June 30, 2010

The Honorable Sandy Praeger
Chair
Health Insurance and Managed Care B Committee
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 701
Washington, DC 20001

Dear Commissioner Praeger:

On behalf of the American Medical Association (AMA) and its physician and student members, I am writing to comment on rate review and the "Rate Filing Disclosure Form" that the National Association of Insurance Commissioners (NAIC) B Committee is considering. Section 1003 of the Patient Protection and Affordable Care Act (PPACA) requires the Secretary of the Department of Health and Human Services (HHS) to work with states to establish an annual review of unreasonable rate increases. We have been following NAIC's considerable work to assist the Secretary with this task, and we applaud your efforts in this regard. We hope that our comments will be useful to your work on this topic moving forward.

While the AMA has not adopted policy that supports or opposes rate review specifically, we do have several policy positions that are integral to this discussion. Also, even though the AMA does not have specific policy on rate review, we rely on state medical associations to determine the best policy course for their respective states on this issue. For example, the Medical Society of the State of New York (MSSNY) supported a recently enacted bill that includes a prior approval requirement for health insurance premiums issued in New York. That legislation also required that health insurers meet an 82 percent medical loss ratio for the small group and individual health insurance policies they write, up from current state law and the new federal law.

Health Insurance Transparency

As you and your colleagues know from our previous testimony before the B Committee, the AMA has launched an extensive health insurance transparency campaign. The goal of the campaign is to provide patients with a clear understanding of how health insurers are spending their premiums, so that patients can receive the maximum value for the premium that they pay. Such transparency will also reward companies that reduce waste and administrative overhead and spend more of the premium dollars that they collect on patient care.

We think that broad transparency is critical to the rate review process in order to provide patients with the information that they need to make informed purchasing decisions and to provide regulators with the information that they need to determine if a rate filing is "unreasonable." We are also advocating our position of health insurance transparency to both HHS and NAIC as they continue their work to establish a strong medical loss ratio requirement. Transparency of how health insurance premiums are spent, clearly distinguishing medical costs from administrative costs and providing enrollees with maximum value for their benefit dollars are principles that must be part of both rate review and medical loss ratio regulations.

The cornerstone of the AMA's health insurance transparency campaign is our model bill, the "Health Insurance Premium Transparency Act" (attached). We are providing the model bill to the B Committee to encourage committee members to consider including some of the bill's language in the "Rate Filing Disclosure Form" that the B Committee is reviewing. It is our contention that this form should be as inclusive as possible. This is particularly important since the rate filings that will trigger the use of this form will have been found to be "unreasonable" and will require further investigation.

Specific Recommendations to NAIC "Rate Filing Disclosure Form"

After reviewing the "Rate Filing Disclosure Form," we think that it will provide significant and useful information to patients and regulators. However, we recommend the following additions to make the form more expansive and transparent and to provide patients and regulators with important information:

- In Part A, we recommend including the address of the reporting insurer in A(1) and the actual premium amount in A(8).

- In Part D, we recommend including a specific breakdown of administrative costs for the required 12-month period for:

    - CEO and executive salaries and benefits;
    - Commissions and other broker fees;
    - Utilization and other benefit management expenses;
    - Advertising and marketing expenses;
    - Insurance (including, but not limited to, reinsurance, general liability and professional liability insurance);
    - Taxes (including, but not limited to, state and local insurance, state premium, payroll, federal and state income and real estate);
    - Travel and entertainment expenses;
    - State and federal lobbying expenses; and
    - Other (including, but not limited to, non-executive salaries, wages and other benefits, rent and real estate expenses, certification, accreditation, board, bureau

and association fees; auditing and actuarial fees, collection and bank service charges, occupancy, depreciation and amortization; cost or depreciation of electronic data processing, claims and other services, regulatory authority licenses and fees, investment expenses and aggregate write-ins for expenses).

- In Part D, we recommend including the amount of interest that the health insurer earned on premiums for the required 12 month period, including, but not limited to, interest earned on held claims.

- In Part D, we recommend including the amount recovered from uninsured motorist insurance, accident insurance, workers compensation insurance and other third party liability during the required 12 month period.

- We also recommend that this form be a public record and that any information submitted pursuant to the filing of this form should be a public record as well.

- Finally, we recommend that the B Committee review the definitions from our transparency model bill (see Section 3) as they work on a definitions section for this form. We think that broad definitions are needed in order to capture all of the data needed by consumers and regulators. Our model bill includes definitions for "medical expense," "premiums," "health insurer," "medical expense threshold," "multiple employer arrangement" and "interest." We are also offering comments to the NAIC committees and task forces working on the medical loss ratio issue and would be pleased to collaborate with the B Committee on definitions for "quality" and other categories that are being debated in the medical loss ratio discussion.

Market Concentration

Finally, as we have discussed before the B Committee in previous testimony and correspondence, high concentration in health insurance markets continues to be a problem for patients and physicians. The AMA examined this issue using data on combined HMO and PPO commercial enrollment in health insurance markets across the U.S. Based on the Department of Justice and Federal Trade Commission *Horizontal Merger Guidelines*, it found that 99 percent (309) of the Metropolitan Statistical Areas (MSAs) examined are highly concentrated. And in 54 percent (169) of the MSAs, at least one insurer had a market share of at least 50 percent.[1] This market concentration creates an imbalance in the negotiating power between physicians and insurers. Such an imbalance leads to a host of problems that in the end have a negative effect on patients.

1 "Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2009 Update." American Medical Association.

As NAIC continues its work on rate review, we think that it is important for there to be some leniency in the rate review requirement for new market entrants or niche market insurers. Specifically, it may be appropriate to relax the rate review requirement as necessary to allow for new entrants into the marketplace (e.g. those who have been in business fewer than five years), or to permit the continuation of smaller health insurers that still serve an important niche in a particular market. Studies have shown that a health insurer with fewer than 100,000 lives will be unlikely to be as efficient as a larger insurer; yet a more local plan may offer benefits that the community wants to see continued to maximize choice and access.

Once again, we applaud your efforts to assist with the implementation of the PPACA. This is a monumental task, and NAIC is playing a key role. If there is anything further that my staff or I can do to assist you, please contact Mike Glasstetter, Senior Legislative Attorney, at (312) 464-5033 or michael.glasstetter@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA

cc: Members of the NAIC Health Insurance and Managed Care B Committee

Attachment