

Response to CCIIO's Request for Additional Information

related to Texas' Request for an Adjustment to the Medical Loss Ratio



Texas Department of Insurance

Life/Health Division, Mail Code 106-1A

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November 14, 2011

By electronic mail

Gary M. Cohen
Acting Director, Office of Oversight
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Additional Information to Complete Texas' Application for an Adjustment to the Medical Loss Ratio Standard

Dear Acting Director Cohen:

We provide the following responses to your request for additional information in order to complete Texas' application for an adjustment to the medical loss ratio (MLR).

As the Texas Department of Insurance (Department) expressed in its original application, our primary concern is for market stability. Our analysis shows that the abrupt implementation of an 80 percent MLR standard could negatively affect all carriers in the individual market. Carriers facing dramatic changes to their operations may withdraw from the market rather than threaten their solvency, resulting in fewer consumer choices and an immediate upset in coverage for significant numbers of consumers. Both large and smaller carriers will be required to make significant adjustments. An incremental transition to an 80 percent MLR standard promotes the diversity and health of the individual market during a time of transition.

- 1. At this time the Center for Consumer Information and Insurance Oversight (CCIIO) will provisionally accept information regarding each issuer's number of enrollees and amount of premiums earned in the Texas individual market at the company level, rather than by product. CCIIO reserves the right to request information regarding each issuer's premium and number of enrollees by product, as required by 45 CFR §158.321(d)(1), if CCIIO determines that such information is material.*

However, we ask that the Department comment upon whether any of the issuers listed in the Excel attachment to the Department's application offer unique products for which there are no comparable products offered by other issuers. Further, please comment upon whether the products offered in the Texas individual market are generally comparable to each other in product design and cost.

The cost of products in the individual market varies primarily based on deductible amount, coinsurance amount, and co-payment amount. Consumers’ personal needs and plan design preferences influence the premium amount.

Health insurance products in the Texas individual market are generally comparable in terms of product design; however, some carriers do offer coverage for unique benefits. Elective coverage for less common benefits affects the overall premium charged to the individual insured.

Individual health insurance products must provide mandated benefits and meet mandated coverage provisions. In addition to these mandates, carriers may elect to offer other benefits to consumers. The Department’s review of benefits carriers offer suggests that larger carriers are more likely to provide coverage for substance abuse and mental health. The largest insurer in the Texas individual market offers the sole child-only policy available. Yet, some mid-level carriers also provide unique coverage options. The chart below shows the unique benefits included in policies filed by carriers within the last 10 years or rates filed for review within the last 12 months.

Carrier	Unique Benefits Offered¹
Carrier A	Child-only policy
Carrier B	E-visits, home health, and transplant benefits
Carrier D	Outpatient mental health, occupational coverage, and home health
Carrier E	Outpatient behavioral health or substance abuse benefits
Carrier F	Mental and nervous disorders, substance abuse, and smoking cessation benefits
Carrier I	Ambulatory care, continued care, chemotherapy, and accumulated expense
Southwest Service Life Insurance Company	Catastrophic coverage that pays a daily flat rate amount in addition to major medical benefits
Carrier O	Offer of maternity benefits at additional cost
Carrier Q	Prosthesis and physical therapy, ambulance, radiology, and pathology
Celtic Insurance Company	Psychiatric care
	Offers coverage for mental and nervous disorders and alcohol or drug expenses
Carrier U	Riders are available for doctors’ office visits, well-care services, prescription drugs, and x-ray and lab procedures
Carrier V	Acute/non-chronic mental health services
Carrier W	Mental, emotional, or functional nervous disorders

¹ Data compiled from rate filings received since August 15, 2010, and from form filings received in the last 10 years.

2. *Please provide the most recent 2010 Supplemental Health Care Exhibits (“SHCEs”) for each issuer that has at least 1,000 life-years in the Texas individual market. Please include the 2010 SHCEs for New York Life Ins. Co.; American Medical Security Life Ins. Co.; American Republic Ins. Co.; American National Life Ins. Co.; New Era Life Ins. Co.; and National Health Ins. Co., which may not have been included in the Department’s application, as well as Southwest Life & Health Ins. Co. and issuer “AA,” unless the latter two are no longer active in the Texas individual market. In the alternative, please confirm that the Department does not wish the Secretary to take these issuers’ information into consideration in making a determination. Please also provide the 2010 SHCE for any other issuer that the Department wishes CCIIO to consider in making a determination with regard to the Department’s application.*

As requested, the Department has provided the SHCEs for all carriers that indicated in their response to the data call that they wrote individual coverage in the state and had at least 1,000 life-years. Attachment 1, titled “Carrier SHCE Data,” presents SHCE data in Excel format. Included in this attachment are the SHCEs for the eight carriers CCIIO specifically identified in the above request. Five of the eight carriers were not included in the Department’s initial application. One carrier, New York Life Insurance Company, did not respond to requests for additional data; therefore, it was not included in the application. The remaining four carriers indicated they did not offer individual coverage in their response to the data call. However, according to the SHCE data filed, these carriers do have individual business in the state. These carriers include:

- American Medical Security Life Insurance Company,
- American National Life Insurance Company,
- New Era Life Insurance Company, and
- National Health Insurance Company.

Additionally, in our review of the SHCE data, we identified four additional carriers with partial credibility that were not included in the results of the data call. Like the carriers listed above, these carriers indicated in their response to the data call that they did not offer individual coverage; however, they reported earned premium for individual health insurance on the SHCE. These carriers include:

- Jefferson Life Insurance Company,
- American Public Life Insurance Company,
- LifeSecure Insurance Company, and
- Metropolitan Life Insurance Company.

The Department has provided an updated spreadsheet titled “Section 158.321(d)(2) Revised” as Attachment 2 that reflects the addition of the SHCE data from the carriers listed above. Only one carrier, American National Life Insurance Company, was not included in the updated spreadsheet because it covered fewer than 1,000 lives according to the SHCE.

The Department has estimated the MLRs with credibility adjustments for the carriers above in accordance with 45 CFR § 158.232(c)(i)(2). The Department used a deductible factor of 1.0 because detailed information on the average per-person deductible of policies was not available.

Four of the eight carriers added to the spreadsheet titled “Section 158.321(d)(2) Revised” would pay rebates at an 80 percent MLR standard. The estimated rebates total slightly more than \$620,000 and account less than one half of one percent of the total rebates paid for the entire market. The inclusion of data from these carriers does not change the Department’s original analysis. The current MLR requirement will force carriers to make severe cuts to their expense structures. The Department noted in its application that 10 carriers would have to make reductions in expenses ranging from 1.5 percent to 67.5 percent in order to break even, which could diminish consumer support and access to coverage if carriers make major staff reductions. Carriers may also suffer losses that could reduce their surplus levels and endanger their solvency over time. Our request for an adjustment to the MLR standard proposes a smooth transition that will provide carriers with a reasonable time frame to adjust their business practices while supporting market stability.

- 3. Page 2 of the Department's application states that the Department conducted a data call to gather the data necessary for the Department to complete its application. Please confirm the specific time period represented by the data and please provide a copy of the entire questionnaire submitted to the issuers. Please advise whether the Department believes that the data collected in the Department's data call provide more accurate estimates of issuers' MLRs and rebates than do the 2010 SHCEs. If that is the case, please ask each issuer to provide detailed information about the assumptions used to produce the estimates in the Excel attachment to the Department's application, including, but not limited to: whether significant assumptions were made regarding future business trends; what assumptions, if any, were used to estimate the amount of quality improvement activities and taxes; and whether the credibility adjustments included deductible factors and, if so, what such factors were.*

The Department conducted the data call to collect information for the reporting period of January 1, 2010 – December 31, 2010. See Attachment 3 titled “mlradj_data_form” for a copy of the data call sent to carriers.

Prior to submitting a request for adjustment to the MLR, the Department compared the information collected through the data call with figures provided in the SHCEs.

Figures for premium and covered lives in the total individual market were similar and indicated that, at a high level, data from the data call and the SHCE were comparable. Other, more complex figures such as commissions and underwriting gain were less similar. The figures provided in our data call are more current because carriers had more time to evaluate incurred claims. Figures for non-claims related expenses and rebates would also be more current.

The Department contacted 12 carriers that provided inconsistent data on the SHCE and the data call. Those that responded explained that their calculations for the Department’s MLR data call were more comprehensive. (Three contact persons had not responded at the time this response

was prepared.) All carriers explained that timing played a role. The MLR data call occurred later in 2011 than the SHCE filing, and the calculations had been reviewed a second time.

Other than timing, the specific reasons carriers provided for the discrepancies varied. Several carriers stated that the MLR they reported in response to the data call took into account mini-med plans (included in column 6 of the SHCE), whereas the SHCE preliminary MLR for the individual market (column 1) had not. The reasoning was that mini-med business is to be included in the MLR calculation, although with a special weighting.

Another carrier stated that the earned premium figure they provided on the MLR data call had been lower than the SHCE figure because of a change in the allocation of fee assessments. Moving an assessed fee from the small group column to the individual column reduced the individual premium figure and increased the small group premium figure.

Another carrier stated that incurred claims differed because of different reserving methods. The SHCE value used the “statutory” method which reflected the change in claim reserves on all claims between year-end 2010 and year-end 2009. The MLR method considered only claims incurred in 2010, and reserved these claims using the “run-off” (also known as the percentage completion or claims triangle) method. Thus, the release in 2010 of a claim reserve on a claim incurred in 2009 would reduce the SHCE incurred claim value but not the MLR value.

While the Department shares CCIIO’s interest in gaining a deeper understanding of the methods and assumptions carriers are using to calculate the MLR under the Patient Protection and Affordable Care Act (PPACA), collecting data on the multiple and varied assumptions of all carriers is beyond the scope of the Department’s application. Doing so would necessitate a second data call, which would likely extend the length of the application process beyond the end of the calendar year and the timeline for receiving an adjustment for the 2010 reporting period.

The Department requests that CCIIO consider insight provided by efforts such as NAIC working groups that have focused on questions similar to those posed by CCIIO. Specifically, the Health Care Reform Solvency Impact (E) Subgroup has identified a number of salient issues related to calculating the MLR under the PPACA including calculating federal taxes, integrating agent and brokers’ commissions, and appropriately determining quality improvement expenses, which is still under consideration.

4. With regard to the exhibit entitled “158.321(d)(2)” of the Excel attachment to the Department’s application, please explain why issuers “H,” “W” and “Z”, which appear to be partially credible, did not include credibility adjustments when calculating their MLRs in the column labeled “PPACA MLR with Credibility Adjustment.” Further, please explain why issuer “T” included a negative credibility adjustment.

Scott & White Health Plan (Carrier “H”)

In its response to the data call, this carrier reported a value of 87.8 percent for the column labeled “PPACA MLR without Adjustment.” The carrier had mistakenly used an adjustment of 0 percent and should have used a non-zero value. This carrier provided \$0 as the estimated rebate. Any credibility adjustment would have no effect on the critical value, the estimated rebate.

However, on the spreadsheet entitled “Section 158.321(d)(2) Revised,” the Department has estimated the value for the column labeled “PPACA MLR with Credibility Adjustment” using the same method described in our response to Question 2.

Carrier “W”

This carrier left the number of lives field blank on the initial response to the data call in late April 2011. Subsequent conversations with the contact person finally produced a resubmission on May 19, 2011, with a combined headcount for carrier “W” and another related carrier. The contact person explained that they were unable to provide separate headcounts in a timely fashion. The combined headcount of 1,433 represents less than 3/10 of 1 percent of the total number of lives in the Texas individual market. This carrier provided \$0 as the estimated rebate. Any credibility adjustment would have no effect on the critical value, the estimated rebate. On the spreadsheet mentioned above, the Department has estimated the value for the column labeled “PPACA MLR with Credibility Adjustment” using the same method described in our response to Question 2.

Carrier “Z”

This carrier had originally submitted inconsistent and incomplete data on the initial response to the data call in late April 2011. Subsequent conversations with the contact person finally resulted in a verbal explanation and correction on May 23, 2011. The carrier had mistakenly used an adjustment of 0 percent and should have used 2.6 percent. This carrier provided \$0 as the estimated rebate because the headcount, reported as 1,065, was declining rapidly and was expected to be below 1,000 for 2011. Any credibility adjustment would have no effect on the critical value, the estimated rebate. On the spreadsheet mentioned above, the Department has estimated the value for the column labeled “PPACA MLR with Credibility Adjustment” using the same method described in our response to Question 2.

Southern Farm Bureau Life Ins. Co. (Carrier “T”)

This carrier had originally submitted inconsistent and incomplete data on the initial response to the data call in late April 2011. Subsequent conversations were held, and on July 1, 2011, the contact person stated that she now understood how the credibility adjustment should be calculated and would ask their consultant to revise the values. On July 3, 2011, the carrier verbally reported that the value for the PPACA MLR before the credibility adjustment should have been 74 percent with a credibility adjustment of 2.6 percent, bringing the value for the column labeled “PPACA MLR with Credibility Adjustment” to 76.6 percent. The estimated rebate should have been \$20,698 higher than originally reported (\$589,693 instead of \$568,995). These changes are reflected on the spreadsheet mentioned above.

- 5. For the issuers listed on the exhibit entitled “158.321(d)(2)” of the Excel attachment to the Department’s application, please identify those that have indicated or suggested to the Department that they plan to price their products to meet an 80 percent MLR beginning in 2011 or 2012.*

Carriers have indicated in rate filings submitted to the Department that they plan to price specific products to achieve an 80 percent PPACA MLR standard. Of the 34 carriers listed on “Section 158.321(d)(2) Revised,” 12 have indicated that they are pricing individual products to achieve an 80 percent PPACA MLR. However, more than half of the carriers have not filed recent rate changes with the Department. Additionally, when carriers file rates with target loss ratios below

the current MLR standard, the Department asks for justification from the carrier. Though carriers may price individual products to attain an 80 percent PPACA MLR standard, they may not achieve the standard for the individual market as a whole. Further, in pricing products to comply with the current MLR standard, carriers will be forced to take extreme measures to reduce administrative costs and commissions simply to break even.

6. *Please provide the name of each issuer listed in the exhibit entitled “158.321(d)(2)” of the Excel attachment to the Department’s application that has not specifically requested that its identity remain undisclosed and state whether or not each issuer has filed a 2010 Supplemental Health Care Exhibit.*

Carrier	Confidentiality Requested?	SHCE Filed?
Carrier A	Y	Y
Carrier B	Y	Y
Carrier C	Y	Y
Carrier D	Y	Y
Carrier E	Y	Y
Carrier F	Y	Y
Carrier G	Y	Y
Scott & White Health Plan	N	Y
Carrier I	Y	Y
Carrier J	Y	Y
Southwest Service Life Insurance Company	N	N
Carrier L	Y	Y
Carrier M	Y	Y
Standard Life and Casualty Insurance Company	N	Y
Carrier O	Y	Y
Carrier P	Y	Y
Carrier Q	Y	N
Celtic Insurance Company	N	Y
Citizens National Life Insurance Company	N	Y
Southern Farm Bureau Life Insurance Company	N	Y
Carrier U	Y	Y
Carrier V	Y	Y
Carrier W	Y	Y
Citizens Insurance Company of America	N	Y
State Farm Mutual Automobile Insurance Company	N	N
Carrier Z	Y	Y

7. *Title 45 CFR §158.322(c) requires an estimate of the rebates that would be paid by each issuer for the 2011, 2012, and 2013 MLR reporting years if issuers in the individual market must meet an 80 percent MLR standard in each of those years. The exhibit entitled “158.321(d)(2)” to the Department’s application provides such an estimate for 2011. Please also provide estimated rebates that would be paid by each issuer in the MLR reporting years 2012 and 2013 if issuers in Texas individual market must meet an 80 percent MLR standard. Please provide such information for each issuer that has not specifically stated that it is unable to provide forward-looking data.*

The Department provided rebate estimates that carriers reported for the 2011 year based on 2010 data. The exercise to develop the assumptions and calculations needed to make meaningful projections for future years would result in, at best, inaccurate and uncertain conclusions. Projections based on data prior to 2010 would not take into account the transition that has occurred since the promulgation of the PPACA. Further, the Department feels that projections made based on one year of data would not be adequate to produce empirically grounded estimates. Therefore, based upon 2010 data, expected rebates under the 80 percent MLR standard would be the same for years 2012 and 2013.

Carrier	Estimated Rebate at 80% PPACA MLR
Carrier A	\$89,583,364
Carrier B	\$4,108,336
Carrier C	\$19,348,373
Carrier D	\$18,090,000
Carrier E	\$8,463,259
Carrier F	\$5,500,000
Carrier G	\$0
Scott & White Health Plan ¹	\$0
Carrier I	\$2,695,952
Carrier J	\$2,527,028
Southwest Service Life Ins. Co.	\$2,431,855
Carrier L	\$0
Carrier M	\$236,741
Standard Life and Casualty Ins. Co.	\$1,251,947
Carrier O	\$1,829,163
Carrier P	\$122,473
Carrier Q	\$1,185,093
Celtic Ins. Co.	\$0
Citizens National Life Ins. Co. ¹	\$560,220
Southern Farm Bureau Life Ins. Co.	\$589,693
Carrier U	\$200,658
Carrier V	\$0
Carrier W ¹	\$861,392
Citizens Ins. Co. of America ¹	\$0
State Farm Mutual Automobile Ins. Co.	\$0
Carrier Z ¹	\$333,104
New York Life Ins. Co. ²	\$0
American Medical Security Life Ins. Co. ²	\$264,815
New Era Life Ins. Co. ²	\$85,933
National Health Ins. Co. ²	\$0
Jefferson Life Ins. Co. ²	\$267,381
American Public Life Ins. Co. ²	\$0
LifeSecure Ins. Co. ¹	\$1,995
Metropolitan Life Ins. Co. ²	\$0
Total (All Carriers)	\$160,538,775
Total (All Carriers - Values Reported in Initial Application)	\$158,143,237
Top 8 Carriers	\$145,093,332
Carriers that Filed SHCE Only	\$620,124

¹ The Department estimated the credibility adjustment in accordance with 45 CFR 158.232(c)(i)(2) and estimated the rebate.

² Data from the 2010 Supplemental Health Care Exhibit. The Department estimated the credibility adjustment and the rebate.
Note: Carriers that requested confidentiality in their response to the data call have not been identified.

8. *Title 45 CFR §158.322(d) requires an estimate of the rebates that would be paid by each issuer for the 2011, 2012, and 2013 MLR reporting years if issuers in the individual market must meet the MLR standard that the Department proposes for each of those years. On page 23 of the Department's application packet, the Department provides aggregated rebate estimates for the entire market for these years (under a 71 percent standard for reporting year 2011, 74 percent for 2012, and 77 percent for 2013). Please provide separately for each issuer the estimated rebates that would be paid for MLR reporting years 2011, 2012, and 2013 if issuers must meet the MLR standards that the Department proposes. Please provide such information for each issuer that has not specifically stated that it is unable to provide forward-looking data.*

The estimated rebates for each carrier are calculated with experience for 2010 held constant.

Carrier	Estimated Rebate at 71% PPACA MLR	Estimated Rebate at 74% PPACA MLR	Estimated Rebate at 77% PPACA MLR
Carrier A	\$9,756,604	\$36,365,524	\$62,974,444
Carrier B	\$0	\$0	\$132,527
Carrier C	\$9,450,861	\$12,750,032	\$16,049,202
Carrier D	\$9,740,769	\$12,523,846	\$15,306,923
Carrier E	\$0	\$403,012	\$4,433,136
Carrier F	\$2,439,403	\$3,459,602	\$4,479,801
Carrier G	\$0	\$0	\$0
Scott & White Health Plan ¹	\$0	\$0	\$0
Carrier I	\$0	\$815,055	\$1,755,504
Carrier J	\$381,386	\$1,096,600	\$1,811,814
Southwest Service Life Ins. Co.	\$1,527,446	\$1,828,916	\$2,130,385
Carrier L	\$0	\$0	\$0
Carrier M	\$0	\$0	\$0
Standard Life and Casualty Ins. Co.	\$842,219	\$978,795	\$1,115,371
Carrier O	\$746,106	\$1,107,125	\$1,468,144
Carrier P	\$0	\$0	\$0
Carrier Q	\$0	\$0	\$0
Celtic Ins. Co.	\$0	\$0	\$0
Citizens National Life Ins. Co. ¹	\$392,751	\$448,574	\$504,397
Southern Farm Bureau Life Ins. Co.	\$0	\$0	\$69,376
Carrier U	\$0	\$0	\$0
Carrier V	\$0	\$0	\$0
Carrier W ¹	\$0	\$143,053	\$502,222
Citizens Ins. Co. of America ¹	\$0	\$0	\$0
State Farm Mutual Automobile Ins. Co.	\$0	\$0	\$0
Carrier Z ¹	\$123,960	\$193,675	\$263,390
New York Life Ins. Co. ²	\$0	\$0	\$0
American Medical Security Life Ins. Co. ²	\$0	\$0	\$0
New Era Life Ins. Co. ²	\$0	\$0	\$0
National Health Ins. Co. ²	\$0	\$0	\$0
Jefferson Life Ins. Co. ²	\$165,940	\$199,754	\$233,567
American Public Life Ins. Co. ²	\$0	\$0	\$0
LifeSecure Ins. Co. ¹	\$0	\$0	\$0
Metropolitan Life Ins. Co. ²	\$0	\$0	\$0
Total (All Carriers)	\$35,567,446	\$72,313,563	\$113,230,203
Total (All Carriers - Values Reported in Initial Application)	\$34,884,794	\$71,328,507	\$111,941,748
Top 8 Carriers	\$31,387,637	\$65,502,016	\$103,376,033
Carriers that Filed SHCE Only	\$165,940	\$199,754	\$233,567

¹ The Department estimated the credibility adjustment in accordance with 45 CFR 158.232(c)(i)(2) and estimated the rebate.

² Data from the 2010 Supplemental Health Care Exhibit. The Department estimated the credibility adjustment and the rebate.

Note: Carriers that requested confidentiality in their response to the data call have not been identified.

9. *Please confirm that no issuer in the Texas individual market has submitted a “withdrawal plan” as referenced in 28 Texas Insurance Code (“TIC”) §§827.001-827.011 and 28 Texas Administrative Code (“TAC”) §§7.1801-7.1808. If the Department has received a withdrawal plan from an issuer in the individual market, please indicate the issuer, the date the plan was submitted, and whether the plan was approved, modified, or limited.*

Since March 23, 2010, the Department has approved one withdrawal plan submitted on June 10, 2010, by National Health Insurance Company pursuant to the TIC §§ 827.001-827.011 and 28 TAC §§ 7.1801-7.1808. Additionally, withdrawal plans are pending for the following carriers:

- Tower Life Insurance Company submitted a withdrawal plan to the Department on June 10, 2011.
 - American Republic Insurance Company submitted a withdrawal plan to the Department on October 28, 2011.
 - World Insurance Company submitted a withdrawal plan to the Department on October 28, 2011.
10. *Page 14 of the Department’s application references TIC §§ 827.001-827.011 and 28 TAC §§ 7.1801-7.1808 as the authorities governing an issuer’s withdrawal from the individual market. As we read TIC §§ 817.003 and 817.005(a), the Commissioner shall approve the issuer’s withdrawal plan if the plan provides for (1) meeting the issuer’s contractual obligations; (2) providing service to the issuer’s policy holders and claimants; and (3) meeting any statutory obligations. TIC § 817.005(b) allows the Commissioner to “modify, restrict or limit a withdrawal plan as necessary if the Commissioner finds that a line of insurance subject to the withdrawal plan is not offered in a quantity or manner to adequately cover the risks in Texas or to adequately protect the residents and policyholders in Texas.” Please clarify what, if any, additional guidelines, guidance, or requirements the Commissioner uses in determining whether to approve, limit, or restrict withdrawals from the individual market. Such information may be in the form of statute, regulation, or official or unofficial guidance.*

Sections 827.001-827.011 of the Texas Insurance Code and 28 TAC §§ 7.1801-7.1808 are the authority used by the Department in administering withdrawals from Texas’ individual market.

11. *As we read 28 TAC § 7.1086, a withdrawal plan shall be deemed approved if a hearing is not held within 30 days of filing the plan, or if the plan is not denied within 30 days after a hearing is held. Please indicate the shortest timeframe in which an issuer could effectuate a withdrawal from the Texas individual market.*

Texas Insurance Code § 827.005 and 28 TAC § 7.1806 address approval of withdrawal plans, both in regard to affirmation approval and deemed approval. The Commissioner, for example, may, by order, set the date on which a carrier’s withdrawal begins. Depending on the specific individual facts and circumstances, the timeframe within which a carrier could effectuate a withdrawal from the Texas market is variable. It is therefore difficult to indicate the shortest timeframe in which a carrier could effectuate withdrawal from the individual health market. As a matter of practice, the letter of acknowledgement provided to a carrier pursuing withdrawal from a market indicates anticipated processing time of between 90 and 180 days. Carriers

pursuing withdrawal are advised that deemer date timeframes do not start until the file is considered complete. Because of the notice required by 28 TAC § 3.3038(e) to be furnished by an insurer withdrawing from the individual health market, and a similar notice required by 28 TAC § 11.506(3)(D)(vi) for HMOs, at least 180 days would be required to fully effectuate withdrawal by implementing such withdrawal pursuant to a completed withdrawal plan.

12. *As stated by the Department on page 15 of its application, TIC § 827.006 prohibits an issuer that withdraws from writing all lines of insurance in Texas from re-entering the Texas health insurance market for a period of five years, unless the issuer receives the Commissioner's approval. As further explained by the Department, TAC § 7.1808 provides that an issuer that withdraws from only a single line of insurance in Texas may re-enter the market at any time, so long as the issuer receives the Commissioner's approval. Please comment on what, if any, additional guidelines, guidance, or requirements the Commissioner may use in determining whether to permit an issuer to re-enter the individual market. Such information may be in the form of statute, regulation, or official and unofficial guidance.*

Regulations at 28 TAC § 7.1808 provide that a carrier may not resume writing a withdrawn line of insurance in this state unless it complies with all applicable statutory and regulatory provisions governing the authorization to write such a line, and receives the written approval of the Commissioner to resume such writing. As part of the process of determining whether to permit a carrier to reenter the individual market, the Commissioner may review the factual basis for the withdrawal in relation to the request to reenter the market, to assure that the carrier's reentry does not result in the carrier's attainment of an objective through the withdrawal-reentry process that otherwise would violate, for example, Texas Insurance Code provisions addressing unfair methods of competition or deceptive acts or other prohibited practices (e.g. TIC Chapter 541).

13. *Pages 16 through 20 describe Texas' mechanisms to provide options to consumer in the event an issuer withdraws from the individual market and specifically outlines provisions related to the Texas Health Insurance Pool ("the Pool"). Please confirm whether or not the Pool is currently accepting enrollees and whether or not the Pool has an open enrollment period. Please also confirm the current number of enrollees in the Pool, and discuss its current capacity to handle additional enrollees.*

The Pool is currently accepting enrollees. Texas Insurance Code Chapter 1506 contains no open enrollment provisions for the Pool. As of August 2011, the Pool has 25,671 enrollees. The Pool has capacity to accept additional enrollees based on the structure of the pool and its statutory authority set out in the Texas Insurance Code Chapter 1506. Blue Cross and Blue Shield of Texas is the Pool's third party administrator and handles enrollment, medical claims processing, and premium collection for the Pool. BlueChoice Network is the Pool's preferred provider network. The Pool charges premiums for the policies that it issues. Rates and rate schedules are developed pursuant to statutory criteria, submitted by the Pool to the Commissioner for approval, and may not be used until approved by the Commissioner. The rates are capped at 200 percent of the standard risk rate addressed in Chapter 1506. Because claims and expenses for the Pool's operation exceed collected premiums, the Pool collects additional funds from health insurance companies through an assessment process. Based on administration and network capabilities, the Pool presently has capacity to accept and service additional enrollees.

14. *Pages 9 and 13 of the Department’s application state that eight issuers have less than 11% of their total individual business in Texas and therefore may choose to withdraw. Please identify these eight issuers.*

Our application stated that eight companies had less than 11 percent of their individual business in Texas. That list has been updated and now includes nine companies, which are listed below. Those that did not request confidentiality have been identified. The Department calculated the percent by taking the amount of total earned premium in the individual market in Texas as a percent of the total earned premium companies reported for their nationwide business in the individual market.

Carriers that have the bulk of their business located outside of Texas may elect to concentrate on markets with more favorable regulatory requirements. In its analysis, the Department identified those carriers that might be more likely to exit the market and focus on select markets outside of the state without an adjustment to the MLR standard.

Carriers with Less than 11% of their Individual Business in Texas
Carrier C
Carrier G
Carrier I
Carrier J
Carrier O
Carrier P
Celtic Insurance Company
Carrier U
State Farm Mutual Automobile Insurance Company

15. *With regard to Appendix 2 of the Department’s application entitled “Technical Workgroup Meeting Minutes,” please identify which issuers’ representatives have made the following statements:*

“Another representative said that the mutual holding company has already begun to take action to meet the MLR requirements by considering cutting quality programs and agent commissions. She suggested that these cutbacks will make clear to states that a market disruption will result from MLR standards.” (p. 43 of the Department’s application)

“The representative explained that some companies, including the one she represents, were already taking action [regarding agents as a result of the MLR standards] in anticipation of the MLR requirements.” (p. 44 of the Department’s application)

Please also confirm whether these are the issuers that have indicated that they “plan to alter their commission schedules once contracts expire to cover the costs of anticipated rebates,” as stated on page 9 of the Department’s application.

Both statements were made by a representative from the Texas Association of Life and Health Insurers. We do not have information on the individual carriers that “plan to alter their commission schedules,” only that a number of representatives discussed the likelihood at the meeting.

Sincerely,

Jan M. Graeber, ASA, MAAA
Director/Chief Actuary
Life, Accident and Health Office
Texas Department of Insurance

Attachments

Attachment 1 – Carrier SHCE Data

Attachment 2 – Spreadsheet entitled “Section 158.321(d)(2) Revised” which includes the estimated rebate amounts

Attachment 3 – Data call sent to carriers entitled “mlradj_data_form.pdf”