Senator John D. (Jay) Rockefeller IV, Chairman

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ROCKEFELLER TO NAIC COMMISSIONERS: REJECT HEALTH CARE INDUSTRY'S 11TH HOUR LOBBYING EFFORT

"Make sure that consumers and businesses get a better value for their health insurance," Rockefeller writes Commissioners

WASHINGTON, D.C.—Today, Senator John D. (Jay) Rockefeller IV, Chairman of the U.S. Senate Committee on Commerce, Science, and Transportation, sent a letter to the members of the National Association of Insurance Commissioners' (NAIC) Health and Managed Care (B) Committee urging them to stand strong against the health insurance industry's last minute attempt to water down key consumer protections included in the health care reform bill.

"I appreciate all the work NAIC's members have been doing to implement the medical loss ratio provision and many other parts of the health care law—but now is not the time to stand down," Chairman Rockefeller said. "I urge you to reject the health care industry's eleventh-hour lobbying campaign to erode key consumer protections—protections that will help Americans finally get the care they pay for and deserve."

The members of NAIC's Health and Managed Care (B) Committee are slated today to consider guidelines for the implementation of the new minimum medical loss ratio (MLR) law. Chairman Rockefeller championed the MLR provisions included in the health care reform bill, and has continued to fight to make sure they aren't weakened in the implementation process.

Chairman Rockefeller's letter to members of NAIC's Health and Managed Care (B) Committee follows:

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.

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