House Small Business Subcommittee

The New Medical Loss Ratios

Testimony of Timothy Stoltzfus Jost

Thank you Chairman Coffman and Subcommittee Members for the opportunity to address you today on the important topic of how medical loss ratios help small businesses. My name is Timothy Stoltzfus Jost and I am a law professor at Washington and Lee University. I am also a consumer representative to the National Association of Insurance Commissioners and a member of the Institute of Medicine.

The Medical Loss Ratio Rule: Saving Money and Jobs for American Small Businesses

Of all of the Affordable Care Act health insurance reforms that are currently in effect, the most important and beneficial for American small businesses is the minimum MLR requirement. Had this provision, which is first in effect this year, been in place last year, American small businesses would have received rebates of $447.4 million according to a thorough study conducted by the actuaries of the National Association of Insurance Commissioners.[1] Insurers are already moderating the premium increases they are imposing on small businesses to avoid paying rebates—even reducing premiums in some cases. The MLR requirement is reducing the cost of health insurance for American small businesses as we speak. It thus demands the full support of this committee.

Section 2718 of the Public Health Services Act, added by section 10101(f) of the Affordable Care Act and implemented by regulations issued by the Department of Health and Human Services, requires health insurers in the small group market to spend at least 80 percent of their premium revenues (after the cost of taxes and regulatory fees are deducted) on payments for clinical services and expenses that improve the quality of care. An insurer that fails to meet this target must refund each year to its enrollees—including small businesses--an amount equal to the product of the difference between the 80 percent MLR target and its actual MLR and the total amount of premium revenue (after taxes and regulatory fees) that it collected that year.

Nearly sixty percent of small businesses offer their employees health benefits.[2] The average annual premium for single coverage for small businesses is nearly $5000 a year and for family coverage over $14,000.[3] Between 2001 and 2011, premiums for small group family coverage grew by 103 percent.[4] The cost of health insurance is one of the largest, and fastest growing, items in the budgets of many American small businesses.

Fortunately, relief is on the way through the MLR requirement. First, many small businesses will receive rebates from insurers that fail to meet the MLR requirement on August 1 of next year, and each August thereafter. The NAIC study concluded that nearly

16% of small businesses, 23% of all small business employees, would have received rebates totaling almost $450 million had the rule been in effect last year.[5] Carl McDonald, a respected Wall Street analyst with Citi, concluded from his own review of the data that the top five U.S. insurers alone would have rebated almost $282 million to small businesses.[6] Actual rebates for 2011 may be greater or less, but they are certain to be substantial, and will most likely be used under rules released earlier this month by HHS and the Department of Labor to reduce premiums for health insurance going forward.[7]

But the purpose of the MLR requirement is not to generate rebates, but rather to reduce premiums. It does this in two ways. First, it provides a strong incentive for insurers to become more efficient, reducing administrative costs. There are widespread reports that insurers are doing this, including a GAO report from last summer.[8] As insurers reduce bureaucracy, they are able to reduce premiums for small businesses.

More importantly, however, the MLR requirement ensures that as medical costs themselves are reduced, premiums are reduced accordingly. It has been widely reported that the growth in health care spending has dropped significantly in the recent past.[9] This may be due in part to reduced utilization because of the recession or because of increased cost sharing, but also is attributable to reductions in prices, such as those caused by a number of widely used drugs going generic. As medical inflation declines, however, the MLR requirement forces insurers to pass the savings directly on to consumers in reduced premiums.[10] Already last summer, the GAO found that the MLR was driving down premium increases.[11] I have heard a number of reports in recent weeks of businesses that are seeing dramatic reductions in premium increases, indeed in some cases reductions in premiums themselves, directly because of the MLR requirement. I have also heard state insurance commissioners relate that insurers in their states are filing requests to decrease premiums or offer premium holidays, again specifically because they would rather reduce premiums now than pay rebates later.[12]

The Minimum Medical Loss Ratio is Not Destabilizing Insurance Markets

Some argue, however, that the MLR rule is destabilizing insurance markets. Although some insurers have had to change their business practices to meet the MLR requirements, most are already in compliance. A study by the GAO found that 70 percent of the 610 insurers in the small group market that are subject to the MLR requirement, covering 76% of covered lives, would have been in full compliance with the MLR requirement in 2010 had the rule been in effect.[13] Presumably even more will be in compliance in 2011, since they have had a full year to adjust their business models. Moreover, some states had MLR requirements that approximated the federal MLR requirement in place before 2011, and in those states insurers should already be in compliance.

Section 2718 delegated to the NAIC the responsibility for establishing the definitions and methodologies to be used by HHS for implementing the MLR rule. The statute specifically charged the NAIC and HHS to consider the special circumstances of "smaller plans, different types of plans, and newer plans." The NAIC conducted an open process

that fully involved interested parties, including insurers and brokers and agents, as well as consumer representatives and regulators. The NAIC recommendations were adopted nearly in their entirely by HHS.[14]

As written, the rule makes special accommodation for smaller insurers, recognizing that their claims experience can vary randomly from year to year. Insurers with fewer than 1000 covered lives are not even required to pay rebates initially, and insurers with fewer than 75,000 covered lives—the vast majority of insurers in the country—receive an upwards adjustment to their MLR for "credibility" of their experience. Insurers that predominantly sell high deductible policies also get a special upwards adjustment to accommodate their business model. Insurers entering a new market receive special accommodations under the rule. All insurers get to claim money they spend on health care quality improvement—for example expenditures to improve patient outcomes and safety, to reduce errors, to improve wellness and prevention, and to prevent hospital readmissions—in the numerator of the MLR formula. Under HHS' recently issued final rule, insurers can also claim part of their accreditation costs as well as the cost of converting to the ICD-10 claims coding system as quality improvement expenses.

After all of these adjustments accrue in the insurers' favor, some will still fall short of the federal minimum standard and have to pay a rebate to their customers. Even then, however, there is little evidence that this is having an effect on competition in insurance markets. Section 2718 permits states to petition HHS for adjustments to the MLR target in the individual market if the state believes that strict application of the MLR rule will destabilize their market. Seventeen states have petitioned for an adjustment, indicating that two thirds of the states did not believe the MLR was having a destabilizing effect on their markets. HHS has granted adjustments to six states, denied four requests, and seven are still pending.

A paper issued by the Galen Institute last week claims that the MLR requirement is leading to a "radical restructuring" of health insurance, and cites examples of a number of insurers who are ceasing the offering of certain plans or withdrawing from certain markets.[15] If one looks further at the sources cited in the paper, however, virtually none of these withdrawals had anything to do with health reform, much less with the MLR requirement. Empire Blue-Cross Blue Shield, for example, attributed its elimination of thirteen group plans to four years of financial losses, which can hardly be the fault of the MLR rule which went into effect only this year. The Principle Financial Group ceded its health insurance business to United and left the market because "our medical business has been declining in relative size for a number of years."[16] It decided to focus on other lines of business. Cigna also stated that it decided to cease offering small group coverage in several states for strategic business reasons, but remained in the individual market where it will still be subject to the MLR. UniCare explicitly stated that its decision to leave Virginia was not based on health reform. National Health had only 60 policies in New Mexico and the "thirteen plans" that left Iowa were apparently owned by a single insurer, which only covered 700 Iowans and thus would not have had to pay rebates in 2011.

The HHS Indiana MLR adjustment request determination, mentioned prominently in the Galen paper, illustrates the problem with attributing changes in dynamic markets to health reform. The Galen paper claims that "nearly 10 percent of the state's health insurance carriers have withdrawn from the market because they are unable to comply with the federal medical loss ratio requirement." In fact Indiana claimed initially that five insurers had withdrawn from its individual market, later adding two more.[17] However, one of the initial five, it turned out, had never actually sold policies in Indiana. Two more had MLRs well in excess of the 80 percent requirement and did not claim that the MLR requirement had anything to do with them leaving the market. Another insurer stated that its withdrawal had nothing to do with health reform, yet another withdrew because it was under a rehabilitation order, while a third stated that it withdrew for unrelated business reasons. The remaining two insurers both had fewer than 1000 enrollees in Indiana, and would not have had to pay rebates in 2011. None of the insurers claimed that they were leaving Indiana because of the MLR requirements.

Nationally, hundreds of insurers sell thousands of health insurance plans. The market for health insurance is very dynamic, with insurers coming and going from markets all the time for their own business reasons. To attribute every withdrawal from insurance markets to MLR requirements is to misunderstand profoundly insurance markets. Most insurers are in fact trying to comply with the ACA MLR requirement and stay in the game for 2014, when the exchanges and premium tax credits will provide a huge new market for health insurance.

Congress Should Not Increase Premiums for Small Businesses to Protect the Income of Brokers and Agents

The most vociferous complaints about the MLR requirement have come from agents and brokers, who believe that the MLR requirement is reducing their commissions. There is some evidence that one way in which insurers are reducing their administrative costs is by cutting their marketing costs, including agent and broker commissions. It is not accurate, though, to say that the MLR is "forcing" the reduction of this one administrative expense. Insurers have choices about how to reduce their administrative costs. Agent and broker commissions compete with other administrative costs and with profits. In a year in which the largest insurers made record profits, it is clear insurers made a choice.

Cuts in agent and broker commissions are far from universal. This issue was studied closely by the NAIC task force. It concluded "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." [18] The NAIC's conclusion was based in large part on state-by-state data submitted by the National Association of Health Underwriters (NAHU), which showed a complex pattern in which some companies in some states were cutting commissions, others were not, and many were changing their method of compensation, moving from percentage commissions to per-member per-month compensation. The GAO in its July report concluded that most of the insurers it interviewed were cutting commissions, but it interviewed only eight insurers, hardly a representative sample. The Insurance

Information Institute recently reported that the number of employed insurance agents and brokers actually increased between 2010 and 2011 by 5500.[19]

The effect of the MLR on agent and broker commissions must be understood in context. Historically, agents and brokers have been paid based on percentage of premiums. As health insurance premiums have grown dramatically in recent years, so have commissions. Yet the level of effort required of agents and brokers has remained largely the same, or perhaps with increased use of IT and automated eligibility and enrollment systems has even decreased. Commissions have also varied dramatically from state to state. A report from the Kaiser Family Foundation issued last week found that average commissions in the small group market varied from less than 1% of premiums in Alabama and North Dakota to about 7% of premiums in Utah and California.[20] From the data NAHU submitted to the NAIC, it appears that when commissions have been cut, they have often been cut from very high levels – as high as 15 to 20 percent -- to levels more in accordance with the market generally.

Congress does not exist, of course, to protect the income of any special interest group. If there were solid data that the MLR was causing consumers to lose access to the valuable services of agents and brokers, that might be a subject of concern. But the NAIC found no evidence that this was happening. Indeed, the NAIC study found that states with high state MLR requirements had not experienced loss of access to agent and broker services.[21] The NAIC plenary, as has been widely reported, did recently decide to recommend in a closely divided and politically contentious vote to recommend that Congress amend the MLR law to preserve consumer access to agents and brokers. It produced no evidence, however, that consumers are having difficulty finding agents and brokers. Indeed, none of the state MLR adjustment requests have yet produced evidence of reduction in agent and broker services to consumers, and some states have not even asserted that this is an issue.

Any cuts in agent and broker commissions are occurring because of the business decisions of insurance companies. Insurers have been looking for a way to cut their marketing costs and have moved away from commissions, switching to per-member per-month. Many insurers are also marketing directly over the internet. The MLR gave the insurers an opportunity to all act together at once to cut their marketing expenses without risking antitrust scrutiny—and to blame their decisions on the Affordable Care Act, which many insurers dislike for other reasons. If Congress were to withdraw agents and brokers commissions from the MLR denominator, as H.R. 1205, a bill offered by Congressman Rogers, would permit, it is likely that insurers would increase their administrative costs and profits—and small business premiums--but it is unlikely that they would restore commission cuts.

Agents and brokers do provide valuable services for small businesses. They deserve fair compensation for these services. The NAIC found that the average insurer paid about 4.5 percent of premiums in commission in the small group market.[22] This compares with the approximately 13.6 percent of premiums that insurers spend on pharmaceutical costs, and a probably even lower percentage on primary care.[23] I am not sure that Congress should

be in the business of deciding how much agents and broker should be paid, but I am doubtful an argument can be made for restoring 20 percent commissions at a time when many small businesses are struggling to meet premium payments to cover basic medical care.

Repealing or Amending Medical Loss Ratio Requirements Will Increase the Deficit

Finally, Congress must consider one other issue—the effect of any legislative changes in the MLR requirement on the federal budget deficit. Premiums paid for small business health insurance coverage are taxable neither to employers nor to employees. Premiums are not only free from the income tax, but also from payroll taxes (as well as from state income tax in many states). That means for an employee in the 15 percent tax bracket, 30.3 percent of the cost of health insurance coverage is written off as lost tax revenue. For an employee in the 28 percent bracket, 43.3 percent of the premium is lost in tax revenue. If, as is widely reported, the MLR is resulting in lower premium increases, or even in premium decreases, small businesses will retain more in profits and employees in cash income. This also means, of course, that more taxes are going toward federal deficit reduction.

If you change the MLR rule to allow insurers to add commissions of 5, or 10, or even 20 percent on top of the 20 percent insurers can already claim for administrative expenses to the cost of an insurance plan sold to a small business, you are increasing the cost of doing business for small businesses and killing job creation. But you are also increasing the size of the federal deficit, and not insignificantly. The CBO has yet to price legislation to amend the MLR, but I will be surprised if the cost is not in the billions, perhaps tens of billions, of dollars over the ten year budget window. If you are serious about the budget deficit, reject any legislative changes to the MLR.

Conclusion

The MLR is a powerful tool to control health premium costs. It is bringing down health insurance costs for small businesses, promoting their prosperity and facilitating job creation. It is encouraging insurers to be more efficient and to cut unnecessary administrative costs. Any attempt to eliminate the MLR or to change it to allow insurer spending to continue unchecked can only raise costs for small businesses and for all insured Americans. I encourage you to support small business by keeping a strong MLR.

References

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