



November 10, 2010

Hon. Kathleen Sebelius
Secretary, Health and Human Services
Attention: DHHS-2010-MLR
DHHS-2010-PRR
Hubert H. Humphrey Building Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius,

We receive emails every day from Americans who are struggling to pay the latest double-digit increase in their health insurance premiums. As you know, the health reform law did nothing to cap runaway rate hikes. However, two provisions of the law meant to at least curb the premiums consumers pay are now in your court: rules to require insurance companies to spend more on actual health care and less on administration and profit, and rules to define and require insurance companies to justify “unreasonable” premiums before they take effect. The insurance industry, in the wake of the midterm election, is refocusing its efforts against these provisions on your agency.

The industry’s chief lobby group, America’s Health Insurance Plans (AHIP), recently hired new high-level executives with direct connections to HHS and the Justice Department.¹ They join a thousand or more² health insurance and related lobbyists who flooded the National Association of Insurance Commissioners during the writing of proposed regulations. The insurers have threatened to disrupt insurance markets if health reform regulations are not to their liking. We urge you to reject such intimidation.

You must instead strengthen new rules intended to shine a spotlight on insurer spending and make the insurance industry more efficient in providing health care. This must include a strong definition of what constitutes an “unreasonable” rate increase, given the unaffordable double-digit premium increases³ that insurers are now imposing on existing customers. Your definition will govern whether insurers have to publicly defend their rate increases, and should be as simple and inclusive as possible to ensure that any questionable increase receives additional review. We recommend that an “unreasonable” premium increase be defined to include: an increase that is greater than 10%, greater than 150% of the rate of medical care inflation as calculated by the Bureau of Labor Statistics, or is proposed by an insurance company that failed to meet its medical loss ratio target in the previous year.⁴ Your department’s delay in releasing this definition undermines

¹“Health insurance group undergoes major changes post-reform,” by Julian Pecquet, The Hill blog, Oct. 31 2010. <http://thehill.com/blogs/healthwatch/health-reform-implementation/126699-health-insurance-group-undergoes-major-changes-in-post-reform-era>

² Wendell Potter, Huffington Post column, October 19. “I am writing this between meetings at the fall conference of the National Association of Insurance Commissioners (NAIC) here in Orlando. I am one of 28 people selected by the NAIC to represent the interests of consumers. The insurance industry and other special interests are represented here by more than a thousand lobbyists.” http://www.huffingtonpost.com/wendell-potter/thank-you-unitedhealth-gr_b_768811.html

³ Kaiser Family Foundation, “Recent Premium Increases Imposed by Insurers Averaged 20% for People Who Buy Their Own Health Insurance,” June 21, 2010. News release: <http://www.kff.org/kaiserpolls/posr062110nr.cfm>

⁴ Letter to HHS by Consumer Watchdog. May 14, 2010. <http://www.consumerwatchdog.org/resources/RateReview.Comments.pdf>

consumers' trust in health reform and encourages insurers to continue bullying consumers with unfair premium hikes.

You must also strengthen new rules intended to make the insurance industry more efficient in providing health care. Insurance lobbyists have already succeeded in weakening proposed medical loss ratio regulations developed by the National Association of Insurance Commissioners.

Under the proposal delivered to you, many companies will have an easy time meeting a new floor of 80% to 85% of premium dollars spent on medical care (the medical loss ratio). Under constant lobbying, the NAIC over-broadened what is counted as health care. The proposal, now awaiting action by your office, would also allow deduction of nearly all federal and state taxes from premium revenue before the ratio of medical spending is calculated. Even so, insurers are demanding indefinite waivers from the proposed rules.

But the insurance industry wants far more. Its chief and most damaging additional demands are, in brief:

1. **To combine each plan of a single insurer at the national level.** The NAIC proposal would measure plans' MLR at the state level, the level at which plans are regulated. Combining them nationally for purposes of the medical loss ratio would allow insurers to gouge customers in high-profit states by offsetting areas of low medical spending with higher proportions in better-regulated states. Such aggregation would also demolish the intent of the law.⁵
2. **To deduct insurance broker fees from premiums before measuring MLR.** Brokers typically get up to 20% of a plan premium in the year it is sold, and up to 5% every year that the individual or small business plan remains in effect. Insurers have always considered the broker fee an administrative cost. If the deduction is allowed, the MLR minimum of 80% in those markets will become meaningless.⁶
3. **To give many plans a larger percentage "bonus"** in calculating whether they have met the 80% individual/small business minimum and the 85% group plan minimum for health care spending. The NAIC proposal already offers up to several percentage points of slack in calculating MLR for plans with too little sales volume to be fully "credible" statistically. The insurance industry continues to seek expansion of these "credibility adjustments," even though the proposed rule already allow credits of up to 14% in the calculation of plans' MLR.⁷

In addition to resisting additional insurer demands that would entirely cripple the MLR regulations, Consumer Watchdog asks that you reject certain concessions already obtained by the health industry lobby. These include:

1. **Inclusion of public health marketing campaigns as "health quality improvements."** The NAIC

⁵ Sen. John D. Rockefeller, letter to NAIC Commissioners, Oct. 14, 2010. "In particular, the large for-profit insurers are asking you to ignore the plain-language definition of "health insurance issuer" in the ACA and other federal statutes, and allow insurers to aggregate their large group medical loss ratio data across state lines and business entities. ... [A]llowing insurers to aggregate their medical loss ratio at a national level deprives the consumers of individual states of the new medical loss ratio law's most important protections." <http://www.docstoc.com/docs/58407483/hcr-mlr-rockefeller-letter101410>

⁶ J. Dugan, "Insurance Lobbyists Never Sleep," Consumer Watchdog Oct. 11, 2010. <http://www.consumerwatchdog.org/corporateering/articles/?storyId=36460>

⁷ Letter to NAIC by NAIC consumer representatives, Oct. 8, 2010. See page 7. http://www.naic.org/documents/committees_conliaison_1010_mlr_comments.pdf

proposal would allow insurance companies to count as health care certain marketing costs—such as anti-tobacco or anti-obesity messages—that are largely intended to improve a corporate image. There is no provable connection between health quality and such marketing campaigns, especially those aimed at a general public by an insurance company. Even in conjunction with a public health agency, insurer’ marketing campaigns do not meet the purpose of the medical loss ratio rule—providing value for premium dollars paid by the insurers’ customers. They may also, and more insidiously, help insurers identify people they do not want to insure. Such generalized marketing must not be part of the medical loss ratio.⁸

2. Excessive tax deductions. The proposed regulations would allow insurers to deduct almost all federal and state taxes, including income taxes, from their premium revenue before calculating the medical loss ratio. According to a letter sent to the NAIC by the chairs of Congressional committees most closely involved in writing the health reform law, Congress did not intend to allow such broad deductions, despite the rather vague language of the law as passed.⁹ Insurance company lawyers overtly threatened lawsuits¹⁰ if the NAIC did not follow the corporate interpretation of the law. The result was regulation-by-threat, which HHS should undo.

3. Lack of transparency for administrative costs counted as “health quality improvements,” including: provider accreditation fees, prospective utilization review and telephone hotlines. Each of these activities is generally considered a cost-reduction, claims adjustment or administrative activity. For example, accreditation fees paid to the National Committee for Quality Assurance include some measures of health quality improvement, but primarily address the quality of a health plan, not of health care.¹¹ Due to the dubious nature of these expenditures, the regulation requires an insurer to justify counting them as health quality improvements by explaining specifically how they: improve health outcomes, prevent hospital readmissions, improve patient safety, reduce medical errors or promote wellness. However, the explanation will be made in a “regulator only supplemental filing”¹² that won’t allow the public to gauge the legitimacy of insurers’ claims. These expenses are marginally connected to health care to begin with and should be publicly justified. In fact, any explanation provided by insurers as to why an expense was categorized as a health quality improvement should be publicly available.

8 Ellen R. Shaffer, Center for Policy Analysis, on Huffington Post Aug. 27, 2010. “1. Premium dollars will be further frittered away on marketing campaigns re-dubbed as "health awareness." 2. Real public health department initiatives, and funding for same, will be undermined as already scarce public health staff are diverted to determining whether particular insurance company campaigns are legitimate or not. 3. Smoking cessation campaigns, for example, can help insurance companies identify and then cherry-pick customers, either excluding smokers from coverage, or charging them more (the excess charges remain legal even after new rules take effect in 2014).” http://www.huffingtonpost.com/ellen-r-shaffer/medical-loss-ratio-and-pu_b_695460.html

9 Letter to Kathleen Sebelius by six Congressional committee chairs, Aug. 10, 2010. It stated that “[F]ederal income taxes and payroll taxes were not intended to be excluded from the denominator.” Available via <http://politi.co/aLmaZt>
See also a detailed defense of the committee chair’s opinion by Prof. Timothy Jost, a national expert on health insurance law, www.naic.org/documents/committees_lhatf_ahwg_100818_jost_100815.pdf

¹⁰ AHIP comment letter <http://www.consumerwatchdog.org/resources/NAICCommentAHIPtaxesIRD064.pdf>

¹¹ Letter to NAIC by NAIC consumer representatives. Oct. 8, 2010. See page 6.
http://www.naic.org/documents/committees_conliaison_1010_mlr_comments.pdf

¹² “Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013” as transmitted by NAIC to HHS. Oct. 27, 2010.

Ultimately, consumers cannot expect to pay a fair price for health insurance until all insurance companies are required to justify, and get approval for, every premium change, and until the public is allowed to fully participate in the rate review process. We urge you to encourage the states to enact and enhance prior approval rate regulation and consumer participation. Strong rules on medical spending and premium review are nevertheless your strongest currently available tools to protect consumers from insurer profiteering and greed.

Sincerely,



Judy Dugan



Carmen Balber