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Congress of the United States
U.S. House of Representatives
Committee on Small Business
2361 Rayburn House Office Building
Washington, DC 20515–6315

Memorandum

To: Members, House Committee on Small Business Subcommittee on Investigations, Oversight and Regulations
From: Committee Staff
Date: December 15, 2011
Re: Hearing, "Medical Loss Ratios: More Medical Value or Just Eliminating Jobs?"

On Thursday, December 15, 2011, the House Small Business Subcommittee on Investigations, Oversight and Regulations will meet at 10:00 a.m. in Room 2360 of the Rayburn House Office Building for the purpose of receiving testimony on the Medical Loss Ratio requirements under the Patient Protection and Affordable Care Act[1] and its attendant regulations. Witnesses will include Mitchell West, Insurance Broker, Health Choice One, Greenwood Village, CO; Gary Livengood, Principal, What a Stitch, LLC, Mt. Airy, MD; Grace-Marie Turner, President, Galen Institute, Alexandria, VA; and Timothy Jost, Professor of Law, Washington and Lee University School of Law, Lexington, VA.

I. Introduction

The American people continue to be concerned about the cost of health care. Recent polls have found that people are divided about the Patient Protection and Affordable Care Act,[2] the health care reform law that will affect almost every American. Some states are beginning to establish health insurance exchanges, as mandated under the Act, but almost half have not. The United States Supreme Court is scheduled to decide the constitutionality of the Act early in 2012. Against this backdrop, large and small businesses and their employees are trying to budget and plan for 2012 when the health care outlook is uncertain. An important part of the law, the Medical Loss Ratio provision, will influence how insurers spend money received from premiums.

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[1] Pub. L. No. 111-148, 124 Stat. 119, 42 U.S.C. 18001 (2010) as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029, 42 U.S.C. 1305 (2010), hereinafter "PPACA" or "The Act." Note: Several parts of PPACA amended existing laws, such as the Public Health Service Act, adding new sections of those laws.

[2] Gallup Poll, November 12, 2011, *available at*: http://www.ibtimes.com/articles/250741/20111116/americans-lean-repealing-health-care-reform-law.htm.

A. Current Law

Under the Act, beginning on January 1, 2011, the Medical Loss Ratio (MLR) provision[3] requires insurers to spend the majority of premium dollars on direct health care for patients and efforts to improve care quality, and places a cap on administrative costs.

The Act directed the National Association of Insurance Commissioners (NAIC)[4] to develop recommendations for calculating the MLR standards for private health insurance companies.[5] The MLR is a basic financial indicator which usually refers to the percentage of insurance premium revenue that insurers devote to their enrollees' medical claims. The Act requires insurers in the individual and small group market[6] to spend 80% of premium dollars on medical costs and those in the large group market to spend 85% on medical costs.[7] It requires insurers in the large group market to spend at least 85% of premium dollars on medical costs. This means the amount that can be spent on administrative or "non-claims" expenses, minus federal and state taxes and other permissible expenses, is limited to 20% in the individual and small group market, and 15% in the large group market.[8]

If the insurer fails to meet these minimum requirements, it must issue rebates to its customers beginning in 2012. Rebates are refunds issued to the employer, employee or other entity that paid the premiums.[9] The rebate will consist of a payment or a credit towards future insurance premiums. The law allows the Secretary of Health and Human Services to adjust the MLR in a state if it is determined that the MLR may destabilize the individual and small group health insurance market.[10]

To implement the MLR provisions of the Act, on November 22, 2010, HHS issued an interim final rule[11] with comment period setting forth definitions and methodologies for calculating the MLR, adopting NAIC's recommendations. The rule exempts insurance carriers with fewer than 1,000 insured lives from the rebate requirement.[12] Insurers began reporting MLRs to the HHS' Center for Consumer Information and Insurance Oversight on January 1, 2011.

B. Medical Loss Ratios Over Time

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[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1001, §2718, 124 Stat. 119 (2010); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 10101(f), § 2718, 124 Stat. 119 (2010).

[4] NAIC is the organization of insurance commissioners for the 50 states, the District of Columbia and the five U.S. territories.

[5] Pub. L. No. 111-148 §§ 10001(5), 10101(f), 124 Stat. 119, 130, 885.

[6] Small group markets are usually those with coverage of "small employers." The Act defines small employers as those with an average of 1 to 100 workers, and a large employer as having an average of 101 or more workers.

[7] Public Health Service Act § 2718(a), 124 Stat. 119, 42 U.S.C. § 300gg et seq. (2010).

[8] *Id.*

[9] Public Health Service Act § 2718(b), 124 Stat. 119.

[10] Public Health Service Act § 2718(d), 124 Stat 119.

[11] 45 CFR Pt. 158 (2010), *available at*: http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf.

[12] *Id.*

Before the Act, there was little information available on MLRs and, in particular, the amount insurance companies paid for medical claims. In July, 2010, the U.S. Government Accountability Office (GAO) reported that from 2006 through 2009, traditional MLRs (those set by states) on average exceeded the Act's MLR requirements.[13] This means traditional MLRs reflected higher spending by insurers on medical claims as compared to administrative costs. By April 2010, thirty four states had established MLRs, with more MLRs in the individual and small group markets than in the large group market.[14] If a state had established an MLR higher than that in the Act, the higher percentage prevails and applies to insurers in that state.[15]

Because insurance has been regulated by the states, MLRs have varied widely because states have defined medical care differently and have differing levels of competition.[16] In North Dakota, for example, the medical loss ratio is 55%, which means 55% of premium dollars are spent on medical care, but in New Jersey it is 80%. There are also geographic MLR differences between urban and rural areas.[17]

II. Rationale for the MLR

A. Reduce the Cost of Health Care Coverage

According to the Act, the MLR provision was included to assist in "bringing down the cost of health care coverage."[18] In the past, some insurance companies were criticized for spending a substantial portion of customers' premium dollars on administrative expenses, salaries, overhead and marketing. [19] For example, the group Consumer Watchdog said that removing brokers' commissions from the administrative calculation would "allow insurance companies to ignore the original intent of the law, which was to force insurers to operate more efficiently..."[20]

In response, Congress included the MLR minimum requirements, which were designed to improve insurance company transparency and accountability. The MLR standards were, in part, intended to help ensure policyholders receive the most value for their premium dollars.[21] Beginning in January, 2011, health insurers were required to begin submitting to HHS' Office of Consumer Information and Insurance Oversight a report for each state in which they are licensed to provide

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[13] U.S. GOVERNMENT ACCOUNTABILITY OFFICE, Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements 18, July 2011, (GAO-11-711).

[14] HEALTH AFFAIRS, MEDICAL LOSS RATIOS, ROBERT WOOD JOHNSON FOUNDATION 2, November 12, 2010, *available at*: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=30.

[15] 45 CFR Pt. 158, *supra* note 7 at 74887.

[16] HEALTH AFFAIRS, *supra* note 13.

[17] *Id.*

[18] Pub. L. No. 111-148 § 2718(b)(1)(A), 124 Stat. 119.

[19] *High Health Care Costs: Who's To Blame?* CONSUMER REPORTS, *available at*: http://www.consumerreports.org/health/doctors-hospitals/health-care-security/who-is-to-blame-for-high-costs/health-care-security-costs.htm. *See also* DEPARTMENT OF HEALTH AND HUMAN SERVICES, GETTING YOUR MONEY'S WORTH ON HEALTH INSURANCE, *available at*: http://www.healthcare.gov/news/factsheets/2010/11/medical-loss-ratio.html.

[20] Jenny Ivy, *Consumer Group Slams Agents' MLR Petition*, BENEFITS PRO, March 4, 2011, *available at*: http://www.benefitspro.com/2011/03/04/consumer-group-slams-agents-mlr-petition.

[21] *Id.*

coverage.[22] The report must detail the amount of total earned premiums; total reimbursement for clinical services; total spent on activities to improve quality; and total spending on other non-claims costs.[23]

Some experts think the federal MLR will not only fail to control costs, but could increase them.[24] These experts believe the easiest way to have a high MLR is to allow medical costs to escalate and balance out high administrative costs.[25] They also predict insurers will be discouraged from investing in administrative services that could save consumers money.[26]

B. Improve the Quality of Medical Care

By requiring that insurance companies spend more of each premium dollar on health care and activities to improve the quality of health care, health care reform advocates believed they could improve the quality of health care. In the Act, Congress delegated to the NAIC the responsibility of defining the methodologies and measures of health care quality.[27] In September 2010, NAIC submitted to Secretary of Health and Human Services Sebelius a list of five quality improvement objectives, such as health and wellness programs, designed to improve the quality and delivery of health care.[28] These objectives were included in the final rule issued by Secretary Sebelius on November 22, 2011.

III. Impact of MLR on Small Businesses

There has been a great deal of discussion about the effect of the Act's MLR requirements on insurance agents, many of whom are small business owners; small insurance companies; customers; and insurance markets.

A. Small Insurance Companies

In today's economy, small insurers, like most small firms, are struggling just to keep their doors open. Typically, it costs small firms disproportionately more than large firms to comply with federal laws and regulations. A study commissioned by the Small Business Administration found that it costs small companies an average of $10,585 per employee to comply with federal regulations, which is 36% higher than the cost facing large companies.[29] If small insurers cannot meet the Act's new MLRs, and

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[22] Public Health Service Act, *supra* note 7 at 2718(a).
[23] *Id.*
[24] Robert Laszewski, *The 300 Page MLR Rules – About As Valuable as Taking your Shoes Off at the Airport,* Health Policy and Market Blog, *available at:* http://healthpolicyandmarket.blogspot.com/search?updated-min=2010-01-01T00:00:00-05:00&updated-max=2011-01-01T00:00:00-05:00&max-results=32.
[25] *Id.*
[26] *Id.*
[27] Public Health Service Act, supra note 7 at § 2718(c).
[28] HEALTH AFFAIRS, *supra* note 8.
[29] NICOLE V. CRAIN AND W. MARK CRAIN, SMALL BUSINESS ADMINISTRATION, OFFICE OF ADVOCACY, THE IMPACT OF REGULATORY COSTS ON SMALL FIRMS (2010), *available at*: http://www.sba.gov/sites/default/files/rs371.pdf.

are forced to pay rebates to their customers, they may be unable to compete and forced out of business.

Small insurers are usually community based, so if they close their doors, the economy of the surrounding community and its businesses are usually affected as well. Many of these businesses are small firms – and they employ about half of all U.S. workers.[30] They are also the companies that sponsor the local children's baseball teams and donate to local charities. The *Wall Street Journal* raised questions about the ability of smaller insurers to meet the new targets and some could fail as a result.[31]

B. Insurance Agents and Small Businesses

Generally, small business owners spend time away from their business to review insurance options, purchase coverage and administer that coverage.[32] A small business owner often needs the counsel of a licensed, professional insurance agent to help him review the myriad of plans, purchase coverage and administer the coverage.[33] With a small company, the owner can rely on a personalized assessment of the business and its insurance needs. After the sale, the agent often reviews the business' coverage annually to determine if it is still adequate, and can guide the owner through the claims process. Small business owners, in particular, must be sure that every scarce dollar they spend is necessary to the functioning of the business. As the health care landscape changes and additional provisions of the Act become effective, small business owners will rely even more on insurance agents to help them navigate through the law's numerous and complex provisions.[34]

Most insurance agents or brokers are small business owners themselves. Typically, they sell health insurance as well as other policies, such as auto, life, disability and long term care coverage. Agents are licensed by their state and must adhere to a code of ethics that requires them to make recommendations on the basis of the customer's best interest.[35]

The agent can be affiliated with one insurance company or remain independent and represent many insurance companies. The agent's income is a commission based on the products and services that are sold, and that commission is included as part of the MLR calculation.[36] As a result, a significant number of health insurance companies have reduced agent commission levels, particularly in the individual

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[30] U.S. SMALL BUSINESS ADMINISTRATION, ADVOCACY SMALL BUSINESS STATISTICS AND RESEARCH, FREQUENTLY ASKED QUESTIONS, *available at*: http://web.sba.gov/faqs/faqindex.cfm?areaID=24.

[31] *Postponing ObamaCare*, WALL ST. J. editorial, November 26, 2010, *available at*: http://integrate.factiva.com/en/search/article.asp.

[32] Letter from Susan Eckerly, Senior Vice President, NFIB, to the Office of Consumer Information and Insurance Oversight, Department of Health and Human Services 10, *available at*: http://www.dol.gov/ebsa/pdf/1210-AB42-0153.pdf.

[33] *Id.*

[34] Randall D. Cebul, *Organizational Fragmentation and Care Quality in the U.S. Healthcare System*, JOURNAL OF ECONOMIC PERSPECTIVES 93, Vol, 22, No. 4 (Fall 2008).

[35] Comment Letter, National Association of Health Underwriters, May 14, 2010, *available at:* http://www.nahu.org/legislative/mlr/NAHU%20Comments%20on%20MLR.pdf.

[36] 45 CFR Pt. 158, *supra* note 7 at 74864.

market. [37] The NAIC recently asked HHS to take action to protect agent commissions.[38] If agents are forced to close their doors, small business failures will increase, and small business owners, who are their clients, will lose a critical tool in their ability to assess, purchase and service insurance plans.

In its July 2011 report, GAO found that almost all insurers it interviewed were reducing brokers' commissions and making adjustments to premiums in response to the Act's MLR requirements in an effort to decrease their company's MLRs.[39] Some of the insurers said the new MLR requirement provide an incentive to increase spending on quality improvement activities, but others said the MLR requirements were not a factor in decisions about activities to improve health care quality.[40]

The National Association of Health Underwriters (NAHU) asked HHS to remove brokers' commissions from the MLR because the commissions are essentially "pass through expenses"[41] and 100% of the fees are transferred to independent third parties.[42] NAHU asked for broker commissions to be removed from the MLR because the service agents provide benefits consumers and the health care system as a whole.[43]

If an insurer fails to meet the MLRs and must issue rebates, the rebates may be issued to the employer, who may be required to provide the rebate to the employee.[44] In high turnover industries, such as retail, the process of locating former employees could be tedious and time consuming.

C. Destabilizing the Insurance Market

The Act allows the Secretary of Health and Human Services to adjust the MLR in a state if it is determined that the MLR may destabilize the individual health insurance market.[45] States may apply for an MLR adjustment, and the public may comment on that request. [46] To qualify for the adjustment, a state must submit data demonstrating that requiring insurers in the individual market to meet the 80% MLR would result in fewer consumer choices and higher premiums. [47]

There is some concern about how to define "health care." In late 2010, the National Association of Insurance Commissioners submitted to the Department of Health and Human Services a model

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[37] Resolution Urging the U.S. Department of Health and Human Services to Take Action to Ensure Continued Consumer Access to Professional Health Insurance Producers, National Association of Insurance Commissioners (November 22, 2011), *available at*: http://www.naic.org/documents/committees_ex_phip_resolution_11_22.pdf.
[38] *Id.*
[39] U.S. GOVERNMENT ACCOUNTABILITY OFFICE, *supra* note 14 at 15.
[40] *Id.* at 16.
[41] Letter from Janet Trautwein, Executive Vice President and CEO, National Association of Health Underwriters, to Secretary of Health and Human Services 7, May 14, 2010, *available at*: http://www.nahu.org/legislative/mlr/NAHU%20Comments%20on%20MLR.pdf.
[42] *Id.*
[43] *Id.* at 8.
[44] Public Health Service Act § 2718(b), 124 Stat. 119.
[45] Pub. L. No. 111-148 §§ 10001(5), 10101(f), 124 Stat. 119, 130, 885 (2010). http://www.nahu.org/legislative/mlr/NAHU%20Comments%20on%20MLR.pdf.
[46] 145 CFR Pt. 158, *supra* note 11.
[47] *Id.*

regulation for how MLRs should be computed and how insurance company activities should be defined and categorized.[48] NAIC was initially divided on the issue of agent commissions and considered omitting them from the MLR calculation altogether.

At the time, NAIC determined that the Act did not provide a definitive method for omitting commissions, but its transmittal letter to Secretary Sebelius with NAIC's recommended uniform standards and methodologies for computing MLRs encouraged Secretary Sebelius to "recognize the essential role served by [insurance] producers and accommodate producer compensation arrangements in any MLR regulation promulgated."[49] In its letter notifying Secretary Sebelius of the completion of its work, NAIC's officers pointed out that "consumers will not benefit if companies are forced out of the market and individuals are left without coverage."[50] In a January, 2010 letter to Majority Leader Reid and then-Speaker Nancy Pelosi, NAIC expressed concern that a loss ratio of 80% in the individual market may not be realistic for many insurers, and an "improper or overly strident application of the MLR and rebate program could threaten the solvency of insurers or significantly reduce competition in some insurance markets."[51]

In its November 22, 2010 interim final regulation, MLRs were to be effective January 1, 2011. In the regulation, Secretary Sebelius agreed with NAIC's recommendation that the Act requires broker commissions to be included in the MLR calculation.

In June 2011, NAIC's Health Care Reform Actuarial Working Group to its Health Insurance and Managed Care Committee considered historical data from health insurance companies, health underwriters and states to estimate the effect of excluding agent commissions from the administrative portion of the MLR. Their report found that a significant number of insurance companies have reduced commission levels, but a significant number have not.[52] On November 22, 2011, NAIC supported a resolution calling on HHS to act on legislation to protect broker commissions.[53] The resolution cited growing concern over insurance market disruption caused by the MLR requirements.[54]

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[48] Press Release, National Association of Insurance Commissioners, NAIC Adopts Final Medical Loss Ratio Regulations (October 21, 2010), *available at*: http://www.naic.org/Releases/2010_docs/naic_adopts_final_mlr_regs.htm.

[49] Letter from the National Association of Insurance Commissioners to Secretary of Health and Human Services Kathleen Sebelius (October 27, 2010), *available at*: http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

[50] Letter from Jane L. Cline, Susan Voss, Kevin McCarty, Kim Holland, Roger Sevigny and Sandy Prager, National Association of Insurance Commissioners, to Secretary Kathleen Sebelius 4 (October 13, 2011), *available at:* http://www.naic.org/documents/committees_ex_grlc_mlr_sebelius_letter_101013.pdf.

[51] Letter from Jane L. Cline, National Association of Insurance Commissioners, to Majority Leader Harry Reid and House Speaker Nancy Pelosi (January 6, 2010).

[52] NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, RECOMMENDATIONS BY NAIC HEALTH CARE REFORM ACTUARIAL WORKING GROUP (June 2011), *available at:* http://www.naic.org/documents/committees_b_ha_tf_110519_report_phia.pdf.

[53] NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, *supra* note 35.

[54] *Id.*

D. Consumers

Some have argued that higher MLRs indicate a better quality of health care or health care cost savings.[55] In May 2011, an NAIC working group released estimates of rebates that would have been paid by insurers if the new MLRs had been in effect in 2010.[56] NAIC estimated that the Act's MLR provisions would have resulted in consumers saving almost $2 billion in 2010, and about half of the rebates would have gone to consumers in the individual insurance market.[57] A study prepared for Senate Commerce, Science and Transportation Committee Chairman Jay Rockefeller (D-AR) concluded that the MLR provisions would reduce consumer costs through rebates, but also because insurance companies will try to reduce their MLR liability exposure by decreasing premiums.[58] A similar report prepared by the staff of Senator Tom Coburn (R-OK) found that the Act's MLRs may raise the cost of premiums, because an insurer who must issue rebates may have to raise premiums to compensate for the lost revenue.[59]

IV. States Requesting a Phase-In of the MLR Requirements

Several states have requested a phase-in of the MLR requirements, as they are permitted to do.[60] This temporary relief would allow them a temporary adjustment the MLR. Florida and Michigan, for example, recently asked for a temporary phase-in. Michigan's request cited the possibility that the MLR requirements might force insurance companies to exit the state and destabilize its insurance market. As a result, Michigan requested that insurers meet a 65% MLR standard in 2011, followed by a 70% standard in 2012 and a 75% standard in 2013.

In Michigan, consumer groups responded by saying that a small risk of some companies leaving should not prevent the implementation of provisions that are designed to make the insurance market a more level playing field.[61] More than ten states and Guam have applied for adjustments. HHS recently rejected MLR phase-in requests from several states on the grounds that the insurance market was not truly destabilized.[62]

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[55] Report for Chairman Jay Rockefeller by the Majority Staff, Office of Oversight and Investigations, Senate Committee Commerce, Science and Transportation 2 (May 24, 2011), *available at:* http://commerce.senate.gov/public/?a=Files.Serve&File_id=d20644bc-6ed2-4d5a-8062-138025b998ef.

[56] Report by the National Association of Insurance Commissioners, May 19, 2011, *available at*: http://www.naic.org/documents/committees_b_ha_tf_110519_report_phia.pdf.

[57] *Id.*

[58] Report for Chairman Jay Rockefeller, *supra* note 51.

[59] Re-Examining PPACA's Federally-Mandated Medical Loss Ratios, Office of Senator Tom Coburn, September 9, 2011, *available at*: http://coburn.senate.gov/public/index.cfm/rightnow?ContentRecord_id=8b873136-06e9-4820-8f7b-e9b3828e33a4.

[60] 45 CFR Pt. 158, supra note 11.

[61] Jason Millman, *Michigan Groups Ramp Up Fight Over MLR Waiver*, POLITICOPRO, November 10, 2011, *available at*: https://www.politicopro.com/michigangroupsrampupfight/asp.

[62] Health Care Waivers Nixed for Indiana, Louisiana, POLITICO (November 29, 2011), *available at*: http://www.politico.com/news/stories/1111/69250.html.

V. Legislative Action

On March 17, 2011, Representative Mike Rogers (R-MI) introduced H.R. 1206, the Access to Professional Insurance Advisors Act. The bill, which currently has 139 cosponsors, would amend Section 2718 of the Public Health Service Act to exclude remuneration paid for licensed insurance producers from administrative cost calculations for purposes of calculating the MLR of a health insurance plan. On June 3, 2011, Rep. Tom Price (R-GA) introduced H.R. 2077, legislation that would repeal Section 2718 of the Public Health Service Act (the MLR provision). The bill has 21 cosponsors. H.R. 1206 and H.R. 2077 were referred to the House Energy and Commerce Subcommittee on Health, but no action has been scheduled.

VI. Conclusion

This hearing will provide Members with the opportunity to learn more about the Act's Medical Loss Ratio provisions and their effect on small businesses, including small insurers and insurance agents.