BEFORE THE DEPARTMENT OF INSURANCE, FINANCIAL

INSTITUTIONS & PROFESSIONAL REGISTRATION

STATE OF MISSOURI

TRANSCRIPT OF PROCEEDINGS

PUBLIC HEARING

December 28, 2010

Jefferson City, Missouri

BEFORE: John Huff, Director of the Department of Insurance

INDEX

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DIRECTOR HUFF: I think we'll go ahead and get started, keep folks moving on their holiday schedule. So thanks for being with us today. My name's John Huff. I'm the director of the Missouri Department of Insurance, Financial Institutions & Professional Registration. It's 9:05 on Tuesday, December 28, 2010, in Room 500 of the Truman State Office Building in Jefferson City, Missouri.

The Department has retained the services of a court reporter for this hearing. The purpose of the hearing is to solicit testimony on the record related to the particular effect of the medical loss ratio on the individual health insurance market in Missouri, so that's important for us to remember. We'll only be talking about the individual market, not the small group or the large group market.

The U.S. Department of Health and Human Services, HHS, recently promulgated regulations implementing provisions of the Patient Protection and Affordable Care Act. Some people call it PPACA; I will probably just call it the Affordable Care Act.

One such provision is the requirement that health insurance issuers must meet specific specified annual loss ratios or pay rebates to enrollees, also known as the medical loss ratio. PPACA specifies the large group plans must have a loss ratio of 85 percent or higher, and

small group and individual plans must have a loss ratio of 80 percent or higher. Health insurance issuers are required to report these ratios to HHS each year. If the ratio is not met, the issuer must pay rebates to its insurers.

The regulations issued by HHS allow the Secretary to adjust the MLR standard that must be met by issuers offering coverage in the individual market in a state for a given MLR reporting year, if it is determined that the application of the 80 percent MLR standard may destabilize the individual market in the state.

If I may ask you to sign in. There's a log up here.

As stated in the notice for this hearing, the Department seeks testimony from individual consumers, insurers, or carriers, HMOs, professional associations, public interest groups, and from any other person with an interest in medical loss ratio rules as they apply to health insurance marketplace in Missouri.

I would ask that your testimony should specifically address any or all of the following issues: One, whether Missouri should request an adjustment to the MLR for the individual market in the state; if so, the appropriate adjusted MLR, and suggestions for the length of transitional period in Missouri; the consequences to

companies offering individual coverage in Missouri if an adjustment is not sought; the consequences to brokers or agents offering products in the individual market if an adjustment is not sought; and any other matter bearing on the criteria HHS has identified of the impact of the risk of market destabilization.

Your testimony may address the impact of medical loss ratios on individuals, insurers, agents, or any other person or entity. I would ask that your testimony be brief, specific, fact based, and focused on the Missouri health insurance marketplace. Supporting data should be targeted to conditions in the state of Missouri.

I will use the information gathered, along with information from other sources, to determine whether Missouri should request an adjustment to the medical loss ratio rules from the U.S. Department of Health and Human Services.

A sign-in sheet marked witness list has been prepared and is here before me on this desk (indicating). If you've not already done so, I now ask that those who wish to be heard today come forward and sign up on the witness list. Please list your name and your company, or any other affiliation, after your name. If you signed in as an attendee and you care not to testify, that's okay too. We'll move along a little bit more quickly.

At this time I take official notice of Exhibit 1, the notice of hearing for this proceeding and the detailed description for the submission of comments incorporated in the notice. Exhibit 1 is admitted into the record.

(Exhibit 1 was received into evidence at this time.)

DIRECTOR HUFF: We will proceed with testimony in the order each witness's name appears on the witness list. Each witness will be allowed no more than 15 minutes to offer testimony on the record. If an interested person or entity wishes to make additional comments beyond that time limit, I welcome them to submit such comments in a sworn affidavit before the close of business Thursday, December 30, 2010.

If a witness is not substantially addressing the questions in the notice or is only offering repetitive or cumulative evidence, I may exercise my discretion to limit testimony to less than the full amount of time.

Any questions before we get started? If not, we'll go down the list here and ask folks if they want to testify. And if you don't mind, I think I'll be seated here.

Amy Smoucha?

MS. SMOUCHA: I'm Amy. I have a quick

question. One of our leaders at Missouri Health Care for All can only be here until 9:30. Can I allow him to testify first?

DIRECTOR HUFF: Just a moment.

MS. ERICKSON: Do you need to be sworn in?

DIRECTOR HUFF: I think she's just asking a question.

MS. ERICKSON: Okay.

DIRECTOR HUFF: I'm sorry.

MS. SMOUCHA: Is it possible to go out of order for someone who can only be here until 9:30, who is also on the list?

DIRECTOR HUFF: Any objection? Okay. That's fine.

MS. SMOUCHA: Great.

DIRECTOR HUFF: If you would, come up to the table.

(Witness sworn by Director Huff.)

JIM HILL,

having been sworn, testified as follows:

DIRECTOR HUFF: If you would, state your name and your affiliation.

MR. HILL: My name is Jim Hill. I'm on the steering committee for the Missouri Health Care for All. Missouri Health Care for All is a grassroots, nonpartisan

movement of faith and community leaders committed to securing quality affordable health care for all Missourians. We have 120 organizations who have endorsed our principles for a just health care system, and in addition, we have more than 7,300 grassroots members.

We were very glad to see a public process begin in Missouri on the components of the Affordable Care Act. In addition, we see the questions of how to hold insurance companies accountable to Missouri families and consumers as fundamental to realizing the benefits of the new law.

Missouri Health Care for All firmly believes that we have a moral obligation to make sure that every person and family in our state has access to the rich health care resources Missouri enjoys. We understand that there's a long way to go until everyone has health care that they can afford that's available to them in the community where they live, no matter where they live, or how much money they make.

Still, we are committed to that vision and to holding Missouri officials and companies that conduct business in Missouri accountable to that vision. We strongly assert that investing in health care for all is both critically important for the well-being of all Missourians, and a sound economic investment. Based on

faith and ethical values, we affirm that all persons should have the opportunity for health care and healing.

So it is our position that Missouri should not seek an adjustment or waiver on the medical loss ratio status for insurance carriers. Reasons for that being that the medical loss ratio rules are good for consumers and small businesses who purchase insurance.

As you know, the medical loss ratio assures that we receive value for our premium dollars by requiring 80 percent or more premium dollars being spent on medical care versus administrative costs, profits, advertising, CEO pay, claims administration, and lobbying. Missouri consumers need more value for our premium dollars, and insurance companies must be required to deliver more value and more affordable premiums.

The medical loss ratio was intended to put effective pressure on insurance companies to do a better job, to decrease administrative costs, to deliver more value to Missouri consumers. It is one of the few cost containment provisions in the Affordable Care Act, and it will impact many insured families in our state.

The medical loss ratio was a sound public policy. Assuring that a reasonable percentage of health care premiums benefit consumers and families is good public policy. We are concerned about compromising that consumer

protection for vital families in Missouri in order to benefit the health insurance industry.

The top five for-profit health insurers alone reported $12.2 billion in profits in 2009. Without the minimum loss ratio -- medical loss ratios, which are still well below the average achieved in the 1990s, health plans would continue to spend excessively on profits, disproportionate CEO pay packages, lobbying, and many other administrative activities.

Missouri consumers need transparency to assure that the -- the value of our premium dollars. The Department of Health and Human Services identifies six criteria that would be used to determine the risk of destabilization in the insurance market; however, in Missouri we do not have specific data readily available to consumers to evaluate the effect on the marketplace. Only two other states, Georgia and Montana, have so little transparency with regard to insurance premiums and their medical loss ratios.

It will be critically important for the Department of Insurance to improve information available to consumers about rate increases and medical loss ratios now that the state and federal government have a greater capacity to protect consumer interests.

We do know that Missouri families and small

businesses have been saddled with staggering premium increases. My own insurance premium, as a small business, went to over $18,000 for my wife and I, and we, neither one, have a serious illness. The cost of insurance grew by a startling 83 percent between 2000 and 2009 for Missouri consumers.

The transparency of a medical loss ratio means that for the first time Missouri consumers can actually learn and understand what insurance companies are doing with our premium dollars and to shop wisely with that knowledge. For Missouri consumers the medical loss ratio provisions are a significant opportunity and an important piece of the Affordable Care Act that makes coverage more affordable and makes the system more transparent.

The new medical loss ratio rules will ensure that consumers get good value for their premiums. In addition, granting a waiver would deny Missourians their rebates from companies that fail to meet the MLR standard.

Any potential adjustment should involve rigorous assessment by the Department of Insurance and should be transparent and should involve significant consumer input and engagement.

The medical loss ratio is sound public policy. If Missouri experiences adverse consequences due to this, the solution is to modify state laws to protect

consumers. Many tools are available, including rate review, more stringent requirements on carriers who wish to sell policies in Missouri, and stronger consumer protections.

We strongly urge Director Huff to not request a waiver lowering the medical loss ratio standards for the state of Missouri. And I'll leave a copy of my remarks.

DIRECTOR HUFF: Thank you, Mr. Hill. And you would like this document to be admitted into evidence as well?

MR. HILL: Yes.

DIRECTOR HUFF: Okay. The documents will be admitted for purposes of supplementing the testimony. Thank you, Mr. Hill.

(Exhibit No. 2 was admitted into evidence at this time.)

DIRECTOR HUFF: Okay. We'll go back to the top of my list. Amy?

(Witness sworn by Director Huff.)

AMY SMOUCHA,

having been sworn, testified as follows:

DIRECTOR HUFF: If you'll state your name and your affiliation, please.

MS. SMOUCHA: My name is Amy Smoucha and I'm

statewide health care organizer with Missouri Jobs with Justice. And I'd like to speak today on behalf of health care consumers in Missouri, and urge you to fully implement the federal medical loss ratio. We believe it will be harmful for Missouri consumers if the Department obtains an adjustment to the new MLR standards.

Jobs with Justice is a coalition of labor, community, faith, and student groups. We have more than 100 member organizations in the state and grassroots membership of more than 10,000 Missourians. Our members, who are working people and middle class families, have a significant stake in the implementation of the Affordable Care Act, and especially provisions that will make heath care premiums more affordable and insurance companies more accountable to consumers.

We are greatly concerned that if the State seeks a federal adjustment to the medical loss ratio, working and middle class families in our state will lose an important premium protection, and will be forced to forfeit rebates that they're entitled to under the federal law.

I'm going to submit my entire written testimony, but skip over anything that's redundant because we agree in many ways with what Reverend Hill talked about.

The medical loss ratio provision of the Affordable Care Act is intended to ensure that consumers

get good value for their health care dollar. These provisions are good for Missouri's workers and for families purchasing in the individual market. Missouri desperately needs protection from soaring premiums and decreasing value.

As the previous gentleman testified, our health insurance premiums grew 83 percent between 2000 and 2009. We contrast that with median wages, which grew only 23 percent. The cost of health care premiums for working families is soaring out of control. It's growing at unsustainable rates and insurance companies can and must deliver more value.

We also agree that transparency is a key benefit of the medical loss ratio provision, and that it should be fully implemented to give consumers the access to the data about how health insurers are spending our money.

In addition, we know that some insurers in the state have claimed that being required to spend 80 cents of every premium dollar on medical care and quality improvement would force them to stop selling policies in the individual market. Truthfully, Missouri consumers are fed up with that way of thinking.

We're fed up with unjustified premium increases that leave too many of us with ever increasing premiums or uninsured. We're also fed up with insurers who

seek to control the market and then take advantage of consumers with high premiums and low value policies.

Data available on the individual -- on the insurance market website shows that three of the five top insurers writing policies in Missouri's individual market are close to meeting the MLR standard or at the 80 percent standard. Other insurers should be able to lower their administrative expenses and meet the standard as well.

For instance, the website indicates that Healthy Alliance, the insurer that holds the largest share of the individual market in Missouri, spends less than 70 percent of premiums on care. We want to know why one company with more than half of the market share in the individual market is unable to deliver a competitive medical loss ratio. That's a very important question for consumers. Healthy Alliance and other insurers need to work with consumers and the Department to help create a more competitive value for premium health insurance system.

One of our concerns is that some of the companies, like Healthy Alliance, a subsidiary of WellPoint, has significant profits and a CEO salary that exceeds $11 million. Is it really reasonable to claim that they can't do better by consumers in Missouri's market and actually meet the medical loss ratio standards?

And we second the idea that if such insurers

can't meet the challenge of competitive MLRs, Missouri should create stronger rules for insurance companies. For example, we should create new regulations that bar any health insurer who leaves Missouri's individual health marketplace, or who redlines geographic areas, we should bar them from being eligible to sell policies in the exchanges in 2014. So they better do right now if they want to be included later.

We also believe strongly that a thorough transparent process must be conducted if Missouri moves forward to seek a waiver. Insurance carriers need to answer some basic questions: Why are administrative costs in our plan so high? Why can't they be brought down? Why can insurers meet medical loss ratio standards in other states, like Kansas, but not in Missouri? That's an important question to us.

It's also important for the State to conduct a thorough transparent assessment of which insurers will or will not meet the medical loss ratio requirements, and consumers need access to that information. It's essential to know which insurers fall into the gap, since protecting a few insurers by seeking an adjustment means lowering the standard statewide for all carriers and denying that protection for all consumers in the individual market. That's important to us.

So in conclusion, we really commend Director Huff for voting with the other insurance commissioners across the country for this rule, and we hope that you stand by that vote in Missouri, and we stand by you if you do. And on behalf of consumers and working families in our state, we respectfully urge you not to request an adjustment to the medical loss ratio for our state. Enforce the rule fully and hold insurance carriers in Missouri accountable to higher standards.

DIRECTOR HUFF: Thank you, Ms. Smoucha. Any questions of Ms. Smoucha? Very well.

MS. SMOUCHA: Thank you.

DIRECTOR HUFF: I'll take your written testimony.

MS. SMOUCHA: Oh, actually, I brought with me the written testimony of a member of Jobs with Justice and Missouri Health Care for All, Bernadette Gronborg, and I'm not going to read it, but she is a consumer who lives in Festus, who purchases in the individual market, and is exactly why this matters. She has a high deductible policy, $15,000 deductible. She has never filed a claim on the policy and her premiums have gone up twice this year. So her entire story is available. She's exactly the kind of -- the consumer who represents why we can't adjust the MLR standard.

DIRECTOR HUFF: Ms. Smoucha, I'm reminded by Jim McAdams, our general counsel, does that testimony have an affidavit on it from the consumer?

MS. SMOUCHA: It doesn't. Is there a way to enter it into the record informally and I can have her submit it as an affidavit, because we have until the 30th. Can we just --

DIRECTOR HUFF: We'll just -- sure.

MS. SMOUCHA: Great. Thank you.

DIRECTOR HUFF: Thank you very much. So Exhibit 3 will be your notes that supplement your testimony. And then Exhibit 4 will be the memo from Ms. Gronborg that we'll look forward to seeing the affidavit on. Thank you very much.

(Exhibit Nos. 3 and 4 were admitted into evidence at this time.)

DIRECTOR HUFF: You're going to have to help me with the next name, Hilg-- initial K? No? The next person on the list is K. Hilgadiack?

MS. HILGADIACK: Yes. I don't need to speak.

DIRECTOR HUFF: Okay. Thank you.

Chris Moody, are you testifying?

MR. MOODY: I'm not here to speak. Thank you.

DIRECTOR HUFF: Thank you.

Mr. Gibbons? Tim Gibbons?

MR. GIBBONS: Yes, sir.

(Witness sworn by Director Huff.)

TIM GIBBONS,

having been sworn, testified as follows:

DIRECTOR HUFF: If you would, state your name and spell it for the court reporter, and what your affiliation is.

MR. GIBBONS: My handwriting's not good enough apparently. It's usually not. Tim Gibbons; I'm with the Missouri Rural Crisis Center. We're a -- that's spelled T-i-m G-i-b-b-o-n-s. We are a statewide nonprofit farm and rural organization representing 56 member families. I would like to thank y'all for the opportunity to testify. And hope y'all had a merry Christmas and have a happy New Year.

Missouri should not seek an adjustment or waiver of the medical loss ratio standards for insurance carriers. Our members, comprised of Missouri's family farmers and rural citizens, have significant experience in the individual insurance marketplace. And under the current rules, farm families are not getting value for their premium dollars.

Family farmers are extremely dependent on

the private individual marketplace, 30 percent versus the national average of 8 percent, and they have been paying into a marketplace and getting very inadequate health coverage. Increasingly many of our members cannot afford to purchase any coverage at all with soaring premiums and low value of the coverage available.

We see the MLR standards as a good first step in holding insurance companies accountable for affordable premiums, increasing transparency in the individual and small group markets, and assuring rural families and family farmers of good value for their premium dollars.

MRCC has partnered with several community groups, including St. Louis University and the Access Project, to produce a report about access to health insurance for family farmers and ranchers in Missouri. Our report, based on 2006 data, revealed the problems Missouri farmers and ranchers are facing in the individual insurance marketplace.

And please note, premium costs and value for premium spent has gotten significantly worse for farm families and rural citizens since the 2006 data we compiled.

The report shows many things, but four things stand out: Farmers and ranchers who purchase

policies directly through the individual marketplace had significantly higher total health care costs than those who were insured through off-farm coverage.

Number two, controlling for age and health status. Families insured through the individual market spent $2,117 more on health care, on average, than those insured through off-farm jobs.

Number three, farmers and ranchers who bought insurance in the individual market relied overwhelmingly on the costliest types of policies, those with high premiums, and high deductibles. The fact that so few of those purchasing insurance in the individual marketplace have low-deductible plans suggests that low-deductible plans aren't really there.

And number four, people with high-premium policies spent significantly more overall on health care than those who had low premium policies.

Therefore, we believe the medical loss ratio policy is headed in the right direction. The transparency of the medical loss ratio means that for the first time consumers can get an answer to the basic question, Where are the dollars spent on our premiums actually going.

Missourians have absorbed outrageous and unsustainable premium rate increases in our state in the last few years. And to reiterate what Amy and the

gentleman before said, our health care costs have gone up 83 percent through 2009, while median earnings in the state grew only 23 percent. That just doesn't -- it's not going to work.

Our report shows that one out of five Missouri farmers and ranchers surveyed reported that health care costs contributed to their financial problems, including making it difficult to pay off farm and ranch loans, causing them to delay ranch or farm investments, and increasing the need to take off-farm work.

Some insurers in the state have claimed that being required to spend 80 cents of every premium dollar on medical care and quality improvement would force them to stop selling insurance in the individual marketplace, and MRCC is very concerned -- the Missouri Rural Crisis Center is very concerned about access to health insurance and choice of insurers in rural areas.

However, data available on the Insurance Department website seems to indicate that several insurers are close to meeting the spending target, as Ms. Smoucha mentioned before. Other insurers would need to lower their administrative expenses, or if administrative spending exceeded the target, they would have to rebate consumers the difference.

Missouri consumers need increased

transparency to assure value for our premium dollars. The State must create a strong transparent process of assessing which insurance will or will not meet the MLR requirements. The federal formula for calculating the medical loss ratio already makes reasonable accommodations for plans that are small or new or have low annual limits. It is unfair to consumers to say that the State needs to seek an adjustment because a few companies don't meet the new standard. That's the point of the law is to change their behavior, not to sanction it.

It is unfortunate that in Missouri we do not have rules that require insurance companies to provide appropriate data. And as the gentleman before has said, only two other states have so little transparency with regard to insurance premiums and the MLR. The Department of Insurance needs to do much more to protect consumers and require plans to submit standard data.

We commend the director for voting with every other state insurance commissioner in unanimous support for the federal regulations and we appreciate your vote, especially given the significance of the medical loss ratio as an important piece of the Affordable Care Act that makes coverage more affordable and makes the system more transparent to our members, family farmers and rural citizens of our state.

So therefore, we strongly urge the director of the Department of Insurance not to seek a waiver for the adjustment of the MLR for the state of Missouri. Thank you very much.

DIRECTOR HUFF: Thank you, Mr. Gibbons. Any questions for this --

MS. KEMPKER: Please.

DIRECTOR HUFF: Yes.

MS. KEMPKER: I'm Mary Kempker; I'm the market reg director. You had mentioned the access report. Did you bring a copy of it or is it still available?

MR. GIBBONS: It is online. I can also maybe give it through the comment period. I wonder if there's a way to attach a document online through the December 30th comment period?

DIRECTOR HUFF: You can scan it and send it to us.

MR. GIBBONS: I can scan it and send it to you. It's actually sitting on my desk right now. I meant to bring it, but I was halfway here and realized. I apologize for that.

DIRECTOR HUFF: Any other questions? Did you want to submit that as a supplement?

MR. GIBBONS: Yes, please. And I appreciate the opportunity.

Just to give you one example, Lutheran Family and Children's Services works with many people, including pregnant women in crisis. And we see firsthand the cost to the individual mothers and the individual babies that are born, but there's -- born without adequate health care. But there's also an enormous monetary cost to the State. There's a considerable difference between a healthy baby that's born versus a low birth weight or premature baby, which is often the case when parents don't have adequate health insurance or don't have health insurance.

So we're just kind of here to weigh in and support others that are here to suggest that Missouri not take this waiver.

DIRECTOR HUFF: Thank you, Ms. Silea.

MS. SILEA: Short and sweet, and I have nothing to submit.

DIRECTOR HUFF: Thank you, Ms. Silea. Any questions of Ms. Silea? Thank you very much.

MS. SILEA: Thank you.

DIRECTOR HUFF: As I go through the log here, I see a lot of 314's and 816's, so I thank folks for coming over at an early hour from St. Louis and Kansas City area particularly.

Mr. Shoehigh?

DIRECTOR HUFF: Thank you for being here. I'll mark your notes as Exhibit No. 5 and admit that into the evidence as well.

(Exhibit No. 5 was admitted into evidence at this time.)

MR. GIBBONS: Thank you kindly.

DIRECTOR HUFF: Ann Silea?

(Witness sworn by Director Huff.)

ANN SILEA,

having been sworn, testified as follows:

DIRECTOR HUFF: If you would, state your name and spell it for the court reporter, and your affiliation, please.

MS. SILEA: My name is Ann Silea, last name S, as in Sam, i-l-e-a. And I'm here on behalf of Lutheran Family and Children's Services. And like most of the others that have spoken already, we do not think that Missouri should seek the waiver for medical loss ratio.

We believe these rules are good for individuals and for businesses, much like Lutheran Family, who are constantly searching for the best quality insurance for employees at a reasonable cost to the agency, which can oftentimes be a bit of a challenge. We also believe that investing in health care for all is critically important to the well-being of its citizens and the state as a whole.

(Witness sworn by Director Huff.)

WILLIAM SHOEHIGH,

having been sworn, testified as follows:

DIRECTOR HUFF: If you will give us your name and your affiliation, and spell it for the court reporter, please.

MR. SHOEHIGH: William Shoehigh, S-h-o-e-h-i-g-h, registered lobbyist, UnitedHealthcare.

UnitedHealth Group appreciates the opportunity to provide written comments on the topic of the effect of medical loss ratio on the individual written -- individual health insurance market in Missouri.

UnitedHealth Group employs 2,400 people in Missouri, provides health coverage to nearly one million residents. Recognized as America's most innovated health care company by Fortune magazine, UnitedHealth Group offers a highly diversified comprehensive array of health and well-being products and services, empowers individuals, expands consumer choice, and strengthens patient/provider relationships.

Through our six businesses, our 78,000 employees serve the health care needs of more than 75 million individuals, develop and advance new health technologies, and enhance financial and operational connectivity across the entire care system. Our role as a

national leader in both private and public health benefits programs enables us to continuously foster innovative health solutions aimed at creating a modern health care system that is more accessible, affordable, and personalized.

The Patient Protection and Affordable Care Act is a large highly complex piece of legislation that requires extensive federal rulemaking and substantial regulatory and process changes for states and insurance companies. Regulators and insurers have many questions that remain unresolved, which make it difficult to answer all of the questions and concerns that consumers and our distribution partners have today.

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 on January 1, 2011, we remain concerned about unintended consequences and potential disruption for consumers.

Through Golden Rule Insurance Company, a subsidiary of UnitedHealthcare, we offer a wide range of quality health insurance options to individuals and families, including lower cost high deductible plans, health savings accounts, and traditional plans. In addition, we offer short-term health insurance coverage

designed to bridge temporary gaps in health insurance coverage. Our products cover workers between jobs; new graduates, who do not have enough insurance coverage through their parents; and others who purchase their own health insurance because they are retired, self-employed, or because their employer does not offer employer sponsored health insurance.

With specific regard to the individual health insurance market, we are concerned that the current MLR requirement of 80 percent, effective January 1, 2011, could create significant disruption in the market for the reasons outlined below: Number one, some carriers may stop selling to new customers. Some newer carriers may conclude that their small scale will not allow them to cover the cost of distribution and administration of new business.

As you know, the individual market business is priced to a lifetime loss ratio. As a practical matter, the loss ratio pattern for underwritten medical business is not level over the lifetime of any given policy because there are typically lower medical loss ratios in the early years of a policy, followed by higher medical loss ratios in later years. At the same time, administration and commission costs are highest in the first year of a new health insurance policy.

The combination of high first year costs to

underwrite new business and potential consumer rebates because of low loss ratios in the earlier years could lead some carriers to cease new business sales. Without a phase in of the 80 percent requirement or the latitude to use a rolling year method to calculate loss ratios, there may be the unintended consequence of less competition in the market.

Number two: Carriers could exit the market rather than maintain a book of business at a loss. Nationwide our average individual premium rates are approximately half the cost of similar coverage in the group market, primarily because of individual underwriting. Administrative costs and commissions, however, are roughly equivalent on a per person basis. Therefore, as a percentage of premiums, individual product administrative costs are roughly twice as large as in the small group market.

Consequently, compliance with the 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.

Point three: Customers could lose important resources for information if brokers are forced out of the marketplace. Today, a significant proportion of individual

health insurance in the market is purchased by consumers with the assistance of a professional licenced insurance broker. As a result brokers are vital to the smooth functioning of the insurance market.

Many consumers tell us they would not consider buying a complex product like health insurance without the help of an insurance professional. Consumers rely upon brokers as a single point of contact to, A, present them with a wide variety of carriers, plans, designs, and prices; B, help them select the best plan for them and navigate the enrollment and underwriting the process; and C, provide assistance with service needs.

As millions of new entrants to the health insurance market obtain individual insurance coverage for the first time, the role of brokers will be even more important than it is today. Because the price for individual health insurance is much lower on average than group insurance prices, and because of the considerable up-front investment in servicing new customers, broker commissions tend to be the highest in the first year and much lower in the following years of a policy.

For example, a typical schedule might feature a 20 percent first year commission and 5 percent trailing commission. Under an 80 percent MLR regime, 100 percent of first year administrative and profit allowance

will be consumed by the typical broker commission. Clearly this structure is unsustainable and will necessitate lower commission percentages then those used today.

As a result, in July of this year we notified all our brokers that we may have to lower commissions on January 1, 2011, for all business sold after July 2010. Substantially lower commissions will mean fewer trusted advisors in the market to guide consumers. In the absence of a robust broker distribution channel, consumers will be forced to contact each insurer, one at a time, to learn about all available options. Retaining these advisors is critical for those Missourians who rely on their services.

By phasing in 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 Missouri consumers.

Lastly, point four: Younger, healthier consumers could have fewer choices. Absent a transition period to the new MLR requirement, we are concerned that there will be fewer health insurance options available in the individual health insurance market for one of the largest segments of the uninsured population. At the lower commissions required to meet the new MLR rules, brokers may

be unable to offer these products to consumers and, therefore, leave young, healthier consumers with fewer health insurance alternatives.

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

We appreciate the time and attention you have given to this issue and thank you for your opportunity to submit comments for your consideration.

DIRECTOR HUFF: Thank you, Mr. Shoehigh. If I could just ask a couple of questions. The individual market then for UnitedHealthcare is served -- is it -- this is a question: Is it served exclusively through Golden Rule then?

MR. SHOEHIGH: Yes, sir.

DIRECTOR HUFF: And do you have a sense with the regulations that have been approved with the definition of the MLR by HHS, what the MLR would have been for Golden Rule in 2010?

MR. SHOEHIGH: I can't provide you that answer, Director Huff, but I will relay that question to the appropriate folks at Golden Rule and ask them to respond by the designated time for submitting comments.

DIRECTOR HUFF: And then --

MR. SHOEHIGH: If you would, restate the question one more time, Director.

DIRECTOR HUFF: Sure. What the -- I see --

MR. SHOEHIGH: What it would have been?

DIRECTOR HUFF: What it would have been for 2010, the MLR for the individual market, and obviously through Golden Rule.

And as I understood your testimony, you're requesting that Missouri does make a request of HHS to adjust or transition. Does UnitedHealthcare or Golden Rule have a proposal for what that transition or adjustment would be?

MR. SHOEHIGH: I will make sure we respond in writing to those questions, sir.

DIRECTOR HUFF: Any other questions for Mr. Shoehigh?

MS. KEMPKER: I would like to add to that, if I may.

DIRECTOR HUFF: And with an affidavit.

MR. SHOEHIGH: Yes. Yes.

MS. KEMPKER: Mr. Shoehigh --

MR. SHOEHIGH: Yes, ma'am.

MS. KEMPKER: -- in the description of your proposal, if it includes not only the specific ratios you

feel you need during the adjustment period, but what the adjustment period should be because the interim final rule allows the states to request an adjustment for one year or two year or three years.

MR. SHOEHIGH: Ratios and the period. Yes, ma'am.

DIRECTOR HUFF: Any other questions for Mr. Shoehigh?

MS. KEMPKER: I do have one more question. I mean, being that Golden Rule is one of the major carriers in the individual market, failure to request an adjustment, what impact would that have on Golden Rule? Would they cease offering products? Would they withdraw from the market?

MR. SHOEHIGH: I got it, Ms. Kempker.

MS. KEMPKER: Thank you.

MR. SHOEHIGH: I'll have a response for you.

DIRECTOR HUFF: As long as you're making your list, the only other question I have, and this won't surprise you, has Golden Rule begun selling child only policies again in Kentucky? And I assume they're no longer offering those in Missouri.

MR. SHOEHIGH: Got it.

DIRECTOR HUFF: Thank you. We will take your written testimony --

MR. SHOEHIGH: Thank you, sir.
DIRECTOR HUFF: -- to supplement your testimony as Exhibit No. 6.
(Exhibit No. 6 was admitted into evidence at this time.)
DIRECTOR HUFF: Mr. Butler?
MR. BUTLER: I don't have anything at this time, but our members may submit written testimony before the deadline.
DIRECTOR HUFF: All right. The deadline is close of business December 30th.
MR. BUTLER: Okay. Thank you.
DIRECTOR HUFF: Dr. Beck?
(Witness sworn by Director Huff.)
REA BECK,
having been sworn, testified as follows:
DIRECTOR HUFF: If you will state your name and spell it for the court reporter, and tell us your affiliation.
DR. BECK: I'm a retired adult/child psychiatrist, practicing in the city of St. Louis. Since retirement, I've been active in trying to get good health care and working to get good government in our state.
Missouri, I read recently, stands out for what it isn't doing. The state dropped another notch in

health ratings this year, while some other states improved their showings, according to the report by the United Health Foundation, the American Public Health Association, and Partnership for Prevention.
The study now says Missouri ranks 39th in the nation of the states. Last year it was 38th. The list reflects health behaviors, public and private health policies, and community and government environmental conditions.
Medicare has a 3 percent administration cost. A lot of us in medical care wanted single-payer Medicare for all or another government run health care program for the health care bill. Congress wanted the new health care bill to use private health care insurance companies, which a lot of us were not really happy with. A public option or a single-payer, we felt would significantly cut costs, would ensure more people get coverage and better coverage.
The health insurance companies are the -- from what I've read, the second highest profit making business in the United States. The CEOs get millions of dollars. So for them to say that they can't make an MLR of 80 to 85 percent, doesn't hit me as reasonable.
Three of the five large insurance companies in the state of Missouri are able to make about 80 percent

now, MLR. Why the other companies can't, as you heard before, the transparency is not clear. If they feel they can't be competitive, I say, Good, let them leave. Therefore, it doesn't seem too much to me that we ask them to maintain the 80 to 85 percent MLR ratio.
DIRECTOR HUFF: Thank you, Dr. Beck. Did you have anything written that you wanted to submit?
DR. BECK: Yes, I do.
DIRECTOR HUFF: Any questions of Dr. Beck? Thanks for coming. We'll mark your written comments as Exhibit No. 7 to supplement your testimony.
(Exhibit No. 7 was admitted into evidence at this time.)
DIRECTOR HUFF: Sidney Watson from St. Louis University, one of my alma maters.
PROFESSOR WATSON: That's right.
(Witness sworn by Director Huff.)
SIDNEY WATSON,
having been sworn, testified as follows:
DIRECTOR HUFF: If you would, state your name and affiliation for the record, please.
PROFESSOR WATSON: Sidney Watson. It's S-i-d-n-e-y W-a-t-s-o-n. And I'm a professor of law in the Center for Health Law Studies at the law school at St. Louis University.

My research focuses on access to private health insurance, Medicaid, and Medicare. My students and I followed the debates around the Affordable Care Act and have also followed the development of the NAIC's deliberations around the medical loss ratios, and my students submitted comments to the proposed federal regulations. So it's my pleasure to be here today to talk to you in response toward -- for your -- of your request for public comment.
I want to begin by pointing out that the recently issued interim final regulations provide that a request for an adjustment from a state will be granted only if the Secretary deems there is a reasonable likelihood that the 80 percent medical loss ratio requirement in the individual market would destabilize the individual markets.
The comments to those regulations make it clear that a state does not have to submit evidence that it's a certainty that the market would be destabilized, nor will the Secretary grant an adjustment because there's only a remote possibility. What the Secretary's looking for is some actual evidence of a reasonable likelihood. The Secretary's concern and NAIC's concern was that a lack of competition would actually harm consumers.
With that in mind I want to make a couple of comments today. The first one has to do with the

information that HHS will require states to submit if they request an adjustment. That information is laid out in the interim final rule. And I'm sure the Department is familiar with it, but for the sake of the public comments I want to share with the public what information would need to go along with the request for an adjustment.

Among other items, for every insurer in the individual market the State would need to submit information about the number of enrollees in each plan, individual premium data by product, and the insurer's market share.

For insurers covering more than 1,000 enrollees, the State must also provide the total earned premium in the individual market, the medical loss ratio reported pursuant to state law, but also the estimated medical cost ratio using the new definition set forth in the interim final rule that were developed by NAIC; fourth, the brokers' commissions, the total brokers' commissions for each insurer; five, the estimated rebates for each insurer using the definitions in the new regulations; six, the net underwriting profit for the individual market and the consolidated business for the insurer in the state; seven, the after tax profit and profit margin for the insurer's individual market and consolidated business in the state; eight, the risk-based capital level for the

insurer; and nine, whether the insurer has provided a notice of exit to the Department of Insurance.

The Secretary's concern in looking at these requests for adjustment is, one, this concern about the possibility for destabilization. The question is not just whether insurance have met this 80 percent threshold for medical loss ratios given prior recording requirements, but whether they are likely to meet them going forward, and whether having to pay rebates to consumers may threaten the solvency of those insurers or cause them to withdraw from the market.

Yesterday I reviewed on the web some of the wonderful reports that you make available to the public. According to the 2009 Department of Insurance supplemental data report for accident and health individual comprehensive medical expenses, which is what we refer to as the individual market, there were 14 insurance companies in 2009 that enrolled at least 1,000 Missourians and for whom the Department would need these nine additional items of information.

While the Department of Insurance annual report provides medical loss ratios, it's not medical loss ratios that comply with the new Affordable Care Act regulations. And at least on the Department of Insurance report I saw, there was no information about net

underwriting profits, after tax profits, profit margins, risk-based capital levels, or brokers' commission. It is not clear either that the total earned premiums there reported on the Department of Insurances report is the information that HHS requests about individual premium data by product.

I would urge the Department -- and although I commend the Department for having this hearing today and asking us for our comments, I think this is the data that the Department needs to gather from the individual insurers to be able to make an assessment of whether to move forward on a request for an adjustment.

I would hope that before the Department makes a decision to move forward that this data would be collected, be made available to the public, and then another hearing be held at which the public would have an opportunity to review this data and to make additional comments based on this evidence that would be considered by the Secretary of HHS.

I also have some comments I'd be willing to make about some guesstimates and some estimates based upon the available data that is on the Department of Insurance site if you'd like me to do that.

DIRECTOR HUFF: Feel free to do so.

PROFESSOR WATSON: Okay. You certainly know

your data better than I do, but let me begin by commenting briefly about how the Affordable Care Act and the NAIC developed definitions of medical loss ratio differ from the medical loss ratio data that's been reported by insurers here in Missouri.

The Affordable Care Act's medical loss ratio provision provides that health insurers, including grandfathered plans, but not self-insured plans, are to report to the Department of Health and Human Services each year the percentage of their premium revenue they spend on clinical services for enrollees, activities that improve health care quality, and all other nonclaims cost, excluding federal and state taxes and licencing and regulatory fees.

Beginning in 2011, as your notice of hearing today points out, insurers in the individual market must spend at least 80 percent of their premium revenues, excluding state and federal taxes and licencing and regulatory fees, on health care and quality improvement activities. Insurers that fail to meet these medical loss ratios will have to rebate the differences to their enrollees.

States can require higher medical loss ratio percentages, and as we're discussing today, HHS has the authority to adjust the state medical loss ratio

requirements downward where necessary to prevent destabilization in the individual market.

The Affordable Care Act's medical loss ratio definitions differ from the one Missouri has used for medical loss ratio reporting because it includes quality improvement activities in the medical loss ratio numerator and excludes taxes, fees, and licenses from the denominator.

The Department of Health and Human Services in its notice of rulemaking estimate that these changes in the medical loss ratio calculation, combined with some behavioral changes that we hope to prompt as a result of requiring reporting, will result in insurance companies on average reporting medical loss ratio increases of about 4 percent. And I pick their, HHS's, mid-range estimate. Three percent of that is the result of now including quality improvement along with clinical costs in the medical loss ratio. The other 1 percent is prompting reductions in overhead and administrative costs.

It's also important to note that the new Affordable Care Act medical loss ratio computing rules take into account the special circumstances of smaller plans, different types of plans, and newer plans, which were mentioned previously in testimony today.

Medical loss ratios, particularly for

smaller insurers, can be highly volatile, ping-ponging from year to year. Down one year, up the next, going well below 80 percent in one year, and well above the next because of a few large medical claims. Statistical averaging just doesn't work with smaller groups.

HHS's interim final regulations address these issues by treating very small insurers with smaller than 1,000 members in a state as so small as to be statistically noncreditable. I do love that term. And these smallest insurers will be deemed to meet the medical loss ratio standards and will not be subject to paying rebates.

I notice that the 2009 supplemental data from the Department lists Golden Rule as having 66 covered lives and .1 percent of the market. I don't know how accurate that is today in terms of their covered lives, but given that size, under the new interim final rules, they would be deemed to meet the medical loss ratio requirements and not subject to rebates because of -- they have under 1,000 members. I think that might respond to one of the questions earlier.

Second, the interim final rules also treat slightly larger, but still smaller plans, having between 1,000 and 75,000 enrollees, as -- by giving them credibility adjustments, a bump up, a bonus, of up to

8.3 percentage points in their medical loss ratios if they fail to meet the 80 percent medical loss ratio target in one or two out of the next three years.

The smaller plans also make this even additional adjustment of up to 6.1 percent on top of that 8.3 percent if they are high deductible plans. Again, recognizing the volatility of high deductible plans in any one year and giving them an opportunity to have some cross year averaging. All that's -- although that's not actually the language.

Finally, the interim HHS regulations allow new entrants into the insurance market a break for a year, giving them a full year's experience before they must either meet the new medical loss ratio targets or pay rebates. So I think some of the concerns that were expressed about smaller plans and high deductible plans have been addressed, and they are taking care of under the rules as they exist, without a need for an adjustment.

The purpose of the medical loss ratio rules are to drive efficiency, not to produce rebates. The cost estimates at the federal level are that in the individual market the average medical loss ratio reported under the new rules in 2011 will be 86.5 percent. That's 6.5 percent above that 80 percent level at which -- under which a rebate would be required.

Nationwide there are very few large insurers that cover most Americans. And nationwide only 2 percent of insurers will be fully creditable. That means large enough to have to fully comply with the new medical loss ratios in all states. However, those 2 percent of health insurers cover 50 percent of individual insurance enrollees. Sixty-eight percent of insurers will be completely noncreditable in at least one state. But these insurers only cover about 1 percent of enrollees.

I mention this because the role of large insurers holds true in Missouri, if my data from 2009 continues to be correct. According to that data there's only one insurer in the individual market who covers more than 75,000 enrollees and would be fully creditable under the new rules and that is Healthy Alliance, with about 78,000 insureds and 50.5 percent, at least in 2009, of the individual market.

Thirteen other Missouri insurers cover between 1,000 and 43,000 people and will be partially creditable under these new MLR rules. These insurance companies range from Blue Cross Blue Shield of Kansas City, which has 22 percent of the market and reported a medical loss ratio of just over 80 percent in 2009.

I'll provide you with my written testimony where I've done some back-of-the-envelope figuring as to

how these new creditable rules affect the smaller insurers.
These 13 insurers cover about 48 percent of the individual market; 7 of these 13 appear to be able to meet the 80 percent medical loss ratio. It may be with these extra bonus points that more of them will be able to meet them. It's simply hard to know given the differing definitions and the length of time since we've gotten the information.
And that's why I encourage the Department to get additional information and to do the actual calculations as required by the Affordable Care Act before we make decisions, particularly about smaller insurers' ability to meet the medical loss ratio requirement.
I'd like to conclude by saying that I think the question we do need to address is that the state's largest insurer in the individual market, Healthy Alliance, reported a medical loss ratio of only 67 percent in 2009. That's 13 points below the 80 percent medical loss ratio, and even if we assume a bump up of 4 percent for them, they will still be below the 80 percent. If they continue with that medical loss ratio, they will in 2011 need to pay rebates to their shareholders.
Before we can make any decision, before the Department can make any decision about whether that's likely to destabilize the market, there are certainly

questions about the net worth and the net profit of Healthy Alliance, which is a fully owned subsidiary of WellPoint, one of the country's largest most profitable health insurers.
Thanks to the Department for having this hearing today. If I can be of any further assistance to you, either in doing back-of-the-envelope calculations or in volunteering some of my wonderful joint law students/health policy students to help the Department in a more formal way, I'd be happy to do that.
DIRECTOR HUFF: Thank you, Professor Watson. Any questions? Do you go by Professor?
PROFESSOR WATSON: Yes.
DIRECTOR HUFF: Okay.
MS. KEMPKER: No. But I would encourage her to possibly meet with Brent on the data because Brent is the manager of statistics department and he probably would be able to answer some of the concerns on the data as presented.
DIRECTOR HUFF: And I think he's our sole Ph.D. in the Department. Be happy to accept your written comments to supplement your testimony. Thank you, Professor. Marked as Exhibit 8 and accepted.
(Exhibit No. 8 was admitted into evidence at this time.)

DIRECTOR HUFF: Ruth Ehresman?
(Witness sworn by Director Huff.)
RUTH EHRESMAN,
Having been sworn, testified as follows:
DIRECTOR HUFF: If you would please state your name and spell it for the court reporter please and your affiliation.
MS. EHRESMAN: Sure. My name is Ruth Ehresman; it's E-h-r-e-s-m-a-n. And I'm representing the Missouri Budget Project. Good morning. I am the director of health and budget policy for the Missouri Budget Project, and I really appreciate the chance to speak with you this morning.
Missouri Budget Project is a public interest organization. Our mission is to advance public policy that creates economic opportunity for all Missourians, particularly low and moderate income Missourians. We do that through independent research analysis and advocacy. The Missouri Budget Project really believes that access to affordable health care for all Missourians is essential to their economic well-being, as well as to the well-being of the state.
One of the goals of the Affordable Care Act was to strengthen protection for consumers and to assure a good value for their health dollar, and we believe that

establishing a minimum loss -- medical loss ratio is one way to accomplish that. It's also a way to bend the curve of health care costs by assuring that profits for insurance companies is reasonable.
We believe that health care is such a basic necessity to the well-being of families and their ability to work and support themselves. And we believe that critical to that, to access to affordable health care, is affordable health insurance. We think it's reasonable that we create structures, rules, to assure reasonable profits for those who provide insurance similar to the way we place some limits on utilities that provide other basic services to Missourians. We do believe that the medical loss ratio standard is sound public policy and it greatly strengthens consumers.
Many of the points in my written testimony have been covered. I just want to hit the high points. We believe that greater transparency is important in Missouri. Others have talked about Missouri along with two other states that don't require health insurance companies to file rate increases with the state. Along with 16 other states, we have no requirements for medical loss ratios. Thirty-four states do have requirements, including six of Missouri's surrounding states.
Now, we understand that those vary widely by

state, and we believe that by standardizing the definition of medical loss ratio we are greatly going to strengthen consumer protection, not only in Missouri, but in other states as well.

The second point I'd like to make, we do believe the HHS guidelines were developed in a very thoughtful bipartisan balanced manner, and should not be easily dismissed or modified. We greatly appreciate Director Huff's work with the NAIC and just want to note that those recommendations were approved unanimously by the insurance commissioners.

The third point is we do believe that achieving the medical loss ratio standards appear to be reachable. Dr. Watson explained in great detail the changes to medical loss ratio and what can be counted as part of that. We believe that that will help insurance companies that currently that don't meet the required 80 percent ratio, but believe that those are reachable.

And last of all, at this point we fully support the medical loss ratios as they have been defined in regulation and believe that at this point there is no evidence that Missouri should seek an adjustment.

Again, Dr. Watson outlined critical information to making that decision. And if after that data is gathered, if it appears we need to do that to

protect consumers and not destabilize the individual market, then we do urge you to have -- to continue the pattern of having -- making this information public in a timely way and giving an opportunity for consumers to have input in another hearing so we continue kind of on the path that we've begun here this morning. We do ask that you make it at ten o'clock. That would be really helpful for those of us who are traveling.

Anyway, thank you very much for this hearing this morning. Thank you for your work on this. We look forward to working with you and look forward to making a better life for Missourians.

DIRECTOR HUFF: Thank you, Ms. Ehresman. Any questions for Ms. Ehresman? If you'd like to submit anything --

MS. EHRESMAN: Yes, please.

DIRECTOR HUFF: -- that's written.

Thank you. Written comments marked as Exhibit 9 will be admitted to supplement your testimony. Thank you very much. And we apologize for the earliness of the hour.

(Exhibit No. 9 was admitted into evidence at this time.)

DIRECTOR HUFF: Two more on the list. Kit, are you here?

MR. WAGAR: No, I'm not here.

DIRECTOR HUFF: Great. You're welcome anytime.

And Mr. Colby?

MR. COLBY: Brief comments.

(Witness sworn by Director Huff.)

BRIAN COLBY,

having been sworn, testified as follows:

DIRECTOR HUFF: If you will state your name and spell it for the court reporter, and tell us your affiliation.

MR. COLBY: Yeah. My name's Brian, B-r-i-a-n, Colby, C-o-l-b-y, and I work for the Missouri Health Advocacy Alliance. We are collaborative of health policy advocates from around the state and we seek to unite the consumer voice, and I would be speaking from that perspective today.

I'm only going to say a few things that -- many things have already been said, but I wanted to point out a couple different things. One of which is that it was pointed out by Professor Watson that Healthy Alliance is a subsidiary of WellPoint. We would like to emphasize that WellPoint is a well-capitalized and very profitable company. According to my research last night, it has an estimated market capitalization of $22.5 billion and

showing retained earnings of $10.5 billion on the last quarterly report, that of September 2010.

The other item I would like to address is the comments to the fear of barriers to entry for newer plans. Some industry representatives have argued that the MLR creates a barrier of entry because of the nature of the market that sees a front loading of administrative costs due to customer acquisition and the experience of claims in outer years.

We believe that ACA anticipated this potential disruption and mitigated its impact by allowing newer plans an adjustment consistent with NAIC recommendations. Certain insurers that have newly joined the insurance market may be able to delay reporting of the medical loss ratio until the next year. Allowing insurance companies to defer reporting newer business, reduces barriers to market entry by reducing the risk of failing to meet the MLR standard and having to pay a rebate.

The other item that I would like to point out is that the purpose of the MLR provision was to incentivize insurers to move to a business model that spends more of the premium dollar on patient care and the quality of that care. As evidence of that, I would like to read a letter Commissioner Jane Cline, president of the National Association of Insurance Commissioners, dated

May 7, 2010, from Senator Jay Rockefeller, chair of the Senate Commerce Committee, that made clear the purpose and intent of the provision of this law.

And I'm quoting the letter now: Data analyzed by the Senate Commerce Committee staff and others show that many insurers already meet the newly established medical loss ratio requirement in the group and individual markets that go into effect next January. But the data shows that in some markets and some product lines, insurers are not yet meeting the new requirements.

The purpose of this legislation is to provide health insurance companies falling below this requirement a new incentive to spend more of every premium dollar on patient care and on quality of that care. To the extent that insurers try to invent ways to gain the minimum medical loss ratio requirement without changing their actual business practices, they are defeating the purpose of medical loss ratio provision, end quote.

This demonstrates the intent of the provision to change interior behavior. And that will conclude my testimony. And we will be submitting written testimony by e-mail and I can take questions if you'd like.

DIRECTOR HUFF: Okay. Thank you, Mr. Colby. Any questions for Mr. Colby? Thank you very much.

Is there anyone else that -- that's the end

of my list that I had in front of me. Is there anyone else that wished to testify this morning? If not, I will go ahead and I'll mark this witness list as Exhibit No. 10 and admit it into evidence.

(Exhibit No. 10 was admitted into evidence at this time.)

DIRECTOR HUFF: And as all persons who wished to testify have done so, the hearing is now concluded at 10:25 a.m. The hearing record will be left open until 5:00 p.m. central time Thursday, December 30, 2010, to receive additional written comments or rebuttal in the form of sworn affidavits. Is there any other business to be brought before the Department? If not, we'll conclude and we'll be off the record.

(The hearing was concluded at 10:25 a.m.)

(Off the record.)

CERTIFICATE OF REPORTER

I, Kristy B. Bradshaw, CCR within the State of Missouri, do hereby certify that the testimony that appears in the foregoing hearing was taken by me; that the testimony was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this meeting was taken, and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

_____

Kristy B. Bradshaw, CCR