South Carolina Department of Insurance

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MARK SANFORD
Governor

SCOTT H. RICHARDSON
Director of Insurance

Via Hand Delivery

November 10, 2010

The Honorable Mark Sanford, Governor
State of South Carolina
Post Office Box 12267
Columbia, South Carolina 29211

The Honorable Glenn F. McConnell, President *Pro Tempore*
South Carolina Senate
101 Gressette Building
Columbia, South Carolina 29201

The Honorable Robert W. Harrell, Jr., Speaker
South Carolina House of Representatives
506 Blatt Building
Columbia, South Carolina 29201

Dear Governor Sanford, Senator McConnell and Speaker Harrell:

As you know, Congress recently enacted and President Obama subsequently signed into law the Affordable Care Act.[1] Its enactment and implementation is arguably the most far-reaching and significant development in the regulation of the health insurance industry to date. As a result, the ACA has had and will continue to have a considerable impact on the way we operate at the state level. In addition to the policy issues that you will face regarding the specifics of the Act, in the coming months we'll be asking you to consider its impact on our role as a regulatory agency.

In the interim, I am writing to update you on our role and response to-date as there are some provisions of the Affordable Care Act that have already required action of this Department. Our efforts thus far have focused on ensuring the protection of South Carolina's policyholders and the ongoing sustainability of our health insurance markets. What follows is an overview of some of the more significant developments in the seven months since enactment.

[1] The Patient Protection and Affordable Care Act, Public Law No. 111-148, was subsequently amended by the Health Care and Education Reconciliation Act, Public Law 111-152. They are collectively referred to as the "Affordable Care Act."

I. Temporary High Risk Pool Program/ Pre-Existing Condition Insurance Plan

Overview

The Affordable Care Act provides for the immediate creation of a temporary high risk health insurance pool program. Similar in concept to this State's existing high risk pool, the South Carolina Health Insurance Pool, this program is designed to make health insurance available to individuals that are unable to access private coverage due to their health status. As we understand it, the temporary high risk pool program is meant to be a temporary program to provide coverage for people with pre-existing conditions until the majority of the Act's insurance-related requirements become effective in January 2014. These include, for example, the prohibition on pre-existing condition exclusions and the implementation of the Health Insurance Exchange program. In order to be eligible for participation in the temporary high risk pool program, an individual must be uninsured for six months, be denied coverage by a private carrier due to a pre-existing condition, and be a citizen, national, or lawful resident of the United States.[2]

State Response

The Secretary of the U.S. Department of Health and Human Services, Secretary Sebelius, contacted state governors across the nation in a letter dated April 2, 2010 requesting feedback on states' interest in implementing this program at the state level. Governor Sanford declined to contract with HHS to take on this responsibility in a letter dated April 30, 2010. Because the State of South Carolina declined to serve as a contractor, HHS has contracted with the Government Employees Health Association, Inc. to administer the program in South Carolina. Additional information about the program, named the Pre-Existing Condition Insurance Plan (PCIP), is available on the Internet at www.pcip.gov or by calling 1 (866) 717-5826 Monday through Friday, 8 a.m. to 11 p.m., Eastern Time.

Outstanding Issue(s)

As previously indicated, South Carolina currently operates a high risk pool, the South Carolina Health Insurance Pool (SCHIP), which was created by act of the General Assembly.[3] It is a non-profit entity whose membership is comprised of all insurers and HMOs authorized to issue or provide health insurance coverage in the State.

SCHIP coverage is generally available to a person who has been a South Carolina resident for at least 30 days and meets the following criteria:

- They were turned down for private health insurance coverage for health reasons;
- They were accepted for private health insurance, but have pre-existing illnesses or conditions excluded from coverage for a period exceeding 12 months; or
- They are paying health insurance premiums for comparable coverage which are more than 150% of the premium levels charged by the Pool.

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[2] *See* Section 1101 of the Patient Protection and Affordable Care Act.
[3] *See* Chapter 74 of Title 38 of the South Carolina Code of Laws.

SCHIP premium rates are required to be self-sustaining and are generally not subsidized by the government.[4] In contrast, Congress appropriated $5 billion in federal funding to pay claims and administrative costs relating to the temporary high risk pool program through 2013.[5] As a result, a 45 year old enrollee in PCIP would pay a monthly premium of $462 while that same individual would pay a monthly premium of $936.25 (male) or $1,129.03 (female) if enrolled in SCHIP.[6]

Unfortunately, SCHIP enrollees are unable to take advantage of the temporary high risk pool program without discontinuing their current coverage and going uninsured for six months. The same is true for individuals that have other forms of health insurance, regardless of whether or not it provides coverage for their pre-existing conditions. This inequity is one of the issues detailed in Governor Sanford's letter to Secretary Sebelius, a copy of which is enclosed, declining to implement this program at the state level.

We have received numerous inquiries from consumers as a result of their inability to immediately switch from their current coverage to the Pre-Existing Condition Insurance Plan. Unfortunately, we have no authority to take corrective action. Because Congress specifically included as an eligibility criteria that an individual must have been uninsured for six months, it appears that Congress would need to take action to effect a resolution to this unfortunate situation.

II. Immediate Market Reforms

Overview

While many of the ACA's insurance-related provisions do not go into effect until January 1, 2014, there are several key provisions that became effective on September 23, 2010 (six months after the enactment of the Patient Protection and Affordable Care Act):

- No lifetime limits on dollar value of benefits;
- Restricted annual limits on dollar value of certain benefits as defined by the U.S. Department of Health and Human Services;
- Rescissions of coverage prohibited (except for fraud or intentional misrepresentation);
- Extension of coverage for dependent children up to age 26;
- Pre-existing condition exclusions prohibited for children up to age 19;
- Enhanced internal and external appeals processes for enrollees;
- Benefits for preventive services required, with no cost sharing;
- Access to pediatricians and OB/GYNs; and
- Coverage for emergency services at in-network cost-sharing level with no prior authorization requirements.

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[4] There are two ways in which SCHIP premium rates may be minimally subsidized: (1) through receipt of federal grants, which are used to offset consumers' premiums; and (2) through assessment of the member insurers in the case of Pool operations resulting in a deficit.

[5] *See* Section 1101 of the Patient Protection and Affordable Care Act.

[6] The SCHIP premiums are quoted from the SCHIP 80/60 Rates Schedule Effective January 1, 2010. They represent the discounted rates found in Table 1 (applicable to all applicants except those that are eligible for SCHIP because their premiums for comparable coverage exceeded 150% of SCHIP premiums).

State Response
The Department issued Bulletin 2010-04 in June, which sets forth the procedures for carriers to file the necessary changes to their policy forms in order to comply with the ACA's immediate market reforms. We are currently processing these filings.

The Department expects insurers and HMOs to comply with the Act's immediate market reforms on or before September 23, 2010. As such, the Department will disapprove policy forms that do not comply with the immediate market reforms for failure to meet the requirements of law. Furthermore, should the Department determine that an insurer or HMO is using a policy form that is not in compliance, that carrier will be deemed to be in violation of South Carolina law and subject to the penalties set forth in Section 38-2-10.

Outstanding Issue(s)
The Affordable Care Act includes a requirement that individual and group health plans may not impose any pre-existing condition exclusions. While this requirement generally becomes effective in 2014, Congress made it effective for enrollees under the age of 19 for any plan/ policy years beginning on or after September 23, 2010.[7]

A problem has arisen due to the U.S. Department of Health and Human Services' implementation of the under 19 portion (the immediate market reform portion) of this requirement. In federal regulations, HHS went further than Congress by saying that the under 19 requirement prohibits an individual under the age of 19 from being denied coverage through denial of benefits for a pre-existing condition or through denial of enrollment for coverage based on the pre-existing condition.[8] HHS' actions have essentially expanded this requirement into a guaranteed issue requirement for individuals under the age of 19.

This has caused a great deal of disruption in the marketplace in South Carolina and other states; carriers have stopped writing child-only coverage because they can't accept "healthy" children and deny coverage to "unhealthy" children. The Department is having ongoing discussions with our carriers and we are currently in the process of developing a plan to, hopefully, encourage carriers to again write this coverage. We are hopeful that these efforts will enable us to reach some sort of positive resolution for South Carolina's children and families soon.

III. Federal Grants

Overview
The Affordable Care Act provides for a considerable number of funding opportunities for a variety of programs and initiatives. These range in subject matter from increasing the number of primary health care providers to implementing Health Insurance Exchanges.

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[7] *See* Section 2704 of the Public Health Service Act, as added by Section 1201 of the Patient Protection and Affordable Care Act.
[8] "Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule," 75 Federal Register 123 (June 28, 2010), pp. 37188 – 37241.

Thus far, the U.S. Department of Health and Human Services has implemented three one-year grant programs relating to the insurance aspects of the Affordable Care Act:

- Health Insurance Premium Review Grant
- Health Insurance Exchange Planning and Establishment Grant
- Consumer Assistance Grant

Additional information regarding these grants is detailed in the *State Response* subheading below.

State Response

The Department has applied for and been awarded funding through each of the three grants listed above. What follows is a description of each grant and an overview of the Department's goals for each grant program.

a. Health Insurance Premium Review Grant

Grant Amount: $1,000,000
Award Date: August 16, 2010
Grant Length: 12 months

Congress appropriated a total of $250 million for the premium review grant program for federal fiscal years 2010 through 2014.[9] HHS has indicated that it plans to distribute the $250 million in funding for the Health Insurance Premium Review Grants in several phases over the next few years. This Department's grant is a part of the first phase of awards, which made available $1 million to each state applying for and receiving a Premium Review Grant. According to HHS, they awarded a total of $46 million in grants through the first phase to fund Premium Review Grant programs in 45 states and Washington, D.C.

SCDOI plans to use the Premium Review Grant funding to improve our rate review process, increase transparency and accessibility, and develop and upgrade technology systems.

The goals of the Premium Review Grant project are to:

1. establish a process for the comprehensive annual review of health insurance premiums to protect consumers from unreasonable, unjustified and/or excessive rate increases;
2. analyze the potential for abusive rating practices in different segments of the health insurance market;
3. enhance our systems to enable us to capture required data, aggregate data, and report critical information about health insurance rate filings;
4. automate the process for reviewing rate filings; and
5. review trends and rating practices in the individual as well as the small and large group health insurance market to help develop policy initiatives and make recommendations aimed at ensuring health insurance rates charged within the State are fair and reasonable.

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[9] *See* Section 2794 of the Public Health Service Act, as added by Section 1003 of the Patient Protection and Affordable Care Act.

b. Health Insurance Exchange Planning and Establishment Grant

Grant Amount: $1,000,000
Award Date: September 30, 2010
Grant Length: 12 months

In addition to requiring the creation of Health Insurance Exchanges by January 1, 2014, the Affordable Care Act provides funding assistance to states for the planning and establishment of Exchanges.[10] HHS announced the first round of grants on July 29, 2010. These so-called Exchange Planning Grants make available up to $1 million per state and are designed to help states determine whether they should establish an Exchange and, if so, assist in the initial planning activities for development of a state-based Exchange.

Governor Sanford designated the S.C. Department of Insurance as the lead agency for the Exchange Planning Grant. South Carolina was subsequently awarded one of 49 $1 million grants by HHS on September 30, 2010. The State's Exchange Planning Grant is for a period of one year. It will be housed within this Department and overseen by a DOI employee designated as the Principal Investigator. The Grant provides for the hiring of a Project Manager, who will be responsible for the day-to-day operations of the program, and a Project Coordinator.

The Exchange Planning Grant provides for the creation of a South Carolina Health Exchange Planning Committee (SCHEPC) made up of key stakeholders. The SCHEPC will be tasked with making recommendations to the Governor and General Assembly regarding whether it is feasible for South Carolina to create an Exchange and, if so, propose a plan for the successful implementation and ongoing sustainability of a state-based Exchange.

The goals of the Exchange Planning Grant are to:

1. complete a comprehensive review of the status of South Carolina's health insurance marketplace;
2. determine whether it is advisable and feasible for South Carolina to operate an Exchange, and if so, what the Exchange should look like and how it should function;
3. develop a detailed report on the issues that may impact the successful implementation of an Exchange and, if appropriate, develop a timeline, detailed implementation plan and budget for Exchange development; and
4. compile a final report to be presented to the Governor, South Carolina General Assembly and Secretary of the U.S. Department of Health and Human Services with policy recommendations on the feasibility of establishing an Exchange in this State and a detailed implementation and funding strategy, if applicable.

To be clear, the State's receipt of an Exchange Planning Grant neither implies nor requires State support for establishment of a state-based Exchange. This Grant merely provides the necessary funding for the State to undertake activities that will allow you, as policymakers, to make an informed decision regarding the feasibility of establishing a state-based Exchange.

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[10] *See* Section 1311 of the Patient Protection and Affordable Care Act.

c. Consumer Assistance Grant

Grant Amount: $441,000
Award Date: October 19, 2010
Grant Length: 12 months

Congress appropriated $30 million in initial funding under the Affordable Care Act to assist states and territories in educating consumers about their health coverage options, empower consumers, and ensure access to accurate information.[11] The primary goal of this funding opportunity is to assist states in establishing or strengthening consumer assistance programs that provide direct services to consumers with questions or concerns regarding their health insurance. HHS announced the availability of $29 million in funding on July 22, 2010 for the Consumer Assistance Grant program. State funding is determined based on population, with a minimum award amount of $120,000.

This Department was awarded a Consumer Assistance Grant in the amount of $440,000 on October 19, 2010.

What follows is a summary of how the Department plans to utilize these resources:

- Partner with organizations that provide enrollment assistance to South Carolina consumers;
- Provide training on the Affordable Care Act to insurers and agents;
- Enhance the consumer assistance provided by current DOI staff with temporary grant employees, student interns, and non-profit volunteers;
- Expand consumer education and outreach services, including development of printed literature, webinars, and other easily downloadable educational materials from the Department's website; and
- Enhance IT systems to support tracking of consumer inquiries through consumer complaint databases.

Outstanding Issue(s)
The Department is still in the initial phases of implementing these three federal grant programs. Additional information and updates on the status of these programs will be provided to you as these grants progress.

IV. Minimum Medical Loss Ratios

Overview
Beginning January 1, 2011, health insurance issuers in the individual, small group, and large group markets will be required to pay rebates to enrollees if their Medical Loss Ratio (MLR) in a plan year is less than the minimum ratio established under federal law.

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[11] *See* Section 2793 of the Public Health Service Act, as added by Section 1002 of the Patient Protection and Affordable Care Act.

The minimum MLR for the large group market is 85%. The minimum MLRs for the individual and small group markets are 80%.[12] For example, this means that an individual insurance issuer must spend 80¢ out of every $1 in premium revenues on reimbursements for clinical services provided to enrollees and activities that improve health care quality.[13]

The Act permits states to require a higher minimum MLR for any of these markets. It also authorizes the HHS Secretary to adjust the minimum MLR requirement with respect to a specific state if the Secretary determines that the application of the 80% ratio may destabilize the individual market in that state.

State Response
The Department sent a letter to Secretary Sebelius on July 15, 2010 requesting a waiver of the 80% MLR requirement for policies issued in the individual market. This request proposes a phased-in implementation that would apply the following minimum MLR requirements to the State's individual market: 65% in 2011, 70% in 2012, 75% in 2013, and 80% in 2014 and thereafter. I have enclosed a copy of this letter, which documents the reasons for this request.

Outstanding Issue(s)
The Department received a response from HHS on October 8, 2010 that acknowledged receipt of our July 15th request. Their response, a copy of which is enclosed, indicated that HHS will not make a determination on the waiver request until after the agency issues regulations implementing the MLR requirements, which are required to be issued by December 31st. The Department is, therefore, still awaiting a final determination from HHS regarding our proposed phase-in of the minimum MLR requirement for the State's individual health insurance market.

V. Administrative Issues

Overview
The sheer size and breadth of the Affordable Care Act has necessitated changes in the organizational structure and duties of federal as well as state agencies. Given that the U.S. Department of Health and Human Services is the principal federal agency responsible for implementing the Act, HHS created the Office of Consumer Information and Insurance Oversight in April. OCIIO's mission is to provide "leadership for implementing the provisions of the health reform bill that address private health insurance." Information regarding OCIIO is available on the Internet at www.hhs.gov/ociio.

Additionally, HHS has created a website, www.healthcare.gov, specifically tailored to providing information relating to the Affordable Care Act.

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[12] *See* Section 2718 of the Public Health Service Act, as added by Section 1001 and Section 10101 of the Patient Protection and Affordable Care Act.
[13] Premium revenue must be adjusted to exclude Federal and State taxes and licensing or regulatory fees and must also account for risk adjustment, risk corridors, and reinsurance.

State Response

The Department has assigned a staff member, Cathy Cauthen, to act as the principal contact for the Affordable Care Act. In her role as the Affordable Care Act Coordinator, Ms. Cauthen serves as a point of contact for HHS and interested parties on the Act and is responsible for coordinating the Department's efforts to respond to its implementation. In addition to the above, this includes the development of a Health Care Reform webpage as a part of the Department's website. This webpage, available by accessing the Department's website, www.doi.sc.gov, is intended to provide consumers and interested parties with information regarding the insurance-related provisions of the Affordable Care Act and state-specific updates. It currently provides information, for example, on the immediate market reforms and also provides links to federal websites regarding the Act.

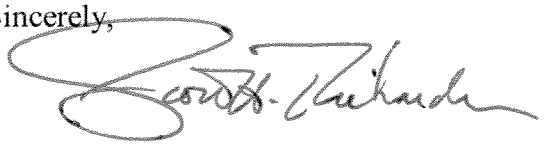
Outstanding Issue(s)

Currently, there are no major outstanding administrative issues. Additional information and updates will be provided to you as necessary.

As I have indicated previously in this correspondence, the Affordable Care Act places significant emphasis on state involvement in the implementation and regulation of the Act's insurance-related provisions. While there are many unknowns and it is still relatively early in the implementation process, I am hopeful that this correspondence will provide you with some helpful information on the Act's implications on the State and this agency's response thus far.

Please call me at any time should you wish to discuss this in more detail. You may also contact Kendall Buchanan, the Department's Legislative Liaison, at (803) 737-6124 or kbuchanan@doi.sc.gov.

Sincerely,



Scott H. Richardson, CPCU
Director

Cc: Governor-elect Nikki Haley
Chairman Harvey Peeler, Senate Medical Affairs Committee
Chairman David Thomas, Senate Banking and Insurance Committee
Chairman Leon Howard, House Medical, Military, Public and Municipal Affairs Committee
Chairman Bill Sandifer, House Labor, Commerce and Industry Committee

Enclosures (3)

State of South Carolina
Office of the Governor

MARK SANFORD
GOVERNOR

POST OFFICE BOX 12267
COLUMBIA 29211

April 30, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Sebelius,

I am writing in response to your letter of April 2, 2010, requesting that states notify you by April 30th of their interest in contracting with the U.S. Department of Health and Human Services (HHS) to operate a new, temporary high risk pool program created by the Patient Protection and Affordable Care Act of 2009. It's my understanding that if our state does not agree to operate a second high risk pool then the federal government will administer the temporary pool program and provide coverage to qualified South Carolinians.

For the past few weeks, the South Carolina Department of Insurance has been exploring the possibility of contracting with the federal government to operate a temporary high risk pool program. After analyzing the Act and discussing it with your agency, we've concluded that the program has too many unknowns and imposes too many potential burdens on our state's taxpayers. For the following reasons, therefore, the State of South Carolina will decline to set up and operate a second high risk pool program.

South Carolina's funding allocation to operate this mechanism, according to your agency's estimates, is to be $74 million. The most important question for us is, "And then what?" Once the $5 billion Congress appropriated to operate these programs through 2014 has run out, how will these programs continue to be funded? Richard Foster, the chief actuary for the Centers for Medicare and Medicaid Services, has recently reported that the high risk program would run out of money as early as next year or 2012. With no assurances that the federal government will continue to fund the program after the initial $5 billion is gone, we think it would be irresponsible for South Carolina to agree to operate another bureaucracy on behalf of the federal government. That's especially true given the tough budgetary times in which we find ourselves.

In order to prevent the temporary high risk pool from incurring unfunded liabilities, our state would need to cap enrollment. Our preliminary actuarial estimates indicate that, based on the Act's rating requirements and the state's estimated funding allocations, we would need to limit enrollment to between 750 to 1,200 South Carolinians. This cap represents a tiny fraction of the eligible population – estimated to be between 20,000 and 120,000 people. Furthermore, far fewer people could be covered than are currently covered by South Carolina's high risk pool.

I would also point out that this pool program is particularly inequitable for the 2,000 participants in South Carolina's existing high risk pool. Participants in the state's current pool pay up to 200 percent of the standard premium for their policies – yet under the new pool people with relatively similar health conditions, who are relatively better off, are eligible to pay half the price for nearly identical coverage. Furthermore, current participants may not participate in the federal high risk pool unless they drop their current coverage for 6 months. Moreover, people who have responsibly maintained their insurance will still have to pay their premiums while their federal tax dollars subsidize pool participants. This plan invites people to tiptoe closer to financial ruin while creating backwards incentives for responsible taxpayers.

The decision now before our state is whether we will serve as a contractor for this temporary federal program – not whether one will be formed. A temporary high risk pool will be established in South Carolina regardless of whether the state agrees to administer it. Given the fact that we are not in a financial position to administer another federal program – the costs of which are unknown and essentially unknowable – we will not be administering this federal program.

Sincerely,

Mark Sanford

cc: South Carolina Congressional Delegation
The Honorable Scott Richardson, South Carolina Department of Insurance
The Honorable Glenn F. McConnell
The Honorable Robert W. Harrell, Jr.
The Honorable Hugh K. Leatherman, Sr.
The Honorable David Thomas
The Honorable Dan Cooper
The Honorable William E. Sandifer III

South Carolina Department of Insurance

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MARK SANFORD
Governor

SCOTT H. RICHARDSON
Director of Insurance

July 15, 2010

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Individual Market Medical Loss Ratio Waiver

Dear Secretary Sebelius:

Thank you for your leadership as our nation makes the important transitions in our health insurance marketplaces required by the Affordable Care Act (the Act). The State of South Carolina has always emphasized providing affordable, meaningful health insurance to its citizens that is backed by solvent, well managed health insurers and health maintenance organizations (HMOs). As a part of its regulatory responsibilities, the Department of Insurance monitors the insurance market and attempts to address issues related to the availability and affordability of insurance products for South Carolina's consumers. The health insurance market is no exception. South Carolina has introduced a number of legislative reforms intended to increase the availability of health insurance products at reasonable prices. The Act has been passed by Congress with the same basic objective.

In reviewing the provisions of the Act, it has come to our attention that some provisions may have an unintended, deleterious impact on the consumers of this state. If implemented as currently proposed, the 80% medical loss ratio requirement will not increase consumer choice in health insurance products or make coverage more affordable or readily available. As you know, the health insurance marketplace differs among the states. The Act takes this variation into account and allows state-by-state waivers to minimize disruption in the existing individual markets as we make the transition to the exchange-based markets in 2014.

Accordingly, South Carolina requests a waiver of the 80% minimum medical loss ratio requirement for individual health insurance policies offered in South Carolina until 2014 in accordance with Section 2718 of the Public Health Service Act. *See* Patient Protection and Affordable Care Act Section 1001(5) and Section 10101(f). To avoid the potential problem of consumers not being able to find health insurance coverage at affordable prices, we propose to phase in the 80% loss ratio requirement and would respectfully request that the following minimum medical loss ratio requirements be substituted as the applicable loss ratios for the State of South Carolina: 65% in 2011, 70% in 2012, 75% in 2013, and 80% in 2014 and thereafter. The reasons that support gradually phasing in the minimum loss ratio requirements follow.

I. Current Rate Filing and Guaranteed Loss Ratio Requirements

Under South Carolina law, individual health insurance rates must be filed with the Department of Insurance (DOI) in one of two ways. First, the rates must be filed for prior approval by the DOI with justification for the proposed rate increase. The DOI has the right to request additional data and to reject the rate increase. Second, the health insurance issuer must file new rates with a loss ratio guarantee. If the loss ratios for the

products in the filing fail to meet the guaranteed loss ratio, the issuer must refund premium in the subsequent year so that the guarantee is met. *See* S.C. Code Ann. § 38-71-310(E) (2002). In all cases, the DOI uses the National Association of Insurance Commissioners' (NAIC) *Guidelines for Filing of Rates for Individual Health Insurance Forms* to determine the minimum acceptable loss ratio for health insurance products. For comprehensive health insurance products, this minimum medical loss ratio is 55%, depending on the renewability clause stated in the contract. In South Carolina, the medical loss ratio is defined as the ratio of incurred claims to earned premiums.

II. Underwriting and Its Impact on Loss Ratios

Moreover, South Carolina law allows issuers to underwrite new applicants for health insurance coverage. An individual may be accepted as a standard risk, offered a higher rate based on their health status, offered a policy with a condition rider based on their health status, or rejected for coverage by the health insurance issuer. Health insurance that is underwritten in this way demonstrates significant variation in loss ratios based on the duration of the policy as the effect of the underwriting process wears off as the duration lengthens. Individuals in their first year of coverage typically have an average loss ratio that is significantly less than the average loss ratio for individuals who have had coverage for three or more years. The durational mix of an issuer's block of business significantly affects its average loss ratio for its entire block. Suddenly implementing a new, significantly higher minimum medical loss ratio would have a very different impact on different health insurance companies based upon the durational mix of their blocks of business even if every other aspect of how those companies do business is identical.

III. Commissions and Their Impact on Loss Ratios

Most individual health insurance is sold through insurance producers (i.e., agents) in South Carolina. Health insurance issuers must include the commissions paid to producers in their health insurance rates. Competition between the state's issuers requires each issuer to maintain an adequate commission arrangement for producers. The transition to an 80% minimum medical loss ratio will require changes in these commission arrangements. Since some of the current arrangements are contractual between the health insurance issuer and the producer, it will take time for changes in the commission arrangements to have a full impact on the aggregate level of commissions paid by an issuer.

IV. Insurance Availability Issues

Absent a waiver, the South Carolina Department of Insurance believes that the new federal minimum medical loss ratio will create disruption in our individual health insurance market. This will have a disparate impact on smaller carriers and could cause a decrease in competition as carriers exit the marketplace, thus resulting in less consumer choice. We believe that health insurance issuers can make a transition from the existing requirements to the new requirements, but that the transition should be phased in to allow issuers the time to make the necessary adjustments, encourage them to stay in the market, and to minimize the potential market disruptions If issuers are not allowed a period of transition from the current South Carolina requirements to the new federal requirements in 2014, consumers will not be able to find coverage and will be denied the choice the Act was intended to create. While we have not received reports of market exits from major carriers, we are increasingly concerned that some of our smaller carriers will exit the market, making health insurance less available and affordable. This will likely result in the complete domination of the market by one or two carriers. This is not our understanding of the purpose of the Act nor do we believe that it is in the best interest of South Carolinians.

Therefore, we would ask for approval of our waiver request and plan for gradually phasing in the minimum medical loss ratio requirements. Based upon the information set forth above, we believe you will agree with our determination that implementing an 80% minimum medical loss ratio for individual products before 2014 will destabilize the South Carolina individual health insurance marketplace and hurt consumers. As noted above, we request that the following minimum medical loss ratio requirements be substituted for the state of South Carolina: 65% in 2011, 70% in 2012, 75% in 2013, and 80% in 2014 and thereafter.

Thank you for your consideration of this request. Please feel free to contact me at (803) 737-6805 or Leslie Jones, the Department's chief actuary, at (843) 577-3413 if you have any questions.

Sincerely,

Scott Richardson, CPCU
Director