GALEN INSTITUTE

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Sen. John D. Rockefeller, Chairman
Sen. John Thune, Ranking Member

Hearing on

"Delivering Better Health Care Value to Consumers: The First Three Years of the Medical Loss Ratio"

May 21, 2014

Testimony presented by
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Chairman Rockefeller, Ranking Member Thune, and members of the committee, thank you for the opportunity to testify today on "Delivering Better Health Care Value to Consumers: The First Three Years of the Medical Loss Ratio."

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy reform. I served as an appointee to the Medicaid Commission from 2005-2006, as a member of the Advisory Board of the Agency for Healthcare Research and Quality, and as a congressional appointee to the Long Term Care Commission in 2013.

The Long-Term Care Commission, as you know, was created as a result of the repeal of the Community Living Assistance Services and Supports Act (CLASS Act), repeal legislation that Ranking Member Thune sponsored and which was enacted after the administration was unable to find a viable path forward for implementation of the program. I want to thank you, Chairman Rockefeller, for your leadership and the hard work of your staff in kick-starting the work of the commission. I believe that we produced, in our 100-day sprint to complete our work, a valuable report that gained bi-partisan support for a wide range of important recommendations.[1]

In addition, Mr. Chairman, I want to thank you for the hearing on July 16, 2009, on "Competition in the Healthcare Marketplace" before the Subcommittee on Consumer Protection, Product Safety, and Insurance which Sen. Pryor chaired and which you attended.[2] I found the hearing to be extremely valuable in showing the broad bi-partisan support for competition and innovation in the health sector. As a direct result, we have subsequently sponsored at the Galen Institute a series of major annual conferences on "The Value of Innovation in Health Care." We invite speakers from around the country to describe their work on health care innovation before policymakers in Washington, from presentations about the operating room of the future, to the latest biomedical research technologies, and transformative consumer solutions such as Walmart's $4 generic drugs program.

Consumer protections

I don't think there would be any disagreement on either side of the aisle about the goal of today's hearing, entitled "Delivering Better Health Care Value to Consumers." Consumer protection and transparency are crucial goals of health reform. To make sure that consumers can know the amount of premium dollars being spent on medical care versus administrative expenses, the

ACA specifies the medical loss ratio (MLR) which health plans must meet. Plans participating in the individual and small group markets must spend at least 80 percent of premium dollars on medical costs and those in the large group market, 85 percent. Those who fail to meet the percentages must provide rebates to consumers.

Consumers and businesses already have received rebates from health insurance companies that failed to meet the MLR requirements. Certainly they appreciate receiving these checks, but I think it is important to look at the larger issue of consumer protections to see if the law is meeting these goals.

While it is too soon to know what premium increases will be in 2015, it is fairly certain that most consumers will see at least modest increases but others are likely to see significant hikes. Given that consumers were promised they would save an average of $2,500 a year on premiums for a family if the ACA were enacted, they are looking for relief. I believe it is important to look at other factors that are keeping premiums high.

Higher taxes and fees

The American Academy of Actuaries details in a May 2014 report the major drivers behind expected 2015 premium increases.[3] "The majority of premium dollars goes to medical claims, which reflect unit costs (e.g., the price for a given health care service), utilization, the mix and intensity of services, and plan design." Further, the report explains, "Premiums must cover administrative costs, including those related to product development, enrollment, claims processing, and regulatory compliance. They also must cover taxes, assessments, and fees, as well as profit (or, for not-for-profit insurers, a contribution to surplus)."

The report discusses the increase in the health insurer fee, which collects about $8 billion a year from health insurers this year, increasing to $14.3 billion in 2018 and more than $100 billion over ten years.[4] "In general, insurers pass along the fee to enrollees through an increase in the premium," the actuaries write. The tax on health insurance alone will add $350 to $400 to a family's health insurance premiums in 2016.[5]

Other taxes and fees in the health law also will be passed along to consumers. These include taxes on medical devices and drugs, new fees to administer health insurance exchanges, and reinsurance fees to help offset higher-cost patients in the individual market.

These additional costs directly resulting from the law will be much larger than any health insurance efficiencies under the MLR.

Lack of competition

Premiums for health insurance vary greatly across the states. A recent report in *The New York Times* explains that lack of competition is a key reason.[6] For example, a 27 year old enrollee in Jackson, Mississippi, pays $336 a month for the second cheapest silver plan on the federally run

exchange in the state. That's more than twice what the same person in Nashville would pay – $154 – and more than the $138 a young person in Tucson would pay for the same policy.

A crucial reason for the price differences: Lack of competition among insurers. There are only two insurers in the market in Mississippi. In Nashville's exchange, four insurance companies compete. In Tucson, eight companies are vying for the 27 year old's business. More competition leads to lower prices.

Premiums in the exchanges are 11 percent higher than they would be if all of the insurers participating in a market in each state had participated in the exchange, according to research soon to be published by economists Leemore Dafny and Christopher Ody from Northwestern University and Jonathan Gruber of the Massachusetts Institute of Technology. Greater competition not only would save consumers money in lower premiums but it also would save taxpayers money if they didn't have to subsidize the higher cost of insurance in these areas with little competition.

When hospitals know that only a few health plans are competing, they have much less incentive to negotiate discount prices. That manifests in higher premiums because insurers can't drive as hard a bargain to reduce costs. The end result of less competition among health plans is higher costs for consumers.

I include in the appendix to my testimony a list of health insurance companies that announced they were exiting the market over a period of 20 months after the law was passed. They are leaving for a variety of reasons. Some companies decided that they could not viably compete in the exchanges, others were overburdened with onerous state regulations, and others left the health insurance market because of concerns about the ACA's costs and regulations.

Consumers need more, not less, competition, both from existing as well as new innovative companies, in order to contain premium costs.

Limiting options for small employers

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 often 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. HSAs provide consumers with a spending account to pay for routine health care expenses as well as good catastrophic coverage to cover major costs.

However, the MLR regulations only include in the medical cost ratio those payments made directly by insurers toward medical expenses. Health care costs paid by individuals from their spending accounts 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 directly 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, 2013 about 15.5 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 the latest figures available from the industry group America's Health Insurance Plans. Only about 5 percent of HSA policies have claims above the deductible.[7]

Therefore, one of the tools that small businesses have found to be most valuable in helping them offer affordable coverage is significantly constrained by the MLR rule.

Investing in a better system

Certainly consumers want to see the great majority of their premium dollars going to medical care. But the complex systems still being developed to implement the ACA require a major investment in new technology, both on the part of government and health plans.

Because of the serious problems with healthcare.gov and with many state websites, health plans received inaccurate information about enrollees and were forced to complete applications manually. This process was time consuming and extremely costly. In addition, the "back end" of the website to process information for payment is not yet built and when it is, it will require companies to build new interfaces to connect with the exchange computers – again adding to administrative cost. No one wants this, but it is a necessary investment for the system to work. There are also administrative costs associated with the detailed reporting required of the companies to comply with the MLR.

In addition, the final MLR rules released on December 2, 2011, rejected insurers' requests that the health expenditure side of the MLR equation include anti-fraud efforts. 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. This has the unfortunate result that health insurance companies actually 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 individuals and employers to 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. With limited commissions, individuals and small businesses will not have access to these services and will have to fend for themselves.

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

Transparency

A shared goal of health reform is to promote transparency. Several insurers are developing a collaborative effort to provide consumers with more transparent information about prices. For example, Aetna, Humana, and UnitedHealth are working with a new nonprofit research organization called the Health Care Cost Institute to develop and provide consumers "free access to an online tool that will offer consumers the most comprehensive information about the price and quality of health care services." Other health plans could soon join Aetna, Humana and UnitedHealth in the effort.

Many companies also are working hard on delivery system reform and investing in initiatives to improve the quality of care, but establishing these initiatives requires an upfront investment that must come out of their administrative expense allocation, affecting their MLR calculation. The ACA regulations, however, are very restrictive in what is allowed for these developmental costs to be excluded from the MLR, and this impedes their incentive to innovate.

Given the right incentives and more flexibility to respond to consumer demands, the industry could develop new consumer-friendly initiatives to increase quality and transparency. Giving consumers more choices, transparency in costs and benefits, and the ability to select from among meaningfully different health plans are keys to developing a more responsive system.

Conclusion

While we certainly share the goal of protecting consumers to assure that they get better value in health care and health coverage, I am concerned that provisions of the ACA actually work against that goal. Higher taxes and fees on health insurance are passed along to consumers in the form of higher premiums. A lack of competition among insurers in states means there is little incentive for hospitals and other providers to negotiate lower rates, again driving up the cost of premiums. The ACA has the unintended result of interfering with one of the health insurance options that has been popular with small business by not counting spending on medical care from Health Savings Accounts as medical expenditures for purposes of the MLR calculation. And other provisions also produce unintended consequences, such as giving health insurers less incentive to fight fraud and making it more difficult for insurers and brokers to be there to assist individuals and small businesses with insurance decisions and claims.

I believe the ACA must be modified going forward. I look forward to the opportunity to work with you on the shared goal of getting consumers the best value for their health care dollars. Thank you for the opportunity to testify today, and I look forward to your questions.

Appendix

Health plans have left markets[9]

Health insurance carriers began leaving markets soon after the ACA was enacted. They are leaving for a variety of reasons. Some companies decided that they could not viably compete in the exchanges, others were overburdened with onerous state regulations, and others left the health insurance market because of concerns about new costs and regulations.

If there are fewer insurance companies offering coverage, consumers and employers are limited in their choices. This also means they are limited in their options to shop among competing plans to find the one that offers the best value for the best price. In addition, the insurance carriers themselves have less negotiating power with providers if there are fewer insurers in a market.

The end result is that there is less competition in the health insurance market in many states and that means higher costs for consumers.

Here is a list that we compiled in 2011 as examples of 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.[10] 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.[11] 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.[12] Aetna also has pulled out of Colorado's individual market because of concerns about its ability to compete there, dropping 22,000 members.[13] 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.[14]

In New Mexico, four insurers — National Health Insurance, Aetna, John Alden, and Principle — stopped offering insurance to individuals or to small businesses — drying up the market and driving out competition.[15]

In Virginia, 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.[16]

The American Enterprise Group announced in October 2011 that it would stop offering non-group health insurance in more than 20 states.[17] 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 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 the ACA and concluded its best course was to stop selling health insurance policies.[18]

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 (and it had reached an agreement with UnitedHealthcare to renew coverage for Guardian clients).[19] 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 the ACA.

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.[20]

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.[21] 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.

ENDNOTES

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