



June 10, 2011

The Honorable Kathleen Sebelius  
Secretary  
Department of Health and Human Services  
Office of Consumer Information and Insurance Oversight  
ATTN: MLR Division  
Room 737F  
200 Independence Avenue, SW  
Washington, DC 20201

**RE: Kentucky Request for an Adjustment of the Medical Loss Ratio Standard**

Dear Secretary Sebelius:

Kentucky Voices for Health respectfully submits the following comments to the Department of Health and Human Services (HHS), Office of Consumer Information and Insurance Oversight (OCIO) in response to the February 16, 2011 request from the Kentucky Department of Insurance for an adjustment of the medical loss ratio standard in the Affordable Care Act. Kentucky's waiver request was deemed complete by CMS in a letter dated May 31, 2011.

Kentucky Voices for Health is a broad coalition of nearly 150 organizations working to improve Kentuckians' health and health care coverage. The coalition's leadership team is composed of representatives from AARP Kentucky, Advocacy Action Network, American Cancer Society, American Heart Association, American Lung Association, Catholic Conference of Kentucky, Covering Kentucky Kids and Families, Kentucky Council of Churches, Kentucky Equal Justice Center, the Kentucky Injury Prevention and Research Center, and Kentucky Youth Advocates. Kentucky Voices for Health receives grant funding from the Public Welfare Foundation through the Foundation for a Healthy Kentucky.

Starting this year, the Patient Protection and Affordable Care Act (ACA) requires insurers to spend a reasonable share of premium dollars on medical care and quality improvement efforts. Insurers that sell health plans to individuals and families in the "individual market" must spend at least 80 percent of the premium dollars they collect on medical care and quality improvement. If insurers do not meet these requirements, they will have to refund the excess to policyholders in the form of rebates. With an estimated 150,000 Kentuckians in the individual market, this new requirement is extremely important to hold health insurers accountable and make sure the money they spend on health insurance actually goes to pay for health services, as opposed to administration, marketing, and profits.

Essentially, Kentucky's pending request for an adjustment of the medical loss ratio standard in the individual market argues the market is fragile for a variety of reasons and would phase-in the new medical loss ratio by increasing Kentucky's current 60 percent ratio by five percent per year until it reaches 80 percent in 2014. While this phase-in approach appears reasonable given the fact that Kentucky's individual market is dominated by one insurer (with 85 percent of the market) and the other insurers cover a limited number of policyholders, there are several points raised in the waiver request that warrant comment.

Kentucky's waiver request is based to a significant degree on the state's experience with health insurance reforms in the 1990s. In 1994, the Kentucky General Assembly enacted HB 250 which contained a number of health insurance reforms that became effective on July 15, 1995. These reforms included standardization of health plans (insurers were limited to five plan models with varying levels of co-pays and deductibles in each model), a limit on pre-existing condition exclusions, a guaranteed issue requirement, and a requirement that health plans be subject to modified community rating (which eliminated medical underwriting). The legislation also included the creation of a health purchasing alliance, which served as a health insurance brokerage for all state employees, schools districts, state universities and local government.

As materials submitted with Kentucky's waiver request indicate, there was disruption in Kentucky's health insurance market as a result of these reforms. Over 40 carriers subsequently stopped selling individual coverage and left the Kentucky market, leaving one insurer in a dominant position. As a result, the reforms were modified by the 1996 Kentucky General Assembly and ultimately repealed in 1998. (The Kentucky General Assembly only met once every two years at the time.)

While these events are a matter of record, it is important to note that Kentucky's experience with state-level health insurance reform may not be predictive of what will happen under the Accountable Care Act. There are several significant differences between the new federal law and Kentucky's experience of 17 years ago that should be noted for the record:

- While a number of the reforms enacted by Kentucky in 1994 are also contained in the ACA, there is one critical provision that was not in Kentucky's law—a mandate that individuals obtain health coverage. Without such a mandate, young, healthy people could opt out of coverage, leaving health insurers with higher costs. This is not the case under the ACA.
- Although a number of insurers left Kentucky's individual market in the 1990s, the Kentucky Department of Insurance reported at the time that most of these carriers covered fewer than 100 policyholders. With such a small book of business, it was to the financial advantage of many carriers to simply leave the market than comply with the state law.
- Under the ACA, a health insurer will not be able to avoid compliance by leaving the state. Health insurers will be required to transform their business practices and cannot move across the state border to escape a federal law.

While Kentucky Voices for Health does not oppose the phase-in approach proposed by the Kentucky Department of Insurance, it is our view that Kentucky's experience in the 1990s is a prime example of the difficulties of state-level health insurance reform (particularly for a state with seven states on its borders) rather than a predictor of what will occur under the implementation of the ACA.

Finally, the potential for refunds to consumers under the medical loss ratio requirement highlights the need for greater transparency in health insurance rates. Consumers should have greater access, through state-maintained web sites or other means, to information that details how health insurers spend premium dollars under a particular policy. At a minimum, this information should break down, by dollar and percentage amounts, total expenditures for:

- Hospital services
- Physician services
- Pharmacy
- Other health services
- Agent Commissions
- Other administrative costs
- Profits/Executive compensation

This information should also provide key trends under the health insurance policy that would explain premium rates (utilization of services is increasing, cost of drugs and other service is up, etc.).

These comments are intended to strengthen the ACA's goals of promoting transparency in health insurance and ensuring that health premium dollars go to pay for health care and not profits and administrative costs. To achieve these goals, it is critical that the 150,000 Kentuckians in the individual market not only know how their hard earning health insurance dollars are being spent, but that they will receive an appropriate refund if their premiums are not spent in accordance with federal law.

Respectfully submitted,



Jodi Mitchell  
Executive Director  
Kentucky Voices for Health

120 Sears Avenue, Suite 212 ● Louisville, KY 40207

Phone: (502) 502-1406 ● Fax: (502) 690-3555

[www.kentuckyvoicesforhealth.org](http://www.kentuckyvoicesforhealth.org)