Request for Adjustment to the Medical Loss Ratio for the State of Texas

Executive Summary

The enclosed document requests an adjustment to the Medical Loss Ratio (MLR) requirements under the Patient Protection and Affordable Care Act (PPACA) for the individual market in Texas. It was prepared by the Texas Department of Insurance (the Department) in accordance with 45 C.F.R. Part 158, *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule,* Subpart C.

In order to successfully transition to an 80% MLR over time and still allow for an acceptable profit margin, there needs to be systemic changes in the administration of health insurance business that cannot be achieved in a one or two year timeframe.

This adjustment is critical to ensure the ongoing stability of the individual health insurance market in Texas. With the high uninsured rate in Texas and the expected major expansion of the individual market in 2014, including enrollees in the health insurance exchange, it is especially critical that Texas retain its current carriers and allow for new entrants in the market. Carrier financial losses in 2011 – 2013 could reduce risk based capital levels leading up to 2014 when there will be added pricing uncertainty and the need for capital in order to write this additional business. The relevant issues are not specific to Texas alone, and the Department continues to urge you to apply relief to business in all states.

The Department has collected and analyzed the required data in support of the adjustment request. The analysis shows that the 2010 average PPACA MLR after adjustments for credibility was 70.8% for those carriers with at least 1,000 lives in the individual health insurance market. Had the 80% MLR requirement been in place in 2010, Texas carriers would have refunded $158.1 million, virtually eliminating the total net underwriting profits of $158.6 million. Only 7 of 26 carriers subject to the requirements achieved an MLR of 80% in 2010. Of the top eight carriers, two exceeded an 80% PPACA MLR, with one of those incurring losses in the year.

Without an adjustment, the current MLR requirement will force carriers, regardless of size, to make dramatic cuts in their expense structures to remain profitable. Such cuts are likely take the form of reduced commissions for agents and brokers. It is also likely that a number of carriers would exit the market, choosing instead to focus on select products and states. The loss of these carriers would constitute a material difference in the availability of health insurance options and would decrease competition, which is vital to ensuring the highest quality and value of individual coverage.

Current Individual Market Characteristics

A total of 39 carriers covered lives in the individual health insurance market in Texas in 2010. Of these, 26 carriers had 1,000 or more lives, and would therefore be subject to the MLR requirements for their business in the state. Carrier A covers over half of the individual policyholders in Texas, with approximately 56% of the market share based on covered lives. The next largest carrier, Carrier B, has 8.4% market share. The top eight carriers, each with over 1.5% market share, cover approximately 90.3% of the market.

The next 18 carriers cover approximately 9.5% of the market. For the purposes of analysis and discussion, carriers were grouped into three categories according to market share based on number of enrollees: top eight carriers, mid-level carriers, and non-credible carriers.

Participation Uncertainty for Mid-Level Carriers in the Individual Market

The Department asked the carriers to submit the data collected for this adjustment request. The data suggest that the immediate implementation of the MLR requirements in 2011 will significantly impact mid-level carriers in the individual market. The average PPACA MLR (with credibility adjustments) for mid-level carriers was 75.3%. The majority of carriers (13 of 18) did not meet the MLR requirement in 2010 and would be required to pay rebates.

- In 2010, the average underwriting profit for these carriers was 7.1% of premium, less than 1% greater than estimated rebates of 6.3% of premium.
- Average commissions were 12.1% of premium, about one and a half times the 8.2% for larger carriers, reflecting greater reliance on agents and brokers by mid-level carriers.
- Administrative costs, excluding commissions, were 19.7% of premium, greater than the 17.4% for the top eight carriers. This highlights that for these carriers fixed costs have a greater impact due to a smaller premium base. The average premium volume for mid-level carriers was only $11.5 million, which starkly contrasts to the average $190.2 million for larger carriers.
- Reducing these expenses by 6.3% of premium would require a reduction of almost a third—an extremely difficult task to accomplish without time to adjust business practices.

As part of the data call, carriers were asked whether they intend to exit the market. The respondents were to indicate "Yes," "No," or "Uncertain." Of the 18 mid-level carriers (those with 1,000 or more lives but not in top eight), 2 indicated "Yes," 9 indicated "Uncertain," and 7 indicated "No." In total, 11 of 18, or 61% indicated that they intend to or are uncertain as to whether they will exit the market. If all 11 of them were to exit the market, almost 47,000 people would have their coverage disrupted and need to find replacement coverage. In addition, the choices for all individual policyholders would be reduced. This represents a material reduction in consumer choices, with 11 of 26 carriers (42%) subject to the MLR requirements considering an exit.

Potential Instability for Larger Carriers in the Individual Market

While none of the top eight carriers indicated that they planned to exit the market, or were uncertain whether they would stay in, this likely understates the potential for market exit. Carriers indicated at a technical workgroup meeting that they would be reluctant to disclose plans to withdraw from the market due to the potential impact on current sales. All carriers will need to continue to strategically evaluate their lines of business and ability to remain viable. Based on 2010 experience, many of these carriers face significant challenges under an 80% MLR requirement. Only one of these carriers exceeded an 80% MLR in 2010 while showing positive earnings. Similar to the market as a whole, the larger carriers averaged a 70.2% PPACA MLR (with credibility adjustments) in 2010.

It is clear from the data that the payment of the rebates will require more than simply reducing the profit margins of these major carriers. Estimated rebates averaged 9.5% of 2010 earned premiums. Carriers may consider reductions in three major components that make up retention: profit, commissions, and general administrative expenses. Based on average carrier results in 2010, it is not feasible for these carriers in aggregate to make up the difference by only eliminating or reducing a single one of these components:

- The average underwriting profit of these carriers was 9.5% of premium, approximately equal to total rebates.
- Average commissions were 8.2% of premium.
- Administrative costs, excluding commissions, were 17.4% of premium. Therefore, to reduce them by 9.5% of premium represents a reduction of more than half.

In actuality, the top eight carriers and mid-level carriers will need to use a combination of approaches in order to ultimately meet the 80% MLR requirement over time. Even at a break-even position (0% profit), the needed expense reductions are significant for many of these carriers. Of the six top carriers who would have paid rebates in 2010, four would have paid rebates in excess of underwriting profits. For those four carriers to break even in 2010, they would have needed to not only forgo profits, but also reduce their administrative and commission costs. The needed reduction percentages range from 1.5% to 36.8% of administrative and commission costs, with two carriers needing reductions in excess of 20% of current levels. Six of the 13 mid-level carriers paying rebates will require dramatic reductions in commissions and administrative expenses in order to break even (0% profit). The percentage reductions are between 17.0% and 67.5%. While such decreases may be achievable through major staff reductions, such actions will not produce sustainable administrative efficiencies which are necessary to reduce administrative costs permanently and maintain necessary consumer support and access. Alternatively, carriers will incur financial losses, reducing their capital and surplus levels and potentially endangering their solvency over time.

Proposed Transition Levels

The Department proposes the following phase-in to 2014:

Proposed MLR Adjustment	
2011	71%
2012	74%
2013	77%
2014	80%

Carriers have not had sufficient time to change their business models in 2011 compared to 2010. Therefore, the Department recommends that the 2011 MLR be set at the average experience from 2010, with linear phase-in until the 2014 requirement. The recommendation incorporates the PPACA-defined MLR calculation.

Summary Results

The Texas Department of Insurance conducted a careful study of the individual and small group health insurance markets in Texas to assess the impact of the MLR provision of the PPACA. On April 20, 2011, the Department sent out a data call to carriers. Based on the results of the data, the Department determined that the implementation of the 80% MLR standard for the individual market beginning in calendar year 2011 would likely result in changes in the individual market that would negatively impact competition and consumer choice. In light of this conclusion, the Department requests that the Secretary grant the state an adjustment to the MLR for three years. The Department proposes the following adjustment: 71% for 2011, 74% for 2012, and 77% for 2013 (See Table 1).

Table 1: Proposed MLR Adjustment	
2011	71%
2012	74%
2013	77%
2014	80%

A gradual transition to the 80% standard will promote stability in the individual market as the broad changes called for under the PPACA take effect. Over 700,000 Texans—or 2.8% of the state population—purchase insurance through the individual market in the state. In 2010, 39 carriers offered individual health insurance. Carriers vary greatly in terms of the scale at which they operate. Twenty-six carriers met the credibility standard of 1,000 enrollees outlined in the MLR regulations. Within this group, 8 carriers accounted for just over 90% of the market—approximately 655,000 individuals (See Table 2). However, a significant number of smaller carriers also exist in the Texas market. In addition to the top eight, 18 mid-level carriers provide coverage to more than 1,000 enrollees each, and over 70,000 Texans purchased insurance from these carriers. Another 13 carriers operate in the market with enrollees ranging from 1 to 1,000 lives. The individual market in the state has been marked by a healthy degree of competition that promotes availability and choice for Texans seeking insurance.

Table 2: Market Share Aggregated	
Largest Carrier	56.1%
Top 2	64.5%
Top 3	72.0%
Top 4	78.0%
Top 5	83.4%
Top 6	86.3%
Top 7	88.4%
Top 8	90.3%

An immediate shift to the 80% MLR standard will require carriers to dramatically alter their current practices, which may weaken the Texas market. In 2010, carriers had a weighted average MLR under the PPACA of 70.9% with credibility adjustments (See Table 3). Over half of carriers in the market, including six of the eight largest carriers, fell short of the requirement. Together, carriers would pay an estimated $158.1 million in rebates for 2010. Rebates in that amount would essentially eliminate underwriting gains for the market, which totaled $158.6 million in 2010. Even the top carriers will be required to restructure their businesses to avoid financial losses.

Table 3: Premium, MLR with Credibility Adjustment, and Covered Lives by Carrier[1]

Carrier	Total Earned Premium	PPACA MLR with Credibility Adjustment	Number of Covered Lives
Carrier A	$937,263,079	69.9%	407,187
Carrier B	$146,379,172	76.9%	60,872
Carrier C	$121,508,683	62.4%	54,745
Carrier D	$94,392,640	60.5%	43,506
Carrier E	$130,875,363	73.7%	39,215
Carrier F	$34,834,829	63.8%	21,130
Carrier G	$29,217,455	87.3%	15,141
Carrier H	$27,874,732	87.8%	14,048
Carrier I	$38,167,764	71.4%	10,533
Carrier J	$25,141,280	69.4%	7,900
Carrier K	$10,324,147	55.8%	7,741
Carrier L	$24,667,247	87.9%	6,915
Carrier M	$8,694,815	77.2%	5,133
Carrier N	$4,552,537	52.5%	3,528
Carrier O	$13,517,328	64.8%	3,380
Carrier P	$9,350,984	78.4%	3,302
Carrier Q	$8,817,236	93.5%	3,217
Carrier R	$4,683,160	81.7%	3,037
Carrier S*	$2,067,686	44.9%	2,845
Carrier T	$17,162,979	74.0%	2,711
Carrier U	$7,455,021	77.4%	2,451
Carrier V	$7,421,649	88.5%	1,676
Carrier W	$13,430,594	65.4%	1,433
Carrier X	$338,124	76.4%	1,120
Carrier Y*	$7,275,601	125.2%	1,120
Carrier Z*	$2,992,066	57.5%	1,065

[1] The PPACA MLRs with credibility adjustments for the companies identified above with asterisks were estimated because they were reported as 0%.

The following figures (1–4) show carriers' operating items compared to earned premium for carriers in the individual health insurance market.

Operating Items compared to Earned Premium[2]

Figure 1: All Credible Carriers

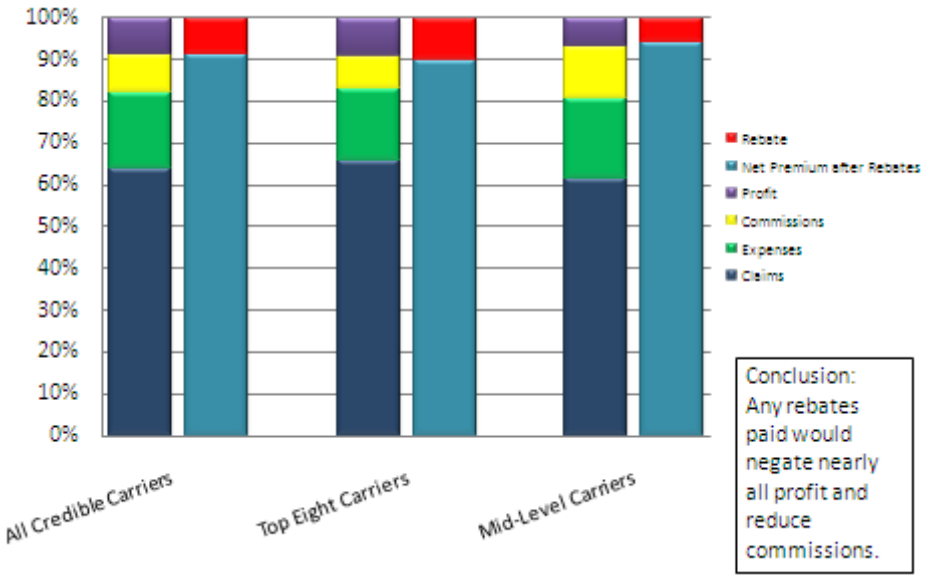


Figure 1 reflects averaged figures for all credible carriers and is further divided by top eight and mid-level carriers. Figure 1 highlights that aggregated rebates for the market are approximately equivalent to profit. Thus, rebates would require many carriers to make dramatic changes to their expense structures. Such changes would likely take the form of reductions to agents' and brokers' commissions or result in some carriers exiting the individual market, choosing instead to focus on select products and states.

[2] Percentages above relate to earned premium. The estimated difference between the actual and PPACA MLR's for these carriers average approximately 5%, making the effective MLR requirement approximately equal to 75% (varies by carrier).

Figure 2: Mid-Level Carriers that Indicated "Yes" or "Undecided" about Exiting the Market[3]

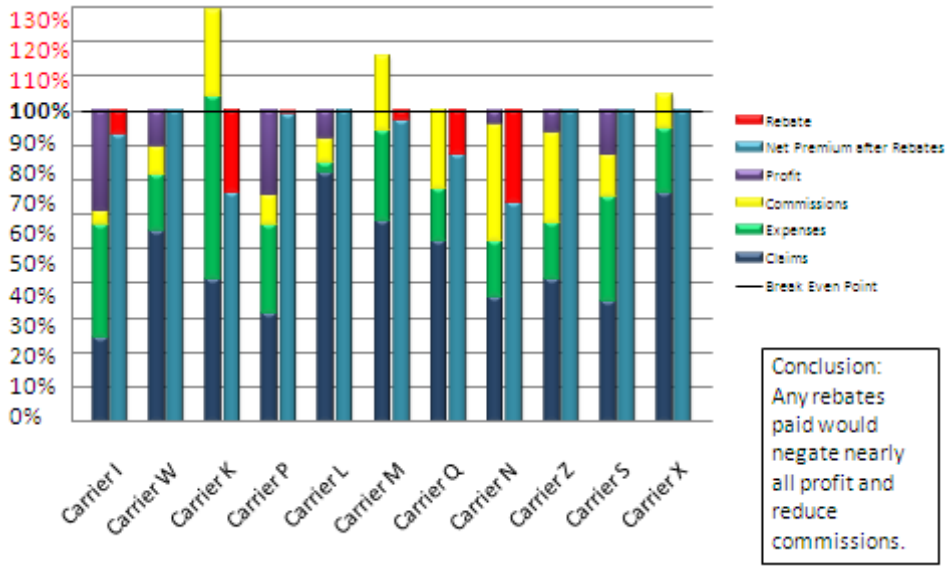


Figure 2 shows the operating items compared to earned premiums for the 11 mid-level carriers that have notified the Department of their intent to exit the market or indicated uncertainty about remaining in the market. Of these carriers, 9 would pay rebates and 4 of these would have to make reductions in expenses ranging from 36.4% to 67.5% to avoid losses.

Figure 3: Mid-Level Carriers Likely to Remain in the Market

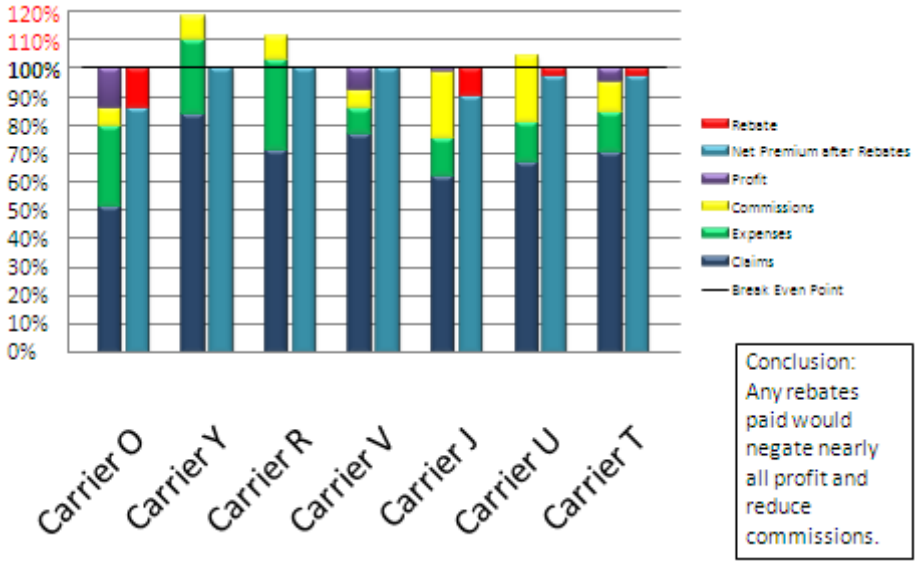


Figure 3 shows the carriers that are likely to remain in the market. Two will have to pay rebates and reduce expenses—by 17.0% and 24% respectively—to breakeven.

[3] Data for Carrier S, Carrier W and Carrier X are estimated because carriers were unable to submit correct and/or complete data.

Figure 4: Top Eight Carriers

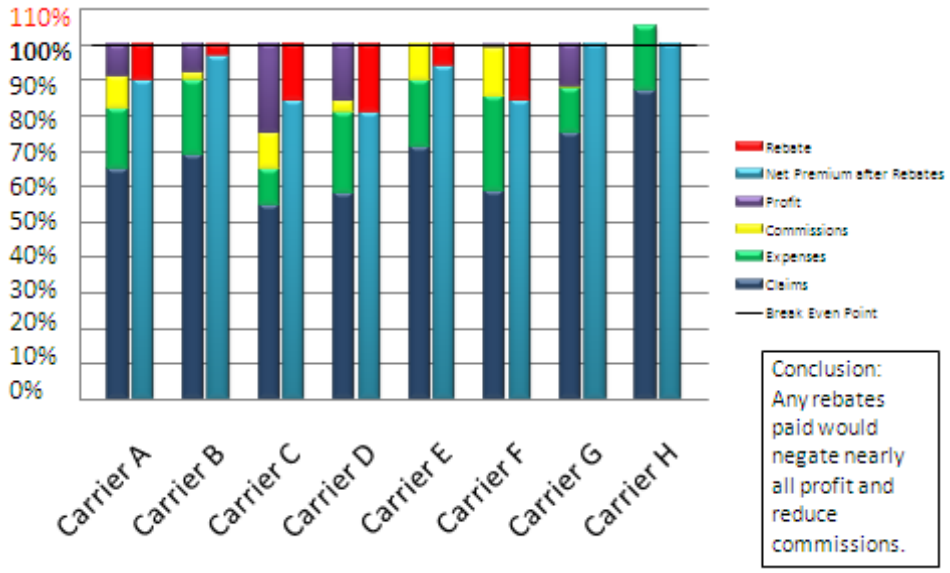


Figure 4 shows the operating items compared to earned premium for the top eight carriers.

The financial challenges facing carriers in the individual market are apparent from the figures above. Of the 26 credible carriers, 18 will have to pay rebates. Those rebates will exceed underwriting profits for 10 of the carriers. For mid-level carriers, the MLR requirements will necessitate that carriers rapidly adjust business models in order to remain profitable.

- Thirteen of the 18 mid-level carriers will be required to pay rebates that comprise 6.3% of premium. Net underwriting profit, which accounts for 7.1% of premium, exceeds this amount by just over 1%.
- Average commissions were 12.1% of premium, which reflects a greater reliance on agents and brokers by these carriers to distribute their products.
- Administrative costs, excluding commissions, were 19.7% of premium. This is greater than the average 17.4% for the top eight carriers. The data suggest that administrative expenses have a greater impact on these carriers because of a smaller premium base.

These challenges extend to the top eight carriers as well.

- Only one carrier in the top eight met an 80% MLR and was profitable.
- The average underwriting profit for these carriers was 9.5% of premium, approximately equal to total rebates.
- General administrative costs, excluding commissions, averaged 17.4% of premium and commissions accounted for 8.2% of premium.
  For two of the carriers, rebates exceed profit and commissions combined.
- One of the carriers had negligible earnings, yet estimated rebates of $8.5 million, representing 22% of administrative and commission costs.

Meeting the MLR standard will require carriers to adopt abrupt and dramatic changes in their expense structures, and carriers may be forced to take a number of actions that would negatively impact the market.

- First, carriers may reduce commission rates if they are not limited contractually. Reductions are likely to result in less access to agents by consumers.
- Second, carriers may work to find administrative economies. It will be difficult for carriers to reduce general administration by the needed magnitude in the short time frame required.
- Carriers may elect to incur losses in the short-term. There are a number of larger carriers in the market better positioned to withstand financial shortfalls. Yet, even those carriers may need to operate with lower capital and surplus at a time of uncertainty and expected future growth in the market.
- Finally, carriers may opt to drop out of select markets.
    - Nine out of 26 credible carriers have indicated they are uncertain whether they will remain in the market.
    - National carriers may choose to focus on a smaller number of states: eight carriers have less than 11% of their individual business in Texas.

The data indicate that carriers will feel pressure to significantly reduce commissions for agents and brokers in order to meet the MLR standard. Indeed, carriers in the individual market are already making adjustments that may negatively impact Texans. At a technical workgroup meeting the Department held in March 2011, industry representatives explained that some carriers have already begun cutting commissions. Others plan to alter their commission schedules once contracts expire to cover the costs of anticipated rebates.[4]

Limiting access to agents and brokers will prevent many Texans from receiving meaningful information in order to make health insurance decisions. Texas is home to large rural and elderly populations that often rely upon agents for information regarding coverage options and assistance as they negotiate technical aspects of insurance. Agents occupy a critical place in the individual health insurance marketplace; a reduction in their availability would mean diminished quality in individual health insurance.

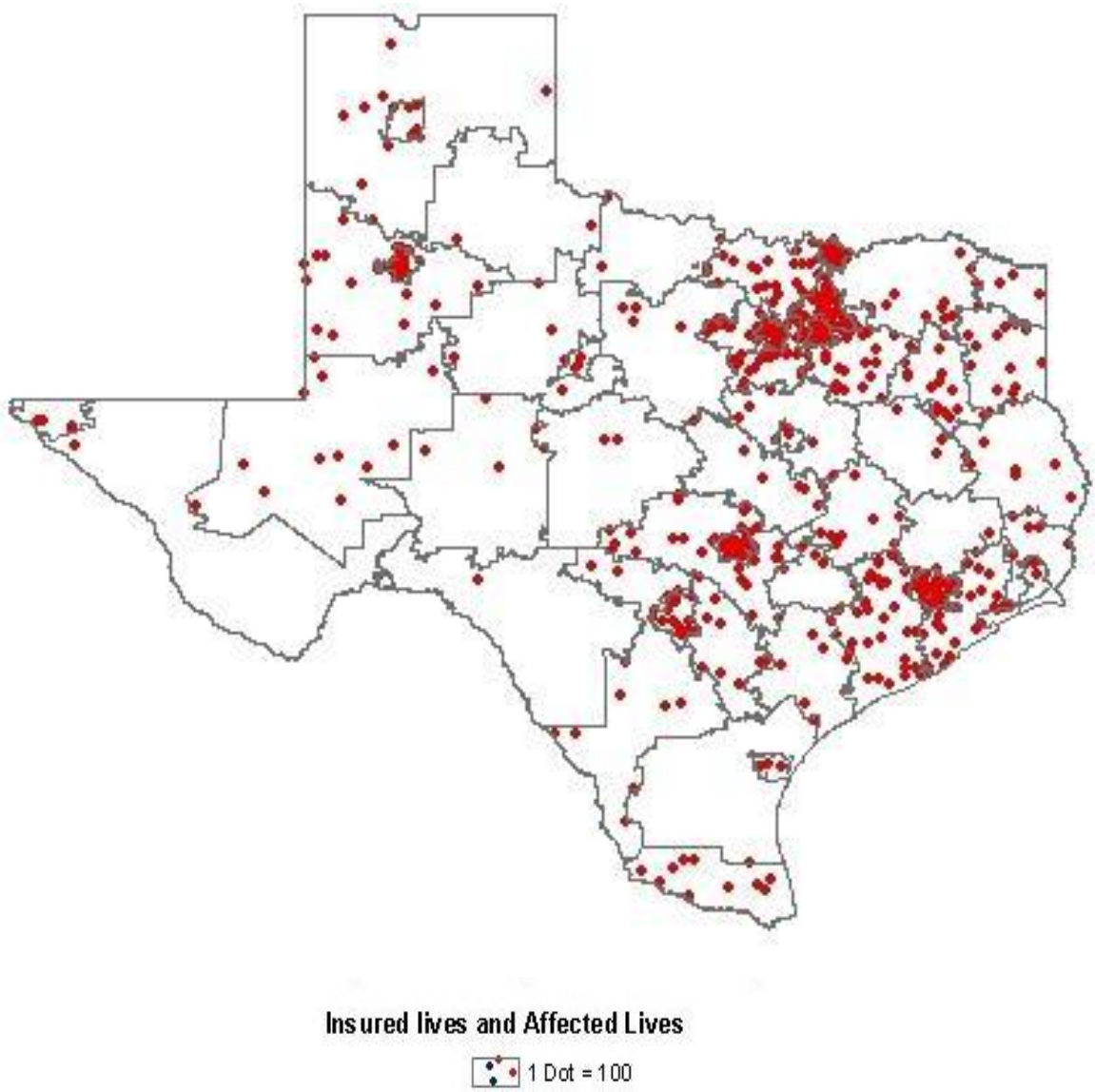
If carriers are unable to reduce administrative costs, they may face financial losses or choose to exit the market. While none of the largest eight carriers have notified the Department of their intent to exit the individual market, all carriers will need to continue to strategically evaluate their lines of business and ability to remain viable.

Larger carriers may be better suited to weather the short-term losses that will accompany the immediate implementation of the MLR requirement than mid-level carriers. In fact, 9 of the 18 mid-level carriers indicated that they were uncertain whether they would remain in the market. In addition, eight carriers that cover fewer than 1,000 lives were undecided about staying in the market. The Department modeled the potential effects of a market change to evaluate the impact on Texans.[5] The following analysis depicts the possible outcome should those carriers that indicated uncertainty exit the individual market.

[4] See Appendix 2 for detailed minutes from the meeting.
[5] Analysis includes the data submitted by carriers with fewer than 1,000 enrollees. These carriers cover a total of 1,430 enrollees or approximately .002% of the total market.

If all 17 mid-level and non-credible carriers that expressed doubt about remaining in the individual market were to exit, 47,000 individuals would be affected. Figure 5 below shows the population that would be affected by a large scale market change. The exit of uncertain carriers from the market would constitute a significant change in consumer choices.

Figure 5: Population Affected by Potential Market Change



The data suggest that the Texas market already has a high level of market concentration, with some regions particularly vulnerable to a decrease in provider options should carriers exit. The Department used the Herfindahl-Hirschman Index (HHI) to quantify statewide and regional market concentration to evaluate the impact of a market exit on competition. The HHI is a widely accepted measure of market concentration and is calculated as the sum of the squares of the market share of each carrier in the market, multiplied by 10,000. HHI values fall between 0 and 10,000, with 10,000 indicating higher concentration (less competition) and values close to zero

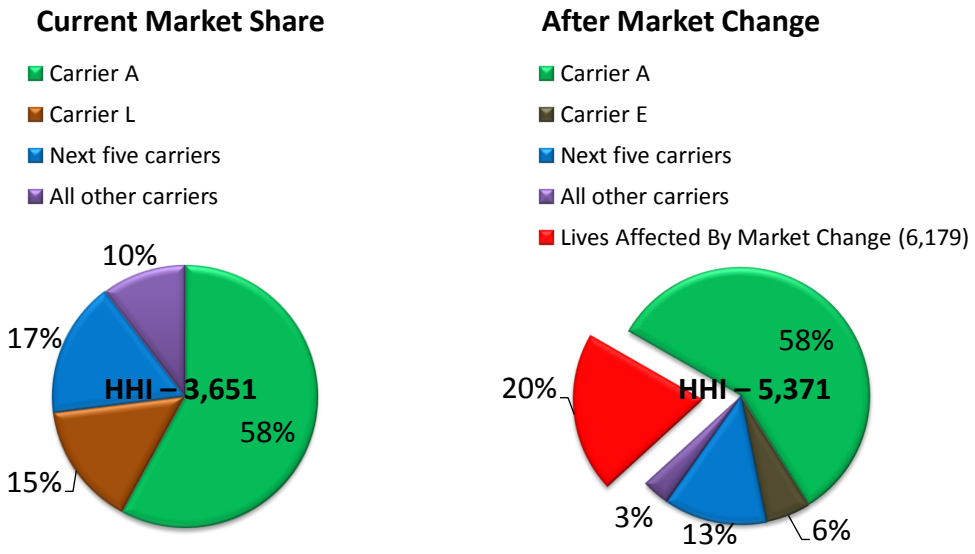
indicating less market concentration (more competition). The U.S. Department of Justice and the Federal Trade Commission generally classify markets into three types using HHI values[6]:

- Unconcentrated markets: HHI below 1500
- Moderately concentrated markets: HHI between 1500 and 2500
- Highly concentrated markets: HHI above 2500

The Department used information carriers provided for the number of enrollees by three-digit zip code to perform the calculation. The statewide HHI is 3,371. The results suggest that the individual market is already "highly concentrated." This is due in large part to the high market share of Carrier A. The possible exit of even a few carriers from the market could heighten the degree of concentration. An analysis of 11 common regions within the state highlights those areas across where further consolidation with the potential exit of mid-level carriers could limit Texans' options for coverage. [7]

Southeast Texas, for example, has a markedly high HHI of 5,413, with Carrier A comprising 71% of the market. Assuming uncertain mid-level carriers were to leave the market, 7% of the market would be affected. If no new carriers entered the market, the HHI for this region would rise to 5,974. The most dramatic rise in market concentration could occur in the Panhandle region. In that case, uncertain carriers account for 20% of the market. Their possible exit would result in rise in the HHI from 3,651 to 5,371 (See Figure 6 below). Other regions such as Central Texas and South Central Texas show HHIs within the moderate range—2,125 and 2,808 respectively. In these regions, Carrier A remains the dominant carrier; however, mid-level and small carriers occupy a larger share of the market.

Figure 6: Effects of Market Change on the Panhandle Region



[6] Horizontal Merger Guidelines, U.S. Department of Justice and the Federal Trade Commission, Issued August 19, 2010. HHI is defined on p. 18.
[7] For the complete regional analysis, see Appendix 3 Regional Analysis of MLR Impact.

The MLR requirement is likely to result in decreased competition across the state. It is possible that mid-level carriers that currently bring diversity and competition to the individual market may exit, choosing instead to focus on select states or products. Some regions in Texas with already high HHIs would show even higher rates of concentration and some areas may see dramatic spikes in concentration. Given the potential negative effects of a market change, retaining existing carriers in the individual market is necessary to maintain sufficient consumer choice and value.

Figure 7: Regional Distribution of Mid-Level Carriers

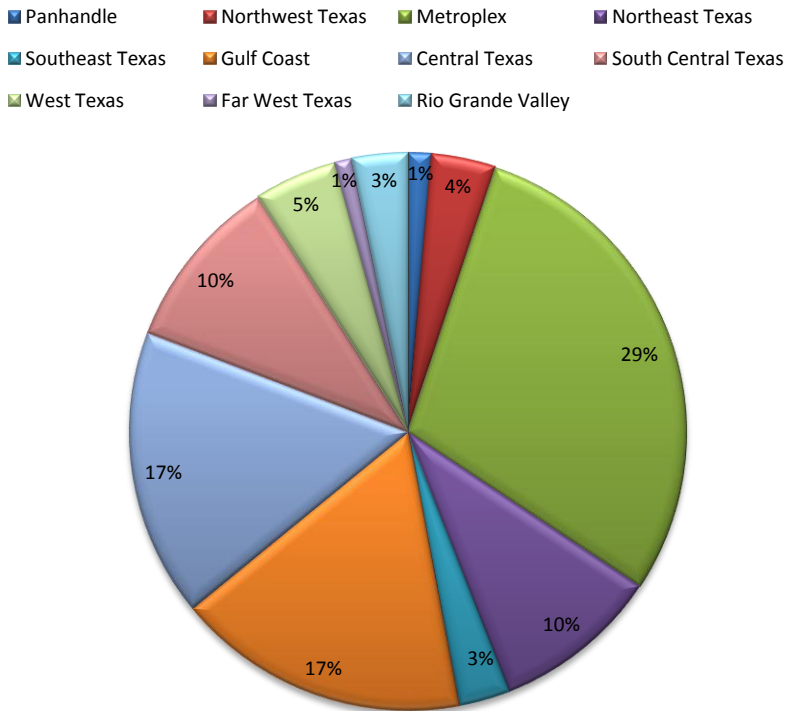


Figure 7 shows the regions where mid-level carriers write their business. For example, the majority of mid-level carrier business is centered in the Metroplex (29%).

The Department's analysis also suggests that the MLR requirement may prevent new entrants in the individual market. The Texas market has a significant number of small carriers (n=13) covering fewer than 1,000 lives. The MLR credibility adjustment may create a threshold that prohibits smaller carriers from expanding their market share, as the possibility of rebates may serve as a deterrent for growth. These small carriers may struggle to reach effective economies of scale to remain profitable in new regulatory climate. Therefore, any potential decrease in competition is especially concerning to the individual market since the likelihood for new entrants may be lessened should the MLR requirement take effect in 2011.

In its analysis, the Department considered the effects of the MLR on the small group market. There was the potential for the MLR to hobble carriers that served both markets. However, the data show that a majority of carriers in the small group market are already achieving the 80% MLR requirement. Sixty-four percent of carriers (14 of 22) are operating at an MLR of 80% or higher. For 7 of the 8 remaining carriers that fall

short of the MLR requirement, rebates range from 5% to 12% of premium. The MLR requirement will likely have a significant negative effect on one carrier in the market whose rebate accounts for 42% of their total premium. However, this is not representative of the market and does not justify an adjustment to the MLR for the small group market.

While the Department cannot predict the impact of the MLR requirement on the individual market, the data presented outline several potential effects that would constitute a destabilization. Because many carriers at varying scales have not achieved the required MLR, it is likely that carriers will make drastic cuts in their expenses to ensure profitability in the short-term. Though large carriers were reluctant to state their intention to exit the market, these carriers will be required to make severe cuts to costs in the short-term to remain profitable. These measures are likely to take the form of cuts to agents' and brokers' commissions, which could result in a decrease in quality and access to health insurance for many Texans. The restructuring and innovation necessary to achieve the MLR requires time. Without a period of transition, carriers will likely slash agents and brokers' commissions, with the result of diminishing access to health care for many Texans.

It is also very possible that some carriers will choose to leave the Texas market. A significant number of mid-level carriers (n=9) and non-credible carriers (n=8) expressed uncertainty about remaining in the market. For some of these carriers the Texas market accounts for less than 11% of their total business nationwide. They may focus on markets that are more viable in terms of financial solvency. These carriers bring needed competition to the Texas market. The MLR requirement holds the potential to stifle entry and growth by smaller carriers in the individual market. A transition would allow these carries additional time to restructure their operating practices and remain competitive.

At present, Texas has a diverse market with sufficient competition. However, given that the market is already "highly concentrated" based on an HHI measurement, any decrease in competition could negatively impact consumer choice. It is priority of the Department to preserve existing competition and encourage increased competition. The data suggest that a gradual transition to the 80% MLR requirement will allow carriers to adjust business practices while ensuring the stability of the market, of which over 700,000 Texans rely on for coverage, in the interim.

45 C.F.R. §158.321 Information regarding the State's individual health insurance market.

45 C.F.R. §158.321(a) State MLR standard. The State must describe its current MLR standard for the individual market, if any, and the formula used to assess compliance with such standard.

Typically, information on loss ratios is collected and considered as a part of a holistic actuarial analysis of rate filings. The Department evaluates loss ratios in conjunction with other variables to analyze the reasonableness of rate increases. MLRs vary across rate filings for individual health insurance coverage. In the recent past, major medical policies were usually priced to achieve a lifetime loss ratio of 55%. The variation is even greater for small group health benefit plans. MLRs have ranged from 50 to 100% with the average falling between 71 and 73%.

45 C.F.R. §158.321(b) State market withdrawal requirements. The State must describe any requirements it has with respect to withdrawals from the State's individual health insurance market. Such requirements include, but are not limited to, any notice that must be provided and any authority the State regulator may have to approve a withdrawal plan or ensure that enrollees of the exiting issuer have continuing coverage, as well as any penalties or sanctions that may be levied upon exit or limitations on re-entry.

The statutory and regulatory withdrawal requirements for the State of Texas for both the individual and the small group health insurance market and Health Maintenance Organizations (HMOs) are found in Title 28 of the Texas Insurance Code (TIC) §§827.001—827.011 and at 28 Texas Administrative Code (TAC) §§7.1801—7.1808 (see Appendix 1). Section 827.003 of the TIC and 28 TAC §7.1804 provide when a withdrawal plan is required. Section 827.004 of the TIC requires that a withdrawal plan be constructed to protect the interests of the people of Texas and indicate the dates on which the insurer intends to begin and to complete the plan. Further, the plan must provide for meeting the insurer's contractual obligations; providing service to the policyholders and claimants; and meeting any applicable statutory obligations. The contents of the withdrawal plan for the individual, small group health insurance market, and HMOs are set forth in 28 TAC §7.1805. The withdrawal plan requires provisions for notifying all the affected Texas policyholders and certificate holders, and for HMOs the enrollees and contract holders, of the dates of the beginning and completion of the total or substantial withdrawal and how the withdrawal will affect them, including, but not limited to:

- a copy of the notice and an explanation of the manner in which the notice will be provided;
- either affirmation that such notice will be provided within 30 days of the approval of the withdrawal plan or a request to provide the notice at some other specified date or time which request must be approved by the Commissioner; and
- the identification of any provision of the TIC or TAC under which notice is mandated.

Also, the withdrawal plan for insurers and HMOs includes in part as follows:

- identification of the line or lines of insurance being totally withdrawn or affected by having total annual premium volume reduced by 75% or more;
- identification of policy forms by number and type (for HMOS identification of form number of evidences of coverage) affected by the withdrawal;
- the dates the insurer or HMO intends to begin and complete its withdrawal;
- an explanation of the reasons for the withdrawal;
- provisions for meeting all of the insurer's or HMO's contractual obligations and for providing service;
- information of Texas business;
- provisions for identifying of special circumstances;
- identification of any third party contracts which may provide for the continuity of care to enrollees of special circumstances;
- number of and estimated amount of all losses outstanding in Texas, including claims incurred but not reported;
- a plan to handle these losses;
- provisions for meeting any applicable statutory obligations;
- a list of any other products the insurer will continue to offer in Texas or the HMO will continue to sell in Texas in each service area; and
- for insurers and HMOs filing total withdrawal plans, an affirmation that no new business will be solicited by the insurer or HMO in Texas during or following the withdrawal period unless the insurer or HMO first complies with 28 TAC §7.1808 (see discussion below).

Section 827.005(b) of the TIC provides that the Commissioner may modify, restrict, or limit a withdrawal plan as necessary if the Commissioner finds that a line of insurance subject to the withdrawal plan is not offered in a quantity or manner to adequately cover the risks in Texas or to adequately protect the residents and policyholders of Texas. The Commissioner may by order set the date on which the insurer's withdrawal begins. Pursuant to pursuant to §827.007 of the TIC, the Commissioner may impose the civil penalties under Chapter 82 of the TIC (see Appendix 1) on an insurer that fails to obtain the Commissioner's approval before the insurer:

- withdraws from writing a line of insurance in Texas; or
- reduces the insurer's total annual premium volume by 75% or more in any year.

Section 827.006 of the TIC requires that an insurer that withdraws from writing all lines of insurance in Texas may not, without the approval of the Commissioner, resume writing insurance in Texas before the fifth anniversary of the date of withdrawal. In addition, 28 TAC §7.1808 states that any insurer or HMO totally or substantially withdrawing from writing any line of insurance in Texas and required to file a withdrawal plan, may not resume writing the withdrawn line without complying with all applicable statutory and regulatory provisions governing authorization to write such line of insurance and receiving the written approval of the Commissioner to resume such writing.

45 C.F.R. §158.321(c) Mechanisms to provide options to consumers. The State must describe the mechanisms available to the State to provide consumers with options in the event an issuer withdraws from the individual market. Such mechanisms include, but are not limited to, a guaranteed issue requirement, limits on health status rating, an issuer of last resort, or a State-operated high risk pool. A description of each mechanism should include detail on the issuers participating in and products available under such mechanism, as well as any limitations with respect to eligibility, enrollment period total enrollment, and coverage for pre-existing conditions.

The mechanism available to the State of Texas to provide consumers with options in the event an issuer withdraws from the individual market is the Texas Health Insurance Pool (Pool). The statutory requirements for the Pool are found in the TIC §§1506.001—1506.305. Subchapter O, 28 TAC §§21.2301—21.2306 contain procedures for notifying persons of eligibility for coverage under the Pool. The Pool is a quasi-governmental entity that is managed by a nine member Board of Directors appointed by the Commissioner of Insurance. The Pool has a Plan of Operation as provided in TIC §1506.201. In addition to information regarding the Pool as provided in the TIC, the Pool website http://txhealthpool.com/ contains information regarding the Pool including but not limited to applications, benefits, contacts, Outline of Coverage, eligibility, non-eligibility, preexisting conditions, enrollment, forms, premium rates, and Frequently Asked Questions (FAQs).

Issuers
Blue Cross and Blue Shield of Texas is the Pool's third party administrator. The Pool has selected BlueChoice Network as its Preferred Provider Organization. Medco Health Solutions is the Pool's pharmacy benefits manager.

Products Available
Section 1506.151(a) of the TIC provides that the Pool shall offer coverage consistent with major medical expense coverage to each eligible individual. The FAQs on the Pool website state that the Pool provides major medical expense coverage including coverage for prescription drugs. Further, benefits are provided up to a $3,000,000 lifetime maximum benefit. Currently, the Pool offers five plans:

- Plan I has a $1,000 deductible;
- Plan II has a $2,500 deductible;
- Plan III has a $5,000 deductible;
- Plan IV has a $7,500 deductible; and
- Plan V (Health Savings Account-Qualified) has a $3,000 deductible.

In addition, Plans I, II, & III have a $200 prescription deductible, Plan IV has a $500 prescription deductible, and Plan V has a $1,450 prescription deductible.
Regarding rates, §1506.105 of the TIC addresses premium rates. Section 1506.105(d) provides in part that the Pool shall establish the standard risk and §1506.105(e) states that in no event may the Pool premium rates exceed 200% of the standard risk rate. The Monthly Premium Rate Tables (effective date 05/01/2011) are found at the Pool website at http://txhealthpool.com/rates.html. The monthly premium rate is determined by deductible plan, age gender, tobacco user status, and zip code. For example, a non-tobacco user 45-49 year old male living in Area 2, with a Plan I would pay a monthly

premium of $796 while a female with equivalent factors would pay $911, and for Plan V, the male would pay $574 and the female would pay $651.

Eligibility and Enrollment
In addition to the TIC requirements described below, the Pool website also describes Pool eligibility and non-eligibility.
Eligibility for coverage requirements are listed in TIC §1506.152. Section 1506.152(a) provides in part as follows:

An individual who is a legally domiciled resident of Texas is eligible for coverage from the Pool if the individual:

- provides evidence that the individual is a federally defined eligible individual who has not experienced a significant break in coverage;
- is younger than 65 years of age and provides evidence that the individual has maintained health benefit plan coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because the individual did not reside in that state and submits an application for Pool coverage not later than the 63rd day after the date the coverage was terminated;
- is younger than 65 years of age and has been a legally domiciled resident of Texas for the preceding 30 days, is a citizen of the United States or has been a permanent resident of the United States for at least three continuous years, and provides to the Pool:
    - a notice of rejection of or refusal to issue for health reasons substantially similar individual health benefit plan coverage from a health benefit plan issuer;
    - certification from an agent or salaried representative of a health benefit plan issuer that states that the agent or representative cannot obtain substantially similar individual coverage for the individual from any health benefit plan issuer that the agent or representative represents because, under the underwriting guidelines of the issuer, the individual will be denied coverage as a result of a medical condition of the individual;
    - an offer to issue substantially similar individual coverage only with conditional riders;
    - a diagnosis of the individual with one of the medical or health conditions on the list adopted under §1506.154; or
    - evidence that the individual is covered by substantially similar individual coverage that excludes one or more conditions by rider; or
- provides evidence that, on the date of application to the Pool, the individual is certified as eligible for trade adjustment assistance or for pension benefit guaranty corporation assistance.

Dependents and certain family members are also eligible for coverage from the Pool as provided in §1506.152(b) and §1506.152(c).

Section 1506.153 in the TIC contains ineligibility for coverage provisions.

Notwithstanding §1506.152 as discussed above, TIC §1506.153(a) provides in part that an individual is not eligible for coverage from the Pool if:

- on the date Pool coverage is to take effect, the individual has health benefit plan coverage from a health benefit plan issuer or health benefit arrangement in effect, except as provided in §1506.152(a)(3)(E);
- at the time the individual applies to the Pool, except as provided in §1506.153(b) (discussed below), the individual is eligible for other health care benefits, including an offer of benefits from the continuation of coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), other than as provided in §1506.153(A), (B), and (C);
- within 12 months before the date the individual applies to the Pool, the individual terminated coverage in the Pool, unless the individual:
    - demonstrates a good faith reason for the termination; or
    - is a federally defined eligible individual;
- the individual is confined in a jail or prison;
- any of the individual's premiums are paid for or reimbursed under a government-sponsored program or by a government agency or health care provider;
- the individual's prior coverage with the Pool was terminated:
    - during the 12–month period preceding the date of application for nonpayment of premiums; or
    - for fraud; or
- the individual is eligible for health benefit plan coverage provided in connection with a policy, plan, or program paid for or sponsored by an employer, even though the employer coverage is declined.

Section 1506.153(b) provides that an individual eligible for benefits from the continuation of coverage under COBRA, who did not elect continuation of coverage during the election period, or whose elected continuation of coverage lapsed or was cancelled without reinstatement, is eligible for Pool coverage. However, eligibility is subject to a minimum 180–day exclusion of coverage under §1506.155(a—1) (discussed below). Further, under §1506.153(c) an individual eligible for benefits from the continuation of coverage under Subchapter F or G, Chapter 1251, or Subchapter G, Chapter 1271 of the TIC, who did not elect continuation coverage during the election period, or whose elected coverage lapsed or was canceled without reinstatement, is eligible for Pool coverage, also subject to a 180-day exclusion of coverage under §1506.155(a—1). However, the 180-day exclusion of coverage under §1506.153(c) does not apply following a period of continuation coverage under COBRA. As of April 2011, the total Pool enrollment was 26,385.

Preexisting Conditions

Preexisting conditions are also discussed on the Pool website. In the TIC, preexisting conditions are addressed in §1506.155. In part, §1506.155(a) provides except as provided in this section and §1506.056 concerning adjustments, Pool coverage excludes charges or expenses incurred before the first anniversary of the effective date of coverage with regard to any condition for which:

- the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care, or treatment within the six-month period preceding the effective date of coverage; or
- medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

Further, §1506.55(a—1) provides, except as provided by Section 1506.056, Pool coverage for an individual eligible pursuant to §1506.153(b) or (c) excludes charges or expenses incurred before the first anniversary of the effective date of coverage with regard to any condition for which:

- the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care, or treatment within the six-month period preceding the effective date of coverage; or
- medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

However, §1506.155(b) provides that the exclusion provided by §1506.155(a) (discussed above), does not apply to a federally defined eligible individual or an individual who:

- was continuously covered for a period of at least 12 months, excluding any waiting period, by creditable coverage that terminated not earlier than the 63rd day before the effective date of coverage under the Pool; and
- applied for Pool coverage not later than the 63rd day after the date the creditable coverage described by §1506.155(b)(1) terminated.

If an individual was covered by creditable coverage that was in effect at any time during the 12–month period preceding the effective date of the individual's coverage under the Pool, the Pool shall subtract from the exclusion period required under §1506.155(a) the period that the individual was covered under that creditable coverage and any waiting period that applied before that creditable coverage became effective.

If an individual eligible under §1506.153(b) was covered by creditable coverage at any time during the 12–month period immediately preceding the effective date of the individual's coverage under the Pool, the Pool shall subtract from the exclusion period required under §1506.155 (a–1) up to 180 days of:

- the period during which the individual was covered under the creditable coverage; and
- any waiting period that applied before the creditable coverage became effective.

A preexisting condition provision may not be applied to an individual who has been certified as eligible for trade adjustment assistance or for pension benefit guaranty corporation assistance, if the individual:

- was continuously covered by a health benefit plan for a period of three months before the individual's separation from employment; and
- applies for coverage from the Pool not later than the 63rd day after the date on which the prior coverage was terminated.

Termination of Pool Coverage

Section 1506.158(a) of the TIC provides that an individual's Pool coverage ends:

- on the date the individual ceases to be a legally domiciled resident of Texas, unless the individual:

    - is a student younger than 25 years of age and is financially dependent on a parent covered by the Pool;
    - is a child for whom an individual covered by the Pool may be obligated to pay child support; or
    - is a child who is disabled and dependent on a parent covered by the Pool, regardless of the age of the child;
- on the first day of the month following the date the individual requests coverage to end;
- on the date the individual covered by the Pool dies;
- on the date State law requires cancellation of coverage;
- at the option of the Pool, on the 31st day after the date the Pool sends to the individual any inquiry concerning the individual's eligibility, including an inquiry concerning the individual's residence, to which the individual does not reply;
- on the 31st day after the date a premium payment for Pool coverage becomes due if the payment is not made before that day;
- on the date the individual is 65 years of age and eligible for coverage under Medicare, unless the coverage received from the Pool is Medicare supplement coverage issued by the Pool; or
- at the time the individual ceases to meet the eligibility requirements for coverage.

Notwithstanding §1506.158(a) (discussed above), §1506.158(b) provides that the coverage of an individual who ceases to meet the eligibility requirements for coverage terminates on the earlier of:

- the first premium due date after the date the Pool determines the individual does not meet the eligibility requirements; or
- the first day of the first month after the month in which the Pool determines the individual does not meet the eligibility requirements.

45 C.F.R. §158.321(d)(1) For each issuer who offers coverage in the individual market in the State its number of individual enrollees by product, available individual premium data by product, and individual health insurance market share within the State.

A spreadsheet entitled "Sec158321d1" is attached separately that presents the number of enrollees and market share by carrier. Given the size and complexity of the individual market in Texas, collecting and compiling data by carrier and product type would present a significant challenge to the Department. Consequently, as in the Iowa Insurance Division (IID) application for an adjustment to the MLR (see CCIIO's letter to IID dated 04/19/11), the Department requests CCIIO to accept information regarding each issuer's number of enrollees and amount of premiums earned in the Texas individual health insurance market as a whole, rather than by product. The Department has focused its analysis at a higher level of aggregation in order to determine whether the MLR requirements would destabilize the individual market.

45 C.F.R. §158.321(d)(2)

The information required of this section is presented in the spreadsheet "Sec158321d2" that is uploaded separately.

45 C.F.R. §158.322 Proposal for adjusted medical loss ratio

The Department proposes the following phase-in to 2014:

Proposed MLR Adjustment	
2011	71%
2012	74%
2013	77%
2014	80%

a) **An explanation and justification of how the proposed adjustment to the MLR was determined.**

Carriers have not had sufficient time to change their business models in 2011 compared to 2010. Therefore, the Department recommends that the 2011 MLR be set at the average experience from 2010, with linear phase-in until the 2014 requirement. The recommendation incorporates the PPACA-defined MLR calculation.

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

Ultimately, the Department believes that the insurance industry will be able to achieve the minimum MLR provisions of the PPACA. However, achievement of these goals will not likely be possible within the accelerated timeframe of PPACA without negative consequences for members, providers, plans, employees, and agents.

If a waiver of the accelerated timeframe is not granted for the State, it is likely that some plans will leave the market, reducing competition and consumer choice. The remaining plans will be left with few options other than urgent across-the-board administrative expense cuts. This approach will likely have negative results for all stakeholders such as:

- Reduced service levels for providers and members;
- Constrained distribution channels reducing consumer choice and competition;
- Unintentional constraints on high-value administrative work that supports quality and management of utilization/cost;
- Reduction of technology investments and innovation; and
- Increases in payments for fraudulent or wasteful claims.

In addition, because the majority of an insurer's administrative expense comes in the form of employee salaries and benefits, employee layoffs will most likely be a component of any insurer's administrative expense reduction plan.

The Department believes that most, if not all, plans recognize the value of reducing administrative costs. In a market where prices are competitive, administrative cost reductions can be driven to the bottom line. However, achievement of meaningful, sustainable administrative cost reductions will require **careful consideration**, **investments in technology**, and **industry collaboration**. All of this takes time.

Careful Consideration.
Due to the interconnected nature of health plan administration, reductions in one operational area may be offset by increases in another area. For example, a reduction in physician relations expense may be offset by an increase in claims rework due to erroneous claims submissions and an increase in customer service calls by physicians. Likewise, changes resulting in reduced call center service levels may result in increased duplicate claims submission by providers frustrated by the change in customer service.

Identifying and implementing cost reduction initiatives requires careful consideration to ensure that downstream or secondary effects are identified and managed. This takes time for study, communication with stakeholders, implementation, and monitoring.

Investments in Technology.
Historically, the most significant administrative expense improvements have come about through investments in technology. Plans have invested billions of dollars in self-service capabilities for providers and members; use of electronic claims and auto-adjudication; document management and workflow; and other systems designed to improve administrative efficiency. We believe there are additional gains that industry can achieve through technology and that the MLR provisions will spur these investments. However, implementation of technology takes time and considerable resources. For example, installation of a new core system can take 18 to 36 months at a minimum; and implementation of new functionality within existing systems can take months to design, build, and test. These types of changes expose plans to significant operational risk, necessitating a controlled, well-planned, and resource intensive implementation effort.

Industry Collaboration.
In addition to technology, some of the most meaningful administrative cost reductions achieved to-date have come about through industry collaboration. For example, collaboration initiatives between payers and providers, or payers and employers, have found ways to streamline processes, share resources, and eliminate low value and/or duplicative work. Some of the most meaningful administrative expense reductions will come about through collaboration and goal alignment among industry stakeholders. To do so, however, takes time.

In summary, the Department believes that the administrative expense reduction goals of PPACA are achievable. However, it will take time to implement these initiatives in ways that drive meaningful, sustainable reductions without significant negative impacts on industry stakeholders.

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

Carriers estimated that they would have paid $158.1 million in rebates in 2010 had the 80% MLR requirement been in place in that year.

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

Based on 2010 experience, estimated rebates at the phase-in MLRs would have been:

71%: $34.9 million
74%: $71.3 million
77%: $111.9 million

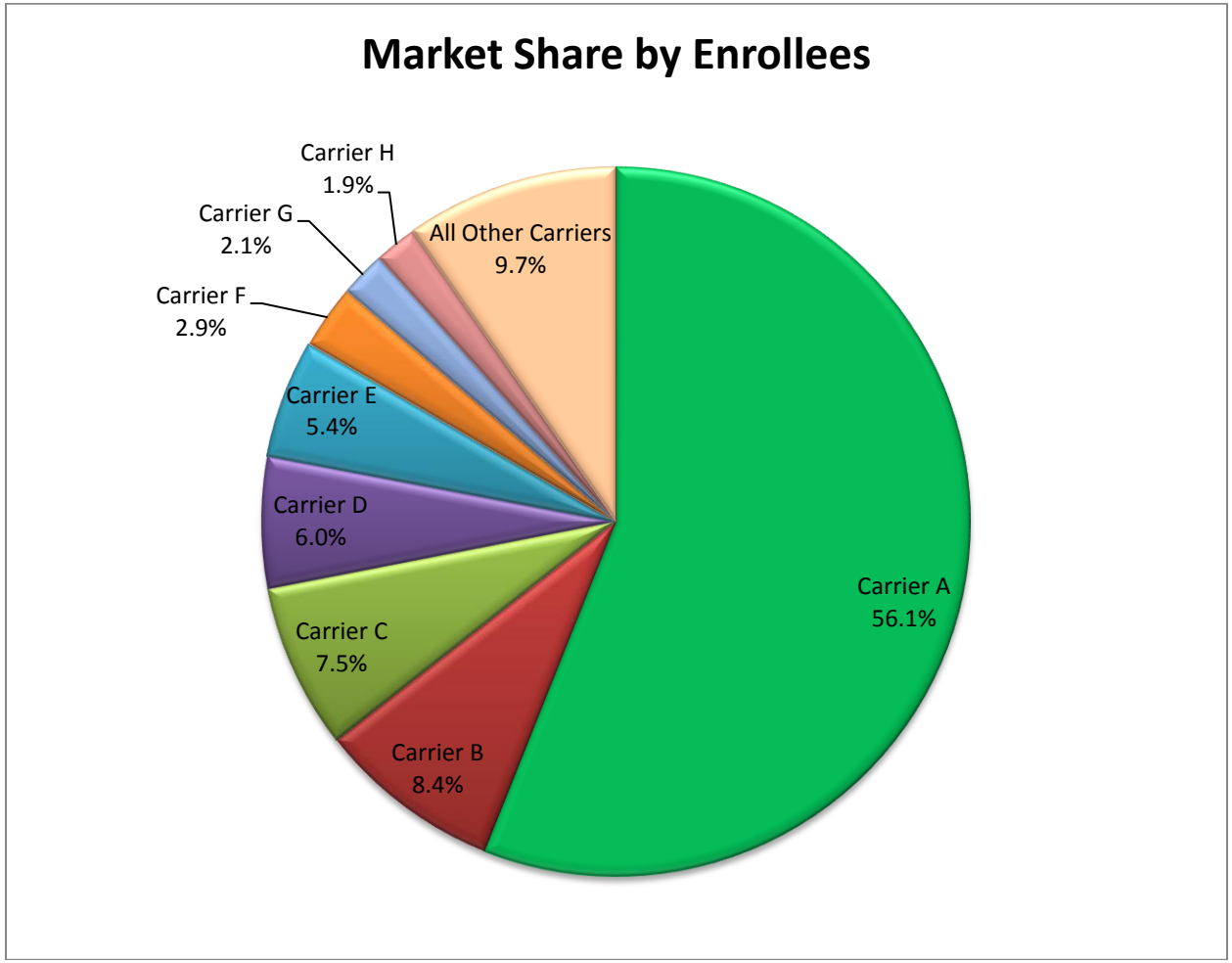
45 C.F.R. §158.323 State contact information. A State must provide the name, telephone number, email address, and mailing address of the person the Secretary may contact regarding the request for an adjustment to the MLR standard

Jan Graeber, Deputy Commissioner and Chief Actuary of the Life/Health Division
333 Guadalupe
P.O. Box 149104
Austin, TX 78714-9104
(512) 332-3401
jan.graeber@tdi.state.tx.us

Information Requested of 45 C.F.R. §158.321(d)(1)

Texas Individual Health Insurance Market			
Carrier	**Number of Enrollees**	**Market Share by Enrollees**	**Total Earned Premium**
Carrier A	407,187	56.0566%	$937,263,079
Carrier B	60,872	8.3801%	$146,379,172
Carrier C	54,745	7.5366%	$121,508,683
Carrier D	43,506	5.9894%	$94,392,640
Carrier E	39,215	5.3986%	$130,875,363
Carrier F	21,130	2.9089%	$34,834,829
Carrier G	15,141	2.0844%	$29,217,455
Carrier H	14,048	1.9340%	$27,874,732
Carrier I	10,533	1.4501%	$38,167,764
Carrier J	7,900	1.0876%	$25,141,280
Carrier K	7,741	1.0657%	$10,324,147
Carrier L	6,915	0.9520%	$24,667,247
Carrier M	5,133	0.7066%	$8,694,815
Carrier N	3,528	0.4857%	$4,552,537
Carrier O	3,380	0.4653%	$13,517,328
Carrier P	3,302	0.4546%	$9,350,984
Carrier Q	3,217	0.4429%	$8,817,236
Carrier R	3,037	0.4181%	$4,683,160
Carrier S	2,845	0.3917%	$2,067,686
Carrier T	2,711	0.3732%	$17,162,979
Carrier U	2,451	0.3374%	$7,455,021
Carrier V	1,676	0.2307%	$7,421,649
Carrier W	1,433	0.1973%	$13,430,594
Carrier X	1,120	0.1542%	$338,124
Carrier Y	1,120	0.1542%	$7,275,601
Carrier Z	1,065	0.1466%	$2,992,066
Carrier AA	870	0.1198%	$2,449,706
Carrier AB	361	0.0497%	$795,209
Carrier AC	59	0.0081%	$59,961
Carrier AD	48	0.0066%	$747,555
Carrier AE	33	0.0045%	$170,992
Carrier AF	32	0.0044%	$80,790
Carrier AG	9	0.0012%	$230,160
Carrier AH	7	0.0010%	$84,087
Carrier AI	6	0.0008%	$19,078
Carrier AJ	3	0.0004%	$48,361
Carrier AK	3	0.0004%	$223,508
Carrier AL	3	0.0004%	$54,910
Carrier AM	1	0.0001%	$15,661
Total	**726,385**	**100.0000%**	**$1,733,386,149**

Information Requested of 45 C.F.R. §158.321(d)(1)



Information Requested of 45 C.F.R. §158.321(d)(2)

Carrier[8]	(i) Total Earned Premium	(ii) Actual Loss Ratio	(iii) PPACA MLR without Credibility Adjustment	PPACA MLR with Credibility Adjustment	(iv) Total Commissions	(v) Estimated Rebate[9]
Carrier A	$937,263,079	64.8%	69.9%	69.9%	$88,760,707	$89,583,364
Carrier B	$146,379,172	69.3%	76.0%	76.9%	$2,962,466	$4,108,336
Carrier C	$121,508,683	54.7%	60.8%	62.4%	$12,365,472	$19,348,373
Carrier D	$94,392,640	57.9%	58.9%	60.5%	$2,500,271	$18,090,000
Carrier E	$130,875,363	70.6%	72.1%	73.7%	$12,981,672	$8,463,259
Carrier F	$34,834,829	58.6%	61.8%	63.8%	$4,852,135	$5,500,000
Carrier G	$29,217,455	75.2%	84.4%	87.3%	$75,613	$0
Carrier H	$27,874,732	86.7%	87.8%	87.8%	$57,420	$0
Carrier I	$38,167,764	34.2%	68.0%	71.4%	$1,345,307	$2,695,952
Carrier J	$25,141,280	62.4%	65.4%	69.4%	$5,843,797	$2,527,028
Carrier K	$10,324,147	51.1%	52.8%	55.8%	$2,546,992	$2,431,855
Carrier L	$24,667,247	81.7%	84.0%	87.9%	$1,734,655	$0
Carrier M	$8,694,815	68.5%	71.7%	77.2%	$1,885,796	$236,741
Carrier N	$4,552,537	45.9%	47.7%	52.5%	$1,547,747	$1,251,947
Carrier O	$13,517,328	51.2%	59.3%	64.8%	$844,362	$1,829,163
Carrier P	$9,350,984	41.2%	72.2%	78.4%	$787,025	$122,473
Carrier Q	$8,817,236	62.5%	88.4%	93.5%	$1,373,963	$1,185,093
Carrier R	$4,683,160	70.5%	73.3%	81.7%	$383,019	$0
Carrier S*	$2,067,686	44.9%	44.9%	44.9%	$250,599	$0
Carrier T	$17,162,979	70.5%	80.0%	74.0%	$1,804,195	$568,995
Carrier U	$7,455,021	67.2%	70.2%	77.4%	$1,681,932	$200,658
Carrier V	$7,421,649	76.7%	79.5%	88.5%	$462,753	$0
Carrier W*	$13,430,594	64.9%	65.4%	65.4%	$1,137,491	$0
Carrier X*	$338,124	76.4%	76.4%	76.4%	$33,770	$0
Carrier Y	$7,275,601	83.6%	117.5%	125.2%	$593,319	$0
Carrier Z	$2,992,066	51.0%	57.5%	57.5%	$778,276	$0**
Total (All credible carriers)	**$1,728,406,171**	**64.5%**	**69.9%**	**70.8%**	**$149,590,754**	**$158,143,237**
Top 8 Carriers	**$1,522,345,953**	**65.0%**	**69.7%**	**70.2%**	**$124,555,756**	**$145,093,332**

[8] Carrier S, Carrier W and Carrier X (*) were unable to provide correct and/or complete data.
[9] Carrier Z was unable to provide an estimated rebate (**).

Information Requested of 45 C.F.R. §158.321(d)(2)

Carrier	(vi) Net Underwriting Profit Individual Market	(vi) Net Underwriting Profit Consolidated	(vii) After-tax Profit Individual Market	(vii) After-tax Profit Consolidated
Carrier A	$85,817,488	$263,186,937	$64,301,076	$197,199,937
Carrier B	$11,823,957	$30,963,525	$0	$48,216,070
Carrier C	$29,480,015	$30,939,861	$19,139,377	$20,081,732
Carrier D	$15,015,451	$31,352,201	$7,102,270	$13,405,928
Carrier E	($26,357)	($1,133,911)	$2,562,448	$2,994,883
Carrier F	$307,890	$4,816,064	$183,353	$2,868,036
Carrier G	$3,479,577	$45,029,938	$2,201,828	$28,794,059
Carrier H	($1,293,045)	($4,623,523)	($1,293,045)	($3,103,882)
Carrier I	$11,200,681	$11,243,866	$10,820,036	$10,861,682
Carrier J	$335,730	$335,730	$218,225	$216,225
Carrier K	($2,990,539)	($2,990,539)	($1,726,745)	($1,726,745)
Carrier L	$1,923,481	$1,001,355	$2,125,795	$3,016,796
Carrier M	($1,422,199)	($1,360,447)	($1,354,473)	($1,211,344)
Carrier N	$177,347	$177,347	$86,882	$86,882
Carrier O	$1,935,810	$4,155,818	$2,124,016	$5,845,799
Carrier P	$2,290,800	$2,286,177	$2,219,667	$2,214,628
Carrier Q	($28,667)	$833,092	$260,760	$586,181
Carrier R	($487,652)	($519,803)	($429,496)	($461,647)
Carrier S*	$274,277	$0	$0	$0
Carrier T	$849,025	$849,025	$552,000	$552,000
Carrier U	($256,970)	($256,970)	($167,031)	($167,031)
Carrier V	$585,660	$162,270	$635,570	$458,944
Carrier W	$1,373,870	$5,541,353	$551,995	$3,579,456
Carrier X*	($18,661)	$0	$0	$0
Carrier Y	($1,277,708)	($1,277,708)	($3,244,812)	($3,244,812)
Carrier Z	$188,603	$488,232	$176,458	$470,535
Total (All credible carriers)	**$159,257,864**	**$421,199,890**	**$107,046,154**	**$331,534,312**
Top 8 Carriers	**$144,604,976**	**$400,531,092**	**$94,197,307**	**$310,456,763**

Information Requested of 45 C.F.R. §158.321(d)(2)

Carrier	(vii) After-tax Profit Margin Individual Market	(vii) After-tax Profit Margin Consolidated	(viii) Risk Based Capital Level	(ix) Exit Market?
Carrier A	6.86%	2.60%	1083.8%	N
Carrier B	0.00%	3.10%	765.0%	N
Carrier C	15.75%	15.30%	654.0%	N
Carrier D	7.52%	2.80%	525.0%	N
Carrier E	1.96%	1.90%	594.5%	N
Carrier F	0.53%	5.70%	704.0%	N
Carrier G	7.54%	3.70%	467.0%	N
Carrier H	-4.64%	-0.60%	408.8%	N
Carrier I	28.35%	28.40%	500.0%	U
Carrier J	0.87%	0.90%	1218.0%	N
Carrier K	-16.73%	-16.60%	1247.6%	U
Carrier L	8.62%	1.20%	369.0%	U
Carrier M	-15.58%	-13.10%	332.0%	U
Carrier N	1.91%	1.90%	13.6%	Y
Carrier O	15.71%	8.10%	569.5%	N
Carrier P	23.74%	23.70%	500.0%	U
Carrier Q	2.96%	3.60%	921.8%	U
Carrier R	-9.17%	-9.80%	622.0%	N
Carrier S*	0.00%	0.00%	0.0%	U
Carrier T	3.22%	3.20%	200.0%	N
Carrier U	-2.24%	-2.20%	1500.0%	N
Carrier V	8.56%	1.10%	486.4%	N
Carrier W	4.11%	6.40%	603.0%	Y
Carrier X*	0.00%	0.00%	0.0%	U
Carrier Y	-44.60%	-44.00%	853.0%	N
Carrier Z	5.90%	15.30%	500.0%	U

APPENDICES

Appendix 1 – 45 CFR 158.321(b)—State Market Withdrawal Requirements.

Relevant Texas Statutory and Regulatory Authority
Texas Insurance Code, Chapter 827. Withdrawal and Restriction Plans

Sec. 827.001. DEFINITIONS. In this chapter:

(1) ‘‘Insurer’’ means an insurance company or other legal entity authorized to engage in the business of insurance in this state, including a reciprocal or interinsurance exchange, a Lloyd’s plan, and a county mutual insurance company. The term includes an affiliate. The term does not include a farm mutual insurance company or an eligible surplus lines insurer regulated under Chapter 981.

(2) ‘‘Rating territory’’ means a rating territory established by the department.

Sec. 827.002. EXEMPTION. This chapter does not apply to a transfer of business from an insurer to a company that:

(1) is within the same insurance group as the insurer;

(2) is authorized to engage in the business of insurance in this state; and

(3) is not a reciprocal or interinsurance exchange, a Lloyd’s plan, a county mutual insurance company, or a farm mutual insurance company.

Sec. 827.003. WITHDRAWAL PLAN REQUIRED. An insurer shall file with the commissioner a plan for orderly withdrawal if the insurer proposes to:

(1) reduce the insurer’s total annual premium volume by 50 percent or more;

(2) reduce the insurer’s annual premium by 75 percent or more in a line of insurance in this state; or

(3) reduce in this state, or in any applicable rating territory, the insurer’s total annual premium
volume in a line of personal automobile or residential property insurance by 50 percent or more.

Sec. 827.004. PROVISIONS OF WITHDRAWAL PLAN. A withdrawal plan filed under Section 827.003 must:

(1) be constructed to protect the interests of the people of this state;

(2) indicate the dates on which the insurer intends to begin and to complete the plan; and

(3) provide for:

(A) meeting the insurer’s contractual obligations;

(B) providing service to the insurer’s policyholders and claimants in this state; and

(C) meeting any applicable statutory obligations, such as payment of assessments to the guaranty fund and participation in an assigned risk plan or joint underwriting arrangement.

Sec. 827.005. APPROVAL OF WITHDRAWAL PLAN. (a) Except as provided by Subsection (b), the commissioner shall approve a withdrawal plan that adequately provides for meeting the requirements prescribed by Section 827.004(3).

(b) The commissioner may modify, restrict, or limit a withdrawal plan under this section as necessary if the commissioner finds that a line of insurance subject to the withdrawal plan is not offered in a quantity or manner to adequately cover the risks in this state or to adequately protect the residents of this state and policyholders in this

state. The commissioner may by order set the date on which the insurer's withdrawal begins.

(c) A withdrawal plan is deemed approved if the commissioner:

(1) does not hold a hearing on the plan before the 61st day after the date the plan is filed with the commissioner; or

(2) does not deny approval before the 61st day after the date a hearing on the plan is held.

Sec. 827.006. RESUMPTION OF WRITING INSURANCE AFTER COMPLETE WITHDRAWAL. An insurer that withdraws from writing all lines of insurance in this state may not, without the approval of the commissioner, resume writing insurance in this state before the fifth anniversary of the date of withdrawal.

Sec. 827.007. PENALTIES. The commissioner may impose the civil penalties under Chapter 82 on an insurer that fails to obtain the commissioner's approval before the insurer:

(1) withdraws from writing a line of insurance in this state; or

(2) reduces the insurer's total annual premium volume by 75 percent or more in any year.

Sec. 827.008. RESTRICTION PLAN. (a) Before an insurer, in response to a catastrophic natural event that occurred during the preceding six months, may restrict writing new business in a rating territory in a line of personal automobile or residential property insurance, the insurer must file a proposed restriction plan with the commissioner for the commissioner's review and approval.

(b) The commissioner may modify, restrict, or limit a restriction plan under this section as necessary if the commissioner finds that a line of insurance subject to the restriction plan is not offered in this state in a quantity or manner to adequately cover the risks in this state or to adequately protect the residents of this state and policyholders in this state in light of the impact of the catastrophic natural event. The commissioner may by order set the date on which the insurer's restriction begins.

(c) A withdrawal plan must be filed and approved under Sections 827.003 and 827.004 if an insurer's decision not to accept new business in a line of personal automobile or residential property insurance results in a reduction of the insurer's total annual premium volume by 50 percent or more.

Sec. 827.009. DEPOSIT OF SECURITIES. Under this chapter, the commissioner may require the deposit of securities in this state in trust in the name of the commissioner if the commissioner determines, after notice and hearing, that there is reasonable cause to conclude that the interests of the people of this state are best served by the deposit.

Sec. 827.010. MORATORIUM. (a) The commissioner may impose a moratorium of not longer than two years on:

(1) the approval of withdrawal plans; or

(2) the implementation of plans to restrict the writing of new business described by Section 827.008.

(b) A moratorium under this section may be imposed on plans implemented after the commissioner has published notice of intention to impose a moratorium on plans under Subsection (a)(2).

(c) The commissioner may annually renew a moratorium imposed under this section.

(d) To impose or renew a moratorium under this section, the commissioner must determine, after notice and hearing, that a catastrophic event has occurred and that as a result of that event a particular line of insurance is not reasonably expected to be available to a substantial number of policyholders or potential policyholders in this state or, in the case of lines of personal automobile or residential property insurance, in a rating territory.

(e) The provisions of Chapter 2001, Government Code, relating to contested cases apply to the notice and hearing.

(f) The commissioner by rule shall establish reasonable criteria for applying the standards for determining whether to impose a moratorium under this section.

Sec. 827.011. RULES. The commissioner shall adopt rules as necessary to enforce this chapter.

28 Texas Administrative Code (TAC), Chapter 7, Subchapter R—Withdrawal Plan Requirements and Procedures

28 TAC Sec. 7.1801 Purpose

The purpose of this subchapter is to provide orderly and uniform procedures, as required by law and dictated by sound public policy, for any authorized insurer or HMO filing a plan of withdrawal with the Commissioner of Insurance pursuant to the Insurance Code, Article 21.49-2C. Nothing in this subchapter authorizes or allows an insurer or HMO to withdraw from any coverage if such withdrawal would violate any federal or state law or any provisions contained in a contract or evidence of coverage or a policy or certificate of insurance itself.

28 TAC Sec. 7.1802 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Annual Statement--Annual statement most recently filed by the insurer or HMO with the Texas Department of Insurance.

(2) Association coverage--Coverage under a health benefit plan issued to an association or bona fide association as those terms are defined in §21.2702 of this title (relating to Association Plans).

(3) Commissioner--Commissioner of Insurance.

(4) Department--Texas Department of Insurance.

(5) Individual coverage--Coverage issued by an HMO that provides an individual health care plan as defined in Insurance Code Article 20A.09(l).

(6) Large employer coverage--Coverage under a health benefit plan issued to a large employer as those terms are defined in §26.4 of this title (relating to Definitions).

(7) Line of insurance--Each line of business as specified in §7.1803 of this title (relating to What Constitutes a Line of Insurance).

(8) HMO--A health maintenance organization licensed under Insurance Code Chapter 20A.

(9) Medicaid--The Medicaid program under Title XIX of the Social Security Act of 1965.

(10) Medicare--Has the same meaning as specified in §3.3303 of this title (relating to Definitions)

(11) Medicare+Choice plan--Has the same meaning as specified in §3.3303 of this title.

(12) Small employer coverage--Coverage under a health benefit plan issued to a small employer as those terms are defined in §26.4 of this title.
(13) Enrollees of special circumstances--As described in Insurance Code Articles 3.70-3C, §4 and 20A.18A(c).
(14) CHIP--The Texas Children's Health Insurance Program under Texas Health and Safety Code Chapter 62.
(15) Withdrawal--
(A) Substantial withdrawal occurs when an insurer or HMO on its own initiative plans to reduce the company's total annual premium volume for a line of insurance, as defined in §7.1803 of this title, by 75% or more, except when the insurer or HMO meets any exception specified in §7.1804(b) of this title (relating to When a Plan Is Required).
(B) Total withdrawal occurs when an insurer or HMO on its own initiative plans to no longer engage in the writing of a line of insurance, as defined in §7.1803 of this title except when the insurer or HMO meets any exception specified in §7.1804(b) of this title.

28 TAC Sec. 7.1803 What Constitutes a Line of Insurance
(a) For purposes of this subchapter, a line of insurance is defined as each line of business as specified in paragraphs (1)(A)-(P), (2)(A)-(PP), and (3)(A)-(K) of this subsection, and including any line written in by the insurer or HMO on the annual statement pages specified in this section, for which financial data was reported by the individual withdrawing insurer or HMO filing any of the annual statement pages specified in this section, or any duly promulgated equivalent pages, of the annual statement forms specified in this section, or any duly promulgated equivalent forms, and including any line of business that is duly promulgated to be added to the annual statement pages specified in this section or to any duly promulgated equivalent page.
(1) For an insurer that is required to file the Life and Accident and Health Annual Statement, Texas State Page 21, Reporting Direct Business in the State of Texas During the Year, or the Health Statement, Exhibit of Premiums, Enrollment and Utilization, reporting direct business in the State of Texas (page 34 of the Health Statement), in addition to any line of insurance written in by the insurer, each of the following is a line of insurance:
(A) ordinary life;
(B) group and individual credit life;
(C) group life;
(D) industrial life;
(E) ordinary annuity;
(F) group annuity;
(G) ordinary annuity and other fund deposits;
(H) group annuity and other fund deposits;
(I) small employer coverage;
(J) group and individual credit accident and health;
(K) individual accident and health coverage including collectively renewable accident and health, noncancellable accident and health, guaranteed renewable accident and health, non-renewable for stated reasons only accident and health, and other accident only;
(L) group accident and health other than association, large employer or small employer coverage;
(M) Medicare+Choice plan;
(N) CHIP coverage;
(O) association coverage; or

(P) large employer coverage.

(2) For an insurer that is required to file the Property and Casualty Annual Statement, Exhibit of Premiums and Losses, page 15, (coded "Statutory Page 14"), in addition to any line written in by the insurer, each of the following is a line of insurance:

(A) fire;

(B) allied lines;

(C) earthquake;

(D) flood;

(E) farmowners multiple peril;

(F) homeowners multiple peril;

(G) Texas commercial multiple peril (non-liability portion);

(H) growing crops (all other);

(I) multiple peril crop;

(J) inland marine;

(K) ocean marine;

(L) small employer coverage;

(M) group and individual credit accident and health;

(N) individual accident and health coverage including collectively renewable accident and health, noncancellable accident and health, guaranteed renewable accident and health, non-renewable for stated reasons only accident and health, and other accident only;

(O) group accident and health other than association, large employer or small employer coverage;

(P) Medicare+Choice plans;

(Q) CHIP coverage;

(R) association coverage;

(S) large employer coverage;

(T) workers compensation;

(U) Texas commercial multiple peril (liability portion);

(V) financial guaranty;

(W) medical malpractice liability (physicians--including surgeons and osteopaths);

(X) medical malpractice liability (all other health care professionals);

(Y) medical malpractice liability--hospitals;

(Z) medical malpractice liability (all other health care facilities);

(AA) product liability;

(BB) other general liability;

(CC) fidelity;

(DD) surety;

(EE) glass;

(FF) burglary and theft;

(GG) boiler and machinery;

(HH) credit guaranty;

(II) mortgage guaranty;

(JJ) aircraft (all perils);

(KK) private passenger auto no-fault personal injury protection;

(LL) other private passenger auto liability;

(MM) commercial auto no-fault personal injury protection;

(NN) other commercial auto liability;

(OO) private passenger auto physical damage; or

(PP) commercial auto physical damage.

(3) For an HMO that is required to file the Health Statement, Exhibit of Premiums, Enrollment and Utilization, reporting direct business in the State of Texas (page 34 of the Health Statement), in addition to any line of insurance written in by the HMO, each of the following is a line of insurance for the purposes of this subchapter:

(A) small employer coverage;

(B) large employer coverage;

(C) health care services for Medicaid delivered under a contract with the Texas Health and Human Services Commission;

(D) health care services for Medicare or a Medicare+Choice plan delivered under a contract with the federal Centers for Medicare and Medicaid Service;

(E) CHIP coverage;

(F) individual coverage;

(G) association coverage;

(H) limited service group coverage;

(I) limited service individual coverage;

(J) single service group coverage; and

(K) single service individual coverage.

(b) Nothing in this section authorizes or allows an insurer or HMO to cancel or non-renew any coverage that would violate any law or provisions contained in a contract or evidence of coverage or a policy or certificate of insurance itself.

28 TAC Sec. 7.1804 When a Plan Is Required

(a) Any authorized insurer or HMO must file with the Commissioner of Insurance a plan of orderly withdrawal before the insurer or HMO undertakes total or substantial withdrawal from a line of insurance.

(1) The insurer or HMO undertakes total withdrawal from a line of insurance when it takes any action on its own initiative that will result in the insurer's or HMO's ceasing to write a line of insurance, as defined in §7.1803 of this title (relating to What Constitutes a Line of Insurance). An insurer or HMO will not be held to have acted on its own initiative in effecting a total withdrawal from a line of insurance when it acts pursuant to a Commissioner disciplinary or administrative directive or order, or when the insurer or HMO acts pursuant to a directive of a supervisor, conservator, or receiver. If any out-of-state directive or order is not provided to the Commissioner within 30 days of the issuance of any such directive or order, the insurer or HMO will be held to have acted on its own initiative.

(2) The insurer or HMO undertakes substantial withdrawal from a line of insurance when it takes any action on its own initiative that will result in reducing the insurer's or HMO's total annual premium volume in Texas for the current calendar year for a line of insurance, as defined in §7.1803 of this title, by 75% or more of the total annual premium volume in Texas for the immediately preceding calendar year for such line of insurance. An insurer or HMO will not be held to have acted on its own initiative in effecting a substantial withdrawal from a line of insurance when it acts pursuant to a Commissioner disciplinary or administrative directive or order, or when the insurer or HMO acts pursuant to a directive of a supervisor, conservator, or receiver. If any out-of-state directive or order is not provided to the Commissioner within 30 days of the issuance of any such directive or order, the insurer or HMO will be held to have acted on its own initiative.

(b) Exceptions. An insurer or HMO is not required to file a plan of orderly withdrawal, but shall instead notify the Department, when:

(1) the insurer is transferring business from the insurer to a company within the same insurance holding company system, as defined in the Insurance Holding Company

System Regulatory Act, the Insurance Code, Article 21.49-1, §2, and admitted to do business in this state;
(2) the line of business is written by a stipulated premium company unless such line is written pursuant to the Texas Insurance Code, Article 22.23(b) or Article 22.23A;
(3) the HMO is transferring business from the HMO to an affiliated HMO; or
(4) the line of insurance from which the HMO is withdrawing is Medicare, a Medicare+Choice plan or a Medicaid contract as provided in §7.1803(a) of this title.
(c) If an insurer or HMO comes within an exception provided in subsection (b) of this section, such notification must be sent to the Department simultaneously with any notification required to be provided to any other state or federal agency. The notification will be accepted for information only and shall affirm that any appropriate state or federal agency has been notified of the company's intent to withdraw, and shall include the effective date of non-renewal, the names of the Texas counties affected, and the number of insureds or enrollees affected.
(d) This subchapter does not modify or supercede any requirement under the Insurance Code or any other state or federal law to notify policyholders or enrollees that an insurer or HMO will not renew any coverage; however, before any such notice is given a withdrawal plan must be filed with the Department and approved by the Department under §7.1806 of this title (relating to Plan Submission and Approval Procedures) when a plan is required by this section.

28 TAC Sec. 7.1805 Contents of Withdrawal Plan
(a) Except for withdrawing HMOs, which are addressed under subsection (b) of this section, a withdrawing insurer shall file a plan of orderly withdrawal with the Commissioner that is constructed to protect the interests of the people of this state. The plan must be signed by at least one officer of the insurer and, for each line of insurance being withdrawn or having total annual premium volume reduced by 75% or more, must contain the following:
(1) identification, in accordance with the line of insurance designations in §7.1803 of this title (relating to What Constitutes a Line of Insurance), of the line or lines of insurance being totally withdrawn or affected by having total annual premium volume reduced by 75% or more;
(2) identification of the policy forms by number and type affected by the withdrawal;
(3) the dates the insurer intends to begin and complete its withdrawal;
(4) an explanation of the reasons for the withdrawal;
(5) provisions for notifying all of the affected Texas policyholders and certificateholders of the dates of the beginning and completion of the total or substantial withdrawal and how the withdrawal will affect them, including, but not limited to:
(A) a copy of the notice and an explanation of the manner in which the notice will be provided to policyholders and certificateholders; and
(B) either affirmation that such notice will be provided within 30 days of the approval of the withdrawal plan or a request to provide the notice at some other specified date or time, and such request must be approved by the Commissioner;
(C) identification of any provision of the Insurance Code or Texas Administrative Code under which notice is mandated.
(6) provisions for meeting all of the insurer's contractual obligations, including, but not limited to:
(A) notification of all affected agents of the insurer of the date the insurer intends to begin and complete the withdrawal;

(B) for fire and casualty insurers, a statement affirming the insurer's compliance with the provisions of the Insurance Code, Article 21.11-1, relating to cancellation of agency contracts;

(C) for insurers writing liability coverage as specified in the Insurance Code, Article 21.49-2A, a statement affirming the insurer's compliance with the provisions of Article 21.49-2A, relating to cancellation and nonrenewal of certain liability insurance coverage; and

(D) for insurers writing property and casualty coverage as specified in the Insurance Code, Article 21.49-2B, a statement affirming the insurer's compliance with the provisions of Article 21.49-2B, relating to cancellation and nonrenewal of certain property and casualty policies;

(7) provisions for providing service to the insurer's Texas policyholders and claimants;

(8) information on Texas business, including:

(A) for insurers filing total withdrawal plans, the total annual premium volume and the number of policies and certificates and covered persons in Texas for each line to be withdrawn;

(B) for insurers filing substantial withdrawal plans, the total annual premium volume and number of policies and certificates and covered persons in Texas before substantial withdrawal is effected and the estimated total annual premium volume and number of policies and certificates and covered persons in Texas after substantial withdrawal is effected for each line to be substantially withdrawn;

(C) estimate of what percentage of the Texas market the withdrawal constitutes;

(D) any information necessary to assist the Commissioner in determining whether a market availability problem is created by the total or substantial withdrawal, the extent of the problem, and what market assistance may be needed to alleviate the problem, including, but not limited to, the following:

(i) type of location and geographic area subject to the withdrawal if not statewide (identify type of area such as suburban, urban, rural, or list specific rating territories) and zip codes if entire state not included in withdrawal; and

(ii) if applicable, types of risks no longer being covered (for example, if no longer writing private passenger auto insurance coverage for single-car families or for persons without supporting business; or if no longer providing homeowner's insurance coverage for low-value homes, or in areas with high loss-ratios, or in areas with historically high exposure to natural disasters). The information listed in this clause is provided for purposes of example only and is not intended to be a comprehensive or exhaustive list.

(E) if an insurer is unable to provide the exact number of policies and certificates and covered persons, the insurer shall provide estimates and explain how the estimates were determined;

(9) provisions for identifying policyholders or certificateholders of special circumstances;

(10) identification of any third party contracts which may provide for the continuity of care to enrollees of special circumstances;

(11) number of and estimated amount of all losses outstanding in Texas, including claims incurred but not reported;

(12) a plan to handle the losses specified in paragraph (11) of this subsection, including, but not limited to:

(A) identification of what assets will be available for paying outstanding incurred but not reported claims, claims in the course of settlement, and associated loss adjustment expenses;

(B) identification of who specifically will administer the run-off of the business; and

(C) an actuarial opinion certifying that adequate reserves are available to pay outstanding claims.

(13) if Texas policyholders or certificateholders are to be reinsured, the filing of a reinsurance agreement pursuant to all statutory and regulatory requirements and, when applicable, the filing of an assumption certificate;

(14) provisions for meeting any applicable statutory obligations, including, but not limited to:

(A) payment of any guaranty fund assessments;

(B) participation in any assigned risk plan, pool, fund, facility, or joint underwriting arrangement; and

(C) payment of any taxes.

(15) a list of any other products the insurer will continue to offer in Texas; and

(16) for insurers filing total withdrawal plans, affirmation that no new business will be solicited by the insurer in this state during or following the withdrawal period unless the insurer first complies with §7.1808 of this title (relating to Requirements To Resume Writing Insurance).

(b) A withdrawing HMO shall file a plan of orderly withdrawal with the Commissioner that is constructed to protect the interests of the people of this state. The plan must be signed by at least one officer of the HMO and, for each line of insurance being withdrawn or having total annual premium reduced by 75% or more, must contain the following:

(1) identification, in accordance with the line of insurance designations in §7.1803 of this title, of the line or lines of insurance being totally withdrawn or affected by having total annual premium volume reduced by 75% or more;

(2) identification by form number of the evidences of coverage affected by withdrawal;

(3) the dates the HMO intends to begin and complete its withdrawal;

(4) an explanation of the reasons for the withdrawal;

(5) provisions for notifying all of the affected Texas enrollees and contractholders of the dates of the beginning and completion of the total or substantial withdrawal and how the withdrawal will affect them, including, but not limited to:

(A) a copy of the notice and an explanation of the manner in which the notice will be provided to enrollees or contractholders;

(B) either an affirmation that such notice will be provided within 30 days of the approval of the withdrawal plan or a request to provide the notice at some other specified date or time, and such request must be approved by the Commissioner; and

(C) identification of any provisions of the Insurance Code or the Texas Administrative Code under which notice is mandated;

(6) provisions for meeting all of the HMO's contractual obligations, including, but not limited to, notification to all affected agents of the HMO of the dates the HMO intends to begin and complete the withdrawal;

(7) provisions for providing service to the HMO's Texas enrollees and providers;

(8) information on Texas business, including:

(A) for HMOs filing total withdrawal plans, the total annual premium volume and the number of affected contractholders and enrollees in Texas for each line to be withdrawn;

(B) for HMOs filing substantial withdrawal plans, the total annual premium volume and the number of affected enrollees and contractholders in Texas before substantial withdrawal is effected and the estimated total annual premium volume and number of enrollees and contractholders in Texas after substantial withdrawal is effected for each line to be substantially withdrawn;

(C) an estimate of what percentage of the Texas HMO market the withdrawal constitutes, as measured by enrollee;

(D) an estimate of what percentage of the HMO's service area or service areas the withdrawal constitutes and the counties affected by the withdrawal; and

(E) any information necessary to assist the Commissioner in determining whether a market availability problem is created by the total or substantial withdrawal, the extent of the problem, and what market assistance may be needed to alleviate the problem;

(9) provisions for identifying enrollees of special circumstance;

(10) identification of any third party contracts which may provide for the continuity of care to enrollees of special circumstance;

(11) number of and estimated amount of all losses outstanding in Texas, including claims incurred but not reported;

(12) a plan to handle the losses specified in paragraph (11) of this subsection, including, but not limited to:

(A) identification of what assets will be available for paying outstanding incurred but not reported claims, claims in the course of settlement, and associated loss adjustment expenses;

(B) identification of who specifically will administer the run-off of the business, if any; and

(C) an actuarial opinion certifying that adequate reserves are available to pay outstanding claims;

(13) provisions for meeting any applicable statutory obligations;

(14) for HMOs filing total withdrawal plans, an affirmation that no new business will be solicited by the HMO in this state during or following the withdrawal period unless the HMO first complies with §7.1808 of this title;

(15) a list of any other products the HMO will continue to sell in Texas in each service area; and

(16) for HMOs filing total withdrawal plans, quarterly financial projections from the beginning of the withdrawal to the completion of the withdrawal. The quarterly financial projections shall include:

(A) a balance sheet;

(B) an income statement;

(C) a statement of cash flows; and

(D) members.

(c) The filing of a single consolidated withdrawal plan for all withdrawing insurance companies or HMOs in the same holding company system, as defined in the Insurance Holding Company System Regulatory Act, the Texas Insurance Code Article 21.49-1, §2, does not meet the requirements of this subchapter. A separate withdrawal plan must be filed for each insurance company or HMO intending to totally or substantially withdraw from a line or lines of insurance.

28 TAC Sec. 7.1806 Plan Submission and Approval Procedures

(a) Any insurer or HMO filing a plan of orderly withdrawal should submit the plan to the Texas Department of Insurance, Company Licensing and Registration, Mail Code 305-2C, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe Street, Austin, TX 78701.

(b) The withdrawal plan shall be deemed approved if the Commissioner has not held a hearing within 30 days after the complete plan is filed or has not been denied approval within 30 days after the hearing.

(c) No plan shall be considered "filed" until such date as the withdrawing insurer or HMO has provided to the Commissioner all information and material necessary to constitute a completed plan of orderly withdrawal, as required under this subchapter.

(d) Within 10 business days of the Commissioner's receipt of the withdrawal plan, the insurer or HMO will be notified by letter either that the plan is sufficient to constitute a completed plan of orderly withdrawal that meets all of the requirements of this subchapter or that the plan is insufficient to constitute a completed plan of orderly withdrawal that meets all of the requirements of this subchapter and what information and material must be provided in order for the insurer or HMO to have filed a completed plan of orderly withdrawal, as required under this subchapter.

28 TAC Sec. 7.1807 Filing of Annual Financial Statement and Other Required Data and Information

Any insurer or HMO filing a total withdrawal plan or a substantial withdrawal plan shall continue to file all annual financial statement data, other required statistical and data filings, other reporting, and any other department-requested information applicable to any withdrawn line until all policyholder obligations for such line in this state are fulfilled. This section does not exempt an insurer or HMO from any filings or information requests required by the Department.

28 TAC Sec. 7.1808 Requirements to Resume Writing Insurance

Any insurer or HMO totally or substantially withdrawing from writing any line of insurance in this state and required to file a plan of orderly withdrawal pursuant to the Insurance Code, Article 21.49-2C, may not resume writing the withdrawn line in this state without complying with all applicable statutory and regulatory provisions governing authorization to write such line of insurance in this state and receiving the written approval of the Commissioner to resume such writing.

28 Texas Insurance Code, Chapter 82. Sanctions

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 82.001. DEFINITION. In this chapter, ‘‘authorization’’ means a permit, license, certificate of authority, certificate of registration, or other authorization issued or existing under the commissioner’s authority or this code.

Sec. 82.002. APPLICATION OF CHAPTER. (a) This chapter applies to each company regulated
by the commissioner, including:

(1) a domestic or foreign, stock or mutual, life, health, or accident insurance company;

(2) a domestic or foreign, stock or mutual, fire or casualty insurance company;

(3) a Mexican casualty company;

(4) a domestic or foreign Lloyd’s plan insurer;

(5) a domestic or foreign reciprocal or interinsurance exchange;

(6) a domestic or foreign fraternal benefit society;

(7) a domestic or foreign title insurance company;

(8) an attorney’s title insurance company;

(9) a stipulated premium insurance company;

(10) a nonprofit legal service corporation;

(11) a health maintenance organization;

(12) a statewide mutual assessment company;

(13) a local mutual aid association;

(14) a local mutual burial association;

(15) an association exempt under Section 887.102;

(16) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;

(17) a county mutual insurance company; and

(18) a farm mutual insurance company.

(b) This chapter also applies to:

(1) an agent of an entity described by Subsection (a); and

(2) an individual or a corporation, association, partnership, or other artificial person who:

(A) is engaged in the business of insurance;

(B) holds an authorization; or

(C) is regulated by the commissioner.

(c) The commissioner's authority under this chapter applies to each form of authorization and each person or entity holding an authorization.

Sec. 82.003. PROCEEDINGS UNDER OTHER LAW. The commissioner's authority under this chapter is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law.

SUBCHAPTER B. IMPOSITION OF SANCTIONS

Sec. 82.051. CANCELLATION OR REVOCATION OF AUTHORIZATION. After notice and opportunity for a hearing, the commissioner may cancel or revoke an authorization if the holder of the authorization is found to be in violation of, or to have failed to comply with, this code or a rule of the commissioner.

Sec. 82.052. OTHER SANCTIONS. In addition to the cancellation or revocation of an
authorization under Section 82.051, the commissioner may:

(1) suspend the authorization for a specified time not to exceed one year;

(2) order the holder of the authorization to cease and desist from:

(A) the activity determined to be in violation of this code or a rule of the commissioner; or

(B) the failure to comply with this code or a rule of the commissioner;

(3) direct the holder of the authorization to pay an administrative penalty under Chapter 84;

(4) direct the holder of the authorization to make restitution under Section 82.053; or

(5) take any combination of those actions.

Sec. 82.053. RESTITUTION. (a) The commissioner may direct the holder of an authorization to make complete restitution to each Texas resident, each Texas insured, and each entity operating in this state that is harmed by a violation of, or failure to comply with, this code or a rule of the commissioner.

(b) The holder of the authorization shall make the restitution in the form and amount and within the period determined by the commissioner.

Sec. 82.054. CANCELLATION ON FAILURE TO COMPLY. If it is found after hearing that a holder of an authorization has failed to comply with an order issued under Section 82.052, the commissioner shall cancel each authorization held by the holder.

Sec. 82.055. INFORMAL DISPOSITION. (a) The commissioner may informally dispose of a matter under this subchapter by consent order, agreed settlement, stipulation, or default.

(b) An informal disposition may include a provision under which the holder of the authorization agrees to a sanction under this subchapter with the express reservation that:

(1) the holder does not admit a violation of this code or of a rule; and

(2) the existence of a violation is in dispute.

Sec. 82.056. NOTICE TO OTHER STATES. The commissioner shall give notice of an action taken under this subchapter to the insurance commissioner or other similar officer of each state.

Appendix 2 – Technical Workgroup Meeting Minutes

Background
TDI held a meeting on Wednesday, March 2, 2011, to welcome comments on three sections of the PPACA federal regulations:

- 45 CFR Part 158, Subpart C – Potential Adjustment to the MLR;
  - Section 158.322 – Proposal for adjusted medical loss ratio;
  - Section 158.330 – Criteria for assessing request for adjustment to the medical loss ratio;
- 45 CFR Part 154, Subpart C – Effective Rate Review Programs;
  - Section 154.301 – HHS's determination of effective rate review programs.

Katrina Daniel, Senior Associate Commissioner with the Life, Health, and Licensing Program, began by stating that the primary focus of the meeting would be to better understand what data TDI might gather and present should the department decide to submit to HHS a request to adjust the MLR standard as per Sections 158.322 and 158.330. As a part of this, TDI asked industry representatives to comment on the data requirements as laid out in the regulations and to provide insight on how companies currently gather and utilize data and how data could be collected moving forward. The group was provided with a summary of the relevant sections of the regulations, which served as an informal agenda for the meeting.

Section 158.321 –
Information supporting a request for adjustment to the medical loss ratio
TDI collects consumer data from companies on a quarterly basis through data calls. The next data call is due to TDI on March 8, 2011. The department sought industry comments on whether the data call template could be amended to include MLR data requirements.

One industry representative from noted that while the company could provide historical data, as a publicly traded company, it does not provide forward-looking data. The MLR regulations require companies to make projections to calculate future MLRs and rebates. The company does not disclose that information.

The representative also explained the company valued the opportunity to submit information they deem important and see as pertinent to their MLR and rebate calculations.

There appeared to be a level of consensus from industry representatives that companies would be reluctant to disclose highly sensitive market information or any plans to withdraw from the individual market in Texas.

Another representative said that the mutual holding company has already begun to take action to meet the MLR requirements by considering cutting quality programs and agent commissions. She suggested that these cutbacks will make clear to states that a market disruption will result from MLR standards.

Another representative who participated by telephone said that though the carrier can provide some projections for smaller states, MLR projections for the Texas market would be more difficult to make given the size and variation of the population and market.

A representative from another company stated that their company would be unwilling to submit proprietary information but that aggregating data does provide some confidentiality.

Ana Smith-Daley, Deputy Commissioner of Policy with Life, Health and Licensing, asked if the state made the reporting requirements more confidential, would companies be more likely to comply and provide information.

Jan Graeber, Acting Deputy Commissioner and Chief Actuary with the Life/Health Division, asked what other information companies could provide to support a waiver.

An industry representative explained that the company would be willing to provide data on the impact that trying to meet the MLR is having on agents. Agents, she projected, may leave the individual and small group markets for the large group market as their commissions are cut, which would limit consumers options and access to coverage.

Smith-Daley posed whether TDI should ask companies what action they will take regarding agents as a result of the MLR standards.

The representative explained that some companies, including the one she represents, were already taking action in anticipation of the MLR requirements. The representative pointed out a paragraph on page 74887 of the 45 CFR Part 158 and explained that the data HHS requested from companies aimed to give a picture of the following:

- Impact on premiums,
- Benefits and cost sharing, and
- Consumer access to agents and brokers.

Smith-Daley asked whether companies would be willing to provide data that spoke to those three dimensions. Industry representatives were hesitant to provide a response, and Smith-Daley followed up by asking whether the MLR adjustment or waiver should apply to certain companies based on market share. The majority of representatives did not support this. One representative stated that there should be a “level playing field.”

A representative also noted the market varied considerably with respect rural or urban consumers. There would be fewer options for rural consumers and market destabilization would disproportionately affect their access to insurance.

TDI asked whether companies could provide data that reflected the number of affected lives by zip code to present a more representative picture of the market. TDI suggested this information might be requested of companies should the department decide to request a waiver.

Section 158.322 – Proposal for an adjusted MLR

Industry representatives explained that it would be difficult to estimate a MLR because rates and contracts have been defined since the prior year. Also, some companies explained that they do not track data on cost sharing, medical trend and utilization rates

at the state level. Instead, they aggregate data at the national level, making it a challenge to estimate MLRs for specific states.

When asked by Daniel if there were data collection models in other states that companies favored, the industry expressed a preference for Kentucky's method of collecting data. Daniel requested that industry representatives provide TDI with examples of other states' data requests so that TDI might consider those in the development of its process, to which representatives agreed.

TDI asked industry what they would do differently if HHS grants the waiver for the individual market.

One representative replied that though he could not comment on the specific effects of a waiver, but offered that for many companies the waiver might be the difference between profit and loss. The waiver, in his view, would enable carriers to stay in the market.

Section 158.330 – Criteria for assessing request for adjustment to the loss ratio
Another representative explained that in terms of market destabilization and Section 158.330 that it is unlikely that companies would disclose any intention to leave the market because agents would cease to sell their products. Companies may lose competitive advantage from the disclosure of proprietary information.

Another representative noted that market destabilization might force consumers into high risk pools, which may not be able to support the increased number of enrollees.

Appendix 3

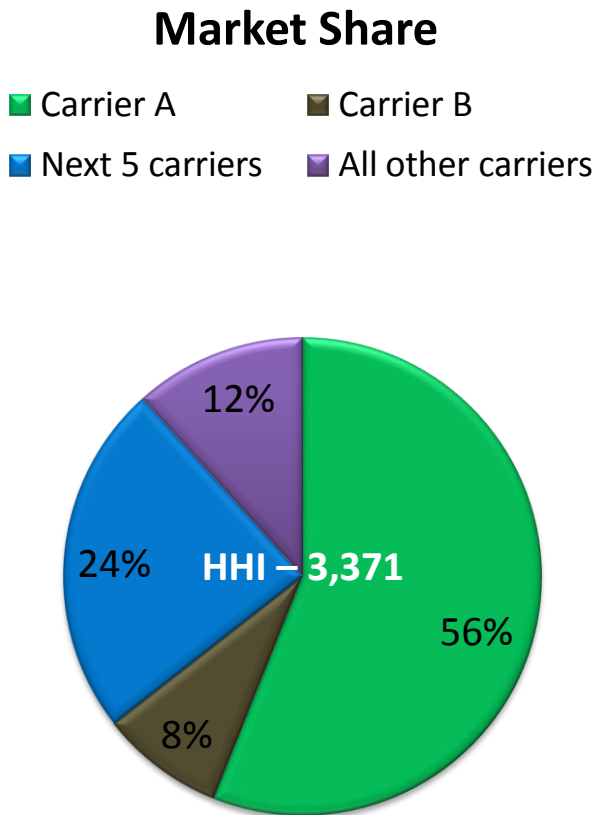
Regional Analysis of MLR Impact

Current Individual Market

Total Population
25,010,265

Insured Population
726,385

Current HHI: 3,371



Current Individual Market

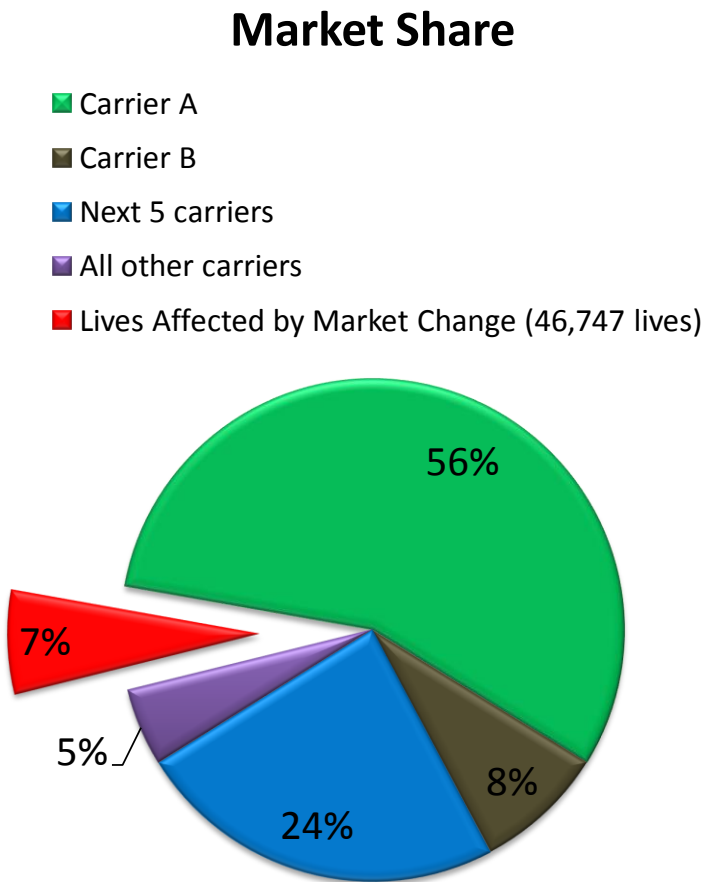
- Two largest carriers account for 64.5% of the state market
- High market concentration as indicated by majority of regions with HHI measures over 2,500
- Market concentration varies across regions

- Average MLR for all Carriers: 70.8%
- Average MLR for Top Eight: 70.2%
- Average MLR for Mid-Level: 75.3%

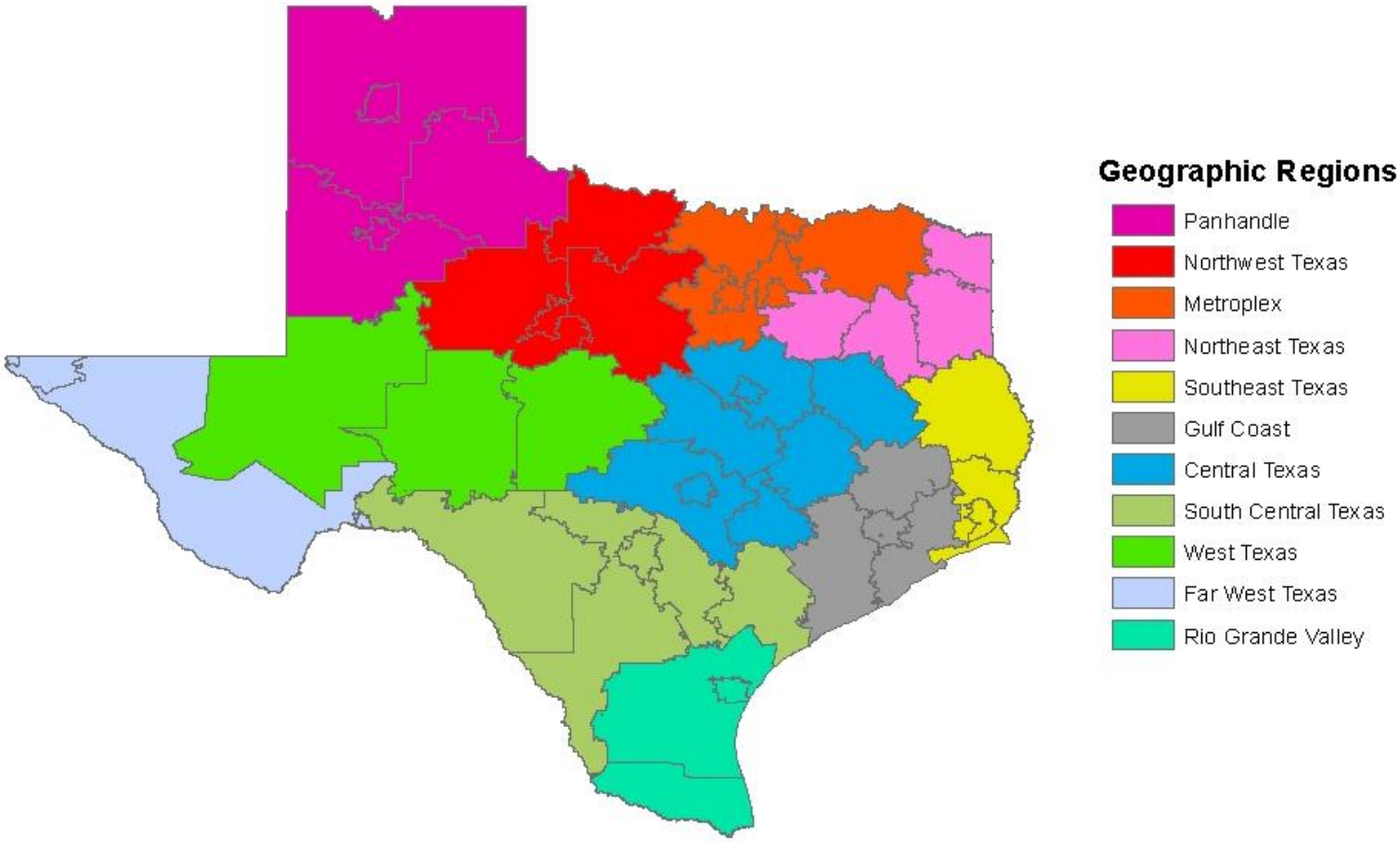
Individual Market after Market Change

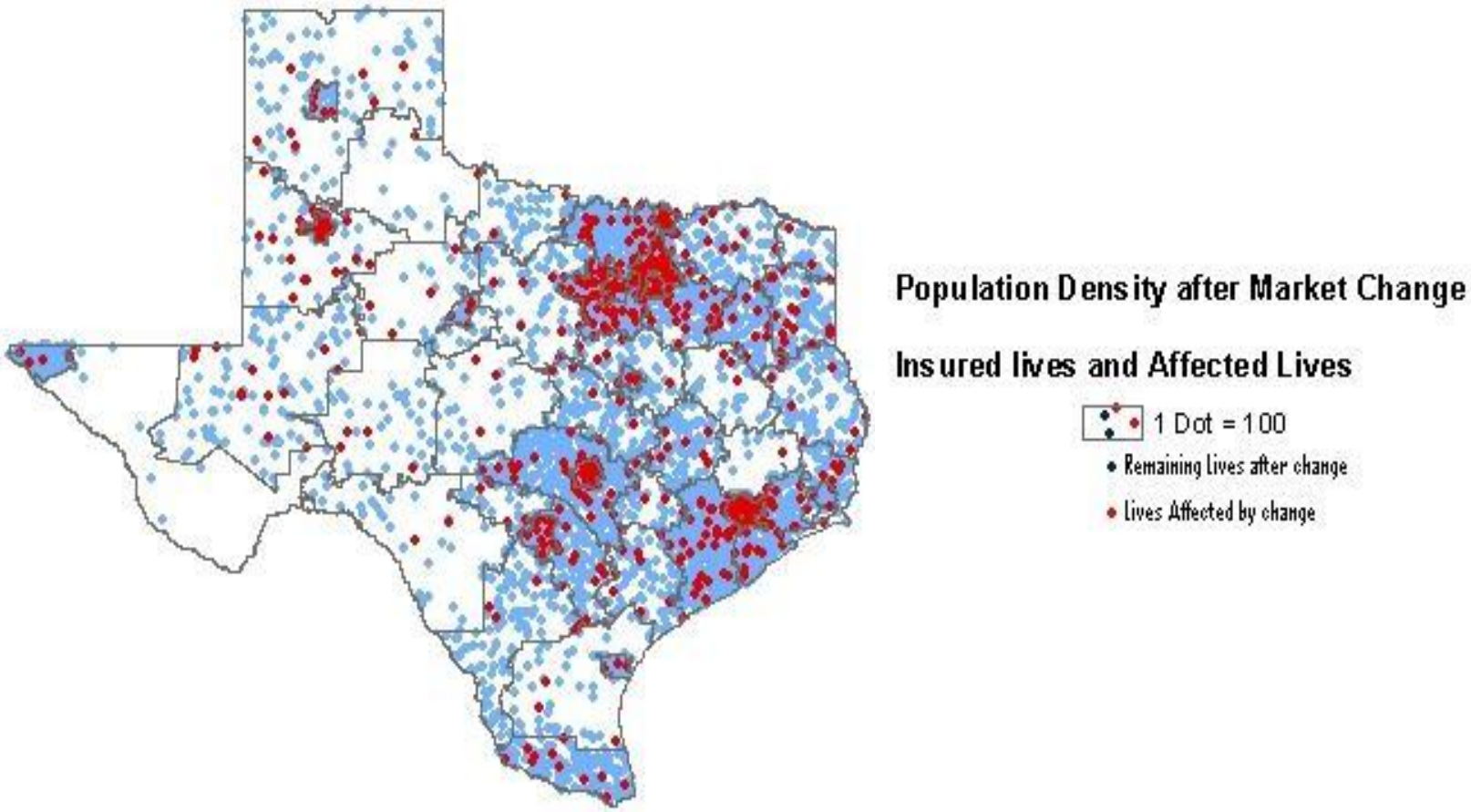
Insured Population:
678,245

Estimated HHI: 3,846

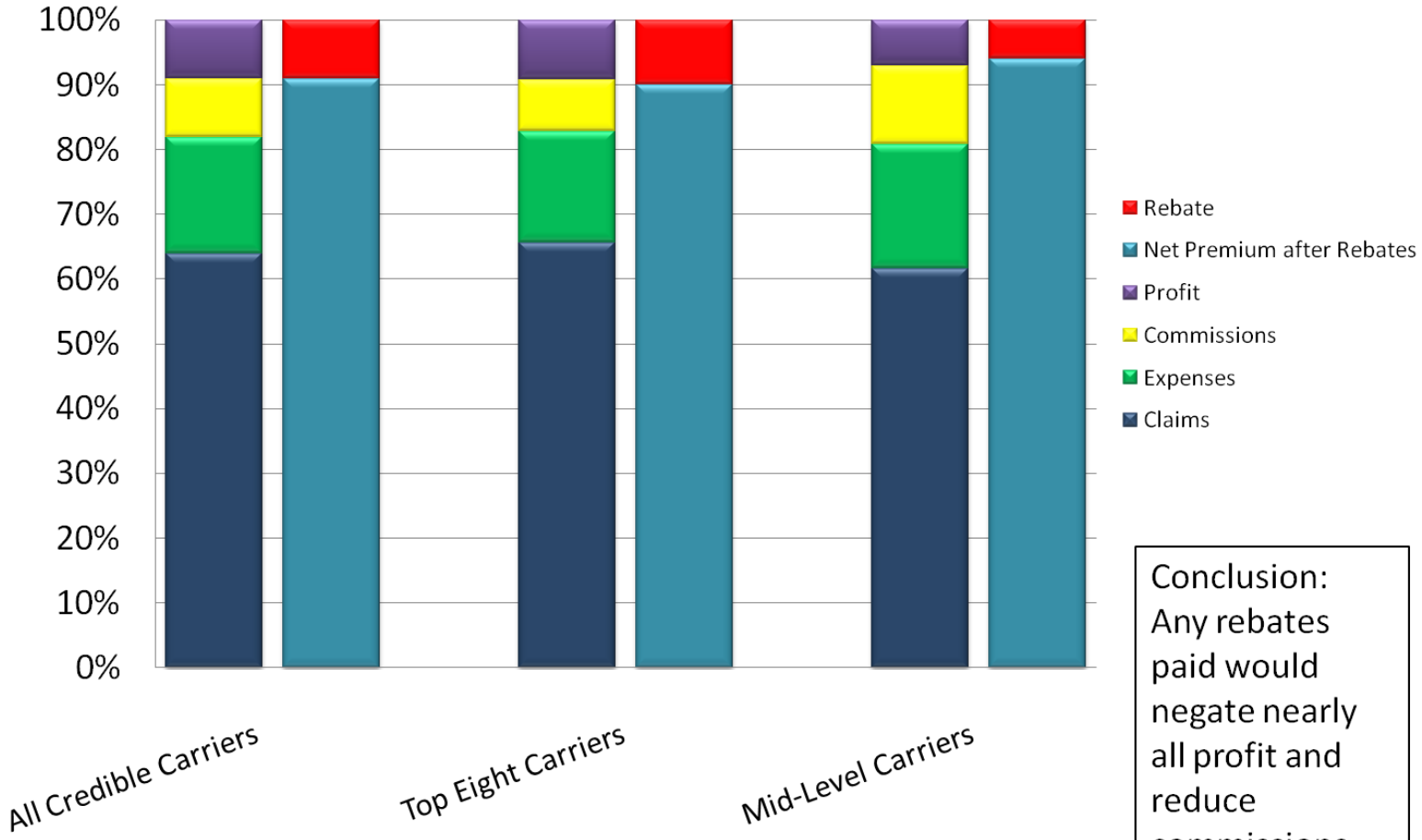


Market Change: All carriers who plan to exit the market or are uncertain of exit.


Geographic Regions
Panhandle
Northwest Texas
Metroplex
Northeast Texas
Southeast Texas
Gulf Coast
Central Texas
South Central Texas
West Texas
Far West Texas
Rio Grande Valley


Population Density after Market Change
Insured lives and Affected Lives
1 Dot = 100
Remaining Lives after change
Lives Affected by change

Operating Items Compared to Earned Premium

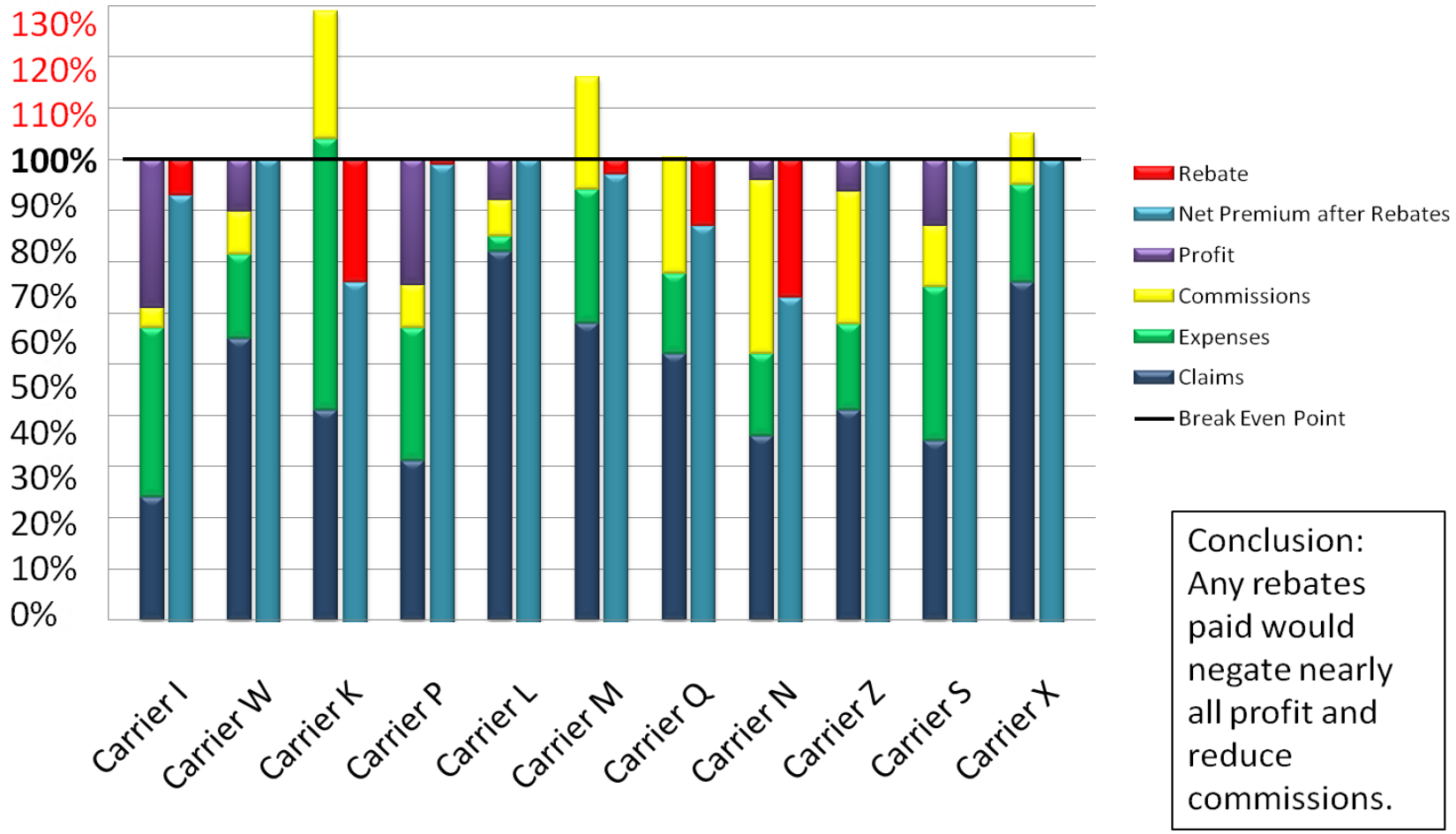


Conclusion: Any rebates paid would negate nearly all profit and reduce commissions.

Operating Items Compared to Earned Premium

Mid-Level Carriers

"Yes" or "Undecided"



Conclusion: Any rebates paid would negate nearly all profit and reduce commissions.

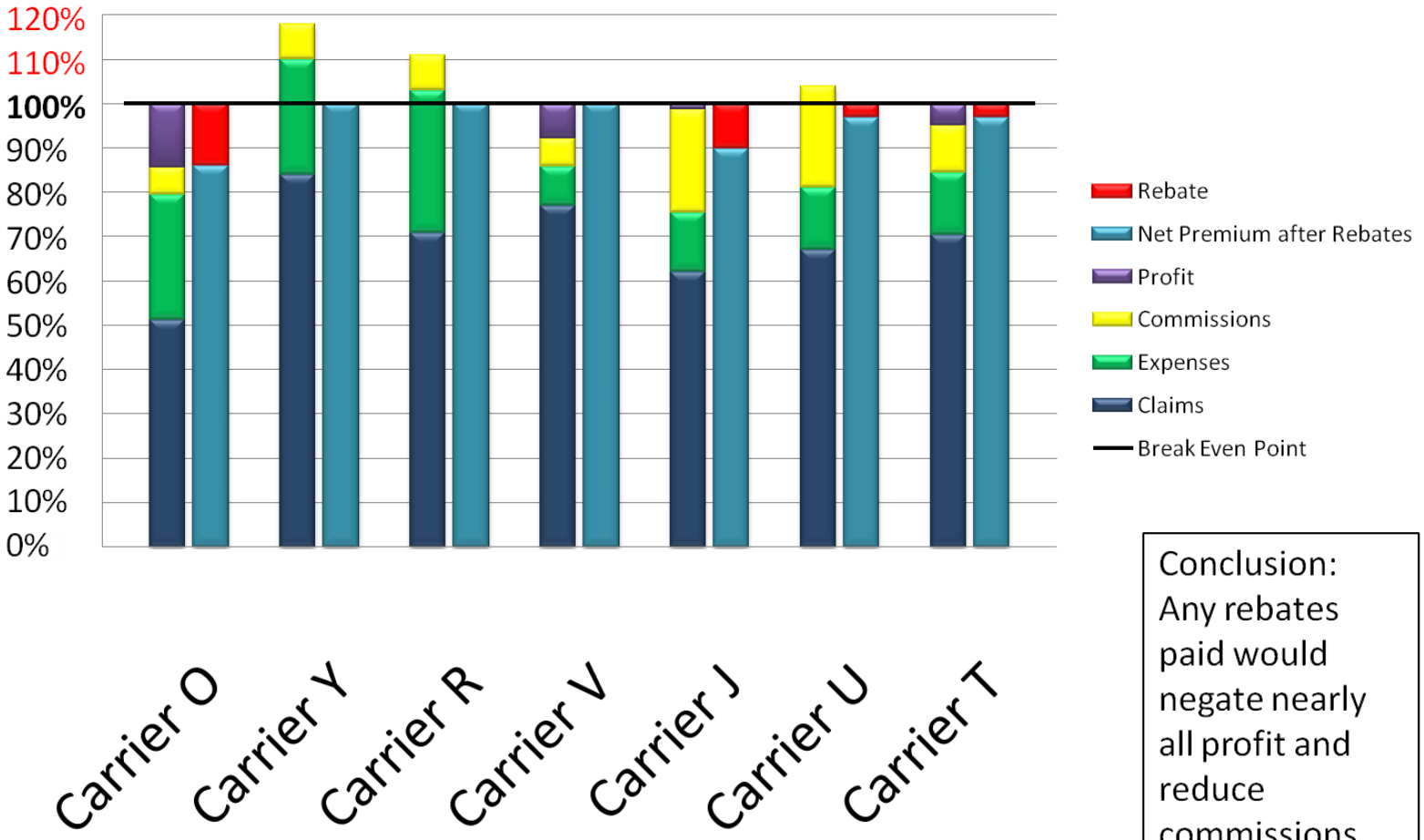
10

[10] Data for Carrier S, Carrier W and Carrier X are estimated because carriers were unable to submit correct and/or complete data,

Operating Items Compared to Earned Premium

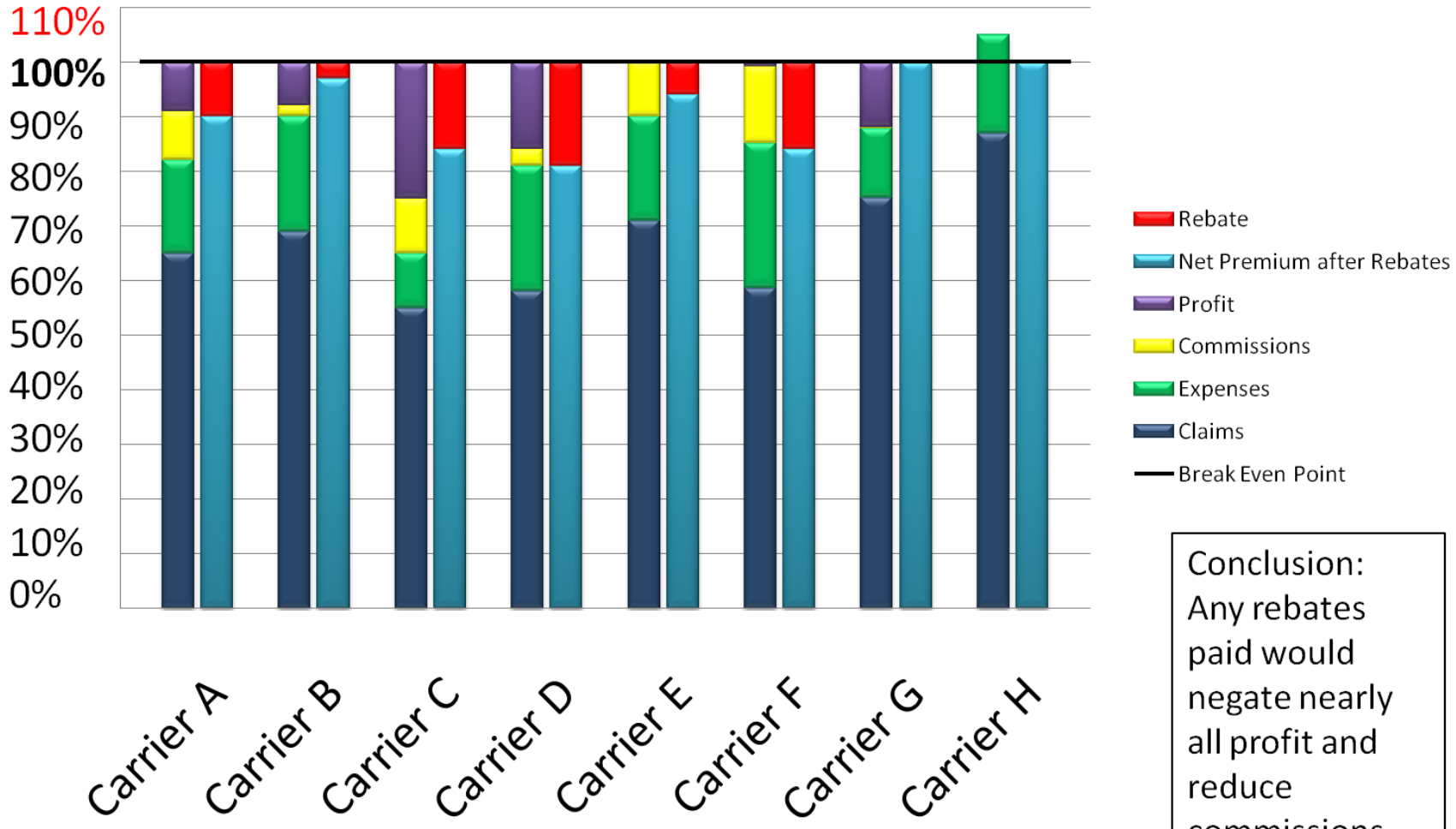
Mid-Level Carriers

"No"



Conclusion:
Any rebates paid would negate nearly all profit and reduce commissions.

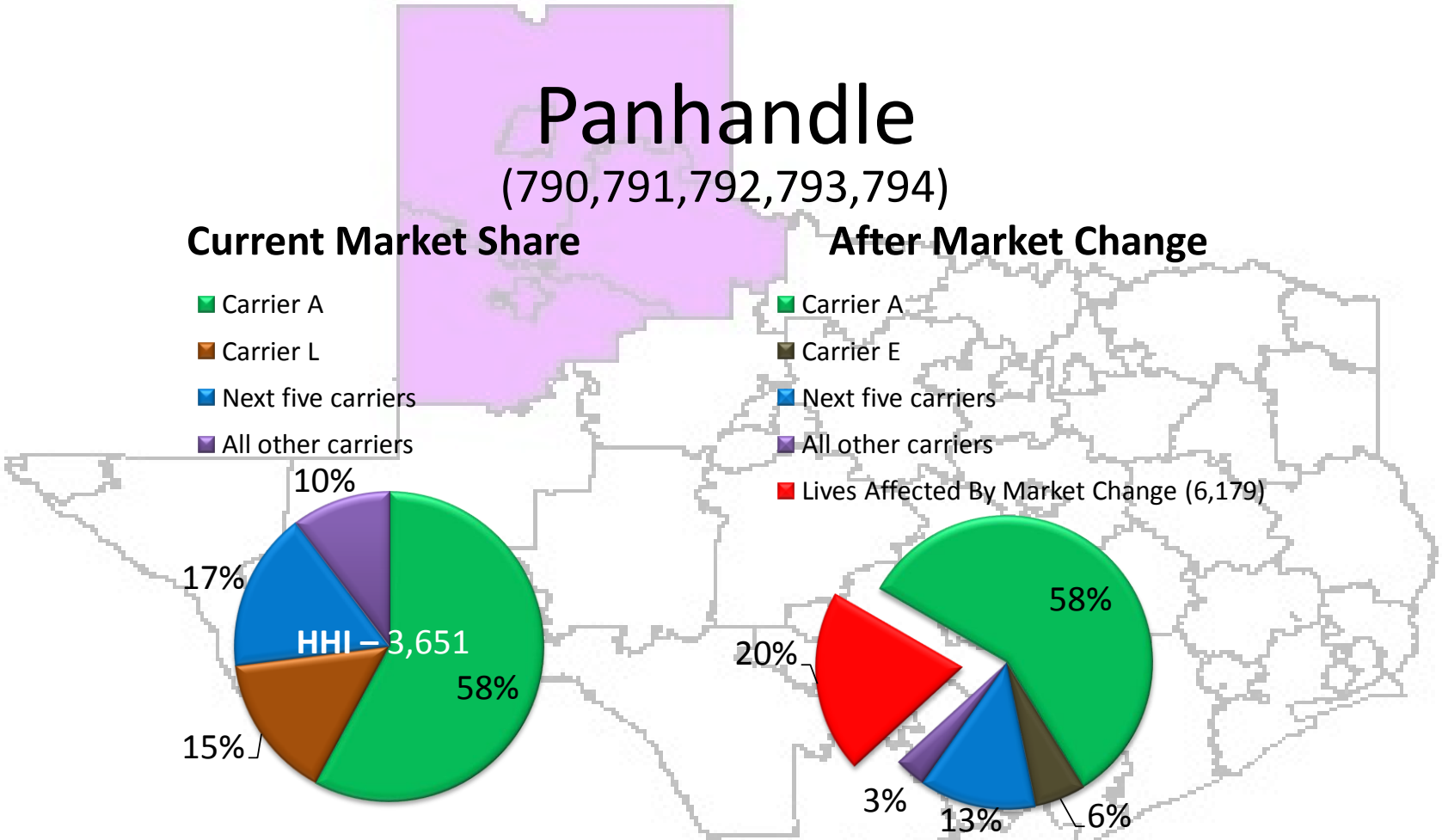
Operating Items Compared to Earned Premium
Top Eight



Conclusion:
Any rebates paid would negate nearly all profit and reduce commissions.

Panhandle

(790,791,792,793,794)



Effects of Market Change

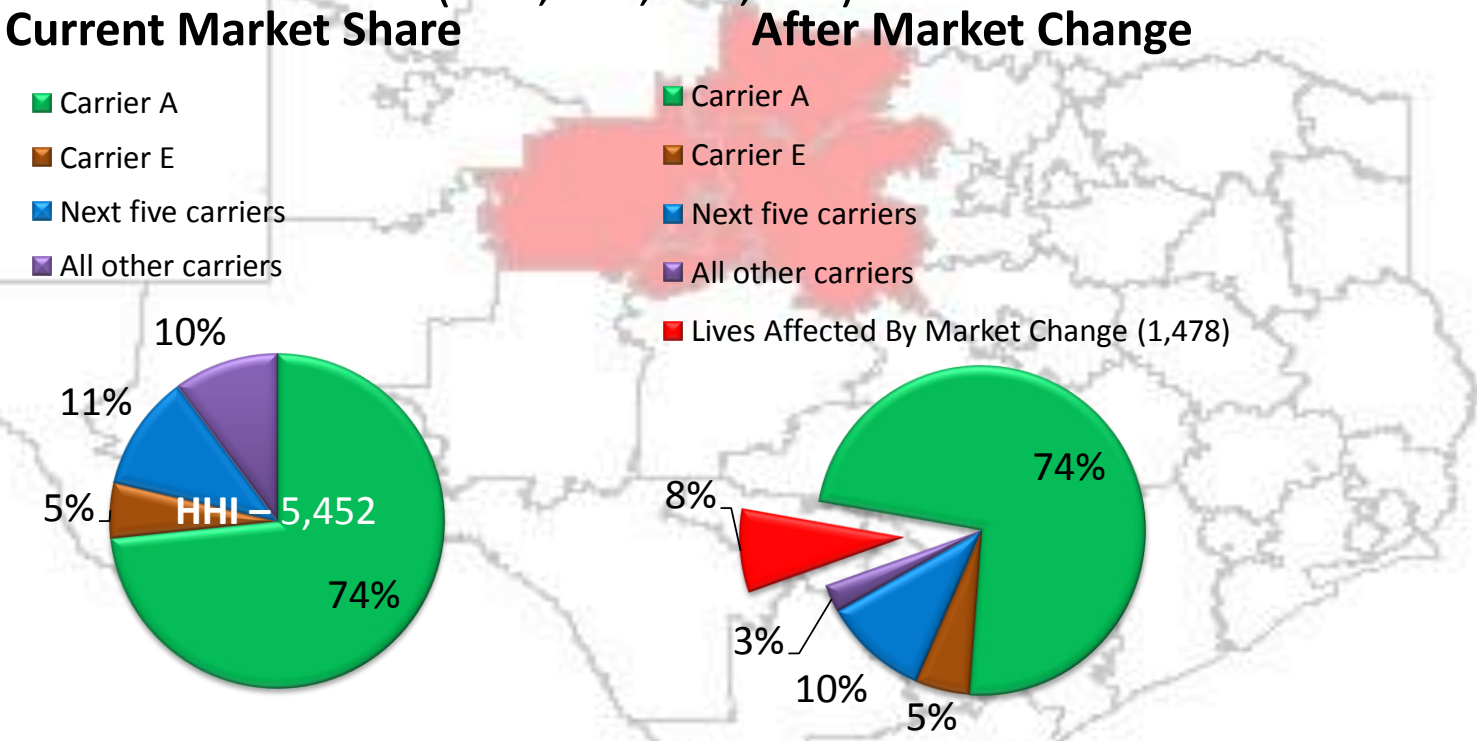
Percentage affected by change – 20.23%
HHI – 5,371

Regional lives *before* Market Change – 30,538
Regional lives *after* Market Change – 24,359

Market Change: All carriers who plan to exit the market or are uncertain of exit.

Northwest Texas

(763,764,795,796)



Effects of Market Change

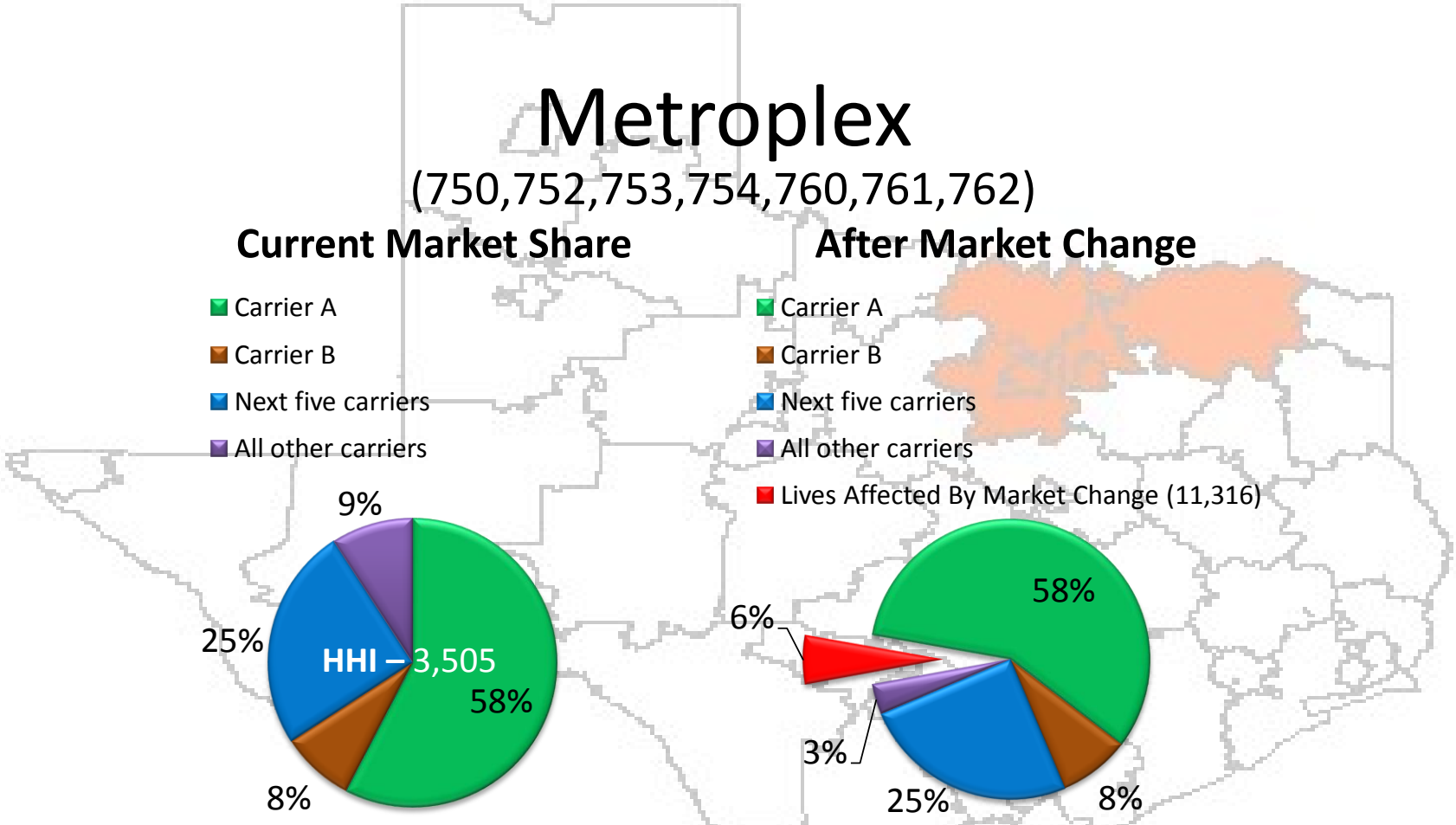
Percentage affected by change – 7.93%
HHI – 6,421

Regional lives *before* Market Change – 18,646
Regional lives *after* Market Change – 17,168

Market Change: All carriers who plan to exit the market or are uncertain of exit.

Metroplex

(750,752,753,754,760,761,762)



Effects of Market Change

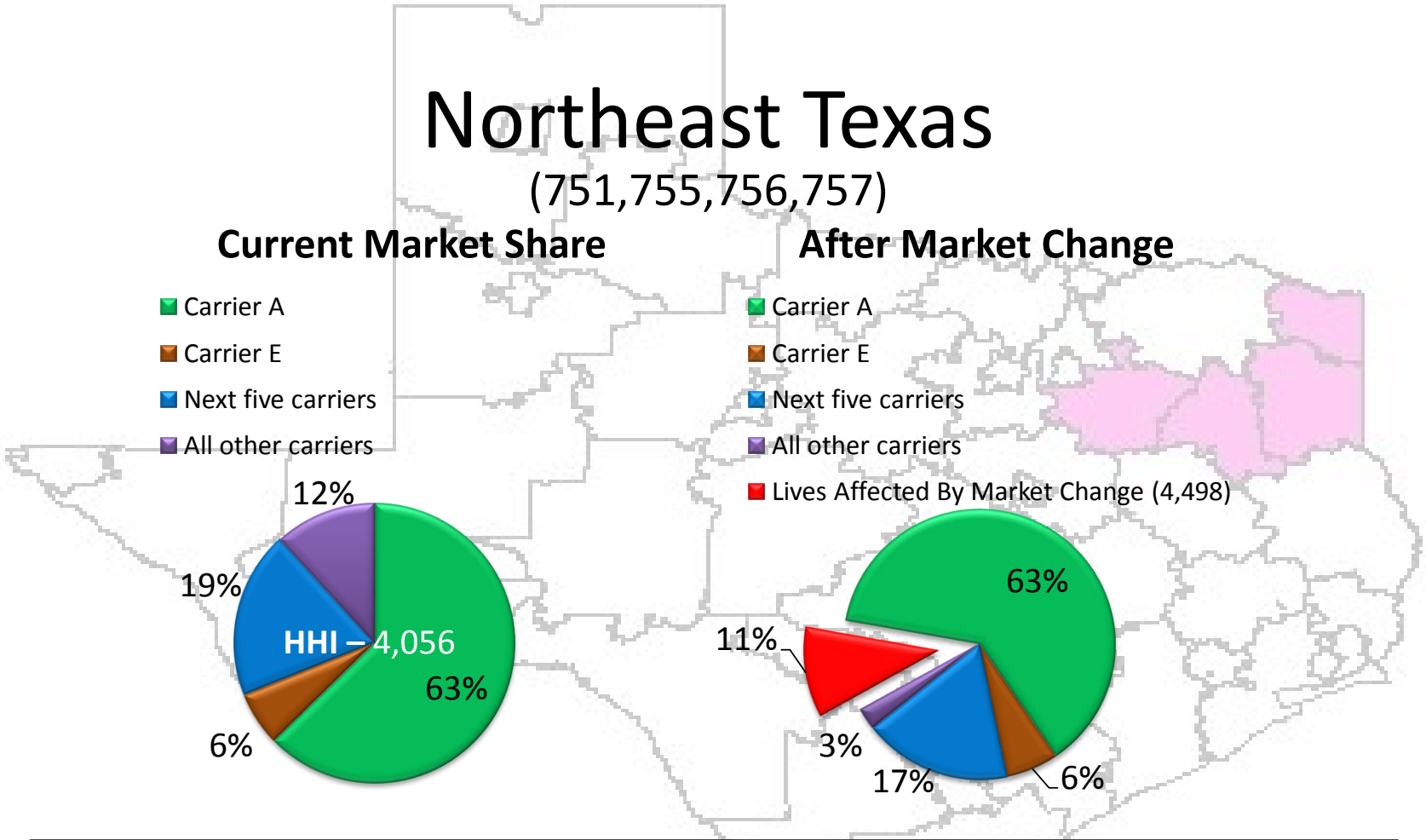
Percentage affected by change – 5.67%
HHI – 3,933

Regional lives *before* Market Change– 199,693
Regional lives *after* Market Change – 188,377

Market Change: All carriers who plan to exit the market or are uncertain of exit.

Northeast Texas

(751,755,756,757)



Effects of Market Change

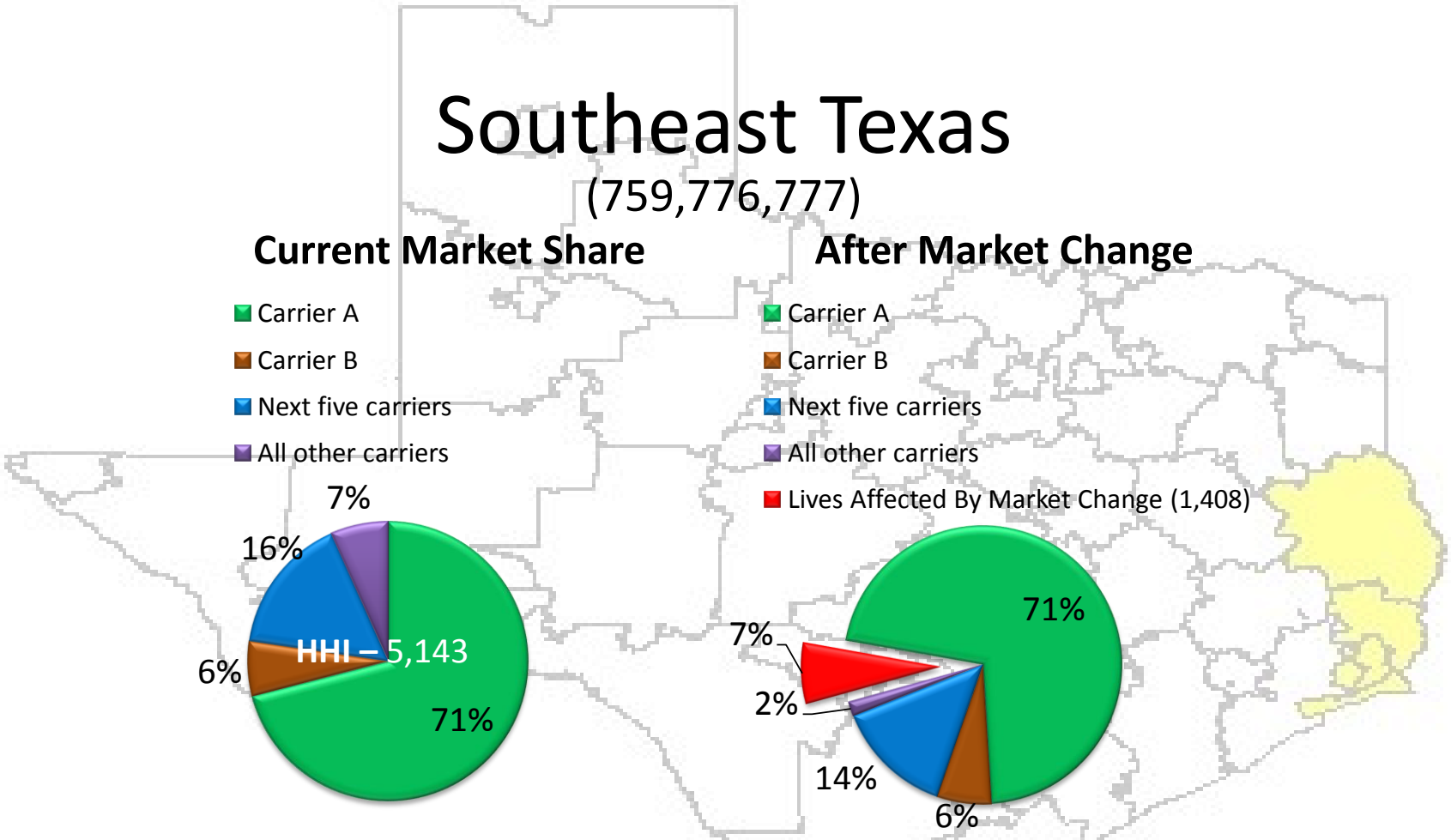
Percentage affected by change – 10.83%
HHI – 5,075

Regional lives *before* Market Change – 41,521
Regional lives *after* Market Change – 37,023

Market Change: All carriers who plan to exit the market or are uncertain of exit.

Southeast Texas

(759,776,777)



Effects of Market Change

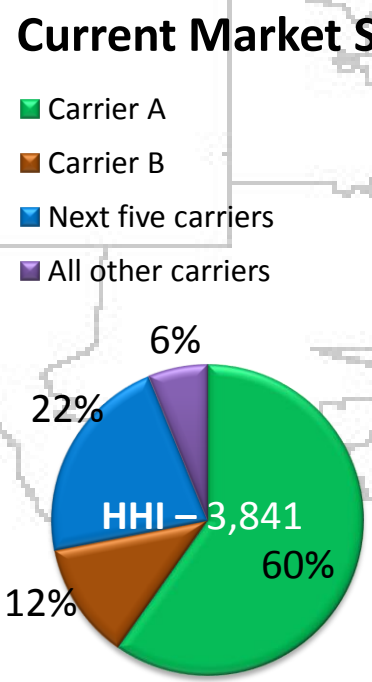
Percentage affected by change – 7.34%
HHI – 5,974

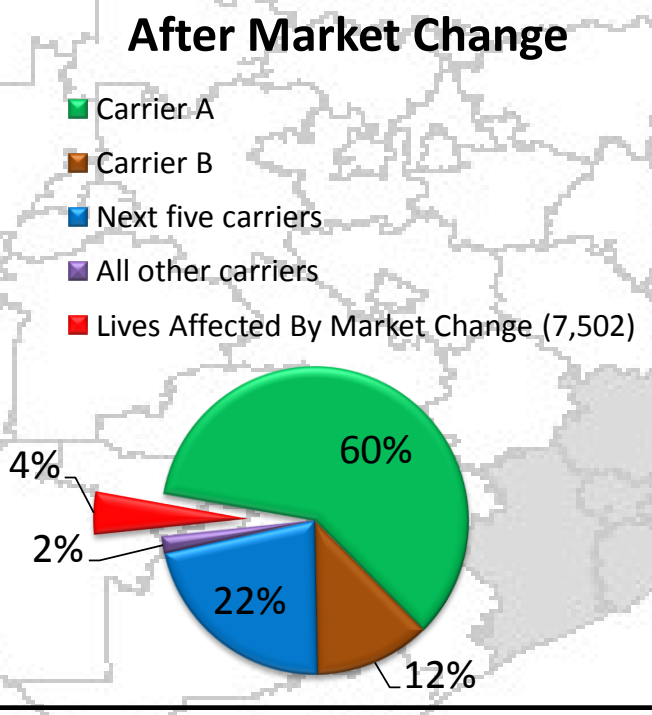
Regional lives *before* Market Change – 19,192
Regional lives *after* Market Change – 17,784

Market Change: All carriers who plan to exit the market or are uncertain of exit.

Gulf Coast

(770,772,773,774,775)





Effects of Market Change

Percentage affected by change – 4.39%
HHI – 4,197

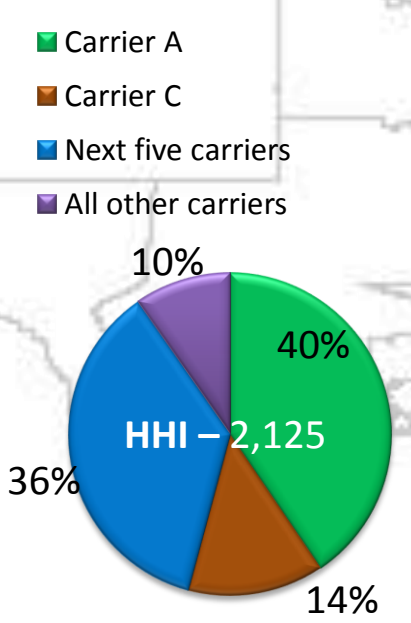
Regional lives *before* Market Change – 171,051
Regional lives *after* Market Change – 163,549

Market Change: All carriers who plan to exit the market or are uncertain of exit.

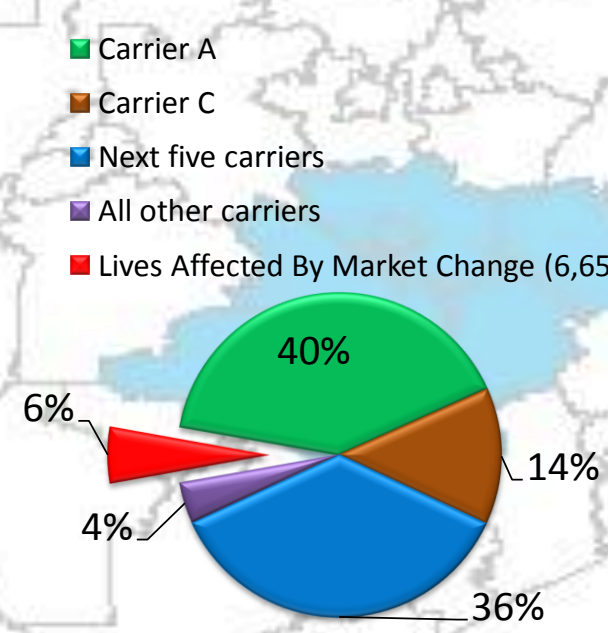
Central Texas

(733,758,765,766,767,778,786,787,789)

Current Market Share



After Market Change



Effects of Market Change

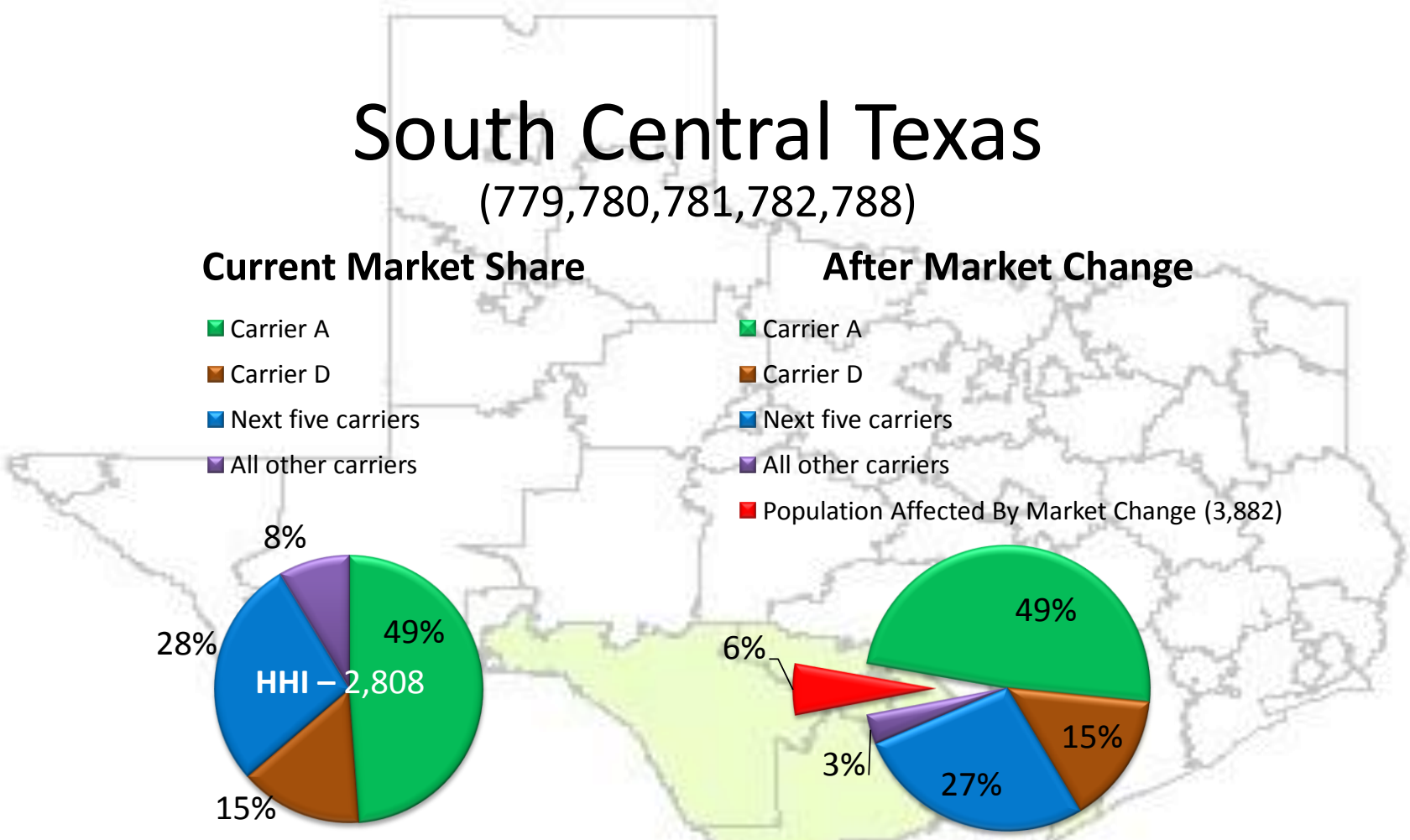
Percentage affected by change – 5.54%
HHI – 2,377

Regional lives *before* Market Change – 120,171
Regional lives *after* Market Change – 113,519

Market Change: All carriers who plan to exit the market or are uncertain of exit.

South Central Texas

(779,780,781,782,788)



Effects of Market Change

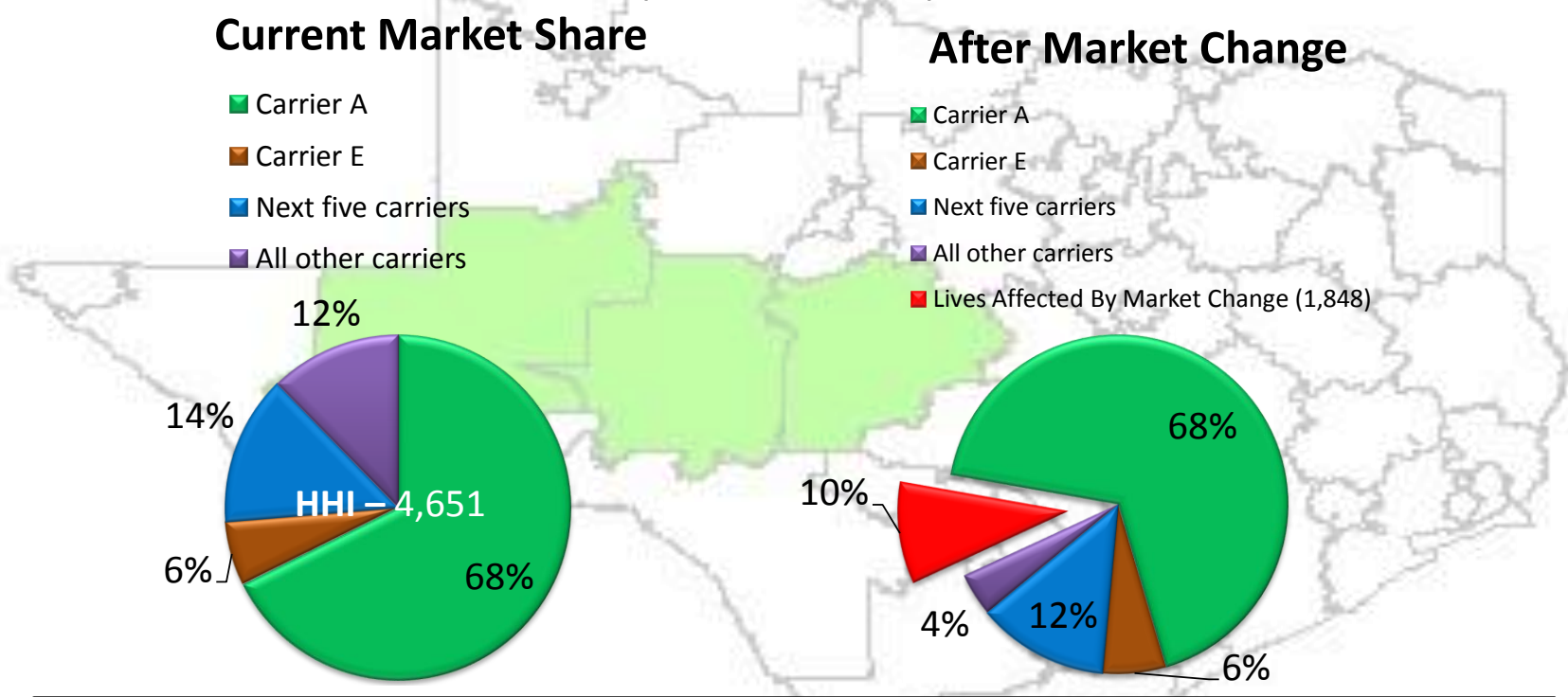
Percentage affected by change – 5.75%
HHI – 3,154

Regional lives *before* Market Change – 67,501
Regional lives *after* Market Change – 63,619

Market Change: All carriers who plan to exit the market or are uncertain of exit.

West Texas

(768,769,797)



Effects of Market Change

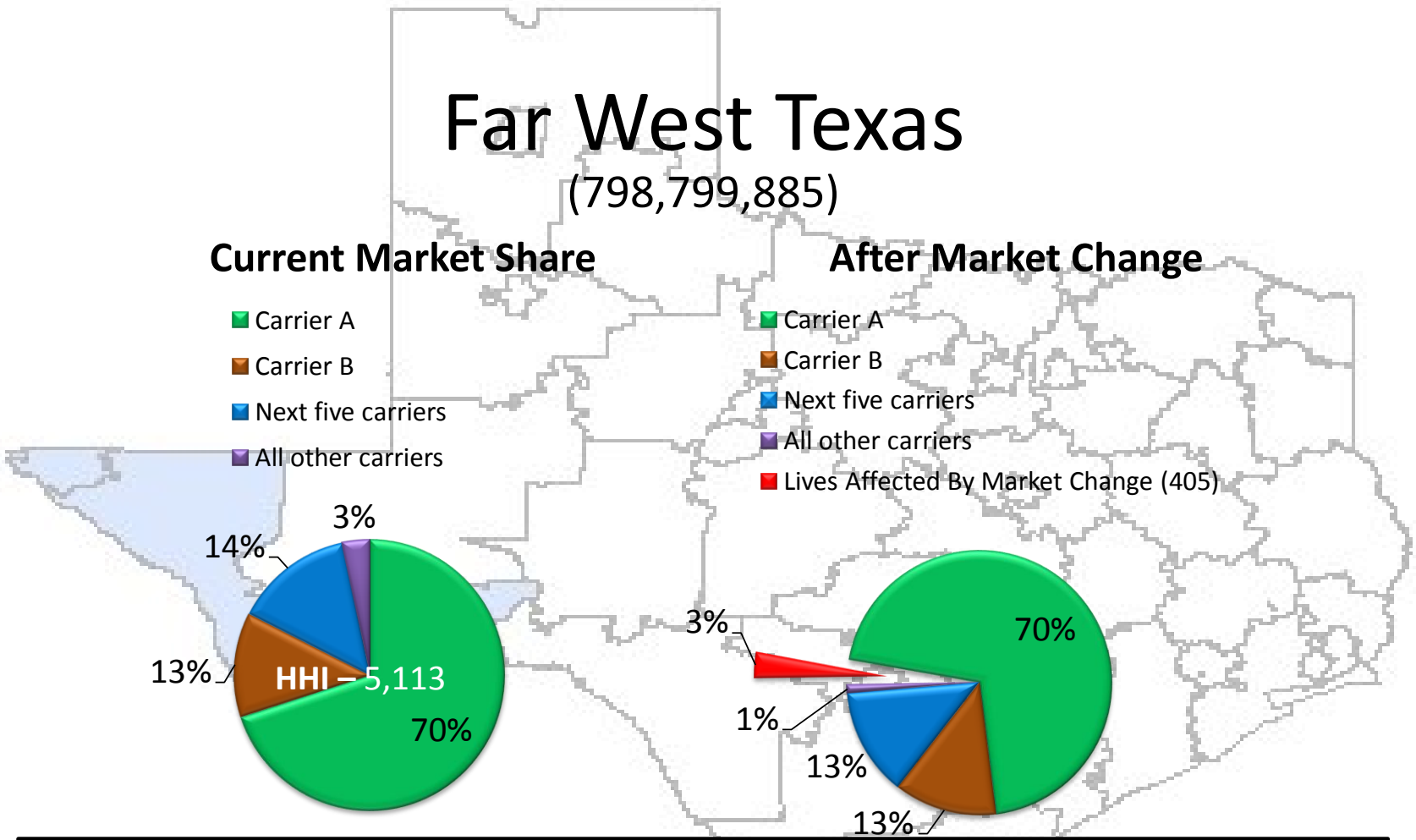
Percentage affected by change – 9.73%
HHI – 5,685

Regional lives *before* Market Change – 18,998
Regional lives *after* Market Change – 17,150

Market Change: All carriers who plan to exit the market or are uncertain of exit.

Far West Texas

(798,799,885)



Effects of Market Change

Percentage affected by change – 3.32%
HHI – 5,466

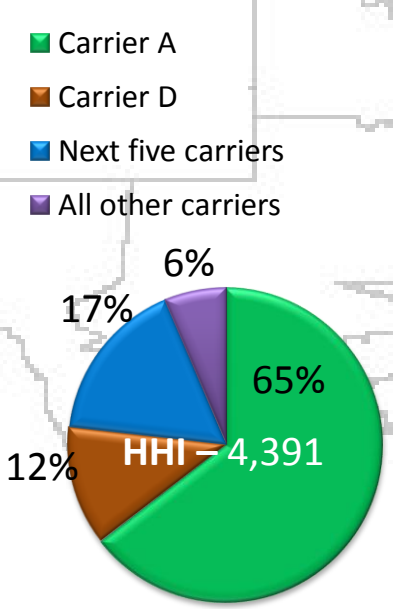
Regional lives *before* Market Change – 12,217
Regional lives *after* Market Change – 11,812

Market Change: All carriers who plan to exit the market or are uncertain of exit.

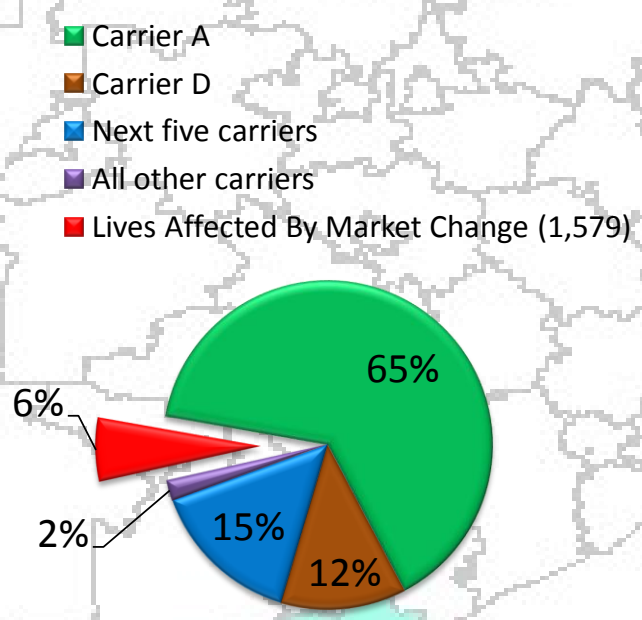
Rio Grande Valley

(783,784,785)

Current Market Share



After Market Change



Effects of Market Change

Percentage affected by change – 6.20%
HHI – 4,982

Regional lives *before* Market Change – 25,464
Regional lives *after* Market Change – 23,885

Market Change: All carriers who plan to exit the market or are uncertain of exit.