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Committee on Small Business
Subcommittee on Investigations, Oversight and Regulations

Rep. Mike Coffman, Chairman

Hearing on

"New Medical Loss Ratios:
Increasing Health Care Value or Just Eliminating Jobs?"
December 15, 2011

Testimony presented by
Grace-Marie Turner
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Executive summary
The Patient Protection and Affordable Care Act (PPACA) already is leading to a loss of affordable options for health insurance for small employers, to a loss of jobs inside and outside the health sector, and to higher health costs that make hiring new workers a risky proposition, especially for struggling small businesses.

The percentage of small businesses offering health insurance has declined from 68 percent in 2000 to 59 percent in 2011. The health law that so many small business owners had hoped would benefit them by lowering costs is instead harming their ability to continue to offer health insurance at all. At least partly because of early provisions of PPACA, premiums for job-based health insurance rose in 2011 by an average of $1,303 per family — at the rate of 9 percent. A family policy now costs an average of $15,073.

The "medical loss ratio" (MLR), which mandates that health insurance carriers spend most of the money they collect from premiums on direct medical care, is contributing to the dislocations in the small group and individual markets, which small businesses rely on for coverage. A growing number of carriers are leaving these markets because they can't meet the Department of Health and Human Services' (HHS) inflexible tests.

Many states have applied to Washington to delay implementation, arguing that some carriers would be forced to stop selling policies in their states if they were not given relief from the MLR rules. This will lead to less competition and higher prices. The HHS has refused many requests, and the deterioration in available private-sector coverage already has begun. In my testimony, I provide a list of examples of companies pulling out of markets from New York to Colorado, Indiana to New Mexico, and Virginia to Utah.

One of the tools that small businesses have found to be most valuable in helping them offer affordable coverage — high-deductible health plans — could be strangled by the obscure and complex MLR regulation.

PPACA already is having a direct impact on jobs in the health broker industry. Brokers are closing their doors, laying off workers, and depriving clients of their services. A recent survey found that 21 percent of independent health insurance agency owners have been forced to downsize their businesses.

Clearly, millions of people are having their coverage disrupted, violating the promise that President Obama — and virtually all of those in Congress who voted for the law — made to the American people. As the cascade continues, support will grow for an alternative approach to PPACA. I look forward, Mr. Chairman, to talking with you and with members of the committee about a better, more sustainable path forward to affordable health insurance.

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By Grace-Marie Turner, Galen Institute

Chairman Coffman and Members of the Subcommittee, my name is Grace-Marie Turner and I am president and founder of the Galen Institute, a non-profit research organization specializing in market-based solutions to health reform. I appreciate the opportunity to testify today about the Medical Loss Ratio rules and their impact on health insurance and the jobs market. I will focus on the economic effects of the new MLR rules on small businesses, including the impact on the businesses' growth, jobs creation, and health costs.

Losing coverage

The Patient Protection and Affordable Care Act (PPACA) already is leading to a loss of affordable options for health insurance for small employers, to a loss of jobs inside and outside the health sector, and to higher health costs that make hiring new workers a risky proposition, especially for struggling small businesses.

A major survey of employer plans provides evidence of how PPACA is destabilizing employer-based health insurance. Earlier this year, McKinsey & Company surveyed 1,300 employers across industries, geographies, and employer sizes, and concluded that PPACA will lead to a "radical restructuring" of job-based health coverage.[1] McKinsey found that 45 to 50 percent of employers say they will definitely or probably pursue alternatives to employer-sponsored health insurance in the years after it fully takes effect in 2014. One-third of employers say they will "definitely or probably drop coverage after 2014." Among employers who knew most about the new health law, half said they were likely to drop coverage.

An estimated 156 million non-elderly Americans get health insurance at work,[2] according to the Employee Benefit Research Institute,[3] and that means as many as 78 million people could be forced to find other sources of coverage.

Large companies can self-insure and better insulate themselves from the early changes inflicted by PPACA. Not so small businesses, which are more exposed to changes in the marketplace. As I document below, many carriers already are leaving the market for individual and small group insurance. When fewer carriers offer insurance and when fewer options of affordable coverage are available, small businesses are hit the hardest.

The percentage of small businesses offering health insurance has declined from 68 percent in 2000 to 59 percent in 2011.[4] The health law that so many small business owners had hoped would benefit them will instead harm their ability to continue to offer health insurance to their workers.

One of the most fervent promises President Obama made to the American people before passage of the health overhaul law was "If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what."[5]

But, even before the law fully takes effect, millions of people are losing the coverage they have now, and tens of millions more surely will follow.

Health costs rising

A Kaiser Family Foundation and Health Research and Educational Trust survey of employer-sponsored coverage released in September 2011 quantified what businesses across the country already know.[6] It found that premiums for job-based health insurance rose in 2011 by an average of $1,303 per family — at the rate of 9 percent. A family policy now costs an average of $15,073. President Obama repeatedly said families would see savings to their health premiums of $2,500 a year by the end of his first term — not an increase of $1,303 in one year.

There are a number of factors that contribute to rising health costs, including the mandates, rules, regulations, and spending in the health law. We are already seeing the impact of the law's early provisions, such as not charging patients deductibles or co-payments for preventive care, raising the ceiling on what insurance pays adds to premium costs, and requiring employers that offer dependent coverage to add "children" up to age 26 to their parents' policies. All of these mandates cost money and add to premium costs. And we have only seen the beginning of the cascade of mandates in the law that will fuel further health cost increases. I will describe more about this in my testimony below.

Medical Loss Ratio rules

I would like to turn to the specific provision in PPACA that is the focus of this hearing — the "medical loss ratio" (MLR), which mandates that health insurance carriers spend most of the money they collect from premiums on direct medical care.

This rule and the Department of Health and Human Services' (HHS) strict interpretation of it are contributing to the dislocations in the small group and individual health insurance markets, hitting small businesses hardest.

The MLR rules require health insurance carriers to spend 85 percent of the money they collect from premiums on direct medical care for large groups and 80 percent for individual and small groups. The remainder can be spent on administrative overhead and profit.

HHS has been very inflexible in listening to the real world impact of its regulations implementing this provision.

As an example of HHS' inflexibility, the final MLR rules released on December 2, 2011, rejected insurers' requests that the health expenditure side of the MLR equation include both anti-fraud efforts and all costs associated with implementing ICD-10 codes — a huge and costly

requirement that they change their billing categories to include more than 140,000 new billing codes.[7]

That means the new MLR rules constrain the ability of health plans to fight fraud because that spending now must count toward their administrative expenses. If health plans spend too much protecting policyholders from fraud, the plans will be penalized and forced to send rebates to the policyholders. It's a Catch-22. Health insurance companies will have a *disincentive* to fight fraud and protect policyholders' premium dollars.

The National Association of Insurance Commissioners also had petitioned HHS to exclude broker fees from the administrative portion of the calculation. That request also was rejected by HHS regulators. This means agents and brokers, many of whom function as valued outside human resources departments for many small and medium-sized employers, will have trouble getting compensated for their work. The brokers help employers find the policies that meet their needs, negotiate terms, benefits, and premium costs with insurers, and then help navigate the claims process for the client company's employees. Without commissions, businesses will not have access to these services and will either have to do the work themselves or leave their employees to fend for themselves.

The National Association of Insurance and Financial Advisers (NAIFA) said it was disappointed that the final regulations did not permit insurers to exclude agent and broker fees from administrative expenses.[8]

Forced rebates

Health insurers that are unable to comply with this increasingly complex maze of MLR rules will be required to provide premium rebates if they exceed the allowed medical loss ratio for administrative expenses. "If your insurance company doesn't spend enough of your premium dollars on medical care or quality improvement this year, they'll have to give you rebates next year," according to CMS acting administrator Marilyn Tavenner.[9]

Companies that sell policies to individuals and small groups have higher marketing costs and higher customer service expenses, and it is especially difficult for them to meet the MLR tests because their administrative costs are necessarily higher. In addition, high-deductible policies provide customers protection against large medical expenses, but carriers may not pay out the required percentage every year in medical claims, making it very difficult for them to meet the MLR tests. Many health insurance companies have slashed the number of employees, cut agent commissions, and taken other harsh steps to reduce overhead, but this is also slashing customer services.

Many carriers said they could meet the test given time, but Sec. Sebelius refused to listen to the carriers when they asked her to use her authorized discretion to delay for at least a year the MLR requirement.

The stakes are high. Aetna warns it may hemorrhage up to $100 million thanks to MLR rules this year.[10] According to *Fortune* magazine, health insurance is among the least profitable industry

sectors in America. *Kaiser Health News* concludes, "With the nation's health care spending estimated at $2.5 trillion this year, even the elimination of insurers' profits and executive compensation would lower health care spending by just 0.5 percent."[11]

Discriminating against HSAs

The MLR rules also discriminate against high-deductible health plans, which are especially popular among small businesses with slim profit margins. These businesses want to offer health insurance to their workers but cannot afford the generous plans that larger companies offer. Health Savings Accounts (HSAs) and other consumer-directed plans allow companies to provide an affordable alternative to their workers.

But the MLR regulations only counts payments made directly by insurers as medical expenses. Health care costs paid by individuals below the deductible don't qualify, making it hard for these plans to meet the 80 percent MLR test. In other words, HHS rules mean that if an individual pays for a health care service to meet the deductible, the expenditure does not count toward the MLR ratio, even though the full amount is actually a payment for medical services.

As of January, about 11.4 million people were covered by HSA plans. The average deductible for small group HSA plans ranged from $2,820 to $2,957 in 2011, according to industry group America's Health Insurance Plans. Only about 5 percent of HSA policies have claims above the deductible.[12]

"If it is too difficult [for HSAs to meet the MLR test], insurance companies won't offer them," said Roy Ramthun, who played a major role in writing HSA regulations during the Bush administration. "That would mean the most affordable policies would go off the market."

Therefore, one of the tools that small businesses have found to be most valuable in helping them offer affordable coverage could be strangled by this obscure and complex regulation.

ObamaCare regulations cause havoc in the states

Many states have applied to Washington to give them flexibility because they say many carriers can't comply with the MLR rules. Thirteen states that have applied to the federal government for temporary "adjustments" in MLR rules have been granted waivers. But the Obama administration has turned down requests from Indiana, Louisiana, North Dakota, and Delaware that they be granted waivers from the health law's strict directives.

Indiana argued that some carriers would be forced to stop selling policies in the state if they were not given relief from the rules. This would lead to less competition and higher prices for consumers. Indiana asked HHS to lower the threshold MLR percentage companies would have to meet, provide a permanent waiver for high-deductible plans, and provide a waiver for new entrants into the individual market until 2014. Louisiana asked HHS to lower the MLR percentages to 70 percent for 2011 and 75 percent for 2012.

Health and Human Services officials said in letters on November 27, 2011, to the insurance commissioners in Indiana and Louisiana that the government is denying their requests.[13]

"Once again, the Obama administration took a position in favor of higher health care costs and against personal freedom," said Indiana Governor Mitch Daniels after receiving the letter notifying him of Washington's decision. "Today's letter is further proof that the PPACA is a catastrophe for America and must be repealed."[14] The MLR rules are particularly difficult to meet for plans such as Health Savings Accounts which offer high-deductible coverage, and Indiana has a particularly high concentration of the popular cost-saving plans. Indiana had proposed an alternative approach to phase in the MLR triggers, but it was denied by HHS.

In addition, North Dakota warned that if the government denied its request for a waiver that "consumers would be left without coverage" and many would have trouble finding new coverage, especially if they have a health condition. Washington denied its request as well.

This Washington-knows-best attitude that is guiding the creation of more than 10,000 pages of rules and regulations to implement the health law will continue to cause a cascade of lost coverage because it is ignoring market forces in favor of Washington rule-making.

The health law already is harming the ability of small businesses to find health insurance as a growing number of carriers are leaving markets, shrinking the pool of options available to small business owners.

One of the perverse effects of the MLR rules likely will be higher health premiums. If health insurance companies are limited in their ability to cut costs by reducing fraud, for example, they can also meet the MLR test by increasing premiums. A higher premium produces a larger denominator, and therefore the 20 percent available for administrative expenses would be a larger amount of money. With fewer competitors in the market and a smaller number of products available, carriers would be able to charge higher premiums. Small employers would be squeezed. The federal government may have the hubris to believe it will be able to force carriers to hold down premium prices, but this is simply another form of price controls. No matter how complex and opaque, price controls have not worked for 4,000 years, and they won't work here either.

Medical Loss Ratio regulations as job killers

PPACA already is having a direct impact on jobs in the health broker industry. Dennis Lockhart, President of the Federal Reserve Bank of Atlanta, reports that:[15]

> In addition to slow and uncertain revenue growth, contacts in this recovery are frequently citing a number of other factors that are impeding hiring. Prominent among these is the lack of clarity about the cost implications of the recent health care legislation. We've frequently heard strong comments to the effect of "my company won't hire a single additional worker until we know what health insurance costs are going to be."

Many economists believe that uncertainty about the cost of the employer mandate is a key contributor to the stubbornly high unemployment rate.[16]

But the immediate impact of job losses has been felt most acutely in the broker community. A recent survey found that 21 percent of independent health insurance agency owners have been forced to downsize their businesses, including laying off employees. [17] An additional 26 percent have also had to reduce the services they provide to their clients. Many agents have lost their jobs and their main source of livelihood, and those who remain in the business have seen their compensation plummet.

The HHS rules require health plans to treat independent agent and broker compensation as part of health plan administrative costs — even though they aren't employed by health insurance carriers. Brokers and agents run their own businesses, hire their own employees, and pay all of their own office expenses, working for their clients to find the best and most affordable health insurance, usually from a range of health carriers.

None of the compensation goes to the health insurer, yet HHS rules require that it be counted against the insurer's allowable administrative cost.

Agents bring a great deal of value to their clients, yet these clumsy rules are shoving them aside. Not only do they help individuals and small businesses find the most appropriate and affordable policy from many competing carriers, but they also help companies find and establish wellness and disease-management programs and navigate the often-complex claims process. They are a crucial element in the equation of helping businesses find the most appropriate and affordable health policies for their employees.

Many smaller companies do not even have an HR department so, as the Congressional Budget Office has noted, agents and brokers often "handle the responsibilities that larger firms generally delegate to their human resources departments — such as finding plans and negotiating premiums, providing information about the selected plans, and processing enrollees."

There will continue to be a need for licensed, trained professionals to help individuals, employers and employees with their health insurance needs. Yet in every state, as a direct result of the new law's MLR provisions, agency owners are reporting that they are reducing services to their clients, cutting benefits, and eliminating jobs just to stay in business. In some instances, they are simply closing their doors.

Other studies show additional job losses as a result of provisions in PPACA. The National Federation of Independent Business's Research Foundation studied the private-sector job loss that will result from just one provision in PPACA — the Health Insurance Tax (HIT). The rise in the cost of employer-sponsored insurance stemming from the HIT will result in a reduction in private sector employment by 125,000 to 249,000 jobs in 2021, with 59 percent of those losses falling on small business. [18]

Health plans are already leaving markets

The deterioration in available private-sector coverage already has begun. Citizens in states around the country have learned that carriers are leaving markets. Some of the carriers are exiting because of onerous state regulations, others are victims of a faltering economy, but the cascade has been accelerated by the rules that already have taken effect and the many more that are to come as a result of PPACA, including the MLR.

Employers work very hard to find the balance in keeping the cost of health insurance as low as possible while offering the benefits that employees want and need. Part of the way they are able to do this is by seeking bids from competing insurers and amending and adjusting benefit structures. But if there are fewer companies offering coverage, employers will be limited in their choices. This also means they are limited in their options to help keep costs down.

Here are some examples of the many carriers leaving the private health insurance market:

In New York, Empire BlueCross BlueShield said it will drop in the spring of 2012 health insurance plans covering about 20,000 businesses in the state. Mark Wagar, president and CEO of Empire, said that the company will eliminate seven of the 13 group plans it currently offers to businesses that have two to 50 employees. The move is expected to have a great and potentially "catastrophic" impact on small businesses in New York, according to James L. Newhouse, president of Newhouse Financial and Insurance Brokers in Rye Brook, NY.[19] This loss of competition inevitably will lead to higher prices and fewer choices for businesses and their employees.

In Colorado, World Insurance Company/American Republic Insurance Company announced in October 2011 that it is leaving the individual market, citing the company's inability to comply with insurance regulations.[20] Also in Colorado, Aetna will stop selling new health insurance to small groups in the state and is moving existing clients off its plans this year, affecting 1,200 companies and 5,200 employees and their dependents.[21] Aetna also has pulled out of Colorado's individual market because of concerns about its ability to compete there, dropping 22,000 members.[22] It also has dropped out of the small-group market in Michigan and several other states.

In Indiana, 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. Indiana was hoping to bring the companies back by asking the Department of Health and Human Services for a waiver from the rule, but Washington refused in late November 2011 to grant the waiver.

In Iowa, 13 plans have left the health insurance market since June of 2010, citing regulatory concerns.[23]

In New Mexico, four insurers — National Health Insurance, Aetna, John Alden, and Principle — are no longer offering insurance to individuals or to small businesses — drying up the market and driving out competition.[24]

In Utah, Humana is ending its participation in the Utah Health Exchange, leaving only three carriers participating in the exchange.[25]

In Virginia, UniCare has eliminated its individual market coverage for about 3,000 policyholders.[26] And shortly after the health law was enacted in 2010, a new Virginia-based company, nHealth, announced it was closing its doors, saying that the regulatory burdens posed by the health law made it impossible to gain investor support to continue operating.[27]

The American Enterprise Group announced in October 2011 that it would stop offering non-group health insurance in more than 20 states.[28] As a result, 35,000 people will lose the health coverage they have now. The company cited regulatory burdens, including the medical loss ratio requirements, in explaining its decision to leave the markets. This means there will be less competition in these 20 states, resulting in higher prices for consumers in many cases.

Principal Financial Group, based in Iowa, announced in 2010 that it would stop selling health insurance, impacting 840,000 people who receive their insurance through employers served by the company. The company assessed its ability to compete in the new environment created by PPACA and concluded its best course was to stop selling health insurance policies.[29]

Another 42,000 employees of small and midsize employers learned in January 2011 they were losing their health coverage with **Guardian Life Insurance Co.** of America. The company announced it was leaving the group medical insurance market (it had reached an agreement with UnitedHealthcare to renew coverage for Guardian clients).[30] Guardian began withdrawing from the medical insurance market in specific states more than a decade ago, and says it would be leaving the market with or without PPACA.

Cigna announced that it is no longer offering health insurance coverage to small businesses in 16 states and the District of Columbia: California, Connecticut, Florida, Georgia, Hawaii, Illinois, Kansas, Missouri, New Hampshire, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Texas, Virginia, and Washington, D.C.[31]

These announcements that carriers are leaving markets accelerates a trend that the American Medical Association says leaves four out of five metropolitan areas in the United States without a competitive health insurance market.[32] The report found that in about half of the metropolitan markets, at least one health insurer had a commercial market share of 50 percent or more. In 24 states, the two largest health insurers had a combined commercial market share of 70 percent or more.

This is a negative and destructive trend, leaving fewer carriers to serve these markets and giving small businesses and the insurance agents who serve them less leverage to negotiate better benefits and lower rates among competing companies.

Other dislocating regulations

The committee may want to look into other regulations and directives from HHS that are dislocating the market and impacting small businesses:

Children-only policies

One of the provisions of the health law that the Obama administration touts most enthusiastically is the requirement that employers who offer dependent coverage allow employees to add their 26 year old "children" to their policies. It is highly ironic, then, that another provision is causing huge losses of coverage among children whose parents or guardians were buying health insurance policies for them on their own.

One of the earliest indications of lost coverage came in June 2010 when Health and Human Services Secretary Kathleen Sebelius told health insurers that they must write policies for children under 19, including those with pre-existing conditions, no matter when their parents and guardians apply. This creates an incentive for parents to wait to buy the coverage until the children have a significant medical condition. This in turn creates a substantial risk of "adverse selection," which makes it financially unsustainable for health plans to continue to offer these policies. Rather than wait for this to happen, many carriers have decided to leave this market altogether.

Sen. Michael Enzi, ranking Republican on the Health, Education, Labor, and Pensions Committee, asked his staff to survey the states to find out how many were offering child-only policies.[33] All 50 states responded to the HELP Committee survey, and 17 said there are no carriers currently selling these plans to new enrollees in their states. One of the largest insurance markets in the country, Texas, has seen all of its carriers drop child-only health insurance. Other states that no longer have carriers selling child-only plans include Alaska, Arizona, Connecticut, Delaware, Florida, Georgia, Idaho, Minnesota, Nebraska, Nevada, North Dakota, Oklahoma, South Carolina, Tennessee, West Virginia, and Wyoming. The HELP Committee updated its survey of the child-only market and released a paper in August 2011 with a detailed summary of the states impacted.[34]

The MLR rules represent just one set of market-distorting regulations imposed by the health law. Guaranteed issue and community rating rules to come will further dislocate the health insurance market, making it difficult for most carriers to continue to offer policies. We should expect this cascade of lost coverage to continue.

Sicker employees could be shoved out

Two University of Minnesota law professors write that ObamaCare actually provides incentives for "targeted employer dumping" of sicker workers into taxpayer-subsidized health exchanges.[35]

The article, "Will employers undermine health care reform by dumping sick employees?" by Amy Monahan and Daniel Schwarcz, explains how companies could redesign their health benefit programs to make it more costly for sicker employees to stay with the company health plan and encourage them to opt instead for the exchanges.

Monahan and Schwarcz write that this "would expose these exchanges to adverse selection caused by the entrance of a disproportionately high-risk segment of the population into the insured pool." They said that, "Not only would this undermine the spirit of health care reform, but it would jeopardize the sustainability of the insurance exchanges."

In spite of this, senior HHS officials have said it would be a good thing for employers to "dump [their] people into the exchange,"[36] and that Speaker Pelosi talked favorably about ObamaCare as a way "for businesses to be emancipated from health care costs because they have a way out or whatever works for them."[37]

The only problem is that it would NOT be good for sicker employees, who would surely have greater difficulty finding physicians to see them under what surely will be lower payment rates in the exchanges, and it would be bad for taxpayers, who will have a much bigger bill to pay for exchange subsidies.

The Ohio Department of Insurance commissioned a study on what to expect from ObamaCare from the actuarial firm Milliman, Inc. of Seattle. Milliman's report estimates that 790,000 Ohioans will lose their private health insurance. Further, health insurance premiums in the individual market could increase by as much as 55 percent to 85 percent when ObamaCare takes full effect in 2014. Small businesses could see premium increases, and, in many cases, "these changes could be greater than 25 percent," not counting regular medical inflation.

A total of 688,000 Ohio residents will move OUT of employer coverage, and most of those getting coverage in the new state exchanges will be people who lost their employer coverage because firms have new incentives to "dump" their workers.

The employer mandate

We have written extensively about the risks of the employer mandate.[38] Even though small businesses are exempt if they have fewer than 50 employees, it presents a huge obstacle to their growth. And even if the company is small enough to escape the mandate, each of the employees still will be subject to the individual mandate in PPACA. The costs and disruptions are enormous.

Looking toward the future

Long before the law fully takes effect, PPACA is harming workers and employers as they face fewer choices for health insurance.

Clearly, millions of people are having their coverage disrupted, violating the promise that President Obama — and virtually all of those in Congress who voted for the law — made to the American people. As the cascade continues, support will grow for an alternative approach to PPACA. I look forward, Mr. Chairman, to talking with you and with members of the committee about a better, more sustainable path forward to affordable health insurance, especially for small businesses.

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