



PUBLIC PROTECTION CABINET

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February 16, 2011

Honorable Kathleen Sebelius
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight, Office of Oversight
Attn: MLR Division
Room 737F
200 Independence Ave. SW
Washington, DC 20201.

Via Electronic Mail

Dear Secretary Sebelius:

After a careful review of the regulations implementing the new medical loss ratio standards and an examination of our marketplace, I have concluded that an adjustment request pursuant to Section 2718 of the Public Health Service Act is essential for the Commonwealth of Kentucky until 2014. This is a formal request for an adjustment to the medical loss ratio (MLR) standard for Kentucky's individual health insurance market pursuant to Subpart C of the interim final regulation.

Kentucky's marketplace is still recovering from a failed health reform effort in the early nineties that completely destabilized our individual market with the departure of 43 health insurance companies from our marketplace, which left consumers with few insurance options. The proposed adjustment would create a three year transition period during which the MLR standard remains at Kentucky's present 65% for 2011 and increases by 5% each year reaching 80% in 2014. The detailed information required by Subpart C is included on the following pages and accompanying attachments.

Thank you for your attention to this request.

Sincerely,

A handwritten signature in blue ink that reads "Sharon P. Clark".

Sharon P. Clark
Commissioner

attachments

Request for Adjustment of Individual Market Medical Loss Ratio

State: Kentucky

If the Secretary determines that there is a reasonable likelihood that application of the 80% MLR to a state's individual market will destabilize the market, she may adjust the required MLR for the individual market for up to 3 reporting years. This adjustment must be requested by the state's insurance commissioner.

In requesting an MLR adjustment, the state must submit the following information to the Secretary, along with any additional information that would support its request. If data are unavailable, or their collection is unduly burdensome, the state may notify the Secretary of that fact.

Information regarding the State's individual health insurance market.

a) Current MLR standard in the individual market, including formula used to assess compliance:

Kentucky does not have a specific MLR standard applicable to all products in the individual market. However, the Department considers loss ratios in the analysis of whether premium is reasonable in relation to benefits provided, which is a factor in the rate approval process. KRS 304.17A-095(3) sets forth the factors that are examined in determining if a premium is reasonable:

(3) In approving or disapproving a filing under this section, the executive director shall consider:

- (a) Whether the benefits provided are reasonable in relation to the premium or fee charged;*
- (b) Whether the fees paid to providers for the covered services are reasonable in relation to the premium or fee charged;*
- (c) Previous premium rates or fees for the policies or contracts to which the filing applies;*
- (d) The effect of the rate or rate increase on policyholders, enrollees, and subscribers;*
- (e) Whether the rates, fees, dues, or other charges are excessive, inadequate, or unfairly discriminatory;*
- (f) The effect on the rates of any assessment made under KRS 304.17B-021; and*
- (g) Other factors as deemed relevant by the executive director.*

The Commissioner (executive director) has deemed that based upon the guaranteed lifetime minimum loss ratio (discussed below) a loss ratio less than 65% would be a factor that may suggest an unreasonable premium in relation to benefits.

Insurers have the option to file rates using Kentucky's guaranteed lifetime minimum loss ratio, which in the individual market is 65%. Kentucky's guaranteed lifetime minimum loss ratio is calculated over the lifetime of the policy. The calculation of the loss ratio is set forth in 304.17A-095(7) as follows:

When determining a loss ratio for the purposes of loss ratio guarantee, the insurer shall divide the total of the claims incurred, plus preferred provider organization expenses, case management and utilization review expenses, plus reinsurance premiums less reinsurance recoveries by the premiums earned less state and local premium taxes less other assessments. For purposes of determining the loss ratio for any loss ratio guarantee pursuant to this section, the commissioner may examine the insurer's expenses for preferred provider organization, case management, utilization review, and reinsurance used by the insurer in calculating the loss ratio guarantee for reasonableness. Only those expenses found to be reasonable by the commissioner may be used by the insurer for determining the loss ratio for purposes of any loss ratio guarantee.

For new products or products without credible experience, insurers must also file durational (yearly) loss ratios with the Department setting forth the projected loss ratios for each successive year of the product. These durational factors must be calculated in order to cumulatively yield a lifetime loss ratio of 65%. Insurers are held to the durational loss ratios filed with the Department for any given year. See 806 KAR 17:150 sections 8 and 9.

If insurers utilize the guaranteed lifetime minimum loss ratio rules for a given product, that product's rates are deemed approved and the standard rate review process does not apply. If an insurer has filed a product under the guaranteed lifetime minimum loss ratio and the product does not meet the applicable loss ratio, the insurer must make a refund to insureds covered under the policy during the policy year at issue. Refunds less than ten dollars are not paid to the insured; however, insurers must pay such refund amount to the Commonwealth. The relevant statute is 304.17A-095(6) and 806 KAR 17:150 Sections 8 and 9.

b) Market withdrawal requirements

Describe any requirements with respect to withdrawals from the individual health insurance market. Such requirements include, but are not limited to, any notice that must be provided and any authority the State regulator may have to approve a withdrawal plan or ensure that enrollees of the exiting issuer have continuing coverage, as well as any penalties or sanctions that may be levied upon exit or limitations on re-entry.

If an insurer elects to discontinue offering a specific market segment of health benefit plans, such as exiting the individual market completely, the insurer must seek approval from the Kentucky Insurance Commissioner. The insurer must notify all affected insureds ninety (90) days prior to the date of discontinuation of coverage. See KRS 304.17A-240(3)(a). The statute does not contain sanctions or penalties for exiting or re-entering a market segment, but there are sanctions if an insurer entirely exits the market. An insurer that exits all segments of the Kentucky insurance market must not issue any policies in Kentucky for a period of five years after the last plan discontinuance or non-renewal, whichever is later.

To date, since the passage of the Affordable Care Act, Kentucky has received notice of two insurers exiting our individual market. This leaves Kentucky with eight carriers offering individual insurance, Anthem controls 85% of the market. Kentucky's market is just beginning to recover from failed health reform efforts from the early 90s and cannot afford to lose another carrier. In the interests of increasing competition, thereby lowering costs and increasing customer satisfaction, Kentucky must encourage a vital and diverse insurance market.

c) Mechanisms to provide options to consumers

Describe the mechanisms available to the State to provide consumers with options in the event an issuer withdraws from the individual market. Such mechanisms include, but are not limited to, a guaranteed issue requirement, limits on health status rating, an issuer of last resort, or a State-operated high-risk pool.

Mechanism	Description
Kentucky Access	State-operated high-risk pool

Kentucky does not require insurers to guarantee issue in the individual market unless the applicant is under the age of 19, although all individual policies are guaranteed renewable unless an insurer is exiting the market or the market segment. Therefore, if a carrier did exit the individual market, members who are over the age of 19 and apply for coverage through a private insurer will undergo traditional underwriting, up to and including declination. Kentucky carriers offering coverage for children up to the age of 19 in the individual market are required, pursuant to the Affordable Care Act to provide guaranteed issue coverage. Beginning in 2011, Kentucky has an annual open enrollment period in January for child-only policies. Children who lose coverage during the year, such as due to a carrier exiting the market or otherwise losing group coverage, will have a special enrollment period.

There is a plus or minus 35% rating band allowed in the statutes for the individual market which would function as the limit on underwriting; on renewal there is also a 20% adjustment limit for health status factors. The relevant language is set forth in KRS 17A-0952(1) through (3):

Premium rates for a health benefit plan issued or renewed to an individual, a small group, or an association on or after April 10, 1998, shall be subject to the following provisions:

(1) The premium rates charged during a rating period to an individual with similar case characteristics for the same coverage, or the rates that could be charged to that individual under the rating system for that class of business, shall not vary from the index rate by more than thirty-five percent (35%) of the index rate upon any policy issuance or renewal, on or after January 1, 2003.

(2) Notwithstanding the thirty-five percent (35%) variance limitation in subsection (1) of this section, insurers offering an individual health benefit plan that is state-elected under sec. 35(e)(1)F of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201, may vary from the index rate by more than thirty-five percent (35%) for individuals who are eligible for the health coverage tax credit under the following conditions:

(a) The insurer certifies that the individual does not meet the insurer's underwriting guidelines for issuance of an individual policy;

(b) The policy meets the requirements for state-elected coverage under the Trade Act of 2002; and

(c) The premium rate is actuarially justified and has been approved by the Department of Insurance pursuant to KRS 304.17A-095.

(3) The percentage increase in the premium rate charged to an individual for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

(b) Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the individual and dependents as determined from the insurer's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the insurer's rate manual for the class of business.

The payor of last resort in Kentucky is the state high risk pool, Kentucky Access, as established under KRS Chapter 304, Subtitle 17B. To be eligible for Kentucky Access, an individual must meet the requirements of KRS 304.17B-015(2):

(2) Any individual who is not an eligible individual who has been a resident of the Commonwealth for at least twelve (12) months immediately preceding the application for Kentucky Access coverage is eligible for coverage under Kentucky Access if one (1) of the following conditions is met:

(a) The individual has been rejected by at least one (1) insurer for coverage of a health benefit plan that is substantially similar to Kentucky Access coverage;

(b) The individual has been offered coverage substantially similar to Kentucky Access coverage at a premium rate greater than the Kentucky Access premium rate at the time of enrollment or upon renewal; or

(c) The individual has a high-cost condition listed in KRS 304.17B-001.

The following individuals are excluded from Kentucky Access per KRS 304.17B-015(4):

(4) An individual shall not be eligible for coverage under Kentucky Access if:

(a) 1. The individual has, or is eligible for, on the effective date of coverage under Kentucky Access, substantially similar coverage under another contract or policy, unless the individual was issued coverage from a GAP participating insurer as a GAP qualified individual prior to January 1, 2001. A GAP qualified individual shall be automatically eligible for coverage under Kentucky Access without regard to the requirements of subsection (2) of this section; or

2. For individuals meeting the requirements of KRS 304.17A-005(11), the individual has, or is eligible for, on the effective date of coverage under Kentucky Access, coverage under a group health plan.

An individual who is ineligible for coverage pursuant to this paragraph shall not preclude the individual's spouse or dependents from being eligible for Kentucky Access coverage. As used in this paragraph, "eligible for" includes any individual and an individual's spouse or dependent who was eligible for coverage but waived that coverage. That individual and the individual's spouse or dependent shall be ineligible for Kentucky Access coverage through the period of waived coverage;

(b) The individual is eligible for coverage under Medicaid or Medicare;

(c) The individual previously terminated Kentucky Access coverage and twelve (12) months have not elapsed since the coverage was terminated, unless the individual demonstrates a good faith reason for the termination;

(d) Except for covered benefits paid under the standard health benefit plan as specified in KRS 304.17B-019, Kentucky Access has paid two million dollars (\$2,000,000) in covered benefits per individual. The maximum limit under this paragraph may be increased by the department;

(e) The individual is confined to a public institution or incarcerated in a federal, state, or local penal institution or in the custody of federal, state, or local law enforcement authorities, including work release programs; or

(f) The individual's premium, deductible, coinsurance, or copayment is partially or entirely paid or reimbursed by an individual or entity other than the individual or the individual's parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, grandchild, guardian, or court-appointed payor.

Generally speaking, the premiums for Kentucky Access, although they do not fully cover the cost of the program, are prohibitively high for some individuals. The premiums remain high due to the disproportion of members with high cost conditions. Therefore, many individuals who might lose coverage in the private market will not be able to afford coverage through Kentucky Access. The premiums for coverage through Kentucky Access are limited by KRS 304.17B-013:

304.17B-013 Premium rates for health benefit plans under Kentucky Access.

(1) The schedule of rates, premium rates charged to enrollees, deductible amounts, copayment amounts, coinsurance amounts, and other cost-sharing amounts shall be established by the department. Premium rates charged to enrollees are not intended to fully cover the cost of providing health care coverage to Kentucky Access enrollees, and any claims in excess of premium rates shall be covered by the Kentucky Access fund.

(2) Premium rates for health benefit plans provided under Kentucky Access shall bear a reasonable relationship to each other. Premium rates shall be varied based on age and gender. The initial premium rates for plan coverage shall not exceed one hundred fifty percent (150%) of the applicable individual standard risk rates, as established by the department. In no event shall premium rates exceed one hundred seventy-five percent (175%) of the rates applicable to individual standard risks.

(3) Premium rates for coverage issued by Kentucky Access shall be established annually by the department, using reasonable actuarial principles, and shall reflect anticipated experience and expenses for risks under Kentucky Access.

The Commonwealth of Kentucky is concerned that, if insurers were to exit the market, there would be an unsustainable influx of eligible individuals into Kentucky Access. With the current budgetary environment, the Commonwealth could not sustain the kind of increase in membership that would occur with an additional carrier exiting the market.

In describing each mechanism, include detail on the issuers participating in and products available under such mechanism, as well as any limitations with respect to eligibility, enrollment period, total enrollment, and coverage for pre-existing conditions.

Mechanism	Issuers Participating	Products Available	Limitations			
			Eligibility	Enrollment Period	Total Enrollment	Pre-existing Conditions
Kentucky Access	None	Traditional \$500 Preferred \$1,500 Premier \$500 Premier \$1,000 Premier \$1,500 Child Only \$1,500 NOTE: Pharmacy and Mental Health riders can be purchased with all plans, except the child only plan. No riders may be purchased with that one.	See KRS 304.17B-015	Continuous enrollment with annual renewal	As of 10/31/10 – 4,841 members	Yes, but not for HIPAA eligible individuals

d) Issuers in the State’s individual market

1) *For every issuer who offers coverage in the individual market, please provide its number of individual enrollees by product, available individual premium data by product, and individual health insurance market share within the state.*

Please see attached excel chart labeled d1.

2) *For each issuer who offers coverage in the individual market with more than 1,000 enrollees, please provide the following additional information:*

- i) Total earned premium on individual market health insurance products in the State;*
- ii) Reported MLR pursuant to State law for the individual market business in the State;*

- iii) *Estimated MLR for the individual market business in the State, as determined in accordance with §158.221 of this part;*
- iv) *Total agents' and brokers' commission expenses on individual health insurance products;*
- v) *Estimated rebate for the individual market business in the State, as determined in accordance with §158.221 and §158.240 of this part;*
- vi) *Net underwriting profit for the individual market business and consolidated business in the State;*
- vii) *After-tax profit and profit margin for the individual market business and consolidated business in the State;*
- viii) *Risk-based capital level; and*
- ix) *Whether the issuer has provided notice of exit to the State's insurance commissioner, superintendent, or comparable State authority.*

Please see attached Excel Chart labeled d2.

Proposal for adjusted medical loss ratio

A State must provide its own proposal as to the adjustment it seeks to the MLR standard. This proposal must include:

(a) An explanation and justification of how the proposed adjustment to the MLR was determined;

Kentucky would like to request an adjustment to the MLR standard to allow for a transition period over the next three years in order to allow newer carriers to compete with established carriers and to protect the role of agents in the insurance industry. Kentucky requests the following phase in period:

2011	65%
2012	70%
2013	75%

In 2011, carriers have already entered into agent commission agreements and provider contracts that are binding. They have not had time to adjust their business structure to account for the new MLR. For established carriers with big blocks of business this is not a concern as they have sufficient business to offset the restriction, but for carriers that are relatively new to our market, who are on the cusp of credibility or who are seeking to grow their current block beyond credibility, the 80% MLR will have a crippling effect on their business model. It would have a chilling effect on the proliferation of carriers in our market. Additionally, it will cause a further reduction in commissions to agents which will force a reduction in qualified licensed personnel servicing the consumers in our market. 65% is the current standard in our market and the Department would like to keep this standard for 2011, ramping up the MLR by 5% each year, reaching the required standard in 2014. Market changes that are implemented too quickly cause disruption, and Kentucky and its citizens cannot afford further disruption.

(b) An explanation of how an adjustment to the MLR standard for the State's individual market will permit issuers to adjust current business models and practices in order to meet an 80 percent MLR as soon as is practicable;

Kentucky's individual marketplace remains fragile and in recovery after a previous health reform effort in the 1990s (see attached white paper, Market Report on Health Insurance, 1999). Kentucky's version of health reform included a guaranteed issue market with no corresponding individual mandate, modified community rating (MCR), mandates requiring coverage for certain medical conditions, and a more stringent review of rate filings. The legislation passed in 1994 and immediately a large number of insurers exited our market. In the years that followed, a persistent trend existed of more carriers leaving the market than entering. Those carriers that entered the market were writing excepted benefits (non-major medical) or large group policies. Ultimately, Kentucky was left with a very limited major medical individual market, with Anthem Blue Cross Blue Shield as the predominant carrier. See attached, History of Kentucky Health Carriers 1990-1999.

Many carriers who exited our market are just beginning to return and grow their market share (for example Aetna, Time). For this reason, it is vital that Kentucky make every effort to encourage new business and competition in our marketplace. It appears from the research that has been performed that while the larger established carriers can meet the proposed loss ratio, newer carriers would not be able to meet the proposed standard. The Department believes that imposing the 80% loss ratio will stifle growth in Kentucky for the carriers with a smaller market share. Carriers will have limited incentive to grow beyond the credibility standards (1000 covered lives). Implementing a transitional period will allow carriers time to build their client base and allow Kentucky to incentivize growth during the transition period. Allowing a transition period for the loss ratio requirements over a three year period will assist newer carriers to ultimately meet the 80% loss ratio in 2014 by allowing time for underwriting on the current block of new policies to stabilize. Also, the newer carriers will be able to build a more significant market share to offset new business expenses. This will create a more varied and vibrant individual market. To continue to encourage larger carriers who have the market share to meet the 80% MLR while discouraging growth in the newer carriers will result in a stagnant market, which harms consumers.

All carriers informed the Department that in order to meet the 80 percent MLR, they would be reducing agent commissions in future years. Most carriers have begun this process in anticipation of the MLR requirements and will likely continue this trend without an adjustment to the MLR requirements. The Department believes that agents are an important resource for consumers, not just in selling products, but in assisting individuals throughout the life of their policy. Agents are often the means by which the Department learns of consumer protection issues and claims payment issues. Consumers need this assistance and if insurers are forced to further reduce their commissions to meet the 80% MLR, many agents will stop servicing the individual market. The Department does not have the resources to meet this need and Navigators for the Exchanges will not be available for many years. The role of the agent is valuable and necessary. Creating a transition period to allow carriers to ramp up to the 80% MLR will allow insurers a period to maintain current agent commissions. Therefore, the agent community will be able to continue to service clients who so desperately need assistance, especially in the years prior to the exchange when there is a great deal of misinformation about health reform. Also, agents will have a period of time to adjust their own business models to assure that they are able to continue in their much needed role in the new environment.

(c) An estimate of the rebates that would be paid if the issuers offering coverage in the individual market in the State must meet an 80 percent MLR for the applicable MLR reporting years; and

At this time, our most established carrier has represented to the Department that they will not be required to pay any rebates under the Affordable Care Act. However, if held to the current MLR standard, carriers with smaller market share or who have recently entered Kentucky's individual market may be required to pay crippling rebates if they grow past the credibility point. Such carriers will be incentivized under the new scheme to keep their market share small (or risk being subject to the 80% MLR standard) or to withdraw from the market and participate only in states where they have a large enough market share to meet the 80% standard. (Time (Assurant) is potentially in this situation. Time has stated they would have to consider discontinuation or exiting some markets in light of the MLR requirement). A strict imposition of the 80% MLR to Kentucky will only discourage competition in Kentucky and thereby the Kentucky individual health insurance market will stagnate. Therefore, the Department of Insurance believes that a strict focus on the amount of rebates that will be paid is ignoring the bigger issue. Large carriers will not pay a rebate, but a stagnant market is also extremely harmful to consumers. The Commonwealth of Kentucky would argue that a stagnant market is a destabilized market.

(d) An estimate of the rebates that would be paid if the issuers offering coverage in the individual market in the State must meet the adjusted MLR proposed by the State for the applicable MLR reporting years.

The Rebate estimate will remain at zero for the most established carrier; however the Department continues to argue that this is not the measure of a destabilized market.

State contact information.

Please provide contact information for the person the HHS may contact regarding the request for an adjustment to the MLR standard.

Name: Sharon P. Clark, Commissioner

Telephone number: 502-564-6026

E-mail address: SharonP.Clark@Ky.gov
Cc: Sharron.Burton@ky.gov

Mailing address: P.O. Box 517; Frankfort, KY 40602

Physical Address: 215 West Main St, Frankfort, KY 40601

Additional Information: *If a state holds a public hearing, the report from that hearing should be attached to the request.*