Exhibit A

Correspondence of Chairman Rockefeller

United States Senate

COMMITTEE ON COMMERCE, SCIENCE,
AND TRANSPORTATION

WASHINGTON, DC 20510–6125

WEB SITE: http://commerce.senate.gov

August 21, 2009

Stephen J. Hemsley
President and Chief Executive Officer
UnitedHealth Group
9900 Bren Road East
Minnetonka, MN 55343

Dear Mr. Hemsley:

I am writing to request information about how your company spends the health insurance premiums it collects from consumers and businesses. I am particularly interested in determining the percentage of policyholders' premium dollars that your company uses to pay actual healthcare claims as compared to administrative costs and profits. I am also requesting information about how your company discloses its financial practices to your current and potential customers.

Over the last six months, the Senate Committee on Commerce, Science, and Transportation has been investigating the business practices of the health insurance industry and the impact these practices have on consumers. As part of this investigation, the Committee has held a series of hearings examining the many obstacles consumers face when they attempt to make informed purchasing decisions in the health insurance market. These hearings have shown that one of the greatest difficulties American consumers face today is getting clear, accurate information about health insurance products. At one of the hearings, a prominent consumer advocate summarized this problem by stating, "consumers have no idea how health insurance works" and that "insurance companies know this and take advantage of it in how they design and market their plans."[1]

As consumers and businesses face ever increasing healthcare premiums, it is particularly important for them to be able to compare all aspects of the healthcare plans available to them. Yet, in most states, consumers and businesses cannot easily access a simple, but important piece of information: the amount of premium dollars that insurance companies receive compared to the amount they pay out in healthcare claims (known as the "medical loss ratio"). This ratio varies widely by company and type of plan and is a key piece of information for consumers and businesses when they are seeking to compare insurance plans. However, insurance companies do not appear to readily disclose this information to consumers and businesses.

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[1] Senate Committee on Commerce, Science and Transportation, *Hearing on Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (June 24, 2009), Testimony of Nancy Metcalf, Senior Program Editor, Consumer Reports.

To assist the Committee in understanding the variation among medical loss ratios for health insurance products, the administrative costs and other expenses that contribute to lower medical loss ratios, the profits that correspond to various medical loss ratios, and what information about actual and relative medical loss ratios is available to consumers and businesses seeking to purchase insurance, I request that you answer the following questions and provide the following information:

1. With respect to all major medical insurance policies offered by your company, please provide information detailing the dollar amounts of premiums your company received and healthcare claims it paid for each of the past five years in each state in which your company offers health insurance.[2] For each such state, please provide separate information for each of the following:

   a. The individual health insurance market;
   b. The small group health insurance market; and
   c. The large group health insurance market.

2. With respect to all major medical insurance policies offered by your company, please provide information detailing your company's profits, administrative expenses, and other costs not specifically tied to healthcare claims for each of the past five years in each state in which your company offers health insurance. For each such state, please provide separate information for each of the following:

   a. The individual health insurance market;
   b. The small group health insurance market; and
   c. The large group health insurance market.

3. Identify and describe each state law that requires your company to maintain a minimum medical loss ratio for any segment of the health insurance market, and describe any instances, in the last five years, in which your company has had to pay refunds to purchasers of health insurance because of its failure to meet minimum medical loss ratio requirements. Your description should include the annual amounts of any such refunds.

4. For each of the last five years, please provide information about the number of covered lives in each state in which your company offers major medical insurance. For each such state, please provide separate information for each of the following:

   a. The individual health insurance market;
   b. The small group health insurance market; and

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[2] As used throughout this letter, "state" means each of the 50 States, the District of Columbia, and Puerto Rico.

c. The large group health insurance market.

5. Provide your company's nationwide medical loss ratio for the major medical insurance products it offers for each of the last ten years in:

a. The individual health insurance market;
b. The small group health insurance market; and
c. The large group health insurance market.

6. If your company offers products that involve the payment of healthcare claims, but are not treated by your company as individual, small group or large group major medical insurance, please provide information that identifies and describes each such product your company offers. This request does not seek information about any Medicare, Medicare Advantage, Medicaid or other publicly funded healthcare program. Your description should include:

a. The name of each such product;
b. A description of each such product, including an explanation of why it does not constitute individual, small group, or large group insurance;
c. For each of the last five years information about the amounts paid by purchasers for each such product, claims paid, and profits made by your company in each state in which each such product is offered.

7. To the extent that the information you have provided in response to the first six questions in this letter is inconsistent with any information provided by your company in any filings with the National Association of Insurance Commissioners, any state regulator, or the Securities and Exchange Commission or with any information provided by your company in communications with industry analysts, please describe and explain the inconsistencies.

8. Does your company make information about medical loss ratios available to consumers and businesses shopping for major medical insurance? If not, why not? If so, please describe how it does so. Are there other ways that consumers or businesses shopping for health insurance can learn of your company's medical loss ratios for the products for which they are shopping? If so, how can they do so?

Please provide your responses to the Committee by Tuesday, September 8, 2009.

The Committee is conducting this investigation under the authority of Senate Rules XXV and XXVI. Enclosed with this letter is a document providing additional information about how

to respond to this document request. If you have any questions about this request, please contact Lisa Hone or John Williams of the Committee staff at 202-224-1300.

Sincerely,

John D. Rockefeller IV
Chairman

Enclosure

Cc: Kay Bailey Hutchison
Ranking Member

United States Senate
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION
WASHINGTON, DC 20510–6125
WEB SITE: http://commerce.senate.gov

November 2, 2009

H. Edward Hanway
Chairman and Chief Executive Officer
CIGNA Corporate Headquarters
Two Liberty Place
1601 Chestnut Street
Philadelphia, PA 19192

Dear Mr. Hanway:

In the course of investigating how the health insurance industry spends consumers' premium dollars, the Senate Commerce Committee has found serious inconsistencies in the way CIGNA and its subsidiaries provide business information to the public and to their regulators. I am writing to request that you immediately provide information clarifying the amount of premiums you receive and the claims you pay for your group health insurance products.

Health insurance premiums have increased by more than twice the rate of inflation over the last decade. Consumers are seeing their health care premiums skyrocket, and many are concerned that fewer premium dollars are actually being spent on their medical care. The business side of health insurance refers to the percentage of premium dollars actually used to provide medical services as a "medical loss" on insurers' balance sheets, because paying medical claims reduces insurers' profit margins. This seems to run counter to the very purpose of health insurance. With nearly half a trillion dollars in premium subsidies proposed to be paid to private health insurance companies by taxpayers as a part of health care reform, it is critical that consumers have a guarantee that the overwhelming majority of subsidy dollars are going toward actual medical care.

I believe insurers have an obligation to use consumers' premium dollars in a way that maximizes the benefit to their policyholders. I also believe that consumers have the right to know what insurance companies are doing with their money. The medical loss ratio, the percentage of every dollar paid to an insurer in premiums that it uses to deliver health care, is a very basic measure of the value a consumer is getting from his or her health insurance. Just as a car buyer might use gas mileage to choose one car model over another, medical loss ratios are a tool that can help consumers compare various health insurance options. For this reason, I proposed setting an appropriate minimum medical loss ratio for insurers during the Senate Finance Committee's markup of the health reform bill, and intend to raise the issue again when health care reform is debated on the Senate floor.

To learn more about medical loss ratios in the commercial health insurance market, on August 21, 2009, I wrote to CIGNA and fourteen other large health insurance companies

requesting information about their medical loss ratios broken down by state and by the individual, small, and large group market segments. Collectively, these fifteen companies control more than half of the entire fully-insured marketplace, and represent a driving force in market behavior and price setting. The purpose of this request was to compile medical loss information in a way that would be useful for consumers shopping for individual health insurance policies or for business owners shopping for group policies for themselves and their employees.

In reviewing the responses CIGNA and other companies have made to my August 21 letter, I have been surprised to learn that insurance companies consider segment-specific medical loss ratio information "proprietary" and "business sensitive" and deliberately withhold it from the public. Instead of disclosing medical loss ratios to help consumers and small business owners make informed health care choices, health insurance companies have hidden them behind a wall of corporate secrecy.

Because CIGNA and other large, for-profit insurers have been reluctant to share their medical loss information with the Committee on a voluntary basis, the Committee staff has been analyzing premium and claims data these companies have already filed with the National Association of Insurance Commissioners (NAIC). As described in more detail below, the analysis shows that in the individual and small group segments, insurers spend a significantly smaller portion of each premium dollar on patient care than they do in their large group business. It also shows that the large for-profit health insurers appear to be squeezing out more profits for Wall Street investors by spending a lower percentage of premium dollars on patient care than other insurers.

In the course of this investigation, the Committee has also found serious inconsistencies in the way CIGNA and its subsidiaries provide business information to the public and to their regulators. Specifically, CIGNA appears to have submitted state insurance regulatory filings that do not accurately describe your business activities in the small and large group business segments. This failure to submit accurate medical loss ratio information to state insurance agencies not only appears to violate the law; it also undermines the efforts of policymakers, consumer advocates, and regulators to determine whether consumers are getting a fair value for their health care premium dollars.

In order to correct this problem, I request that you immediately submit accurate financial information both to this Committee and to state authorities.

A. Background on the Medical Loss Ratio

One of the basic financial measures used in the health care industry is the percentage of health insurance premiums that insurers use to provide health care to their customers. This

percentage is commonly known as the "medical loss ratio."[1] For example, if an insurer uses 75 cents out of every premium dollar to pay its customers' medical claims, the company has a medical loss ratio of 75%. A medical loss ratio of 75% indicates that the insurer is using the remaining 25 cents of each premium dollar to pay expenses that do not directly benefit policyholders, such as salaries, administrative costs, advertising, agent commissions, and profits.

Regulators, consumers, policy makers, investors and even insurance companies themselves use medical loss ratios to assess how insurers manage their assets and provide health care services to their customers.[2] But these groups analyze medical loss ratios for different purposes. Regulators, consumers and policymakers study them to determine if insurers are spending an appropriate portion of premium dollars on medical services. Investors and the insurance companies they own use medical loss ratios determine the companies' profitability.

Regulators and Consumers

State insurance regulators use medical loss ratio information to make sure that insurers operating in their states are financially solvent and that consumers are getting sufficient value for their health insurance premiums.[3] According to a recent review of state insurance laws by America's Health Insurance Plans (AHIP), 32 states currently require insurance companies to report medical loss ratios in either their individual or group major medical insurance markets.[4]

Many of these states have taken the further step of implementing "minimum medical loss ratios" to limit the portion of premium dollars insurers can use for administrative expenses and profits. In a recent study on the impact of minimum medical loss ratios in the small group market in Texas, the Center for Public Policy Priorities made the following observation:

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[1] Some insurers use different terms to describe this ratio, such as "medical cost ratio," "benefits expense ratio" or "medical care ratio." According to one health care expert, "traditionally, actuaries had called this fraction the *medical loss ratio* (M.L.R.), because it represents what insurers "lose," so to speak, to doctors, hospitals and other providers of health care. Because that terminology comes across as indelicate, however, the preferred term now is the mellower *health benefit ratio* (H.B.R.)" Uwe E. Reinhardt, *How Much Money Do Insurance Companies Make? A Primer.* New York Times Economix Blog (Sept. 25, 2009) (online at http://economix.blogs.nytimes.com/2009/09/25/how-much-money-do-insurance-companies-make-a-primer).

[2] American Academy of Actuaries Loss Ratio Working Group, *Loss Ratios and Health Coverage* (November 1998) (online at http://www.actuary.org/pdf/health/lossratios.pdf).

[3] *Id.*

[4] America's Health Insurance Plans, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations* (Sept. 8, 2009). This document was provided to the Committee by at least 3 different insurance companies. *See also* Families USA Health Policy Memo, *Medical Loss Ratios: Evidence from the States* (June 2008) (online at http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf).

> Some states set minimum medical loss ratios by law to prevent insurance companies from charging excessive rates and retaining large margins for profit and other non-medical expenses. Establishing a minimum standard for the proportion of premiums spent on medical care provides consumers with an assurance that the majority of their premium dollars are used to help them finance their health care – the reason people buy health insurance.[5]

Thirteen states require insurance companies to maintain minimum medical loss ratios in their individual markets.[6] These minimum ratios range from a low of 50% in Pennsylvania to a high of 80% in neighboring New Jersey.[7] Thirteen states require companies to maintain minimum medical loss ratios in their small group markets (generally, businesses with fewer than 50 employees), with minimum ratios ranging from 60% to 82%.[8] Five states require companies to maintain minimum medical loss ratios in their large group markets.[9] These minimums range from 65% to 85%.

At least five of these state minimum ratio laws require insurers to return premium payments to consumers if their medical benefits payments fall below the state-mandated minimum percentages.[10] In response to the Committee's inquiry to the 15 largest health insurers whether they had issued rebates in compliance with these refund laws over the past 5 years, 4 insurers reported they returned amounts totaling $73.2 million. The fact that the insurance companies do, on occasion, dip below required minimum loss ratios suggests that minimum loss ratio standards keep the percentage of premium dollars spent on healthcare higher than it would be without such a requirement.

From the perspective of an individual consumer or business shopping for insurance coverage, medical loss ratios provide useful information about the relative value of health plans with similar benefit structures. Just as a car buyer might use gas mileage to choose one car model over another, "medical loss ratios are one additional tool consumers can use to compare similar products and better understand what they get for their premium dollar."[11]

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[5] Center for Public Policy Priorities, *How to Improve the Health Insurance Market Using Medical Loss Ratios* (No. 09-400) (May 15, 2009) (online at http://www.cppp.org/files/3/400_MLR_report.pdf).

[6] America's Health Insurance Plans, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations* (Sept. 8, 2009).

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] *Id.* According to AHIP, these five states are Maine, New Jersey, New York, North Carolina, and South Carolina.

[11] Center for Public Policy Priorities, *How to Improve the Health Insurance Market Using Medical Loss Ratios* (No. 09-400) (May 15, 2009) (online at http://www.cppp.org/files/3/400_MLR_report.pdf).

Investors

The health care consulting group, PricewaterhouseCoopers, reports that: "MLRs [medical loss ratios] are closely watched barometers of financial performance for investors."[12] But unlike regulators and consumers, who are looking for medical loss ratios high enough to demonstrate that a health insurance product is a good value, potential investors are looking for low ratios. Low and declining medical loss ratios signal to the market that an insurer is successfully containing its medical costs and is likely to operate profitably in the future.[13] A guide to investing in health companies on the Investopedia website counsels investors that the medical loss ratio "is the key ratio investors consider. It basically tells the investor how much the medical expenses are as a percentage of premiums…Investors like to see a low medical cost ratio."[14]

On June 24, 2009, a former CIGNA executive, Wendell Potter, testified before the Commerce Committee that CIGNA and other for-profit insurance companies are under intense pressure from Wall Street to contain their medical costs. At the end of every quarter, Mr. Potter testified, insurance executives provide their financial results on investor conference calls.

> On these calls, Wall Street investors and analysts look for two key figures: earnings per share and the medical loss ratio…To win the favor of powerful analysts, for-profit insurers must prove that they made more money during the previous quarter than a year earlier and that the portion of the premium going to medical costs is falling. Even very profitable companies can see sharp declines in stock prices moments after admitting they've failed to trim medical costs. I have seen one insurer's stock price fall 20 percent or more in a single day after executives disclosed that the company had to spend a slightly higher percentage of premiums on medical claims during the quarter than it did during a previous period. The smoking gun was the company's first-quarter medical loss ratio, which had increased from 77.9% to 79.4% a year later.[15]

According to Mr. Potter, for-profit insurers employ several different strategies to exert continuous downward pressure on their medical loss ratios. In the individual market, for-profit

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[12] Pricewaterhouse Coopers' Health Research Institute, *Beyond the Sound Bite: Review of Presidential Candidates' Proposals for Health Reform*, 38 (Nov. 2007).

[13] American Academy of Actuaries Loss Ratio Working Group, *Loss Ratios and Health Coverage*, 7 (November 1998). "From the investor's perspective, the lowest loss ratio is best because it means more risk margin to provide for profit and for potential adverse experience fluctuations."

[14] Investopedia, *Investing in Health Insurance Companies,* (online at http://www.investopedia.com/articles/stocks/09/investing-in-health-insurance.asp) (accessed Oct. 26, 2009).

[15] Senate Committee on Commerce, Science and Transportation, *Hearing on Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (June 24, 2009), Testimony of Wendell Potter.

insurers engage in post-underwriting rescission, where insurers "look carefully to see if a sick policyholder may have omitted a minor illness, or a pre-existing condition when applying for coverage, and then they use that as a justification to cancel the policy."[16] In the small group market, Mr. Potter described how insurers "purge" small businesses with high health care expenses by increasing premiums to unsustainable levels.[17]

The Health Insurance Industry's Conflicting Loss Ratio Numbers

For-profit health insurance companies such as CIGNA struggle to please two different audiences with sharply divergent interests. On the one hand, they try to demonstrate to regulators and consumers that they use a high percentage of premium dollars to provide health care. At the same time, as Mr. Potter explained to the Committee, insurers know that Wall Street will reward them for containing their benefit expenses and lowering their medical loss ratios.

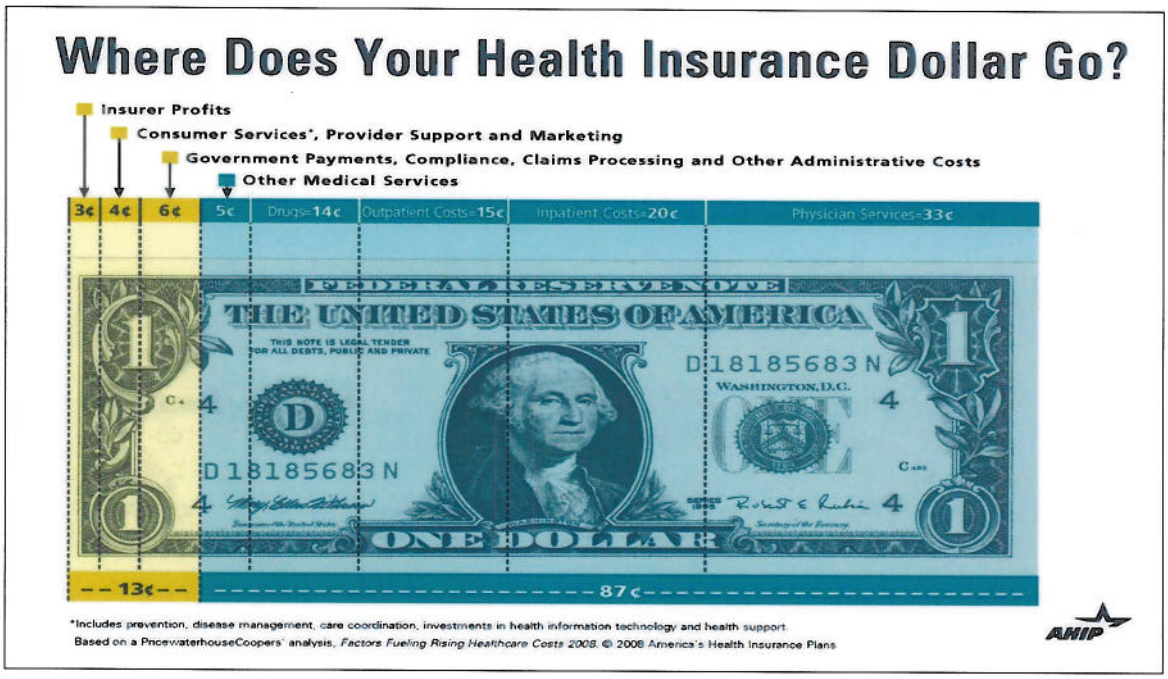

FIGURE I – AHIP Presentation of the Expenditure of a Premium Dollar

During the health care reform debate this year, the health insurance industry has provided one set of premium-benefit numbers to the public and to Congress, and presented a different one

[16] *Id. See also,* U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Termination of Individual Health Policies by Insurance Companies,* 111th Congress (June 16, 2009).

[17] *Id. See also,* U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on the High Cost of Small Business Health Insurance: Limited Options, Limited Coverage*, 111th Congress (Oct. 20, 2009).

to their investors. In an expensive public relations effort, the health insurance industry's association, America's Health Insurance Plans (AHIP), has repeatedly cited a report it commissioned from PricewaterhouseCoopers that purports to show that in 2008, 87% of health insurance premiums were spent on health care costs, while 13% were spent on administrative costs.[18] As part of this public relations effort, AHIP has repeatedly published graphics showing that the industry spends 87% of every premium dollar on health care (see Figure I above).

However, the industry's representation that insurance companies spend 87 cents of every premium dollar on medical care is contradicted by its own financial reporting. A review of the Securities and Exchange Commission (SEC) filings of the six largest, publicly-traded health insurers, including CIGNA, shows that not a single one of those companies spent 87 cents of every dollar on medical care for their customers in 2008 (see Table I below).

Company	2008 Medical Loss Ratio
Aetna	81.5%
CIGNA	84.8%
Coventry	84%
Humana	84.5%
UnitedHealth	82%
WellPoint	83.6%

TABLE I – 2008 Medical Loss Ratios Presented by For-Profit Insurers to Their Investors

Given that CIGNA and the five other companies listed in Table I above collected more than $70 billion in premiums from their commercial insurance customers in 2008, the difference between AHIP's 87% figure and the companies' actual figures equates to billions of dollars that the health insurance industry claims to spend providing health care, but actually uses to bolster its profits or pay other non-benefit expenses.

Further evidence that AHIP's 87% premium-benefit figure misrepresents the true ratios within the health insurance industry is an analysis published by PricewaterhouseCoopers Health Research Institute in 2007. The analysis shows that, over the past 15 years, the medical-loss ratios of publicly traded health insurance companies have dropped from the 90-95% range to the low 80s.[19] According to this PricewaterhouseCoopers report, it has been almost a decade since the industry-wide medical loss ratio was higher than 85% (see Figure II).

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[18] PricewaterhouseCoopers, *Factors Fueling Rising Healthcare Costs 2008*, Prepared for AHIP (Dec. 2008).

[19] PricewaterhouseCoopers' Health Research Institute, *Beyond the Sound Bite: Review of Presidential Candidates' Proposals for Health Reform*, 39 (Nov. 2007).

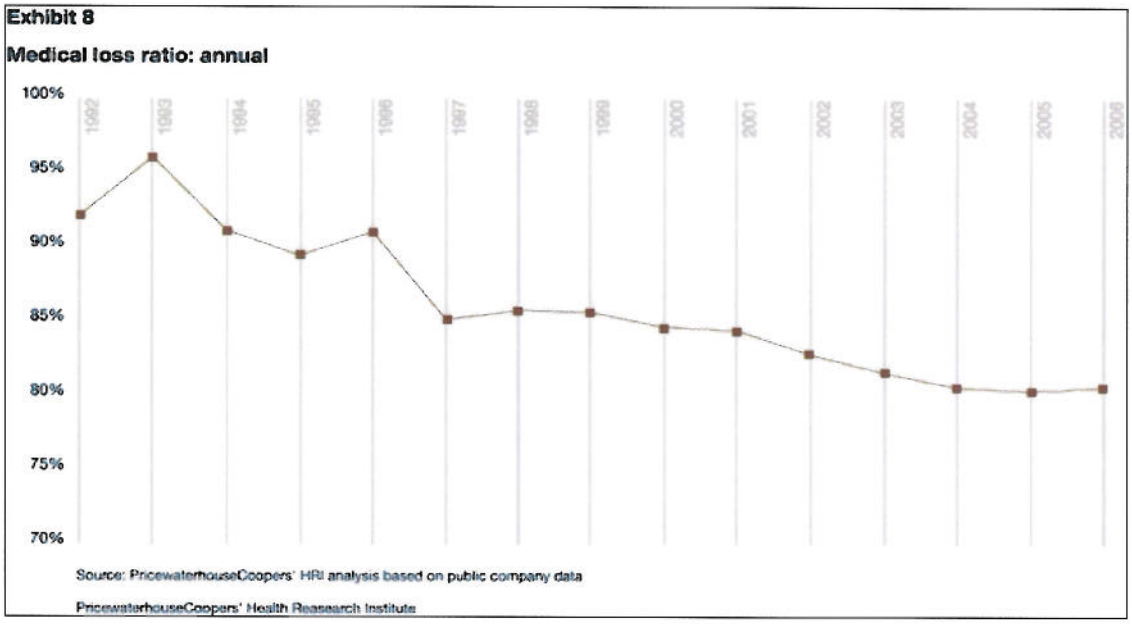

FIGURE II – PricewaterhouseCoopers Analysis of Medical Loss Ratio

In his June 24 testimony before the Commerce Committee, Mr. Potter cited this PricewaterhouseCoopers analysis as evidence of "just how successful the insurers' expense management and purging actions have been over the last decade in meeting Wall Street's expectations." [20] A reduction of a few points in the industry's medical loss ratio "translates into a difference of several billion dollars in favor of insurance company shareholders and executives and at the expense of health care providers and their patients."[21]

Medical Loss Ratios as a Tool for Consumers

Although medical loss ratios are a widely used indicator of performance in the health insurance industry, they do not provide consumers with information about the quality or effectiveness of the care they will receive through a particular health insurance product. In fact, health insurers have been quick to point out to Committee staff the shortcomings of the medical loss ratio, repeatedly directing the Committee's attention to an academic article in which the author calls the medical loss ratio an "accounting monstrosity."[22]

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[20] Senate Committee on Commerce, Science and Transportation, *Hearing on Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (June 24, 2009), Testimony of Wendell Potter.

[21] *Id.*

[22] James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, Health Affairs, Vol. 16, No. 4, 186 (July/Aug. 1997) (online at http://content.healthaffairs.org/cgi/reprint/16/4/176).

The author of this article, as well as other health care experts, make a number of valid points about the limitations of the medical loss ratio. For example, the fact that an insurer is spending a higher fraction of its premium dollars on health care than a competitor does not necessarily mean the company's policyholders are getting higher quality health care. In addition, the medical loss ratio does not always credit the expenditures health insurers make on wellness programs, disease management, fraud detection, and other efforts that ultimately lead to lower health care costs and greater efficiency.[23]

While it is clear that consumers need to consider other measures of quality and efficiency when they are making decisions about buying health insurance, the medical loss ratio gives individuals and small businesses a tool to evaluate health plans competing for their business. For this reason, some states require the public reporting of insurers' medical loss ratios for the individual and small group markets, and some state insurance commissioners even provide medical loss ratio information directly to the public.

The Minnesota Insurance Commissioner, for example, publishes an annual report listing the medical loss ratios of every insurer selling individual and small group insurance in the state. Thanks to this publication, a small business in Minnesota has easy access to information about insurers in the state selling health care coverage to small businesses (see Figure III).[24]

Company	2008 Premiums	2008 Claims	Loss Ratio
** BCBSM, Inc.	$ 653,722,304	$ 575,861,930	88%
* Blue Plus	$ 48,759,855	$ 41,201,622	84%
Federated Mutual Insurance Company	$ 49,392,832	$ 38,008,412	77%
* First Plan of Minnesota	$ 3,182,079	$ 2,370,060	74%
* HealthPartners	$ 278,518,347	$ 235,252,391	84%
HealthPartners Insurance Company	$ 27,331,492	$ 24,499,173	90%
John Alden Life Insurance Company	$ 2,272,757	$ 2,386,327	105%
Medica Insurance Company	$ 420,079,849	$ 365,607,299	87%
Noridian Mutual Insurance Company	$ 1,907,774	$ 1,869,102	98%
* PreferredOne Community Health Plan	$ 47,807,129	$ 41,005,321	86%
PreferredOne Insurance Company	$ 2,049,719	$ 1,621,953	79%
Principal Life Insurance Company	$ 3,318,219	$ 2,182,137	66%
Sanford Health Plan	$ 314,961	$ 228,064	72%
Time Insurance Company	$ 3,135,076	$ 4,315,288	138%
Union Security Insurance Company	$ 296,327	$ 205,685	69%
Total	$ 1,542,088,720	$ 1,336,614,764	87%

FIGURE III – 2008 Minnesota Small Group Medical Loss Disclosure

[23] *Id.*

[24] Minnesota Department of Commerce, *Report of 2008 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies, Nonprofit Health Service Plan Corporations and Health Maintenance Organizations* (June 2009, revised Aug. 1, 2009) (online at http://www.state.mn.us/mn/externalDocs/Commerce/Current_Loss_Ratio_Report_052104013421_LossRatioReport.pdf).

Other state insurance commissioners that provide segment-specific medical loss ratio information to consumers include West Virginia and Colorado, which compile this information in annual reports. Maine and Washington make certain health insurance company filings available in online comparison tools that any member of the public can access. Many other state insurance commissioners include some portion of insurers' medical loss ratio information in their annual statements.[25]

Although AHIP and the insurance industry publicly focus on companies' overall medical loss ratios, regulators and consumer advocates look at medical loss ratios at the market-segment level because loss ratios vary dramatically by product type. Specifically, they collect and analyze data subdivided according to the the individual, small group and large group markets. As Mark Hall, Professor of Law and Public Health at Wake Forest University, has noted, these three market segments are "distinct segments, each of which is governed by fundamentally different economics and regulation."[26] They constitute different product lines, are sold by different sales forces, and are serviced by different corporate divisions, "as distinct in their economic and legal characteristics as are mobile homes, condominiums, and single-family homes."[27]

Each of these business segments has different premium-benefit structures due to varying costs of marketing, underwriting, and administration. In general, according to the American Academy of Actuaries, "loss ratios for plans in the individual market will typically fall below those in the small group market, which in turn will fall below those in the large group market."[28]

One of the significant administrative expenses related to selling individual and small group policies is the cost of reviewing applicants' health histories, or "medical underwriting." According to Professor Hall, medical underwriting and other administrative steps insurers take to limit their risks can consume up to 20-25% of premiums in the individual market and 10-15% of

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[25] *See, e.g.,* Washington State Office of the Insurance Commissioner, *Insurance Commissioner's Annual Report 2008* (2008) (online at http://www.insurance.wa.gov/publications/annual_reports/2008ReportAppendix/AnnualRpt2008.pdf); Maine Bureau of Insurance, *2008 Financial Results for Health Insurance Companies in Maine* (2008) (online at http://www.maine.gov/pfr/insurance/consumer/financial_results_health_insurers.htm); State of West Virginia Offices of the Insurance Commissioner, *Accident and Health Insurance Market Report for 2008* (Nov. 2008) (online at http://www.wvinsurance.gov/LinkClick.aspx?fileticket=dNz-c9pDQEg%3d&tabid=207&mid=795).

[26] Mark A. Hall, *The Geography of Health Insurance Regulation*, Health Affairs, Vol. 19, No. 2, 173 (Mar./Apr. 2000). (online at http://content.healthaffairs.org/cgi/reprint/19/2/173.pdf).

[27] *Id.*

[28] American Academy of Actuaries, *Critical Issues in Health Reform: Minimum Loss Ratios* (July 2009) (online at http://www.actuary.org/pdf/health/loss_july09.pdf).

premiums in the small group market.[29] Thus, comparisons of medical loss ratios that include a breakdown of loss ratios by individual, small and large group markets are more meaningful for consumers and small businesses looking to purchase health insurance.

B. The Commerce Committee's Investigation

Although some state regulators collect and make medical loss ratio information available to their citizens, in most insurance markets in the United States, individual consumers and small businesses do not have ready access to medical loss ratio information about the insurance products offered for sale in their areas. Similarly, while insurers routinely share their company-wide medical loss ratios with their investors, they do not make available the medical-loss ratio information that would be most useful to consumers – the ratios of policies offered in particular market segments and geographic areas. For example, WellPoint informed the Committee that it "does not typically make medical loss ratios available to the purchasers of health benefits. This is because a medical loss ratio is an accounting tool that is not a measurement of quality or efficiency."[30]

In an attempt to find out about medical loss ratios in the individual, small and large group markets and to learn how the health insurance industry collects, uses, and publicizes medical loss ratio information, I wrote CIGNA and the 14 other largest health insurance companies on August 21, 2009, requesting medical loss information broken down by state and business segment. Collectively, these fifteen companies control more than half of the entire fully-insured marketplace. Dividing the commercial health insurance market into the individual, small group and large group segments, the letter asked the companies to provide information showing what fraction of premiums they spent providing medical care to their customers, and describing how they spent the portion of premiums that did not go to providing medical care.

Some of the companies that received the August 21 letter – generally those that are non-profit entities and operate primarily in a single state – provided complete responses to the Committee's request on a timely basis. Most of the for-profit national health insurance companies, including CIGNA, however, have still not voluntarily provided complete responses to the Committee's request.

CIGNA and other large for-profit companies have cited a variety of reasons for their reluctance to provide the requested information, but all of them have stressed the "confidential and proprietary" nature of medical loss ratio information broken down by state, and by the individual, small group and large group market segments. While the companies have acknowledged that they are required to report medical loss ratio information by market segment

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[29] Senate Committee on Finance, *Hearing on 47 Million and Counting: Why the Health Care Marketplace is Broken* (June 10, 2008), Testimony of Mark A. Hall.

[30] Letter from Stephen Northrup, Vice President, Federal Affairs, WellPoint, to Chairman John D. Rockefeller IV, U.S. Senate Committee on Commerce, Science and Transportation (Sep. 8, 2009).

in a number of states where they do business, they argue that disclosing this information in states where they are not currently required to report it would cause them competitive harm.

Publicly Available Information About Insurers' Medical Loss Ratios

While the Committee is continuing discussions with CIGNA and other companies about voluntarily providing the information requested in the August 21 letter, we have learned that much of the information these companies claim to be confidential and competitively sensitive is available to the public through forms the companies file with state insurance regulators. In particular, all companies that sell major medical insurance subject to the regulation of state insurance commissioners annually file a form called the "Accident & Health Policy Experience Exhibit."[31] This form, which was developed by the National Association of Insurance Commissioners (NAIC), requires companies to disclose the premiums they have earned and the claims they have paid in their individual, small group, and large group businesses.[32]

Because the largest for-profit health insurers have been reluctant to share their medical loss ratio information with the Committee – claiming this information is "confidential" and "business sensitive" – we have compiled this information from the numbers they have publicly filed on their NAIC Policy Experience Exhibits. Although this company-provided data has some limitations, it provides a clear picture of how medical loss ratios differ by market segment.[33]

In 2008, for example, American consumers and employers paid health insurers almost $200 billion in premiums for major medical health insurance coverage provided to 58 million Americans in the individual, small group, and large group markets. As Table II below shows, the medical loss ratio for the individual segment (79%) was lower than the group segments, and the small group ratio (82%) was lower than the large group ratio (86%). In other words, while insurers used 14 cents out of every large group premium dollar for non-benefit expenses, they used 21 cents out of every individual premium dollar for non-benefits expenses.

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[31] NAIC's instructions for the 2008 Accident & Health Policy Experience Exhibit define Comprehensive/Major Medical as "Policies that provide fully insured indemnity, HMO, PPO, or Fee for Service coverage for hospital, medical, and surgical expenses." *Official NAIC Annual Statement Instructions: Health*, 502 (Aug. 2008).

[32] The instructions to this exhibit divide "Single Employer" group policies into "Small Employers," as the term is defined in a particular state, and "Other Employers." *Official NAIC Annual Statement Instructions: Health*, 503 (Aug. 2008). States generally follow the definition of "Small Employer" defined in the federal Health Insurance Portability Act (HIPAA), which is an employer with between 2 and 50 employees. 42 USC § 300gg-92.

[33] See the notes to Exhibit 1 attached to this letter.

Market Segment	Premiums	Paid Claims	Ratio
Individual (8.4 million lives)	$20.4 billion	$16.1 billion	79%
Small Group (17.8 million lives)	$60.3 billion	$49.4 billion	82%
Large Group (32.1 million lives)	$109.7 billion	$94.1 billion	86%

TABLE II - 2008 Medical Loss Ratios by Market Segment – All Insurers

A separate analysis of the premium and claims information reported by the six largest for-profit insurers, however, shows that these companies spend less of every premium dollar on health care than the rest of the market. The six largest for-profit companies – Aetna, CIGNA, Coventry, Humana, UnitedHealth Group, and WellPoint – had a cumulative medical loss ratio in the individual market of 74%, five points lower than the industry as a whole. They reported medical loss ratios of 80% and 84% in the small and large group markets, respectively, both of which are two points lower than the industry-wide ratios.

Market Segment	Premiums	Paid Claims	Ratio
Individual (2.9 million lives)	$6.8 billion	$5.1 billion	74%
Small Group (8.3 million lives)	$27.9 billion	$22.3 billion	80%
Large Group (13.2 million lives)	$40.9 billion	$34.4 billion	84%

TABLE III - 2008 Medical Loss Ratios by Market Segment – Largest For-Profit Insurers

As Mr. Potter, the former CIGNA executive, explained in his Commerce Committee testimony, reducing medical loss ratios by even a few points "translates into a difference of several billion dollars in favor of insurance company shareholders and executives."[34] To illustrate this principle, if these six companies' medical care expenditures had tracked industry-wide 2008 medical loss ratios, they would have spent $1.7 billion more on providing health care than they actually did.

C. CIGNA's Failure to Disclose Its Group Business to the Commerce Committee and Its Insurance Regulators

Attached to this letter is a table (Exhibit 1) showing the premium dollars collected, claims paid, and medical loss ratios reported by the six largest for-profit health insurance companies for the calendar year 2008 to the National Association of Insurance Commissioners. This table presents the information broken down by the individual, small group and large group market segments.

[34] Senate Committee on Commerce, Science and Transportation, *Hearing on Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (Jun. 24, 2009), Testimony of Wendell Potter.

A review of the data presented in this table (Exhibit 1) shows that CIGNA has failed to report its financial information in a manner that is consistent with the other five companies included in the table. According to the information you have filed with your insurance regulators, CIGNA and its subsidiaries did no business in the small group segment in 2008, and only a minimal amount of business in the large group segment.[35] Instead, CIGNA reports more than $5 billion worth of business in a catch-all "other group" category.[36] This reporting does not appear to accurately reflect your company's operations in these two market segments, and it directly contradicts statements you made to the Committee in a recent letter about your small business market.

There is an abundance of publicly available information demonstrating that CIGNA markets and sells insurance products in the small and large group segments. Through basic online searches, Committee staff has obtained CIGNA marketing materials advertising small group policies as well as a 2008 press release quoting CIGNA's "senior vice president of CIGNA HealthCare's individual and small group segment."[37] A review of information on state insurance regulator websites also shows that CIGNA has disclosed small or large group business in certain state filings.[38] For instance, in its filing with the New Jersey Department of Banking and Insurance, CIGNA HealthCare of New Jersey claimed $36.9 million in large group premiums and $1 million in small group.[39]

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[35] The Committee's conclusions are based on a manual review of the 2008 Accident & Health Policy Experience Exhibits for the following CIGNA subsidiaries: Connecticut General Life Insurance Company, Allegiance Life & Health Insurance Company, CIGNA Insurance Services Company, CIGNA Life Insurance Company of New York, Life Insurance Company of North America, Alta Health & Life Insurance Company, CIGNA Insurance Group, CIGNA Worldwide Insurance Company, CIGNA Healthcare of Pennsylvania, CIGNA Healthcare of Arizona, CIGNA Healthcare of North Carolina, CIGNA Healthcare of Florida, CIGNA Healthcare of Ohio, CIGNA Healthcare of Texas, Great West Healthcare of Illinois, CIGNA Healthcare Centennial State, Great West Healthcare of Texas, CIGNA Healthcare of Maine, CIGNA Healthcare of New York, CIGNA Healthcare of New Hampshire, CIGNA Healthcare of New Jersey, CIGNA Healthcare of Utah, CIGNA Healthcare of Massachusetts, CIGNA Healthcare of Indiana, CIGNA Healthcare of Delaware, CIGNA Healthcare of the Mid-Atlantic, CIGNA Healthcare of Illinois, CIGNA Healthcare of Colorado, CIGNA Healthcare of Tennessee, CIGNA Healthcare of St. Louis, CIGNA Healthcare of Connecticut, CIGNA Healthcare of South Carolina, and CIGNA Healthcare of Georgia.

[36] An examination of CIGNA's 2006 and 2007 Accident & Health Policy Experience Exhibit filings shows that CIGNA's reporting followed the same pattern in those two years.

[37] Business Wire, *CIGNA Rolls out New Suite of Health Plans for Individuals and Small Employer Groups* (Oct. 28, 2008).

[38] According to the websites of the following state insurance commissioners, CIGNA has reported or listed as available specific small or large group business: Maine, West Virginia, Texas, New Jersey, South Carolina, Florida.

[39] New Jersey Department of Banking and Insurance, *2008 Preliminary Commercial Loss Ratio Market Share Report* (Aug. 25, 2009) (online at http://www.state.nj.us/dobi/lifehealthactuarial/2006comhealth_loss.pdf).

As mentioned above, CIGNA's failure to disclose that it has small group business is also at odds with a letter you wrote to the Committee on September 2, 2009, in which you provided details about CIGNA's small group business, which you defined as employers with 2 to 50 employees. You explained that "CIGNA's historical presence in the small group market has been limited, and currently this business represents approximately 50,000 members."[40]

Thus, based on the plain language reading of the NAIC Exhibit's instructions and on the way your competitors disclosed their market segment information on these forms, it is clear that the information you provided in these Policy Experience Exhibits is inaccurate. CIGNA sold small and large group policies valuing as much as $5 billion to consumers in 2008, but failed to report this activity to state regulators.

This failure to provide accurate business information not only shows that your company is failing to comply with the requirements of state insurance laws; it also undermines the efforts of regulators and policymakers to protect consumers from unfair insurance industry practices. A number of states have made the policy decision to provide special protections to certain types of businesses seeking to purchase health insurance for their employees. To enforce these protections, they have required you and other insurance companies to disclose information about how you do business in their jurisdictions. Your company appears to have flouted these requirements and made it more difficult for regulators and consumers to hold you accountable for your conduct.

In order to understand why CIGNA has failed to disclose accurate information about its business practices to its insurance regulators and to the public, I request that you provide the Committee with the following information and answer the following questions:

- Please explain why CIGNA and its subsidiaries appear to have misclassified as much as $5 billion dollars worth of health insurance business;

- Please produce accurate data showing your company's nationwide medical loss ratio for the major medical insurance products it currently offers, or has offered in the past, for each of the last ten years in:

  a. The individual health insurance market;
  b. The small group health insurance market; and
  c. The large group health insurance market; and

- Please explain how CIGNA intends to amend its state insurance filings, for both the calendar year 2008 and previous years, to accurately reflect your business activities in the individual, small, and large group market segments.

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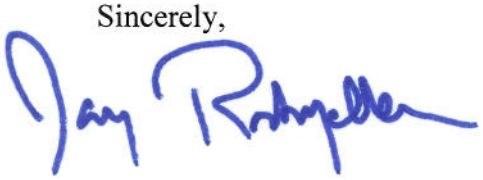
[40] Letter from H. Edward Hanway, Chairman and Chief Executive Officer, CIGNA Corporation, to John D. Rockefeller IV, Chairman, U.S. Senate Committee on Commerce, Science, and Transportation (Sept. 2, 2009).

I request that you provide this information to the Committee by November 9, 2009.

The Committee is making this request under the authority of Senate Rules XXV and XXVI. If you have any questions, please contact John Williams or Lisa Hone with the Committee staff at (202) 224-1300.

Please also note that I am sending a copy of this letter to New Hampshire Insurance Commissioner Roger Sevigny, the current president of the National Association of Insurance Commissioners.

Sincerely,



John D. Rockefeller IV
Chairman

Enclosure

cc: Kay Bailey Hutchison
Ranking Member

Roger A. Sevigny
President, National Association of Insurance Commissioners

Exhibit I - Premiums, Claims, and Loss Ratios

Comprehensive Major Medical Insurance for the 6 Largest Public Insurance Companies (2008)

	Individual			Small Employer			Large Employer		
	Premiums	*Paid Claims*	***Loss Ratio***	*Premiums*	*Paid Claims*	***Loss Ratio***	*Premiums*	*Paid Claims*	***Loss Ratio***
Aetna	$843,692,044	$617,705,102	**73%**	$8,875,867,031	$7,290,075,280	**82%**	$5,459,969,978	$4,476,646,659	**82%**
CIGNA	$61,571,932	$53,460,251	**87%**	$0	$0	--	$12,609,503	$8,117,238	**64%**
Coventry	$121,003,570	$79,610,830	**66%**	$942,048,835	$742,735,050	**79%**	$2,108,245,345	$1,743,470,356	**83%**
Humana	$464,653,831	$333,424,223	**72%**	$2,556,931,493	$1,974,696,888	**77%**	$2,831,401,783	$2,332,915,906	**82%**
UnitedHealth	$585,335,682	$485,607,210	**83%**	$8,464,932,032	$6,684,677,470	**79%**	$13,421,315,270	$11,220,132,212	**84%**
WellPoint	$4,760,267,838	$3,494,528,874	**73%**	$7,106,213,785	$5,615,930,436	**79%**	$17,148,822,998	$14,622,518,775	**85%**
Total	**$6,836,524,897**	**$5,064,336,490**	**74%**	**$27,945,993,176**	**$22,308,115,124**	**80%**	**$40,982,364,877**	**$34,403,801,146**	**84%**

Notes

*Data is based on Accident and Health Policy Experience Exhibit (A&H Policy Exhibit) filings made by the companies and their subsidiaries with the National Association of Insurance Commissioners (NAIC). In the A&H Policy Exhibits, data about comprehensive medical insurance sold to individuals is under the heading "Individual, Comprehensive Major Medical With Contract Reserves." Data about comprehensive medical insurance sold to small employers (usually between 2-50 employees) is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Small Employer." Data about major medical insurance sold to large employers is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Other Employer."

*NAIC's calculation of Loss Ratio takes into account "Change in Contract Reserves," which is not specifically identified in this chart, and does not usually affect the loss ratio significantly.

*Data is limited to fully-insured business, comprehensive major medical insurance. Self-insured, administrative-services only, FEHB, Tricare and Medicare are not included in this chart.

*Data does not include information about entities regulated by the California Department of Managed Health Care (DMHC), because such entities do not file A&H Policy Exhibits with NAIC. Companies that have substantial amounts of major medical business and file with DMHC include, but are not limited to: Blue Cross of California (a WellPoint subsidiary) and PacifiCare of California (a UnitedHealth subsidiary).

*In 2008, Golden Rule, a UnitedHealth subsidiary, sold the bulk of its individual insurance through associations and other groups, therefore it is not represented as Individual Business in the A&H Policy Exhibit, but rather is reported as "other associations and discretionary trusts." If the premiums and claims reported by Golden Rule were included as individual major medical insurance, UnitedHealth's total premiums in the individual insurance category would increase to $1,590,952,160; its claims would be $1,121,724,504. Including these numbers in UnitedHealth's individual business line drops the company's loss ratio to 70.5%, and decreases the total individual loss ratio from 74% to 73%.

*NAIC data includes full year financial data for companies acquired by Humana rather than just the data following their acquisition. The NAIC data does not include Humana's Puerto Rico operations.

United States Senate
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION
WASHINGTON, DC 20510–6125
WEB SITE: http://commerce.senate.gov

May 7, 2010

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

Dear Secretary Sebelius:

I am writing to share my thoughts with you about the implementation of the new law establishing minimum medical loss ratios in the commercial health insurance market. I am extremely concerned that the health insurance industry is mounting an all-out effort to weaken this important consumer protection provision included in the health care reform legislation President Obama signed into law in March. I appreciate the complexities you face as you work to implement the medical loss ratio provision over the next few months, but I also urge you to keep in mind the very simple principle underlying this provision – most of consumers' health insurance premiums dollars should be going to pay for patient care, not for insurers' administrative costs and profits.

There is no doubt that the health insurance industry has now shifted its focus from opposing health care reform to influencing how the new law will be implemented. The new minimum medical loss provisions, which take effect on January 1, 2011, are currently a focus of the health insurance industry's lobbying efforts. The authors of an April 27, 2010, Barclays Capital health care market analysis explained the reason for this focus very clearly:

> As we have spoken about on numerous occasions, **we believe that the definition of Medical Loss Ratios for the purpose of health care reform will be one of the most important events for the year for managed care stocks** [bold in original].[1]

While I understand that regulators need to consider the financial implications of this new law for health insurance companies, I also want to remind you (in bold type) **that the implementation of these new minimum medical loss ratios will be one of the most important events for consumers and small businesses before health insurance exchanges start operating in 2014.**

Data analyzed by the Senate Commerce Committee staff and others show that many insurers already meet the newly established medical loss ratio requirements in the group and

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[1] Joshua R. Raskin, Barclay's Capital Equity Research, *Health Care – Managed Care Industry Overview: First Sign of MLR Language Positive* (April 27, 2010).

individual markets that go into effect next January. But the data also show that in some markets and some product lines, insurers are not yet meeting the new requirements.[2] The purpose of the legislation is to provide health insurance companies falling below the requirements a new incentive to spend more of every premium dollar on patient care and the quality of that care. To the extent insurers try to invent ways to "game" the minimum medical loss ratio requirement without changing their actual business practices, they are defeating the purpose of the medical loss ratio provision.

Based on media reports and comments that have been filed with the National Association of Insurance Commissioners (NAIC), it is clear that health insurance companies are focusing on two key areas in medical loss ratio implementation: 1) they are proposing that medical loss ratio information be aggregated in a way that conceals important variations in the health insurance market, which would make it easier for insurers to meet the new minimum medical loss ratios of 80% in the individual and small group markets, and 85% in the large group market, and 2) they are eager to classify as many expenses as possible as medical or "quality-improving" expenses, which would also make it easier for them to meet the new minimum medical loss ratios and avoid paying rebates to their policyholders.

In this letter, I will address both of these issues and present health insurance company financial information that I think will assist you in the implementation process. I believe that medical loss ratio information should be aggregated at a level that will be useful for consumers shopping for individual or group coverage in a specific market area. I also believe that health insurance companies must be able to prove that a particular expense actually improves health care quality before insurers can count it as a medical expense.

1. Minimum Medical Loss Ratios Must Be Aggregated and Reported in a Way that Benefits Consumers

For-profit health insurers routinely report company-wide medical loss ratio information to their investors in their quarterly financial reports. For investors, a stable or declining company-wide medical loss ratio means that a company is controlling its costs and is more likely to be profitable in upcoming quarters. For regulators, company-wide medical loss ratios can provide useful information about a company's overall financial condition and its ability to meet its future claims obligations.

As I have pointed out on several occasions, however, medical loss ratios vary widely by insurance product type and by geographic location. As a result of this variation, company-wide

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[2] Senate Committee on Commerce, Science, and Transportation, *Staff Report on Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers* (April 15, 2010) (online at http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0fd052-4ca6-4c12-9fb1-a5e4a09c0667).

medical loss ratio information has little or no value for a consumer shopping for health insurance in the individual or group markets.[3]

For example, WellPoint told its investors that, in 2009, its overall commercial medical loss ratio was 82.6%. But as a recent Senate Commerce Committee staff report demonstrated, consumers purchasing WellPoint insurance products in the individual and small group markets experienced medical loss ratios significantly below the company-wide rate (73% and 79%, respectively).[4]

There was not only a great deal of variation between different market segments. There was also great variation within each of the market segments. A table included in the Commerce Committee staff report shows that in 2009, WellPoint customers purchasing individual or small group policies from different WellPoint subsidiaries in different states were subject to widely varying medical loss ratios.

2009 Medical Loss Ratios for Selected WellPoint Subsidiaries by Market Segment

	Individual Segment	Small Group Segment	Large Group Segment
Anthem Health Plans of NH	62.9%	87.9%	88.4%
Anthem Health Plans of VA	72.1%	66.6%	79.4%
Rocky Mountain Hospital & Medical	74.1%	79.9%	83.1%
Blue Cross Blue Shield of GA	75.5%	78.0%	86.0%
Anthem Health Plans of KY	79.4%	80.9%	82.0%
Anthem Health Plans of ME	95.2%	86.9%	89.5%

Source: 2009 NAIC Accident & Health Policy Exhibit Filings

For example, WellPoint customers purchasing individual health insurance policies in New Hampshire were subject to a very low medical loss ratio (62.9%), under which WellPoint used more than one-third of its customers' premium dollars for administration and profits. Across the border in Maine, however, consumers purchasing individual insurance from WellPoint enjoyed a much higher medical loss ratio of 95.2%.

The Commerce Committee staff report also noted similar variations in the small and large group markets. While small employers purchasing group health insurance in Virginia were subject to a medical loss ratio of 66.6%, small business owners in neighboring Kentucky

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[3] *See e.g.*, Letter from Chairman Rockefeller to Mr. H. Edward Hanway, Chairman and CEO of CIGNA (Nov. 2, 2009) (online at: http://commerce.senate.gov/public/index.cfm?p=HearingsandPressReleases&ContentRecord_id=dab514f7-1fc7-496b-a8b8-712987792fa8&ContentType_id=77eb43da-aa94-497d-a73f-5c951ff72372&Group_id=165806cd-d931-4605-aa86-7fafc5fd3536&MonthDisplay=11&YearDisplay=2009).

[4] *Supra*, note 2.

experienced a medical loss ratio (80.9%) that already exceeds the minimum loss ratio level set in the health reform law.

This information clearly shows that medical loss ratios significantly vary according to where consumers live and in which market segment they are shopping for health insurance. Aggregating medical loss ratio data at the national or multi-state levels therefore will not capture this diversity of consumer experience and would potentially deprive consumers in states such as New Hampshire or Virginia of the new law's benefits. For example, aggregating medical loss ratios at high levels would make it difficult for regulators to identify harmed consumers such as the New Hampshire individuals or Virginia small businesses, who are entitled to rebates because they are subject to medical loss ratios that fall below the minimums set in the new law.

Likewise, aggregating medical loss ratio between market segments (such as combining individual and small group medical loss ratios) fails to capture the significant differences between insurance coverage offered in the different market segments.

I therefore recommend that you require insurers to report their medical loss ratio information at a level of aggregation that would allow consumers living in a particular State or other definable geographic region to determine how insurers are spending their health care premium dollars.[5] Aggregating this information at too high a level will present consumers with misleading averages of multiple, disparate markets. For the same reason, I also recommend that insurers provide separate medical loss ratio information for the individual, small and large group market segments.

2. *Insurers Must Demonstrate that their Quality-Improving Expenditures Are Actually Benefiting Consumers*

Health insurance companies and insurance regulators have generally defined the medical loss ratio as the value of the claims an insurer pays in a certain period ("incurred claims") divided by the total value of the premiums the insurer collects during the period. The medical loss ratio provision in the new health care law makes an important change to this definition by creating a new accounting category for expenditures on "activities that improve health care quality."[6] These quality-improving expenditures will not be considered as administrative expenses, but as medical expenses that can help insurers attain the new minimum medical loss ratios of 80% in the individual and small group markets, and 85% in the large group market.

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[5] In situations where health insurance companies do not have sufficient premium volumes to develop statistically reliable medical loss ratio data for a particular State, the Secretary and/or State regulators should have the discretion to determine the level of aggregation that will provide credible loss experience for consumers.

[6] Sec. 2718(a)(2) of Title XXVII, Part A of the Public Health Service Act, as added by Sec. 10101(a) of Title X of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010).

This new expense category will give health insurance companies whose insurance products fall below the new federally required minimum medical loss ratios a strong financial incentive to reclassify their existing administrative expenses. For example, under the new law, if an insurer collected $100 million in premiums from business owners for small group coverage, and then used $78 million of these premiums paying claims and $22 million on administrative costs and profits, it would be required to rebate $2 million to its policyholders. But if the insurer found a way to reclassify 2% of its administrative expenses as "quality improvement expenses," it would then meet the 80% minimum medical loss ratio for small groups, and would be able to keep the $2 million.

The recent Commerce Committee staff report discussed how insurers are actively reviewing their accounting practices and attempting to shift expenses from the administrative to the medical side. For example, WellPoint has already announced it has started "reclassifying" certain expenses it has traditionally classified as administrative, such as nurse hotlines, disease management, and clinical health policy. By reclassifying these expenses as quality-improvement expenses, WellPoint projected its company-wide 2010 medical loss ratio would increase by 1.7%. This "accounting reclassification" means that the company has converted more than a half a billion dollars of 2010 administrative expenses into medical expenses.[7]

The purpose of the "health care quality improvement" category in the medical loss ratio provision was not to provide health insurance companies new opportunities to cook their books. The purpose of the provision was to encourage health insurers to spend money on health care services that have been demonstrated to improve the safety, timeliness, and effectiveness of patient care. This provision and many other similar provisions included in other titles of the new health care reform law reflect President Obama's and the Congress' commitment to improving the quality of health care delivery and ultimately patient health outcomes in the United States.

I appreciate that developing a definition of "activities that improve health care quality" in a period of several months is a difficult task. I also appreciate that insurers are probably bombarding your office with lists of "quality-improving" expenditures they would like you to include in the definition you are currently developing. For these reasons, I recommend that you ground your definition of quality-improving activities in the already existing research on health care quality that the Agency for Healthcare Research and Quality has performed in consultation with non-governmental entities.

If insurers propose that certain types of expenditures, such as "disease management" or "clinical health policy" expenses, be considered quality-improving expenses under the new law, you should require them to substantiate these claims. You should require them to demonstrate that these expenses will improve health care quality, as that term is currently defined and

[7] *Supra*, note 2.

understood by a consensus of the groups that track health care quality indicators and establish health care quality standards.[8]

Once these evidence-based definitions are established, you should also require health insurance companies to consistently apply them to their balance sheets. An insurer should not be able to define an expense as medical one year when it finds itself below the minimum medical loss ratio, but then define it as administrative another year when it is above the minimum. In addition, the definitions should be modified over time as health care quality research provides new information about health care delivery best practices.

As a reference point, you should consider what health insurers are currently spending on so-called "cost containment" expenses. An accounting guidance issued by the NAIC in 2002, known as "SSAP 85," allows health insurers to subtract certain "cost containment expenses" from their claims adjustment expenses, and thereby reduce their reportable administrative expenses. SSAP 85 defines cost containment expenses as expenses that "serve to reduce the number of health care services or the cost of such services."[9] Cost containment expenses include spending on activities such as case management, fraud detection, disease management, and smoking cessation programs.

While some of the activities currently defined as cost containment expenses in SSAP 85 should not be included in the definition of "activities that improve health care quality," health insurers' actual reported cost containment expenses provide a useful benchmark. While insurers are telling you what they intend to spend on quality improvement in future years, cost containment expense reports show what portion of every premium dollar insurers are currently investing in improving the efficiency of health care delivery.

Cost containment data reported to NAIC and analyzed by the Senate Commerce Committee staff shows that insurers currently invest only a tiny portion of their premium revenues in cost containment activities. Attached to this letter is a table showing the 2009 cost containment expenses of 113 health insurers that exclusively or almost exclusively sold comprehensive health coverage in the fully insured market.[10] This table shows that these companies spent an average of 1.15% of their premium dollars on cost containment activities.

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[8] A number of commenters to the NAIC have discussed whether certain preventive health services should be defined as quality-improving expenses. These comments do not appear to have considered another new provision in Title I of the health care reform law (Sec. 2713), which requires insurers to pay the full costs of preventive services that have received high ratings from the U.S. Preventive Services Task Force. This new coverage requirement is likely to have the short-term effect of moderately increasing insurers' incurred claims expenses and therefore their medical loss ratios.

[9] NAIC, *SSAP No. 85: Claims Adjustment Expenses, Amendments to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* (June 10, 2002).

[10] Using NAIC data from the 2009 Health Annual Statement Blank (the "Orange Book"), Committee staff analyzed the cost containment expenses of the 113 health insurance companies writing over 90% of their business in comprehensive major medical, with at least $10 million in earned premiums. The analysis was limited to this group because cost containment expenses are reported on a company-wide, rather than a product-specific, basis. See the table attached to this letter for more information.

For example, the table below shows cost containment data for the 11 UnitedHealth subsidiaries that almost exclusively sold comprehensive health insurance in 2009. All but one of these companies spent less than 1% of their premium dollars on cost containment.

2009 Cost Containment Expenses by Selected UnitedHealth Subsidiaries

	Premiums Collected	Cost Containment Expenses	% Cost Containment of Premiums
Oxford Health Insurance Inc	$4,357,890,632	$9,924,656	0.2%
Optimum Choice Inc	$460,388,489	$2,885,216	0.6%
Neighborhood Health Partnership Inc	$431,571,309	$2,406,816	0.6%
UnitedHealthcare of IL Inc	$80,827,326	$445,012	0.6%
UnitedHealthcare of KY Ltd	$48,995,795	$280,137	0.6%
UnitedHealthcare of TX Inc	$32,417,101	$161,581	0.5%
United Healthcare of LA Inc	$29,185,947	$132,112	0.5%
UnitedHealthcare Ins Co of the River	$68,136,654	$471,191	0.7%
Health Net Insurance Co NY Inc	$726,780,187	$13,975,695	1.9%
Mamsi Life & Health Ins Co	$120,260,636	$641,177	0.5%
Pacificare Life Assurance Co	$184,723,354	$1,285,486	0.7%

Source: NAIC Health ("Orange Book") Filings

Because insurers have strong financial incentives to "MLR shift" as many expenses as possible from the administrative to medical side, I urge you to review with skepticism any insurance industry proposal that would allow insurers to claim that they will spend significantly higher portions of premium dollars on quality improvement in the year 2011 than they are currently spending on cost containment.

For example, Carl McDonald, an Oppenheimer health care market analyst, recently discussed a scenario in which insurers could shift as much as 500 basis points (or 5%) of premium revenues from administrative to medical.[11] Such a shift, which represents a 400% increase over current levels of cost containment spending, clearly suggests insurers are discovering accounting loopholes, rather than actually investing in improving patient care.

Conclusion

During the process of implementation of the medical loss ratio provision, I urge you to keep in mind that it was not written to help health insurers' maximize their profitability over the next three years. The purpose of this provision was to provide consumers in the individual and group markets an assurance that most of their premium dollars would be spent on health care, rather than on administrative costs and profits. I look forward to working with you on this and

[11] Carl McDonald and James Naklicki, Oppenheimer & Co. Inc. Equity Research Industry Update, *The Average Person Thinks He Isn't – Minimum Medical Loss Ratio Analysis* (Apr. 8, 2010).

other important consumer protection issues as the new health care reform law is implemented over the next few years.

Sincerely,

John D. Rockefeller IV
Chairman

cc: Kay Bailey Hutchison
Ranking Member

United States Senate
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION
WASHINGTON, DC 20510–6125
WEB SITE: http://commerce.senate.gov

May 7, 2010

Commissioner Jane L. Cline
President
National Association of
Insurance Commissioners
2301 McGee Street
Suite 800
Kansas City, MO 64108-2662

Dear Commissioner Cline:

I am writing to share my thoughts with you about the implementation of the new law establishing minimum medical loss ratios in the commercial health insurance market. I am extremely concerned that the health insurance industry is mounting an all-out effort to weaken this important consumer protection provision included in the health care reform legislation President Obama signed into law in March. I appreciate the complexities you face as you work to implement the medical loss ratio provision over the next few months, but I also urge you to keep in mind the very simple principle underlying this provision – most of consumers' health insurance premiums dollars should be going to pay for patient care, not for insurers' administrative costs and profits.

There is no doubt that the health insurance industry has now shifted its focus from opposing health care reform to influencing how the new law will be implemented. The new minimum medical loss provisions, which take effect on January 1, 2011, are currently a focus of the health insurance industry's lobbying efforts. The authors of an April 27, 2010, Barclays Capital health care market analysis explained the reason for this focus very clearly:

> As we have spoken about on numerous occasions, **we believe that the definition of Medical Loss Ratios for the purpose of health care reform will be one of the most important events for the year for managed care stocks** [bold in original].[1]

While I understand that regulators need to consider the financial implications of this new law for health insurance companies, I also want to remind you (in bold type) **that the implementation of these new minimum medical loss ratios will be one of the most important events for consumers and small businesses before health insurance exchanges start operating in 2014.**

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[1] Joshua R. Raskin, Barclay's Capital Equity Research, *Health Care – Managed Care Industry Overview: First Sign of MLR Language Positive* (April 27, 2010).

Data analyzed by the Senate Commerce Committee staff and others show that many insurers already meet the newly established medical loss ratio requirements in the group and individual markets that go into effect next January. But the data also show that in some markets and some product lines, insurers are not yet meeting the new requirements.[2] The purpose of the legislation is to provide health insurance companies falling below the requirements a new incentive to spend more of every premium dollar on patient care and the quality of that care. To the extent insurers try to invent ways to "game" the minimum medical loss ratio requirement without changing their actual business practices, they are defeating the purpose of the medical loss ratio provision.

Based on media reports and comments that have been filed with the National Association of Insurance Commissioners (NAIC), it is clear that health insurance companies are focusing on two key areas in medical loss ratio implementation: 1) they are proposing that medical loss ratio information be aggregated in a way that conceals important variations in the health insurance market, which would make it easier for insurers to meet the new minimum medical loss ratios of 80% in the individual and small group markets, and 85% in the large group market, and 2) they are eager to classify as many expenses as possible as medical or "quality-improving" expenses, which would also make it easier for them to meet the new minimum medical loss ratios and avoid paying rebates to their policyholders.

In this letter, I will address both of these issues and present health insurance company financial information that I think will assist you in the implementation process. I believe that medical loss ratio information should be aggregated at a level that will be useful for consumers shopping for individual or group coverage in a specific market area. I also believe that health insurance companies must be able to prove that a particular expense actually improves health care quality before insurers can count it as a medical expense.

1. Minimum Medical Loss Ratios Must Be Aggregated and Reported in a Way that Benefits Consumers

For-profit health insurers routinely report company-wide medical loss ratio information to their investors in their quarterly financial reports. For investors, a stable or declining company-wide medical loss ratio means that a company is controlling its costs and is more likely to be profitable in upcoming quarters. For regulators, company-wide medical loss ratios can provide useful information about a company's overall financial condition and its ability to meet its future claims obligations.

As I have pointed out on several occasions, however, medical loss ratios vary widely by insurance product type and by geographic location. As a result of this variation, company-wide

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[2] Senate Committee on Commerce, Science, and Transportation, *Staff Report on Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers* (April 15, 2010) (online at http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0fd052-4ca6-4c12-9fb1-a5e4a09c0667).

medical loss ratio information has little or no value for a consumer shopping for health insurance in the individual or group markets.[3]

For example, WellPoint told its investors that, in 2009, its overall commercial medical loss ratio was 82.6%. But as a recent Senate Commerce Committee staff report demonstrated, consumers purchasing WellPoint insurance products in the individual and small group markets experienced medical loss ratios significantly below the company-wide rate (73% and 79%, respectively).[4]

There was not only a great deal of variation between different market segments. There was also great variation within each of the market segments. A table included in the Commerce Committee staff report shows that in 2009, WellPoint customers purchasing individual or small group policies from different WellPoint subsidiaries in different states were subject to widely varying medical loss ratios.

2009 Medical Loss Ratios for Selected WellPoint Subsidiaries by Market Segment

	Individual Segment	Small Group Segment	Large Group Segment
Anthem Health Plans of NH	62.9%	87.9%	88.4%
Anthem Health Plans of VA	72.1%	66.6%	79.4%
Rocky Mountain Hospital & Medical	74.1%	79.9%	83.1%
Blue Cross Blue Shield of GA	75.5%	78.0%	86.0%
Anthem Health Plans of KY	79.4%	80.9%	82.0%
Anthem Health Plans of ME	95.2%	86.9%	89.5%

Source: 2009 NAIC Accident & Health Policy Exhibit Filings

For example, WellPoint customers purchasing individual health insurance policies in New Hampshire were subject to a very low medical loss ratio (62.9%), under which WellPoint used more than one-third of its customers' premium dollars for administration and profits. Across the border in Maine, however, consumers purchasing individual insurance from WellPoint enjoyed a much higher medical loss ratio of 95.2%.

The Commerce Committee staff report also noted similar variations in the small and large group markets. While small employers purchasing group health insurance in Virginia were subject to a medical loss ratio of 66.6%, small business owners in neighboring Kentucky

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[3] *See e.g.,* Letter from Chairman Rockefeller to Mr. H. Edward Hanway, Chairman and CEO of CIGNA (Nov. 2, 2009) (online at: http://commerce.senate.gov/public/index.cfm?p=HearingsandPressReleases&ContentRecord_id=dab514f7-1fc7-496b-a8b8-712987792fa8&ContentType_id=77eb43da-aa94-497d-a73f-5c951ff72372&Group_id=165806cd-d931-4605-aa86-7fafc5fd3536&MonthDisplay=11&YearDisplay=2009).

[4] *Supra*, note 2.

experienced a medical loss ratio (80.9%) that already exceeds the minimum loss ratio level set in the health reform law.

This information clearly shows that medical loss ratios significantly vary according to where consumers live and in which market segment they are shopping for health insurance. Aggregating medical loss ratio data at the national or multi-state levels therefore will not capture this diversity of consumer experience and would potentially deprive consumers in states such as New Hampshire or Virginia of the new law's benefits. For example, aggregating medical loss ratios at high levels would make it difficult for regulators to identify harmed consumers such as the New Hampshire individuals or Virginia small businesses, who are entitled to rebates because they are subject to medical loss ratios that fall below the minimums set in the new law.

Likewise, aggregating medical loss ratio between market segments (such as combining individual and small group medical loss ratios) fails to capture the significant differences between insurance coverage offered in the different market segments.

I therefore recommend that you require insurers to report their medical loss ratio information at a level of aggregation that would allow consumers living in a particular State or other definable geographic region to determine how insurers are spending their health care premium dollars.[5] Aggregating this information at too high a level will present consumers with misleading averages of multiple, disparate markets. For the same reason, I also recommend that insurers provide separate medical loss ratio information for the individual, small and large group market segments.

2. *Insurers Must Demonstrate that their Quality-Improving Expenditures Are Actually Benefiting Consumers*

Health insurance companies and insurance regulators have generally defined the medical loss ratio as the value of the claims an insurer pays in a certain period ("incurred claims") divided by the total value of the premiums the insurer collects during the period. The medical loss ratio provision in the new health care law makes an important change to this definition by creating a new accounting category for expenditures on "activities that improve health care quality."[6] These quality-improving expenditures will not be considered as administrative expenses, but as medical expenses that can help insurers attain the new minimum medical loss ratios of 80% in the individual and small group markets, and 85% in the large group market.

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[5] In situations where health insurance companies do not have sufficient premium volumes to develop statistically reliable medical loss ratio data for a particular State, the Secretary and/or State regulators should have the discretion to determine the level of aggregation that will provide credible loss experience for consumers.

[6] Sec. 2718(a)(2) of Title XXVII, Part A of the Public Health Service Act, as added by Sec. 10101(a) of Title X of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010).

This new expense category will give health insurance companies whose insurance products fall below the new federally required minimum medical loss ratios a strong financial incentive to reclassify their existing administrative expenses. For example, under the new law, if an insurer collected $100 million in premiums from business owners for small group coverage, and then used $78 million of these premiums paying claims and $22 million on administrative costs and profits, it would be required to rebate $2 million to its policyholders. But if the insurer found a way to reclassify 2% of its administrative expenses as "quality improvement expenses," it would then meet the 80% minimum medical loss ratio for small groups, and would be able to keep the $2 million.

The recent Commerce Committee staff report discussed how insurers are actively reviewing their accounting practices and attempting to shift expenses from the administrative to the medical side. For example, WellPoint has already announced it has started "reclassifying" certain expenses it has traditionally classified as administrative, such as nurse hotlines, disease management, and clinical health policy. By reclassifying these expenses as quality-improvement expenses, WellPoint projected its company-wide 2010 medical loss ratio would increase by 1.7%. This "accounting reclassification" means that the company has converted more than a half a billion dollars of 2010 administrative expenses into medical expenses.[7]

The purpose of the "health care quality improvement" category in the medical loss ratio provision was not to provide health insurance companies new opportunities to cook their books. The purpose of the provision was to encourage health insurers to spend money on health care services that have been demonstrated to improve the safety, timeliness, and effectiveness of patient care. This provision and many other similar provisions included in other titles of the new health care reform law reflect President Obama's and the Congress' commitment to improving the quality of health care delivery and ultimately patient health outcomes in the United States.

I appreciate that developing a definition of "activities that improve health care quality" in a period of several months is a difficult task. I also appreciate that insurers are probably bombarding your office with lists of "quality-improving" expenditures they would like you to include in the definition you are currently developing. For these reasons, I recommend that you ground your definition of quality-improving activities in the already existing research on health care quality that the Agency for Healthcare Research and Quality has performed in consultation with non-governmental entities.

If insurers propose that certain types of expenditures, such as "disease management" or "clinical health policy" expenses, be considered quality-improving expenses under the new law, you should require them to substantiate these claims. You should require them to demonstrate that these expenses will improve health care quality, as that term is currently defined and

[7] *Supra*, note 2.

understood by a consensus of the groups that track health care quality indicators and establish health care quality standards.[8]

Once these evidence-based definitions are established, you should also require health insurance companies to consistently apply them to their balance sheets. An insurer should not be able to define an expense as medical one year when it finds itself below the minimum medical loss ratio, but then define it as administrative another year when it is above the minimum. In addition, the definitions should be modified over time as health care quality research provides new information about health care delivery best practices.

As a reference point, you should consider what health insurers are currently spending on so-called "cost containment" expenses. An accounting guidance issued by the NAIC in 2002, known as "SSAP 85," allows health insurers to subtract certain "cost containment expenses" from their claims adjustment expenses, and thereby reduce their reportable administrative expenses. SSAP 85 defines cost containment expenses as expenses that "serve to reduce the number of health care services or the cost of such services."[9] Cost containment expenses include spending on activities such as case management, fraud detection, disease management, and smoking cessation programs.

While some of the activities currently defined as cost containment expenses in SSAP 85 should not be included in the definition of "activities that improve health care quality," health insurers' actual reported cost containment expenses provide a useful benchmark. While insurers are telling you what they intend to spend on quality improvement in future years, cost containment expense reports show what portion of every premium dollar insurers are currently investing in improving the efficiency of health care delivery.

Cost containment data reported to NAIC and analyzed by the Senate Commerce Committee staff shows that insurers currently invest only a tiny portion of their premium revenues in cost containment activities. Attached to this letter is a table showing the 2009 cost containment expenses of 113 health insurers that exclusively or almost exclusively sold comprehensive health coverage in the fully insured market.[10] This table shows that these companies spent an average of 1.15% of their premium dollars on cost containment activities.

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[8] A number of commenters to the NAIC have discussed whether certain preventive health services should be defined as quality-improving expenses. These comments do not appear to have considered another new provision in Title I of the health care reform law (Sec. 2713), which requires insurers to pay the full costs of preventive services that have received high ratings from the U.S. Preventive Services Task Force. This new coverage requirement is likely to have the short-term effect of moderately increasing insurers' incurred claims expenses and therefore their medical loss ratios.

[9] NAIC, *SSAP No. 85: Claims Adjustment Expenses, Amendments to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* (June 10, 2002).

[10] Using NAIC data from the 2009 Health Annual Statement Blank (the "Orange Book"), Committee staff analyzed the cost containment expenses of the 113 health insurance companies writing over 90% of their business in comprehensive major medical, with at least $10 million in earned premiums. The analysis was limited to this group because cost containment expenses are reported on a company-wide, rather than a product-specific, basis. See the table attached to this letter for more information.

For example, the table below shows cost containment data for the 11 UnitedHealth subsidiaries that almost exclusively sold comprehensive health insurance in 2009. All but one of these companies spent less than 1% of their premium dollars on cost containment.

2009 Cost Containment Expenses by Selected UnitedHealth Subsidiaries

	Premiums Collected	Cost Containment Expenses	% Cost Containment of Premiums
Oxford Health Insurance Inc	$4,357,890,632	$9,924,656	0.2%
Optimum Choice Inc	$460,388,489	$2,885,216	0.6%
Neighborhood Health Partnership Inc	$431,571,309	$2,406,816	0.6%
UnitedHealthcare of IL Inc	$80,827,326	$445,012	0.6%
UnitedHealthcare of KY Ltd	$48,995,795	$280,137	0.6%
UnitedHealthcare of TX Inc	$32,417,101	$161,581	0.5%
United Healthcare of LA Inc	$29,185,947	$132,112	0.5%
UnitedHealthcare Ins Co of the River	$68,136,654	$471,191	0.7%
Health Net Insurance Co NY Inc	$726,780,187	$13,975,695	1.9%
Mamsi Life & Health Ins Co	$120,260,636	$641,177	0.5%
Pacificare Life Assurance Co	$184,723,354	$1,285,486	0.7%

Source: NAIC Health ("Orange Book") Filings

Because insurers have strong financial incentives to "MLR shift" as many expenses as possible from the administrative to medical side, I urge you to review with skepticism any insurance industry proposal that would allow insurers to claim that they will spend significantly higher portions of premium dollars on quality improvement in the year 2011 than they are currently spending on cost containment.

For example, Carl McDonald, an Oppenheimer health care market analyst, recently discussed a scenario in which insurers could shift as much as 500 basis points (or 5%) of premium revenues from administrative to medical.[11] Such a shift, which represents a 400% increase over current levels of cost containment spending, clearly suggests insurers are discovering accounting loopholes, rather than actually investing in improving patient care.

Conclusion

During the process of implementation of the medical loss ratio provision, I urge you to keep in mind that it was not written to help health insurers' maximize their profitability over the next three years. The purpose of this provision was to provide consumers in the individual and group markets an assurance that most of their premium dollars would be spent on health care, rather than on administrative costs and profits. I look forward to working with you on this and

[11] Carl McDonald and James Naklicki, Oppenheimer & Co. Inc. Equity Research Industry Update, *The Average Person Thinks He Isn't – Minimum Medical Loss Ratio Analysis* (Apr. 8, 2010).

other important consumer protection issues as the new health care reform law is implemented over the next few years.

Sincerely,

John D. Rockefeller IV
Chairman

cc: Kay Bailey Hutchison
Ranking Member

United States Senate

COMMITTEE ON COMMERCE, SCIENCE,
AND TRANSPORTATION

WASHINGTON, DC 20510–6125

WEB SITE: http://commerce.senate.gov

July 20, 2010

Commissioner Jane L. Cline
President
National Association of
Insurance Commissioners
2301 McGee Street
Suite 800
Kansas City, MO 64108-2662

Dear Commissioner Cline:

For the past few months, the National Association of Insurance Commissioners (NAIC) has been conducting a series of meetings to develop the uniform standards and definitions necessary for the implementation of the new law establishing minimum medical loss ratios in the commercial health insurance market. My staff and I have followed these proceedings closely because the medical loss ratio requirement is one of the most important consumer protection provisions included in the health care reform legislation that President Obama signed into law in March.

While I have several concerns about medical loss ratio implementation that I will address in this letter, I want to first commend the NAIC staff and working group leaders for creating a fair, deliberative process that has allowed interested parties to share their comments and ideas about how this important new law will take effect. Although their work is not yet finalized, the working groups have developed a basic framework that both addresses the financial implications the new law may have for health insurance companies, and requires insurers to demonstrate in measurable, verifiable ways that they are spending larger portions of each premium dollar on patient care.

My biggest concern about this process remains the one I expressed in the letter I sent you on May 7, 2010 – it is clear that health insurance companies are sparing no expense to weaken this new law and the protection it promises to America's consumers.[1] Health insurance companies and their allies have been furiously lobbying the NAIC to write the medical loss ratio

[1] Letter from Chairman Rockefeller to Commissioner Jane L. Cline, President, National Association of Insurance Commissioners (May 7, 2010) (online at: http://commerce.senate.gov/public/index.cfm?p=HearingsandPressReleases&ContentRecord_id=0ac42ce4-5b3c-4bc2-8f81-d5c98cffca95&ContentType_id=77eb43da-aa94-497d-a73f-5c951ff72372&Group_id=165806cd-d931-4605-aa86-7fafc5fd3536&MonthDisplay=5&YearDisplay=2010).

definitions in a way that will allow them to continue doing business as they did before the passage of health care reform.

The resources health insurance companies are throwing into their effort to weaken the medical loss ratio law appear almost limitless. Health insurance industry lobbyists, lawyers, and consultants pore over every word of NAIC draft proposals, monitor every teleconference, and swamp the NAIC working groups with comments and proposed revisions. By my count, the health insurance companies and their allies have now submitted almost 160 comment letters – totaling more than 600 pages – to the NAIC regarding implementation of the new medical loss ratio law. In contrast, representatives for the tens of millions of consumers and businesses who could potentially benefit from this law have submitted 23 comment letters.

As I wrote you in my May 7 letter, the purpose of the medical loss ratio provision was to make sure that most of consumers' health insurance premium dollars are going to pay for patient care, not for insurers' administrative costs and profits. As data collected and analyzed by the Senate Commerce Committee staff shows, many health insurance companies already operate with medical loss ratios that meet or exceed the new federally required minimums that go into effect on January 1, 2011; but many others do not.[2] These companies will have to decide whether they will continue with their current business model and pay rebates to their customers, or change their business practices to increase the portion of each premium dollar they spend on patient care.

While I recognize that implementing these new minimum loss ratios will create short-term challenges for some of the insurance carriers that NAIC members regulate, I respectfully request that you and your fellow Insurance Commissioners keep the consumers of your states foremost in your minds. As you continue to be deluged by letters, comments, and analyses from the insurance industry, I ask you to recall that the purpose of the new medical loss ratio law is to give the citizens and businesses of your states the health care coverage they pay for and deserve.

In this letter I will discuss the strategies health insurance companies have been employing to game the new minimum medical loss ratio law. The new law was intended to hold health insurance companies accountable for the way they use consumers' premium dollars. Health insurers' lobbying efforts have been focused on convincing the NAIC to adopt definitions that would allow them to escape this accountability and continue business as usual. With the exception of two issues I will discuss – fraud detection expenses and public disclosure – NAIC officials have so far wisely rejected these efforts and I urge you to continue doing so as the implementation process moves forward.

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[2] Senate Committee on Commerce, Science and Transportation, Office of Oversight and Investigations Majority Staff Report, *Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers* (Apr. 15, 2010) (online at: http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0fd052-4ca6-4c12-9fb1-a5e4a09c0667).

The Health Insurance Industry Has Been Aggressively Lobbying the NAIC to Weaken the Definition of "Quality Improvement Expenses"

The Patient Protection and Affordable Care Act (PPACA) established for the first time federally required minimum medical loss ratios in the commercial health market. The new law sets the minimum medical loss ratios at 80% in the individual and small group markets, and 85% in the large group market. Insurers that fall below these levels are required to pay rebates to their policyholders.[3] While the standard method of calculating medical loss ratios in the insurance industry involves simply dividing an insurer's incurred claims by the value of premium dollars collected, the new law creates a new accounting category for expenditures on "activities that improve health care quality."[4] The new law allows health insurance companies to add their quality improvement expenditures to their incurred claims to calculate their medical loss ratios.

For example, if an insurer collects $100 million in premiums from business owners for small group coverage, and then uses $78 million of these premiums to pay claims and $22 million to pay administrative costs and profits (thereby operating at a 78% medical loss ratio), it would have to rebate $2 million to its policyholders. Under the new law, however, the insurer can meet the new law's 80% minimum loss ratio requirement, and thereby avoid paying rebates, if it can demonstrate that it spent $2 million of the premium dollars (2%) on "quality improvement expenses."

As I wrote to you in my May 7 letter, the purpose of this new category is to encourage health insurance companies to spend money on health care services that have been demonstrated to improve the safety, timeliness, and effectiveness of the care patients receive. In that letter, I urged you to carefully consider how you define "quality improvement expenses" during the implementation of this law, since health insurance companies have a strong financial incentive to reclassify as many administrative and business functions as possible as "quality-improving" expenditures in order to avoid paying rebates.

Over the past few months, the health insurance industry has behaved true to form. It has deluged the NAIC PPACA Actuarial Subgroup of the Accident and Health Working Group and the Health Reform Solvency Impact Subgroup of the Financial Condition (E) Committee with hundreds of pages of comments urging them to adopt a definition of quality improvement activities that would sweep in a whole host of operational and administrative expenses that have little or nothing to do with improving the quality of patient care. The effect of such a vague definition of quality improvement would be to allow insurers to meet the requirements of the new law without actually providing more or better care to their customers.

The Solvency Impact Subgroup wisely rejected the insurance industry's position that the term "Quality Improvement (QI) Expenses" should mean whatever the health insurance

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[3] Sec. 2718 of Title XXVII, Part A of the Public Health Service Act, as added by Sec. 10101(a) of Title X of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010).

[4] *Id.*, Sec. 2718(a)(2)

companies want it to mean. Instead, the Subgroup insisted that quality improvement expenses should actually "advance the delivery of patient-centered care," and should be "capable of being objectively measured."[5]

In hundreds of pages of comment letters, and in more than 20 hours of teleconferences, health insurance companies and their allies have lobbied the Solvency Impact Subgroup to weaken the principle that the "quality improvement" classification should be limited to expenses that have been proven – in an objective, verifiable way – to improve patient care. Instead, the industry would like the NAIC to believe that almost any expenditure health insurers make in the normal course of their business is intended to improve the quality of the care their policyholders receive. Some of the expenses insurers have claimed as quality improvements are the following:

- The money health insurance companies spend processing and paying claims;
- The money health insurance companies spend creating and maintaining their provider networks;
- The money health insurers spend updating their information technology systems to code medical conditions and process claims payments;
- The money health insurance companies spend to protect against fraud and other threats to the integrity of their payment systems; and
- The money health insurance companies use to conduct "utilization review" of paid claims to detect payments the companies deem inappropriate and retroactively deny them.

While these expenditures may promote cost containment or overall business efficiency and profitability, they do not directly improve the quality of care their patients receive and should not be shoehorned into the definition of quality improvement expenses. Accepting the industry's argument that almost any operational expenditure improves the quality of patients' care defeats the intent of the legislation to reward companies for focusing on services that have been demonstrated through evidence-based research to improve patient outcomes.[6]

For example, a number of insurers argued that the costs of running customer call centers staffed by health care professionals should be classified as "quality improvement expenses." But they offered very little evidence that the purpose of these call services is to improve the delivery

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[5] *See e.g.,* NAIC Health Reform Solvency Impact (E) Subgroup, *Draft Proposed Supplemental Health Care Exhibit to 2010 Annual Statement and Instructions for Life, Health, Property & Fraternal Insurers* (adopted by Subgroup on July 1, 2010) (adopted by NAIC Financial (E) Committee on July 7, 2010) (hereinafter "Currently Proposed MLR Exhibit") (online at: http://naic.org/documents/committees_e_hrsi_final_blanks_prop.pdf).

[6] According to a report released last week by two leading industry analysts, health insurance companies still have large potential savings in the administrative area: "Said differently, managed care plans have never demonstrated the ability to materially cut administrative spending. There's no question that these plans are very inefficient, and that there is the potential for big cost cuts, but we wouldn't forget that at its core, most plans in the industry are reliant on very old systems that limit how much productivity can be improved." Carl McDonald and James Naklicki, Citi Investment & Research Analysis, *Heads I Win, Tails You Lose: Initiating Coverage of the Diversified Managed Care Industry* (July 12, 2010).

of patient care rather than perform general administrative services, such as answering questions about coverage or billing. After lengthy discussions, the Solvency Impact Subgroup decided that these call center expenses should be considered administrative unless the insurer can demonstrate that the call centers provided actual quality improvement services that:

- Improve Health Outcomes;
- Prevent Hospital Readmissions;
- Improve Patient Safety and Reduce Medical Errors; or
- Promote Wellness and Health.[7]

For months, insurance industry representatives have been bitterly complaining to the NAIC that this "objective, verifiable results requirement" is overly narrow and restrictive. In a June 16, 2010 letter, for example, the Blue Cross Blue Shield Association (BCBSA) complained to the NAIC that requiring measurable and verifiable evidence that an expense improves the quality of care presented "unnecessary barriers and unreasonably high standards" for insurers.[8] BCBSA instead proposed a standard under which insurers could count as a quality improvement any expense that health insurance companies believed would "increase the likelihood" of better health outcomes.[9]

Figure 1 - UnitedHealthcare's June 28, 2010, Suggested Edit to the Definition of Quality Improvement Expenses

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) Expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for health services that are designed to improve health care quality and increase the likelihood of desired health outcomes ~~in ways that are capable of being objectively measured and which produce verifiable results and achievements~~.

Under standards such as this one, health insurance companies could claim that virtually any expenditure improves the quality of care their patients receive, and then have no obligation to prove their claims. In a June 28, 2010, letter to the NAIC, UnitedHealthcare made this point by suggesting an edit that literally crossed out the passage in the Subgroup's definition of quality

[7] These quality improvement goals mirror the goals listed in Section 2717 of PPACA ("Ensuring Quality of Care"), *supra*, note 3.

[8] Letter from Joan Gardner, Executive Director, State Services, Blue Cross Blue Shield Association to NAIC Health Reform Solvency Impact (E) Subgroup (June 16, 2010) (online at: http://www.naic.org/documents/committees_e_hrsi_100617_comment_bcbsa.pdf).

[9] *Id.*

improvement expenses that requires measurable, verifiable results (see Figure 1).[10] According to United and other health insurers, having to provide evidence to their customers and regulators that their expenditures are actually effective is an unreasonable burden.

Fraud Detection Expenses Should Not Be Considered Medical Expenses for the Purpose of Calculating the Medical Loss Ratio

In spite of health insurance companies' intense lobbying over the past few months, the Solvency Impact Subgroup charged with developing the new medical loss ratio reporting form (the "Blank") has appropriately rejected the industry's requests that they be allowed to classify a broad array of cost containment and administrative expenses as quality improvement expenses.[11] The instructions accompanying the proposed medical loss ratio reporting form list a number of expense items that are "broadly excluded" from the definition of quality improvement expenses. These are expenses that do not significantly contribute to improving health outcomes, preventing hospital re-admissions, reducing medical errors, or promoting health and wellness.

The one exception to this positive result is the Solvency Impact Subgroup's decision to allow health insurers to count some or all of their "fraud and abuse detection" expenditures as medical expenses for the purpose of calculating medical loss ratios.[12] While fraud detection is an important activity in both private and government-funded health care systems, its primary purpose is not to improve the quality of patient care. Health insurance companies should not be allowed to count their fraud expenditures towards satisfying the law's medical loss ratio requirements.

Identifying fraud and recovering fraudulently paid claims are undoubtedly valuable activities. Successful fraud prevention contains the overall cost of health care, and it identifies and removes bad actors from the health care system. But most of the fraudulent activity in our health care system involves billing and claim payments, rather than the medical treatment delivered to patients. According to the Federal Bureau of Investigation (FBI), the most prevalent forms of health care fraud involve providers who bill for health care never rendered, or who overcharge payers for medically necessary health care services.[13] While these types of fraudulent activities are a huge problem in our health care system, and cost Americans billions of

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[10] Letter from Thomas J. McGuire, Senior Deputy General Counsel, UnitedHealthcare to NAIC Health Reform Solvency Impact (E) Subgroup (June 28, 2010) (online at: http://www.naic.org/documents/committees_e_hrsi_100629_comments_united_healthcare.pdf).

[11] In my May 7 letter, I discussed the issue of cost containment expenses in more detail and presented data on how much money health insurance carriers spend on such expenses. *Supra*, note 1.

[12] Currently Proposed MLR Exhibit, *supra*, note 5, at 10. While the current Blank does not explicitly classify anti-fraud expenditures as quality improvement expenses, it allows carriers to "recognize" the expenses in the numerator of the medical loss ratio calculation, up to the amount of claims recovered as a result of the expenditure or the amount of anti-fraud expenses reported, whichever is less.

[13] Federal Bureau of Investigation, *Financial Crimes Report to the Public, Fiscal Year 2009* (online at http://www.fbi.gov/publications/financial/fcs_report2009/financial_crime_2009.htm).

dollars every year, they do not directly impact the quality of patient care, which is the focus of the new minimum medical loss ratio provision.

An additional problem created by this exception is that neither the reporting form nor its instructions provide a detailed definition of "fraud and abuse detection" expenses, which gives health insurance companies wide latitude to reclassify administrative expenses as fraud detection. For example, an insurance company could argue that the quintessentially administrative activity of reviewing consumer insurance applications for accuracy and completeness is actually an anti-fraud activity.

A recent example of a blatantly disingenuous health insurance industry "fraud and abuse detection" program was the practice of post-underwriting rescissions in the individual health insurance market. As was well documented by a series of reports and hearings by the House Energy & Commerce Committee, a number of health insurance companies denied claims and canceled policies of consumers who became sick and required expensive health care services.[14] While the companies' stated rationale for these post-underwriting reviews was to detect cases of fraud, it was clear from the evidence gathered in the Energy & Commerce investigation that the true purpose of these reviews was to avoid paying legitimate claims.[15] It would be truly ironic if a health insurance company could claim that money it spent to deny paying legitimate claims to its policyholders for needed medical care could be considered a "quality improvement expense."

The NAIC Should Not Protect Information about Health Insurance Companies' Quality Improvement Expenses from Public Disclosure

I strongly support the NAIC's Solvency Impact Subgroup's position that health insurance companies should have to produce objective, verifiable evidence that their expenditures are actually improving the quality of patient care before they can claim them as quality improvement expenses. I am disappointed, however, that the current NAIC draft form would prohibit the public release of the evidence insurers submit to substantiate their quality improvement expenses.

Under the reporting form instructions as they are currently drafted, health insurance companies would submit detailed descriptions of their quality expenses, including their expense

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[14] *See, e.g.,* U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 16, 2009) (online at: http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1671:energy-and-commerce-subcommittee-hearing-on-terminations-of-individual-health-policies-by-insurance-companies-&catid=133:subcommittee-on-oversight-and-investigations&Itemid=73).

[15] *Id.*, Testimony of Brian A. Sassi, President and CEO, Consumer Business, WellPoint, Inc. ("Rescission is one tool employed by WellPoint and other health insurers to protect the vast majority of policyholders who provide accurate and complete information from subsidizing the costs related to fraud and material representation. The bottom line is that rescission is about combating costs driven by fraud and misrepresentation.")

allocation methods, in a "separate, regulator only supplemental filing."[16] In other words, the NAIC would block consumers and independent researchers from obtaining important information about how health insurance companies are spending billions of consumers' premium dollars on purportedly quality-improving expenses.

While I acknowledge that health insurance companies have valid concerns about protecting their proprietary business information, I have to remind you that the health insurance industry has a track record of withholding valuable consumer information based on inappropriate business secrecy claims. When the Senate Commerce Committee began collecting information on health insurance industry medical loss ratios last year, many health insurance companies informed me that even basic information about how many premium dollars they spend on patient care versus administrative costs was "proprietary" and "business sensitive."[17]

In spite of the fact that the health insurance industry celebrates "transparency" and "consumer-driven" health care, I have found that the health insurance companies resist disclosing even basic financial information to consumers, providers, and outside experts. In an investigation the Commerce Committee conducted last year, for example, we found that health insurance companies failed to disclose to consumers and providers crucial information about how the companies calculated their out-of-network claims payments.[18] Consumers can take more responsibility for their health care decisions only if health insurance companies disclose the information consumers need to make informed, educated choices.

To address the health industry's refusal to share important policy and coverage information with American consumers, Congress included a number of new disclosure requirements in the new health reform legislation, including the medical loss ratio public reporting requirement in Section 2718 of the bill. The first paragraph of this section requires insurers to submit a "Clear Accounting of Costs" to the Secretary of Health and Human Services (HHS), and requires the HHS Secretary to make these costs readily available to the public. The preceding section of the law (Section 2717) establishes a separate quality of care reporting requirement for insurers. Protecting important consumer information behind a "regulator only" firewall is clearly not consistent with the spirit of laws such as these.

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[16] Currently Proposed MLR Exhibit, *supra*, note 5, at 18 and 23.

[17] *See* Letter from Chairman Rockefeller to Mr. H. Edward Hanway, Chairman and CEO of CIGNA (Nov. 2, 2009) (online at: http://commerce.senate.gov/public/index.cfm?p=HearingsandPressReleases&ContentRecord_id=dab514f7-1fc7-496b-a8b8-712987792fa8&ContentType_id=77eb43da-aa94-497d-a73f-5c951ff72372&Group_id=165806cd-d931-4605-aa86-7fafc5fd3536&MonthDisplay=11&YearDisplay=2009).

[18] *See, e.g.,* Senate Committee on Commerce, Science, and Transportation, Office of Oversight and Investigations Majority Staff Report, *Underpayments to Consumers by the Health Insurance Industry* (June 24, 2009) (online at: http://commerce.senate.gov/public/?a=Files.Serve&File_id=d930ee6d-24bf-4436-92ea-8a1d1bf1a5be).

Conclusion

I appreciate the hard work you and other NAIC members have been doing to implement the minimum medical loss ratio provision and many other parts of the new health care reform law. The health care reform law will continue to present us with both opportunities and challenges as the various provisions of the law phase in over the next few years. During this sometimes difficult process, I urge you to remember that our ultimate goal is decent, affordable health care for all American families. I look forward to continue working with you towards this goal.

Sincerely,

John D. Rockefeller IV
Chairman

cc: Kay Bailey Hutchison
Ranking Member

The Honorable Kathleen Sebelius
Secretary of Health and Human Services

United States Senate
COMMITTEE ON COMMERCE, SCIENCE
AND TRANSPORTATION
WASHINGTON, DC 20510-6125
WEB SITE: http://commerce.senate.gov

October 14, 2010

Commissioner Jane L. Cline
President
West Virginia Offices of the Insurance Commissioner
Post Office Box 50540
Charleston, West Virginia 25305

Dear Commissioner:

As you and other members of the NAIC's Health and Managed Care (B) Committee prepare to vote out the guidelines for the implementation of the new minimum medical loss ratio law, I am writing to express my strong support for the approach to calculating medical loss ratio data that your Actuarial Subgroup has developed over the past several months through an open and deliberative process. Requiring insurers to report their medical loss data and pay rebates at the state level means that the consumers of your state will receive the benefits Congress intended when it passed this law — better value for their health care premium dollars.

For the past few months, your Committee and its subgroups have held more than 70 hours of open teleconferences to develop the definitions and methodologies necessary to implement the Affordable Care Act's (ACA) minimum medical loss ratio requirements. Under this new law, insurers must pay rebates if they spend less than 80% of their customers' premium dollars on medical care in the individual and small group markets; in the large group market, the minimum ratio is 85%. There is a general consensus that the draft definitions and methodologies your Committee exposed on October 5, 2010, strike the proper balance between the concerns expressed by health insurance companies and the new law's goal of delivering more medical care for each consumer premium dollar. Underlying this consensus is a clear recognition that NAIC and other insurance commissioner staff members conducted these meetings in a scrupulously fair manner that allowed all interested parties to raise and discuss their concerns.

Unfortunately, as I predicted in a letter I wrote to the NAIC on May 7, 2010, the large for-profit insurers – Aetna, CIGNA, Humana, UnitedHealth, and Wellpoint – are now mounting a furious eleventh-hour lobbying effort to override the consensus the B Committee's Actuarial

Subgroup painstakingly developed through countless hours of discussion and deliberation. Although these companies actively participated in the B Committee's months-long process, they are pressing you to ignore the B Committee's work product and instead adopt changes that were considered and rejected months ago.

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. As I discussed in my May 7 letter, allowing 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. Under the health insurance companies' proposal, consumers in a state with medical loss ratios falling below the law's new requirements would have no right to rebates, as long as the health insurance company's overall national average remained above the law's new requirements.

As regulators charged with implementing the ACA's medical loss ratio provision, you have proceeded in good faith and through a transparent process to make sure that consumers and businesses get a better value for their health insurance premium dollars. Medical loss ratios aggregated at the state and entity level reflect the actual market conditions consumers and businesses in your state face when they are trying to buy health insurance. Insurance companies should not have the carte blanche to avoid paying rebates to consumers in states where they sell low-value plans.

I urge you to maintain this important pro-consumer perspective and to reject the health insurance industry's last-minute attempt to erode the good work of your Committee.

Sincerely,

John D. Rockefeller IV
Chairman

United States Senate

COMMITTEE ON COMMERCE, SCIENCE,
AND TRANSPORTATION

WASHINGTON, DC 20510-6125

WEB SITE: http://commerce.senate.gov
PHONE: (202) 224-5115

March 15, 2011

Commissioner Susan E. Voss
President
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Dear Commissioner Voss:

The National Association of Insurance Commissioners (NAIC) Executive Committee has apparently re-opened the issue of whether agent and broker commissions should be exempted from the minimum medical loss ratio requirements created by the 2010 federal health care reform law. Although this issue was thoroughly discussed and then resolved during the extensive deliberative process that the NAIC conducted last year, I am writing to provide you with additional information about why Congress included agent and broker commissions in the medical loss ratio calculation, and how this provision helps American consumers and businesses get a better value for their health insurance premium dollars.

While I disagree with the NAIC's decision to re-visit this issue, I wholeheartedly share your appreciation for the valuable work that licensed health insurance agents and brokers do on behalf of their customers. I recognize the valuable role agents and brokers play in helping American consumers and businesses purchase health insurance. I look forward to working with state and federal regulators to make sure that agents and brokers continue to play this role in today's transitional health insurance market and in the health insurance exchanges that will begin operating in 2014. But I cannot support a proposal that would allow agents, brokers, and health insurance companies to retain the estimated $1 billion in benefits that American consumers will receive next year thanks to the health care reform law.

The purpose of the law's minimum medical loss ratio requirements was to encourage health insurance companies to deliver health care services to their customers in a more efficient and cost-effective way. While many insurers were already delivering health care at levels that met or exceeded the law's minimum medical loss ratio targets of 80% and 85%, many others were not. I am encouraged by the fact that the new law is prompting many health insurance companies that were not meeting these targets to conduct a long-overdue review of their business operations and make changes that will result in higher-quality care and lower premiums for their customers.

In the course of their cost and service reviews, some health insurance companies have announced reductions in the sales commissions they will pay agents and brokers who sell their products. Other companies have announced that they are changing their agent and broker fees from a percentage basis to a per-member-per-month basis. For many health insurance companies, commission payments are one of their largest non-claim, administrative expenses, and have been rapidly rising in recent years because they are linked to health care inflation.

As you know, the National Association of Health Underwriters (NAHU) and other agent and broker representatives raised concerns about these commission changes on many occasions during last year's NAIC deliberations over how the minimum medical loss ratios would be calculated. In order to protect their commissions from further reductions, agent and broker groups proposed removing their fees from the medical loss ratio formula. The final medical loss ratio regulations released by the NAIC on October 21, 2010, however, included commission costs in the formula. As I will discuss in greater detail later in this letter, the NAIC's final regulations were consistent with Congress's intent that the agent and broker payments be included in the calculation of health insurance companies' "earned premiums."

In several previous letters I have written to NAIC leaders, I praised the NAIC for the skill and fairness with which it managed the development of minimum medical loss ratio definitions last year. In the face of intense lobbying by a variety of business and consumer groups, the NAIC commissioners and staff developed regulations that balanced the business needs of the health insurance industry with the law's goal of increasing the value of the money American consumers spend on health care. No interest group got everything it wanted, but the process was fair and it established a reasonable regulatory framework for all of the health insurance industry's many players.

I am therefore surprised that the NAIC has decided to re-open the debate over minimum medical loss ratios on behalf of just one of the many interest groups that was not completely satisfied with the NAIC's final minimum medical loss regulations. On March 3, 2010, Florida Insurance Commissioner Kevin McCarty's Professional Health Insurance Advisors Task Force released draft federal legislation that would exclude agent and broker commissions from the medical loss ratio calculation. This is the same proposal that NAHU and other agent and broker groups unsuccessfully offered during the NAIC's 2010 deliberations. It is probably not a coincidence that two weeks before he released this draft, Commissioner McCarty received NAHU's "Spirit of Independence" award, which praised him for, among other things, his efforts to "exclude agent and broker commissions from the MLR [medical loss ratio] calculation." [1]

The proposal offered by NAHU and Commissioner McCarty would protect the income of health insurance agents and brokers, but at the expense of millions of American consumers and businesses. Indeed, their proposal would undermine one of the key consumer-protection provisions of the health care reform law. As I discuss in more detail below, the NAHU-McCarty

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[1] National Association of Health Underwriters Press Release, *NAHU Awards Insurance Commissioner a Top Honor* (online at http://www.nahu.org/media/releases/2011/CCSpiritAward2011.pdf) (Feb. 17, 2010).

proposal is not consistent with congressional intent, and it flouts the NAIC's own accounting standards. It would also allow the health insurance industry to retain a large portion of the billion or more dollars in premium cuts and rebates that the current law requires it to share with American consumers in early 2012. I urge you and other NAIC members to take a closer look at how this proposal will affect the consumers of your states before you endorse it.

1. *When Writing the Medical Loss Ratio Legislation, Congress Relied on the NAIC's Definition of "Premiums Earned"*

The purpose of the minimum medical loss ratio provision in the health care reform law was to encourage health insurance companies to spend a larger portion of their customers' premium dollars on medical care. In the individual and small group markets, the law requires health insurance companies to spend 80% of their customers' premium dollars on providing health care services or improving the quality of those services. In the large group health insurance market, the minimum medical loss ratio target is 85%. Insurers that do not meet these levels are required to pay pro rata rebates to their customers; the greater the amount the health insurance company falls below the 80% and 85% targets, the larger rebate it pays its policyholders.

This provision was developed and drafted after extensive analysis of the medical loss ratio data that health insurance companies report to state regulators and the NAIC. Both Congress and the Congressional Budget Office relied on this data to determine minimum medical loss ratio levels that fell in the middle range of the individual and group medical markets. While many companies were selling health insurance coverage that met or exceeded the 80% and 85% medical loss ratio levels, a "significant minority" of insurers were operating below these levels.[2] The purpose of the legislation was to give this latter group a new financial incentive to provide their customers a better value for their premium dollars. Because we relied on the NAIC's data when we developed the 80% and 85% minimum medical loss ratio levels in the health care reform law, we were also relying on the NAIC's formula for calculating the medical loss ratio. That formula is the following:

$$\text{Medical Loss Ratio} = \frac{\text{Incurred Claims + Change in Contract Reserves}}{\text{Premiums Earned.}}^{[3]}$$

In the NAIC formula, "Premiums Earned" includes any and all payments a health insurance company makes to an agent or broker involved in the sale of the policy. The portion of the consumer's premium dollar that is paid out as a commission is included in the denominator, but not in the numerator, meaning it is counted as a non-claim, "administrative"

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[2] Congressional Budget Office, *Budgetary Treatment of Proposals to Regulate Medical Loss Ratios* (Dec. 13, 2009); Senate Committee on Commerce, Science, and Transportation, Office of Oversight and Investigations, *Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers*, 111th Cong. (Apr. 15, 2010).

[3] *See e.g.*, National Association of Insurance Commissioners, *Annual Statement Blank for the Year 2008 – Health*, at Supp. 8. (Accident and Health Policy Experience Exhibit).

expense. In other words, the NAIC treats the commission as part of the health insurance company's cost of delivering health care services to its customers. The higher the payment to an agent or broker, the lower the medical loss ratio is under the NAIC formula. In the instructions it provides to regulated health insurance companies, the NAIC defines "written premium" as:

> ...the contractually determined amount charged by the reporting entity [the health insurance company] to the policyholder for the effective period of the contract based on the expectation of risk, policy benefits, and expenses associated with the coverage provided by the terms of the contract.[4]

The NAIC treats commission payments as an expense "associated with the coverage provided by the terms of the contract," which is consistent with the financial reporting practices of the health insurance industry. A key item in any health insurance company's financial filing is its report on "Selling, General, and Administrative" (SG&A) expenses. The "Selling" part of the SG&A expenses includes the company's marketing and distribution costs, whether those costs are incurred through direct advertising or paying third-party agents and brokers for selling their products. Health insurance industry analysts keep a careful eye on companies' SG&A expenses; lower SG&A expenses indicate that a company is being run efficiently and delivering a better value to both its customer and its shareholders.

Until a few months ago, the health insurance agents and brokers' main trade association, the National Association of Health Underwriters (NAHU), also considered commissions to be a part of a consumer's premium payment. In a glossary that is still available on www.nahu.org, NAHU defines "commission" as:

> part of an insurance premium, which is paid by an insurance company to an agent or broker for procuring and servicing the business for the insurance company/client. Depending upon the size of the group being insured, these commissions average between three and ten percent of the premium paid by the employer.[5]

But after the passage of health care reform in March 2010, NAHU abruptly changed its position on the accounting of agent and broker commissions. Instead of considering commissions as one of the administrative costs that health insurance companies "load" on to consumer premiums, NAHU began arguing that agent and broker commissions are unrelated to insurers' administrative costs. According to this novel theory, the agent and broker commission was a direct payment from the consumer to the agent that merely "passed through" the health insurance company for administrative convenience.[6] Besides being inconsistent with the NAIC and health care industry's accounting standards, my staff has not been able to locate even one

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[4] Official NAIC Annual Statement Instructions, Health, for the 2008 Reporting Year (Aug. 2008), at 63.

[5] National Association of Health Underwriters Website, Consumer Information, Glossary of Terms (online at http://www.nahu.org/consumer/glossary.cfm) (accessed on Mar. 11, 2011).

[6] Letter from Janet Trautwein, Executive Vice President and CEO, National Association of Health Underwriters to National Association of Insurance Commissioners (May 17, 2010).

state minimum medical loss ratio law that treats commissions in the manner NAHU and Commissioner McCarty are proposing.

It is no mystery why NAHU made this 180-degree policy change. If they are counted as sales-related administrative costs, agent and broker commissions are subject to the SG&A belt-tightening many health insurance companies have been going through in order to meet the health reform law's minimum medical loss ratio targets and deliver a better value to their customers. Because in many cases, commissions represent one of insurers' largest SG&A costs, they have been one of the companies' obvious cost-cutting targets. In April 2010, barely a month after the passage of the health care reform law, Humana's CEO told investors that, due to the new minimum medical loss ratio requirements, "there is going to be pressure on commissions; there is just no question about it."[7]

Health insurance companies have repeated this message over and over since the passage of the health care reform law, both in their communications with investors and with agents and brokers who sell their products. In a recent investor teleconference, Aetna CEO Mark Bertolini commented:

> While brokers have been, and will remain, key partners with Aetna, we have been consistent in our conclusion that the minimum MLR [medical loss ratio] requirements in health care reform law would and have catalyzed changes in broker compensation arrangements. Generally, our framework for creating transparency and our commission structure has been, first, where possible, to ensure transparency to allow larger customers to continue to negotiate fees directly with their broker or consultant; second, to restructure commissions so they are decoupled from annual health care inflation, improving affordability and driving future operating efficiencies; and third, to reduce the level of commissions to improve the affordability of our offerings.[8]

From the health insurance companies' perspective, the mathematical necessity of reducing high commission payments is obvious. The company cannot limit its non-claims expenditures to 20% (in order to comply with the law and avoid paying rebates) if it is paying 10% or more of every premium dollar to agents and brokers. Alan Katz, a former NAHU officer and an influential policy voice in the agent and broker community, recently walked his blog readers through the insurers' calculations:

> As noted previously here, reducing broker commissions is compelled by the math of the MLR [medical loss ratio] requirements. The PPACA requires carriers to spend 20 percent of the premiums they receive from individual and small group clients on medical care and health improvement efforts... A carrier [health insurance company] with a mature block of business need 7-to-9 percent to keep the lights on, the staff paid, and other administrative costs. They look for a margin of roughly 4-to-5 percent (they may not always get it, but that's what they'll likely aim for). The remaining 6-to-9 percent

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[7] *Health Overhaul Hits Sales Commissions*, Wall Street Journal (May 18, 2010).

[8] Aetna Inc., 4th Quarter 2010 Earnings Conference Call (Feb. 4, 2010).

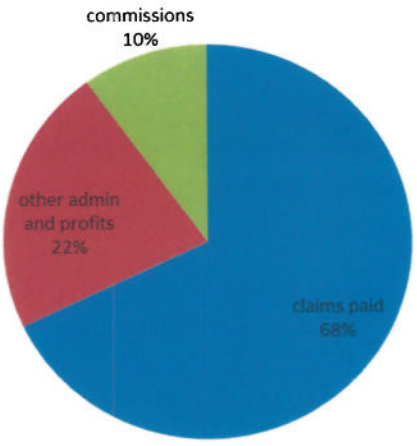
> can be devoted to broker commissions. In some states this is roughly what insurers are paying their producers [agents and brokers] now; in other states, especially in the individual market, this represents a substantial pay cut.[9]

NAHU and the agents and brokers it represents are understandably unhappy that the new minimum medical loss ratio requirements are exerting downward pressure on their commission income. Their response has been to lobby legislators and insurance regulators for a special exemption that would remove their commission payments from the calculation of "earned premiums," the number that serves as the denominator of the medical loss ratio formula. Commissioner McCarty and other insurance commissioners proposed this change at the October 2010 NAIC meeting in Orlando, and he proposed it once again on March 3, 2010, through the NAIC Executive Committee's Professional Health Insurance Advisors Task Force. While this proposal might help some agents and brokers protect their income from slowed growth or reductions, it deprives millions of consumers and businesses from the long-overdue premium relief they are entitled to receive under the current law.

2. *Excluding Agent and Broker Commissions from Medical Loss Ratio Calculations Means Fewer Rebates and Higher Premiums for American Consumers and Businesses*

While NAHU has presented its proposal to the NAIC and others as a simple "administrative" fix, it would actually make an unprecedented change to the method that the NAIC and the health insurance industry use to calculate medical loss ratios. In addition, the proposal would make it more difficult for consumers and small businesses to understand how their premium dollars are being used, and it would eliminate a large portion of the more than a billion dollars in rebates and/or premium reductions consumers and small businesses could receive under the health care reform law in early 2012.

FIGURE I - How Mega Health Insurance Company Spent Each Premium Dollar in Maine - 2009



To illustrate this point, Figure I shows how the Mega Life & Health Insurance Company spent the approximately $25 million in policyholder premium dollars the company earned in the Maine individual health insurance market in 2009.[10] Although detailed data on agent and broker commissions in the individual and small group markets are not widely available, Mega was forced to disclose this information

[9] *Tracking Commission Changes*, The Alan Katz Health Care Reform Blog, (Nov. 19. 2010) (online at http://alankatz.wordpress.com/2010/11/19/tracking-commission-changes/).

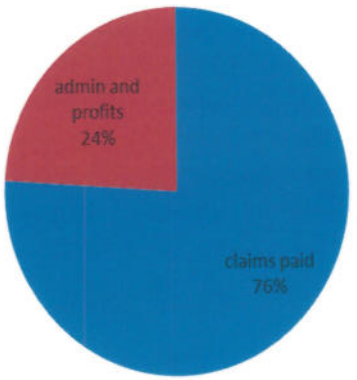
[10] Maine Request for an Adjustment of the Medical Loss Ratio Standard (online at http://cciio.cms.gov/programs/marketreforms/mlr/mlr_maine.html) (accessed on Mar. 14, 2010).

during the State of Maine's request for an individual market minimum medical loss ratio waiver from the Department of Health and Human Services (HHS). The company used 68 cents out of every dollar to pay its customers' medical claims, and it used the remaining 32 cents for administrative costs and profit. As the figure shows, about a third of the company's non-claims expenditures (10%) went to paying sales commissions to agents and brokers. If Mega had been subject to the health care reform law's minimum medical loss ratio requirements in 2009, it would have owed its almost 14,000 Maine customers a $3 million rebate (about $218 per customer), because its claims payments fell 12 percentage points below the law's target of 80%.

Figure II, on the other hand, shows what would have happened if the commission payments were eliminated from the calculation of "earned premium," as proposed by NAHU and Commissioner McCarty. With the $2.5 million of commission payments eliminated from the denominator, Mega appears to have spent 76% of every premium dollar on their patients' medical claims, which is only 4 percentage points below the health care reform law's 80% minimum medical loss ratio target. Under the proposed calculation method, the rebate consumers would receive goes down from $3 million to $1 million (or roughly $72 per customer).[11] Removing commissions from the law's definition of earned premiums allows health insurance companies and agents and brokers to pocket millions of dollars that would have been returned to consumers in the form of rebates, as Congress intended this law to do.

In addition, a calculation of the medical loss ratio that excludes commissions paid to agents and brokers gives consumers a misleading impression of how much of each premium dollar is going towards their medical care. As Figure II shows, eliminating the commission payment could lead consumers to believe that more than three-quarters of their premium dollars are going to medical care. In reality, the actual value they are getting for their premium dollars (68%) is significantly lower.

Figure II - Mega Health Insurance Company Use of Maine Premium Dollars, Excluding Agent and Broker Commissions - 2009



While this Maine Mega example involves transferring only $2 million in consumer rebates back to the health insurance industry, HHS recently estimated that in 2011, the first year the minimum medical loss ratio requirements apply to the U.S. individual and group markets, health insurance companies may pay out as much as $1.5 billion in rebates to their customers.[12] By eliminating commissions

[11] This analysis excludes the temporary "credibility adjustment factor" that Mega would receive under the law, which would raise the company's medical loss ratio even closer to 80%.

[12] U.S. Department of Health and Human Services, *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act*, 75 Fed.Reg. 230, 74864, at 74907-74909 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158).

from earned premiums (the denominator of the medical loss ratio formula) and thereby inflating the amount of claims paid (the numerator), NAHU's proposal would transfer a significant part of the potential $1.5 billion pool of consumer rebate money back to the health insurance industry.

Some health care analysts have predicted that many health insurance companies will decide to avoid paying rebates by lowering their premiums. Citibank analyst Carl McDonald explained this theory in the following way:

> Of course, it's highly doubtful that consumers will ever receive checks coming anywhere close to these amounts. The reason is that **plans that are currently offering products with very low loss ratios have already begun lowering premium rates** [emphasis added]. Since margins will be going down because of the minimum MLRs [medical loss ratios], many plans have concluded that a better strategy is to lower prices in order to attract more beneficiaries, with the hope that the higher volumes will help to offset some of the margin compression. So consumers are likely to receive a rebate check around June of next year, but the total rebates disbursed will likely be a lot lower than all the figures we're citing.[13]

Whether it is through cash rebates or through lower premium payments, millions of American consumers will benefit from the pressure the minimum medical loss ratio law is exerting on the health insurance industry to deliver a better value to its customers. Under the proposal advocated by NAHU and Commissioner McCarty, consumers would lose most of these benefits. The money that was intended to give consumers relief from the high cost of health care would instead be converted into additional revenue for agents, brokers, and health insurance companies.

3. Agent and Broker Commissions Significantly Benefit from Health Care Inflation

NAHU representatives repeatedly complain that the health care reform law does not do enough to restrain increases in the cost of medical care. The group fails to mention, however, that agents and brokers play a part in these increases, because their commissions are generally based on a percentage of the total premium paid by individuals or small businesses. The consequence of this payment structure is that agents and brokers earn more revenue when their clients pay higher premiums. Conversely, their income drops if medical costs decrease.

As Figure III shows, over the past decade, insurance premiums have been rising at an average annual rate of 6-7%.[14] Figure III demonstrates that agent and broker commissions linked to this rate of medical inflation have roughly doubled in the past ten years. Because the

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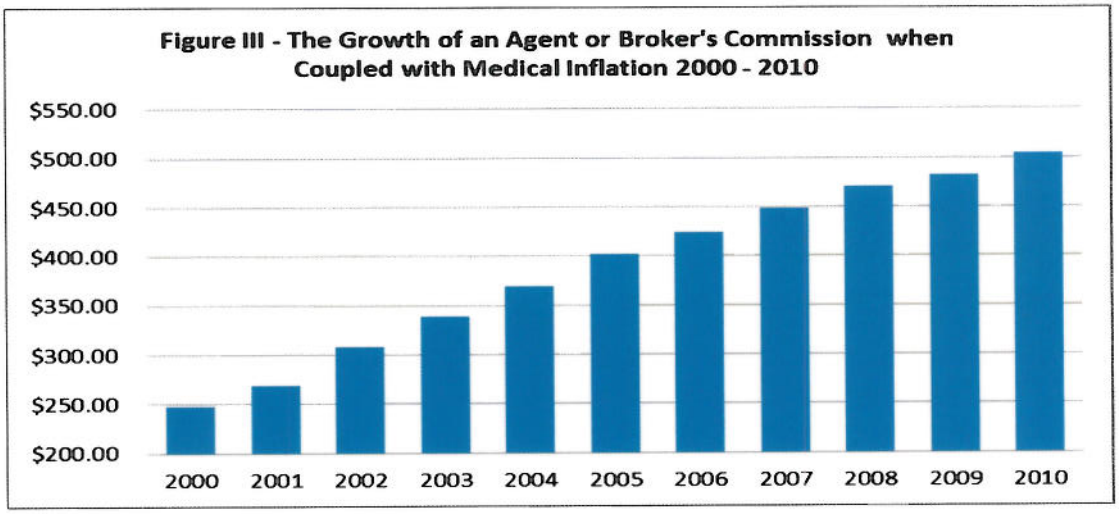
[13] *If You Think Nature Is a Friend, Then You Sure Don't Need an Enemy: HHS Issues MLR Guidelines*, Citigroup Global Markets, Industry Overview, Managed Care (Nov. 22, 2010).

[14] Figure III applies a 10% commission to the average annual premiums for individual health insurance coverage, as presented in, The Kaiser Family Foundation and Health Research & Education Trust, *Employer Health Benefits: 2010 Annual Survey* (Sep. 2, 2010). (Online at http://ehbs.kff.org/pdf/2010/8085.pdf)

cost of medical care has been rising much faster than the costs of other goods and services in the U.S. economy, these commission increases represent real income gains for agents and brokers paid on a percentage basis. It is important to keep these increases in mind when considering agents and brokers' concerns about reduced income. Even a reduced annual increase in income will feel like a cut to agents and brokers accustomed to increases in the 6-7% range.

Since the passage of the health care reform law in March 2010, the health insurance industry has recognized that the agent and broker commissions will have to be "decoupled" from the rate of medical inflation. As Aetna CEO Mark Bertolini explained in the investor teleconference cited above, decoupling commissions from health care inflation will both improve "affordability" and drive "future operating efficiencies."[15] Even Janet Trautwein, NAHU's Executive Vice President and CEO, predicted to the Wall Street Journal last year that, "eventually there won't be any more percentage commissions."[16]



Instead of percentage-based commissions, more agents and brokers will receive monthly fees based on the number of customers they have enrolled with a health insurance company. Alan Katz, the former NAHU officer, recently explained the reasons for this change to the trade publication, Benefits Selling:

> [Agents and brokers'] rent is not going up as fast as health insurance premiums. Therefore, since their compensation is tied to the premiums, they're getting a cost of living increase that goes beyond the cost of living…that will come to an end. Which means that commissions will be disassociated from premiums and it will be a flat fee based on the number of employees and dependents.[17]

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[15] *Supra*, note 8.

[16] *Supra*, note 7.

[17] *Can brokers survive health reform*?, Benefits Selling (Nov. 1, 2010) (online at http://www.benefitssellingmag.com/Issues/2010/November-2010/Pages/Can-brokers-survive-health-reform.aspx).

While NAHU representatives say they support restraining the increasing costs of health care, they are currently engaged in an all-out effort to exempt themselves from one of the health care reform law's most important new cost containment measures, the law's new minimum medical loss ratio requirements. The law is encouraging health insurance companies to review their administrative costs and make changes that will provide a better value at a lower cost to their customers. The proposal offered by NAHU and Commissioner McCarty to insulate sales commissions from these changes may help agents and brokers preserve their income, but it will harm the millions of American consumers who are currently paying too much money for too little health care.

4. Additional Concerns

I would like to share a few additional observations with you about NAHU's and Commissioner McCarty's proposal to exempt agent and broker commissions from the minimum medical loss ratio formula. I urge the NAIC to consider these issues before endorsing their proposal.

- **The health care reform law already gives states a way to seek relief if the medical loss ratio law is causing market disruptions.** NAHU claims that the minimum medical loss ratio law "is causing disruption in all insurance markets" and is "having a devastating financial impact" on agents, brokers, and their clients. NAHU cites this nationwide "disruption" to justify exempting their commissions from the minimum medical loss ratio calculation. The problem with this argument is that states already have a way to seek relief from the law's requirements if they are disrupting their insurance markets. HHS has already granted a waiver on this basis to one state (Maine) and is considering waiver requests from others. In its final minimum medical loss ratio rule, HHS explicitly stated that it will consider the law's impact on agents and brokers when it considers these waiver requests.[18]

- **The NAHU/McCarty proposal penalizes health insurance companies that are already providing high-value health care to their customers.** As noted above, the majority of health insurance companies in the individual and group markets are already providing health care at efficiency levels that meet or exceed the 80% and 85% targets set in the minimum medical loss ratio law. These companies have achieved their high ratios under the current rules that require them to count their agent and broker commissions as part of their earned premiums. Changing the rules to exempt commissions from this calculation, as NAHU and Commissioner McCarty are proposing, effectively rewards these companies' less efficient competitors.

- **The NAHU/McCarty proposal will discourage innovation in the way health insurance companies market and distribute their products.** The legislative proposal offered by NAHU and Commissioner McCarty carefully restricts the minimum medical loss ratio exemption to "licensed independent insurance producer remunerations." This

[18] *Supra*, note 11, at 74877.

provision will certainly benefit health insurance companies that have made the business decision to distribute and market their products through third-party agents and brokers, but it penalizes any company that has decided to distribute and market its products in other ways. Agent and broker commissions will not count as "administrative costs," while all other marketing and distribution costs will. For example, it will penalize insurers that sell their products through employee sales forces or through direct marketing. It will also discourage health insurance companies from investing in innovative marketing strategies that use the Internet and social media to communicate with consumers.

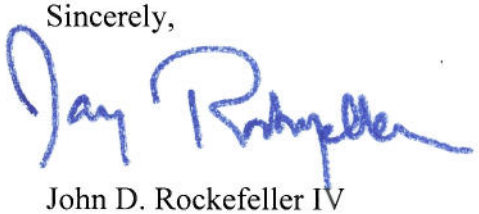
Conclusion

Thanks to health care reform, tens of millions of currently uninsured Americans will be entering the health insurance market over the next few years and will be able to purchase affordable, comprehensive health care coverage. While the health insurance industry opposed health care reform and spent hundreds of millions of dollars trying to defeat it, many in the industry now acknowledge that these millions of new market entrants present an exciting new business opportunity. While profit margins on each sale in the new marketplace might be smaller, sales volumes will be higher.

I hope and fully expect that independent agents and brokers will play a crucial role in this new marketplace, and that they will benefit from these higher potential sales volumes. More than ever, individuals and small businesses will need help understanding how health insurance works, and agents and brokers are well positioned to meet this need. While federal and state policymakers should be working closely with agents and brokers to make a smooth transition to this new marketplace, we cannot and should not shield them from the important changes that are occurring – especially if it is at the expense of millions of American consumers and businesses who are already paying too much for their health insurance.

Finally, I would like to once again express my appreciation for the hard work that NAIC members and staff have done to implement the health care reform law up to this point. I will continue working with you to address and solve the problems that inevitably arise when our country takes on an issue as complicated and important as reforming our health care system. Millions of American consumers are depending on us to get it right. We cannot let them down.

Sincerely,



John D. Rockefeller IV
Chairman

cc: Kay Bailey Hutchison
Ranking Member

United States Senate
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION
WASHINGTON, DC 20510–6125
WEB SITE: http://commerce.senate.gov

November 21, 2011

Commissioner Kevin McCarty
President Elect
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Dear Commissioner McCarty:

A number of times this year, you have attempted to persuade the National Association of Insurance Commissioners (NAIC) to endorse weakening the important consumer protections provided by the minimum medical loss ratio provision of the health care reform law. Your fellow Insurance Commissioners have been understandably hesitant to publicly support your efforts because there is growing evidence – some of which comes from NAIC itself – that the medical loss ratio law will save consumers billions of dollars over the next few years through lower health care premiums and rebates.

Your latest attempt to get the NAIC on record in opposition to the minimum medical loss ratio law is a resolution that you and your fellow Insurance Commissioners are scheduled to consider in a conference call tomorrow, on November 22, 2011. The current draft of this resolution calls on Congress and the Department of Health and Human Services (HHS) to take steps to address the negative impacts you claim consumers are experiencing as a result of the minimum medical loss ratio law. Yet in the many "whereas" clauses that precede this resolution, you offer no evidence that the law is harming consumers. Even worse, your resolution pointedly ignores the months of careful work conducted by NAIC's professional staff that shows just the opposite – that the law is helping millions of American consumers get a better value for their health care premium dollars.

Lawmakers entrusted the NAIC with a number of important responsibilities during the implementation of the health care reform law, including the development of definitions and methodologies for the minimum medical loss ratio law. The NAIC has performed this challenging work with skill and professionalism, and has developed a well-deserved reputation for fairness and integrity. You and your fellow Insurance Commissioners risk damaging this reputation by putting forward a resolution that appears to be placating one special interest group and that so clearly contradicts evidence in the NAIC's carefully assembled record.

1. There is Little or No Evidence that the Minimum Medical Loss Ratio Law is Reducing Consumers' Access to Agents and Brokers

The premise of your resolution is that the minimum medical loss ratio law is hurting consumers by reducing the commissions that health insurance companies pay to agents and brokers. Because commission payments are shrinking, you argue, agents and brokers are less able to help consumers purchase health insurance, and consumers are losing access to the services of agents and brokers. While I share your appreciation for the valuable services that agents and brokers provide many individuals and businesses, your resolution provides absolutely no evidence that the "adverse effects" you describe in the resolution are actually occurring.

At the NAIC's March 2011 meeting in Austin, Texas, the Executive Committee's Professional Health Insurance Advisors Task Force, which you head, instructed the Health Insurance and Managed Care (B) Committee to collect agent and broker commission data. Your Task Force took this step because some of your fellow Insurance Commissioners, as well as many consumer advocates, complained that you had not presented convincing evidence to support your claim that the law was harming consumers' access to agents and brokers. Over the next several weeks, the B Committee's Health Care Reform Actuarial Working Group gathered commission data from industry groups and state regulators.

In early June, the B Committee reported back to you that the quality of the available data was not high enough to reach reliable conclusions about trends in agents and brokers' commissions.[1] In many markets, the report observed, insurance companies appeared to be lowering their commissions. But in other markets, commission levels were steady, or even increasing.[2] One of the report's "observations" was the following:

> In 2011, a significant number of companies have reduced commission levels, particularly in the individual market. **However, a significant number of companies have not reduced commissions in 2011.**[3]

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[1] National Association of Insurance Commissioners, Report of the Health Care Reform Actuarial (B) Working Group to the Health Insurance and Managed Care (B) Committee on Referral from the Professional Health Insurance Advisors (EX) Task Force Regarding Producer Compensation in the PPACA Medical Loss Ratio Calculation (May 26, 2011) (online at http://www.naic.org/documents/committees_b_exposure_110607_phia_charge_report.pdf) (hereinafter "May 2011 NAIC B Committee Report"). Commissioner Praeger also noted in her June 9, 2011, memorandum transmitting this report to you that the commission data sets "proved to be incomplete and have significant limitations."

[2] Because commissions are generally calculated as a percentage of total premiums paid, a lower year-over-year commission rate does not necessarily mean agents and brokers have received lower payments from the insurance carriers; for the same reason, a steady commission rate generally means increased year-over-year revenues for agents and brokers.

[3] May 2011 NAIC B Committee Report, *supra*, note 1, at 3.

Your resolution includes the first sentence of this observation to support your claim that the medical loss ratio law is causing agent and broker commissions to drop. But it does not include the second part of this observation (the bolded part above) because this sentence suggests that the law may be having no effect at all on agent and broker commissions. By selectively quoting this observation from the Committee Report, your resolution creates the misleading impression that the NAIC identified a trend in commission rates that it did not actually find.

Your resolution also fails to mention that when the Committee surveyed states with relatively high existing minimum medical loss ratios, the states reported that while the minimum ratios caused some reductions in agent and broker commissions, consumers "continue to have access to insurance and producers without noticeable problems."[4] This finding contradicts the assertion in your resolution that minimum medical loss ratio requirements reduce consumers' access to the services of agents and brokers.

The Department of Health and Human Services (HHS) has reached similar conclusions when it has reviewed states' requests for temporary adjustments to the minimum medical loss ratio law. To date, HHS has not yet found any convincing evidence that "consumers may be unable to access agents and brokers" under the minimum medical loss ratio law.[5]

For example, in its request for a temporary adjustment, the Kentucky Department of Insurance asserted that the minimum medical loss ratio law would reduce agents and brokers' commission rates, "which will force a reduction in licensed personnel servicing the consumers in our market."[6] The data Kentucky submitted to HHS, however, showed that the insurance carrier that sells over 80% of individual policies in Kentucky, Anthem of Kentucky, had actually increased its agent and broker commissions in 2011. On that basis, HHS concluded that the law would have little or no impact on consumers' access to agents and brokers.[7]

In a similar case, HHS rejected Georgia's claim that the medical loss ratio law would reduce Georgia consumers' access to agents and brokers. HHS based this decision in part on commission data submitted by the National Association of Health Underwriters (NAHU) to the NAIC. This data showed that none of the surveyed Georgia insurance carriers had lowered their

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[4] *Id.* at 7

[5] Section 158.330(4)(c) of the minimum medical loss ratio regulations adopted by HHS requires the Secretary to consider this factor when assessing requests for medical loss ratio adjustments. U.S. Department of Health and Human Services, *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act*, 75 Fed.Reg. 230, 74864, at 74931 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158).

[6] Letter from Sharon P. Clark, Commissioner, Kentucky Department of Insurance to Katheleen Sebelius, Secretary, U.S. Department of Health and Human Services (Feb. 16, 2011), at 6 (online at http://cciio.cms.gov/programs/marketreforms/mlr/states/Kentucky/mlr_cover_letter_application.pdf).

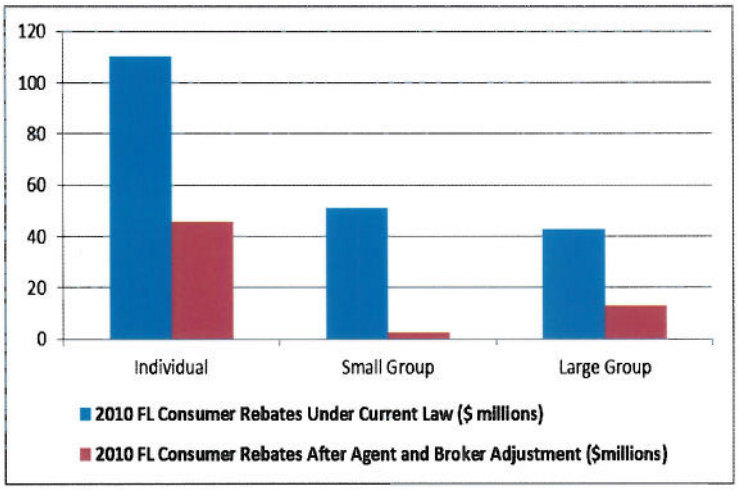
[7] Letter from Steven B. Larsen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services, to Sharon P. Clark, Commissioner, Kentucky Department of Insurance (July 22, 2011), at 8 (online at http://cciio.cms.gov/programs/marketreforms/mlr/states/Kentucky/ky_mlr_adj_determination_letter.pdf).

commission rates between 2010 and 2011.[8] HHS rejected Delaware's claim that the minimum medical loss ratio law would result "in a huge decrease in the number of active agents selling individual health insurance products," after noting that eight out of the nine Delaware insurers that provided data to NAHU did not lower their commissions between 2010 and 2011.[9]

2. American Consumers are Getting Rebates, Lower Premiums, and Other Benefits Thanks to the Minimum Medical Loss Ratio Law

While there is little evidence that the minimum medical loss ratio law is affecting consumers' access to the services of agents and brokers, there is a great deal of evidence showing that the law has created a strong incentive for health insurance companies to give their customers a better value for their health insurance dollars. To date, the best analysis of the financial implications of the minimum medical loss ratio law is the May Report that NAIC's B Committee performed at your request.

The Report analyzed the detailed 2010 financial information that health insurance companies were required to disclose for the first time in the Supplemental Health Care Exhibit (SHCE) forms they filed with the NAIC and their state regulators. While the authors of the report were careful to note that their calculations differed in small ways from the calculations that will be performed at the end of 2011, the first year consumers are entitled to rebates under the law, they estimated that American consumers would have received almost $2 billion in rebates in 2010.[10] For example, the report estimated that Florida consumers and businesses would have received $200 million in rebates from the insurance companies operating in your state.[11] These rebates are represented by the blue bars in the accompanying chart.



[8] Letter from Steven B. Larsen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services to Ralph T. Hudgens, Georgia Commissioner of Insurance (Nov. 8, 2011), at 10-11 (online at http://cciio.cms.gov/resources/files/Files%202/11072011/final_ga_mlr_adj_determination_letter.pdf).

[9] Letter from Steven B. Larsen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services to Karen Weldin Stewart, Delaware Insurance Commissioner (Sep. 9, 2011), at 6-7 (online at http://cciio.cms.gov/programs/marketreforms/mlr/states/delaware/de_mlr_adj_determination_letter.pdf).

[10] May 2011 NAIC B Committee Report, *supra*, note 1, at 26-28.

[11] *Id.*

At your request, the B Committee analyzed the 2010 SHCE data to determine how exempting agent and broker commissions from the minimum medical loss ratio's calculation would affect the level of rebates American consumers receive. As you know, the B Committee found that exempting agents and brokers' commissions from the calculation would have wiped out more than 60% of the $2 billion in estimated 2010 rebates. As shown by the red bars in the chart presented on the previous page, this change would have reduced rebates paid out to Florida consumers by $142 million.[12]

Under this scenario, consumers do not lose just hundreds of millions of dollars in annual rebates. Just as importantly, health insurance companies lose the incentive the current law gives them to run their businesses more efficiently and deliver a better value to their customers at a lower cost. Furthermore, it is very likely that agents and brokers themselves will not benefit from this policy change, because health insurance companies would be likely to keep these canceled rebates as additional revenue rather than pass them on to agents and brokers as higher commission payments.

As was discussed in a report that the Senate Commerce Committee released in May 2011, health insurance companies operating at ratios below the law's 80% and 85% targets can comply with the law by either directly paying rebates to their customers, or by lowering their premiums to raise their medical loss ratios above the minimum targets and avoid paying rebates.[13] Investigators from the Government Accountability Office (GAO) documented this latter strategy in a July 2011 report on how the health insurance industry is implementing the new minimum medical loss ratio law. According to this report:

> A regulator from one state insurance commissioner's office said that some insurers in that state have not applied for premium increases and are making adjustments to lower premiums as a strategy to increase their MLRs, and commented that reducing premiums is the best strategy for insurers to improve value for consumers.[14]

It is already clear that the current minimum medical loss ratio law is benefiting American consumers and businesses by giving health insurance companies a strong incentive to spend their customers' premium dollars more efficiently and carefully. The law is helping consumers get more value out of each health care dollar they spend. Billions of premium dollars that the health insurance companies would have been able to keep as profits before the passage of the health care reform law, are now being used for patients' care and improving the quality of their care. These benefits will only continue to accrue as more and more Americans take part in a reformed

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[12] *Id.*

[13] Senate Committee on Commerce, Science, and Transportation, *Staff Report on Consumer Health Insurance Savings Under the Medical Loss Ratio Law* (May 24, 2011) (online at http://commerce.senate.gov/public/ ?a=Files.Serve&File_id=98f51e42-e9ef-441a-a5e3-6bdac44d6a27).

[14] Government Accountability Office, *Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements* (July 2011) (GAO-11-711), at 18. While your resolution contains one excerpt from this report that discusses lower commission rates, it omits the report's lengthy discussion of how the minimum medical loss ratio is causing insurers to lower their premiums.

health insurance market – a market in which agents and brokers will continue to play a valuable role.

Conclusion

As I wrote Commissioner Voss in a letter earlier this year, I stand ready to work with the NAIC and the health insurance industry to make sure that agents and brokers continue to play the vital role they play in today's health insurance market. I am heartened by the fact that HHS has taken concrete steps to make sure that agents and brokers will be able to serve American consumers in the new health insurance marketplace. But we should never lose sight of our ultimate goal - helping American families and businesses get better, affordable health care.

Sincerely,

John D. Rockefeller IV
Chairman

cc: Kay Bailey Hutchison
Ranking Member