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Health

Joint Public Hearing of Florida Office of Insurance Regulation and
the Florida Health Insurance Advisory Board on Market Impact of
Federal Health Care Legislation
May 4, 2010

Testimony of Steve Dziedzic, Chief Actuary of Assurant
Health, Regarding Market Disruption and the Need for
Transitional Relief.

Good Afternoon, my name is Steve Dziedzic. I am currently the Chief Actuary of Assurant Health, and have been an actuary in the individual market for 18 years. I would like to thank the Florida Office of Insurance Regulation and the Florida Health Insurance Advisory Board for inviting me to participate in today's hearing. It is an important opportunity to explore the effects the new Medical Loss Ratio outlined in the Patient Protection and Affordable Care Act will have on the individual market. In addition to my testimony today, Assurant Health will also submit written comments regarding the Medical Loss Ratio calculation.

The application of an 80% medical loss ratio in the individual market in 2011 will likely significantly disrupt the individual market in the State of Florida and nationally, and in turn, limit choices for consumers. Medical loss ratio regulations must be drafted to provide transitional relief to carriers between 2011 and 2014 to avoid increasing the uninsured population and reducing consumer choice. The NAIC was tasked with proposing the medical loss ratio definitions and methodologies with an eye toward smaller plans being able to remain and allowing newer plans to enter the individual health insurance market. It is important to protect these objectives to ensure a vibrant and thriving health insurance market for all Americans.

It is imperative that carriers receive transitional relief to avoid market disruption. The medical loss ratio requirements should be 70% from 2011 to 2013 and move to 80% in 2014. By providing transitional relief, consumers benefit as they will be able to keep the insurance they have, get the advice they need and find the solutions they want.

Individual policies that are currently in force were priced and sold based on certain assumptions, many of which cannot immediately be changed. Similarly, individual plans currently being sold were priced with assumptions made prior to the new law being passed and the underlying distribution and administrative expenses also cannot be changed quickly. It is these realities that limit insurers' ability to meet a new, higher, medical loss ratio immediately. Individual Medical plans have been priced at the agent commission level currently in place. In addition, the current pricing reflects a complicated set of administrative and distribution costs that cannot be removed from the system overnight. Because insurers have only a limited ability to alter the underlying expense structure on these in force and current plans, requiring rebates on these policies based on an 80% medical loss ratio in 2011 can negatively impact insurers' surplus and, potentially, insurers' solvency.

Where the difference between the priced-for medical loss ratio and that imposed by the new law is significant enough, insurers may be forced to discontinue sales and ultimately withdraw from the individual market. When a carrier withdraws from a market, it results in the cancellation of its individual health plans. The discontinuation of sales or market exit are more likely for smaller insurers as they have fewer products and less in force business upon which to spread any resulting losses. These actions could have a devastating impact on the individual insurance market and could leave many Americans uninsured.

Since the guarantee issue provisions of the law are not effective until 2014, those with existing health conditions who have their coverage canceled would face significantly diminished options. The risk pools contemplated by the law require that individuals with pre-existing conditions be uninsured for six months in order to be eligible for coverage. This unintended consequence would cause many Americans -- especially the most vulnerable -- those with pre-existing health conditions -- to be left without insurance right at the time they need it most. The potential result would be an individual health insurance market dominated by a few large carriers, leaving those consumers who can still purchase -- those without pre-existing conditions -- limited choices.

This is why it is so important that transitional relief be granted in the individual market beginning in 2011 until 2014.

In 2014, when all States are required to provide health insurance exchanges, the individual market is guaranteed issue, and subsidies are provided to ensure access to all, insurers will be able to move some of the acquisition costs out of their pricing. However, in today's individual market the purchase of health insurance is an important and sometimes overwhelming decision for a consumer. It is difficult to make an apples-to-apples comparison of the many plans offered by the various health insurance companies. Independent health insurance agents provide an invaluable service to consumers and act as counselors to provide guidance and advice to individuals as they try to make the best choices for their family.

Agent compensation reflects the important and vital role they play in today's health insurance market.

In addition, individual health insurance companies incur underwriting expenses at the time of issue. Because the individual market is not guaranteed issue, all individual carriers must incur these underwriting expenses to align benefits and price. Once the market becomes guaranteed issue in 2014, some of these expenses will be reduced. However, such a reduction is not possible prior to the market reforms that are to be implemented in 2014.

A market place with limited choices, fewer carriers and cancelation of current coverage is not what the legislature intended when they passed this historic and comprehensive health care reform law. If transitional relief is not granted, it will be more difficult for consumers to keep the insurance they have, get the advice they need and find the solutions they want.

Thank you again for giving me the opportunity to discuss this vitally important topic. Assurant Health stands ready to work with all interested parties as regulations are drafted to help ensure a stable, vibrant individual health insurance market place.

Additional Comments of Assurant Health Regarding the Calculation of the Medical Loss Ratio

Activities that Improve Healthcare Quality

As the NAIC determines what expenses should be included in the definition of activities that improve health care quality in the calculation of the medical loss ratio under section 2718 of the Patient Protection and Affordable Care Act, Assurant Health submits the following for your consideration

“Activities that improve health care quality” should be defined to include activities that: 1) relate directly to an individual patient’s care; 2) provide tools to educate and inform patients about their current or future care; 3) prevent unnecessary and inappropriate care; and 4) ensure a minimum level of health care quality. All of these activities improve the quality of health care and/or enhance access to quality care.

Costs Related to Case Management and Patient Care

Costs related to the involvement in the care of customers bear a clear relationship to improving health care quality. For example, board certified physicians and licensed nurses that are available to our customers. These medical professionals interact with our customers in a variety of ways. To ensure that appropriate care is being delivered, medical staff may evaluate care to ensure it is medically necessary and appropriate. At times, independent review is utilized to determine medical necessity. In addition, we have a dedicated staff of nurses who perform case management duties which help customers manage their chronic and serious illnesses.

These professionals also help patients become more informed about their care and/or condition and understand the health care process, including the ongoing management of chronic conditions. This information allows customers to make better health care choices and avoid unnecessary or inappropriate treatment. It also allows individuals to choose the right level of care for their condition and maintain compliance with the appropriate course of treatment. Moreover, the information and services provided by our medical team spurs discussion between providers and patients, resulting in a more open dialogue about the most effective treatment options. This involvement in patient care and the costs related to this involvement directly improve health care quality.

Costs for Educational and Informational Tools Related to Patient Care

Costs related to certain tools also improve the quality of health care. Tools that provide customers with information on how to best access care are important and effective components of an overall health care strategy. These tools might allow an insured to call and get information on qualified physicians in their area, as well as the costs associated

with each one. This information is valuable in helping individuals find and choose quality health care. Such tools may also aid making determinations about accessing affordable care and educate our customers, allowing for better choices regarding their health care.

Another important tool is the development of the PHR (Personal Health Record). The PHR is a single collection of an individual's health record. This will allow for more prompt and effective treatment. It also allows an insured to be more knowledgeable about his/her own health history, which will produce better health care choices. In addition, a single, complete health record makes it easier and more efficient for providers to evaluate patients, also resulting in better care.

These same quality information tools are linked to cost information. Studies have shown that cost is linked to quality. These tools further the goals of price transparency which will aid in keeping prices down, thereby giving access to more citizens. It will also allow individuals to evaluate their providers to determine the best value for their money. Patients will be able to access and evaluate cost and quality information as they make their healthcare decisions. This is a necessary component to both increase the quality of care through consumer behavior as well as bend the cost curve for that care. As quality and price become more transparent, they will be factored into patients' decisions on the selection of providers. This will result in lower quality providers being driven out of business, thereby increasing the overall quality of care in the health care system.

Costs Related to Prevention of Unnecessary or Inappropriate Health Care

Similarly, costs related to post-treatment review of billings improve health care quality. For example provider fraud investigations are vital to ensuring that care is not being provided by unqualified providers and that treatment is accepted in the medical community and is appropriate. These investigations decrease the number of unnecessary tests/procedures and the inherent health care risks that are related to these unnecessary services. In addition, this information is communicated to the affected individuals and thereby educates him/her about any unnecessary care. This results in a decrease in inappropriate care and more informed consumers that are better able to make quality health care decisions.

Insurers also evaluate billings for compliance with generally accepted coding practices. Reviewing for unnecessary, duplicative, or cumulative billings increases the efficiency and ensures proper care in the future. One example of this kind of evaluation is the conversion to ICD-10, which classifies diseases used for clinical and epidemiological storage and retrieval of diagnostic information, health services payment, standardized health records, and public health assessment. The Department of Health and Human Services has already recognized that ICD-10 "will move the nation toward a more efficient, quality-focused health care system by helping accelerate the widespread adoption of health information technology," January 15, 2009 DHHS Press Release (former DHHS Secretary Mike Leavitt).

Costs Related to Ensuring a Minimum Level of Health Care Quality

Many insurance carriers offer plans with network providers. These networks support the credentialing process and minimum credentialing requirements, which confirm providers' board and DEA certifications, and state licenses, and ensure sufficient education and training. In addition, searches are conducted for any negative actions against providers, including malpractice data queries, CAQH databases, fraud, lawsuits, and any negative actions by a health plan, hospital, Medicaid, Medicare, State Board, or other professional organization. Moreover, network providers are also monitored periodically to ensure they continue to meet credentialing requirements.

Networks also ensure members have access to quality providers who agree to a fair and reasonable rate for services. Networks monitor the adequacy and accessibility of their network physicians: the number of physicians available compared with the population in a geographic area (ensuring a member has adequate selection amongst providers and all specialties represented); the distance a member may need to travel to access available providers (ensuring accessibility according to the standard of their community); and the accessibility of such providers (wait times to get an appointment, wait times in the office). Furthermore, Network representatives act as a liaison for resolving quality issues encountered with network providers. In addition, Networks set policies and procedures which they require their providers to abide by to ensure continuity of care and coordination of care. All of these activities ensure that patients seeking care from a network provider will know their provider meets minimum standards of professionalism and quality of care. Not only do these activities help our customers avoid low quality providers, but they serve as a constant check on provider conduct and thereby improve the overall quality of health care.

Credibility Standards

Lastly, to avoid additional market disruption, the premium amounts upon which the medical loss ratio is based must meet a sufficient level of credibility. Without an appropriate credibility threshold, insurer experience would fluctuate significantly from year to year, which would result in significant variability in the premium rates charged to consumers. In addition, the variability in insurer experience could negatively impact insurer financial results and, potentially, its solvency. This risk may lead carriers to exit certain states, refuse to enter others, and/or refuse to introduce new products. It would also act as a barrier to entry for new insurers looking to enter the individual market.

The credibility threshold is needed since without it, one or two large claims can significantly impact an insurers' loss ratio. In addition to the large claims element, there are numerous items that can fluctuate significantly and thus significantly impact health care costs. These include fluctuations in: medical trend; insured utilization (which can vary based on changes in consumer habits, life or financial situation, media reports, or cost sharing); provider practices (e.g., defensive medicine, billing, and changes resulting

from consumer behaviors); insured anti-selective behavior (e.g., lapses and the relative health of those that lapse); and new medical treatments and technologies. Protections should exist to minimize the market disruption that could result from these fluctuations. We agree with the position that America Health Insurance Plans (“AHIP”) presented in their May 10, 2010 letter to Chair of the NAIC Health Care Reform Solvency Impact (E) Subgroup, Lou Felice. In that letter, AHIP presented a modified version of the credibility adjustment table that is included in the NAIC Annual Medicare Supplement Refund Calculation form. The adjustments would be necessary to account for a non-Medicare population.
