TO: Scott Kipper, Nevada Insurance Commissioner
Nevada Division of Insurance
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From: Michael Dillon, CEBS, REBC
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RE: **Support of Nevada Regulation R122-24I**

First, I would like to thank the Nevada Division of Insurance for taking up this vital matter requiring claims transparency by Nevada insurance companies in the group market. This data belongs to the employer, not the insurance company. It is their data. I brought this issue to the Division's attention at the Commissioners Agent Advisory Committee and the Life & Health Advisory Committee. I want to thank all the stakeholders who have participated in the working groups outside of this hearing to bring a solution that provides transparency to protect Nevada Employers as consumers for their employees and their families.

The most important reason for this change is that it is a consumer protection issue for Employers, their employees, and their family members insured under the Group Insurance Program. I want to be clear that there is no benefit to the Brokers. As agents and brokers, we advocate for our clients. This change will provide an employer with the data they are entitled to see to get the most competitive insurance rates with the limited carriers available to them in the State.

The faux objection by insurance companies is that they protect the privacy concerns of individual claims data. This objection is all smoke and mirrors. Under HIPPA, employers and brokers must keep information that comes into their possession confidential from those who do not need to see and use it only for the business purposes required.

Employers see this same information for Workers' Compensation claims. They also see this same information on self-funded and level-funded plans that currently go down to 2 employees and large groups of over 100 lives.

The current situation is used against employers to force them into expensive renewals. Health insurance premiums are the second largest cost for employers, and they need the ability to shop for their employee benefits program.

The typical group renewal process sees an insurance carrier release a health insurance offer with a 15 to 50 percent increase annually 60 days before the renewal. The explanation for the unsustainable rise is a combination of healthcare

trend increases of roughly 10 percent, the block of business receiving an increase, and, most importantly, the group running poorly in their specific large claims and aggregate claims as a whole.

Evaluating large claims is always the most significant driver of this last piece, and having transparency into these claims is critical to understanding if these claims could be in error and should have been handled under the subrogation of claims through another policy, such as workers' compensation or an auto policy. The other significant consideration is whether these claims are shock claims vs. ongoing future claims, risks the insurance company must rate. There is never a decrease. Once that is done, there is some back and forth between the insurance company and the broker, further decreasing that window until the renewal with open enrollment looming, typically done 30 days before the renewal date.

If an alternative carrier sees a renewal with a 30% increase, they will decline to quote the RFP because they make assumptions with the limited data the incumbent carrier provides.

Again, thank you for bringing this issue forward, which will benefit employers' costs and protect consumers, employees, and families' costs, who most always have a cost share in the premium.