

# HEALTH CARE FOR AMERICA **NOW!**

The Honorable Kathleen Sebelius  
Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

October 12, 2011

Submitted Via Electronic Mail:  
[MLRAdjustments@hhs.gov](mailto:MLRAdjustments@hhs.gov)

## **Indiana Adjustment Request**

Dear Secretary Sebelius:

I am writing to oppose the Indiana Insurance Commissioner's proposal to rob millions of dollars from consumers by reducing the minimum medical-loss ratio to 65% for calendar year 2011, 68.5% for 2012, 72.5% for 2013, and 76.5% for 2014.

A health plan's medical-loss ratio (MLR) gives consumers a straightforward calculation of how their premium dollars are spent. The Affordable Care Act (ACA) sets a minimum level of spending on medical benefits and quality improvement at 80% of premium revenue in the individual and small-group markets. Congress, backed by evidence provided by the Congressional Budget Office, concluded that an 80% minimum MLR in the individual and small-group markets was attainable by efficiently-operated insurers.

Indiana's proposed starting MLR of 65% for 2011 is unreasonably low. When taking into account the various expense, premium and credibility adjustments, a 65% MLR is comparable to an actual loss ratio of 55% to 60%. Also, it is no longer possible for an insurance company to leave the Indiana market in 2011 because of the required notice to policyholders. Therefore, whatever loss ratio standard is implemented for 2011 cannot impact the individual health insurance market in Indiana for 2011. In addition, the state asks for the adjustment to extend beyond 2013; since the Secretary does not have the statutory or regulatory authority to adjust the MLR after 2013, that part of the request should be summarily dismissed.

Under current law, the state estimates that rebates of \$23.7 million would be paid to Indiana consumers for insurance purchased in 2011. Indiana declined to take all adjustments into account to arrive at an accurate rebate estimate or to estimate the amount of rebates for 2012 and 2013. The state also did not estimate the rebates lost to consumers if the MLR thresholds are adjusted as requested, but given the fact that the four largest rebates come from insurers with an MLR of at least the 65% level proposed by the Indiana Department of Insurance (IDOI), almost all of the rebates would be lost under the IDOI proposal. Indiana is therefore requesting that tens of millions of dollars requests be transferred from consumers to insurance companies at a time when insurance premiums are steadily rising and consumers' incomes are not. Finally, since the

Department apparently has no idea what rebates will be owed by Indiana insurers in 2012 or 2013, its conclusion that adjustments will be necessary for those years is not credible.

Indiana states that issuers of consumer-driven health plans will have a particular difficulty reaching the required 80% threshold. But the National Association of Insurance Commissioners (NAIC) in its MLR review proceedings did not find that consumer-driven plans warranted a lower MLR target, and instead modified credibility adjustments to account for high-deductible plans. Indiana also suggests that new entrants will have a hard time reaching this level, but the federal MLR rule makes express allowance for new entrants. 45 C.F.R. § 158.121. Moreover, the federal rule allows new issuers to accumulate contract reserves against later negative experience. 45 C.F.R. § 158.140. Most of the insurers in Indiana's non-group market do not have credible enrollments and are not subject to the rebate requirement. In all, it is not clear that the Indiana Department of Insurance fully understands the MLR rule and its effect on the individual insurance market.

Adjustments to the MLR may be granted only if "the Secretary determines that the application of such 80 percent may destabilize the individual market" in a state. PHSA § 2718(b)(1)(A)(ii). HHS regulations implementing this provision of the law provide that the Secretary may adjust the MLR standard in a state only if there is a "reasonable likelihood" that application of the requirement will cause disruption. 42 C.F.R. § 158.301. HHS regulations set out information that states must submit criteria that HHS must apply in determining whether or not to grant a state an adjustment. 42 C.F.R. § 158.321, 158.330. Indiana has failed to make the case that its individual insurance market will be destabilized without the adjustment it requests.

**Indiana has offered no evidence that any insurers have exited the state or will exit the state or cease offering coverage absent an adjustment.**

Indiana provides no evidence that insurers have left the Indiana market due to the application of a minimum MLR. Indiana's request is largely based on the fact that five of the 60 issuers in the Indiana non-group market stopped writing new policies in 2010 and 2011. Indiana provided the notifications of withdrawal filed by these issuers. None mentioned the MLR requirement as their reason for withdrawal. In fact, one insurance company stated that the withdrawal "... is in no way related to health care reform." In addition, according to the documents supplied by the IDOI, none of these insurance companies would need to pay a rebate under the 80% MLR requirement, so the MLR could not reasonably have been a factor in their decisions. Indeed, several, if not all, of these issuers continue to do business in other states where they are subject to the same MLR requirements.

The five insurance companies that have stopped writing new business are a small part of the overall market, constituting less than 3% of the individual covered lives. That means that more than 50 insurance companies remain in Indiana to service the individual health insurance market; they can easily accommodate the new business that would have been written by these five companies. Neither is there any evidence offered as to the normal turnover in the individual insurance market in Indiana. It is not uncommon for small insurers to stop writing blocks of business or to even exit a market for all kinds of reasons, and the fact that a handful of insurers have stopped writing policies in a particular year is not necessarily an unusual event.

Indiana offers no evidence that insurers will leave the market absent an MLR adjustment. Under federal law, an insurer must give 180 days notice before leaving the non-group market. No insurer has given notice of withdrawal beyond those that have already stopped writing new business (which were for reasons other than the MLR requirement), and none could give notice and exit for 2011. Furthermore, if a company withdraws from the market it may not reenter the market for five years. This restriction makes it unlikely that any health insurance company with a significant enrollment would withdraw from Indiana in 2012 or 2013 given the greatly expanded, and federally subsidized, individual market that will be available to them through the exchange beginning in 2014.

**Indiana has offered no evidence that, absent an adjustment, enrollees will lose coverage due to insurers leaving the state.**

Because Indiana has offered no evidence that any insurer will leave the state absent an adjustment, it has also failed to prove that any enrollee will lose coverage because of insurers exiting the state.

**Indiana has not demonstrated that access to agents and brokers will be disrupted if an adjustment is not granted.**

The adjustment request expresses a concern that requiring companies to meet the statutory MLR requirement will result in reduced commissions and loss of agents and brokers. It has provided no evidence to support this claim; there is little evidence of serious erosion in commissions since the federal MLR requirement has gone into effect; and lower commissions do not mean that access to brokers is compromised.

We attach data on Indiana insurance commissions submitted by the National Association of Health Underwriters to the NAIC. We note that only one insurer listed reduced individual commissions between 2010 and 2011 (from 15% to 12% for new policies) and one other between 2009 and 2010 (from 20% to 10% for first-year commissions and from 5% to 3% for commissions beyond Year 5). Otherwise commissions have remained stable.

The federal rule does not guarantee that broker and agent compensation will never be reduced, but rather that consumers must have adequate access to brokers and agents. No evidence is provided that implementation of an 80% MLR will reduce access. Moreover, granting an adjustment would not guarantee that broker and agent compensation would be increased. There is no reason to believe insurers would not simply retain increased income as profit rather than pass it on to agents and brokers.

**Alternative coverage is available to Indiana insurance consumers if an insurer exits the state.**

If an insurer does withdraw from Indiana, it is likely that an individual formerly covered by that insurer will be able to get coverage through one of the remaining insurers. Indeed, two of the insurers that exited the market in the past year stated that they have been able to transfer their

policies to other insurers, a third stated its intent to continue servicing existing policies and a fourth indicated it had no active business in the state. Moreover, Indiana admits that its high-risk pool and the federal Pre-existing Condition Insurance Plan are available for enrollees who may lose coverage because an insurer withdraws from the market. There is no evidence of potential loss of coverage caused by enforcement of the 80% requirement.

**If granted, this adjustment request would cause a substantial loss to Indiana consumers.**

Indiana consumers will lose more than \$20 million in rebates for 2011 alone if this request is granted. They will also be deprived of the rebate provision's overall effect on driving down premiums for the next several years. There is no evidence that premiums or cost-sharing would increase or benefits be reduced if the adjustment is not granted.

This request would protect the largest and most profitable insurers in the state at the expense of consumers. WellPoint subsidiary Anthem would save approximately \$9 million in consumer rebates. Two UnitedHealth Group subsidiaries, Golden Rule and United Healthcare, together would save more than \$5.5 million. MEGA would save nearly \$2 million. No explanation is given to understand why these profitable firms cannot achieve the minimum MLR.

Indiana has failed to establish that this adjustment request is necessary. Granting it would steal millions of dollars from consumers in the form of rebates and downward pressure on future premiums. We request that this adjustment proposal be denied.

Sincerely,

A handwritten signature in black ink, appearing to read "Ethan Rome". The signature is stylized and cursive.

Ethan Rome  
Executive Director

## Indiana

2011						
Carrier	Group Size	Plan Type	Annual Premium	First Year	Renewal	
			(If Available)			
152	1	Individual		15%	10%	
	2-9	Product I	10%			
	10+	Product II	\$0-8000	10%		
			\$8001-20000	\$800 + 6% excess		
			\$20001-50000	\$1520 + 3.5% excess		
			\$50000-150000	\$2570 + 1.25% of excess		
			\$150001-500000	\$3820 + .5 of excess		
			\$500,001+	\$5570 + .25 of excess		
Broker may also negotiate commission, i.e. 5% flat, or 7% 1st year, 4% flat renewal						
153	Individual	Medical	12%		4%	
154	All	All	10% Flat			
155	2-50	Medical	5%			
156	Individual	Medical	12%		4%	
		Medical	15%			
157	Individual	Medical	10% 1st Year	5% yrs 2, 3, & 4	3% yrs 5+	
	2-3	Medical	Tier I	\$19 PEPM	\$6 PEPM	
	4-25			\$26 PEPM	\$22 PEPM	
	26-50			\$23 PEPM	\$19 PEPM	
	51-99			\$19 PEPM	\$16 PEPM	
	2-3	Medical	Tier II	\$20 PEPM	\$7 PEPM	
	4-25			\$28 PEPM	\$26 PEPM	
	26-50			\$24.50 PEPM	\$21 PEPM	
	51-99			\$21 PEPM	\$17 PEPM	
	2-3	Medical	Tier III	\$21 PEPM	\$20 PEPM	
	4-25			\$29 PEPM	\$28 PEPM	
	26-50			\$25 PEPM	\$24.50 PEPM	
	51-99			\$22 PEPM	\$21 PEPM	
	100+	Negotiated				
158		Option I	10%		n/a	
		Option II	15%		5.00%	
159	2-50	Medical	1st & 2nd Year: 8% 3rd year and beyond: 7%			
160	Individual	Medical-Under age 60	10%	3% renew yrs 2-4	1% renew yrs 5+	
		Medical-Over age 60	5%	3% renew yrs 2-4	1% renew yrs 5+	

Data submitted by the National Association of Health Underwriters to the National Association of Insurance Commissioners Professional Health Insurance Advisors (EX) Task Force, Spring 2011. Data referenced by:  
[http://www.naic.org/documents/committees\\_b\\_exposure\\_110607\\_phia\\_charge\\_report.pdf](http://www.naic.org/documents/committees_b_exposure_110607_phia_charge_report.pdf)

**2010**

Carrier	Group Size	Plan Type	Annual Premium	First Year	Renewal	
			(If Available)			
152	1	Individual		15%	10%	
	2-9	Product I	10%			
	10+	Product II	\$0-8000	10%		
			\$8001-20000	\$800 + 6% excess		
			\$20001-50000	\$1520 + 3.5% excess		
			\$50000-150000	\$2570 + 1.25% of excess		
			\$150001-500000	\$3820 + .5 of excess		
	\$500,001+	\$5570 + .25 of excess				
Broker may also negotiate commission, i.e. 5% flat, or 7% 1st year, 4% flat renewal						
153	Individual	Medical	15%		4%	
154	All	All	10% Flat			
155	2-50	Medical	5%			
156	Individual	Medical	12%		4%	
		Medical	15%			
157	Individual	Medical	10% 1st Year	5% yrs 2, 3, & 4	3% yrs 5+	
	2-3	Medical	Tier I	\$19 PEPM	\$6 PEPM	
	4-25			\$26 PEPM	\$22 PEPM	
	26-50			\$23 PEPM	\$19 PEPM	
	51-99			\$19 PEPM	\$16 PEPM	
	2-3	Medical	Tier II	\$20 PEPM	\$7 PEPM	
	4-25			\$28 PEPM	\$26 PEPM	
	26-50			\$24.50 PEPM	\$21 PEPM	
	51-99			\$21 PEPM	\$17 PEPM	
	2-3	Medical	Tier III	\$21 PEPM	\$20 PEPM	
	4-25			\$29 PEPM	\$28 PEPM	
	26-50			\$25 PEPM	\$24.50 PEPM	
	51-99			\$22 PEPM	\$21 PEPM	
100+	Negotiated					
158		Option I	10%		n/a	
		Option II	15%		5.00%	
159	2-50	Medical	1st & 2nd Year: 8% 3rd year and beyond: 7%			
161	2-50	Product I	18%		8%	
		Product II	14%		9%	
160	Individual	Medical-Under age 60	10%	3% renew yrs 2-4	1% renew yrs 5+	
		Medical-Over age 60	5%	3% renew yrs 2-4	1% renew yrs 5+	

Data submitted by the National Association of Health Underwriters to the National Association of Insurance Commissioners Professional Health Insurance Advisors (EX) Task Force, Spring 2011. Data referenced by: [http://www.naic.org/documents/committees\\_b\\_exposure\\_110607\\_phia\\_charge\\_report.pdf](http://www.naic.org/documents/committees_b_exposure_110607_phia_charge_report.pdf)

2009						
Carrier	Group Size	Plan Type	Annual Premium	First Year	Renewal	
			(If Available)			
162	Individual	Medical	Level I	15%	10%	
			Level II	18%	10%	
			Level III	20%	10.0%	
	2-50	Medical	\$0-\$1,000,000	6%		
152	1	Individual		15%	10%	
	2-9	Product I	10%			
	10+	Product II	\$0-8000	10%		
			\$8001-20000	\$800 + 6% excess		
			\$20001-50000	\$1520 + 3.5% excess		
			\$50000-150000	\$2570 + 1.25% of excess		
			\$150001-500000	\$3820 + .5 of excess		
	\$500,001	\$5570 + .25 of excess				
Broker may also negotiate commission, i.e. 5% flat, or 7% 1st year, 4% flat renewal						
153	Individual	Medical	15%		4%	
154	All	All	10% Flat			
155	2-25	Medical	8%	3 > in force = 8% or 3 < in force = 5%		
	26-50	Medical	7%	3 > in force = 7% or 3 < in force = 5%		
	3-200	Other Products	20%			
			10%			
163	2+	Medical	15%			
164	2+	Life, LTD, & STD	10%			
157	Individual	Medical	20%		5%	
	2-25		\$30 per employee per month		\$30+ CPI Adjustment	
	26-50		\$25 per employee per month		\$25+ CPI Adjustment	
	51-99		5%			
	100+		Negotiated			
158		Option I	10%		n/a	
		Option II	15%		5.00%	
159	2-50	Medical	10%		8%	
165	1-3	Medical	\$10 per enrolled EE			
	4-15		\$37 per enrolled EE			
	16-25		\$35 per enrolled EE			
	26-50		\$23 per enrolled EE			
	51+		5% or negotiable			