

ADDITIONAL COMMENT BY PREFERRED MEDICAL PLANS TO FLORIDA OFFICE OF INSURANCE
REGULATION

Comment with regard to definition of Medical Loss Ratios and inclusion in minimum Medical Loss Ratio requirements

It is essential that the definitions of Medical Loss Ratio and what is included in the minimum requirements for any of the various insurance groups include reasonable estimation of various reserves used to ensure solvency and the ability to pay claims.

In general, all groups will have the need to account for the following:

- A claims reserve or claims runout reserve. This reserve is used to ensure that plans have adequately reserved for the cost of claims payout and unpaid claims adjustment expenses associated with settling of unpaid claims.
- A premium deficiency reserve. This reserve may be used by a health plan if it needs to meet solvency requirements under state insurance regulations, is at risk of not meeting such requirements at various periods of time, but especially at year end, or indeed must make contributions to remain solvent.

The reserves above are vital to the health of the plan and insurance industry in each state and therefore reasonable estimations of such reserves, as certified by independent auditors/actuaries, must be included in the medical loss ratio definitions and in the minimum requirements.

Individually under-written policies generally have an Active Life Reserve. In general, individual policies are written and such premiums are set over a durational period of enrollment through the use of lifetime medical loss ratios. Therefore, unlike other insurance vehicles, there is no true concept of a benefit year for most individual policies. These policies generally see lower medical loss ratios in the early years and higher loss ratios in later years. Such policies and premiums are written to “smooth out” the premium and the Active Life Reserve taken on such policies from year to year have the effect of smoothing out the medical expenses of such policies. In effect, the reserve acts as a pre-funding mechanism whereby higher claims in the later periods are paid for by the reserve (which is paid for by available premium) in earlier periods. This is made possible by the lower initial medical expenses. This practice is standard and not only recognized but required by state regulatory authorities and in is compliance with NAIC requirements.

The issue described above is mentioned in Section 2718(a) of the Public Health Services Act created by the Patient Protection and Affordable Care Act Section 1001 and Section 833 of the Internal Revenue Code as modified by Section 9016 of the Patient Protection and Affordable Care Act. The section reads in part: “A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, *with respect to each plan year*, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (*or change in contract reserves*) to earned premiums. ... (emphasis added). The Section is ambiguous in that it is unclear exactly how Active Life Reserves in general, and changes in such reserves from year to year,

are treated for the purposes of the definition and minimum requirements in Section 2718(b). Further, the language speaks to “with respect to each plan year,” which would lead one to believe that adequate Active Life Reserves for individual policies might not be factored into the definitions or minimum requirements.

In general, the definitions cannot exclude such reserves as it would be extremely discriminatory against individual market insurance vehicles. Not recognizing the durational factor or Active Life Reserves for individual policies and, thus, requiring a rebate because a medical loss ratio may be below 80% in a given year would result in underfunding of the individual policies thereby resulting in the insolvency or non-viability of the product or major rate increases in later years for these policyholders. The Active Life Reserve is sound policy and is in the best interest of furthering predictable and affordable health insurance premiums moving forward. This is especially important at times that insurers are growing individual policy business, which is very likely as we lead up to and the first few years after January 1, 2014.

At the same time, a negative change in such reserve from year to year could also have a negative financial impact on plans offering individual insurance products. There could be any number of reasons for the negative change in such reserves, including declining membership or re-estimates. Including negative changes in the definitions and minimum requirements could result in insurers paying out rebates on historical experience in a future year and create solvency and other financial hardship issues.

While we advocate for the general inclusion of all reserves, especially Active Life Reserves, in the MLR definitions and minimum requirements, we do believe that flexibility should be included for negative changes to reserves, or that state regulatory officials should be given regulatory authority to take circumstances surrounding such negative changes in such reserves into consideration when considering MLR and rebate calculations in a given year.