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By email and Federal Express

February 23, 2016

Ted Nickel
Commissioner
Wisconsin Office of the Commissioner of Insurance
125 South Webster St.
Madison, WI 53703-3474

Katherine L. Wade
Commissioner
State of Connecticut Insurance Department
153 Market St.
Hartford, CT 06103

Dear Commissioners Nickel and Wade:

The American Hospital Association (AHA), whose members include nearly 5,000 hospitals, health systems and other health care organizations, and 43,000 individuals, is writing to raise serious concerns about whether provisions in the Affordable Care Act (ACA) that set minimum medical loss ratios (MLRs) and provide rate review standards might, as some have argued, temper the anticompetitive effects that will follow in the wake of the pending mergers of Anthem with Cigna and Aetna with Humana.

The proposed acquisitions would reduce the number of major commercial health insurance companies in the United States from five to just three and would lead to a serious lessening of competition by reducing options available to American consumers in hundreds of markets that already are highly concentrated. As expert economists have shown, previous consolidation of health insurers has led to premium increases.[1] More consolidation will lead to further premium increases, thereby diminishing the promise of affordable health care for all.

We are deeply concerned that the Florida Office of Insurance Regulation's recent approval of the Aetna-Humana merger with very limited remedies was premised, in part, on the Office's

[1] *See, e.g.*, Leemore S. Dafny, *Evaluating the impact of health insurance industry consolidation: learning from experience*, Commonwealth Fund, Issue Brief, November 2015, available at www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/nov/1845_dafny_impact_hlt_ins_industry_consolidation_ib.pdf.

acceptance of the argument that medical loss requirements in Florida, and more recently in federal, law effectively limit any entities' ability to exercise market power, independent of market concentration.[2]

As discussed below, that argument does not withstand scrutiny.[3] We believe that state regulators should be extremely skeptical about the validity of such arguments. We urge that you share this letter with all your colleagues on the respective task forces you chair to inform the analyses of the task forces and the regulators in the individual states.[4]

The Minimum MLR Standard Will Not Protect Consumers from Higher Premiums

The ACA's MLR provision is intended to ensure that consumers get value for their premium dollar when purchasing health insurance. The ACA requires an insurer selling in the individual or small group market to use at least 80 percent of each premium dollar to pay for medical care (i.e., claims costs) and quality improvement activities. The minimum threshold for the large group market is 85 percent. Insurers must report their MLRs to the Centers for Medicare & Medicaid Services (CMS), which provides for oversight of insurer compliance and also provides for public disclosure of insurer MLR data. If insurers do not meet or exceed the 80 or 85 percent MLR standard, they are required to pay refunds or rebates to their enrollees. While the MLR has helped improve the value of health insurance products (because the percentage of enrollees in plans meeting the minimum standards has increased each year), for the following reasons it does not create an effective brake on premium increases in concentrated markets:

- About three of every five workers are in plans that are not covered by the ACA's MLR standard (or by any state MLR requirements). This is largely because MLR requirements do not apply to private sector, self-insured health plans. If a self-insured employer plan purchases administrative services and/or stop-loss (reinsurance) coverage from an insurer, the cost of those products is not subject to the MLR constraints.

- The MLR does not address the premium amount. It only requires that a minimum percent of that premium be used for medical claims and quality enhancing activities.

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[2] Florida Office of Insurance Regulation, Report on review of the Aetna Inc.'s acquisition of Humana and affiliates (Feb. 12, 2016) at 20, available at www.floir.com/siteDocuments/Report_on_Review_of_the_Aetna_Inc_Acquisition_of_Humana_and_Affiliates.pdf.

[3] See also Mark V. Pauly, Ph.D., *The worst of both worlds: mergers like Anthem-Cigna and Aetna-Humana could lead to higher premiums and higher costs.* US News & World Report Policy Dose (July 29, 2015), available at www.usnews.com/opinion/blogs/policy-dose/2015/07/29/why-health-insurance-mergers-could-mean-higher-premiums.

[4] An earlier AHA analysis of the why MLR and rate review standards are not a defense to further heath plan consolidations can be found on the AHA website at http://www.advancinghealthinamerica.org/wp-content/uploads/2015/09/Plan-consolidation-MLR-factsheet_8-18-15_clean.pdf and http://www.advancinghealthinamerica.org/wp-content/uploads/2015/09/Rate-Review-Factsheet_8.27.15_final.pdf.

- Similarly, the MLR regulations seek to limit insurer profits but would not protect consumers from post-merger harm that would result from the loss of competitors. Insurers may still find it profitable to raise premiums and pay consumers higher rebates in order to retain higher profits. For example, national MLRs in 2013 were 86 percent, 84 percent and 89 percent for the individual, small group and large group markets (compared with the required minimums of 80 percent for individual and small group market and 85 percent large group market floors). This suggests insurers will have room for post-merger price increases while still meeting minimum MLR standards.[5]

- The federal rules for reporting MLRs provide for aggregation at a relatively high level. In general, the MLR is not based on each policy offered by an insurer, but on the insurer's annual aggregate performance within each market (individual, small group or large group) and state.[6] This broad application of the MLR, as required by the ACA's implementing regulations, can mask potentially wide differences in the return on premium for an insurer's different health insurance products. Consequently, the MLR does not provide a limit on the ability of an insurer to offer specific products that fail to meet the minimum MLR threshold.

- Some insurers may get around the MLR requirements in ways that will enable them to increase premiums. Labeling profits as costs is one possibility; an insurer could create a separate quality improvement arm and charge that arm fees that offset profits exceeding the MLR minimum standard.[7]

- The ACA allows insurers to classify expenses for certain quality improvement activities as clinical benefits and count them as medical claims. To raise their MLRs, some insurers may identify some administrative costs as quality improvement expenses. Although CMS has provided detailed guidance on reporting requirements for quality improvement expenses, there is likely still some room for reclassification of costs.

- Resource constraints limit the ability of CMS to provide much oversight of insurers' MLR reporting. CMS can only do a detailed review of issuer MLR reporting compliance for a small number of insurers each year.

Rate Review Standards

In addition to the ACA's MLR standards, some argue rate review will apply pressure on insurers to hold down rate increases. Under the ACA's federal rate review standard, health insurance carriers are required to file and publicly justify proposed rate increases of 10 percent or more.

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[5] Dafny, *supra*, Note 1; Robert Book, *How the Medical Loss Ratio Requirement Could Increase Health Insurance Premiums and Insurer Profits at Taxpayer Expense* (April 2013), available at http://americanactionforum.org/uploads/files/research/MLR_Paper_Final.pdf.

[6] A loss ratio computed separately for an insurer's specific book of business would be subject to more volatility due, for example, to unexpected utilization changes than would a measure across the insurer's entire book of business.

[7] Dafny, *supra*, Note 1.

States – typically, through their insurance departments – may provide for additional review of health insurance carriers' rates.

Most states review rates that have been filed but do not require the rates be approved before insurers can charge them ("file and use"). Some states require the insurer to obtain "prior approval" of their rates and may require an insurer to change its rates in order to be able to sell the policy. While rate review has the potential to slow the rate of premium increases, its effect is likely to be modest unless the state goes a step further and actually ***regulates*** the rates that insurers charge. Moreover:

- Federal rate review is not universal. It only applies to non-grandfathered plans offered in the small and individual markets and, in most states, to non-association sponsored health plans. In 2011, when the Department of Health and Human Services (HHS) issued the final rate review rule, it estimated that 35 million people would be covered by products subject to rate review. That represented about 17 percent of the commercial market for health insurance.[8]

- The federal rate review process does not preempt states' own rate review laws or procedures. As a result, the wide variation in the effectiveness of states' processes has continued post-ACA. State processes continue to vary with respect to the authority each state gives its insurance department to reject or revise proposed rates.[9]

- Some states may not support strong rate review even if the insurance department has the authority to reject or modify rates.[10]

- In states that have not been identified by HHS as having effective review processes, HHS has been slow to make rates transparent. And, importantly, although HHS may take into account recommendations by state regulators about excessive or unjustified rate increases in determining which plans may be offered as Qualified Health Plans through health insurance exchanges, HHS does not have the authority to reject rates.[11]

- In some states, rate review results in ***higher***, not lower rates. The Commonwealth Fund reported last year several examples of states that urged insurers to raise rates even more than insurers proposed.[12]

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[8] Final Rule with Comment Period: Rate Increase Disclosure and Review, 76 *Federal Register* 29964 - 29988, available at http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf.
[9] Available at http://consumersunion.org/wp-content/uploads/2014/04/Exhibit-A-State-List-Public-Participation.pdf; http://www.healthcaredive.com/news/state-rate-regulation-is-there-one-future-or-50/391431/.
[10] Reed Abelson, Health insurers raise some rates by double digits. *The New York Times* (Jan. 5, 2013), *available at* http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?_r=0.
[11] ACA addresses our long history of premium rate hikes. *The Hill*, Congress Blog (June 16, 2014), available at http://thehill.com/blogs/congress-blog/healthcare/209330-aca-addresses-our-long-history-of-premium-rate-hikes.
[12] Proposed premium rate increases for 2016: the jury is still out. *The Commonwealth Fund Blog* (July 21, 2015), available at www.commonwealthfund.org/publications/blog/2015/jul/proposed-premium-rate-increases-for-2016.

- Rate filings are not readily understood by consumers and in some states are not made easily accessible.

Should you have any additional questions, please feel free to contact me directly at mhatton@aha.org or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President & General Counsel