't pretend to be. But I think the thinking is  
8           that a transition into 14 where we would have a  
9           three-month period -- or a three-year period where  
10          we can then move forward with a rolling MLR would  
11          work and give us time to adjust our business model  
12          sufficiently.

13          COMMISSIONER MCCARTY: Ms. Senkewicz.

14          DEPUTY COMMISSIONER SENKEWICZ: Thank you.  
15          In that regard, actually, that raises a question.  
16          Do you think the transition period should be, just  
17          say, lower the number to 70 percent? I believe  
18          now in the individual market for an insurance  
19          carrier as opposed to an HMO, it's 65 percent.  
20          But if we had to transition for three years at 70  
21          and then it goes to 80, or do you think it's  
22          better to have some kind of rolling transition, 70  
23          to 72 to 78 or something like that?

24          MR. CORNE: Well, again, I'm not an actuary,  
25          but I do like to think about change in terms of

1 taking steps at a time to adjust our business  
2 model. Again, that's -- you know, it's a process.  
3 And we're innovative people. We will make it  
4 work. We will figure this out. We will figure  
5 out how to adjust our business model, but I think  
6 we would be better off with handling this over  
7 time, yes.

8 DEPUTY COMMISSIONER SENKEWICZ: Do you have  
9 something?

10 COMMISSIONER MCCARTY: Yes.

11 DEPUTY COMMISSIONER SENKEWICZ: Do you?

12 COMMISSIONER MCCARTY: Yes. But I'll wait  
13 until you're through.

14 DEPUTY COMMISSIONER SENKEWICZ: Thank you.  
15 Actually, I had one other question, Mike. With  
16 respect to your business and the individual -- the  
17 individually-underwritten out-of-state group  
18 market, my understanding is the individual market,  
19 in general, and perhaps your niche of the business  
20 in particular, has, I don't know if it's  
21 significant turnover, but how often do people stay  
22 in your plan duration-wise? And can you kind of  
23 explain to us how that has an effect either on  
24 volatility or, you know, the difficulties in terms  
25 of the disruption in the marketplace if you adjust

1 the MLR.

2 MR. CORNE: There is a lot of transition, and  
3 there are a couple of different types of  
4 transition. Generally, those that come to us that  
5 need individual health insurance are buying it  
6 because they don't have employer-sponsored  
7 coverage. If they had employer-sponsored coverage  
8 with the employers chipping in, they would surely  
9 take that coverage.

10 So, generally, what has happened is they've  
11 either lost their job, and there's a lot of that  
12 right now, or they've decided that they're going  
13 to be -- you know, get into the entrepreneurial  
14 world and become self-employed.

15 So they come in, but a lot of times, those  
16 that have lost their job, subsequently find a job  
17 and so they don't keep our insurance for that  
18 long. So we have a lot of turnover each year.  
19 And that becomes a significant challenge as well  
20 because we're collecting that premium, and if we  
21 only collect six months of premium for someone  
22 that we've just underwritten, chances are there  
23 aren't claims expenses to go with that. You know,  
24 so it's challenging. Did I answer your question?

25 DEPUTY COMMISSIONER SENKEWICZ: Yes. Thank

1           you.

2           COMMISSIONER MCCARTY:   Actually, Ms.  
3           Senkewicz raised an issue, and I'd like to follow  
4           up.  In my visit with Washington in Washington  
5           this week, I had an opportunity to speak with some  
6           of the HHS officials, and specifically, I asked  
7           them questions regarding what would they like to  
8           see in terms of evidence to demonstrate to their  
9           satisfaction what may destabilize the market.  And  
10          what Mr. Angoff suggested is give us what the  
11          phase-in would be.

12          And I'm not putting you on the spot today,  
13          and I'd certainly ask other insurance companies  
14          that are doing business in Florida, if it's 60 or  
15          65 today, would it need to be like 72, 75?  How  
16          would we see that implementation and some  
17          suggestions?

18          You talked about altering your business  
19          model, and that's what I was talking with them  
20          about too.  We have business models, varying  
21          business models, not one size fits all.  We have  
22          different business models in the Florida  
23          marketplace.  We are in some ways blessed to have  
24          a very competitive market, but in that complexity  
25          of that marketplace is different business models.

1           And maybe you could suggest how with respect  
2 to your business model how that phase-in would  
3 work. If you could do that within the next week  
4 or so and augment the record, I would be much  
5 obliged.

6           MR. CORNE: I can give you a thought on that  
7 now, if that would be helpful?

8           COMMISSIONER MCCARTY: Certainly. I just  
9 didn't want to put you on the spot.

10          MR. CORNE: Well, so without getting into  
11 specific numbers, conceptionally, and I'm not  
12 talking about us, per se, but more the market, so,  
13 you know, like I said when I began, my focus --  
14 the focus of my testimony is on the market.

15          So more broadly thinking about it and the  
16 market and the carriers that are in the market,  
17 remembering that they have priced their products  
18 and they sold their products and that business is  
19 all water under the bridge for 2010, it would not  
20 be unreasonable for the 2011 standards to be in  
21 line with what they thought those standards would  
22 be when they priced and sold those products.

23          Now, that doesn't mean that that has to be  
24 the number. You know, that's -- certainly, you  
25 would make that decision better than anyone else.

1 You and your staff are very informed, and we think  
2 that lies with you, but it would not be  
3 unreasonable, I would say.

4 COMMISSIONER MCCARTY: No, I would agree. It  
5 does seem very reasonable, in fact. Any other  
6 questions? Thanks.

7 MR. PRENTISS: Benjamin Cutler.

8 COMMISSIONER MCCARTY: Good morning, Mr.  
9 Cutler.

10 MR. CUTLER: How are you? Thanks.

11 COMMISSIONER MCCARTY: Very well, sir. Thank  
12 you.

13 (WHEREUPON, Mr. Cutler comes forward and is  
14 placed under oath by the court reporter.)

15 WHEREUPON,

16 BENJAMIN CUTLER

17 having been first duly sworn to tell the truth,  
18 testified as follows:

19 MR. CUTLER: Commissioner, deputy  
20 commissioner, advisory board, I appreciate the  
21 opportunity hopefully to provide what will be some  
22 constructive input to your deliberations regarding  
23 the medical loss ratio implementation in Florida.

24 Just a bit of background, I've been in the  
25 insurance for 43 years. I have a fair amount of

1 experience in the Florida marketplace, having  
2 served as president and chief executive officer  
3 (indiscernible) headquartered in Miami from 1998  
4 to 2002 and then chairman from 2002 to 2004.

5 I also served in the past as vice-chair and  
6 chairman of the Health Insurance Association of  
7 America. We merged that association with  
8 America's Association of Health Plans in 2002 to  
9 form what is now known as AHIP. I was the first  
10 chairman of that organization in 2002 and three.

11 For the past several years, I have been a key  
12 member of the individual market task force and the  
13 executive task force of America's Health Insurance  
14 Plans, singularly focused on health care reform.  
15 And we've had several opportunities to provide  
16 numerous recommendations in regards to specific  
17 health care reform issues, not the least of which  
18 regards medical loss ratio.

19 I'm particularly interested in Florida's  
20 perspective on this issue as Florida is far and  
21 away my company's largest state. Today, I serve  
22 as chairman and chief executive officer of U.S.  
23 Health Group, and our two insurance affiliates are  
24 Freedom Life Insurance Company and National  
25 Foundation Life.

1           We cover over 10,000 Florida residents, the  
2 majority of which are major medical accounts and  
3 that amounts to 24 percent of our in-force as well  
4 as 24 percent of our new business, so, obviously,  
5 we have a significant stake in Florida.

6           And while I understand that we're a very  
7 small insurer, I believe my comments on how the  
8 PPACA medical loss ratios will impact our  
9 policyholders in Florida, I think it also applies  
10 to a significant percentage of the roughly 750,000  
11 other individual policyholders in the State of  
12 Florida, and I think that's been supported by the  
13 testimony of my industry colleagues.

14           Now, I've handed out a document. I would  
15 prefer that -- it's a seven-page document -- not  
16 to have to read it. I will if that is required,  
17 but I would prefer just to highlight in the  
18 interest of brevity.

19           COMMISSIONER MCCARTY: We'll enter the entire  
20 document.

21           MR. CUTLER: Thank you. I appreciate that.  
22 Again, I have a couple of key points I'd like to  
23 make. First, as already has been alluded to,  
24 prior to March 23rd, PPACA's effective date,  
25 Freedom, as well as many other health plans issued

1 health insurance coverages under existing rate and  
2 benefit regulations approved by our Florida  
3 regulators.

4 Relying on this authority, we entered into  
5 numerous collateral contracts with third parties  
6 including, as it's been alluded to, multi-year  
7 producer compensation agreements. Depending on  
8 the MLR implementation, we could face numerous  
9 breach of contract claims, and, unfortunately, I  
10 can cite a specific instance very recently in  
11 Florida where we were operating as a carrier in  
12 accordance with Florida insurance regulations, but  
13 lost a multimillion dollar judgement in federal  
14 court. The Court argued that the Florida  
15 regulatory authority did not apply. That was a  
16 painful day for me.

17 Second, we are nearing the end of the third  
18 quarter and have yet to receive comprehensive  
19 regulations which are set to go into effect in 90  
20 days. I'm sure this assemblage can appreciate  
21 that this is a woefully inadequate time to  
22 properly address the myriad of implementation  
23 complexities that companies face with these new  
24 MLR regulations; and in our case, having to deal  
25 with that in 35 states will be problematic.

1           Third, as was discussed, there are  
2           substantive differences between the small group  
3           market and the individual market. The principal  
4           differences include field compensation,  
5           underwriting and issue costs, as well as policy  
6           administrative costs. In our opinion, to apply  
7           the same medical loss ratio criteria to these two  
8           significantly different disparate lines of  
9           business is, in my mind, totally unreasonable, a  
10          perspective I think shared by many others.

11           I'd like to specifically address your  
12          question, commissioner, regarding the transition  
13          rules and what's reasonable because as was  
14          commented, first, the small group premiums,  
15          because there is no underwriting guaranteed issue,  
16          are substantially higher than individual premiums.

17           So for the next -- for this transition  
18          period, we're still going to be dealing with  
19          underwritten individual products. But come  
20          January 1st, 2014, those products are going to be  
21          combined into a risk pool merging the individual  
22          and small group markets where we will be required  
23          to have guaranteed issue.

24           Every document I've read on this suggests  
25          that come January 2014, premiums in the individual

1 market will approach small group premiums, which  
2 more than likely will be more than doubled. So 20  
3 percent for administrative costs, compensation,  
4 marketing expenses, premium tax and profits with  
5 premiums that are double what they are today  
6 creates a totally different business model than we  
7 will be involved with over the next three years.

8 So while we can think about a transition  
9 between 11 and 13, the fact of the matter is the  
10 whole world changes come 2014. And I don't know  
11 how in a transition plan, you can accommodate that  
12 phenomena. To me, that's an interesting challenge  
13 we're going to face as carriers, and I think as  
14 regulators that's a challenge you're all going to  
15 face.

16 Again, to apply an 80 percent medical loss  
17 ratio to small group and individuals during this  
18 transition period we think is unreasonable. I do  
19 think that the 65 transitioning to maybe 70 over  
20 three years, again realizing that come 2014 we're  
21 in a totally different world where 80 percent  
22 might make all the sense in the world. But that  
23 would be my position on your question. Finally --

24 COMMISSIONER MCCARTY: So having a 70 percent  
25 through 2011 through 2014, is that --

1 MR. CUTLER: That would be my recommendation  
2 to avoid disrupting the market. As was pointed  
3 out, we've got an awful lot of business in force  
4 that was written prior to PPACA. We have a number  
5 of collateral contracts, many of those are  
6 multi-year contracts.

7 I think a three-year transition plan to  
8 prepare us for 2014, which is going to, again, be  
9 a whole new world with this new micro market,  
10 would make all the sense in the world. But,  
11 again, I think there's a cliff between December  
12 31st, 2013, and January 1st, 2014, that we need to  
13 at least recognize. The world is going to change  
14 dramatically.

15 COMMISSIONER MCCARTY: Interesting you  
16 describe it as a cliff.

17 MR. CUTLER: I'm not sure I'm scaling up or  
18 scaling down. Maybe I'm rappelling off of it.  
19 All right. I'm sorry.

20 Finally, let me just say, without adequate  
21 transition rules, appropriate credibility and  
22 volatility adjustments, and in our case, because  
23 we are a small carrier, the ability to pool large  
24 claims across states, we feel will cause us to  
25 face dire business conditions.

1           If we're faced with an 80 percent medical  
2           loss ratio in 2011, I think we would have no  
3           alternative but to cancel or non-renew our Florida  
4           business. And that would not only be terribly  
5           disruptive to our current insureds, but would be  
6           devastating to our over 250 producers currently  
7           operating throughout the State of Florida.

8           And I agree with the comment made earlier. I  
9           do believe very strongly that health insurance is  
10          a consultative sale. I think it does require what  
11          I've described as a health navigator. I think  
12          with all the new entrants, it would be a travesty  
13          if we did not continue to have a vibrant  
14          capability for insurance producers and brokers to  
15          help consult with new insureds about how to make  
16          the right decisions around their families' health  
17          care choice.

18          COMMISSIONER MCCARTY: Couldn't agree with  
19          you more.

20          MR. CUTLER: Again, thank you very much,  
21          commissioner and deputy commissioner, for the  
22          opportunity. I'd be happy to answer any  
23          questions.

24          COMMISSIONER MCCARTY: So you believe that  
25          companies will cancel or non-renew without some

1 relief?

2 MR. CUTLER: From a pure solvency  
3 perspective, commissioner, I would have no choice,  
4 and I think a lot of other small carriers -- I  
5 agree very strongly that this 80 percent medical  
6 loss ratio would create a huge barrier to entry.  
7 I can't imagine how -- why any investor would want  
8 to put capital in a business with the regulations  
9 that are proposed by PPACA. I think it would be a  
10 total barrier to entry.

11 MS. GOODHUE: May I ask a question?

12 COMMISSIONER MCCARTY: Absolutely. Please  
13 do.

14 MS. GOODHUE: Okay. Another clarifying  
15 question for my own understanding. So I think you  
16 offer a unique perspective because if it's true  
17 you sell insurance across -- or you have business  
18 in other states?

19 MR. CUTLER: Yes, I do.

20 MS. GOODHUE: Okay.

21 MR. CUTLER: Florida is our largest.

22 MS. GOODHUE: Florida is your largest. So  
23 how would, if there's a transition period in  
24 Florida but not in other states, how would that  
25 impact your business in other states? So I

1 think -- I mean, you mentioned that you might have  
2 to not sell policies in Florida. I'm trying to  
3 understand how Florida is different than other  
4 states.

5 MR. CUTLER: Well, obviously, I think as  
6 you're aware, there are proposed credibility  
7 adjustments. We have probably 15 states where we  
8 don't have significant enough blocks of business  
9 that would be subject to rebate because they're  
10 not credible. In those states that do have -- we  
11 have about 15 states where we have partially  
12 credible blocks of business, and any that we were  
13 forced into 80 percent, again, we would be  
14 required from a solvency perspective to non-renew  
15 or cancel.

16 MS. GOODHUE: Okay. Thank you.

17 DEPUTY COMMISSIONER SENKEWICZ: Just to  
18 clarify, and part of the reason for that, sir, if  
19 I understood you correctly, is because you have  
20 entered into many multi-year collateral contracts  
21 as you indicated, including the broker  
22 compensation contracts, so your choice is going to  
23 be have it -- what else can you -- what else could  
24 be lowered in terms of administrative costs  
25 because you have these collateral contracts?

1           Essentially, you're just stuck between a rock and  
2           a hard place, and that's why you would be --

3           MR. CUTLER:    Pretty much.

4           DEPUTY COMMISSIONER SENKEWICZ:  -- forced to  
5           exit or non-renew because it's not workable for  
6           you.

7           MR. CUTLER:    That's correct.

8           DEPUTY COMMISSIONER SENKEWICZ:  Thank you.

9           MR. CUTLER:    And if we -- again, if we  
10          attempted to go in and modify those multi-year  
11          contractual agreements --

12          DEPUTY COMMISSIONER SENKEWICZ:  Right.

13          MR. CUTLER:    -- we would be exposed to, I  
14          think, significant litigation.  I might mention as  
15          an example, this particular case in Florida was an  
16          eight-year duration litigation.  At the end of the  
17          day, the judgement was for \$50,000 in damages.  
18          The attorneys' fees awarded were 2.8 million.

19          COMMISSIONER MCCARTY:  That brings up a whole  
20          different issue for another hearing.

21          MR. CUTLER:    Right.  Thank you.

22          COMMISSIONER MCCARTY:  Thank you.

23          MR. PRENTISS:   Thank you.

24          COMMISSIONER MCCARTY:  Thank you very much  
25          for your testimony.  I appreciate it.

1 MR. PRENTISS: Julian Lago.

2 (WHEREUPON, Mr. Julian Lago comes forward and  
3 is placed under oath by the court reporter.)

4 WHEREUPON,

5 JULIAN LAGO

6 having been first duly sworn to tell the truth,

7 testified as follows:

8 COMMISSIONER MCCARTY: Welcome, Mr. Lago.

9 MR. LAGO: Thank you. Again, I'd like to  
10 thank Commissioner McCarty and Deputy Commissioner  
11 Senkewicz and the board for the opportunity to  
12 speak. I had the opportunity to address the board  
13 at their May hearing and brought the perspective  
14 of the agent.

15 I serve currently as the immediate past  
16 president for the State of Florida, Florida  
17 Association of Health Underwriters and have kind  
18 of returned more to private practice. And one of  
19 the interesting perspectives I wanted to address  
20 was the role of the agent and the concern that we  
21 have, rightly so, with the implementation of the  
22 minimum loss ratio and the potential impact on the  
23 consumer.

24 With the loss of agents and the role that we  
25 play, I feel that it would be critical that that

1 continue to be an intricate part of the  
2 distribution system. Almost all the carriers that  
3 have addressed and presented to the board have  
4 expressed the important role that agents play, and  
5 I think that that cannot be lost in the  
6 implementation of minimum loss ratios.

7 Personally, I can discuss several issues and  
8 several ways that we, as agents, not only service  
9 our clients, but bring in a real perspective. I  
10 think insurance really does not lend itself to be  
11 a commodity product as has been discussed in other  
12 issues similar to the exchanges and so on of the  
13 purchase of airline tickets, even the purchase of  
14 tires and so on.

15 If you look at insurance as a product and  
16 service, it goes well beyond just a selection from  
17 a price perspective. If you would indulge me in  
18 the comparison, one of the products that as  
19 consumers we buy are tires for our vehicles. And  
20 we certainly don't drive up to the window, grab  
21 the tires and drive off. We have these tires  
22 balanced, put on our vehicles. And as a father of  
23 four, I certainly don't encourage my wife to drive  
24 up and purchase the least expensive set of tires  
25 and have my family drive off in that. We look at

1 all those things.

2 Even with that said, throughout the year, the  
3 safety factor if these tires are not properly  
4 installed and put in place, now you run the risk  
5 of having a product that's defective. With health  
6 care, that product has to match the financial  
7 capabilities of the consumer that's purchasing  
8 that product from the deductible, from their risk  
9 tolerance perspective.

10 And health care, particularly in Florida, is  
11 regional. So in many cases, the agent brings to  
12 the table the knowledge of the appropriate  
13 physicians that participate in networks and so on,  
14 which is invaluable in the selection of health  
15 care. It does not just directly relate to a price  
16 purchase. It has a larger perspective there.

17 So my feeling is that certainly from a  
18 professional agent, which I've been for over 24  
19 years, I see daily clients -- in fact, as health  
20 care reform has evolved and has started to be  
21 implemented, we saw the State of Florida select  
22 to, on the high risk pool, go along with the  
23 federal program. My phone started ringing  
24 immediately.

25 And as the immediate past president, I had

1 the opportunity to travel throughout the State of  
2 Florida and sit and in many cases speak with  
3 literally hundreds of agents throughout the state,  
4 and their stories are very similar.

5 Clients are concerned, and all of a sudden,  
6 they receive notification via newspaper article or  
7 some other media that guarantee issue is  
8 available, but it's the role of the agent now to  
9 let them know that there are certain criterias.  
10 The requirements of being without prior coverage  
11 for six months and so on, that was all lost. All  
12 they saw was that this was opened up.

13 Without the use of agents to even assist in  
14 that, I think currently, and I may be mistaken,  
15 but I believe the numbers have not been  
16 significant in that enrollment process because  
17 there is no method for an agent to really  
18 participate and be involved.

19 Certainly, one can do their own taxes, and  
20 many people choose to do that. But as you  
21 purchase and have a complicated process, you bring  
22 the expert in to help you make sure that you cross  
23 the t's and dot the i's, and that you take the  
24 proper adjustment. Health insurance is a very  
25 complex issue, and I don't need to certainly

1 educate the board on that process. But we feel  
2 that it is critical to have that.

3 I will share a personal story. As an agent,  
4 my office -- I am the employee benefit manager for  
5 a property casualty agency. We have over 115  
6 employees focusing predominately on employee  
7 benefit -- I'm sorry, in property and casualty.  
8 My team consists of about 15 individuals that do  
9 employee benefits for that class of business.  
10 We're located predominately in South Florida, in  
11 Delray Beach, Boca Raton, Palm Beach Gardens,  
12 Stuart and so on.

13 We find we have an older, more mature  
14 marketplace. In many cases, we spend a lot of  
15 time assisting our group clients that reach age 65  
16 migrate into the purchase and selection of a  
17 Medicare supplement product. In that selection, I  
18 can tell you just in the last six months, we've  
19 had numerous people -- and it's kind of a  
20 repetitive story -- persons turn 64 years old,  
21 64-and-a-half, and they get a bombardment of  
22 information.

23 And certainly they have the capability to go  
24 online and go through an exchange and find out all  
25 the information that's there. But the reality is

1 that they appear at our office. They call for an  
2 appointment, and they'll show up in many cases  
3 with a shopping bag full of all this information  
4 that they received trying to decipher Medicare  
5 Supplement to Medicare Advantage, to do I stay on  
6 my employer plan and was my employer plan's  
7 prescription benefit in compliance and do I have a  
8 problem.

9 And we, as agents, will take the time to  
10 obviously decipher that information for our  
11 clients and walk them through that process of  
12 enrolling and making sure that for that  
13 individual -- and there is no cookie-cutter  
14 decision -- that individual makes an economic  
15 decision based on their risk tolerance, their  
16 preference, whether it's a Medicare Advantage  
17 plan, whether a supplement makes sense and so on.  
18 That repeats itself over and over on a daily  
19 basis.

20 I can't overemphasize that health care  
21 benefits cannot be looked at as a commodity that  
22 can be done on the exchange. It's been tried in  
23 other areas, even with life insurance and so on.  
24 Many clients will go online and get a quote but  
25 still come back to the agent for the expertise of

1 the appropriate purchase. We feel that through  
2 medical underwriting has been discussed and just  
3 the implementation phase, it is critical that we  
4 continue to see that.

5 One final point, as in Florida, the reality  
6 of what Florida business is, as much as we  
7 understand there's large employers like state  
8 municipalities and federal programs and large  
9 employers like Walt Disney, the reality of Florida  
10 business is the backbone is small business.

11 Small businesses are the day-to-day, you  
12 know, backbone of our economy. Those businesses  
13 look to the individual agent, not only to help  
14 them through that process, but to migrate into an  
15 HR role. Meaning that complying with all the  
16 requirements and so on is critical there.

17 And I fear that as that marketplace is driven  
18 into the exchanges, and there's not enough role  
19 there for the carriers to properly compensate the  
20 agents, then you're going to have a vacuum there.  
21 And, ultimately, these questions and these issues  
22 revert back to the state. And with all due  
23 respect, I don't know that the state, number one,  
24 has the manpower and so on to be able to provide  
25 the role that agents do.

1           So, again, I thank you for the opportunity,  
2           and I certainly welcome the opportunity to address  
3           the board and answer any questions.

4           COMMISSIONER MCCARTY: Thank you very much  
5           for your testimony, and we appreciate you coming  
6           today and your previous testimony and thank you  
7           again for crystalizing the issue in terms of  
8           real-life examples of people going throughout  
9           their lives and businesses having to make those  
10          choices and the valuable services that agents  
11          provide in navigating a very difficult system.

12          I've heard in one committee I was up visiting  
13          one time and one of the people said, well, you  
14          know, it's just kind of like going online to buy  
15          an airline ticket. Well, you know, buying an  
16          airline ticket online is certainly vastly  
17          different than making health care choices for your  
18          family and business, and we certainly appreciate  
19          you highlighting the important role of an agent.

20          I do want to -- for the record and for the  
21          benefit of this testimony today, we're looking at  
22          focusing on the destabilization of the  
23          marketplace. And, in your opinion, with the  
24          failure to have some alleviation from the  
25          implementation of the loss ratio, 80 percent in

1 the individual market, would that -- do you  
2 believe that would destabilize Florida's market,  
3 and if so, in what way?

4 MR. LAGO: I certainly do believe it would.  
5 You know, one of the important factors is the  
6 entrance of new carriers into the marketplace.  
7 This gives the agent the ability to introduce a  
8 carrier, a new set of products, potentially new  
9 marketplaces, in South Florida in particular.

10 Certainly, you have network-driven products  
11 that are appropriate. They're very basic either  
12 in an HMO model or a PPO model. And our concern  
13 is that as was stated before, the implementation  
14 of the MLR immediately really opens the door for  
15 some of these carriers to depart the marketplace  
16 because their business models are dramatically  
17 interrupted.

18 Again, we're receiving those products,  
19 selling that plan, and all of a sudden, a  
20 properly-underwritten product that's been placed,  
21 that has the ability to allow the carrier to  
22 maintain a balance and a profitable block of  
23 business is completely disrupted. And we're going  
24 to see an exit of carriers in that marketplace.  
25 That requires you, the agent, to have to go back

1 in there and now try to identify in a shrinking  
2 marketplace a product that can replace that.

3 In the individual product in particular,  
4 you're medically underwriting these individuals,  
5 and that is not always an easy task. Even under a  
6 small group, just the transition from one to the  
7 other is going to cause tremendous disruption  
8 there.

9 So I feel personally that not having a  
10 phase-in will cause disruption, not only of new  
11 carriers coming into the marketplace, but an exit  
12 of some, you know, well-established stable  
13 carriers.

14 COMMISSIONER MCCARTY: Ms. Senkewicz.

15 DEPUTY COMMISSIONER SENKEWICZ: Thank you,  
16 commissioner. Actually, to carry that one step  
17 further, let me hearken back to my logic class.  
18 If under the present business model, broker/agent  
19 compensation goes on the administrative expense  
20 side, so absent a change in that, one way, and an  
21 obvious way for carriers to reduce their  
22 administrative costs would be to lower agent  
23 compensation. You know, if this, then that.

24 Do you believe that if that occurred, isn't  
25 there a point at some point below which certain

1 agents would just have to say I can't do this  
2 anymore; I'm going to have to find something else  
3 to do for work to support my family?

4 MR. LAGO: Absolutely. I find as I travel  
5 throughout the state, I have a number of agents  
6 that approach me now that the sale of health  
7 insurance is a very time-consuming product. It  
8 takes time away from other products that actually  
9 pay a higher compensation. In many cases, we  
10 would call it a lost leader, if you would, because  
11 it brings us entry to a client.

12 But the reality is that with that loss of  
13 that agent role there and as the commissions are  
14 further reduced, literally, you have thousands of,  
15 you know, small business individuals that would be  
16 placed out of business in the State of Florida  
17 because the compensation that's there, that's the  
18 entry level to sell other products. And if that's  
19 eliminated, basically, there's going to be an exit  
20 of the insurance industry, the professional agent  
21 in that industry.

22 And I think it's important that we also  
23 reflect back and look at other models that have  
24 been tried. In reality, on the property/casualty  
25 side, a lot of auto market products have been sold

1 direct and so on. And now you start seeing signs  
2 where, "comes with a free agent" advertising and  
3 even the larger are bringing back the retail  
4 establishment where a client can walk in and  
5 purchase a product there.

6 And that's important because after the sale,  
7 there's a lot of servicing issue, and our concern  
8 if the agent's out of the equation -- and we  
9 mentioned the individual products, in particular,  
10 have heavy turnover. So that process re-occurs  
11 itself sometimes in an 18-month period once,  
12 twice, three times. So it's not a onetime sale,  
13 put it on the shelf and forget about it. That  
14 agent's role is repetitive, and it's necessary to  
15 maintain it there.

16 COMMISSIONER MCCARTY: Just to follow up on  
17 Mary Beth's logic class, so just take it from  
18 there: So if we have -- if we move it on the  
19 other side of the ledger and insurance companies  
20 reduce it, it reduces commission; it reduces  
21 agents; it reduces, I would assume, reduces access  
22 to products?

23 MR. LAGO: Absolutely. I mean, that is the  
24 ultimate loss. The choice of products are gone.  
25 You have less selection. And the reality is that,

1 you know, we deal with a consumer that comes to us  
2 and pays attention for a limited period of time.  
3 We educate them through all our crazy vocabulary,  
4 copayments and coinsurance and so on. And as they  
5 understand this process, to think that there's not  
6 sufficient dollars there for someone to educate  
7 them properly in that purchase and selection,  
8 we're talking about something that impacts our  
9 family.

10 I'm the father of a 14-year-old Type 1  
11 diabetic. I can tell you I purchased insurance  
12 for a number of a years. I believe and began to  
13 understand insurance when my son was diagnosed.  
14 We started to take a look at how we purchase our  
15 prescription benefits and so on. The reality of  
16 the product and the quality that we sell goes  
17 beyond a consumer product that we put on the  
18 shelf. This is something that impacts families  
19 and so on.

20 The economic ability of someone, a young  
21 person coming into the marketplace has limited  
22 resources. So you need to allow them to maximize  
23 that purchase and purchase the right product based  
24 on their needs. That is critical.

25 So my concern is as the products shrink,

1 you're going to have less selection, and that  
2 whole implementation, we may, in fact, have an  
3 opposite effect. We're concerned with the price  
4 increasing based on MLR. You're going to have  
5 just those folks that we need, the young, healthy  
6 vulnerables (sic) missing an opportunity to  
7 participate.

8 COMMISSIONER MCCARTY: And just to pursue  
9 that and this is getting a little bit off of that,  
10 in addition to the exodus in the marketplace,  
11 isn't there a risk that without the benefit of an  
12 agent, that we won't get a very good mix of  
13 decisions in terms of the product with the  
14 appropriate -- I mean, the person with the  
15 appropriate product?

16 MR. LAGO: Absolutely. At the end of the  
17 day, the tragedy really is the consumer that ends  
18 up with a product that's not financially sound.  
19 They purchase based on price; they realize that it  
20 has a high deductible; and it just doesn't meet  
21 their expectation, or even worse, a product that  
22 doesn't have the proper match.

23 Again, health care is purchased on a regional  
24 basis. If the doctors that you're trying to use  
25 and the facilities that you use, or, in fact, the

1 type of access you need is not there and you've  
2 made the wrong purchase, that product is really  
3 disastrous for that family. They spend the  
4 dollars and are not getting what they need.

5 So our concern is if you shrink the product  
6 portfolio and you're making the wrong decisions,  
7 you need that role of that agent to help and  
8 assist in that process.

9 COMMISSIONER MCCARTY: Thank you. Ms.  
10 Galleta?

11 MS. GALLETA: And just to elaborate on that,  
12 that role is an ongoing role. The purchase or  
13 acquisition of an insurance product by a young  
14 person isn't necessarily what they'll need for the  
15 rest of their lives. And so developing a  
16 relationship with an insurance professional where  
17 you don't know the questions to ask, but they know  
18 the changes that are happening in your life, keeps  
19 you properly insured and gives you access to  
20 things that you may not know exist that you need.

21 COMMISSIONER MCCARTY: And like when your  
22 status changes over time, you get married, start a  
23 family, other additional products or additional  
24 amendments that need to be made to the products  
25 that you have, you can just put that all in the

1 computer, right?

2 MR. LAGO: Well, the concern is that, again,  
3 what you're seeing on the computer is an outline  
4 of coverage, and you're seeing a price sheet. And  
5 that doesn't necessarily transcend into your true  
6 needs. We could all go online and say I'm buying  
7 a set of tires. But the reality is, does it fit  
8 my vehicle or is it the right vehicle? Is it put  
9 on and is it balanced? Am I going back on a  
10 regular basis and making sure I rotate my tires?

11 And that's -- you know, and I apologize for  
12 the analogy, but the reality is that that role has  
13 to be -- it's ongoing. You just don't go and  
14 purchase a product and set it on and then drive  
15 down the road. You have to maintain it and make  
16 sure that it continues to fit the needs of that  
17 family.

18 We talked about transition. Many, many cases  
19 in Florida, because of the economy, people are  
20 losing their jobs and are looking for a purchase  
21 of individual products. And then they try to  
22 enter, in maybe an entrepreneurial spirit, enter  
23 that (indiscernible) so now you're migrating from  
24 an individual product into the group product, so  
25 there is certainly a transition. And it's a whole

1 different type of purchase. They have to  
2 understand that and the dynamics that come along  
3 with them.

4 COMMISSIONER MCCARTY: As your life  
5 situations change, then so do your needs for  
6 insurance products.

7 MR. LAGO: Absolutely.

8 COMMISSIONER MCCARTY: And the agent plays a  
9 critical role in that.

10 MR. LAGO: Thank you very much.

11 COMMISSIONER MCCARTY: Thank you very much.  
12 Again, I appreciate your time.

13 MR. PRENTISS: Thank you, Mr. Lago. And now  
14 we're going to turn the control of the hearing to  
15 the commission and close out the evidentiary  
16 hearing part of the meeting.

17 COMMISSIONER MCCARTY: I want to again thank  
18 our participants today for your testimony. I  
19 think it's very valuable. We're at a very  
20 critical crossroads in this deliberation of this  
21 process as the testimony has been put out today.  
22 These decisions with regard to how the price of  
23 products were made last year, and we're rapidly  
24 approaching a year where we're going to be  
25 applying rebates if you don't meet that loss

1 ratio.

2 And I think it's very critically important  
3 that we take this opportunity to collect  
4 information that I think would be helpful in  
5 assisting the HHS, the secretary of the HHS, in  
6 determining whether or not the application of the  
7 standard applying in 2011 will be destabilizing to  
8 our marketplace, and I appreciate the testimony  
9 with regard to that issue today.

10 That closes our evidentiary hearing part, and  
11 I would like to leave the record open for  
12 additional comments or affidavits to be supporting  
13 the efforts that we're making with regard to the  
14 determination of the facts that we're hearing  
15 today. We'll keep the record open until Friday,  
16 October 8th, close of business at 5:00.

17 We invite the participants today, as well  
18 other carriers for insurance agents or those  
19 affected in the marketplace to provide further  
20 evidence of potential destabilization of the  
21 individual market for application or  
22 implementation of the loss ratio.

23 Having said that, that concludes it. I would  
24 certainly open up the floor for anyone in the  
25 public who would like to make any testimony today.

(WHEREUPON, the evidentiary portion of the  
public hearing was concluded.)

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STATE OF FLORIDA  
COUNTY OF LEON

I, Tracy A. Lefebvre, Court Reporter and Notary Public for the State of Florida at Large, do hereby certify that I was authorized to and did stenographically report the foregoing proceedings; and that the transcript is a true record of the testimony given by the witnesses and the proceedings had.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in this action.

TRACY A. LEFEBVRE  
Freelance Court Reporter

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