STATE OF FLORIDA
DEPARTMENT OF FINANCIAL SERVICES
OFFICE OF INSURANCE REGULATION

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

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

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

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

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

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

The purpose of our hearing today is to solicit testimony related to the issue of medical loss ratio in the health insurance market and the
particular effect on the individual market. The Federal Health Care Reform Act titled, Patient's Protection and Affordable Care Act, requires health carriers to meet a new minimum loss ratio beginning in 2011. Those minimum loss ratios are 85 percent in the large group and 80 percent in the small group and individual markets.

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

The NAIC, the National Association of Insurance Commissioners, has recently adopted the supplemental health exhibit with instructions delineating these costs. The NAIC, through the Accident and Health Working Group of the Life and Health Actuarial Task Force, is continuing with its related work in the computation of the MLR. And yesterday they received the first draft for comment with expecting to complete their work by the end of September.
The specific issue we will hear today regards the impact of these new minimum loss ratios on the Florida insurance marketplace, and in particular, the individual market. The secretary of HHS is providing in the law the flexibility to adjust the loss ratio requirements in a state if she determines that the 80 percent loss ratio may destabilize the state's individual market. We look forward to hearing your testimony on the panels today and provide information regarding this subject.

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

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

MR. PRENTISS: Thank you, commissioner. My name is Bob Prentiss. I'm assistant general counsel with the Office of Insurance Regulation.
Today's evidentiary hearing is limited in scope. The focus is on the potential adverse impact of the federal requirements related to medical loss ratio, MLR, on the stability of the Florida health insurance markets, and particularly, the individual health insurance market.

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

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

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

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

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

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

WHEREUPON,

MARK LABORDE

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

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

MR. LABORDE: My name is Mark LaBorde. I am
the president for Aetna in the Jacksonville and Tampa markets in Florida.

MR. PRENTISS: You may speak.

MR. LABORDE: Thank you.

COMMISSIONER MCCARTY: Welcome, Mr. LaBorde.

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

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

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

While many of these operations may seem superficially administrative, they represent
critical elements of the support we provide to our
individual customers, employer accounts and
provider partners. Our employees are proud to
serve 16,900 Florida employers, including 15,900
small businesses in partner with over 48,000
Florida medical providers and more than 3,800
Florida agents and brokers.

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

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

To accomplish this, we recommend that the
NAIC and the Federal Department of Health and
Human Services do the following: Establish a
phase-in of the MLR for both the individual and
small group market; second, recognize the
interstate nature of large group business by
allowing for national large group MLR reporting; and facilitate choice of coverage by allowing an aggregation of HMO and PPO coverages.

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

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

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

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

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

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

These products still carry the same administrative requirements associated with underwriting, rating and distribution with many insurers involved with multi-year contracts with brokers and other distribution mechanisms that cannot be modified overnight. A phase-in
gradually raises the current standards every year would allow time for insurers to adjust to the new rules and would help assure continued competition.

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

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

Secondarily, on our second recommendation, the NAIC should recognize the interstate nature of the large group business by allowing for national large group MLR reporting. We are appreciative that the associated industries of Florida
submitted support for this recommendation as well as other MLR improvements to the NAIC earlier this summer.

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

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

Most consumers and public policymakers view the large group market as a success story.
Coverage is administered efficiently, and 95 percent of large employers offer insurance to their employees. Policymakers should be cautious about imposing state-by-state MLR rules in a market that is working well.

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

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

About 44 percent of employers with more than 200 employees allow their employees to choose among more than one option. Insurers may discontinue this popular benefit because these products are priced in a way that blends the PPO and HMO options. If the MLR is forced to be calculated separately, it would not match the underlying premium assumptions. Choices like this could disappear.
In the small group market nationally, enrollees are divided between HMO and PPO enrollment. About 50 percent of enrollees are in PPO coverage and about 41 percent are in HMO. Some insurers may not be able to continue to offer both of these choices if the MLR requirements are to be administered separately on a state-by-state basis.

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

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

The centers for Medicare and Medicaid services, CMS, quantifies the largest drivers of cost increases as hospital costs at 32 percent of spending growth in 2009, physician services at 24 percent of spending and growth in 2009 and
pharmaceuticals at 9 percent of spending growth in 2009.

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

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

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

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

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

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

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

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

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

The ability to comply with that in immediate
form really places us at a real challenge in being able to, as well, offer the robust product offerings we currently have in the marketplace to remain compliant and to effectively be able to afford the administration to undertake those changes that are needed.

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

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

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

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

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

MR. JACKSON: Cost shifting, right.

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

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

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

And when we face those negotiations as an
insurer/payer with those participating hospitals and physicians, they're under a greater pressure for greater demands for reimbursement from companies like Aetna given the continued reduction in the government reimbursement plans like Medicare and Medicaid.

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

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

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

The aggregate view of that particular risk from the insurer point of view is that it is an acceptable medical loss ratio, and based upon the choices that that employer has made on behalf of their employees and their dependants, they believe
that's an appropriate representation of the benefit offering they wish to make to their employees.

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

MS. GALLETA: Thank you.

COMMISSIONER MCCARTY: Are there any other questions?

DEPUTY COMMISSIONER SENKEWICZ: Not at this time.

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

MR. LABORDE: Thank you.

MR. PRENTISS: Mr. Brad Bentley.

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

BRAD BENTLEY

having been first duly sworn to tell the truth,

testified as follows:

MR. PRENTISS: Good morning, Mr. Bentley.

Please state your name, your affiliation and your

(inaudible).

MR. BENTLEY: My name is Brad Bentley. I'm

vice-president of underwriting for AvMed Health

Plans.

MR. PRENTISS: You may proceed.

MR. BENTLEY: Commissioner McCarty, Deputy

Commissioner Senkewicz, members of the Florida

Health Insurance Advisory Board, good morning and

thank you for the opportunity to speak here today.

As I indicated earlier, my name is Brad

Bentley. I'm vice-president of underwriting for

AvMed Health Plans. AvMed is a relatively small,

not-for-profit, regional health plan licensed

solely in the State of Florida.

As such, we are concerned with the minimum

medical loss ratio requirement and the potential

unintended consequences of its immediate

implementation, particularly in the individual

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

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

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

Our first concern as a health plan with low enrollment is simply with the volatility associated with low membership volume and the
resulting inability to accurately predict what the medical loss ratio will be over the policy period.

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

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

Because of the volatility associated with low enrollment, meeting the MLR requirement for smaller health plans such as ours will likely be influenced by more random events as opposed to specific actions taken by us. Thus, for small start-up plans, the MLR calculation result is not a reliable metric to assess health plan value and quality. In fact, I would argue that even for larger plans the MLR metric has limited usefulness.
to the consumer. Rather, each individual consumer must make the decision as to what constitutes value based on his or her own criteria for judging quality, service, and benefits in relation to premiums. Competition across a variety of health plans is what insures that each consumer's own individual needs can be met through the exercise of choice.

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

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

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

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

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

The loss ratio requirement for a new or start-up plan whose entire membership consists solely of new policyholders does not serve its intended purpose on behalf of the consumer. We need to have some alternate mechanism to demonstrate to our customers that our premiums are reasonable in relation to the benefits being provided.
Our third concern deals with the impact of benefit design on the MLR results. We all know that increases in the underlying cost of healthcare are responsible for the level of premium increases that consumers have been faced with. This has driven up consumer demand for policies that have more significant levels of deductibles and member cost-sharing. These policies are becoming more and more popular in the market because of the premium savings that they generate for the purchasers.

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

Our organization invests heavily in quality improvement activities and other services that our members value. The cost of some of those activities and services will be able to be counted in the numerator of the medical loss ratio calculation, but the cost of some of those services may ultimately not be able to be counted.
As members migrate to lower cost benefit designs, health plans will need to spread the same administrative costs over a much lower premium base making it more difficult to meet the minimum loss ratio requirement. In fact, depending upon the average level of medical benefits being purchased by the consumer, one company's MLR may look very differently than another company's MLR when, in fact, they provide the same level of service and have the same level of administrative expense. Again, this points out the flaws inherent in the MLR calculation as a means through which to assess the ultimate value being provided to the consumer.

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

Some plans have expressed the intent to consider the reduction or elimination of services that many consumers find valuable. We do not believe that this is the best result for Florida's
Based on these concerns and others, we strongly urge that the final rules and regulations for implementing the minimum medical loss ratio requirement provide for some transitional relief for companies serving the individual market, especially smaller start-up plans whose own actions may not be able to directly influence the outcome of the MLR test.

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

The State of Florida is fortunate to have an insurance market that has many participants offering many choices for Florida residents. We understand the intent of the MLR requirement and share the same goal of insuring the reasonableness of premium rates being charged in the market; however, we firmly believe that it is competition
among many market participants that will ultimately insure that consumers receive value for their premium dollars.

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

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

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

That concludes my comments. Again, I thank you very much for the opportunity to speak here.
MR. PRENTISS: Thank you, Mr. Bentley. And I'd open it up for questions by the board.

COMMISSIONER MCCARTY: Thank you, Mr. Bentley. We appreciate your testimony, and I think your particular point of view from a small market is a very important part of our market.

How many members do you have in Florida?

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

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

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

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

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


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

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

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

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

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

MR. BENTLEY: That's correct. I mean, we are in the risk business, and we understand that there's an upside gain potential and there's a
downside gain -- or a downside loss potential. And what this does for a new or start-up plan is it completely removes the upside gain potential, leaving essentially losses in future periods. And that is just an untenable way in which to operate a market and I think will reduce competition in the market, which is very badly needed.

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

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

DEPUTY COMMISSIONER SENKEWICZ: I said consider.

MR. BENTLEY: We would have to consider every option available to us in terms of complying with this new regulation. And we think the answer lies in either adjustment of that percentage or some transition or phase-in, especially with respect to new plans who have very volatile claims associated with low enrollment. And, again, whether we comply or not is going to have little to do with actions that we have taken specifically as an organization. They are going to be random events, and I don't think that that was the intent of the
DEPUTY COMMISSIONER SENKEWICZ: And just one final question, at least for now, the transition that most people are talking about is through 2014 because the law is clear, I think, that starting in 2014, it will be calculated on a three-year rolling basis. So do you think that if we were to transition to that higher number, 80 percent in 2014, would that make it easier for you, then, to stay in the market and service your customers and give them value for their dollar?

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

DEPUTY COMMISSIONER SENKEWICZ: Thank you.

COMMISSIONER MCCARTY: Ms. Kammer.

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

MR. BENTLEY: They have that potential, but we are still reviewing that proposal. I don't know if what came out last night is 100 percent consistent with some of what I've seen previously
in development. But we have to take a look at that. Certainly, we would be a proponent of credibility adjustments as a way of reflecting the true risk or the true expected losses within that product line. But it's too early for me to tell because we have not reviewed what came out last night.

COMMISSIONER MCCARTY: Yes.

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

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

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

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

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

And that's what I was trying to point out earlier from a consumer perspective. That's a protection for consumers because what you don't want us doing is rating for the actual risk in
each year because those members will then get very, very high increases as the impact of medical underwriting wears off.

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

MS. GOODHUE: Thank you.

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

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

MR. BENTLEY: It hasn't really impacted it at this point. Our intent is to develop a block of business and then expand into other markets. The new legislation certainly provides one other set of criteria to evaluate in terms of what we
ultimately do in that product line, and it
presents a concern to us in that regard because we
will always have, for quite sometime, even past
2014 if we continue to grow, we're going be
bringing in a lot of people who are at the
beginning level of that claims costs curve. And
they're not going to generate that 80 percent loss
ratio, so that's a consideration for us as we move
forward and consider our future plans.

MS. GALLETA: Thank you.

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

MR. BENTLEY: Thank you.

MR. PRENTISS: Speaker Number 3, Mike Corne.

COMMISSIONER MCCARTY: Welcome, Mr. Corne.

MR. CORNE: Thank you, commissioner.

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

WHEREUPON,

MIKE CORNE

having been first duly sworn to tell the truth,
tested as follows:

MR. PRENTISS: Good Morning. Would you state
your name and your affiliation and what your
position is?
MR. CORNE: My name's Mike Corne. I'm vice-president with Golden Rule Health Insurance Company, and we are a subsidiary of United Health Care.

MR. PRENTISS: You may proceed.

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

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

While we welcome efforts by states and the federal government to gather detailed information about the practical application of new MLR standards that become effective January 1, 2011, we remain concerned about unintended consequences and potential disruption for consumers.
I'd like to focus on the market in my testimony today. While the NAIC is carefully and thoughtfully developing model guidelines for the MLR regulations that are in effect January 2011, we in the industry face the practical problem of having to price insurance policies for 2011. Those that we'll sell next year, we had to price -- begin pricing last February, so, what, eight, nine months ago. Before federal health care reform even passed, we'd already priced those policies.

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

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

As a practical matter, the loss ratio pattern, which he mentioned, for underwritten
medical business is not level over the lifetime of any given policy. There are lower medical loss ratios in the first years, and they are higher in subsequent years.

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

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

Without a phase-in in the 80 percent requirement or the latitude to use a rolling method to calculate loss ratios, there may be unintended consequences of less competition in the market. We think it is a barrier to entry. And I think that was talked about a little bit as well before my presentation -- before this testimony.
You know, it's very difficult to come in because you have 20 percent to work with in that first year, so you're putting on all this new business, and you're probably going to spend more than 20 percent on commissions and other acquisition costs. And you know that between the rebate and the claims paid, you've got to spend 80. So I think you made the point, Ms. Senkewicz, that you're now already over a hundred and you've just started to play. So it's not sustainable and it's a barrier to entry.

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

Nationwide our average individual premium rates are approximately half the cost of similar group coverage, so the individual market, half the cost of the small group market. That is primarily due to individual underwriting. Administrative costs and commissions, however, are roughly equivalent on a per person basis. And I'm talking
about dollars now, so it costs us the same. Therefore, as a percentage of premiums, individual product administration costs are roughly twice as large as in the small group market.

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

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

My third point: Consumers could lose important resources for information if brokers are forced out of the marketplace. Today, the significant portion of individual health insurance in the market is purchased by consumers with the assistance of a professional, licensed insurance
broker. As a result, brokers are vital to the smooth functioning of the insurance market.

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

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

The third thing they do is, of course, they provide ongoing service after the sale. So as service needs arise, maybe the first time someone has a claim or the first time they have a premium
problem, they're going to call their broker, and
the broker is going to help navigate through the
company to get those issues resolved, so they play
an important role.

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

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

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

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

Nevertheless, retaining these advisors is critical for those Floridians who rely on those services. By phasing in the medical loss ratios in the individual market, brokers and insurance companies will be able to adjust to the new market
realities over a reasonable period of time and prevent an abrupt loss of services for Florida consumers. And, again, we're back to the need to have time to adjust our business model.

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

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

And we're concerned because at the lower
commissions required to meet the new MLR rules, brokers may be unable to offer these products to customers, and therefore, leave young, healthier consumers with fewer health insurance alternatives.

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

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

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

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

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

DEPUTY COMMISSIONER SENKEWICZ: 118,684.

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

COMMISSIONER MCCARTY: I know you do. And you're an important player in the individual market particularly, like you said, addressing the gaps in the marketplace and the people that are
going from job to job, and that's an important coverage, as well as the young invincibles.

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

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

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

COMMISSIONER MCCARTY: Yes, I think you're right. Any other questions? Mr. Jackson.
MR. JACKSON: Thank you, commissioner.

Michael, if you can, can you help me to understand how much time you think is needed for purposes of complying with the MLR requirements in terms of transition?

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

COMMISSIONER MCCARTY: Ms. Senkewicz.

DEPUTY COMMISSIONER SENKEWICZ: Thank you.

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

MR. CORNE: Well, again, I'm not an actuary, but I do like to think about change in terms of
taking steps at a time to adjust our business model. Again, that's -- you know, it's a process. And we're innovative people. We will make it work. We will figure this out. We will figure out how to adjust our business model, but I think we would be better off with handling this over time, yes.

DEPUTY COMMISSIONER SENKEWICZ: Do you have something?

COMMISSIONER MCCARTY: Yes.

DEPUTY COMMISSIONER SENKEWICZ: Do you?

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

DEPUTY COMMISSIONER SENKEWICZ: Thank you. Actually, I had one other question, Mike. With respect to your business and the individual -- the individually-underwritten out-of-state group market, my understanding is the individual market, in general, and perhaps your niche of the business in particular, has, I don't know if it's significant turnover, but how often do people stay in your plan duration-wise? And can you kind of explain to us how that has an effect either on volatility or, you know, the difficulties in terms of the disruption in the marketplace if you adjust
MR. CORNE: There is a lot of transition, and there are a couple of different types of transition. Generally, those that come to us that need individual health insurance are buying it because they don't have employer-sponsored coverage. If they had employer-sponsored coverage with the employers chipping in, they would surely take that coverage.

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

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

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

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

You talked about altering your business model, and that's what I was talking with them about too. We have business models, varying business models, not one size fits all. We have different business models in the Florida marketplace. We are in some ways blessed to have a very competitive market, but in that complexity of that marketplace is different business models.
And maybe you could suggest how with respect to your business model how that phase-in would work. If you could do that within the next week or so and augment the record, I would be much obliged.

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

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

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

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

Now, that doesn't mean that that has to be the number. You know, that's -- certainly, you would make that decision better than anyone else.
You and your staff are very informed, and we think that lies with you, but it would not be unreasonable, I would say.

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

MR. PRENTISS: Benjamin Cutler.

COMMISSIONER MCCARTY: Good morning, Mr. Cutler.

MR. CUTLER: How are you? Thanks.

COMMISSIONER MCCARTY: Very well, sir. Thank you.

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

WHEREUPON,

BENJAMIN CUTLER

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

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

Just a bit of background, I've been in the insurance for 43 years. I have a fair amount of
experience in the Florida marketplace, having served as president and chief executive officer (indiscernible) headquartered in Miami from 1998 to 2002 and then chairman from 2002 to 2004.

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

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

I'm particularly interested in Florida's perspective on this issue as Florida is far and away my company's largest state. Today, I serve as chairman and chief executive officer of U.S. Health Group, and our two insurance affiliates are Freedom Life Insurance Company and National Foundation Life.
We cover over 10,000 Florida residents, the majority of which are major medical accounts and that amounts to 24 percent of our in-force as well as 24 percent of our new business, so, obviously, we have a significant stake in Florida.

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

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

COMMISSIONER MCCARTY: We'll enter the entire document.

MR. CUTLER: Thank you. I appreciate that. Again, I have a couple of key points I'd like to make. First, as already has been alluded to, prior to March 23rd, PPACA's effective date, Freedom, as well as many other health plans issued
health insurance coverages under existing rate and
benefit regulations approved by our Florida
regulators.

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

Second, we are nearing the end of the third
quarter and have yet to receive comprehensive
regulations which are set to go into effect in 90
days. I'm sure this assemblage can appreciate
that this is a woefully inadequate time to
properly address the myriad of implementation
complexities that companies face with these new
MLR regulations; and in our case, having to deal
with that in 35 states will be problematic.
Third, as was discussed, there are substantive differences between the small group market and the individual market. The principal differences include field compensation, underwriting and issue costs, as well as policy administrative costs. In our opinion, to apply the same medical loss ratio criteria to these two significantly different disparate lines of business is, in my mind, totally unreasonable, a perspective I think shared by many others.

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

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

Every document I've read on this suggests that come January 2014, premiums in the individual
market will approach small group premiums, which more than likely will be more than doubled. So 20 percent for administrative costs, compensation, marketing expenses, premium tax and profits with premiums that are double what they are today creates a totally different business model than we will be involved with over the next three years.

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

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

COMMISSIONER MCCARTY: So having a 70 percent through 2011 through 2014, is that --
MR. CUTLER: That would be my recommendation to avoid disrupting the market. As was pointed out, we've got an awful lot of business in force that was written prior to PPACA. We have a number of collateral contracts, many of those are multi-year contracts.

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

COMMISSIONER MCCARTY: Interesting you describe it as a cliff.

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

Finally, let me just say, without adequate transition rules, appropriate credibility and volatility adjustments, and in our case, because we are a small carrier, the ability to pool large claims across states, we feel will cause us to face dire business conditions.
If we're faced with an 80 percent medical loss ratio in 2011, I think we would have no alternative but to cancel or non-renew our Florida business. And that would not only be terribly disruptive to our current insureds, but would be devastating to our over 250 producers currently operating throughout the State of Florida.

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

COMMISSIONER MCCARTY: Couldn't agree with you more.

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

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

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

MS. GOODHUE: May I ask a question?

COMMISSIONER MCCARTY: Absolutely. Please do.

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

MR. CUTLER: Yes, I do.

MS. GOODHUE: Okay.

MR. CUTLER: Florida is our largest.

MS. GOODHUE: Florida is your largest. So how would, if there's a transition period in Florida but not in other states, how would that impact your business in other states? So I
think -- I mean, you mentioned that you might have to not sell policies in Florida. I'm trying to understand how Florida is different than other states.

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

MS. GOODHUE: Okay. Thank you.

DEPUTY COMMISSIONER SENKEWICZ: Just to clarify, and part of the reason for that, sir, if I understood you correctly, is because you have entered into many multi-year collateral contracts as you indicated, including the broker compensation contracts, so your choice is going to be have it -- what else can you -- what else could be lowered in terms of administrative costs because you have these collateral contracts?
Essentially, you're just stuck between a rock and a hard place, and that's why you would be --

MR. CUTLER: Pretty much.

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

MR. CUTLER: That's correct.

DEPUTY COMMISSIONER SENKEWICZ: Thank you.

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

DEPUTY COMMISSIONER SENKEWICZ: Right.

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

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

MR. CUTLER: Right. Thank you.

COMMISSIONER MCCARTY: Thank you.

MR. PRENTISS: Thank you.

COMMISSIONER MCCARTY: Thank you very much for your testimony. I appreciate it.
MR. PRENTISS: Julian Lago.

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

WHEREUPON,

JULIAN LAGO

having been first duly sworn to tell the truth,

testified as follows:

COMMISSIONER MCCARTY: Welcome, Mr. Lago.

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

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

With the loss of agents and the role that we play, I feel that it would be critical that that
continue to be an intricate part of the
distribution system. Almost all the carriers that
have addressed and presented to the board have
expressed the important role that agents play, and
I think that that cannot be lost in the
implementation of minimum loss ratios.

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

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

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

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

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

And as the immediate past president, I had
the opportunity to travel throughout the State of Florida and sit and in many cases speak with literally hundreds of agents throughout the state, and their stories are very similar.

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

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

Certainly, one can do their own taxes, and many people choose to do that. But as you purchase and have a complicated process, you bring the expert in to help you make sure that you cross the t's and dot the i's, and that you take the proper adjustment. Health insurance is a very complex issue, and I don't need to certainly
educate the board on that process. But we feel that it is critical to have that.

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

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

And certainly they have the capability to go online and go through an exchange and find out all the information that's there. But the reality is
that they appear at our office. They call for an appointment, and they'll show up in many cases with a shopping bag full of all this information that they received trying to decipher Medicare Supplement to Medicare Advantage, to do I stay on my employer plan and was my employer plan's prescription benefit in compliance and do I have a problem.

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

I can't overemphasize that health care benefits cannot be looked at as a commodity that can be done on the exchange. It's been tried in other areas, even with life insurance and so on. Many clients will go online and get a quote but still come back to the agent for the expertise of...
the appropriate purchase. We feel that through medical underwriting has been discussed and just the implementation phase, it is critical that we continue to see that.

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

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

And I fear that as that marketplace is driven into the exchanges, and there's not enough role there for the carriers to properly compensate the agents, then you're going to have a vacuum there. And, ultimately, these questions and these issues revert back to the state. And with all due respect, I don't know that the state, number one, has the manpower and so on to be able to provide the role that agents do.
So, again, I thank you for the opportunity, and I certainly welcome the opportunity to address the board and answer any questions.

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

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

I do want to -- for the record and for the benefit of this testimony today, we're looking at focusing on the destabilization of the marketplace. And, in your opinion, with the failure to have some alleviation from the implementation of the loss ratio, 80 percent in
the individual market, would that -- do you believe that would destabilize Florida's market, and if so, in what way?

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

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

Again, we're receiving those products, selling that plan, and all of a sudden, a properly-underwritten product that's been placed, that has the ability to allow the carrier to maintain a balance and a profitable block of business is completely disrupted. And we're going to see an exit of carriers in that marketplace. That requires you, the agent, to have to go back
in there and now try to identify in a shrinking marketplace a product that can replace that.

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

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

COMMISSIONER MCCARTY: Ms. Senkewicz.

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

Do you believe that if that occurred, isn't there a point at some point below which certain
agents would just have to say I can't do this anymore; I'm going to have to find something else to do for work to support my family?

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

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

And I think it's important that we also reflect back and look at other models that have been tried. In reality, on the property/casualty side, a lot of auto market products have been sold
direct and so on. And now you start seeing signs where, "comes with a free agent" advertising and even the larger are bringing back the retail establishment where a client can walk in and purchase a product there.

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

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

MR. LAGO: Absolutely. I mean, that is the ultimate loss. The choice of products are gone. You have less selection. And the reality is that,
you know, we deal with a consumer that comes to us and pays attention for a limited period of time. We educate them through all our crazy vocabulary, copayments and coinsurance and so on. And as they understand this process, to think that there's not sufficient dollars there for someone to educate them properly in that purchase and selection, we're talking about something that impacts our family.

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

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

So my concern is as the products shrink,
you're going to have less selection, and that whole implementation, we may, in fact, have an opposite effect. We're concerned with the price increasing based on MLR. You're going to have just those folks that we need, the young, healthy vulnerables (sic) missing an opportunity to participate.

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

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

Again, health care is purchased on a regional basis. If the doctors that you're trying to use and the facilities that you use, or, in fact, the
type of access you need is not there and you've made the wrong purchase, that product is really disastrous for that family. They spend the dollars and are not getting what they need.

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

COMMISSIONER MCCARTY: Thank you. Ms. Galleta?

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

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

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

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

We talked about transition. Many, many cases in Florida, because of the economy, people are losing their jobs and are looking for a purchase of individual products. And then they try to enter, in maybe an entrepreneurial spirit, enter that (indiscernible) so now you're migrating from an individual product into the group product, so there is certainly a transition. And it's a whole
different type of purchase. They have to understand that and the dynamics that come along with them.

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

MR. LAGO: Absolutely.

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

MR. LAGO: Thank you very much.

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

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

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

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

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

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

Having said that, that concludes it. I would certainly open up the floor for anyone in the public who would like to make any testimony today.
(WHEREUPON, the evidentiary portion of the public hearing was concluded.)
REPORTER'S CERTIFICATE

STATE OF FLORIDA
COUNTY OF LEON

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

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

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TRACY A. LEFEBVRE
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