STATE OF INDIANA

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IDOI

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Stephen W. Robertson, Commissioner

May 13, 2011

Via Email and FedEx Overnight
United States Department of Health and Human Services
Attn: The Honorable Kathleen Sebelius
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madam Secretary,

On behalf of the Indiana Department of Insurance (IDOI) and the State of Indiana, I write to request relief from the Patient Protection and Affordable Care Act's (ACA) medical loss ratio (MLR) requirement as provided in 42 USC § 300gg-18(b)(1)(A)(ii) in order to avoid destabilization of the Indiana insurance market. Below you will find information demonstrating the need for a phased-in implementation beginning in 2011 continuing through 2014. This letter addresses the specifics of IDOI's request as related to consumer driven health plans (CDHPs) and these plans' corresponding health savings accounts (HSAs) and individual major medical health insurance policies.

I. Background.

Indiana has a robust individual health insurance market with more than 60 carriers actively marketing and writing business. All but five are smaller carriers, many of which are domestic to Indiana or have a physical presence within Indiana. Indiana's robust market provides consumers with choices and competitive premiums. They also serve to prevent market domination by a single player. Because of the large number of carriers, IDOI provides a comprehensive response based upon information obtained from both the Supplemental Exhibits filed with carriers' annual filings to IDOI as well as information provided by a sampling of 13 carriers offering coverage in Indiana. This represents about 147,357 total covered lives for individual products. Segregating individual responses and attempting to gather information from all carriers selling products in Indiana is unduly burdensome.[1] IDOI respectfully requests that the Secretary move forward with her determination based on the information provided herein.

[1] 45 C.F.R § 158.320 (2010).

42 USC § 300gg-18(b) provides the Secretary with the authority to adjust the percentage within a State:

> (1) Requirement to provide value for premium payments.
>
> (A) [B]eginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis. . . .
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> (ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that *the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.*

The information required to be submitted in support of these requests in sections II and III is provided herein.

II. The State of Indiana respectfully requests a waiver for Consumer Driven Health Plans (CDHPs) sold in both the small group and individual major medical health markets.

In an effort to avoid market destabilization and continue to find innovative ways to bring down the actual cost of health care coverage, IDOI requests on behalf of the State of Indiana that CDHPs sold in both the individual and small group markets be exempt from the 80% minimum medical loss ratio as provided in 42 USC § 300gg-18(b)(1)(A)(ii).

According to America's Health Insurance Plans' (AHIP) 2010 report, enrollments for CDHPs, which are generally coupled with HSAs, have increased nearly 25% from 2009.[2] Currently, Indiana has the fifth highest percentage; 8.1% of the state's population, or approximately 360,000 people under the age of 65 with private health insurance, utilize CDHPs/HSAs. In particular, 73% of Indiana's nearly 29,000 state employees (excluding public university employees) participate in a CDHP/HSA.

Because of the success Indiana has witnessed just through our State personnel's utilization of CDHPs, Indiana strongly supports these plans for cost, affordability and quality purposes. The State of Indiana, as the plan sponsor for its state government employees, contributes about 55% of an employee's deductible into an account for CDHP participants, and the participants may contribute additionally to cover a portion of the out-of-pocket costs. The employee's contribution and control of the HSA continues to encourage individuals to make value-based decisions regarding their health care. Participants are empowered to take control of their health and the services they choose to access. Such empowerment results in patients asking

[2] "*January 2010 Census Shows 10 Million People Covered by HSA/High-Deductible Health Plans.*" America's Health Insurance Plans Center for Policy and Research. May 2010. www.ahipresearch.org.

questions about treatment options, comparing cost and quality among providers and engaging in healthier behaviors to minimize health costs in general.

According to an independent study by Marsh & McLennan Companies (Mercer) commissioned by the State of Indiana in May 2010, there is no evidence that CDHP participants defer important health care services in any material way during the four-year study period.[3] Mercer's conclusion was based on the lack of reporting over the study period of any issues of adverse results from deferred care (e.g., union grievance, press reports), and the migration patterns were a one-way flow from the traditional preferred provider organization (PPO) plans to Indiana's two CDHPs.

Indiana's commitment to CDHPs is further evident in its Medicaid expansion to its citizens through the Healthy Indiana Plan (HIP) which operates similar to a CDHP. HIP provides a CMS approved benchmark equivalent benefits plan to adults under 200% of the federal poverty level (FPL). Consumer choice drives participants to take into consideration quality and cost when making their health care choices. Based on their ability to pay, participants are required to make monthly contributions into their Personal Wellness and Responsibility Account (the POWER account) that funds the plan's deductible. Members have the opportunity to lower their contributions if there is a balance in their account, and they complete their requisite preventative health care services.

There is evidence that the POWER account and the foundation of consumer driven tenets are driving personal responsibility. Emergency room usage is lower in HIP than in Indiana's other Medicaid programs and is lower than other comparable state Medicaid programs. Over 76% of HIP participants received their required preventative services and over 94% of HIP members report satisfaction with the program. HIP provides an alternative to traditional Medicaid programs and shows strong potential for consumer driven plans to impact patient behavior and encourage personal responsibility.

Although deductible factors are included in the proposed MLR regulation, which recognizes that the variability of claims experience is greater under health insurance policies with higher deductibles than under policies with lower deductibles, the factors are not sufficient to stabilize the CDHPs' small group and individual markets. HSAs help to offset and reduce the monthly premiums for participants. In turn, the carrier receives less premium, and paid claims by the plan are reduced because consumers are covering some of their medical costs through their HSA. This encourages the consumer to be an active participant in making health care decisions based on costs, quality, benefits and outcomes. However, because of the necessity of tracking deductible and out-of-pocket costs, administrative costs for the plan remain the same.

Because plans with a large number of policyholder cost-sharing elements (deductibles, co-insurance and co-pays) will have a lower actuarial value (AV) than plans with smaller policyholders cost-sharing elements, loss ratios for CDHPs will naturally be much lower than loss ratios for more expensive policies having more generous benefits. Because of premiums,

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[3] Gusland, Cory, Harshey, Tyler, Schram, Nick, and Swim, Todd. *Consumer-Driven Health Plan Effectiveness Case Study: State of Indiana*, Marsh Mercer Kroll Guy Carpenter Oliver Wyman, Chicago, IL: Mercer Health and Benefits, LLC, May 20, 2010.

individual consumers and small employers tend to trend towards CDHPs. Demographically, younger people tend to trend towards these plans because of affordability. Early entrance into an HSA and CDHP allows for a build-up of an HSA during times of health and availability of increased funds in years of sickness. This combined with the portability of HSAs allows individuals to financially prepare for costs of care later in life. The long-term benefit of these plans is to encourage individuals to consider the costs of health care when they are younger so that they can be engaged with their decisions as they access health care during their more mature years. Ultimately, the education and financial protection aspects of CDHP/HSA plans provide Indiana residents with the tools to manage health care costs over the long-run.

Those carriers with a large number of CDHPs on their books will be at a competitive disadvantage compared with those carriers that do not. Carriers with a large number of CDHPs cannot increase the AV without consumer objection potentially being manifested through consumers dropping their coverage. As a result, carriers are either faced with withdrawing from the CDHP market or paying rebates that could pose solvency issues. None of these unintended consequences should limit the choice for consumers for these plans, nor should they thwart a shared state and federal goal of actually lowering medical costs.

For the reasons mentioned above, Indiana requests a permanent waiver for individual and small group individual CDHPs plans from having to comply with the 80% MLR.

III. IDOI respectfully requests that individual major medical health carriers receive a waiver from the 80% MLR requirement through 2014. In the alternative, IDOI requests that carriers be required initially to meet a 65% MLR, and have it implemented incrementally over a four-year period.[4] IDOI further requests that new market entrants and products be exempt from MLR until 2014.[5]

IDOI has requested relief through 2014 to avoid destabilization of the individual market during this time of significant changes. Current market practice is to maintain the same premium for an individual consumer for the duration of their contract period (e.g. 1 year). Then at renewal, any pricing adjustments requested and approved by IDOI are applied to the renewal term of the policy. Again, the rate provided at renewal is maintained for the next contract term, et cetera. Employers and individuals appreciate the consistent pricing throughout the term of the policy because they are able to budget for insurance expenses. Fluctuations throughout the year would cause significant uncertainty and may increase those unable to maintain insurance.

Today in the group and individual markets any employer or individual may apply and become insured at any time. Therefore, a carrier may have one approved rate on January 1 and

[4] 2011 –65.00%
2012 –68.75%
2013 –72.50%
2014 –76.25%
2015 –80.00%

[5] A new market entrant would be defined as one that has not previously sold individual major medical health insurance products in Indiana for the previous ten year period.

another on July 1 due to pricing adjustments requested and approved by IDOI. Individuals who purchased insurance prior to the July 1 implementation receive one premium through the duration of their contract period and those at July 1 receive the revised premium. Upon renewal the following year, those who purchased prior to July 1 of the previous year will receive any premium adjustments approved subsequent to their purchase. From 2011 through 2013, carriers are able to adjust the rate because new policies are entering the pool all the time. Adjustments may be made and applied to the new and renewing entrants throughout the year in order for the carrier to manage their medical loss ratio.

Effective January 1, 2014, significant market changes will affect the market, among them: guaranteed issue; mandated coverage; the merging of high-risk pools with the standard market; implementation of essential benefits; and the integration of the previously uninsurable population that will initially have high health care costs because of pent-up demand. IDOI believes because of information reviewed thus far that is supported by its actuarial consultants that these dramatic market changes will result in significant premium increases. Unfortunately, accurate pricing without previous experiences may prove to be extremely challenging to the carriers who remain in the market. Allowing the MLR phase-in period to extend through 2014 provides some mechanism to stabilize the rates, maintain current consumer friendly pricing consistency market practices and maintain a robust insurance market.

Unlike today where individuals purchase and renew throughout the year, in 2014 ACA will essentially integrate the whole market into one effective date for policies on January 1, 2014. This includes those previously uninsured and those insured. There will no longer be a dynamic effective date throughout the year, aside from potential open enrollment periods which will be fixed. However, because everyone is mandated to have the defined minimum coverage effective January 1, 2014, there should not be significant renewals throughout the year. The exception will be those who lose coverage from their employers or other qualifying circumstances, and at this time, IDOI is unable to predict whether this will be a significant number of lives. If the carriers continue current market practice of maintaining the same premium throughout the contract period and only adjusting price on renewal, the carriers will be unable to make adjustments throughout the year if they see their experience is better or worse than expected in order to meet MLR. If the carrier under prices the product, it runs the risk of insolvency.

By contrast, if a carrier over prices the product due to fear and market uncertainty, consumers will pay more for the contract period and then may receive a refund approximately six months after the policy term. Therefore, consumers lose the ability to utilize their financial resources in a timely and efficient manner. Additionally, the carrier will have an MLR rebate issue and be subject to significant administrative costs over and above those anticipated which could lead to a solvency issue in the long-run. Thus, giving carriers some relief through 2014 will: 1) encourage carriers to maintain the current market practice of pricing stability throughout the period of the contract that allows consumers to budget for premium; 2) encourage

conservative pricing behavior; and 3) protect solvency participating carriers which ensures that claims will be paid as appropriate.

A. Indiana's Current Individual Health Major Medical Policy Standards.

Indiana law does not identify a specific MLR for major medical insurance policies. However, in reviewing premiums, IDOI relies upon the National Association of Insurance Commissioner's (NAIC) model act, which provides for a 55% lifetime loss ratio per product, as a guide. Indiana has never required a minimum annual MLR by market. ACA's annual minimum loss ratio for rebate purposes differs from the lifetime minimum loss ratio reviewed as part of the rate review process in Indiana. ACA's MLR combines the experience of all individual plans, which adds health quality expenses to the numerator for claims and subtracts taxes from the denominator for premiums. The MLR reviewed by IDOI as part of the rate review process is simply claims divided by premium. IDOI considers both lifetime MLR, which considers the entire lifespan of the insurance product from initial sale to closing of the product, and annual MLR which is the experience from the previous annual cycles, during the rate review process.

Because IDOI has not previously instituted MLR requirements similar to those required by ACA, carriers, particularly smaller local and in many cases provider owned carriers, need time to adjust their pricing accordingly. Information IDOI has received from carriers indicates that many will discontinue sales activities in hopes of minimizing the risk of not meeting MLR requirements, which destabilizes the market by providing fewer choices. Additionally, uncertainty as to benefits, implementation of market reforms throughout most of 2011 and continuous release of new information (*e.g.* Student Health Insurance Regulation released on February 11, 2011) place the market in continuous flux which makes pricing extraordinarily difficult under the best circumstances. Proper pricing is essential for market participation and solvency. Therefore, IDOI believes that without the phased-in implementation of MLR, the health insurance market in Indiana will be destabilized.

B. Operational and Financial Information.

An 80% MLR is much more difficult to meet in the individual market because of higher administrative expenses such as marketing and servicing of the policies on a one-on-one level with consumers. This is the nature of individual products in the market as it is structured currently. In addition, there are lower average premiums coupled with higher average deductibles in this market than in the group market. It is also common for individual plan consumers to submit their payment via credit card, which adds an additional 2-3% in costs depending on the creditor.

For plans underwritten as individual major medical policies, MLRs are much lower in earlier years but increase over time as more health complications develop, resulting in more claims incurred. Because of Indiana's robust market, a portion of the insurance market in Indiana is heavily weighted with newer business because healthy Indiana consumers have the ability to shop the market for the best value. In effect, this limits the ability for the individual

market to meet ACA MLR requirements as compared to other health insurance markets that have a larger, mature mix of old and new policies with correspondingly higher MLRs.

Selling new products that are underwritten during 2011 through 2013 will be disadvantageous to companies that lack large blocks of older business. Thus, new nonprofit carriers, newer companies and new products will face significant if not impossible obstacles to enter the market. These disincentives destabilize Indiana's previously robust and dynamic markets. Only larger and older carriers will have incentive to maintain or increase marketing efforts, thus giving companies with significant market share an even greater advantage and share of the market.[6] Even though the larger carriers would likely be better positioned to immediately implement an 80% MLR, these rebates will not likely be able to be offset by slim business margins. IDOI has attached Exhibit A that shows estimated rebates, individual earned premiums, adjusted earned premium, preliminary MLR, covered lives and net income loss for 2011. As a result, more individual carriers would exit the market. According to www.healthcare.gov, a single 35 year-old female wishing to purchase insurance has more than 240 plan options from among eight of the carriers doing business in Indiana that reported information to HHS. Many others do business in the state currently making even more options available. Exit from the market further reduces choice and destabilizes the Indiana market.

C. Premiums in Indiana.

The average annual new business premium is about $4,800.00 per policy, but there is considerable variation based on age, gender, tobacco use and plan design, among other things. The plan variety and benefit options have a wide range of price points that enable consumers to select affordable coverage that meet their specific needs.

Although there is no statutory limit in Indiana on how much a rate can be increased or decreased based on an individual's health status for individual plans, Indiana Code Title 27 grants the commissioner of IDOI authority to review all rate and form (policy/contract language) filings. Premiums must be reasonable in relation to the benefits provided by the policy.[7] All carriers operating within Indiana must file rates and forms and have them approved by IDOI *before* insurance products are marketed or sold to the public.[8] For the rate review process to begin, the carrier must complete a filing and provide the required data as outlined on the individual checklist at http://www.in.gov/idoi/2592.htm. For example, if a carrier requests a premium increase, it must file the request electronically and provide an actuarial memorandum that includes the following illustrative list that is based on an NAIC model requirement:

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[6] For example, according to information provided in the Medical Supplement to the Annual Financial Filings, Anthem Insurance Inc. has approximately 65% of the market in Indiana in the individual market with the closest competitor Golden Rule Insurance possessing approximately 10% of the market.

[7] Ind. Code § 27-8-5-1.5(l)(1).

[8] Ind. Code § 27-8-5-1.5(g).

- the products affected;
- when the increase would take effect;
- percent of increase requested;
- loss ratio for each product;
- the number of covered lives;
- claims paid;
- medical trends;
- premium collected; and
- a summary report.

Carriers must certify that the information provided to IDOI is accurate. IDOI has the right to request additional information as needed to evaluate the request. Currently, Indiana considers a loss ratio to be the amount of premium spent for claim payments divided by the premium collected.

IDOI has an actuary on staff who reviews all documentation to determine if the insurance company submitted reasonable actuarial assumptions and trends. Additionally, pursuant to the Rate Review Grant I, IDOI contracts with an outside actuarial firm to perform review as well. This part of the review process can involve many conversations between IDOI's actuary and the insurance company. Following the actuarial review, IDOI's compliance review team meets weekly for discussions regarding the carrier's rate request. During this review, it may be determined that additional information is needed to clarify any concerns the team may have.

In addition to the actuarial recommendation, the compliance team considers the history of premium increases, the number of affected insureds and the impact distribution of the increase. The team also considers whether the product is open or closed and the annual Indiana and national medical loss ratios for the product. Once this review process is complete, IDOI approves, disapproves or recommends approval of an increase other than what was originally requested based on its actuarial review. If the carrier accepts the recommended increase, the negotiated rate is approved. If not, the filing is disapproved and the carrier may seek an administrative hearing before the Commissioner.

Because Indiana has sufficient rate review authority, its individual market has remained diverse with numerous carriers offering coverage to thousands of residents. For example, its prospective rate review authority[9] prevents small carriers from under-pricing, which protects the companies' solvency. Similarly, it prevents larger carriers from anti-competitive practices. Most importantly, rates must be actuarially justified in order to be approved. Although most of these carriers are in good financial health, an 80% MLR could force carriers to reevaluate their reserves and risk assessment, resulting in an increased risk based capital (RBC), which, in turn, could increase premiums.

[9] Ind. Code § 27-8-5-1.5(g).

D. Benefits.

Currently, Indiana consumers have a wide variety of benefit options to choose from to meet their financial and health needs. Indiana Code § 27-8-5-3, et seq., provides the minimum individual accident and sickness policy provisions that must be in all individual policies sold in the State of Indiana. In addition to specific contract language, Indiana law also provides for specific mandated benefits. The following are benefits that either must be provided by statute or, if a policy offers them, they must be provided according to particular criteria:

- **Mental retardation.**[10] If an individual accident policy provides that medical expense coverage of a dependent child ended due to the reach of the limiting age for dependent children, the policy must state that the reach of such limiting age does not refer to the termination of medical coverage of dependent child if the child is: (A) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and (B) chiefly dependent upon the policyholder for support and maintenance.[11]

- **Mental Illness and Substance Abuse.** An individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions. Treatment limitations or financial requirements on the coverage of services for a mental illness are prohibited unless similar limitations or requirements are imposed on the coverage of services for other medical or surgical conditions.[12]

- **Pervasive Developmental Disorder (PDD).** The carrier must provide coverage for the treatment of a pervasive developmental disorder of an insured (autism or Asperger's Syndrome).[13] A written treatment plan for each individual with PDD must be developed and signed by the treating physician or a psychologist or physicians specializing in the treatment of PDD and treating the individual with PDD.[14]

- **Newborns.** An individual insurance policy must cover newborns. Benefits applicable for the individual or family member shall be payable with respect to a newly born child of the insured, certificate holder or subscriber from the moment of birth.[15]

- **Dependent Age 24.** Before September 23, 2010, an individual policy must have provided for coverage of a child of the policyholder to children under the age of 24 years, *if the policyholder requests such coverage.*[16] House Bill 1486 of the 2011 legislative session expanded the age to 26 to be consistent with ACA.

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[10] Ind. Code § 27-8-5-2(a).
[11] Ind. Code § 27-8-5-2(a)(8).
[12] Ind. Code § 27-8-5-15.6(d)-(e).
[13] Ind. Code § 27-8-14.2-4.
[14] IDOI Bulletin 179.
[15] Ind. Code § 27-8-5.6-2.
[16] Ind. Code § 27-8-5-28.

- **Orthotic and Prosthetic Devices.** An individual policy must provide coverage for orthotic and prosthetic devices.[17]

- **Mastectomy and Reconstructive Surgery.** An individual policy providing coverage for a mastectomy may not be issued unless it includes coverage for prosthetic devices or reconstructive surgery.[18]

- **Adopted Children.** Any individual policy or plan must cover newly adopted children of the insured or enrollee.[19]

- **Breast Cancer Screening Mammography.** An individual policy must provide coverage for breast cancer screening mammography.[20]

- **Diabetes.** An individual health insurance policy must provide coverage to the insured for the medically necessary treatment for diabetes.[21]

- **Diabetes Self-Management Training.** An individual health insurance policy must provide coverage for medically necessary diabetes self-management training.[22]

- **Coverage for Medical Food.** An individual insurance policy must provide coverage for medically necessary food.[23]

- **Colorectal Cancer Testing Coverage.** An individual insurance policy must provide coverage for colorectal examinations and laboratory tests for cancer in accordance with the American Cancer Society guidelines for an insured who is at least fifty years of age or less than fifty but at a high risk for colorectal cancer according to the American Cancer Society.[24]

- **Reimbursement for Off-Label Drug Treatment.** An individual insurance policy may not exclude coverage of a covered drug for a particular condition on the grounds that the drug has not been approved by the federal Food and Drug Administration (FDA) if the drug is recognized in at least one standard reference compendium, and it is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies.[25]

- **Postpartum Hospital Stay; HIV Testing; Payment.** An individual insurance policy that provides maternity benefits must provide minimum benefits to a mother and her newborn child that cover a minimum length of postpartum stay at a hospital, exam of

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[17] Ind. Code § 27-8-24.2-5.
[18] Ind. Code §27-8-5-26(1)-(2).
[19] Ind. Code § 27-8-5-21(a).
[20] Ind. Code § 27-8-14-6(a).
[21] Ind. Code 27-8-14.5-4.
[22] Ind. Code 27-8-14.5-6(a).
[23] Ind. Code § 27-8-24.1-5.
[24] Ind. Code § 27-8-14.8-3.
[25] Ind. Code § 27-8-20-7.

newborns for disorders listed in Indiana Code § 16-41-17-2[26] and HIV testing of newborns.[27]

- **Inherited Metabolic Disease.** The coverage that must be provided cannot be subject to dollar limits, coinsurance or deductibles that are less favorable to a covered individual than the dollar limits, coinsurance or deductibles that apply to other coverage for prescription drugs or physical illness under the insurance policy.[28]

- **Coverage for Care Related to Clinical Trials.** An individual insurance policy must provide coverage for routine care costs that are incurred in the course of a clinical trial if the policy would provide coverage for the same routine care costs not incurred in a clinical trial.[29]

- **Chemotherapy.** For an individual insurance policy, orally administered chemotherapy must not be subject to dollar limits, copayments, deductibles or coinsurance provisions that are less favorable to an insured than dollar limits, copayments, deductibles or coinsurance for intravenously injected chemotherapy.[30]

- **Morbid Obesity Surgical Treatment.** An individual insurance policy shall offer coverage for non-experimental, surgical treatment by a health care provider of morbid obesity that has persisted for at least five years if nonsurgical treatment supervised by a physician has been unsuccessful for at least six consecutive months.[31]

All policy requirements including mandatory benefits are explained in greater detail on IDOI's filing company individual accident and health policy review standards checklists located at http://www.in.gov/idoi/files/Individual_Checklist_4-10(1).pdf (nonHMO individual policies) and http://www.in.gov/idoi/files/Individual_HMO_Checklist_4-10.pdf (HMO individual policies).

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[26] (1) Phenylketonuria; (2) Hypothyroidism; (3) Hemoglobinopathies, including sickle cell anemia; (4) Galactosemia; (5) Maple Syrup urine disease; (6) Homocystinuria; (7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department; (8) Congenital adrenal hyperplasia; (9) Biotinidase deficiency; (10) Disorders detected by tandem mass spectrometry; and every infant shall be given a physiologic hearing screening examination at the earliest feasible time.
[27] Ind. Code § 27-8-24-4.
[28] Ind. Code § 27-8-24.1-6.
[29] Ind. Code § 27-8-25-8.
[30] Ind. Code § 27-8-32-5.
[31] Ind. Code § 27-8-14.1-4.

E. Amount Paid to Agents/Brokers.

1. Impact on Agents/Brokers.

Indiana has approximately 25,814 licensed resident health agents and 2,682 resident agencies. Absent relief from a waiver, *existing* individual business that was priced according to existing MLR expectations will now be subject to losses for the companies operating in those lines of business. Because carriers negotiated vendor contracts related to administration and claims management as well as agent compensation contracts related to marketing, distribution and servicing of policies, these contracts cannot generally be retroactively changed for policies issued prior to the federal MLR requirements. As a result, this puts significant pressure on companies' operating expenses and exposes them to significant financial losses.

After these agent/broker contracts expire, carriers will likely be forced to reduce agent/broker compensation in order to meet MLR requirements. The per-enrollee costs of claims administration and policy administration are higher for individual policies relative to group prices (expressed as a percentage of premiums). In Indiana, the individual market has traditionally relied heavily on agents and brokers, which generate high distribution expenses, especially in the policy's first year.[32] By contrast, in the group market these same services may be undertaken by a human resources consultant whose compensation is paid by the employer and not incorporated into the premium, which spreads this expense over a large pool of policies.[33]

2. Impact on Consumer Access to Agents/Brokers.

Although the presence of the exchange in 2014 will likely reduce the role of agents and brokers in the long-run, a mass reduction of companies utilizing agents and brokers has a long-term effect because it will disrupt the distribution channel on which many of these smaller carriers rely to bring their products to market. Because smaller carriers cannot rely solely on name brand recognition, agents and brokers are vital until they can modify their marketing strategy to target sales for product placement on the exchange. Between now and 2014, the inability to use agents as a distribution channel could prevent many companies from surviving long enough to market their products on the exchange. In the end, limiting distribution channels via reduction in agents and brokers coupled with an inability to write new business would leave consumers with less choice in both the short-run and long-run. Mitigating the unintended consequences of the MLR requirement, by providing the requested waiver, would enable companies to extend utilization of agents and brokers between now and 2014.

3. Impact on Benefits and Cost-Sharing of Existing Products.

As a result of a carrier minimizing its marketing activity prior to 2014 because of the 80% MLR requirement, carriers may choose to terminate their existing blocks of business and

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[32] http://www.actuary.org/pdf/health/letter_academy_mlr_individual_market.pdf., April 28, 2010.
[33] http://www.actuary.org/pdf/health/aaa_mlr_rfi_response_051410_final.pdf., May 14, 2010.

leave the individual market to avoid inescapable losses and avoid solvency concerns, five have done so already. In fact, Indiana has received letters from carriers warning that a withdrawal from the individual health insurance market could be imminent because of this MLR regulation. Additionally, it has received notices that some carriers may withdraw from the health insurance market altogether. Because of more federal mandates, increased utilization and the likelihood that providers will shift costs of uninsured and underinsured patients to insured patients, the culmination of these trends will likely increase premiums at least in the short-run. As a result, Indiana consumers may be forced to purchase coverage that has fewer benefits and higher cost-sharing components.

Although individual carriers are not statutorily required to notify IDOI that they are withdrawing from the individual market, most carriers do notify this agency out of courtesy. In addition to federal regulations mandating renewal found at 45 C.F.R. 148.22, Indiana law also mandates that existing individual policies be renewed for its policyholders.[34] However, if a carrier has ceased offering new products and, thus, new insureds have ceased entering the pool, premiums skyrocket because it forces those that are healthier to exit from the product prematurely because of spiraling costs, and it leaves only those in the pool that are sick, which is known as a product's death spiral. Because more carriers are likely to pull out and many of the insureds will not be able to obtain more affordable coverage until 2014, it will leave these individuals with no other options but to go without or purchase a plan through the Indiana Comprehensive Health Insurance Association (ICHIA), which is Indiana's high risk pool, or the federal Preexisting Condition Insurance Plan (PCIP). The PCIP is often not a practical solution for the very sick because one has to go without coverage for six months. Although ICHIA works for the traditionally "uninsurable" who have serious, chronic health problems, it was not meant for people who could traditionally obtain health insurance and pay their premiums. Such individuals would not be eligible for PCIP because they were previously insured, but lost coverage because their carrier withdrew from the market. Certainly ACA did not intend such a consequence.

IV. Conclusion.

Indiana's individual major medical insurance market currently enjoys the presence of numerous carriers that offer a vast array of choices for consumers. IDOI believes this is the best way to make prices competitive, by forcing larger carriers to remain consumer focused so that they do not rely solely on leveraging their market share to meet only their needs. On balance, Indiana contends, and has supported its contention with data, that consumer driven plans are cost effective, quality focused and are a tool to help stabilize costs by forcing consumers to contemplate health care consumption.

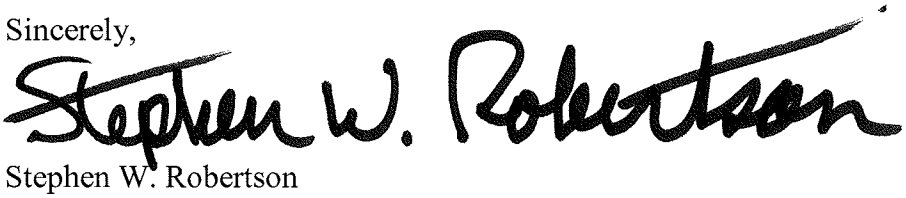
Indiana remains strongly committed to ensuring CDHP plans continue to be available to its residents. Individual carriers likely can meet a 65% MLR in 2011 and phased-in gradually to 80% in 2014 after accounting for permitted adjustments for qualified expenses, taxes and credibility. Without an adjustment to 65% initial MLR that is phased-in over a four-year period of time, carriers will pay out at least the amounts as demonstrated in Exhibit A. This estimate will likely be significantly more because it does not take into account the significant

[34] Ind. Code § 27-8-5-3(a)(13).

administrative expenses associated with the rebates. To date, at least five carriers have withdrawn from the Indiana individual major medical health insurance market since ACA was enacted, totaling just fewer than 3,500 policies or more than 20,000 total covered lives (small group and individual). Currently, another carrier with approximately 1,165 total lives covered is closely contemplating a withdrawal from Indiana's market. At a minimum without the MLR waivers requested herein, choices will be severely limited and IDOI anticipates many more of its carriers will reduce their market presence due to the unintended consequences of 42 USC § 300gg-18(b)(1)(A)(ii). Such withdrawal will destabilize the Indiana insurance market.

For these reasons, IDOI respectfully submits this waiver request and calls for relief from the MLR regulation for both consumer driven health plans (individual and small group) and individual health plans. Please contact Robyn S. Crosson at 317.234.6293 or rcrosson@idoi.in.gov for further questions. Thank you for your time and consideration to these matters.

Sincerely,



Stephen W. Robertson
Indiana Commissioner of Insurance