COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

OFFICE OF OVERSIGHT AND INVESTIGATIONS
MAJORITY STAFF

Delivering Consumers Better Health Care Value for their Premium Dollars: the Success Story of the Minimum Medical Loss Ratio Law

STAFF REPORT FOR CHAIRMAN ROCKEFELLER
MAY 21, 2014

Table of Contents

Exhibits

Executive Summary

One of the important new consumer protections in the 2010 Affordable Care Act (ACA) is the provision that gives health insurance companies a strong financial incentive to reduce their administrative costs and spend a larger part of each premium dollar on high-quality health care for their policyholders.

Using a financial metric already very familiar to insurance carriers and state regulators – the "medical loss ratio" (MLR) – the law encourages health insurance companies to spend at least 80% of their individual and small group policyholders' premiums on medical care or on improving the quality of their care; for large group policies, the target level is 85%. The purpose of this law is to counteract health insurance companies' strong financial incentive to maximize profits, even at the expense of their customer's health care. Companies whose spending on health care-related expenses falls below these "minimum MLR" levels are required to pay rebates to their policyholders.

The law also contains important reporting and transparency provisions. For the first time, it requires health insurance companies to publicly report – by market segment and by state – how much of each insurance premium dollar they are spending on health care versus other expenditures such as marketing, agent and broker commissions, overhead, and profits. Hearings and investigations conducted by Chairman Rockefeller in the Commerce Committee in 2009 established a very clear record that health insurance companies were not voluntarily providing American consumers the segment and state-level information they needed to make informed choices about buying health care. These reporting provisions give consumers and policymakers unprecedented amounts of information about the value of the health insurance products sold in their communities.

During the consideration and implementation of the ACA, health insurance companies and groups representing health insurance agents and brokers aggressively opposed the MLR language, which has come to be known as the "80/20 rule." They predicted that the law would harm patients by discouraging investment and innovation, and by reducing health insurance information and the product choices available to consumers. After enactment of the ACA, the health insurance industry also heavily lobbied Congress, the Department of Health and Human Services (HHS), and the National Association of Insurance Commissioners (NAIC) to make adjustments to address these concerns.

During a sometimes contentious implementation process, Chairman Rockefeller and other consumer advocates urged regulators to reject industry proposals that were inconsistent with Congress's intent and reduced the law's potential benefits for consumers. In particular, consumer advocates fought back a last-ditch effort in 2011 to remove agent and broker fees from the denominator of the MLR formula – a seemingly technical change that would have resulted in increased payments to brokers and agents at the expense of dollars being spent on customers' health care and costing consumers hundreds of millions of dollars in lost rebates.

Industry's dire predictions have not materialized, and two years of data shows that the law has worked as the authors of the law intended. Under the new minimum MLR requirements,

health insurance companies – especially those selling products in the individual market – have increased the value of their products by offering plans that pay more for health services instead of other expenditures. Since ACA enactment, minimum MLRs have risen across all market segments. The table below represents this aggregated rise in MLRs by market segment, for the six largest for-profit health insurers.

Publicly Traded Health Insurance MLR, 2012 versus 2011

	2011	2012	Change
Individual	77.8%	81.2%	336bp
Small Group	77.2%	77.7%	50bp
Large Group	84.0%	85.2%	115bp

Consumers have benefited from these improvements in several ways:

- ***Rebates.*** Millions of American consumers and businesses have received $1.6 billion in rebate checks from their health insurance companies because the insurers' coverage fell below the 80 and 85% MLR thresholds. This figure does not include 2013 rebates, which will be announced later in 2014.

- ***Other Consumer Savings.*** Millions more have benefited from the changes health insurers have been making to avoid paying rebates. For example, reports issued by the non-partisan Commonwealth Fund have found that, in the first two years of the MLR requirements, insurers reduced overhead by a total of $1.75 billion – changes that ultimately reduce the cost of insurance to consumers and the government.

- ***Reduced State-by-State Subsidization.*** Prior to the ACA, health insurers could offer similar health plans in different states but with vastly different MLRs, and companies could make greater profits from plans offered in states that had limited or no MLR requirements. The ACA's new national minimum MLR requirements incentivize health insurers to provide policyholders appropriate value for their premium dollars – no matter what the consumer's state of residence.

- ***Increased Transparency.*** A new trove of data regarding insurance plan performance is now available to help academics, health policy experts, financial analysts, and others understand how the market is working and where improvements are most necessary.

I. The Value of Medical Loss Ratio Requirements

A. The Role of the MLR

Consumers purchase health insurance for access to emergency and preventative medical services and to protect against the financial risks associated with a traumatic medical event. Health insurers collect premiums from policyholders and use those funds to pay for member health care claims, as well as administer benefit coverage, market health insurance products, and pay dividends to investors. The medical loss ratio (MLR) is the proportion of health care premium dollars paid by consumers that is ultimately spent by insurers on health care costs, versus insurers' other expenses. For example, an insurer with an 80% MLR spends 80% of its policyholders' premiums on medical care, while the remaining 20% goes to expenses that do not directly benefit consumers, such as executive bonuses, advertising costs, agent commissions, and profits.

The MLR is a measure that provides different functions for different constituencies. For consumers, the MLR provides a means of evaluating health plans competing for consumer business. The MLR assists potential purchasers of insurance in assessing whether an insurer is spending an appropriate portion of premiums on consumer medical services. From a consumer's perspective, a higher MLR is an indication of a health insurer spending more premium dollars on services that have greater potential consumer benefits.

For investors in health insurance companies, on the other hand, the MLR provides a measure of an insurer's potential profitability. From an investor's perspective, a decrease in the MLR signals reduction in expenditures on medical costs, and with an adequate control of other indirect medical costs, the possibility for an increase in profit.

For both consumers and investors, segmenting MLR information by insurance market type – individual, small group, and large group – provides additional transparency into the insurance market.[1] As noted by Mark Hall, Professor of Law and Public Health at Wake Forest University, the different insurance markets are "as distinct in their economic and legal characteristics as are mobile homes, condominiums, and single-family homes."[2] MLRs can also vary dramatically based on product type; for instance, in the past MLRs typically have been

---

[1] American consumers are insured either through their employer, a private health plan, Medicaid, Medicare, the Children's Health Insurance Program (CHIP), the Veteran's Administration, or uninsured. The Henry J. Kaiser Family Foundation, *Health Insurance Coverage of the Total Population* (accessed May 12, 2014) (online at http://kff.org/other/state-indicator/total-population/). In 2012, 78.5 million consumers were in fully insured plans regulated by the MLR provision. Carl McDonald and Sahil Choudhry, Citi, *Managed Care: Nothing is More Creative Than a Brilliant Mind with a Purpose*, at 4 (Apr. 8, 2014). A fully insured plan is one where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs. Bureau of Labor Statistics, *Definitions of Health Insurance Terms* (online at http://www.bls.gov/ncs/ebs/sp/healthterms.pdf).

[2] Mark A. Hall, *HIPPA's Small-Group Access Laws: Win, Loss, or Draw?,* Cato Journal, at 72 (Spring/Summer 2002).

higher in larger group markets than in the individual market.[3] In contrast, plans marketed as "limited benefit" or "mini-med" typically held lower MLRs than more comprehensive individual health insurance plans.[4]

Health insurers have historically resisted making disclosures of their MLRs or the information relevant to calculating the insurer's MLR. Prior to the Affordable Care Act (ACA), whether an insurer's MLR data was publicly available depended on state regulation. Some states collected and made MLR information available for insurance shoppers, but many did not.[5] In addition, MLR data provided by health insurers to investors was not routinely made available by market segment.[6]

B. The Affordable Care Act's Medical Loss Ratio Requirements

The ACA[7] includes MLR requirements designed to improve the value consumers receive for their health insurance payments and promote transparency in the health insurance market. Under the ACA, individual and small group insurance plans must achieve an 80% MLR, while large group plans must achieve 85%.[8] The ACA also requires that each insurer publicly disclose its MLR data, including premium income and expenditures on medical claims, broken down by market and state.[9] The provision applies to all types of health insurers that offer fully funded health plans, including non-profit and for-profit health insurers and health management organizations (HMOs).[10] Grandfathered health insurance plans are not excluded from the requirement.[11]

---

[3] Senate Committee on Commerce, Science, and Transportation, *Majority Staff Report on Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers* (Apr. 15, 2010). Exhibit A includes this report in addition to all other Commerce Committee majority staff reports concerning the MLR, in chronological order, beginning in 2010.

[4] Timothy Jost, *Implementing Health Reform: Fine-Tuning the Medical Loss Ratio Rules*, Health Affairs Blog (Dec. 3, 2011) (online at http://healthaffairs.org/blog/2011/12/03/implementing-health-reform-fine-tuning-the-medical-loss-ratio-rules/).

[5] *See* Letter from Chairman John D. Rockefeller to H. Edward Hanway, Chairman and Chief Executive Officer, CIGNA, at 11 (Nov. 2, 2009). Exhibit B includes this letter in addition to all other correspondence by Chairman Rockefeller concerning the MLR, in chronological order, beginning in 2009.

[6] *Id*.

[7] Sec. 2718 of Title XXVII, Part A of the Public Health Service Act, as added by Sec. 10101(a) of Title X of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010) (hereafter "PPACA MLR provision").

[8] 45 C.F.R. § 158.210 (2011).

[9] 45 C.F.R. §§ 158.110-120 (2011).

[10] 45 C.F.R. § 158.101 (2011). Self-funded plans (i.e. where the employer or other plan sponsor pays the cost of health benefits from its own assets) are not considered insurers and are therefore not subject to the MLR provision. The MLR standard does not apply even when an insurer administers the self-funded plan on behalf of an employer or other sponsor. The Henry J. Kaiser Family Foundation, *Explaining Health Care Reform: Medical Loss Ratio (MLR)* (Feb. 2012) (online at http://kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/).

[11] 45 C.F.R. § 158.102 (2011). Grandfathered plans are those that were in existence on or before March 23, 2010, and whose plan design has stayed basically the same. They can enroll people after that date and still maintain their grandfathered status, meaning that they are not subject to requirements established by the ACA. Kaiser Health

Under the ACA, a health insurer is required to provide its policyholders with rebates if the insurer does not meet the minimum MLR. Rebates are calculated based on an insurer's MLR in a market segment of a given state. Thus, while an insurer could exceed the minimum MLR in a state's large group market, it could still owe rebates to consumers if it fails to meet the MLR for the individual or small group market in that state. The distribution of rebates depends on the circumstances of the plan. Those consumers who are in the individual market receive rebates directly from the insurer either in the form of a check or as a reduction in future premiums.[12] In the group market, rebates are provided to the employer, who must use the rebate for the benefit of its covered employees.[13]

C. The ACA MLR Provisions Have Benefited Consumers and Small Businesses

The ACA's MLR provisions already have created billions in savings to consumers and small businesses by providing nearly $1.6 billion in rebates and incentivizing insurers to reduce unnecessary health insurer administrative costs and maintain lower premium rates.[14] Further, the reporting requirements of the MLR provisions promote increased insurer transparency and accountability by ensuring that consumers and small businesses have information they can use to measure plan performance and inform insurance shopping decisions. These requirements also provide for a rich source of data that assists experts in analyzing and better understanding the health insurance market.

1. Insurers Have Rebated Hundreds of Millions of Dollars to Consumers and Small Businesses

To date under the ACA, consumers and businesses have received nearly $1.6 billion in rebates from insurers whose MLRs exceeded the ACA thresholds.[15] This includes:

- $591 million in total rebates paid to consumers in the individual market;
- $493 million in total rebates paid to consumers in the small group market; and
- $512 million in total rebates paid to consumers in the large group market.[16]

News, *FAQ Grandfathered Health Plans* (Nov. 13, 2013) (online at http://www.kaiserhealthnews.org/stories/2012/december/17/grandfathered-plans-faq.aspx).

[12] 45 C.F.R. § 158.241 (2011).

[13] 45 C.F.R. § 158.242 (2011).

[14] Cynthia Cox, Gary Claxton and Larry Levitt, The Henry J. Kaiser Family Foundation, *Beyond Rebates: How Much are Consumers Saving from the ACA's Medical Loss Ratio Provision?* (June 2013) (online at http://kff.org/health-reform/perspective/beyond-rebates-how-much-are-consumers-saving-from-the-acas-medical-loss-ratio-provision/).

[15] United States Department of Health and Human Services, *80/20 Rule Delivers More Value to Consumers in 2012* (June 2013) (hereafter "80/20 Rule Delivers More Value to Consumers").

[16] *Id*.

In 2012, 13.1 million Americans received an average rebate of $137 per family for a total of $1.1 billion in rebates;[17] in 2013, 8.5 million Americans received an average rebate of $100 per family for a total of $500 million in rebates.[18] As discussed below, this decrease between 2012 and 2013 in rebates paid to consumers means that more insurers were meeting the threshold MLRs required by the ACA, and that ultimately more premium dollars were being spent by insurers on health care expenses.

2. Improved Insurer Efficiencies Have Resulted in Additional Savings for Consumers and Small Businesses

Rebates represent only a portion of the savings consumers experience from the MLR. By setting a minimum percentage of expenditures for medical care and quality improvement, the MLR requirements limit what an insurer may expend on overhead, which includes administrative costs and profits. Thus, once the minimum MLR is reached, an insurer has incentive to reduce administrative costs in order to increase profits.[19]

For example, the Commonwealth Fund, a non-partisan research organization, has issued several reports analyzing 2010-2012 insurer data regarding administrative expenditures. According to these analyses, the reduction in insurer overhead – and "ultimately, the cost of insurance to consumers and the government" – was $1.4 billion between 2011 and 2012 and $350 million between 2010 and 2011.[20] These reports cite implementation of the MLR rule as a substantial factor driving insurer overhead reductions.[21]

In June 2013, HHS released an additional study of insurer data from 2011 and 2012 reporting that administrative costs as a percentage of consumer health insurance premiums decreased slightly from 2011 to 2012.[22] The chart below depicts this trend across the various markets.

---

[17] United States Department of Health and Human Services, *The 80/20 Rule: How Insurers Spend Your Health Insurance Premiums* (Feb. 2013).

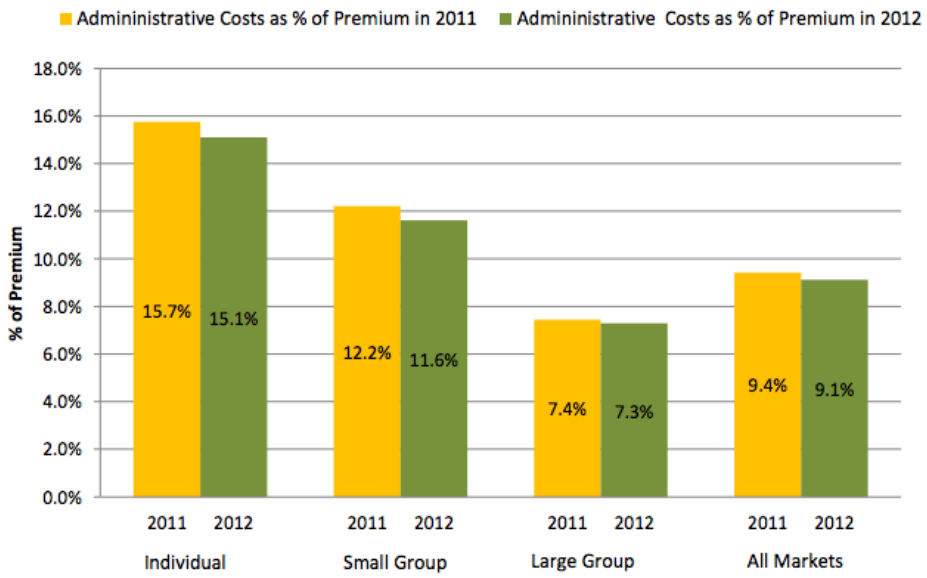
[18] 80/20 Rule Delivers More Value to Consumers, *supra* n.15.

[19] Administrative expenses consist of general and administrative expenses, commissions and advertising expenses, profit and contingencies, and various other expenses that do not directly fund medical care. Centers for Medicare and Medicaid Services (CMS), *Medical Loss Ratio (MLR) Annual Reporting Form Filing Instructions for the 2013 MLR Reporting Year* (Mar. 26, 2014).

[20] Michael J. McCue and Mark A. Hall, The Commonwealth Fund, *Realizing Health Reform's Potential – The Federal Medical Loss Ratio Rule: Implications for Consumer in Year 2* (May 14, 2014); Michael J. McCue and Mark A. Hall, The Commonwealth Fund, *Insurers' Responses to Regulation of Medical Loss Ratios,* at 7 (Dec. 2012). The 2012 report also cites other factors in addition to the MLR rule including competitive and state regulatory factors, which may drive insurers' pricing decisions and operational strategies. *Id.* at 3.

[21] Michael J. McCue and Mark A. Hall, The Commonwealth Fund, *Realizing Health Reform's Potential – The Federal Medical Loss Ratio Rule: Implications for Consumer in Year 2* (May 14, 2014); Michael J. McCue and Mark A. Hall, The Commonwealth Fund, *Insurers' Responses to Regulation of Medical Loss Ratios,* at 7 (Dec. 2012).

[22] 80/20 Rule Delivers More Value to Consumers, *supra* n.15.



Source: HHS

Experts at The Henry L. Kaiser Family Foundation, a non-partisan health research organization, also have found that, beyond receiving rebates, consumers are receiving better value for their premium dollars as health insurers across all three market segments achieve compliance with the new MLR requirements.[23] And in a separate analysis, HHS estimated what consumer premiums in 2012 would have been if MLRs of health insurers had remained at 2011 levels, finding that Americans saved $3.4 billion on their premiums in 2012 as insurance companies improved efficiencies.[24]

3. Minimum National MLR Standard Means Reduced State-by-State Subsidization

Prior to the establishment of national minimum MLR levels, MLR requirements varied from state to state. Under this patchwork of state laws, health insurers could in effect subsidize their efforts to meet the high MLRs mandated in some states by spending low percentages of consumer premium dollars on medical care in other states that lacked meaningful MLR requirements. For instance, in 2009, WellPoint's small group health insurance product in New Hampshire had an MLR of 87.9% but a similar product in Virginia had an MLR of 66.6%.[25] By setting a national floor regarding insurer expenditures on medical care, the ACA's MLR

[23] Cynthia Cox, Gary Claxton and Larry Levitt, The Henry J. Kaiser Family Foundation, *Beyond Rebates: How Much are Consumers Saving from the ACA's Medical Loss Ratio Provision?* (June 2013) (online at http://kff.org/health-reform/perspective/beyond-rebates-how-much-are-consumers-saving-from-the-acas-medical-loss-ratio-provision/).

[24] 80/20 Rule Delivers More Value to Consumers, *supra* n.15.

[25] Senate Committee on Commerce, Science, and Transportation, *Majority Staff Report on Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers*, at 6 (Apr. 15, 2010).

requirement incentivizes insurers to provide consumers a high value for their premium dollar – regardless of the state in which a consumer may reside.

A recent analysis by Carl McDonald, a leading health insurance industry analyst with Citi, demonstrates the substantial gains consumers have experienced since establishment of the nationwide MLR.[26] Over the course of the last two years, publicly traded health insurers have seen their MLRs rise across the board. The six largest publicly traded health insurers – Aetna, CIGNA, Health Net, Humana, UnitedHealth Group, and WellPoint – operate in state markets across the country. In 2011, these publicly traded health insurance companies met the MLR on an aggregated level in only 4 out of 18 market segments. In 2012, the insurers met the minimum MLR requirements in 10 out of 18 market segments.

Figure 2. Commercial Risk Medical Loss Ratios, 2012 Versus 2011

	Medical Loss Ratio											
	Individual			Small Group			Large Group			Total		
	2011	2012	Change	2011	2012	Change	2011	2012	Change	2011	2012	Change
Aetna Inc.	76.2%	81.9%	567 bp	78.5%	82.0%	346 bp	81.0%	84.6%	358 bp	79.8%	83.6%	374 bp
Cigna Corp.	75.6%	101.8%	2618 bp	85.3%	80.6%	-461 bp	83.7%	84.6%	94 bp	83.4%	85.6%	217 bp
Health Net Inc.	85.4%	90.3%	494 bp	78.6%	81.0%	241 bp	87.0%	91.3%	433 bp	84.8%	88.6%	378 bp
Humana Inc.	72.3%	75.2%	284 bp	74.7%	74.9%	23 bp	82.0%	83.9%	187 bp	77.7%	78.9%	111 bp
UnitedHealth Group Inc.	79.5%	80.8%	133 bp	75.2%	75.8%	57 bp	81.9%	82.1%	16 bp	79.7%	80.0%	27 bp
WellPoint Inc.	78.2%	80.1%	199 bp	78.7%	77.6%	-112 bp	87.3%	87.7%	31 bp	83.9%	84.1%	22 bp
Total Publicly-traded	77.8%	81.2%	336 bp	77.2%	77.7%	50 bp	84.0%	85.2%	115 bp	81.6%	82.7%	116 bp
Total Industry	81.2%	83.6%	249 bp	79.8%	80.8%	104 bp	86.5%	87.3%	85 bp	84.3%	85.4%	107 bp

Source: National Association of Insurance Commissioners and Citi Research

Source: Citi

4. MLR Requirements Have Promoted Transparency

For years before the passage of the ACA, consumers paying a monthly medical insurance premium saw their premiums increase annually but had no window into how their health insurance plans were spending premium dollars. The MLR provisions of the ACA promote transparency in the health insurance marketplace by requiring that insurance companies publicly disclose how they spend consumers' premiums dollars. This national reporting requirement means consumers can access data that was previously unreported or available only to state insurance regulators.

Under the ACA, all health insurers are now required to report to HHS aggregated state-level financial data including income from premiums and expenditures on health care claims, quality improvement, taxes, licensing, and regulatory fees.[27] Health insurers report their MLRs at the state level, across all plans, and in each market segment in which they operate. HHS then makes this data publicly available on its website.[28] This data helps consumers gauge the value

[26] Carl McDonald and Sahil Choudhry, Citi, *Managed Care: Nothing is More Creative Than a Brilliant Mind with a Purpose* (Apr. 8, 2014).

[27] 45 C.F.R. § 158.120 (2011).

[28] Centers for Medicare & Medicaid Services, The Center for Consumer Information and Insurance Oversight – Medical Loss Ratio Data and System Resources Home Page (online at http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html).

they are receiving for their premium dollars. In addition, policy experts, financial market participants, regulators, and other researchers now have access to robust insurer data to assess health insurance market activity.

A case in point is comments of a financial analyst who recently used the new MLR data to evaluate commercial risk issues, noting:

> The data set in this report is quite versatile…. [T]he data provides specific details on the states where plans could have too much overlap and run into antitrust issues. And just recently, we were able to analyze the plans that could benefit the most from favorable weather based on where they have the most risk enrollees.[29]

II. A History of the ACA MLR

From the outset of Senator Rockefeller's tenure as Chairman of the Senate Committee on Commerce, Science, and Transportation ("the Committee"), Senator Rockefeller and the Committee have closely scrutinized the health insurance industry's business practices and their impact on consumers. Throughout the health reform debate, the Committee held a series of hearings examining the many obstacles consumers faced when they attempted to make informed purchasing decisions in the health insurance market. The hearings demonstrated that one of the greatest difficulties consumers faced was getting clear and accurate information about health insurance products. The Committee also examined several abusive health insurance practices that focused on how insurers would often take advantage of policyholders while in the pursuit of higher profits.[30]

In 2009, during the development of health insurance reform legislation, the Committee's investigations and oversight work regarding the health insurance industry provided impetus for the MLR requirements that ultimately were included in the ACA. Following enactment of the ACA, Chairman Rockefeller continued vigilant oversight of MLR implementation to make sure consumers and small businesses receive appropriate value for their premiums, and have the information they need to make informed decisions about health plans for themselves and their families. Following is a chronicle of these efforts.

---

[29] Carl McDonald and Sahil Choudhry, Citi, *Managed Care: Nothing is More Creative Than a Brilliant Mind with a Purpose*, at 4 (Apr. 8, 2014).

[30] As Chairman of the Senate Committee on Commerce, Science, and Transportation, Senator Rockefeller has examined the consumer perspective in the American health insurance market. *See* Senate Committee on Commerce, Science, and Transportation, *Hearings on Part I: Deceptive Health Insurance Industry Practices – Are Consumers Getting What They Paid For?* (Mar. 26, 2009); Senate Committee on Commerce, Science, and Transportation, *Hearings on Part II: Deceptive Health Insurance Industry Practices – Are Consumers Getting What They Paid For?* (Mar. 31, 2009); Senate Committee on Commerce, Science, and Transportation, *Hearings on Competition in the Health Care Marketplace* (July 16, 2009); Senate Committee on Commerce, Science, and Transportation, *Hearings on Are Mini Med Policies Really Health Insurance?* (Dec. 1, 2010); Senate Committee on Commerce, Science, and Transportation, *Staff Report on Underpayments to Consumers by the Health Insurance Industry* (June 24, 2009)

A. The Health Reform Debate and the MLR

1. June 2009: Commerce Committee Hearing

On June 24, 2009, the Commerce Committee held a hearing titled "Consumer Choices and Transparency in the Health Insurance Industry" to examine obstacles American consumers face when attempting to obtain clear and accurate information about their health insurance coverage. At that hearing, one of the witnesses, former CIGNA executive Wendell Potter, argued that health insurers had strong incentives to minimize the amount spent on actual medical care in order to promote greater company profits.

Drawing on experiences from his over 20-year career as a senior health insurance industry executive, Mr. Potter testified about the pressure health insurance companies felt from Wall Street to keep medical loss ratios low:

> I have seen an insurer's stock price fall 20 percent or more in a single day after executives disclosed that the company had to spend a slightly higher percentage of premiums on medical claims during the quarter than it did during a previous period. The smoking gun was the company's first-quarter medical loss ratio, which had increased from 77.9 percent to 79.4 percent a year later.[31]

Mr. Potter also asserted that health insurers used techniques to trim their MLRs including dumping and purging sick policyholders to reduce the number of expensive policy holders needing expensive care.[32] Further, Mr. Potter highlighted a 2008 PricewaterhouseCoopers study showing how successful the health insurance industry had become in charging more for health insurance while paying a decreasing share on actual medical care:

> The accounting firm found that the collective medical-loss ratios of the seven largest for-profit insurers fell from an average of 85.3 percent in 1998 to 81.6 percent in 2008. That translates into a difference of several billion dollars in favor of insurance company shareholders and executives at the expense of health care providers and their patients.[33]

2. August 2009: Chairman Rockefeller's Letters to Insurance Company Executives

Following the June 2009 Committee hearing, Chairman Rockefeller wrote to 15 of the largest health insurance companies to further examine MLRs in the individual, small, and large group markets, and how the health insurance industry collects, uses, and publicizes MLR information. These companies collectively controlled more than half of the nation's fully

---

[31] Senate Committee on Commerce, Science, and Transportation, Testimony of Wendell Potter, *Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (June 24, 2009) (S. Rept. 111-344) at 8.

[32] *Id*.

[33] *Id.* at 9.

insured marketplace.[34] The letters sought information on how the companies spent their policyholders' premium dollars, noting that while the MLR is a key tool for understanding the health insurance market, "insurance companies do not appear to readily disclose this information to consumers and businesses."[35]

3. September – October 2009: Senate Committee on Finance Markup of Health Reform Legislation

As the Committee was seeking MLR information from health insurers, from late September through early October 2009, the Senate Finance Committee, on which Senator Rockefeller serves as the Chair of the Subcommittee on Health, began consideration of health reform law legislation.[36] At the time of this legislative markup, Chairman Rockefeller had received incomplete responses to his August letters to health insurers requesting MLR information.

Noting recalcitrance among insurers in providing transparency on consumer premium expenditures, Chairman Rockefeller proposed an amendment establishing an 85% MLR for insurers that participate in the health markets – or "exchanges" – established under the Act.[37] This amendment was based on freestanding legislation introduced in the Senate Committee on Health, Education, Labor, and Pensions the same week by Senator Franken, and cosponsored by Sens. Rockefeller, Whitehouse, Sanders, Begich, Stabenow, and Leahy.[38] During the Senate Finance Committee markup, Senator Rockefeller explained the rationale for establishing minimum national MLR requirements:

> That would seem to me to be a reasonable and fair requirement for a health insurance company whose business in public life is to provide health insurance with premiums that go back and forth. But regardless of what those premiums might be, the majority of the premiums, the majority of what they make is spent on medical care for the people that they are in business to insure.[39]

---

[34] A fully insured plan is one where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs. Bureau of Labor Statistics, *Definitions of Health Insurance Terms* (online at http://www.bls.gov/ncs/ebs/sp/healthterms.pdf).

[35] Letter from Chairman John D. Rockefeller to Stephen J. Hemsley, President and Chief Executive Officer, UnitedHealth Group, at 1 (Aug. 21, 2009).

[36] Shailagh Murray and Lori Montgomery, *Lines Drawn as Senate Panel Begins Debating Health Bill*, Washington Post (Sept. 23, 2009) (online at http://www.washingtonpost.com/wp-dyn/content/article/2009/09/22/AR2009092201548.html). This measure, the "America's Healthy Future Act," ultimately introduced as S. 1796, was one of two major bills being considered by the Senate as part of health reform. The second, the "Affordable Health Choices Act," S.1679, was reported out of the Committee on Health, Education, Labor, and Pensions on September 17, 2009.

[37] Senate Committee on Finance, *Results of Executive Session, America's Health Future Act of 2009* (Sept. 22, 2009) (online at http://www.finance.senate.gov/legislation/details/?id=61f4fb98-a3d0-d85c-d33f-f2c598e1d138).

[38] S. 1730, 111th Cong. (2009).

[39] Senate Committee on Finance, *Continuation of the Open Executive Sessions to Consider an Original Bill Providing for Health Care Reform,* at 195, 111th Cong. (Oct. 1, 2009).

Ultimately, the amendment was pulled from consideration since the Congressional Budget Office (CBO) had not yet provided an evaluation of its cost.[40]

4. November 2009: Letter from Chairman Rockefeller to CIGNA

While many health insurers that were either not-for-profit or that operated primarily in just one state provided Chairman Rockefeller complete responses to his August 2009 request for MLR data, many for-profit health insurers did not. Seeking further understanding of expenditures within this market, the Commerce Committee obtained MLR filing data for 2008 and 2009 submitted by the 15 largest for-profit health insurers to the National Association of Insurance Commissioners (NAIC)[41] pursuant to various state requirements.[42] Committee majority staff examined this data in conjunction with data publicly filed with the Securities and Exchange Commission (SEC) over the same time period.

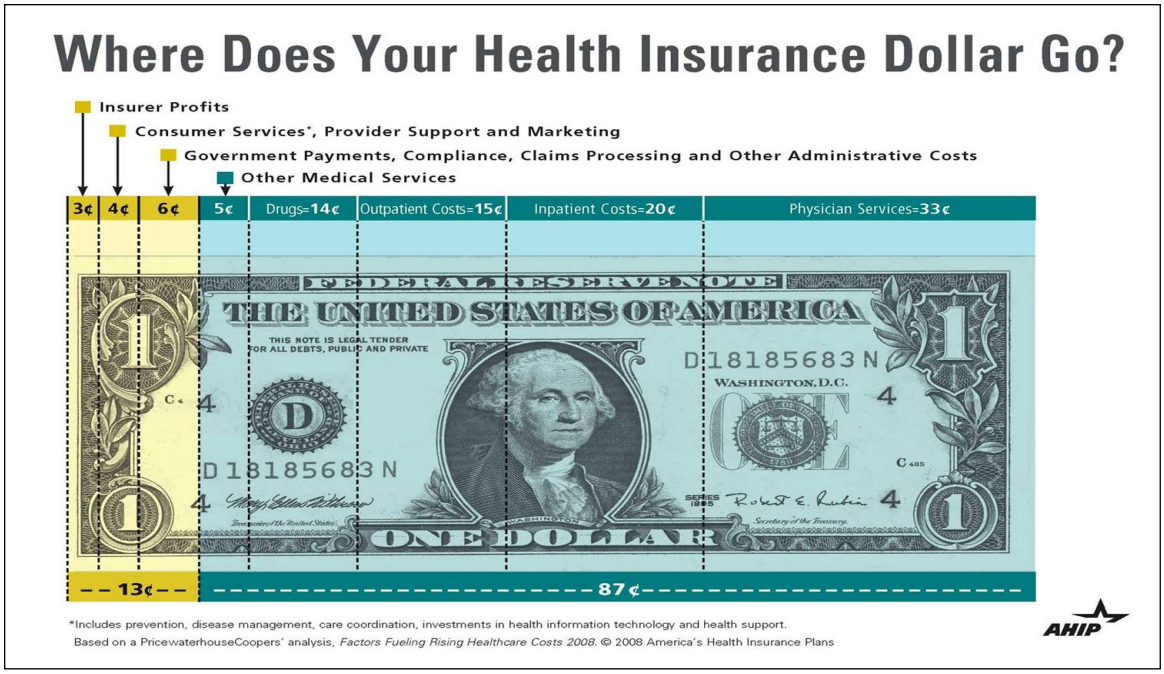
This review found a discrepancy between the MLR information the insurance industry provided to consumers and policy makers versus the MLR information provided to investors during the health reform debate. Specifically, in December 2008, America's Health Insurance Plans (AHIP) issued a report showing an industry-wide MLR of 87% in 2008.[43] Based on the findings of this report, AHIP created the below figure showing that 87 cents out of every 100 is spent on medical care leaving 13 cents for non-medical expenses and profit.

[40] *Id*. at 219.

[41] NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. National Association of Insurance Commissioners, *About the NAIC* (online at http://www.naic.org/index_about.htm).

[42] State Insurance Commissioners require health insurers to file detailed financial disclosures with the NAIC for solvency purposes. As part of these filings, information pertaining to a plan's pre ACA MLR was available.

[43] PricewaterhouseCoopers, *The Factors Fueling Rising Health Care Costs 2008,* Prepared for AHIP, at 2 (Dec. 2008).



However, SEC filings of the six largest publicly-traded health insurers (including CIGNA) showed that none of the health insurers achieved the 87% MLR that the AHIP report cited. In these SEC filings, which are public documents but are targeted to investors and potential investors who are interested in a company's profitability, the companies' reported 2008 MLRs ranged from 81.5% to a high of 84.8%.[44]

When multiplied across the $70 billion health insurers collected in premiums in 2008 alone, these discrepancies in MLR percentages amounted to billions of dollars.[45] Chairman Rockefeller discussed concerns raised by this analysis in a November 2, 2009, letter to the chief executive officer of CIGNA,[46] and CIGNA subsequently refiled its policy exhibits with the NAIC to correct the inaccurate information identified by Chairman Rockefeller.

5. December 2009: Senate Passage of Health Reform Legislation with MLR Provisions

In November 2009, the full Senate took up debate of health reform legislation. Senator Rockefeller successfully pressed for inclusion in the leadership amendment package MLR language similar to what he had proposed in the Senate Finance Committee health reform markup and to what Senator Franken had introduced in his stand-alone bill. The amendment established a minimum MLR of 80% for the individual and small group health insurance segments, and 85% for the large group segment.

---

[44] Letter from Chairman John D. Rockefeller to H. Edward Hanway, Chairman and Chief Executive Officer, CIGNA, at 7 (Nov. 2, 2009).

[45] *Id.*

[46] *Id*. at 15.

The decision to establish minimum medical loss ratios at these levels was guided by the CBO's determination that the majority of insurers were already providing benefits to their customers at or above these levels.[47]

During Senate floor consideration of the leadership amendment package, Senator Bill Nelson from Florida spoke to the legislative intent of the proposed MLR language. Sharing his experiences as a past state insurance commissioner of Florida, Senator Nelson stated:

> For 6 years, I got to see what insurance companies will do. I can tell you. Instead of 85 percent and 80 percent that we are going to require in this bill of every insurance premium dollar they pay out in medical care. I can tell you that some of the insurance companies I regulated back in the State of Florida were down in the sixties. A lot of that was going into big-time administrative offices, all kinds of jets, all kinds of padded expense accounts. …
>
> We need to ensure that the policyholder's premiums and the Federal subsidies that are going into the purchase of private health insurance on the exchange are used for actual medical care and not for wasteful administrative spending and marketing and profits. If we don't do this kind of thing, regulating insurance companies, they are going to take advantage. They are going to take advantage of making more money at the expense of patient care.[48]

The Senate passed the MLR amendment on December 22, 2009,[49] and passed the bill containing this amendment on December 24, 2009.[50] The MLR provisions remained in the final version enacted by Congress after the Senate and House resolved differences between their versions of the bill.[51]

B. Implementation of the Affordable Care Act MLR Provisions

1. Elements of the MLR Formula

Prior to passage of the ACA, the MLR was a calculation that served mainly to provide the shareholders of for-profit health insurance companies with some indication of how much profit the insurer was making. Under the pre-ACA – or "traditional" – MLR definition, the numerator consisted of the company's expenditures for health care claims and the denominator consisted of the company's total premium intake. The ACA MLR definition differs from the

---

[47] Congressional Budget Office, Budgetary Treatment of Proposals to Regulate Medical Loss Ratios (Dec. 13, 2009).

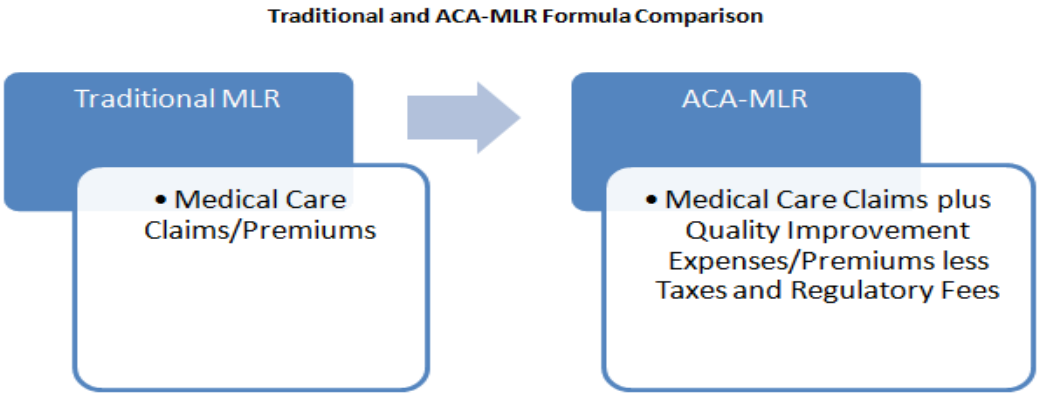
[48] Statement of Senator Bill Nelson, Congressional Record, S13626-13628 (Dec. 20, 2009).

[49] The leadership amendment, S. Amdt. 3276, was introduced on December 19, 2009. *See* Congressional Record, S13491-92. The amendment passed 60-39 on December 22, 2009. *See* Congressional Record, S13716.

[50] U.S. Senate, Roll Call Vote on H.R. 3590 (Dec. 24, 2009) (60 yeas, 39 nays).

[51] The House of Representatives agreed to Senate amendments to the health reform bill on March 21, 2010 by a vote of 219-212. U.S. House of Representatives, Roll Call Vote on H.R. 4872 (Mar. 21, 2010) (219 yeas, 212 nays).

traditional MLR calculation in several ways: (1) it allows a category of expenses considered to involve "quality improvement" to be counted in the numerator; and (2) it allows for a reduction in the denominator reflecting taxes and fees.[52] The figure below demonstrates the difference between a "traditional" MLR and the ACA's MLR.



Source: Mark Farrah Associates

The ACA provided that NAIC would develop the new definitions and methodologies that health insurance companies and regulators would use for purposes of determining compliance with the ACA's minimum MLR requirements.[53] The Secretary of the Department of Health and Human Services (HHS) was then tasked with certifying, by December 31, 2010, the MLR definitions and methodologies developed by the NAIC.[54]

2. NAIC Implementation Process

The NAIC set up two working groups of state insurance commissioners to develop the definitions and methodologies required under the ACA's MLR provisions. One group focused on devising a form for insurers to use to report the components of the MLR; the other was responsible for developing the definitions to be used in the MLR reports.[55] Key terms that required definition in this process included "quality improvement activities," the category of

[52] Under the ACA, federal and state taxes are subtracted from the total amount of premium revenue in the denominator of the MLR ratio. The contours of what constitutes "federal and state taxes," however, were left to the rulemaking process. In the NAIC process, federal taxes were defined as "all Federal taxes and assessments allocated to health insurance coverage reported under section 2718 of the PHS Act, excluding Federal income taxes on investment income and capital gains." HHS adopted this definition in the interim and final rules, noting that investment income and capital gains taxes "are not taxes based on premium revenues, and thus should not be used to adjust premium revenues." Department of Health and Human Services, *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care* Act, 75 Fed. Reg. 74878 (Dec. 1, 2010) (interim final rule).

[53] PPACA MLR provision, *supra* n. 7, at 2718(c).

[54] *Id.*

[55] Timothy Jost, *Implementing Health Reform: Medical Loss Ratios*, Health Affairs Blog (Nov. 23, 2010) (online at http://healthaffairs.org/blog/2010/11/23/implementing-health-reform-medical-loss-ratios/).

costs the ACA's MLR formula allows to be included as part of an insurer's medical costs.[56] As part of its implementation process, the NAIC allowed for participation by interested stakeholders, including insurance company representatives and consumer advocates, providing opportunities to join conference calls and offer written comments.

As the NAIC began the process of determining MLR definitions, consumer advocates and others became concerned that health insurers would work to dilute the MLR in two ways: (1) health insurers might attempt to reclassify certain administrative expenses as medical expenses or use an overly broad definition of "quality improvement expense" that could mask expenses that were actually administrative in nature; and (2) that national aggregation – as opposed to state-level aggregation – of MLR data would allow companies to avoid having to pay rebates to health insurance consumers in states with low MLRs as long as they maintain their MLR above the national level.

Chairman Rockefeller monitored the NAIC implementation process and when appropriate, engaged with the NAIC to push back against efforts by the insurance industry that would have diluted intended consumer benefits of the MLR.

a. April 15, 2010 Committee Majority Staff Report

On April 15, 2010, Chairman Rockefeller released a Commerce Committee majority staff report titled "Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers" ("April 2010 report") to provide background on pre-ACA insurer MLRs. The report analyzed the insurance industry's regulatory filings with the NAIC in 2008 and 2009 as well as insurer responses to the Chairman's August 2009 letter inquiries, and examined the importance of segmenting the MLRs by individual, small and large group segments. The report also highlighted the importance of establishing clear limits on the definition of what constitutes a "quality improvement" cost to prevent insurers from manipulating the new MLR formula to the detriment of consumers.[57]

The April 2010 report's analysis of 2008 and 2009 regulatory filings with the NAIC showed that although many health insurers across the country were already meeting the minimum MLRs set forth in the ACA, the largest for-profit health insurers spent a much smaller portion of premium dollars on medical care in the individual market as compared to the larger group markets.[58] According to this analysis, the largest for-profit insurers used about 15 cents out of every large group premium dollar for non-medical expenses while using more than 26 cents out of every premium dollar for non-medical expenses in the individual market.[59] Leading insurer WellPoint provided a case in point. While WellPoint told its investors in 2009 that its

---

[56] Department of Health and Human Services, *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care* Act, 75 Fed. Reg. 74875 (Dec. 1, 2010) (interim final rule).

[57] Senate Committee on Commerce, Science, and Transportation, *Majority Staff Report on Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers*, at 5 (Apr. 15, 2010).

[58] *Id*. at 3.

[59] *Id*. at 3-4.

overall MLR was 82.6%, its individual and small group market insurance products had MLRs of 74.9% and 81.2%.[60] The table below demonstrates the discrepancies between individual and group plan MLRs discussed in the report.

	Individual		Small Group		Large Group	
	2009	2008	2009	2008	2009	2008
Aetna	75.7%	73.9%	84.2%	82.0%	87.2%	82.0%
CIGNA	88.1%	86.9%	92.1%	---	85.2%	37.2%
Coventry	71.9%	65.8%	78.2%	79.1%	86.0%	82.7%
Humana	68.1%	71.9%	80.0%	77.2%	88.2%	82.4%
UnitedHealth	70.5%	70.3%	81.1%	78.7%	83.3%	83.5%
WellPoint	74.9%	73.1%	81.2%	79.0%	84.9%	85.2%
TOTAL	**73.6%**	**72.5%**	**81.2%**	**79.7%**	**85.1%**	**83.9%**

The April 2010 report also examined data of six large, state-based subsidiaries of WellPoint to assess the expected impact of new MLR requirements at the state level. As shown in the following chart, this data showed substantial variation between states:

	Individual Segment	Small Group Segment	Large Group Segment
Anthem Health Plans of NH	62.9%	87.9%	88.4%
Anthem Health Plans of VA	72.1%	66.6%	79.4%
Rocky Mountain Hospital & Medical	74.1%	79.9%	83.1%
Blue Cross Blue Shield of GA	75.5%	78.0%	86.0%
Anthem Health Plans of KY	79.4%	80.9%	82.0%
Anthem Health Plans of ME	95.2%	86.9%	89.5%

The April 2010 report further raised concerns about how insurers would approach accounting under the new MLR requirements. A separate report issued in the same time frame by health care industry analyst Carl McDonald of Oppenheimer & Co. had highlighted the financial incentive for health insurance companies to shift expenditures from the category of administrative costs to the category of medical costs,[61] suggesting that companies would seek to "MLR shift" their costs from administrative to medical by 5%, or 500 basis points.[62] Pointing to this analysis, the Committee majority staff's April 2010 report asserted that a stricter definition of "quality improvement expenses" would limit the ability of health insurers to "MLR shift" and strongly recommended that regulators "remain vigilant and focused on ensuring that consumers get the benefit of the new federally mandated medical loss ratios."[63]

---

[60] *Id*. at 3.

[61] *See Id*. at 6 citing to Carl McDonald and James Naklicki, Oppenheimer & Co. Inc. Equity Research Industry Update, *The Average Person Thinks He Isn't – Minimum Medical Loss Ratio Analysis* (Apr. 8, 2010).

[62] *Id.*

[63] *Id*. at 7.

b. May 7, 2010, Letters from Chairman Rockefeller to Secretary Sebelius and NAIC Commissioner Cline

As the NAIC continued its deliberations, Chairman Rockefeller wrote to HHS Secretary Kathleen Sebelius and NAIC Commissioner Jane Cline, then the President of the NAIC, to express his deep concern that the health insurance industry was "mounting an all-out effort" to weaken the MLR. In this letter he reminded policymakers that the intent of the MLR was to make sure that "most of consumers' health insurance premiums dollars should be going to pay for patient care, not for insurers' administrative costs and profits."[64]

Specifically, the Chairman highlighted the importance of requiring MLR reports on a state-by-state and market-by-market basis, as opposed to allowing insurers to report aggregate nationwide MLRs, to make sure consumers in a given state have appropriate information to evaluate their insurance options.[65]

These letters also reiterated the concern that insurers have strong financial incentives to "MLR shift" administrative expenses to the medical side, and argued that cost containment data reported to NAIC in 2009 should be viewed as a reference point in assessing insurer predictions about their quality improvement expenditures. Committee staff analysis of this cost containment data showed that insurers invested an average of just 1.15% of their premium dollars on cost containment activities. While noting that cost containment expenses did not precisely overlap with activities that improve health quality, the Chairman argued that the low cost containment expenditures provide grounds for reviewing "with skepticism" proposals that would "allow insurers to claim that they will spend significantly higher portions of premium dollars on quality improvement in the year 2011 than they are currently spending on cost containment."[66]

c. July 20, 2010, Letter from Chairman Rockefeller to Commissioner Cline

On July 20, 2010, Chairman Rockefeller wrote NAIC Commissioner Jane Cline to express concern about mounting evidence of vast imbalances in resources of health insurers versus consumer advocates as they made their case in the NAIC process.[67] In this letter, he also addressed key issues yet to be decided by the NAIC, including the final definition of "quality improvement expenses."[68] At this time, major insurers were arguing against the use of evidence-based standards in defining this term.

---

[64] Letter from Chairman John D. Rockefeller to Kathleen Sebelius, Secretary, Department of Health and Human Services (May 7, 2010); Letter from Chairman John D. Rockefeller to Commissioner Jane Cline, President, National Association of Insurance Commissioners (May 7, 2010).

[65] *Id*. at 3-4. The letters cited data discussed in the April 2010 report showing variation between market segments and within market segments.

[66] *Id.* at 7.

[67] Letter from Chairman John D. Rockefeller to Commissioner Jane Cline, President, National Association of Insurance Commissioners, at 2 (July 20, 2010).

[68] *Id*. at 3-6.

In a June 2010 letter, Blue Cross Blue Shield Association (BCBSA) complained to the NAIC that requiring evidence-based standards in the definitions of "quality improvement expenses" would present "unnecessary barriers and unreasonable high standards" for insurers.[69] UnitedHealthcare Group made a similar point in a letter to the NAIC in a letter providing edits to a draft set of definitions, displayed below, that the NAIC had circulated for comment.[70]

Figure 1 - UnitedHealthcare's June 28, 2010, Suggested Edit to the Definition of Quality Improvement Expenses

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) Expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for health services that are designed to improve health care quality and increase the likelihood of desired health outcomes ~~in ways that are capable of being objectively measured and which produce verifiable results and achievements~~.

In his letter to Commissioner Cline, Chairman Rockefeller argued that an evidence-based approach best reflected the law's intent to "improve the safety, timeliness and effectiveness of the care patients receive,"[71] and that without such an approach, health insurance companies could claim any expense they labeled as improving patient quality as a "quality improvement expense." The Chairman cited the following examples of expenditures that insurers were claiming constituted "quality improvements" but that appeared to have questionable impact on improving the quality of care a policyholder could expect to experience:[72]

- The money health insurance companies spend processing and paying claims;
- The money health insurance companies spend creating and maintaining their provider networks;
- The money health insurers spend updating their information technology systems to code medical conditions and process claims payments;
- The money health insurance companies spend to protect against fraud and other threats to the integrity of their payment systems; and
- The money health insurance companies use to conduct "utilization review" of paid claims to detect payments the companies deem inappropriate and retroactively deny them.[73]

The NAIC working group tasked with devising the definition of "quality improving expenses" ultimately insisted that "quality improvement expenses" should be evidenced based,

[69] *Id.* at 5.

[70] *Id.*

[71] *Id.* at 3.

[72] *Id.* at 4.

[73] *Id.*

should "advance the delivery of patient-centered care," and should be "capable of being objectively measured."[74]

d. October 14, 2010, Letter from Chairman Rockefeller to the NAIC

In early October 2010, as the NAIC neared the end of its deliberations on the MLR definitions and methodologies, the health insurance industry sought to re-open the debate regarding state versus national level aggregation for health insurance company MLRs. Chairman Rockefeller addressed this argument in an October 14, 2010 letter to Commissioner Cline, urging the NAIC to maintain its "pro-consumer perspective and to reject the health insurance industry's last-minute attempt to erode the good work of the [NAIC]."[75] This lobbying effort by the health insurance industry ultimately failed and the NAIC moved to have its final recommendations sent to the Secretary of HHS.

These NAIC recommendations largely reflected Chairman Rockefeller's input on key issues of requiring a thorough and thoughtful definition of "quality improvement expenses," and the requirement that health insurance plans report their MLR performance at the state level.

3. HHS Rulemaking Process

On October 27, 2010, the NAIC provided its final recommendations to the Secretary of HHS, as directed by Public Health Service Act Section 2718(c).[76] HHS began its implementation process by publishing an interim final rule (IFR) in the *Federal Register* on December 1, 2010, with request for public comment. The IFR adopted the NAIC recommendations in full,[77] and ultimately, HHS adopted a final rule on December 7, 2011.[78]

While many stakeholder disagreements were resolved in the NAIC process, stakeholders continued to vigorously debate a number of key issues during the HHS rulemaking process, including the issue of how to properly classify "quality improvement expenses." The rulemaking also explored how expenses associated with health insurance agent and broker commission fees were to be accounted.

---

[74] The NAIC's definition of "quality improving expenses" was ultimately adopted by HHS. *See* Centers for Medicare and Medicaid Services (CMS), *Medical Loss Ratio (MLR) Annual Reporting Form Filing Instructions for the 2013 MLR Reporting Year*, at 14-15, 31 (Mar. 26, 2014).

[75] Letter from Chairman John D. Rockefeller to Commissioner Jane Cline, President, National Association of Insurance Commissioners, at 2 (Oct. 14, 2010).

[76] Letter from the National Association of Insurance Commissioners to Kathleen Sebelius, Secretary, Department of Health and Human Services (Oct. 27, 2010).

[77] Department of Health and Human Services, *Medical Loss Ratio Requirement Under the Patient Protection and Affordable Care Act*, 76 Fed. Reg. 76590 (Dec. 7, 2011) (final rule).

[78] *Id*. at 76574.

a. Activities That Improve Health Care Quality

Insurers and other interest groups argued that a broad definition of "quality improvement expenses" would allow for future innovations. Consumer advocates and provider groups, on the other hand, wanted HHS to more concretely define such expenses to prevent health insurers from essentially nullifying the purpose of the minimum MLR by allowing administrative expenses to be deemed "quality improvements."[79]

The final rule ultimately adopted the approach taken by the NAIC, which provides that a quality improvement activity is one designed to improve health quality and increase the likelihood of desired health outcomes in ways that can be objectively measured, is directed toward individual enrollees or incurred for the benefit of specified segments of enrollees, and is grounded in evidence-based medicine or some other widely accepted criteria.[80] The rule also specifies insurer activities that do *not* qualify as quality improvement expenses. These include activities primarily designed to control costs, fraud prevention activities, customer service hotlines addressing non-clinical member questions, and maintenance of a claims adjudication system, among others.[81]

b. Agent and Broker Fees

The IFR included a section of expenses it called "other non-claims costs" to be calculated as non-medical administrative costs. HHS defined these costs as "expenditures that are not used to adjust premiums, incurred claims, or activities that improve quality care."[82] The NAIC included agent and broker fees in this section, and HHS adopted that approach in the IFR. However, because the NAIC had raised concern over the potential impact on the industry from excluding agent and broker fees from the calculation of medical costs, HHS sought comment on this issue.

In elements of the fully insured health insurance market, insurance agents and brokers serve as the marketing and sales conduit through which an individual or small business would purchase a health insurance product. Agents and brokers who sell health insurance typically had been paid on a commission model, meaning as compensation for their services, they received a percentage of the health insurance policyholder's premiums dollars. Insurance agents and brokers believed that keeping their commissions in the MLR calculation of "other non-claims costs" would lead to reduced commissions, as health insurance plans sought to reduce administrative expenses in order to meet the ACA's MLR requirements.[83]

---

[79] Department of Health and Human Services, *Medical Loss Ratio Requirement Under the Patient Protection and Affordable Care Act*, 75 Fed. Reg. 74876 (Dec. 1, 2010) (interim final rule).

[80] *Id*. at 74875.

[81] *Id*. at 74875-76.

[82] *Id*. at 74877.

[83] Letter from Ken A. Crerar, President, Council of Insurance Agents & Brokers, President, to the Office of Consumer Information and Insurance Oversight (Jan. 31, 2011).

During the comment period, stakeholders addressed the issue of how to classify agent and broker fees. The Council of Insurance Agents & Brokers wrote that agents and brokers provide critical services in the group health insurance market, such as administering benefit programs, assisting with federal and state legal compliance, and advising on mitigating rising costs.[84] The National Association of Health Underwriters said that the fees should not be considered administrative costs, as they are passed-through fees rather than insurer revenue.[85] The U.S. Chamber of Commerce argued that "agents and brokers serve a critical role in the health care marketplace by aiding consumers and employers in determining the health plan that best suits their needs at a premium they can afford."[86]

Other stakeholders expressed support for maintaining agent and broker fees as non-claims costs. AARP called for caution with respect to changes in the treatment of such fees as they relate to the MLR. It urged that changes should "be based on objective evidence with the burden of proof on the issuers to justify such fees as anything other than a non-claims cost."[87] The American Medical Association also supported treating broker fees and commissions as non-claims costs, arguing that these are "quintessential administrative costs" that "do not constitute the provision of medical services or the provision of services to improve the quality of those medical services."[88]

Finally, consumer groups expressed concern that "some insurers have already stated that they intend to collect commissions from enrollees on behalf of brokers and agents but to not count the amounts collected as premium revenue or administrative expenses."[89] These groups therefore urged HHS to support the IFR approach to agent and broker costs and to vigilantly enforce the IFR provisions.

The final rule made no changes to the treatment of agent and broker fees. As such, they were defined as costs to be included in the non-claims cost portion of the MLR.

4. 2011: Additional NAIC Review Regarding Excluding Agent and Broker Commissions

The 2010 mid-term elections brought substantial changes to the composition of Congress and state governments, bringing in a number of new members of Congress and state governors

---

[84] *Id*. at 2-3.

[85] Letter from Janet Trautwein, Executive Vice President and Chief Executive Officer, National Association of Health Underwriters, to Kathleen Sebelius, Secretary, Department of Health and Human Services, at 2 (Jan. 28, 2011).

[86] Letter from Randel K. Johnson, Senior Vice President of Labor, Immigration, & Employee Benefits, and Katie Mahoney, Director of Health Care Regulations, U.S. Chamber of Commerce, to the Office of Consumer Information and Insurance Oversight, at 7 (Jan. 31, 2011).

[87] Letter from David Certner, Legislative Counsel and Legislative Policy Director, AARP, to the Center for Consumer Information and Insurance Oversight, at 3 (Jan. 31, 2011).

[88] Letter from Dr. Michael D. Maves, Executive Vice President and Chief Executive Officer, American Medical Association, to Kathleen Sebelius, Secretary, Department of Health and Human Services, at 2 (Jan. 31, 2011).

[89] Letter from Health Care for America Now to the Office of Consumer Information and Insurance Oversight, at 3.

who opposed the ACA. The composition of the NAIC also saw substantial change, including the election of four new commissioners.[90] In addition, at this time Florida Insurance Commissioner Kevin McCarty was designated NAIC President-elect, for a term beginning in 2012.[91] Throughout the course of 2011, the NAIC saw renewed efforts by the health insurance industry and its allies at the state and federal level to roll back key provisions of the ACA including the MLR.

One of the issues that received attention during this period was the earlier NAIC and HHS decision to exclude agent and broker fees from the determination of medical expenses under the MLR formula. Throughout 2011, Chairman Rockefeller monitored the NAIC's reconsideration of whether agent and broker commissions should be exempted from the MLR calculation, and engaged where appropriate with the NAIC on this issue.

a. March 15, 2011, Letter from Chairman Rockefeller to Commissioner Susan E. Voss

As the debate regarding the treatment of health insurance agent and broker commissions gathered momentum, the NAIC's Professional Health Insurance Advisors Task Force took up the issue.[92] This task force was charged with monitoring the impact of the ACA on health insurance agents and brokers, as well as the health insurance consumers and the insurance market they serve.[93] Commissioner McCarty led the task force and on March 3, 2011, in advance of NAIC's planned spring meeting in Austin, Texas, he released draft federal legislation for public comment. The McCarty Proposal would have excluded agent and broker commissions from the MLR calculation.[94]

Chairman Rockefeller on March 15, 2011, wrote to Commissioner Susan E. Voss, then the President of the NAIC, regarding these renewed attempts to dilute the MLR.[95] This letter highlighted how the NAIC had established a collaborative environment throughout the 2010 MLR implementation process,[96] and noted that the McCarty proposal was "the same proposal that NAHU [the National Association of Health Underwriters] and other agent and broker groups unsuccessfully offered during the NAIC's 2010 deliberations."[97] The letter urged NAIC

---

[90] Chad Hemenway, *Hello. My Name Is…*, National Underwriter Property & Casualty (Dec. 20, 2010) (online at http://www.propertycasualty360.com/2010/12/20/9-hello-my-name-is).

[91] Sean P. Carr, *NAIC Picks New Leaders in Wake of Electoral Defeat*, A.M. Best Newswire (Dec. 15, 2010) (online at http://insurancenewsnet.com/oarticle/2010/12/15/naic-picks-new-leaders-in-wake-of-electoral-defeat-a-240090.html#.U3UZvcfBre8).

[92] National Association of Insurance Commissioners, *Professional Health Insurance Advisors (D) Task Force*, (accessed May 6, 2014) (online at http://www.naic.org/committees_d_health_advisors_tf.htm).

[93] *Id.*

[94] H.R. 1206, 112th Cong. (2012).

[95] Letter from Chairman John D. Rockefeller to Susan E. Voss, President, National Association of Insurance Commissioners (Mar. 15, 2011).

[96] *Id.* at 2.

[97] *Id.*

members to carefully consider how the McCarty proposal could potentially undermine the expected consumer benefits inherent in the ACA's MLR provision.[98]

Specifically, the Chairman's letter pointed out that the ACA's MLR provision was developed and drafted after extensive analysis of the medical loss ratio data submitted by health insurance companies to the NAIC as part of their regular regulatory regime, and both Congress and the Congressional Budget Office relied on data that included in "premiums earned" any and all payments a health insurance company made to an agent or broker related to the sale of a health insurance policy.[99] Chairman Rockefeller argued that excluding agent and broker commissions from the MLR calculation would not only be inconsistent with the health insurance industry's own accounting practices and standards, but would also deprive millions of consumers and business from the rebates and lower premiums they could expect from the MLR provision.[100]

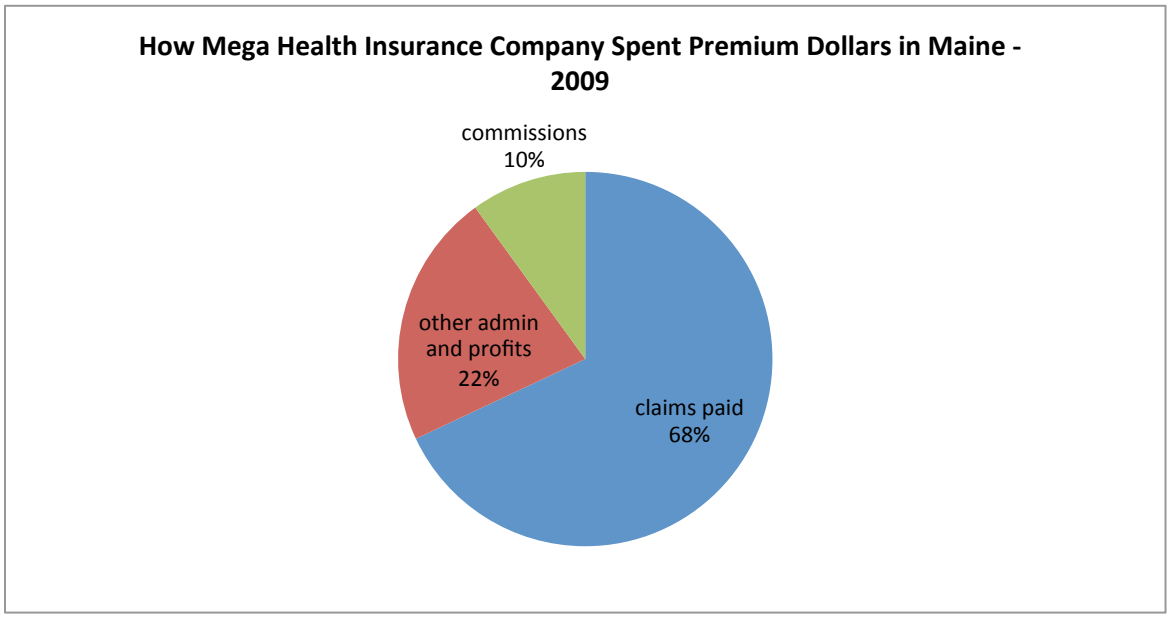
To illustrate how making any changes to agent and broker commissions would have a negative impact on consumers, the letter used data from Maine's request for a MLR waiver.[101] At the time, this kind of detailed data on agent and broker commissions in the individual and group markets was not widely available, but Mega Life & Health Insurance Company (Mega), one of Maine's three major health insurers, was required to disclose it as part of the MLR waiver process. The figure below shows how Mega used its policyholder's premium dollars.

[98] *Id*. at 3-10.

[99] *Id.* at 3. Included within the instructions for regulatory filings, the NAIC provided to health insurers the following definition of "written premium": the contractually determined amount charged by the reporting entity [the health insurance company] to the policyholder for the effective period of the contract based on the expectation of risk, policy benefits, and expenses association with the coverage provided by the terms of the contract. *Id*. at 4.

[100] *Id.* at 4.

[101] *Id.* at 6. The ACA allows the Secretary of Health and Human Services to adjust MLR standards for a state if the state can demonstrate that requiring insurers to meet the 80% threshold could destabilize the individual market, resulting in fewer choices for consumers. A total of 17 states (ME, NH, NV, KY, FL, GA, ND, IA, LA, KS, DE, IN, MI, TX, OK, NC, WI) have applied for MLR adjustments. Centers for Medicare and Medicaid Services, *State Requests for MLR Adjustment* (online at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state_mlr_adj_requests.html).



In its filing, Mega showed that it used 68 cents out of every dollar on medical expenses and used the remaining 32 cents for administrative costs and profit.[102] Of the 32 cents spent on nonmedical expenses, a full third was spent on paying commissions to agents and brokers.[103] Had Mega been subject to the ACA's MLR provision – with medical premiums of approximately $25 million dollars and a medical loss ratio of 68% – it would have owed its almost 14,000 Maine customers a $3 million rebate or about $218 per customer.[104] In contrast, under the McCarty proposal, Mega's $3 million rebate would have decreased to $1 million, denying consumers 66% percent of their rebate. According to Chairman Rockefeller, this meant "money that was intended to give consumers relief from the high cost of health care would instead be converted into additional revenue for agents, brokers, and health insurance companies."[105]

The Chairman's final point was to note that agents and brokers earned more revenue when policyholders paid higher premiums and that any reforms like the MLR that sought to decrease what consumers paid in health premiums would also result in decreased income for agents and brokers. With insurance premiums rising at an average annual rate of 6-7% over the preceding 10 years, the commission of an insurance agent or broker (in absolute dollars) had roughly doubled.[106] As health insurance companies began the process of reviewing their

[102] Letter from Chairman John D. Rockefeller to Susan E. Voss, President, National Association of Insurance Commissioners, at 6-7 (Mar. 15, 2011).

[103] *Id.* at 7.

[104] *Id.*

[105] *Id.* at 8.

[106] *Id.* at 8-9. The figure applies a 10% commission to the average annual premiums for individual health insurance coverage, as presented in, The Kaiser Family Foundation and Health Research & Education Trust, *Employer Health Benefits: 2010 Annual Survey* (Sep. 2, 2010) (online at http://ehbs.kff.org/pdf/ 2010/8085.pdf).

administrative costs in order to be compliant with the ACA's MLR provision any reductions in health insurance premiums increases would invariably feel like a cut to agents and brokers.[107]

The letter concluded by noting that millions of previously uninsured Americans were soon to be eligible to purchase affordable, comprehensive health care coverage. Although these plans would be offered at lower profit margins, insurance companies, agents, and brokers could expect to see higher sales volume.[108]

b. Spring 2011 NAIC Meeting Austin, Texas

In late March 2011, many of the nation's insurance commissioners met in Austin, Texas for the NAIC's Spring national meeting. The McCarty proposal was part of the meeting agenda, and at this point encompassed an endorsement of proposed congressional legislation, H.R. 1206, which provided for exclusion of agent and broker fees from the calculation of administrative costs under the MLR formula.[109]

Preceding the meeting, in addition to Chairman Rockefeller's letter, many consumer advocates also voiced concerns regarding the speed with which the NAIC was moving. Ultimately acknowledging these concerns, the NAIC's Professional Health Insurance Advisors Task Force delayed endorsing the McCarty Proposal and instead agreed to further study the issue through its Health and Managed Care Committee.[110] After several weeks of data gathering, the Health and Managed Care Committee delivered its final report ("May Report") to the NAIC on May 26, 2011.[111]

c. May 24, 2011, Committee Majority Staff Report on 2010 MLR Rebates

On May 24, 2011, Chairman Rockefeller issued a Senate Commerce Committee majority staff report ("May 2011 Commerce Committee Report"), marking the first time that estimated savings from the ACA's MLR provision had been quantified using the health insurance companies' own data. Based on preliminary data gathered by the NAIC, the report showed that consumers nationwide would have received almost $2 billion in rebates from their health insurance companies if the MLR provision had been in place for the 2010 reporting year.[112] It

---

[107] Letter from Chairman John D. Rockefeller to Susan E. Voss, President, National Association of Insurance Commissioners, at 9 (Mar. 15, 2011).

[108] *Id.* at 11.

[109] H.R. 1206, the "Access to Professional Health Insurance Advisors Act of 2011" (112th Congress).

[110] Arthur D. Postal, *NAIC Panel Seeks More Info Before Backing Agent MLR Exemption*, Consumer Watchdog (Mar. 28, 2011).

[111] National Association of Insurance Commissioners, *Report of the Health Care Reform Actuarial (B) Working Group to the Health Insurance and Managed Care (B) Committee on Referral from the Professional Health Insurance Advisors (EX) Task Force Regarding Producer Compensation in the PPACA Medical Loss Ratio Calculation* (May 26, 2011).

[112] Senate Committee on Commerce, Science, and Transportation, *Majority Staff Report on Consumer Health Insurance Savings Under the Medical Loss Ratio Law*, at 1 (May 24, 2011).

also found that more than half of consumers in the individual market would have received rebates in 2010.

The May 2011 Commerce Committee Report also showed that removing agent and broker commissions from the MLR calculation would result in reduced rebates to consumers by more than 60% or nearly $1.1 billion.[113] The below table represents the impact of removing agent and broker commissions from the MLR calculation in each market:

Market	Estimated Consumer Rebate Under Current MLR Law ($ millions)	Estimated Consumer Rebate When Commissions are Excluded from MLR Calculation ($ millions)
Individual	$978	$401
Small Group	$447	$146
Large Group	$526	$215
Total	**$1,951**	**$762**

According to the NAIC data reviewed in the majority staff report, if agent and broker commissions had been removed from the MLR calculation in 2010, consumer's rebates would have reduced from $1.95 billion to $762 million.[114] The report also provided a detailed state-by-state breakdown of the rebates consumers would have lost.

The NAIC's Health Insurance Advisors Task Force, using information gathered by the Health and Managed Care Committee, would eventually vote on June 30, 2011, to endorse the proposal to support H.R. 1206, moving consideration to a plenary group of insurance commissioners. On July 12, 2011, Commissioner McCarty brought the H.R. 1206 support proposal before all 50 insurance commissioners for a vote. After California Commissioner Dave Jones and several other commissioners expressed opposition to H.R 1206, the NAIC ultimately did not hold a plenary vote on the proposal.[115] Although tabled for a time, the McCarty proposal would reappear at the NAIC's 2011 Fall National Meeting in Washington D.C.

d. November 21, 2011, Letter from Chairman Rockefeller to Commissioner Kevin McCarty

Just prior to the NAIC's Fall 2011 meeting, Chairman Rockefeller wrote to Commissioner McCarty reiterating that removal of agent and broker commissions from the MLR calculation would be contrary to congressional intent. The Chairman's letter pointed out that the NAIC's own report found that "a significant number of companies have not reduced commissions in 2011."[116] Further, based on review of new data HHS had obtained from states

[113] *Id.*

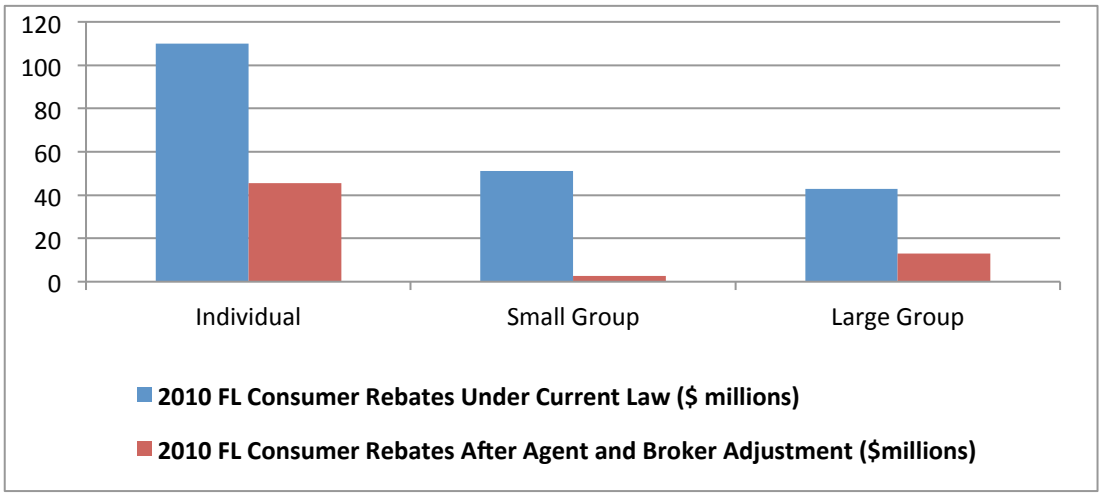
[114] *Id.* at 4.

[115] Arthur D. Postal, *PPACA: NAIC Ices Agent Comp MLR Exclusion Effort,* LifeHealthPro (July 12, 2011) (online at http://www.lifehealthpro.com/2011/07/12/ppaca-naic-ices-agent-comp-mlr-exclusion-effort).

[116] Letter from Chairman John D. Rockefeller to Kevin McCarty, President-Elect, National Association of Insurance Commissioners, at 2 (Nov. 21, 2011).

submitting MLR waiver requests, the letter analyzed the negative impact removing agent and broker commissions would have in a number of states. The letter noted that while Kentucky, Georgia, and Delaware all claimed that the MLR was causing significant disruptions within their agent and broker communities, "[t]o date, HHS has not yet found any convincing evidence that 'consumers may be unable to access agents and brokers' under the minimum [MLR] law."[117] In fact, in Kentucky, agent and broker commissions had actually increased; Georgia saw no decreases; and only one of nine insurers in Delaware decreased commissions.[118]

Chairman Rockefeller stressed that while the early effects of the law had shown that consumers continued to enjoy access to the services of agents and brokers, any changes to the MLR's treatment of agent and broker commissions would have a negative impact on consumers. Using information from the NAIC's May Report, the letter discussed the impact removing agent and broker commission would have for Florida's health insurance consumers. The below chart demonstrates this distinction:



If agent and broker commissions were eliminated from the MLR, Florida consumers would have lost $142 million or over 60% of the estimated $200 million they would have received in rebates if the law had been in effect in 2010. Under the McCarty proposal, consumers would have lost not just hundreds of millions of dollars in annual rebates, but "health insurance companies [would] lose the incentive the current law gives them to run their businesses more efficiently and deliver a better value to their customers at a lower cost."[119] The Chairman emphasized his strong support of the agent and broker community, and at the same time reiterated that any changes to the MLR could not diminish the value of the expected consumer benefits.

[117] *Id.* at 3.

[118] *Id.* at 3-4.

[119] *Id.* at 5.

e. NAIC Endorses Modified McCarty Resolution

On November 22, 2011, Commissioner McCarty introduced a modified agents and brokers resolution before a plenary of NAIC insurance commissioners. Instead of fully endorsing H.R. 1206, the resolution urged HHS to exempt agent and broker commissions from the MLR calculation and for HHS to place a hold on MLR implementation in order for state waiver requests to be filed. The resolution passed 26-20 after a 90-minute debate – and two unsuccessful attempts by insurance commissioners to modify the resolutions language.[120] Many insurance commissioners expressed concerns with the resolution. Commissioner Sandy Praeger, a Republican from Kansas, voiced concern about the future credibility of the NAIC saying, "we [NAIC] were written into the [PPACA] law because we were trusted as experts on this. We are going so far here as to put our credibility in jeopardy."[121]

Ultimately H.R. 1206, although reported out of the House Energy and Commerce Committee, failed to secure a vote on the House floor and died at the end of the 112th Congressional session.[122]

III. Conclusion

Prior to health reform, for-profit health insurers carefully tracked their medical loss ratios and worked to lower them. A low MLR was a signal to investors that an insurer was spending less on health care and had more potential money for shareholders. The inclusion of minimum MLR requirements in health reform changed this dynamic. By setting a floor on health insurer expenditures of premium dollars for consumer medical care, the law prevents for-profit insurers from relentlessly cutting medical expenditures to boost profits.

Today, the medical loss ratio provisions of the health reform law have already proved to be a significant success story for American consumers. In the four years since enactment of health reform, individuals and small businesses across the country have seen billions of dollars of savings due to the MLR requirements, including $1.6 billion in rebates and hundreds of millions of more due to improved insurer efficiencies. At the same time the MLR public reporting requirements have opened a new window into the operations of the insurance industry, helping consumers compare and choose products, and providing new data to help policy experts, financial analysts, and others evaluate industry trends.

Looking forward, the MLR requirements will serve as permanent incentives for the insurance industry to operate with efficiency and transparency, and to make sure consumers receive appropriate value for their premium dollars.

---

[120] Elizabeth D. Festa, *NAIC Narrowly Passes Resolution Urging HHS to Exempt Agent Commissions from PPACA* Standard, LifeHealthPro (Nov. 22, 2011) (online at http://www.lifehealthpro.com/2011/11/22/naic-narrowly-passes-resolution-urging-hhs-to-exem?page=3).

[121] *Id.*

[122] H.R. 1206, 112th Cong. (2012).