AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

February 22, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on HHS Proposed Rule Regarding Rate Increase Disclosure and Review (OCIIO-9999-P)

Dear Secretary Sebelius:

On behalf of the American Medical Association (AMA) and its physician and medical student members, I am writing to offer comments on the proposed rule regarding Rate Increase Disclosure and Review issued by the U.S. Department of Health and Human Services (HHS). We are optimistic that the rate disclosure and review process established by HHS will provide an opportunity to require health insurance issuers to be more transparent in their business practices. The Patient Protection and Affordable Care Act (ACA) will empower patients in their health care purchasing decisions, and readily available, transparent health insurance issuer information will be very important to patients as they go through the purchasing process. We urge the Department to ensure that there is as much transparency as possible in the rate disclosure and review process.

We urge HHS and/or the States to utilize the rate review and disclosure process to require that health insurance issuers calculate health insurance premiums fairly, and that different health insurance products be priced proportionately to their actuarial value. We are particularly concerned about health insurance issuers engaging in the practice of "purging" targeted subscribers by issuing intentionally inflated rate increases not supported by actuarial data. The rate disclosure and review process is another way to eliminate this practice. Further, the HHS funding provided to States to assist with rate disclosure and review should help those lacking actuarial resources to obtain the necessary expertise and staffing levels needed to strengthen their ability to conduct this process.

Besides these general comments, the AMA also has several other specific recommendations on the proposed rule which follow.

Application of the rule to large groups

The proposed rule would exempt large groups from the rate disclosure and review process (§154.103(a)). It uses 50 employees as the dividing line between large groups and small groups. The AMA believes that patients covered by large group plans should enjoy the same protections that patients purchasing health insurance in the small group and individual markets will enjoy once the ACA is fully implemented. AMA research indicates that one or two insurers are dominant in many markets across the country. Large groups may have more leverage in negotiating better terms, such as lower premiums, with insurers than small groups and individuals may have. However, large groups' options may be limited, and they may face higher premiums, when there is high concentration in the health insurance market in their city or state. Therefore, exempting large group plans from the rate disclosure and review process would be a missed opportunity for patients.

Level of data provided to a State as part of the review process

In determining whether or not a State has an effective rate review program, HHS will consider several factors including, if "the State receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination . . ." (§154.301(1)). Further on, the proposed rule lays out several categories of information that must be included (§154.301(4)). The AMA recommends that the information be sufficient for the State to conduct an independent actuarial review of the proposed rate increase. Or in the alternative, the State should have the authority to request information needed to conduct an actuarial review of the proposed rate increase to ensure that it is actuarially sound. This would include data supporting any underlying assumptions that the health insurance issuers may have used to determine the rate increase. The available data should allow an actuary to replicate the rate determination made by the health insurance issuer. The need for this level of information is exemplified by the health insurance issuer "computational errors" that have been brought to light by a review process.

Public comment as part of an effective rate review process

In the preamble of the proposed rule, HHS requests input on whether the public's ability to comment on unreasonable rate increases should be a criterion of whether or not a rate review program is effective. The AMA believes that public comment is integral to a rate review program being effective. The rate review filing and hearing process must be transparent, and public comment is a critical component of this process if it is to be meaningful.

Posting of preliminary justification and final justification information

We commend HHS for including provisions in the proposed rule that would require the posting of various filings and correspondence from health insurance issuers as part of the rate disclosure and review process (§154.215). The AMA believes that patients will be best-served by the posting of information submitted by health insurance issuers. While some information may be redacted under federal rules, we urge HHS to post as much information as possible. This will

provide patients with the opportunity to review these data and determine if they are concerned about the proposed/final rate increase. HHS should also post this information in case States decide they cannot or will not post the rate review information for public review for various reasons.

Structure and competitiveness of the market as a factor in determining unreasonableness

In the preamble of the proposed rule, HHS asks if the structure and competitiveness of a market should be factors when determining the reasonableness of a proposed rate increase. The AMA believes strongly that they should be included as factors. In a recent AMA report, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2010 Update*, we reviewed 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 1997 *Horizontal Merger Guidelines*, we found that 99 percent (357) of the Metropolitan Statistical Areas (MSAs) examined are highly concentrated. Moreover, in 48 percent (171) of the MSAs, at least one insurer had a market share of at least 50 percent.[1] This high market concentration increases the risk of exercise of market power by health insurers which could lead to a host of problems such as inflated premiums for patients and reduced payments to physicians.

Content of rate increase summary

In the proposed rule, HHS lists several useful pieces of information that health insurance issuers would have to include in the "rate increase summary" as part of their preliminary justification of a rate increase (§154.215(e)). We would encourage HHS to require the use of a uniform format for reporting the information to make it understandable for patients. Further, the AMA recommends the inclusion of several other disclosures as well to fully inform patients on how their health insurance issuer is spending their premiums, including:

- 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

[1] *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2010 Update.* American Medical Association. Please note that based on new Horizontal Merger Guidelines issued recently in 2010, after this study was published, the updated proportion of markets that are highly concentrated would be 80 percent.

- 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).[2]

Conclusion

The AMA is aware that comments are forthcoming from the Connecticut State Medical Society (CSMS) based on their experiences with the rate review process in Connecticut. CSMS will have recommendations that they feel would improve the rate review process, and we hope that you will give them all due consideration.

In closing, we are optimistic about the opportunities that the ACA presents for America's patients and physicians. We hope that our comments are helpful in your work on the rate disclosure and review process. If you need further information, please contact Mike Glasstetter at michael.glasstetter@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA

Enclosure

[2] AMA Model "Health Insurance Premium Transparency Act" – enclosed with letter.

IN THE GENERAL ASSEMBLY STATE OF_____

Health Insurance Premium Transparency Act

Be it enacted by the People of the State of _____, represented in the General Assembly:

Section 1. Title. This act shall be known as and may be cited as the "Health Insurance Premium Transparency Act."

Section 2. Purpose.

(a) There is a vital need for employers and consumers to have a clear understanding of how health care premiums are allocated by health insurance companies ("insurers") in this state, and particularly how much of their premium dollars are spent on health care services as opposed to administration, profit or for other purposes. Full transparency of how health care insurance premiums are spent will empower health insurance purchasers to make more informed decisions, and reward companies that minimize administrative waste;

(b) According to the Kaiser Family Foundation, since 1999, average premiums for family coverage have increased 119 percent - from $5,791 in 1999 to $12,680 in 2008. Worker premium contributions have similarly increased from $1,543 to $3,354;

(c) According to the Commonwealth Fund, the fastest rising component of health care spending is administrative overhead. Between 2000 and 2005, the net insurance administrative overhead, including both administrative expenses and insurance

industry profits, increased by 12 percent per year. This increase is 3.4 percent points faster than the average health expenditure growth of 8.6 percent; and

(d) A minimum medical expense threshold is necessary to maximize the value of health insurance premiums, and an important step toward controlling spiraling health care costs, which are due, in part, to the dramatic rise in administrative costs and insurer profits.

Section 3. Definitions.

(a) "Medical expense" The amount of money that the insurer spends on direct medical care services for enrollees during a calendar year. This includes the insurer's total financial obligation for physician services, non-physician health care professional services, hospital and other health facility services, drugs and medical devices and other health care services that the health insurer incurs on behalf of its enrollees, and shall include amounts paid to health care providers for pay-for-performance or other quality or efficiency enhancing initiatives. Medical expense does not include amounts which are the financial responsibility of the enrollee, the insurer's administrative costs, or expenditures for which the insurer is reimbursed by an enrollee's other insurance coverage or other third party liability.

(b) "Premiums" The amount of money that the insurer earns in a calendar year from the sale of health insurance, excluding dividends or credits applicable to prior years..

(c) "Health Insurer" Any entity, including an insurance company authorized to issue health insurance, a Health Maintenance Organization (HMO), or any other entity providing a plan of health insurance, health benefits or health care services, who is subject to the insurance laws and regulations of this state or subject to the jurisdiction of the Commissioner of Insurance of this State andt contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(d) "Administrative Costs" All expenditures associated with the administration of health benefit coverage, including but not limited to, costs associated with claims processing, collection of premiums, marketing, operations, taxes, general overhead, salaries and benefits, quality assurance, utilization review and management, pharmacy and other benefit management, network contracting and management and state and federal regulatory compliance.

(e) "Medical Expense Threshold" The quotient, to the nearest one percent, of the total medical expenses divided by the total premiums.

(f) "Multiple Employer Arrangement" An arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan. In a multiple employer arrangement, the employer assumes all or a substantial portion of the risk and shall include, but is not limited to, a multiple employer welfare arrangement, multiple employer trust or other form of benefit trust.

(g) "Interest" The interest earned on the premiums by the insurer.

Section 4. Annual Premium Transparency Report.

(a) Requirement to Report How Health Insurance Premiums Are Spent. Insurers shall report how health care premiums are spent no later than March 1 of each year for the premiums earned for the immediately preceding calendar year.

(b) Report Contents. Insurers shall report how health insurance premiums were spent for each of the following categories of insurance provided by the insurer: Preferred Provider Organization (PPO), HMO, Point of Service (POS) and High Deductible Health Plan (HDHP). This report shall include the following information for each category of insurance:

(1) A specific breakdown of administrative costs for the preceding calendar year as follows:

i) CEO and executive salaries and benefits;

ii) Commissions and other broker fees;

iii) Utilization and other benefit management expenses;

iv) Advertising and marketing expenses;

v) Insurance, including the following categories of commercial insurance:

a) Reinsurance;

b) General liability;

c) Professional liability insurer; and

d) Other insurance types.

vi) Taxes, including:

a) State and local insurance;

b) State premium;

c) Payroll;

d) Federal and state income;

e) Real estate; and

f) Other taxes.

vii) Travel and entertainment expenses;

viii) State and federal lobbying expenses;

ix) Other expenses, including but not necessarily 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; and

x) Total expenses incurred (subsections 1(i)-(ix) above).

(2) The reporting insurer's name and address;

(3) The insurer's total earned premiums for the preceding calendar year, before dividends or credits applicable to prior years;

(4) The amount of interest earned on premiums for the preceding calendar year;

(5) The amount recovered from uninsured motorist insurance, accident insurance, workers compensation insurance and other third party liability during the preceding calendar year;

(6) The total medical expense incurred during the preceding calendar year;

(7) Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the insurer is in compliance with this Act and regulations promulgated by this Act; and

(8) Such other information as the Insurance Commissioner may request.

(c) Public Record. All data or information required to be filed with Insurance Commissioner pursuant to the Act shall be deemed a public record.

Section 5. Medical Expense Threshold Percentage Requirements.

(a) Insurers. Insurers must spend a minimum of the health insurance premiums earned in a calendar year on medical expense as follows: 80 percent for individual and small employer products, and 85 percent for large employer products.

(b) Report Instructions and Methodology. The instructions and methodology for calculating and reporting medical expense threshold levels and issuing dividends or credits shall be specified by the Insurance Commissioner.

Section 6. Dividend or Credit Distribution.

(a) Distribution of Dividend or Credit for Failure to Comply with Medical Expense Threshold. In each case where the insurer fails to comply with the medical expense threshold requirements set forth in this Act, the insurer shall issue a dividend or credit toward future premiums for the policyholder that is not less than an amount that would meet the applicable minimum requirement.

(b) Regulatory Approval Necessary Prior to Distribution of Dividend or Credit. Prior to distributing any dividend or credit, an insurer must provide the Insurance Commissioner with its plan for the distribution of all required dividends and credits as part of the required annual medical expense threshold. No distributions of

required dividends or credits may be made without prior approval from the Insurance Commissioner.

(c) Calculation of Dividends or Credits. The dividend or credit required to be distributed pursuant to this Act shall be determined by the Insurance Commissioner.

(d) Distributions to Any Covered Employer. The distribution of dividends or credits required under this law shall be made to each employer that was covered for any period in the preceding calendar year.

(e) Distribution to Employers. Insurers that issue health insurance policies through out-of-state trusts, purchasing alliances or other group purchasing organizations, associations or other multiple employer arrangements shall specify in the plan for distribution of dividends or credits that the dividends or credits for such health insurance policies shall be paid or credited, as applicable, to the covered employers, not the trust, association, purchasing alliance or other group purchasing organization, or other multiple employer arrangement.

(f) Reporting of Distribution. If an insurer is required to issue a dividend or credit, the insurer shall include the insurer's calculations of the dividend or credits to be issued due to failure to satisfy the minimum medical expense ratio threshold and an explanation of the insurer's plan to issue these dividends and credits in its Premium Transparency Report.

Section 7. Compliance Audit. The Insurance Commissioner has the authority to perform an audit of any insurer. If the audit shows that an insurer has violated any part of this law, the insurer will be subject to the appropriate penalties and fines.

Section 8. Penalties for Violating Reporting Requirements. Any insurer failing to comply with the reporting requirements of this Act or of any rules promulgated pursuant to the Act, will be subject to a fine of no less than $1,000, and no more than $10,000, per day of violation.

Section 9. Consumer and Employer Rights. Any consumer, employer, or their representatives, shall be entitled toseek an injunction to enforceany obligation established by this Act or any regulation promulgated under this Act.

Section 10. Severability. If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.