To: Julie Fritz, NAIC
Members of the Speed to Market (EX) Task Force
From: Carmen Balber, Consumer Watchdog
Date: August 11, 2010

Re: Rate Filing Disclosure Form

We would like to thank the Task Force for making significant improvements to the amount and quality of data that would be made available to the public in the August 4 draft of the rate filing disclosure form.

Section 2794 of the Affordable Care Act (ACA) requires health insurers to provide "the Secretary and the relevant State a justification for an unreasonable premium increase…" and further requires HHS to ensure public disclosure of "information on such increases and justifications."

As HHS's request for comments on Section 2794 notes, health insurers must "prominently post the justification for an unreasonable premium increase on their Internet Web sites prior to implementation of the increase."

The whole point of such a "justification" is to provide consumers, public advocates, and regulators with the information necessary to evaluate whether a rate is reasonable. The depth of information provided in the form you are currently developing will ultimately determine whether rate review requirements provide new illumination of health insurance rates, or become just another forum for the health insurance industry to obscure data and mislead the public and regulators.

The Affordable Care Act places important emphasis on the use of plain language in insurer communications to ensure consumers understand the information they receive about their insurance policy. This is not, however, an excuse for making the bill's mandated public disclosures light on detail. In-depth information is critical for consumer advocates to be able to meaningfully interpret insurance information, especially when it comes to insurance premium increases based solely on calculations made by an insurance company's employees or contractors.

We support the approach taken by the Task Force in the August 4 draft to divide the disclosure form into a first section meant for consumption by the general public, and two additional sections that will provide regulators and public interest advocates with sufficient information to determine whether a proposed increase that has been found "unreasonable" is justified.

More Detail Regarding Components of "Administrative" Costs

We write with our suggestions for additional disclosures to give regulators and the public a better chance of identifying unnecessary or wasteful spending. Greater detail is needed within the broad category of "administrative cost," as reported in Sections I and III of the August 4 draft, to illuminate the cost drivers behind premium increases. Necessary additions include: lobbying expenditures, campaign contributions, utilization and benefit management expenses, advertising, travel, association fees and insurance. Previous letters from the NAIC's consumer advisors and the American Medical Association propose similar additions. What is the rationale for excluding disclosure of cost information that is in large part already reported elsewhere?

In addition to being posted on the insurers' website, the information must be offered for posting on the state department of insurance's website, or the equivalent. This would help prevent insurers from posting less comprehensive or useful information on their own sites, with the cooperation of sometimes-complaisant public officials, and make comparisons between companies simpler.

Disclosures Must Include Transfers to Affiliated and Parent Companies To Block Insurers From Playing Shell-Games With Premiums

Section III should also detail insurers' monetary transfers from state subsidiaries to both out-of-state affiliates and parent companies.

An analysis by Consumer Watchdog of Blue Cross of California's financial statements found that the company made $2.2 billion in affiliate company distributions on "management agreements and service contracts" in 2007 alone. A detailed chart can be found here: http://www.consumerwatchdog.org/patients/articles/?storyId=32952

Management agreement and service contract transactions with affiliates should be subject to greater scrutiny, including the amount spent on each medical or administrative service provided, to ensure administrative costs are being appropriately accounted for under Section 2718 of the Affordable Care Act. If not itemized, bulk payments to out-of-state affiliates could be used to camouflage excessive administrative costs or profit within the guise of purported payments for services.

In addition, the financial incentive when administrative costs are limited, as they are by the ACA's medical loss ratio requirements, is for the out-of-state affiliates to overcharge for medical services, and for the state entity (in this case Blue Cross of California) to willingly overpay, in order to transfer profit amounts off the balance sheet that would otherwise exceed the limit. The public and regulators need enough information to determine whether affiliate transfers are legitimate payments for services rendered or if insurers are playing a shell game with premiums.

Consumer Watchdog's analysis also found that Blue Cross transferred $4.8 billion in dividends to parent company WellPoint after its 2004 merger with Anthem. These payments were made even as the company proposed premium increases in the individual market totaling 10 times the rate of health care inflation, and as the company was under a mandate, as a condition of the California Department of Insurance's approval of the merger, to limit the use of policyholder premiums to pay merger costs. All dividend and other transfers to the parent company and affiliates must also be disclosed.

Disclosures Should Also Include Policyholder Examples

We also recommend that Section III contain standard policyholder examples that are the same across rate filings for all insurance companies, to demonstrate the impact of a rate change on policyholders in different circumstances and allow for comparisons across companies.

For example, California requires every auto insurance rate filing to calculate the rate for three sample policyholders. The policyholder characteristics and the coverages are the same across companies for ease of comparison. "Rating Example 1" is a single male with one accident who has been licensed for two years. His policy includes minimum liability coverage and no comprehensive or collision. "Rating Example 2" is a single female with no traffic violations who drives a '96 Honda Accord. Her policy includes $100,000/300,000 in bodily injury coverage and a $200 collision deductible.

Similar rating examples for health insurance filings would require an insurer to illustrate the premium impact on, for instance, a single younger applicant, a couple with no children, ages 50-55, and a family with two children. Each example would have different coverage levels and deductibles.

The rating example would be generated for both the current rate and the proposed rate to illustrate changes. It would itemize the impact of each rating factor, and each coverage and deductible characteristic, on the sample policyholder's premium. The aim is for the three rating examples to illustrate the impact of premium changes on a variety of different policyholders, with different coverages. (The auto insurance example is attached for reference, and can be downloaded at: http://www.consumerwatchdog.org/resources/AAARatingExamples.pdf)

We recognize that the coverage details of health insurance policies vary, just as they do for auto insurance policies. Auto insurers whose coverages do not exactly match California's rating examples use the closest substitute – for example a $300 instead of $200 deductible. Such small variation does not detract from the usefulness of the rating example, both to illustrate the impact of a rating change on a variety of policyholders, and to enable comparison across plans.

Please contact Carmen Balber at (202) 629-3043 with any questions.