NEW MEDICAL LOSS RATIOS: INCREASING HEALTH CARE VALUE OR JUST ELIMINATING JOBS?

HEARING

BEFORE THE

SUBCOMMITTEE ON INVESTIGATIONS, OVERSIGHT AND REGULATIONS

OF THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

HEARING HELD DECEMBER 15, 2011

Small Business Committee Document Number 112–049
Available via the GPO Website: *www.fdsys.gov*

U.S. GOVERNMENT PRINTING OFFICE

75–610 WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
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NEW MEDICAL LOSS RATIOS: INCREASING HEALTH CARE VALUE OR JUST ELIMINATING JOBS?

THURSDAY, DECEMBER 15, 2011.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
SUBCOMMITTEE ON INVESTIGATIONS,
OVERSIGHT AND REGULATIONS, WASHINGTON, DC.

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 2360, Rayburn House Office Building. Hon. Mike Coffman [chairman of the Subcommittee] presiding.

Present: Representatives Coffman, Bartlett, Landry, West, and Schrader.

Chairman COFFMAN. Good morning. I call this hearing to order.

I want to welcome our witnesses. We appreciate your participation and look forward to your testimony today.

Under the Health Care Reform Law and its final rule, insurers must spend 80 percent of premium dollars for individual and small group policies on health claims. This medical loss ratio means the amount that can be spent on administrative expenses is limited to 20 percent. If an insurer fails to meet the minimum requirements it must issue rebates for the difference to its customers. Insurance agent commissions are counted as administrative cost under the HHS rule. The agents, often small business owners themselves, assess the unique health insurance needs of small firms, recommend appropriate coverage, and help to process claims.

In several letters to the Department of Health and Human Services, the National Association of Insurance Commissioners (NAIC), the organization of state insurance commissioners which HHS entrusted with recommending the MLR formula, expressed concern about the adverse effects of the MLR on insurance producers, both agents and brokers. On November 27th of this year, NAIC endorsed 26–0, a formal resolution urging HHS to "take whatever immediate actions are available to the Department to mitigate the adverse effects the MLR rule is having on the ability of insurance producers to serve the demands and needs of customers and to more appropriately classify producer compensation in the final rule." Unfortunately, HHS did not include NAIC's recommendations in its rule, and agent and broker compensation remains a part of the administrative calculation.

We want quality health care and affordable insurance premiums, but the MLR is likely to deter small insurers from entering the market and hasten the exit of established ones. Instead of protecting consumers, the MLR may dissuade insurers from making

investments in anti-fraud, anti-waste customer service and transparency tools because they are considered administrative and those costs must be kept low. The MLR is an incentive for insurers to increase, not reduce, premiums because they will need to improve their medical ratio and forgo administrative tools that can ultimately save money. And as NAIC's resolution said, the MLR requirements "have had profound, detrimental marketplace effects for insurance producers, agents, and brokers."

In a recent study on implementation of the new MLRs, the U.S. Government Accountability Office said that "almost all of the insurers" it interviewed had decreased or planned to decrease commissions to brokers or reduce their MLRs so they can avoid issuing rebates. The National Association of Health Underwriters reports that nearly three-quarters of agents have experienced reductions in their income because of MLRs, and more than a fifth have eliminated jobs at their agencies. Clearly, federal medical loss ratios are a bad idea for small business.

I look forward to hearing from our witnesses today. I now yield to the ranking member for opening remarks. Mr. Schrader.

[The information follows:]

Mr. SCHRADER. Thank you, Mr. Chairman.

I appreciate holding this hearing today. While I am not so sure that the medical loss ratio is all together in itself a bad piece of policy, I am concerned about its effect on our agents and our brokers. That was never our intent, I do not think, in passing the medical loss ratio. We are looking for feedback to see if the ratios that were instituted in the Affordable Care Act are actually real, and I think it is very, very important to have this hearing because the agents for small businesses are absolutely critical. There is no way in my small little veterinary practice I was able to delve into the pluses or minuses of the various insurance products that are out there. So these folks are absolutely essential, I think, to make sure that small businesses keep their health care costs down, which is the ultimate goal of the Affordable Care Act.

So we want to really work with a group out here and see if we can modify some of the rules that are coming out and make sure that you guys are part of the benefit, not part of the problem going forward. So thank you all for coming here. And I yield back.

[The information follows:]

Chairman COFFMAN. Thank you.

If Subcommittee members have an opening statement prepared, I ask that they submit that for the record.

I would like to take a moment to explain the timing lights for our witnesses today. You will each have five minutes to deliver your testimony. The light will start out as green. When you have one minute remaining the light will turn yellow. Finally, it will turn red to signify that you are at the end of your time, five minutes. I ask that you try to adhere to the time limit.

STATEMENTS OF MITCH WEST, INSURANCE BROKER, HEALTH CHOICE ONE; GARY LIVENGOOD, PRINCIPAL, WHAT A STITCH, LLC; GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE; TIMOTHY STOLTZFUS JOST, ROBERT WILLETT FAMILY PROFESSOR OF LAW, WASHINGTON AND LEE UNIVERSITY COLLEGE OF LAW

Chairman COFFMAN. It is a pleasure for me to welcome our first witness, a fellow Coloradan and constituent, Mitchell West, to this Subcommittee. Mr. West is an independent insurance broker with Health Choice One in Greenwood Village, Colorado. He provides customized assessments of insurance products for small business clients and assists them with any claims. He holds a B.S. from the University of Southern California. He is testifying on behalf of the National Association of Health Underwriters. I must also mention that Mr. West and his wife, Jamie, have three children. Their son, Trenton, graduated with honors from the U.S. Air Force Academy and is currently stationed in Seattle, Washington. As a U.S. Marine Corps combat veteran, I commend your son for his service to our country. Mr. West.

STATEMENT OF MITCH WEST

Mr. WEST. Chairman and Ranking Member, my name is Mitch West and I am an independent broker in Centennial, Colorado. And I believe I share the sentiments of 22,000 licensed agents in Colorado, as well as the over one million agents across the U.S.

I am a small business owner. I have one full-time employee and this is typical of health insurance agents. I am glad for this opportunity to address what the MLR has meant to us as we have moved forward since its implementation this year. I have a bachelor's degree in biomedical engineering, followed by graduate course level work in industrial systems engineering, electrical engineering, and business administration.

In 2002, I was thrown into a new environment. I was laid off as a result of the dot-com and telecom busts, and I had to find health insurance for my family and I had never been in that situation before. In spite of my background and all the training I had, I was inundated with information. I could not make sense of it. I could not discriminate between what was good, what would not be so good, and at that time it was only with the help of a professional agent that I was able to figure out what to do. And boy was I glad that I had assistance. I realized what the mistake was that I might have made if I had proceeded on my own.

A couple of months later I began my career as a licensed agent and that recent experience was fresh in my mind. As I met with my clients I began to understand that they all had a common element. They had more misconceptions about health insurance than they had real facts, and they did not even know what questions to ask as they were seeking to figure out what would be best for themselves and their families.

I have since worked with over 5,300 clients in 27 states and I have come to the realization that my primary job is to educate my clients. In my written testimony I listed 14 areas and topics which I consider to be essential in covering with my clients, and while this is a very time-consuming approach, I think it is essential and

it is very much appreciated by my clients and it is why I have hundreds and hundreds of clients that have been with me for over eight years.

None of these activities generate one penny of revenue for my business. My only source of income is the commission stream paid after the sale of health insurance policies and all of these commissions come through the insurance companies which I represent. As a direct result of MLR requirements effective January 1 this year, every insurance company I represent, without exception across the United States, severely reduced commission levels. My overhead expenses are unchanged for 2011, and in fact, they will go up next year. The net result to my practice has been a decrease to my bottom-line of 50 percent. You all have business experience. You can imagine the gravity of a 50 percent impact to your bottom-line as a small business.

Many agents, especially those that were in the building phases of their practices, have simply exited the industry. They just could not make cash flow. Others have chosen to move into other areas of insurance where they can be more successful, and for the majority of remaining agents the current situation is not sustainable in the long run.

Millions of Americans are in need of health insurance for a variety of reasons. Put yourself in their shoes. The health insurance environment has never been more complex and confusing and they have never been more in need of professional assistance. I cannot stay in business operating the way I used to, and so my time must be allocated differently. Pro bono work, I just cannot do it anymore. I will be forced to spend less time with all of my current clients and that inevitably means in the long run they will pay more for their insurance and gain lesser benefits. Insurance companies are also cutting staff for the same pressures and reasons that we are, so the double whammy of insurance agents being restricted and insurance companies cutting back on support staff is a negative impact on consumers in general.

HHS was given sole responsibility for implementing and defining the MLR calculation, and they have the power to recognize these facts and make changes. Despite the best efforts of industry groups, consumer groups, the National Conference of Insurance Legislators, the National Association of Insurance Commissioner, and many members of Congress, HHS has been unwavering in their position and has chosen to not act. Therefore, the only solution is a legislative one, and it is needed immediately. Much damage has already been done to tens of thousands of agents and numerous consumers nationwide, the tide must be changed, and it must be changed before the agent community reaches a point of no return.

I appreciate the opportunity to share these thoughts. MLR is an example of legislation which I think has resulted in unintended negative consequences to both small businesses and consumers, and members of Congress need to be aware of these facts and on the behalf of the American people to work with a sense of urgency to correct these issues.

There is significantly more information in my written testimony which I hope will be helpful to the Committee. Thank you.

[The statement of Mr. West follows:]

Chairman COFFMAN. Thank you, Mr. West.

I now yield to Mr. Bartlett to introduce Gary Livengood.

Mr. BARTLETT. Thank you very much. It is really my pleasure to introduce our next witness, Gary Westfall Livengood. He is a graduate of West Virginia Institute of Technology with post-graduate training at the University of Maryland and University of Virginia. Mr. Livengood has a background which really is relevant to what we are discussing today. First of all, you started out as a journalist in the U.S. Army. Thank you, sir, for your service. You organized, developed, and directed all functions for claims offices in a 29 state region for Self-Insured Rail Transportation Corporation. You directed the overall marketing and operational efforts for a 14 office company, one of the nation's largest investigative services companies. You had organizational responsibility for a 200-member cost containment department within a large regional health maintenance organization really relevant to what we are talking about today. And now you are principal of What a Stitch for operational financial, as well as federal and state compliance responsibilities for an embroidery small business with 21 employees providing apparel enhancement for companies and individuals principally throughout the mid-Atlantic region. Thank you very much to Capitol Hill and our hearing.

STATEMENT OF GARY LIVENGOOD

Mr. LIVENGOOD. Thank you, sir. And good morning.

As was indicated, my name is Gary Livengood. I am a principal with What a Stitch, LLC, which is a small commercial embroidery business in Mount Airy, Maryland. I would like to thank the members of the Small Business Committee for the honor of testifying before you today about the health reform law.

To tell you a little bit about me, after serving my country in Vietnam, I worked in a variety of operational positions from various industries for over 35 years. Then my wonderful wife, Louann, somehow got me to agree not to spend my retirement on the golf course like I planned, but rather on helping to grow her hobby into a business that now employs 21 people.

We started What a Stitch in 2002 with one single head sewing machine. The company grew and grew, but then like business owners everywhere, 2008–2009 hit. We are very committed to maintaining the business and keeping the employees, so we dug very deeply into our personal savings just to keep the doors open and we were able to do that. Times still are not great for us but they are better than what they were. I wish I could say that even better times were ahead, but unfortunately, the future continues to look uncertain. I know the intent of the new health law was to help business owners like us, but thus far I do not see it. The new law weighs heavily on my mind anytime we are thinking about hiring new employees or what the future may bring for our small business. It has already put regulatory burdens on our company, and I suspect that there are more compliance issues that are going to be coming forward.

Before we started What a Stitch, my wife was a director of human resources with Amtrak, and I spent my last 13 years as

vice president of operations with United Health Care. Well, eventually with United Health Care. So we may be a little bit more conversant about the administration of group health insurance than your average day-to-day small business owner. Consequently, the day-to-day reliance on our health care agent, Paul Younkins, who is also the co-owner of Allied Resource Management, is not as extensive as many small business owners. But even with our experience, Louann and I just would not consider dropping the services of our agent. He is our insurance policy within an insurance policy. And so far our company has been very lucky. We have not had claims disaster or medical crises that required the full use of Paul's capabilities, but I know that Paul and some of these clients do. And other agents like Paul have far-reaching services to small businesses across the country.

But I understand that our company could experience similar needs at any point in time. If and when that day comes, I am one employee and to have somebody that we know and can trust at no additional cost so that my wife and I will be—they will get the job done for us and my wife and I can concentrate on keeping the company profitable.

Paul, on the other hand, is a businessman like me and he deserves to make a fair living. And when I pay our company's insurance premiums each month, it is clear that a portion of my check is really our agent's fee that is included in our tax bill for tax and convenience purposes.

It is also obvious that our company's total insurance premium rate has nothing to do with the amount the agent gets paid. Our premium costs are driven by the costs of medical care in Maryland, as well as the age and the size of the group of our employees. Paul's fee is just a small percentage of whatever our insurance premium will be, and it is worth every penny.

Unfortunately, it is my understanding that the new health reform law's medical loss ratio requirements are hurting Paul's business and similar business nationally. My company went through several years of declining revenues, so on a personal level I feel for Paul. But I worry about the impact that it is going to have. And if Paul needs to change the nature of his business and cannot afford to handle our account anymore, we may have to seriously consider just dropping our group coverage, saving the money that we put into our employees' premiums, and if the government takes over such benefits and administration, I am hard pressed to believe that we will continue to have the same kind of access to customer service that Paul currently provides.

And I see my time is up, so I thank you for the honor of testifying before this Committee today.

[The statement of Mr. Livengood follows:]

Chairman COFFMAN. Thank you, Mr. Livengood. Thank you.

Our next witness is Grace-Marie Turner. Ms. Turner is president of the Galen Institute of Public Policy Research Organization that she founded in 1995 to promote free market ideas for health reform. Earlier in her career she was executive director of the National Commission on Economic Growth and Tax Reform and served as president of Arnette and Company, a health policy analysis and consulting firm.

Welcome. You have five minutes to present your testimony, Ms. Turner.

STATEMENT OF GRACE-MARIE TURNER

Ms. TURNER. Thank you, Chairman Coffman. Thank you for holding this hearing. Thank you, Ranking Member Schrader, Congressmen Bartlett, West, Landry, and Tipton for this hearing today.

I think it is tremendously important to look at the impact of this otherwise obscure and complex regulation on the real world of health agents, health costs, businesses, and job creation. The Affordable Care Act already is leading to a loss of affordable options in health insurance for small employers. It is leading to a loss of jobs inside and outside the health sector, and to higher health care costs that make hiring workers more difficult, especially for struggling small businesses. Large employers can self-insure and better insulate themselves from the early changes inflicted by the health law, but not so small businesses. They are more exposed to changes in the marketplace.

And as I document in my testimony, many carriers already are leaving the market for individual and small group insurance. When fewer carriers offer insurance and when fewer options are available for coverage, small businesses are hit first and hardest. The percentage of small businesses offering health insurance has declined from 68 percent in the year 2000 to 59 percent in 2011. The health law that so many small businesses had hoped would benefit them by lowering costs is instead harming their ability to continue to offer health insurance at all, at least partly because of early provisions in PPACA. Premiums in the job-based health insurance market rose in 2011 by an average of 9 percent, by $1,300 a year for a family to $15,000 a year for a policy. The medical loss ratio which mandates that health insurance carriers spend most of their money on premiums is contributing to dislocations in the small group and individual markets.

A growing number of carriers are leaving these markets because of HHS inflexibility in interpreting the law. One of the tools that small businesses have found to be most valuable in helping them to afford coverage has been high deductible health plans. These plans are likely to be an early casualty of the MLR rules. They discriminate against high deductible plans because the MLR regulations only count payments made directly by insurers as medical expenses. That means that if an individual pays for a health care service to meet the deductible, the expenditure does not count toward the MLR even though the full amount is actually a payment for medical services. This interpretation by HHS is going to particularly disadvantage high deductible health savings accounts and other account-based plans that health insurers and small businesses have found to be most affordable.

Companies that sell policies in the individual and small group market also have higher marketing costs and higher customer service expenses because they provide services and must sell policies one-on-one. They are really helping their clients to find the most affordable policies that they can for the resources they have. One of the perverse effects of the MLR rules likely will be higher health

care costs. First, the rules are drying up competition and giving carriers little flexibility—giving the remaining carriers the opportunity to increase their premiums. Second, the HHS interpretation of the law for example says that costs in ferreting out fraud have to be considered as part of the administrative costs rather than as part of the overall costs or excluded from the total.

The medical loss ratio regulations also are job killers, as is this whole law. The president of the Federal Reserve Board of Atlanta recently said, "we frequently heard strong comments to the effect that my company will not hire a single additional worker until we know what health insurance costs are going to be." And as we have heard, the first line of impact is in the broker community where a survey found that at least 21 percent of independent brokers already have been forced to downsize their businesses or even close their doors.

As you mentioned, Mr. Chairman, the National Association of Insurance Commissioners has adopted a resolution urging Congress to amend the Federal Health Law to protect broker commissions from the medical loss ratio rules so that they can continue to provide the valuable services that they provide.

In conclusion, one of the most fervent promises that President Obama made to the American people when this law was ramping up toward passage was, "if you like your health plan you can keep your health plan. Period. No one will take it away no matter what." Clearly before the law even takes effect we find that is not true. I detail in my testimony many states in which carriers are already leaving the market. This will impact small businesses first because the small group and individual markets are particularly difficult for carriers to meet this new test. As people are having their coverage disrupted, violating the promise that President Obama made, I am sure that the American people are going to look for other options, and I look forward to working with you and other members of the Committee to achieve the real goals of health reform. Thank you.

[The statement of Ms. Turner follows:]

Chairman COFFMAN. Thank you, Ms. Turner. Thank you Ranking Member Mr. Schrader, for an introduction of Mr. Jost.

Mr. SCHRADER. Thank you, Mr. Chairman. It is my pleasure to introduce Professor Timothy Jost. Thank you for being here.

Professor Jost teaches law at Washington and Lee University School of Law. He is co-author of a case book, Health Law. He is widely throughout the United States to teach health law. Professor Jost is the author of numerous articles on health care regulation and comparative health law and policy, and he is also a consumer representative to the National Insurance Association of Insurance Commissioners. Professor Jost earned his J.D. from the University of Chicago cum laude, very good, in 1975. I come from Illinois myself. So welcome, Professor Jost.

STATEMENT OF TIMOTHY STOLTZFUS JOST

Mr. JOST. Thank you very much. And thank you Chairman Coffman for the opportunity to speak today and Ranking Member Schrader and Committee members.

Of all the Affordable Care Act health insurance reforms already in effect, the most beneficial for American small businesses is the minimum medical loss ratio requirement. The cost of health insurance is one of the largest and fastest growing items in the budgets of small businesses.

Fortunately, the MLR is bringing relief. First, relief will be coming through rebates. A study conducted by the NAIC last spring found that 450 million, a half billion dollars, in rebates would have been paid to nearly 16 percent of American small businesses and 23 percent of all employees had the rule been in effect in 2010. This year, when the rebates are actually paid, the amounts may be larger.

But the purpose of the MLR is not to generate rebates but rather to reduce premiums. The MLR produces a strong incentive for insurers to reduce their administrative costs and thus their premiums. But the real driver of insurance premiums is medical costs, and the most important benefit of the MLR is that as medical costs come down, premiums will be reduced accordingly. Medical cost inflation, in fact, has fallen precipitously in the last couple of years and as medical inflation declines the MLR will force insurers to pass the savings directly to consumers. Already last summer the GAO report that Chair Coffman mentioned said that the MLR was driving down premiums. Aetna in Connecticut recently dropped its premiums to small groups by 3.2 percent while Mountain State Blue Cross in West Virginia announced yesterday that small businesses like Mr. Livengood's will be getting an average reduction in premiums for December of $2,500 for each of 4,200 small businesses, a 75 percent reduction in their premiums. Jim Houser, a small businessman from Portland, Oregon, reports that his premiums went down 3 percent this year and he was told it was because of the MLR. Brian England's small business in Columbia, Maryland, saw his premiums go down 6 percent because of the MLR.

Some argue, however, that the MLR is destabilizing insurance markets, but as another recent GAO report found, most insurers were already at 80 percent before the rule went into effect. The HHS rule provides special treatment for new market entrants, for small plans, for high deductible plans, for limited benefit plans, and for expatriate plans. I would really encourage you to read the rule. It is very widely misunderstood. It allows insurers to exclude fraud recoveries and to claim credit for health quality improvement costs, including the full cost of ICD–10 conversions up to 0.3 percent of premiums, which for most will be their full cost. States also can request MLR adjustments if they believe that it is going to destabilize their insurance markets, but two-thirds of the states did not do so because they did not believe they would have problems.

Ms. Turner's testimony includes a long list of insurers leaving particular markets. I read through all of the citations of her sources and virtually none of those withdrawals are due to the MLR requirement. As an example of this, Indiana in its request for an adjustment claimed that seven insurers were leaving the market. Four of those would not have had to pay rebates under the MLR rule because they were too small or because they already met the MLR. Two said they were leaving for business reasons. One

had not even started selling policies in the state yet. None of them claimed that they were leaving the market because of the MLR.

The most vociferous protests against the MLR requirements have come from agents and brokers, and I certainly understand the valuable services that they provide and their need for compensation. There is some evidence that insurers are cutting agent compensation, although the picture is complicated and, as the NAIC found, many insurers are not.

But it is not at all clear that those cuts are to be blamed on the MLR. For example, in Colorado, every single health insurance provider met the 80 percent requirement before the MLR rule went into effect. So although I do not doubt that Mr. West's commissions have been cut, I do not think it is the fault of the MLR. Cuts in agent and broker commissions are occurring because of business decisions of insurance companies and they are blaming it on the MLR. If Congress took commissions out of the MLR tomorrow, insurers would probably not raise commissions; they would simply take the money for profit.

Finally, Congress must consider what a legislative change would mean for the deficit. Employer-sponsored health benefits are heavily tax subsidized. As the MLR drives premiums down, tax subsidies will go down as well. If you add commissions to the administrative expenses insurers already charge small business, and that is what the Rogers Bill would do, you are increasing the cost of small businesses for doing business. You are increasing their premiums. But you are also increasing the federal budget deficit by billions of dollars. Any attempt to eliminate the MLR rule or to change it to allow insurers to keep spending unchecked can only raise costs for small businesses and indeed for all insured Americans. I encourage you to support small businesses by keeping a strong MLR.

And let me just say, although I am a second over, that I was involved extensively in the NAIC's drafting of the MLR rule. I have followed it very closely and I would be very happy to talk to you about what the MLR rule actually says and does.

So thank you very much for your time.

[The statement of Mr. Jost follows:]

Chairman COFFMAN. Thank you, Mr. Jost.

Let me start out with a few questions. To Mr. West, first of all to you, the eight major health insurers in Colorado have reduced agent commissions as a direct result of the new MLRs. Would you elaborate on your situation and that in Colorado?

Mr. WEST. Yes, I can.

The average composite commission—and I am speaking from my book of business—approximately 1,200 active client folders serving a couple thousand people—the average commission reduction was about 47 percent on the individual insurance markets pre-January 1, 2011 to post-January 1, 2011. I am also licensed and have clients in 27 other states. Every insurance company in every state across the United States with which I am appointed and do business had similar reductions.

And I can tell you that it was attributable to the MLR guidelines because insurance companies could not have met the guidelines and maintained previous commission levels. I mean, the math is

just clear and very direct and obvious. So it was an instantaneous impact that took effect at the stroke of midnight New Year's Eve last year, and it affected every carrier that I work with.

Chairman COFFMAN. Okay. With the new MLRs, you said you are forced to spend time selling other products to maintain your income. How does that affect your company and your small business clients?

Mr. WEST. Well, it is forcing me out of supporting clients in the health insurance domain. Other areas for other types of health insurance products, financial services, of course, were not affected by the MLR. So I, like many of my associates, have been forced into those spaces in order to be able to keep my business alive. I still do active work with my current clients, but I also have to curtail my support for them. I cannot do all of the aftermarket support. I cannot help them with claims issues, problems with their policies. I also cannot be proactive as much as I would like to be in terms of professional development and staying abreast of changes so that I can, in the same manner as I did before, call them in advance of new impacts and changes and advise them how to adapt their coverage for best benefit. So I am just being forced, if you will, into a different business model. And it is my health insurance clients that are going to suffer as a result.

Chairman COFFMAN. Okay. Let us see. Mr. Schrader.

Mr. SCHRADER. Thank you, Mr. Chairman. Good testimony. I appreciate everyone taking the time out of your business schedules and trying to get our economy going by doing business to come here to Washington, D.C. and enlighten us a little bit on the MLR.

I guess I would be interested in everyone's opinion, but Mr. Jost in particular, some of the other issues that have been discussed is that while the MLR takes into account fraud and going after fraud as a positive benefit and all, there is not a lot about prevention. It seems to me that a lot of insurance companies and agents are dissuaded from pursuing early intervention and prevention because they do not get the same benefit under law. Was that discussed at all during the NAIC hearings and such?

Mr. JOST. Yes. And in fact, that is expressly accommodated in the rule. The statute allows the rule (the regulation that HHS was supposed to produce with the advice of the NAIC) to put into the numerator in calculating the MLR both health care costs and health care quality improvement costs. The NAIC spent a long time debating what quality improvement meant and decided that it did not include brokers' commissions but that it did include money that insurers spend on improving patient outcomes, protecting patient safety, preventing medical errors, and, specifically, prevention and wellness activities. And a lot of thought was put into that. The rule also supports IT conversions and ICD–10 conversions and accreditation costs attributable to quality.

So in fact, wellness and prevention activities are explicitly countable in the numerator. They go into the 80 percent; not into the 20 percent.

Mr. SCHRADER. I would get those citations if possible. Obviously there is some misunderstanding about that.

Just, I guess I would go to Mr. West on this. In terms of talking about how small businesses are harmed by, including the commis-

sion fees in the MLR and stuff, can you elaborate in ways that we might be able to get around that a little bit? What are some of the other options? I have signed onto some bills but I am curious your view as to ways we can alleviate some of the negative effects by including commissions in the MLR at this point.

Mr. WEST. Well, the first and foremost impact is on the small businesses that are in that space, the health insurance agents, the people they hire, the businesses they run. As I said, it is immediately evident that if a business overnight suffers a 50 percent reduction in bottom-line, it cannot expand. I have chosen, for my employee, not to cut her salary 50 percent. She would not be able to survive. So I have had to eat that out of my small business. So you can imagine if there are a million licensed agents across the United States, any significant percentage of an impact there translates into jobs and it ripples through the employees and support structures. I have about a 30 percent overheard rate in my business and that is paid out in terms of services and contract labor and there are all kinds of other trickle downs from the effects on my small business.

The other effects to other small businesses, perhaps small businesses that I serve, have to do with the fact that it takes more time and effort to work with those clients as we try to solve their business needs and that time is just no longer available to spend with them. And there is no other place that they can turn in terms of gaining that professional support. And that can be critical in terms of optimizing coverage. Saving premium dollars in the long run can be very substantially impactful to those small businesses.

So from my perspective, undoing that impact that was done (MLR) moves us back at least to the status quo before, in which people were willing to put in that time, develop their businesses, and work on behalf of those consumers and small clients that are the core of my business today.

Mr. SCHRADER. Very good. Ms. Turner, Mr. Jost, I am curious as to what the potential remedy would be in your minds if we were to exclude commission from the basic MLRs. The goal really of the MLR was to improve efficiency. And I do not know—I would be curious about comments. I do not see how agents themselves are inefficient. They actually provide a pretty good service as Mr. West just testified to and just giving small business people that have no background—you guys have background—I have no background in health insurance. Well, I am a veterinarian but other than that I do not have a whole lot of experience. I can fix your horse but it would be nice to, you know, I just do not see agents' overhead—they are more of an informative. They keep my costs down because I do not have to spend or my office manager does not have to spend a lot of time on that.

But I am also concerned about, with all due respect, not that this would ever happen, but insurance agents gaming, including commissions, and they slip some other costs in there that indeed would be part of the administrative overhead that we would like to see them try and get down on their own. So what is the sweet spot in any sort of solution going forward here?

Ms. TURNER. Well, I think—thank you for that question. I think that excluding broker commissions from the MLR calculation

makes the most sense because they are not going to the insurance company. Yet the commissions count in the administrative cost calculation for the company. Of course, the insurance company would rather take the whole 20 percent for itself rather than pay brokers, even though they are providing, as you say, valuable services to their clients, not only in finding more affordable policies but often serving as external HR departments for small businesses and helping with complex claims, et cetera. So the costs are there. They will be borne by small businesses. They will be borne by companies that are going out of business. And they will be borne by businesses that have fewer options for affordable coverage, because they do not have the brokers to help them. So those are real costs. They are not going away.

And whether or not they fit in with some artificial calculation that HHS has determined is really not the point. They are valuable and I think, therefore, should be excluded from the calculation entirely.

Mr. SCHRADER. Yes. Mr. Jost.

Mr. JOST. Yeah. The effect of the Rogers Bill, 1206, of excluding brokers' commissions from the calculation is not to give money directly to brokers; it is to increase the amount that insurance companies can keep. In other words, if the insurance company is now paying 10 percent and keeping 10 percent for its administrative costs because it has a total of 20 percent, it can now keep 30 percent. And it will undoubtedly raise premiums or cease reducing premiums to account for that. Now, it may share some of that money with the brokers. If insurers are paying 5 percent now, they can keep paying that—and that is the average for insurance for small business commissions—they can keep that 5 percent but they now get 20 percent on top of that and they are going to raise the premiums by that 5 percent. So the effect of the Rogers Bill is simply to raise premiums for small businesses. And hopefully insurers will share some of the extra profits they make with agents. And do not just trust me. Carl McDonald, Citibank's investment analyst, put out a report right after the NAIC had its vote and said this is a big deal for insurers. They are going to make a lot more profit and they may share some of it with brokers.

The NAIC worked out a number of recommendations for legislation that would allow commissions to be passed through but then reduce the administrative costs for insurers correspondingly so that consumers would not be hurt. And if you feel that brokers need legislative relief, I would strongly encourage you to look at those alternatives rather than the Rogers Bill which simply increases premiums for small businesses and insureds and passes the money onto insurers in the hope they might share some.

And let me just say one other thing. Although it is entitled the independent brokers' and agents' bill, the way that agent is defined would include employees of insurance companies who sell policies as well. And so insurers could pass all of their marketing costs on to consumers and to small businesses.

Mr. SCHRADER. Very good. I would be interested in that at some point in time also.

Mr. JOST. Sure.

Mr. SCHRADER. Thank you, Mr. Chairman. I yield back.

Chairman COFFMAN. Let me make one point and ask for any comment from any of the members of the panel. First of all, I want to say it is amazing to me intellectually how we have come to this conclusion, you know, whereby the federal government is enacting policies, assuming based on the commerce clause that it has jurisdiction in this particular area where we do not allow small businesses to purchase across state lines today and how that we can impose rules that, in fact, regulate commissions is extraordinary. I think how to bring down cost is to allow the market to work. And I think one of the problems with health insurance in the United States today is we have a regulatory regime that really I do not think fosters competition between insurance companies.

And so one of the concerns that I have about this particular policy is I think that there is perhaps a perverse incentive built in that—and I remember having been a state legislator debating one day a particular mandate on a health insurance company that clearly would have raised costs on small businesses on their premiums and going down to the floor to debate the sponsor of the bill. And I said why is the public sector exempt from your particular mandate? And she said, well, because it costs too much.

Well, you know, I mean, it is extraordinary but we keep putting these things on small business. Well, every time you do that obviously you create an increase in cost. But the beneficiary of the increase in cost under this regulatory framework is going to be the insurance carrier because it is one way I think that this is built in that the higher your premium costs the greater your profits not by competition. And so I think that this is inherently problematic but would any of you like to comment on that? Ms. Turner.

Ms. TURNER. I think that that is really a risk. Many factors go into the cost of health insurance, including care utilization. In a competitive market, if you have more competition, then administrative costs will get wrung out. But when you only have a few carriers left in the market because the competitors that have lower overhead actually have been shoved out, you are going to drive up health care costs. If a carrier is looking to maximize its 20 percent share of the MLR and it has less competition, then it is going to be able to raise the overall premium so that that 20 percent represents a larger number of dollars. And so I think the MLR rule will drive out competition—and hopefully I will have a chance to talk about some of the challenges to my testimony—allowing the few carriers that are left in a market to increase premiums and therefore maximize their share of that 20 percent. And with less competition, who is going to stop them from doing that?

Mr. JOST. If I could respond briefly, the Affordable Care Act actually contains a number of provisions that will increase competition, and I readily admit that some insurance markets, many insurance markets are highly concentrated. One of the things it does, and this program is actively underway right now, is to introduce consumer cooperatives. We have those in a handful of states but there is seed money in the law for loans to establish consumer cooperatives and there is a lot of interest in that.

Another thing the legislation does is to provide that the Office of Personnel Management is supposed to provide multistate plans in every state, just like it does in FEHBP, so that there will be at

least two plans in every state that will be new—well, they will be multistate plans that will be available to establish competition with existing plans.

Another thing the legislation does is that it actually does allow sale across state lines with some controls and not immediately but it does provide for that possibility. That is something state insurance commissioners are very concerned about because they then lose the ability to police what is happening in their states but with appropriate controls I think it is a good idea and it is in the Affordable Care Act.

With respect to regulating the markets, I have one other response. And that is if you look at the actual medical loss ratio of companies, what you find is that the really big plans, the big Blue Cross plans, are there already. They have 85–90 percent MLRs and have for a long time in most states. It is the small insurers that have high administrative costs but the legislation and the regulation takes account of that because smaller insurers actually have reduced MLRs and so do high deductible plans. The insurers have reduced MLRs, so they have an easier target to hit.

So a lot of these problems have already been taken into account in the regulation.

Chairman COFFMAN. More freedom might be a solution but are there any other comments? Yes, Mr. West.

Mr. WEST. I checked with my assistant this morning before the hearing and there are 50 client folders on my desk right now. And these are clients that have all been affected by two major insurers in the state of Colorado exiting the entire market space. And there are a bunch of factors that go into that.

But I am looking at a backlog here, a tremendous amount of work, to work with these clients to understand what to do next and how to save them from becoming uninsured, which is what they are staring at. Okay?

I can tell you that my clients are mystified by what is going on just in general. We have seen in the state of Colorado in the past 18 months an average individual medical premium increase, if I average out all the plans over all the companies, of about 27 percent. And the customers do not understand why. And they are frosted, I guess, is the best way to say it.

The one thing that they would be willing to pay for is my services. But I cannot collect fees for those services. It is for a bunch of regulatory reasons, which are different in every state and in every market that I work. We are prohibited from charging direct fees in some markets. If we were not prohibited, just the inefficiencies of the process of me having to negotiate fees and services with every client and collect and bill would be prohibitive. And so the direct impact of the MLR, which is easily accounted for and which resulted in this 50 percent reduction in commissions, makes the entire situation untenable. Upon request I am happy to do a random sampling of my 1,200 clients. We can call them and ask them, but the last thing they want to do is see me provide less services to them. That may be the biggest value-added component they see in the entire process right now.

Chairman COFFMAN. Thank you Mr. West. The other Mr. West from Florida.

Mr. WEST of Florida. I think Mr. Bartlett plans to go before me.

Chairman COFFMAN. Oh, Mr. Bartlett from Maryland, please.

Mr. BARTLETT. Thank you. You know, if you think about it, essentially all of our regulations are based on one of two premises. The first premise is that every employer, provider or manufacturer is inherently incompetent, evil, or greedy, and they are going to screw the employees and the consumers if we do not protect them with regulations. And the other premise is that every consumer is really incredibly naive and ignorant, and if we do not have a bunch of regulations to protect them, they are going to get taken advantage of and they are going to hurt themselves. And this regulation is no different. I know it was well intentioned and it was intended to reduce the cost of health care but I think it will do quite the opposite because there has to be a cost of compliance here and that can do nothing but drive up the cost of health care.

If, in fact, insurers are making excessive profits because they are paying out too little of the premiums in health care, if we have an open competition, will not new insurers come into the market to share in these profits and therefore drive down the cost of health care? You know, our problem is that our regulations are preventing competition, and competition, I think, will do what this regulation is intended to do but cannot do because it will simply increase the cost of compliance and therefore, drive up the cost of health care. Why should we not reduce regulations and let the market drive down the cost of health care?

Ms. TURNER. Mr. Bartlett, you could not be more correct. In Virginia, across the river from your state, a company called nHealth announced right after the health law passed that it was closing its doors. This new, innovative, company offered primarily high deductible plans but because it saw this regulatory steamroller coming at it, it basically lost investor support. So people lost that opportunity for this new innovative company to provide those options. nHealth has basically left the individual market in Virginia, leaving about 3,000 policyholders without other options.

And you are so right about regulatory compliance when you look at this MLR regulation with pages and pages of rules about how insurers have to document their medical loss ratios. This costs them money to go through this administrative hassle to prove to HHS that they are going through the right administrative hoops. This is completely working against lowering costs and actually helping consumers—and you are so right. People have said health care is just too important to be left to consumers. Well, it is not. The market will respond if those options are available but they are being crushed by regulation.

Mr. JOST. If I could respond briefly, I went to the University of Chicago so I believe in market competition to a point. World Insurance Company, one of the companies that is leaving Colorado, was fined $153,000 by the Colorado State Department of Insurance for a number of marketing problems, including the fact that it excluded coverage from skiing as a high risk activity. Well, in Colorado, a lot of people ski. And so I think that when a company is fined or is even barred from a market for regulatory purposes, sometimes it is a good thing and sometimes it helps consumers.

Not everybody who wants to sell insurance should be allowed to do so.

With respect to competition though in insurance markets, it is really complicated and health economists have studied this for years. Just an example of this, I heard the other day and I cannot substantiate this but I believe it is probably true, that in one of the states where a new cooperative was trying to form under this new law, one of the big insurers had gone around and told providers if you sign a contract with them we are going to terminate your contract with us.

Mr. BARTLETT. But if we had open competition and if we did not have regulations that kept new people from coming in, would not the marketplace take care of this?

Mr. JOST. I do not believe so.

Mr. BARTLETT. You do not believe so?

Mr. JOST. I think if we did that we would have basically about two or three national insurers in every state.

Mr. BARTLETT. Sir, that cannot be true if other people can come in. We are now going to have fewer and fewer insurers because your regulations are driving them out of the market and you are achieving exactly what you set out to avoid with your regulations. Thank you and I yield back, Mr. Chairman.

Chairman COFFMAN. Mr. West of Florida.

Mr. WEST of Florida. Thank you, Mr. Chairman and Mr. Ranking Member. And thanks to the panel members for being here today.

You know, I am a simple soldier and I appreciate your son serving in the Air Force and I appreciate your service in Vietnam where my older brother served. And to me this seems like another example of we have to pass the bill to know what is in it because now we are all of a sudden seeing again the unintended circumstances. And I think that this once again represents a rule, a regulation, whatever you call it that is counterproductive to what established this country and made it great, and that is the free market and enterprise system. I mean, just the same with Dodd-Frank. We are finding out with Dodd-Frank we have more problems with our small community banks and their relationship with our small business owners. And the same thing with this here now with the Patient Protection Affordable Care Act, we find another provision that is causing more problems for our small business owners.

So my initial question to Mr. West, Mr. Livengood, and Ms. Turner is what do you see as the most detrimental effect of this new MLR rule, regulation, whatever you call it within your respective lane?

Mr. LIVENGOOD. I will go first. I am aware that it has become—caused an impact upon my agent's revenue stream and his ability to possibly attend to my needs as deeply as he did in the past because I rely upon my agent heavily. I have implicit confidence in his ability to perform. When I have issues that arise, and that is not often, but when I have issues that arise, I pick up the phone and say, Paul, you have a problem. And I tell him what the problem is. And then I hang up the phone and I know that that problem is going to get resolved expediently and to the best benefit that possibly could occur to me.

So as I see him being concerned about do I want to still stay in this market or do I want to do something, that causes me great concern because if he were not performing, same as my CPA, my attorney, et cetera, et cetera, if they were not performing I have immense leverage. I can terminate the services. If we are dealing with some other entity, such as an insurance exchange, I think I have lost that leverage. But that is my observation and most immediate impact.

Ms. TURNER. Mr. West, I think that the biggest problem is just this "Washington knows best" attitude. I mean, states are the regulators for health insurance and they can solve problems. When a company may go against some regulation about whether or not a ski accident is a covered benefit, that is not a federal problem. And yet states have had to go through amazing paperwork burdens to petition Washington to exclude them from the medical loss ratio rule and to give them some relief.

And HHS in its wisdom has told states like Indiana, "I am sorry, we know best, not you." Mitch Daniels, governor of Indiana, said that denying Indiana the waiver from the MLR rule is going to lead to higher costs. This is working against personal freedom. He says, for example, that in Indiana they have a disproportionately high number of people with health savings accounts and therefore, because, again, of this obscure provision—the MLR rule, it is particularly difficult for Indiana to meet that test even though it is offering businesses in the state more affordable coverage.

And to Mr.—Dr. Jost's comment earlier, a number of companies have said we are leaving not just because of the MLR but because of this burden of regulation of which the MLR is a part. The American Enterprise Group announced just this October that it is leaving the market in 20 states. The MLR is a big reason why. Aetna is leaving the market in many states, including Colorado, because it is saying that it cannot meet the test in the individual and small group markets. So you are losing the exact competition that you are talking about because states are asking Washington for relief from the MRL rule and Washington is telling them, "no, we know better than you do what is right for your health insurance markets." I think it is that arrogance that is really the root of the problem.

Mr. WEST. Congressman, I would use the case of World Insurance in Colorado as a perfect case study. World Insurance was a relatively small insurer that entered the state. They were very creative with their policy definitions and offered an extremely high value product. And that product was based on two premises. One, giving the consumer the ability to tailor their coverage to their needs. The fact that they define skiing as a high risk activity was not evil. It was not illegal. It was simply part of their product offering. Very interestingly enough, they also entered into a partnership with agents and they offered a higher than average commission rate to agents with the understanding that we, as agents, would represent the company to properly deliver that product to consumers. While there are a lot of skiers in Colorado, 95 percent of the residents in Colorado do not ski and they enjoyed the opportunity to knowingly select a plan that would not cover skiing injuries at a substantial premium discount. The direct result of the

MLR calculation and many of the other factors inherent in the legislation was to deem those sorts of practices to be somehow wrong. And World Insurance has left the market space.

I can tell you for a two-year period the World Insurance product was the one that I owned and that I recommended for the vast majority of my clients based on lowest premiums and best value delivery to those consumers under the appropriate circumstances. The moment that I learned from a client or we discussed the issue and he told me "I am a skier," I would immediately say, "Well, then we need to move to another product." Those choices have been all but eliminated from the marketplace now, and the result of the legislation is decreased competition. This company has left the space. Their highly effective, cost effective premiums are no longer available to my clients and I would tell you as a former customer of theirs, there was nothing wrong with the product they delivered.

Mr. WEST of Florida. Thank you. Can I continue on, Mr. Chairman and Mr. Ranking Member?

Chairman COFFMAN. Yes, please do.

Mr. WEST of Florida. Professor Jost, I have a letter here you recently signed on to members of Congress about the medical loss ratio and later states in part that the NAIC unambiguously concluded that a year ago producers' commissions are an administrative cost. And you participated in the NAIC's fall of 2010 meeting. As a matter of fact, I will read the statement out of the letter. "As the NAIC itself concluded a year ago, after extensive deliberations producers' commissions are an unambiguous administrative cost. But at that 2010 meeting, the NAIC took no action on these brokers' commissions and in fact, since January 2010, they have been urging Congress and the HHS to accommodate brokers' commissions in the medical loss ratio.

And I want to read from that NAIC report where it says, "In a recent letter to HHS Secretary Kathleen Sebelius, the NAIC reiterated the important role of insurance agents and brokers. Director Hudson stated that the NAIC encouraged Secretary Sebelius to recognize the essential role of insurance agents and brokers and to accommodate compensation arrangements in any MLR regulation that is promulgated. Director Hudson made a motion, seconded by Commissioner Sevigny, for the NAIC to appoint an executive committee level subgroup to work with HHS to accommodate agent and broker compensation in the MLR particularly during the transition to 2014. And the motion passed."

So my question is why would you sign on to a letter that actually contradicts what happened at this NAIC meeting?

Mr. JOST. Thank you for an opportunity to comment on the NAIC's involvement in this issue because it is a complicated story but I will try to keep it brief.

The NAIC's task under the statute was to come up with definitions, establish definitions and methodologies for implementing the statute. The statute does not permit either HHS or the NAIC to remove agents' and brokers' commissions from the denominator because it is not there. It allows taxes, regulatory fees, various other kinds of adjustments, not agents' and brokers' commissions. So the NAIC recognized that when it unanimously adopted the recommendation—I believe it was unanimous—on the NAIC rule last

year. However, the NAIC is concerned about brokers and agents for the same reason we all are. They do provide valuable services to insured consumers. So they said if there is anything HHS can think of to do here that we did not, please do it. HHS could not think of anything to do that they could not because it read the rule, the statute, exactly the same way that they did. There is no other way to read the statute really.

So the NAIC appointed this task force, executive level task force, to look further into the question because it was a question of great importance to them. The task force in turn asked the Health and Managed Care Committee to look into it and they asked the Health Actuarial Task Force to look into it and they wrote a very comprehensive report which I would really urge all of you to read. What that report found was——

Mr. WEST of Florida. Let me—just for one minute. But when I read this letter, this letter makes me believe that the NAIC is supporting keeping this unambitious rule, this MLR as it is. That is what this letter says to me.

Mr. JOST. That letter is from—I believe that letter is from consumer representatives to the NAIC. We do not speak for the NAIC. We speak for consumers to the NAIC. Let me just finish.

Mr. WEST of Florida. So you are agreeing with something that obviously it seems that the NAIC did not say?

Mr. JOST. The NAIC said in its initial finding that there is no—that the current law does not accommodate them. Anyway, there was a task force—I will make this quick. The task force report found, number one, that although some places agents' commissions were being cut, other places they were not. And number two, that in states that already had MLR rules like the federal rule, consumers were not having a hard time finding agents and brokers, but it did come up with, I believe, nine or 12 alternatives for Congress to consider for changing the law if they wanted to reinstate agents' and brokers' commissions. That, then, has been a subject of debate within the NAIC since that time and just about two weeks ago, on November 22nd, the NAIC Plenary, all of the state insurance commissioners, voted 26 to 20 with 5 abstentions, a very close vote for the NAIC which usually operates by consensus, and frankly, a political vote, voted to recommend to Congress that something be done for agents and brokers. And that is basically what it says.

So it is in your lap but I would strongly urge you for the sake of small businesses, do not drive insurance premiums up when they are just coming down right now.

Mr. WEST of Florida. Everything shows that insurance premiums are going up. I mean, even in my simple little southern, you know, understanding of math, it seems that they are going up, especially since January 2009.

Thank you, Mr. Chairman. I yield back.

Chairman COFFMAN. Thank you, Mr. West.

Let me just raise one question, Mr. Jost. So the thesis behind the MLR rule is that by in effect regulating commissions and, if you will, by virtue of having them in the cap will benefit consumers. Is not that the principle? It will drive more benefit to consumers in terms of health care provider services. Is that not correct?

Mr. JOST. The idea is that when consumers buy health insurance they are looking for insurance for medical care, not for paying a lot for profits and bureaucracy.

Chairman COFFMAN. Sure. Because I remember being a state legislator, again going back in Colorado, where we were—I remember being at a debate one time where the issue was about consumers but from a trial lawyer point of view in personal injury cases. And then the question was should we, in fact, regulate the fees that lawyers can charge as a percentage of the case in order that more benefit go to the victim. But I think that at the end of the day the argument that won out was that the victims could, in fact, shop around for lawyers and get one potentially with perhaps a lower contingency fee. How do you separate those two?

Mr. JOST. I think brokers and agents ought to be paid exactly the way lawyers and accountants and real estate brokers and everybody else is paid. They ought to negotiate a fee with their client and that should be their fee. The MLR then should be raised. Administrative costs should be reduced to recognize the fact that insurers are not now paying for that. But if somebody wants to pay a broker 20 percent of their premium, I think they should have that freedom. So I do not think Congress should tell them.

Chairman COFFMAN. So what should be the cap then for trial lawyers in terms of their contingency fee? What cap should we impose on them so that we protect consumers, so that we protect the victims that they are representing? What cap should be imposed?

Mr. JOST. That is not something I was prepared to testify to today.

Chairman COFFMAN. Oh, but surely you have thought of that. You are a law school professor. Please.

Mr. JOST. If you want me to talk about that, I can talk about that.

Chairman COFFMAN. I would love to know what is 20 percent? Would 20 percent be a fair number?

Mr. JOST. I cannot say. I would have to look at that more closely. I mean, the problem obviously is that lawyers who take——

Chairman COFFMAN. Can you get back to me as to what a fair percentage would be, so you have had time to deliberate that? Because obviously what we want to do, I mean, if we are going to regulate everything, because we do not believe in freedom, because we do not believe that free market competition, which unfortunately we do not have today in the insurance industry because of regulation, that we ought to look in terms of—to follow this logic through to the plaintiff's bar and just say there ought to be a cap on contingencies so that the bulk of the money goes to the victim.

Mr. JOST. You know, I do not have a problem with that and those laws exist in many states but I am not an expert on that.

Chairman COFFMAN. Why not have a federal one?

Mr. JOST. Well, I think that that is a problem that many states have addressed.

Chairman COFFMAN. But should not we—I mean, if we are regulating something that is truly intrastate commerce because we do not allow small businesses and individuals to purchase across state lines, so if obviously the commerce clause is so expansive to warrant the rule that we are discussing today, then why does not the

Congress of the United States have a rule affecting the plaintiff party in every state in the country?

Mr. JOST. I think under the Commerce Clause, Congress could definitely do that and you would have to decide whether that is something that demands your attention. I think that Congress decided two years ago that insurance was, and in fact, since 1946, it has been clear that Congress has the right to regulate insurance. In fact, since 1974, Congress has regulated 85 percent of health care benefits through ERISA, and now they are extending that a little bit.

But I am sorry, I just do not—I am not an expert on attorney fees.

Chairman COFFMAN. Mr. Schrader, any further comments?

Mr. SCHRADER. No, thank you, Mr. Chairman. I think we have covered it pretty well and the goal would be to find some way to take care of the insurance agents and yet keep the intent of reducing health care costs for Americans going forward.

Chairman COFFMAN. Well, I want to thank you all so much for your testimony today. This Subcommittee will continue to closely follow the implementation of the health care law. I ask unanimous consent that members have five legislative days to submit statements and supporting materials for the record. Any objection? Without objection, so ordered. This Subcommittee is now adjourned.

[Whereupon, at 11:20 a.m., the Subcommittee hearing was adjourned.]

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Testimony before the House Small Business Subcommittee on Investigations, Oversight and Regulations Hearing "New Medical Loss Ratios: Increasing Health Care Value or Just Eliminating Jobs?"
December 15, 2011

Chairman Coffman and members of the Subcommittee: Thank you for the opportunity to testify today. My name is Mitchell West and I am an independent health insurance agent and broker in Centennial, Colorado. I am here to testify on behalf of myself and my professional association, the National Association of Health Underwriters. I also believe that I share the sentiments of the 22,019 licensed health insurance agents in Colorado, and the over 1 million insurance agents licensed across the entire United States.

As a sole proprietor with one full-time employee, I am a typical health insurance agent and I appreciate this opportunity to provide perspective on how the Medical Loss Ratio (MLR) requirements of the Patient Protection and Affordable Care Act (PPACA) have affected my industry.

Helping people obtain and use their health insurance is my second-chance career. My degree is in engineering, and I spent 20 years in the aerospace industry as an engineer and program manager working some of the most advanced telecommunications satellite programs of the time. But in 2002, I found myself in unfamiliar territory. I had been covered my entire life by group health insurance that had been provided by employers. When I was laid off as a result of the telecommunications downturn in 2001, I was in need of health insurance for my family.

I was inundated with information and unable to make sense of it. Dozens of companies, hundreds of plans, an unfamiliar vocabulary and marketing materials that all claimed to offer me the best possible solution were only a few of the challenges. To differentiate themselves from their competition, some insurance companies attempted to make their offerings sound unique when they were not. At the same time, other companies claimed their offerings were similar to those of their competitors' when in fact they were not comparable.

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Despite my professional background, I had no confidence in my ability to make a good decision. It was only with the help of a skilled agent that I came to understand how the industry worked, which plans were risky and to be avoided, and which offered the best value. Only then was I able to make a wise choice. I was greatly relieved at the end of the process, especially after realizing that some of the options that I had been considering on my own could have put my family at risk.

A few months later, I began my career as a licensed health insurance agent with my recent experiences fresh in my mind. As I met with clients, I began to understand that consumers often have more misconceptions about health insurance than they do correct information, and that ***they are often not prepared to ask the right questions*** as they approach the very important task of choosing a plan that will protect themselves and their families.

Having since worked with over 5,300 consumers, I have come to recognize that my primary job is client education. Not until this is accomplished can I begin the process of helping a client select the right plan. Once the plan has been selected and procured, I become an educator again, explaining how to use the plan and what to do when circumstances arise. A partial list of topics that I discuss with each and every client includes:

- What defines the value of a health plan
- Types of plans available, and the features of each
- Cost and value of optional features
- Which risks are acceptable and which may not be
- Pros and cons of each plan type
- Insurance companies' strengths and weaknesses
- Claim scenarios, and which plans work best for each scenario
- Effect of pre-existing conditions on price and availability
- How best to deal with specific health conditions
- Network coverage and doctor availability
- Rate locks and future price expectations
- Payment modes
- What happens when there is a claim
- What to do when there is a problem with a claim

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I pride myself on delivering a high level of service, staying in touch with my clients and updating them when changes occur in the health insurance market. Hundreds of my clients have been with me for over eight years. I am constantly reviewing their coverage and making plan changes on their behalf to deal with evolving family situations and the tremendous rate of change of products in the health insurance marketplace. Historically, I have also worked, on a "pro bono" basis, to assist anyone that has called me when they cannot obtain coverage, and have helped many consumers obtain health care through public programs like Cover Colorado. **None of the activities mentioned above generate a single dollar of revenue for my business.**

My only source of revenue is commissions paid after the sale of health insurance policies to my clients, and all of these commissions are paid through the insurance companies whose products I sell.

We have eight major health insurance carriers in Colorado aggressively competing for business in the state. All of these carriers reduced agent commissions over the past year as a direct result of PPACA's MLR requirements as designed by the Department of Health and Human Services. Effective January 1, 2011, for my practice, which is comprised of over 1,200 active clients, my commission reductions averaged 47 percent on new business and 20 percent on existing business/renewals. One of the carriers in Colorado has stopped paying renewal commissions entirely. That means I only get paid for the first year of any contracts I place with that carrier, even though it is my responsibility to service to my clients who are enrolled in their plans for all of the years that my clients stay with this carrier.

My practice has an overhead rate of 30 percent, comprised of rent, licensing fees, employee compensation, marketing, communications, office equipment, transportation, consumables and mandatory continuing education. My overhead expenses are unchanged for 2011, but will increase out of necessity in the future.

Using a figure of 35 percent as the composite reduction in my revenues that are attributable directly to MLR on January 1, 2011, ***the net consequence is a decrease of 50 percent to my bottom line.***

As a sole proprietor, the bottom line of my practice is both my salary and the source of all funds needed to grow or maintain my business going forward.

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Is there any business able to suffer a 50-percent instantaneous reduction in revenue, while costs remain the same, and survive intact?

My experience isn't atypical, either. Many agents I know, in particular those who were in the early stages of building their businesses, have not been able to meet their expenses and have simply gone out of business. Others have chosen to move into other insurance and services sectors in which they can be successful.

I am very fortunate that I previously built a successful practice providing a revenue foundation upon which I can fall back, because I have to sell twice as many policies this year in order to earn the same amount as I did last year. This situation is not sustainable for much longer. I have, thus far, been able to hold on, but many thousands of other agents all across the country who are also working under these circumstances have become unemployed or underemployed, or have permanently left the industry.

The reduction in revenues does not fully describe the total impact of the new health reform law on my business. PPACA has had many widely misunderstood impacts on the health insurance policies of every American citizen. The addition of another layer of change in the form of interpretations and regulatory requirements implemented separately and differently by the regulatory agencies of every one of the 50 states has created further flux and consumer uncertainty.

This means that every policy I have ever sold to every one of my clients in the past has been subject to unforeseen policy amendments, coverage changes and price increases over the past 20 months. A significant amount of my time must now be spent explaining which changes could, will or might in the future affect every one of my clients. This need for extensive additional education applies to all "in-force" policies, which were supposed to be stable contracts that were well understood at the time they were initiated. Making sure my clients completely understand the changes to their benefits is a significant and uncompensated additional burden that I consider a new "overhead expense" attributable to PPACA.

As a result, I am forced to plan for a very different future. I simply cannot stay in business operating the way I used to. My time must now, of necessity, be used differently.

Here are examples of changes that PPACA is forcing me to make:

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- A new prospect with significant medical concerns and personal issues will not get the help that I have been accustomed to providing... I simply cannot spend the time with them and must move on to other opportunities.
- Pro bono support is not an option.... I can only deal with clients who will generate revenue, and I must turn away those with special needs instead of assisting them as I would like to do.
- Current clients will not get the same level of attention... I must spend more time searching for new business just to be able to keep my practice operating.
- I am forced to change the focus of my practice and sell other types of personal insurance products that have an acceptable compensation structure... The percentage of time I spend helping people with health insurance inquiries is in decline.
- I have chosen to not cut the salary of my full-time employee by half... She would not be able to survive financially, so hiring of additional staff to deal with the added burdens from ACA or to grow my practice is not possible.
- Time that I used to spend on professional development in the health insurance area no longer exists... Rather than keeping abreast of trends and finding creative ways to help my clients, I must move on to other markets.
- I fully expect that my health insurance revenues will continue to decline as a share of my total revenues in the coming months as I am forced to change my practice, serving smaller numbers of consumers with their health insurance needs.
- Rather than anticipating the needs of my clients, proactively reviewing their coverage and looking for better solutions for them, I am forced to be reactive and only respond to requests as they come... This inevitably means my clients will pay more for their coverage in the long term and enjoy lesser benefits at any given time because I am unable to spend the time to make sure their plans are optimized in real time.
- I can no longer provide the same level of administrative support to my clients... Helping with banking/payment issues, questions at the time of claims and detailed questions

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about their policies is no longer possible. All of these were value-added services that I now must avoid.

Millions of Americans are in need of health insurance because they have lost their employer-provided coverage, have come to the end of their COBRA coverage, have chosen to start small businesses, have come off of their parents' plans or are entering the workforce for the first time. ***Put yourself in their shoes***; the health insurance environment has never been more confusing and there has never been more of a need for help. The rate of change in the industry is remarkable, making it impractical for consumers to keep themselves informed. How can the average mom or dad be confident that they are choosing wisely when making decisions that have such very important consequences for their families?

I have noticed a rise in the number of discount plans, limited-benefit plans and other types of bundled packages being promoted, as well as the number of call centers and non-licensed marketers selling these products. Their efforts are an attempt to capitalize on the current environment to the detriment of unwary consumers who are confused by the changes and desperate to find a deal that is more affordable but which is too good to be true. Many times, these products are presented in such a way that they can be misunderstood to be traditional health insurance plans providing extensive and comprehensive protection. I am very concerned for the large number of consumers believing they are purchasing reliable and complete health insurance coverage when this is not the case.

While agents are under these pressures, insurance carriers are challenged to reduce their non-claims expenses and they are cutting staff and unable to provide added support to the consumer to pick up the slack. As agents are going out of business or dramatically reducing their level of service, this double whammy will leave more and more consumers without the benefit of an advocate and unable to obtain proper support before, during or after the plan-selection and purchasing process.

This trend is accelerating and ***I believe a tipping point will be reached soon***. With potential new agents perceiving that they cannot make an acceptable income and seeking other opportunities, the population of agents will decline to such an extent that consumers will have

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lost this important asset, even as their need for assistance is increase by the addition of further PPACA changes over the next two years.

The stated intent of PPACA was to help the consumer in a number of categories. The effect of the MLR provisions as currently interpreted and implemented has been a very negative and unintended consequence of this legislation.

HHS was given authority under PPACA to implement the MLR requirements. It is within the power of HHS to recognize the facts presented above and to provide immediate relief by modifying the MLR regulation. Despite the recommendations of industry groups, business organizations, the National Conference of Insurance Legislators, the National Association of Insurance Commissioners and many members of Congress, ***HHS has been unwavering in its position and chosen to not act***.

It would seem, therefore, that the only solution is a legislative one, and it is needed immediately. Much damage has already been done to tens of thousands of agents and countless consumers nationwide. Health insurance agents are highly skilled professionals who deliver valuable services to consumers attempting to navigate an extremely complicated marketplace in which mistakes can result in severe financial impact.

I have never in my career had a client complain about having to pay a commission, which in Colorado is required to be disclosed and transparent to all clients. On the contrary, my clients routinely thank me for my assistance both verbally and by referring their friends and family members to me for assistance.

Agent commissions are not, and never have been, a profit element for the insurance companies. They are rather a "pass-through" fee that is required to be collected this way by a variety of state laws. The embedded commission structure also benefits consumers because fee standardization is achieved across the industry, consumers are relieved of the inconvenience of having to negotiate with agents, and agents are relieved of the burden of having to negotiate and collect their fees separately from their numerous clients. Consumers, agents and insurance companies all benefit from this arrangement and the highest level of service is delivered to the consumer.

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By eliminating agent commissions from the MLR calculation, as would be achieved by the passage of H.R. 1206, the bipartisan Access to Professional Health Insurance Advisors Act of 2011, consumers would be assured of continued access to the support and services that only a community of trained, licensed and experienced agents can provide. Numerous jobs will be preserved at the national level as agents are able to stay in business. New jobs will be created as agents enter the workforce to assist consumers with the increasing complexity of the health insurance marketplace as we enter the era of exchanges and the many new regulatory and insurance product changes that are ahead.

I appreciate the opportunity to share these thoughts with the Committee. This is a case of well-intentioned legislation resulting in unintended negative consequences to small businesses and consumers. Members of Congress need to recognize the problems that have been created and, on behalf of the American people, work with a sense of urgency for a legislative remedy.

WHAT A STITCH LLC

Testimony of Gary Livengood

Principal, What A Stitch, LLC

Before the U.S. House of Representatives' Small Business Subcommittee on Investigations, Oversight and Regulations concerning "New Medical Loss Ratios: Increasing Health Care Value or Just Eliminating Jobs"

December 15, 2011

Good Morning. My name is Gary Livengood, and I am a principal of What A Stitch, LLC, a small commercial embroidery company located in Mt. Airy, Maryland. I would like to thank the members of the Small Business Committee for the honor of testifying before you today about the new health reform law. I plan to address my specific concerns about how its medical loss ratio provisions are threatening my access to the services my health insurance agent provides, as well as how the new law may impact my ability to grow my business and provide health coverage to my employees in the future.

To tell you a little bit about me, after serving our country in Vietnam, I worked in a variety of operational positions in the railroad, investigative services and insurance industries for more than 35 years. Then, a few years ago, my wonderful wife, Louann, somehow got me to agree to spend my retirement not on the golf course, like I planned, but on growing her hobby into a business that now employs 21 people.

We started What A Stitch in 2002 with one sewing machine. The company grew and grew, but then, like small-business owners everywhere, we hit very tough times in 2008 and 2009. We are very committed to our employees, so we dug into our savings and kept the doors open during the rough years. I am very proud that, through great personal sacrifice, we were able retain all of our employees throughout the Great Recession.

While times still aren't great for us, this year has been much better than the last. I wish I could say that even better times are coming for What A Stitch but, unfortunately, the future still looks very uncertain. I know the intent of the new health law was to help business owners like me but, so far, I just don't see it. The new law weighs heavily on my mind every time I think about hiring new employees or how our business may grow and change over the next few years. It has already put regulatory burdens on our

company, due to the required changes to our benefit plan and the grandfathered plan rules. And there are more compliance burdens in our future: the new impending taxes on our premiums, the many notice and reporting requirements, the changes to the way our premium will be calculated, the new essential benefits we'll have to cover, and so on.

Before we started What A Stitch, my wife was a director of human resources for Amtrak and I worked for 13 years, eventually as a vice president of operations, for a small regional HMO that was eventually bought by UnitedHealthcare. Due to our professional backgrounds, my wife and I may know a little bit more about the administration of group health insurance than your average small-business owners. Consequently, our level of day-to-day reliance on our company's health insurance agent, Paul Younkins, and the company he co-owns, Allied Resource Management, is much less extensive than what other small-business owners I know need.

In insurance, we often talk about the 80/20 rule, meaning that about 20 percent of the clients use 80 percent of the services. We are one of Paul's clients who falls soundly in the 80 percent. Unlike many small-business owners, we don't call our agent every day to help us out of jams. We do trust him implicitly, though, and over the years he has come to know us, our employees and the needs of our company well. Paul is our regular source of information about our compliance responsibilities, which is a service that's become increasingly important as health reform is implemented. We rely on him each year when our policy renews to help us provide the best benefits for our employees at the best possible price. We also call on him occasionally to help us with benefit issues that we can't easily resolve. When we do that, it is very comforting to just tell him what the problem is and then hang up the phone and get back to work knowing that it's Paul's problem now. We have complete confidence he will be able to leverage his relationships within the benefit community and reach an expedient solution on our behalf.

Even with our extensive personal experience in the employee benefit world, Louann and I would never consider dropping the services of our agent. He's our insurance policy within an insurance policy. So far, our company and employees have been lucky. We haven't had a claims disaster or a medical crisis to overcome that would require the full use of Paul's capabilities. I know some of his other clients have those kinds of service needs, and other health insurance agents like Paul provide far-reaching services to small-business owners across the country. That's why I am more than happy to pay our agent's commission each month. I understand at any time our company could have similar needs. Eventually,

all health care consumers have a serious benefit problem to address. If and when our when our day comes, I want my employees and family to have someone we know and trust in our corner. My company will need a professional benefit specialist who will work tirelessly at no additional cost to us so my wife and I will be able to focus on keeping our company profitable.

Our agent is a businessman like I am, and he deserves to make a fair living for the services he provides. When I pay our company's insurance premiums each month, it's clear that a portion of my check is really our agent's fee that is included in our bill for tax and convenience purposes. Also, it's obvious that our company's total insurance premium rate has nothing to do with the amount our agent gets paid. Our premium costs are driven by the cost of medical care in Maryland and the age and size of our group of employees. Paul's fee is just a small percentage of whatever our insurance premium will be, and it is worth every penny.

Unfortunately, it's my understanding that the new health reform law's medical loss ratio requirements are having a profound impact on both Paul's business and on all similar businesses nationally. In Maryland, commissions on group policies like mine have been cut by 15 percent or more, which means that Paul's overall business revenue is down significantly. In other states, I hear agents have it far worse. My company just went through several years of declining revenue, and it was extremely difficult to keep our doors open. So I feel for Paul on a personal level.

I also have strong feeling about how this will impact our company. If our agent is forced out of business by the new law, I will have to think very, very seriously about whether or not it will be feasible to continue to provide benefits to our employees. I don't think I will be able to handle the new compliance burdens coming without professional help.

If Paul needs to change the nature of his business and can't afford to handle our account anymore, there is a good chance we will just drop our group coverage, save the money we put into our employee's premiums, and let our employees purchase individual coverage through the new health insurance exchanges. Although if the government takes over our benefits, such as through these new health insurance exchanges, I am hard-pressed to believe that my employees and I will have access to the same kind of customer service that Paul and his company provide.

Obviously, the cost of our health insurance premiums is very important to me, and I dare to say to every American small-business owner. I believe Americans need to take serious steps to get health care costs under control. But to try to do so by over-regulating and cutting the payments to insurance agents and brokers who assist consumers like me is completely missing the forest for the trees.

When I think back on our decision to open What A Stitch nine years ago, knowing what I know now, I am not sure we would make the same choice again. We had no idea the regulatory burden would be this significant.

I would strongly encourage all members of this committee to take a serious look at the strain the new health reform law is putting on companies like ours, as well as on other small businesses like our insurance agency, Allied Resource Management. The first place I suggest you look to for improvements is the section of the law addressing medical loss ratios, so that business owners like me will not have to worry about losing continued access to our health insurance agents and brokers.

Thank you for the honor of testifying before the subcommittee today. If you have any questions, I would be glad to answer them at the appropriate time.

A not-for-profit health and tax policy research organization

Testimony before the U.S. House of Representatives
Committee on Small Business
Subcommittee on Investigations, Oversight and Regulations

Rep. Mike Coffman, Chairman

Hearing on

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

Testimony presented by
Grace-Marie Turner
President, Galen Institute

"New Medical Loss Ratios: Increasing Health Care Value or Just Eliminating Jobs?"

Committee on Small Business
Subcommittee on Investigations, Oversight and Regulations
Testimony by Grace-Marie Turner, Galen Institute

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

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

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

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

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

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

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

"New Medical Loss Ratios: Increasing Health Care Value or Just Eliminating Jobs?"

Hearing before the
Committee on Small Business
Subcommittee on Investigations, Oversight and Regulations
December 15, 2011
By Grace-Marie Turner, Galen Institute

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

Losing coverage

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

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

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

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

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

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

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

Health costs rising

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

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

Medical Loss Ratio rules

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

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

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

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

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

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

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

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

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

Forced rebates

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

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

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

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

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

Discriminating against HSAs

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

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

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

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

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

ObamaCare regulations cause havoc in the states

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

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

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

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

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

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

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

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

Medical Loss Ratio regulations as job killers

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

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

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

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

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

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

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

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

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

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

Health plans are already leaving markets

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

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

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

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

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

In Indiana, nearly 10 percent of the state's health insurance carriers have withdrawn from the market because they are unable to comply with the federal medical loss ratio requirement. Indiana was hoping to bring the companies back by asking the Department of Health and Human Services for a waiver from the rule, but Washington refused in late November 2011 to grant the waiver.

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

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

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

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

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

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

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

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

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

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

Other dislocating regulations

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

Children-only policies

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

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

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

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

Sicker employees could be shoved out

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

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

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

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

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

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

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

The employer mandate

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

Looking toward the future

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

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

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House Small Business Subcommittee

The New Medical Loss Ratios

Testimony of Timothy Stoltzfus Jost

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

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

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

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

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

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

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

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

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

The Minimum Medical Loss Ratio is Not Destabilizing Insurance Markets

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

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

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

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

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

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

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

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

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

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

Cuts in agent and broker commissions are far from universal. This issue was studied closely by the NAIC task force. It concluded "In 2011, a significant number of companies have reduced commission levels, particularly in the individual market. However, a significant number of companies have not reduced commissions in 2011." [18] The NAIC's conclusion was based in large part on state-by-state data submitted by the National Association of Health Underwriters (NAHU), which showed a complex pattern in which some companies in some states were cutting commissions, others were not, and many were changing their method of compensation, moving from percentage commissions to per-member per-month compensation. The GAO in its July report concluded that most of the insurers it interviewed were cutting commissions, but it interviewed only eight insurers, hardly a representative sample. The Insurance

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

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

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

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

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

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

Repealing or Amending Medical Loss Ratio Requirements Will Increase the Deficit

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

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

Conclusion

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

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NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

MEMORANDUM

June 9, 2011

TO: Kevin McCarty, Chair
Professional Health Insurance Advisors (EX) Task Force

FROM: Sandy Praeger, Chair
Health Insurance and Managed Care (B) Committee

RE: Committee report on options for amending the Medical Loss Ratio formula to address concerns about access to agent and broker services

****

On March 27, 2011, the Professional Health Insurance Advisory (EX) Task Force charged the Health Insurance and Managed Care (B) Committee with the task of collecting, analyzing and reporting to the Task Force available data on agent and broker commissions and identifying "options to modify MLR definitions, methodology and/or numerical standards that may be necessary to protect insurance consumers, and to preserve the important role of producers in the health insurance transaction and in the resolution of disputed health insurance claims." The final report adopted by the Committee on June 7, 2011, is attached.

To complete its charge, the (B) Committee referred the task to the Health Care Reform Actuarial (B) Working Group which collected data from the National Association of Health Underwriters (NAHU), Connecture, three large health insurance companies, and several states. However, each of these data sets proved to be incomplete and have significant limitations.

The Working Group, therefore, relied heavily on the data from the NAIC Supplemental Health Care Exhibit (SHCE) for 2010. Using the SHCE data, the Working Group was able to analyze the potential impact of various MLR amendment proposals on potential rebates. It must be noted that the MLR and rebate numbers listed in the report are for analytical use only. These are not the final numbers for 2010, even if the MLR and rebate program were effective in 2010. The final MLR and rebates would be adjusted for credibility based on average deductible and membership instead of membership only, 3-month runoff, and deferrals. More importantly, future years may differ significantly from 2010. As detailed in the report, carriers will likely make changes in their operations as they implement and react to the various provisions of the Affordable Care Act. Therefore the numbers in the report should only be used to demonstrate the relative impact of the various options, not the actual level of rebates expected.

As noted during Working Group and Committee deliberations, the report does not address the issue of whether an adjustment to the MLR formula is necessary or whether consumers will be negatively impacted by agent and broker commission cuts. The charge given the Committee specifically states that they are to provide the options "without determining whether any change is necessary." In addition, the

Working Group determined that there was not enough verifiable data readily available and there was not enough time to collect such data. The Working Group and Committee did receive data from California on commission trends over the past ten years that may be of assistance to the Task Force as you look at the bigger issue of whether a change in the MLR formula is necessary. That data is included as a supplement to the report. The Committee is prepared to collect similar data from other states if the Task Force believes it would be helpful to your deliberations, but it will require more time.

We hope you find the options listed in the attached report, and the analysis of their impact on rebates, useful as the Task Force considers this very important issue. We would be glad to answer any questions regarding the report or provide any additional information the Task Force may need.

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

Introduction

The Professional Health Insurance Advisors (EX) Task Force made the following referral on March 27, 2011 to the Health Insurance and Managed Care (B) Committee at the NAIC's 2011 Spring National Meeting in Austin, TX:

> **Referral Language:** *Health Insurance and Managed Care (B) Committee is to complete the following:*
>
> - *Collect, analyze and report on relevant data regarding the level of commissions and/or other payments to producers in the individual, small and large group markets, including, but not limited to evaluating 2010 gross commission or fee payments as a portion of the denominator in the medical loss ratio (MLR).*
> - *Without determining whether any change is necessary, identify options to modify MLR definitions, methodology and/or numerical standards that may be necessary to protect health insurance consumers, and to preserve the important role of producers in the health insurance transaction and in the resolution of disputed health insurance claims.*
> - *Other related matters as necessary.*

This was then referred to the Health Care Reform Actuarial (B) Working Group (HCRAWG) of the Health Actuarial (B) Task Force on April 4, 2011 for completion.

Executive Summary

The Working Group received various suggestions as to possible ways to modify MLR definitions, methodology and/or numerical standards to support producer compensation. Some of these variations could be combined as appropriate. All of these options are in addition to the default option of making no changes to the current MLR formula. Here is a summary of the variations identified:

1. **Types of compensation in addition to commissions, if any, eligible for special treatment;**
2. **Types of producers for which compensation is eligible for special treatment;**
3. **Limits, if any, on the amount of compensation given special treatment;**
4. **Increase the numerical MLR standards (85% and 80%) to reflect the exclusion of commissions;**
5. **Substitute producer compensation deduction for the federal tax deduction;**
6. **Limit the number of years that special treatment of producer compensation will be applicable to the period prior to 2014 when guaranteed issue will apply and exchanges will be in place.**

The Working Group collected data from the National Association of Health Underwriters (NAHU), Connecture, three large health insurance companies, and several states, regarding commission levels. Each of these data sets are incomplete and have significant limitations and none of the private data was fully exposed for public review and comment, reducing our ability to draw meaningful conclusions from them. In reviewing this data, the Working Group has the following observations:

1. **The numerical data from the three companies, NAHU, and Connecture do not provide a clear trend in commission reductions prior to 2011.**
2. **However, some of the states with higher MLR requirements do report reductions in commissions over several years in their states.**
3. **In 2011, a significant number of companies have reduced commission levels, particularly in the individual market. However, a significant number of companies have not reduced commissions in 2011.**
4. **The states with higher MLR requirements have not observed any problems with consumer access to insurance or to producers.**

The Working Group also evaluated options based upon data derived from the Supplemental Health Care Exhibit (SHCE) for 2010. Highlights from the SHCE 2010 data include the summary tables below showing rebates that would have been payable had the rebate requirement been in effect for calendar year 2010 ("PMPM" refers to "per member per month").

Table A-MLR and Rebate Levels

MLR and Rebate Levels	% of Companies Paying Rebates*	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Individual Market	14.2%	52.9%	73.6%	$978.3	$8.09	121
Small Group Market	15.7%	22.8%	82.3%	$447.4	$2.13	210
Large Group Market	15.0%	14.7%	89.4%	$526.7	$1.13	465

* 3,196 company/state combinations in data, each company counted for each state in which it writes.

The following table captures the relative levels of compensation included in the SHCE data.

Table B-Compensation Levels

Compensation Levels	Producer Commissions (SHCE 10.2) % of Earned Premium	PMPM	Other Sales Expenses (SHCE 10.1) % of Earned Premium	PMPM	Member Months (Millions)
Individual	5.86%	$12.28	1.04%	$2.18	121
Small Group	4.52%	$15.08	0.65%	$2.17	210
Large Group	1.84%	$6.12	0.52%	$1.73	465

Using the SHCE 2010 data, we were able to estimate the effect of 12 modifications had they been in effect in 2010. These modifications reflect changing different components of the MLR calculation, including various caps on those modifications. The basic modification is the first one, excluding agents and brokers fees and commissions. The other modifications are variations from this basic change. Below is a table showing the impact of this basic modification, followed by results of capping the commission adjustment at various levels. The tables showing results for the complete set of modifications considered are contained in the body of the report.

It should be noted that our analysis of rebates that would have been paid for 2010 reflects federal income taxes (FIT) as reported in the SHCE. We had extensive discussions as to whether FIT would have been lower, and rebates therefore higher, if rebates were actually required for 2010. The thinking was that a liability would be held for anticipated rebates, which would reduce profits and therefore reduce FIT. However, an alternate view was that the rebate rules require FIT to be stated ignoring the impact of rebates. Language in the NAIC Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013 contains language that can be interpreted to support that position. The federal regulation, which is the one that applies, seems unclear on this point. We believe this is an important issue that must be resolved before rebates are calculated next year and we stand ready to investigate it further through discussions with federal regulators and interested parties if requested. However, it is only a secondary issue for purposes of this report and we concluded that we did not need to resolve it in order to finalize our report on producer compensation.

The results in Table C are intended to illustrate the relative impact of the first modification, not the actual level of rebates expected. Results for 2011 and later years are likely to differ from 2010 for several reasons. Carriers will likely make changes in their operations as they implement and react to the various provisions of the Affordable Care Act. Changes in commission scales are just one example of this. In addition to operational changes, they are likely to fine-tune accounting procedures with respect to the SHCE reporting. For example, many carriers may not have had time to consider all of the administrative expenses that might qualify as quality improvement expenses for 2010, but may pay more attention to this for 2011, when this item will affect actual rebate calculations.

Modification 1 subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2) from the adjusted earned premium used in the rebate formula.

Table C-Modification 1

	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM
Individual Market	11.1%	31.3%	78.8%	$401.3	$3.32
Differences from Table A	-3.1%	-21.6%	5.2%	-$577.0	-$4.77
Small Group Market	8.4%	7.6%	87.0%	$146.2	$0.70
Differences from Table A	-7.3%	-15.2%	4.7%	-$301.2	-$1.43
Large Group Market	8.9%	5.4%	91.6%	$215.9	$0.46
Differences from Table A	-6.1%	-9.3%	2.2%	-$310.8	-$0.67

It has been suggested that rather than excluding all producer compensation from the formula, the exclusion be capped. We evaluated various caps, both on a percentage of premium basis and a PMPM basis. Generally a cap of about 3-4% would restore half the rebate reduction for individual, while a cap of under 2% would have a similar impact for the small and large group markets. Similarly, a cap of about $6 PMPM would restore half the rebate reduction for individual and a cap under $6 PMPM would do so for both group markets.

As evidenced in Table C, adjusting the MLR calculations for producer compensation, results in an increase in the MLR by several percentage points. The Working Group calculated the "break-even" MLR level that would preserve the level of rebates prior to the commission adjustments. For the three markets (and no commission cap), this break-even level is about 86%, with some variation by market.

The Working Group did not consider modifications to the MLR calculations based on producer type.

Finally, it has been suggested that the producer compensation deduction should replace the federal tax deduction. As discussed above, it is unclear whether FIT would have been lower, and rebates therefore higher, if rebates were actually required for 2010. If the answer is no, then the impact of the suggestion to replace the federal tax deduction with a deduction for producer compensation, had it been in effect in 2010, can be seen by comparing Tables 0 and 11 in the report. This comparison shows a reduction in rebates of 29% in the individual market, 7% in the small group market, and 5% in the large group market. If, on the other hand, FIT would have been lower if rebates were required, we believe rebates in Table 0 would be in the range of 30% higher. This would increase then the reduction in rebates that would result from replacing the federal tax deduction with a deduction for producer compensation to roughly half for the individual market and roughly a quarter in the group markets, thus having a significant impact on the rebate levels if the numerical standards remain the same.

Data Collection

Data to perform analyses to complete the charge were of two general types: NAIC Supplemental Health Care Exhibit (SHCE) Data and producer reimbursement data from outside sources.

NAIC Supplemental Health Care Exhibit Data

Our primary source of data was the Supplemental Health Care Exhibit (SHCE), a new exhibit added to the annual statement reporting requirements to provide data needed for the MLR calculation under the Affordable Care Act (ACA). Data for the year 2010 from the SHCE (a list of elements can be found in Appendix A) as of 4/14/11 was extracted from the NAIC database. The data is unaudited and was used without modification. The collected SHCE data was used to calculate the approximate MLR and rebates in the manner detailed in the NAIC's *Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013 per Section 2718 (b) of the Public Health Service Act* (#190). The data was also used to calculate MLRs and rebates using modifications to the standardized calculation to reflect some of the options identified regarding commissions.

Producer Compensation Data from Outside Sources

Because the SHCE is not available for years other than 2010, we needed to rely on outside sources for data regarding commission trends in prior years and changes occurring in 2011.

National Association of Health Underwriters (NAHU)

NAHU provided compensation schedules by company by state, generally from 2009 through 2011, with a few schedules provided back to 2008. The data was blinded as the information is considered proprietary and is used for competitive differentiation. This blinding presented analytical challenges and, consequently, conclusions reached from the analysis of the data are debatable. It appears that while some commission schedules went down from 2009 to 2010, many more have dropped from 2010 to 2011. Many carriers maintained stable commission schedules between 2009 and 2011, however, and in a few cases schedules went up between 2009 and 2010 or between 2010 and 2011. Complicating the analysis, some schedules were restructured year over year with no apparent indication of the relative level of the subsequent schedule. In particular, some carriers have moved from percentage commissions to PMPM or PEPM (per employee per month) compensation or introduced tiered commission structures. It is not apparent if these restructurings were for new product packaging, strategic positioning, reflection of relative inconsistencies in prior schedules, or for some other reason. There was no indication that reductions in scheduled compensation were intended to offset the growth in premium to maintain a consistent income level for producers, although that may have been a motivating factor for some companies, since premium rates have increased dramatically over the past decade.

On the basis of our analysis we conclude that companies did not systematically decrease the percentage of premium provided as provider compensation between 2009 and 2010. We further conclude there has been a widespread decrease in first year percentage of premium compensation in the individual market in 2011, although trends are less evident with respect to renewal commissions or the group markets. We were unable to analyze changes in absolute dollar amounts of producer compensation, which are the results of applying changing producer compensation schedules to changing premium amounts.

Connecture

Connecture is a software company that provides technology to Health Insurance Carriers, Brokers, and Exchanges, both public & private. Connecture's source for the submitted data was a third-party market research company; not Connecture's clientele. Given the sensitive nature of the data it supplied, Connecture insisted that the data not be made public. The Connecture data is based on broker commission schedules for large carriers from 2005 through 2011. The data appears to show for some larger carriers in the individual market that first year commission percentages have dropped in some states by as much as 30% - 50% in 2011. In other states commissions stayed level or did not drop as dramatically. No pattern can be seen in the individual market renewal commission percentages nor the group market commission percentages. No pattern can be seen in any market for years prior to 2011. The data generally provides validation to conclusions reached with the NAHU data.

Major carriers

The Working Group asked the three largest groups of health insurers, Aetna, United Healthcare, and WellPoint, to submit data showing company experience by individual, small group, and large group lines of business by state for the years 2006-2010. At the suggestion of the companies, a template was prepared to clarify the data request and promote uniformity in the data being submitted to the Working Group. The companies were not able to provide data for all states within the short time available, but provided data for three or four representative states. They also were not able to provide information on current commission scales. The Working Group has identified this as a lower priority. The data was submitted to the Working Group through AHIP (America's Health Insurance Plans), a national association of health insurers, with the names of the companies and states replaced by "1, 2, 3" and "A, B, C". The companies requested confidentiality with respect to the data submitted, even though it was blinded, due to a concern that it would be possible to identify the company and state based on the data. Therefore, it was not available for review by interested parties.

The companies provided data for total direct premiums earned, agents and brokers fees and commissions, and member months. They were unable to break out first-year versus renewal experience in the time allowed. Using this data, the Working Group calculated commission rates both on a percentage basis and a member month basis over the years reported. In reviewing these summary results, there were no detectable commission trends in any of the lines of business leading up to and including 2010. Please note that this is an aggregate result, which is affected by factors such as the states reported, product mix over time, and the relative proportions of new business versus renewal business in each reported year.

States

The Working Group contacted 11 states that have relatively high required minimum loss ratios and asked them to provide comments about the impact of those loss ratios in their states. Ten states responded and Appendix B contains a summary of the responses. The following are general comments about the responses:

1. State calculations of MLR differ from the federal MLR calculation in important ways – especially with respect to the deductions from premium allowed in the federal MLR.
2. Consumers continue to have access to insurance and producers without noticeable problems.
3. There have been some reductions in both individual and small group producer compensation, with more individual health insurance being sold directly to consumers.
4. For several states, the MLR changes have been too recent to allow for changes to be observed.

There were 4 states in addition to the 11 surveyed states that provided data related to producer compensation. Maryland provided some data on compensation arrangements for specific companies. The data went back as far as 2005, but in most cases only the most recent schedules are provided. There are three companies where previous and current compensation schedules can be compared.

For the first company, only the small group schedules can be compared. This shows a switch from a percentage of premium method for commissions to a per employee per month (PEPM) schedule. A second company has reduced per capita per month commission (PCPM) levels by about 15% for both small group and individual business, although it has apparently introduced new incentives, so the overall effect is not known. Finally, a third company introduced a new small group schedule which appears to increase agent compensation, since the percentages are unchanged, but new incentives are added. While this information is limited, it is basically consistent with other information discussed above in that it suggests movement from commission arrangements based on percentages of commissions to a flat dollar amount per employee, particularly for group business.

Maryland provided data from 2002 through 2010 for the ratio of total producer compensation to earned premium for the individual, small group, and large group. The data for all three markets shows sizeable increases in that percentage over the time period. Without more specific data it is only possible to hypothesize about the cause of the increases. This data is only for one state so it is not possible to make nationwide inferences.

California provided data from 2000 through 2010 for the ratio of total producer compensation to earned premium for the individual, small group, and large group. For the individual market, the data were comparable for 2005 through 2010, and for the group markets (large and small) the data were comparable for the period 2003 through 2010. The data for the individual and small group markets shows very modest decreases in commission percentages (substantially less than the increases in premium rates over the observation period) and very modest increases in commission percentages in the large group market.

Data received from the other states is useful for background purposes but does not add to the above analysis.

Options

The following options to modify MLR definitions, methodology and/or numerical standards are ones communicated to us by various parties during our discussions. All of these are variations on the initial proposal to exclude broker compensation from the MLR calculation. Some of these variations could be combined as appropriate. All of these options are in addition to the default option of making no changes to the current MLR formula.

1. Types of compensation in addition to commissions, if any, eligible for special treatment:
    a. Bonuses
    b. Incentives
    c. Direct sales salaries and benefits
    d. Payments by one carrier to another to market the first carrier's health plans
    e. Fees paid to exchanges (beginning in plan year 2014)

2. Types of producers for which compensation is eligible for special treatment:
    f. Independent
    g. Captive
    h. Employees of the carrier

3. Limits, if any, on the amount of compensation given special treatment:
    i. Cap on percentage of premium excluded
    j. Cap on dollar amount per individual policy or group certificate or per member month

4. Increase the numerical MLR standards (85% and 80%) to reflect the exclusion of commissions

5. Currently, the MLR formula allows all federal taxes to be excluded from the calculation. A possible modification to the formula would allow producer compensation to be excluded from the calculation, but would allow the deduction of only those federal taxes that result from the enactment of the ACA. (These taxes will not be levied until 2014.)

6. Limit the number of years that special treatment of producer compensation will be applicable to the period prior to 2014 when guaranteed issue will apply and exchanges will be in place. A variation on this would be grading the allowable excluded amounts from a maximum in the first plan year to no allowable excludable amounts in 2014.

As discussed below, we were able to estimate the effect of many of these options had they been in effect in 2010, from the SHCE. This analysis assumes options 1.a, 1.b, and 1.d, are all treated the same as commissions and that commissions include those paid to captive as well as independent producers. The data in the SHCE did not allow quantification of other options.

As another option, exclusion of producer compensation up to a maximum percentage of earned premium from the MLR calculation could be at the option of each state. The default would be that no producer compensation would be allowed for exclusion. This option was not quantifiable, as there is no way to determine which states would choose this option. However, SHCE data is segregated by state, so the effects of a capped exclusion for a given state could be quantified. SHCE data by state is summarized in Appendix E.

MLR Rebate Estimate Modeling

2010 SHCE data was used to calculate an estimate of MLRs and rebates that would have been payable had the rebate requirement been in effect for calendar year 2010. The exact calculation is given in Appendix D. There are differences between some of the data elements that would be used for an actual MLR rebate calculation and the data that is found in the SHCE, which lead to differences in the calculation used in this analysis and the actual calculation under Section 2718 of PPACA:

- The SHCE defines incurred claims as any claims paid in the reporting year, irrespective of incurral year, plus the year-over-year change in year-end reserve estimates. The actual MLR calculation defines incurred claims as claims incurred in the reporting year and paid as of 3/31 of the following year, plus the estimate of remaining amounts unpaid as of 3/31 of the following year.

- The actual MLR calculation incorporates a credibility adjustment based on the number of life years and the average deductible for a given block of insurance plans. The SHCE does not give deductible information, so it was assumed the deductible adjustment factor in the credibility adjustment was 1.0, implying all deductibles in the SHCE data were less than $2,500. The effect of this assumption is to overstate the rebates

- The impact on federal income taxes that result from rebates is not considered in the calculation for this analysis. Only taxes as reported in the SHCE enter the calculation. Because no rebates are actually payable for 2010, reported taxes do not reflect any adjustment for rebates. It is unclear whether the reported taxes and the rebates calculated would be affected if rebates were payable. (See Appendix C for discussion of this issue).

The variances between the calculated and actual MLRs due to these differences cannot be accurately determined.

The results of the rebate estimate modeling are as follows (PMPM = per-member-per-month). Please see Appendix D for the detailed calculation:

Table 0: no change to current formula

	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Individual Market, Nationwide	14.2%	52.9%	73.6%	$978.3	$8.09	121
Small Group Market, Nationwide	15.7%	22.8%	82.3%	$447.4	$2.13	210
Large Group Market, Nationwide	15.0%	14.7%	89.4%	$526.7	$1.13	465

*3,196 company/state combinations in data, each company counted for each state in which it writes.

The following table shows the relative level of compensation included in the SHCE.

Compensation Levels

Compensation Levels	Producer Commissions (SHCE 10.2) % of Earned Premium	PMPM	Other Sales Expenses (SHCE 10.1) % of Earned Premium	PMPM	Member Months (Millions)
Individual	5.86%	$12.28	1.04%	$2.18	121
Small Group	4.52%	$15.08	0.65%	$2.17	210
Large Group	1.84%	$6.12	0.52%	$1.73	465

The results in the following tables are intended to illustrate the relative impact of the various options, not the actual level of rebates expected. Results for 2011 and later years are likely to differ from 2010 for several reasons. Carriers will likely make changes in their operations as they implement and react to the various provisions of the Affordable Care Act. Changes in commission scales are just one example of this. In addition to operational changes, they are likely to fine-tune accounting procedures with respect to the SHCE. For example, many carriers may not have had time to consider all of the administrative expenses that might qualify as quality improvement expenses for 2010, but may pay more attention to this for 2011, when this item will affect rebate calculations.

Quantifiable Options

As previously mentioned, we were able to estimate the effects of many of the options identified above, assuming they had been applicable in 2010, using 2010 SHCE data.

These modifications exclude either all or some of payments made to producers from the adjusted earned premium, which is both the denominator of the MLR formula, and the amount to which the rebate percentage is applied.

The following table shows which of the items listed in the "Options" section above relate to the various modifications discussed below:

Modification	1.c. Exclude Direct Sales Salaries and Benefits in addition to Commissions	3.a. Cap exclusion as percent of premium	3.b. Cap exclusion per member month	4. Increase the numerical MLR standards	5. Exclude only federal taxes that result from the ACA (none in 2010)
1					
2	X				
3		X			
4	X	X			
5			X		
6	X		X		
7		X		X	
8	X	X		X	
9			X	X	
10	X		X	X	
11					X
12	X				X

Modification 1

This modification subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2) from the adjusted earned premium used in the rebate formula (please see Appendix D for the detailed calculation). Line 10.2 should include bonuses and incentives as well as commissions. However, because this is the first year the SHCE has been completed and the data has not been audited, we cannot verify this with certainty. The results of the rebate estimate modeling are as follows:

Table 1

	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Individual Market, Nationwide	11.1%	31.3%	78.8%	$401.3	$3.32	121
Small Group Market, Nationwide	8.4%	7.6%	87.0%	$146.2	$0.70	210
Large Group Market, Nationwide	8.9%	5.4%	91.6%	$215.9	$0.46	465

Modification 2

This modification subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2), and direct sales salaries and benefits (SHCE Part 1, Line 10.1) from the adjusted earned premium used in the rebate formula (please see Appendix D for the exact calculation). The results of the rebate estimate modeling are as follows:

Table 2

	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Individual Market, Nationwide	10.9%	30.9%	79.5%	$358.6	$2.96	121
Small Group Market, Nationwide	7.9%	7.5%	87.7%	$126.4	$0.60	210
Large Group Market, Nationwide	7.8%	4.1%	92.1%	$195.9	$0.42	465

Modification 3

This modification subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2), capped at a maximum percentage of earned premium, from the adjusted earned premium used in the rebate formula (please see Appendix D for the exact calculation). The results of the rebate estimate modeling are as shown in the three tables below. The results under current law and the results with no cap are shown for comparison. Generally, a cap of between 3% and 4% would restore half the rebate reduction for the individual market, while a cap of under 2% would do so for the group markets (i.e. in Table 3a, 978 – 401 = 577, 577 / 2 = 288, 288 + 401 = 689, 655 < 689 < 800.)

Table 3a

	Individual Market, Nationwide					
Percentage of Earned Premium Cap on Excluded Commissions	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	14.2%	52.9%	73.6%	$978.3	$8.09	121
2%	13.4%	46.7%	74.5%	$800.1	$6.62	121
4%	12.7%	41.3%	75.6%	$655.7	$5.42	121
6%	12.1%	33.0%	76.9%	$556.5	$4.60	121
8%	11.8%	32.7%	77.7%	$485.9	$4.02	121
10%	11.4%	31.5%	78.5%	$425.7	$3.52	121
No Cap	11.1%	31.3%	78.8%	$401.3	$3.32	121

Table 3b

	Small Group Market, Nationwide					
Percentage of Earned Premium Cap on Excluded Commissions	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	15.7%	22.8%	82.3%	$447.4	$2.13	210
2%	12.4%	17.0%	83.9%	$259.9	$1.23	210
4%	10.5%	9.7%	85.2%	$181.3	$0.86	210
6%	9.1%	7.8%	86.0%	$157.7	$0.75	210
8%	8.9%	7.8%	86.5%	$152.1	$0.72	210
10%	8.7%	7.7%	86.7%	$148.9	$0.71	210
No Cap	8.4%	7.6%	87.0%	$146.2	$0.70	210

Table 3c

	Large Group Market, Nationwide					
Percentage of Earned Premium Cap on Excluded Commissions	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	15.0%	14.7%	89.4%	$526.7	$1.13	465
2%	12.0%	9.2%	90.8%	$281.6	$0.61	465
4%	10.0%	5.6%	91.3%	$221.9	$0.48	465
6%	9.4%	5.4%	91.4%	$217.5	$0.47	465
8%	9.4%	5.4%	91.4%	$217.0	$0.47	465
10%	9.4%	5.4%	91.5%	$216.6	$0.47	465
No Cap	8.9%	5.4%	91.6%	$215.9	$0.46	465

Modification 4

This modification subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2) and direct sales salaries and benefits (SHCE Part 1, Line 10.1), the sum of both capped at a maximum percentage of earned premium, from the adjusted earned premium used in the rebate formula (please see Appendix D for the exact calculation). The results under current law and the results with no cap are shown for comparison.

Table 4a

	Individual Market, Nationwide					
Percentage of Earned Premium Cap on Excluded Commissions + Direct Sales	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	14.2%	52.9%	73.6%	$978.3	$8.09	121
2%	13.4%	46.7%	74.3%	$799.5	$6.61	121
4%	12.6%	41.0%	75.5%	$649.2	$5.37	121
6%	12.0%	32.7%	76.8%	$540.0	$4.47	121
8%	11.7%	32.3%	77.7%	$465.5	$3.85	121
10%	11.2%	31.1%	78.4%	$401.8	$3.32	121
No Cap	10.9%	30.9%	79.5%	$358.6	$2.96	121

Table 4b

	Small Group Market, Nationwide					
Percentage of Earned Premium Cap on Excluded Commissions + Direct Sales	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	15.7%	22.8%	82.3%	$447.4	$2.13	210
2%	12.4%	17.0%	83.9%	$256.6	$1.22	210
4%	10.4%	9.6%	85.5%	$171.9	$0.81	210
6%	8.9%	7.7%	86.6%	$142.4	$0.67	210
8%	8.7%	7.7%	87.1%	$135.6	$0.64	210
10%	8.2%	7.5%	87.3%	$130.4	$0.62	210
No Cap	7.9%	7.5%	87.7%	$126.4	$0.60	210

Table 4c

	Large Group Market, Nationwide					
Percentage of Earned Premium Cap on Excluded Commissions + Direct Sales	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	15.0%	14.7%	89.4%	$526.7	$1.13	465
2%	11.6%	8.1%	90.9%	$272.1	$0.59	465
4%	9.5%	4.5%	91.6%	$206.1	$0.44	465
6%	8.6%	4.2%	91.8%	$198.0	$0.43	465
8%	8.3%	4.1%	91.9%	$197.1	$0.42	465
10%	8.3%	4.1%	91.9%	$196.7	$0.42	465
No Cap	7.8%	4.1%	92.1%	$195.9	$0.42	465

Modification 5

This modification subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2), capped at a maximum PMPM amount multiplied by member months, from the adjusted earned premium used in the rebate formula (please see Appendix D for the exact calculation). The results under current law and the results with no cap are shown for comparison. Generally, a cap of between $6 and $12 PMPM would restore half the rebate reduction for the individual market and a cap under $6 PMPM would do so for both group markets.

Table 5a

	Individual Market, Nationwide					
PMPM Cap on Excluded Commissions	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	14.2%	52.9%	73.6%	$978.3	$8.09	121
$6	13.0%	43.5%	75.3%	$724.9	$6.00	121
$12	12.0%	34.1%	77.0%	$548.5	$4.54	121
$18	11.5%	31.7%	78.0%	$445.0	$3.68	121
$24	11.3%	31.5%	78.6%	$412.5	$3.41	121
$30	11.3%	31.5%	78.8%	$406.2	$3.36	121
No Cap	11.1%	31.3%	78.8%	$401.3	$3.32	121

Table 5b

	Small Group Market, Nationwide					
PMPM Cap on Excluded Commissions	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	15.7%	22.8%	82.3%	$447.4	$2.13	210
$6	12.7%	17.2%	83.6%	$269.9	$1.28	210
$12	10.4%	9.9%	84.9%	$192.0	$0.91	210
$18	9.3%	8.4%	85.7%	$161.0	$0.76	210
$24	8.8%	7.7%	86.3%	$152.9	$0.72	210
$30	8.7%	7.7%	86.5%	$149.6	$0.71	210
No Cap	8.4%	7.6%	87.0%	$146.2	$0.70	210

Table 5c

	Large Group Market, Nationwide					
PMPM Cap on Excluded Commissions	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	15.0%	14.7%	89.4%	$526.7	$1.13	465
$6	11.6%	9.2%	90.7%	$288.0	$0.62	465
$12	9.2%	5.5%	91.4%	$223.4	$0.48	465
$18	8.8%	5.4%	91.5%	$217.0	$0.47	465
$24	8.8%	5.4%	91.5%	$215.8	$0.46	465
$30	8.8%	5.4%	91.6%	$215.5	$0.46	465
No Cap	8.9%	5.4%	91.6%	$215.9	$0.46	465

Modification 6

This modification subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2) and direct sales salaries and benefits (SHCE Part 1, Line 10.1), the sum of both capped at a maximum PMPM amount multiplied by member months, from the adjusted earned premium used in the rebate formula (please see Appendix D for the exact calculation). The results under current law and the results with no cap are shown for comparison.

Table 6a

	Individual Market, Nationwide					
PMPM Cap on Excluded Commissions + Direct Sales	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	14.2%	52.9%	73.6%	$978.3	$8.09	121
$6	13.0%	43.3%	75.6%	$719.2	$5.95	121
$12	11.8%	33.7%	77.5%	$534.1	$4.42	121
$18	11.3%	31.3%	78.5%	$420.8	$3.48	121
$24	11.1%	31.1%	79.2%	$378.2	$3.13	121
$30	11.1%	31.1%	79.3%	$365.9	$3.03	121
No Cap	10.9%	30.9%	79.5%	$358.6	$2.96	121

Table 6b

	Small Group Market, Nationwide					
PMPM Cap on Excluded Commissions + Direct Sales	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	15.7%	22.8%	82.3%	$447.4	$2.13	210
$6	12.7%	17.2%	83.7%	$266.3	$1.27	210
$12	10.3%	9.8%	85.1%	$178.2	$0.85	210
$18	9.2%	8.3%	86.1%	$146.0	$0.70	210
$24	8.7%	7.6%	86.8%	$135.2	$0.64	210
$30	8.3%	7.5%	87.2%	$130.8	$0.62	210
No Cap	7.9%	7.5%	87.7%	$126.4	$0.60	210

Table 6c

	Large Group Market, Nationwide					
PMPM Cap on Excluded Commissions + Direct Sales	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Current Law	15.0%	14.7%	89.4%	$526.7	$1.13	465
$6	11.2%	8.1%	90.9%	$277.3	$0.60	465
$12	8.7%	4.4%	91.6%	$207.5	$0.45	465
$18	8.0%	4.2%	91.9%	$198.5	$0.43	465
$24	7.8%	4.1%	92.0%	$196.0	$0.42	465
$30	7.8%	4.1%	92.0%	$195.6	$0.42	465
No Cap	7.8%	4.1%	92.1%	$195.9	$0.42	465

Modification 7

This modification is a variation of modification 3. It subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2), capped at a maximum percentage of earned premium, from the adjusted earned premium used in the rebate formula. In addition, the minimum MLR is adjusted such that the rebate payable under this modification will equal the rebate payable using a calculation with no modification and the statutory minimum MLRs (please see Appendix D for the exact calculation). The results of the rebate estimate modeling are as follows:

Table 7a
Individual Market, Nationwide

Rebate $Millions	$978.3					
Rebate PMPM	$8.09					
Member Months (Millions)	121					
Percentage of Earned Premium Cap on Excluded Commissions	No Cap	2%	4%	6%	8%	10%
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	86.20%	81.64%	83.24%	84.46%	85.37%	85.98%

Table 7b
Small Group Market, Nationwide

Rebate $Millions	$447.4					
Rebate PMPM	$2.13					
Member Months (Millions)	210					
Percentage of Earned Premium Cap on Excluded Commissions	No Cap	2%	4%	6%	8%	10%
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	84.10%	81.66%	83.20%	83.99%	84.08%	84.11%

Table 7c
Large Group Market, Nationwide

Rebate $Millions	$526.7					
Rebate PMPM	$1.13					
Member Months (Millions)	465					
Percentage of Earned Premium Cap on Excluded Commissions	No Cap	2%	4%	6%	8%	10%
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	87.30%	86.52%	87.24%	87.28%	87.29%	87.29%

Modification 8

This modification is a variation of modification 4. It subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2), and direct sales salaries and benefits (SHCE Part 1, Line 10.1), the sum of both capped at a maximum percentage of earned premium from the adjusted earned premium used in the rebate formula. In addition, the minimum MLR is adjusted such that the rebate payable under this modification will equal the rebate payable using a calculation with no modification and the statutory minimum MLRs (please see Appendix D for the exact calculation). The results of the rebate estimate modeling are as follows:

Table 8a
Individual Market, Nationwide

Rebate $Millions	$978.3					
Rebate PMPM	$8.09					
Member Months (Millions)	121					
Percentage of Earned Premium Cap on Excluded Commissions	No Cap	2%	4%	6%	8%	10%
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	87.00%	81.65%	83.31%	84.79%	85.81%	86.52%

Table 8b
Small Group Market, Nationwide

Rebate $Millions	$447.4					
Rebate PMPM	$2.13					
Member Months (Millions)	210					
Percentage of Earned Premium Cap on Excluded Commissions	No Cap	2%	4%	6%	8%	10%
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	84.60%	81.69%	83.30%	84.28%	84.49%	84.55%

Table 8c
Large Group Market, Nationwide

Rebate $Millions	$526.7					
Rebate PMPM	$1.13					
Member Months (Millions)	465					
Percentage of Earned Premium Cap on Excluded Commissions	No Cap	2%	4%	6%	8%	10%
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	87.60%	86.59%	87.47%	87.56%	87.59%	87.59%

Modification 9

This modification is a variation of modification 5. It subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2), capped at a maximum PMPM amount multiplied by member months, from the adjusted earned premium used in the rebate formula. In addition, the minimum MLR is adjusted such that the rebate payable under this modification will equal the rebate payable using a calculation with no modification and the original statutory MLRs (please see Appendix D for the exact calculation). The results of the rebate estimate modeling are as follows:

Table 9a
Individual Market, Nationwide

Rebate $Millions	$978.3					
Rebate PMPM	$8.09					
Member Months (Millions)	121					
PMPM Cap on Excluded Commissions	No Cap	$6	$12	$18	$24	$30
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	86.20%	82.44%	84.49%	85.78%	86.11%	86.17%

Table 9b
Small Group Market, Nationwide

Rebate $Millions	$447.4					
Rebate PMPM	$2.13					
Member Months (Millions)	210					
PMPM Cap on Excluded Commissions	No Cap	$6	$12	$18	$24	$30
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	84.10%	81.54%	82.90%	83.82%	84.05%	84.09%

Table 9c
Large Group Market, Nationwide

Rebate $Millions	$526.7					
Rebate PMPM	$1.13					
Member Months (Millions)	465					
PMPM Cap on Excluded Commissions	No Cap	$6	$12	$18	$24	$30
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	87.30%	86.44%	87.22%	87.29%	87.30%	87.30%

Modification 10

This modification is a variation of modification 6. It subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2), and direct sales salaries and benefits (SHCE Part 1, Line 10.1), the sum of both capped at a maximum PMPM amount multiplied by member months, from the adjusted earned premium used in the rebate. In addition, the minimum MLR is adjusted such that the rebate payable under this modification will equal the rebate payable using a calculation with no modification and the statutory minimum MLRs (please see Appendix D for the exact calculation). The results of the rebate estimate modeling are as follows:

Table 10a
Individual Market, Nationwide

Rebate $Millions	$978.3					
Rebate PMPM	$8.09					
Member Months (Millions)	121					
PMPM Cap on Excluded Commissions	No Cap	$6	$12	$18	$24	$30
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	87.00%	82.49%	84.78%	86.30%	86.77%	86.90%

Table 10b
Small Group Market, Nationwide

Rebate $Millions	$447.4					
Rebate PMPM	$2.13					
Member Months (Millions)	210					
PMPM Cap on Excluded Commissions	No Cap	$6	$12	$18	$24	$30
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	84.60%	81.57%	83.03%	84.08%	84.46%	84.53%

Table 10c
Large Group Market, Nationwide

Rebate $Millions	$526.7					
Rebate PMPM	$1.13					
Member Months (Millions)	465					
PMPM Cap on Excluded Commissions	No Cap	$6	$12	$18	$24	$30
Equivalent Minimum MLR to Match Rebate Under Unchanged Rebate Formula	87.60%	86.51%	87.44%	87.56%	87.59%	87.59%

Modification 11

This modification is a variation of modification 1. It subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2) from the adjusted earned premium used in the rebate formula and adds federal taxes back in (please see Appendix D for the detailed calculation). The results of the rebate estimate modeling are as follows:

Table 11

	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Individual Market, Nationwide	11.4%	35.2%	78.0%	$699.1	$5.78	121
Small Group Market, Nationwide	12.6%	19.2%	85.6%	$415.3	$1.98	210
Large Group Market, Nationwide	12.7%	11.7%	91.1%	$497.9	$1.07	465

As discussed above, it is unclear whether FIT would have been lower, and rebates therefore higher, if rebates were actually required for 2010. If the answer is no, then the impact of Modification 11 can be seen by comparing Tables 0 and 11 in the report. This comparison shows a reduction in rebates of 29% in the individual market, 7% in the small group market, and 5% in the large group market. If, on the other hand, FIT would have been lower if rebates were required, we believe rebates in Table 0 would be in the range of 30% higher. This would increase then the reduction in rebates that would result from replacing the federal tax deduction with a deduction for producer compensation to roughly half for the individual market and roughly a quarter in the group markets, thus having a significant impact on the rebate levels if the numerical standards remain the same.

Modification 12

This modification is a variation of modification 2. It subtracts agents and brokers fees and commissions (SHCE Part 1, Line 10.2), and direct sales salaries and benefits (SHCE Part 1, Line 10.1) from the adjusted earned premium used in the rebate formula and adds federal taxes back in (please see Appendix D for the exact calculation). The results of the rebate estimate modeling are as follows:

Table 12

	% of Companies Paying Rebates	% of Members Receiving Rebates	Median MLR	Rebate $Millions	Rebate PMPM	Member Months (Millions)
Individual Market, Nationwide	11.1%	33.8%	78.8%	$648.6	$5.36	121
Small Group Market, Nationwide	12.4%	18.2%	86.6%	$368.9	$1.76	210
Large Group Market, Nationwide	11.3%	9.6%	91.7%	$453.2	$0.97	465

As with Modification 11, in comparing to earlier tables, it should be kept in mind that those tables do not reflect the possible effect of rebates on taxes reported in 2010.

Modification 13

This modification applies either a percentage of premium or PMPM cap on excludable producer compensation that would vary by market segment. For example, the excludable percentage of earned premium for individual business could be higher than the percentage for small and large group business. The effects of different percentage and PMPM caps are shown in the examples above.

Appendix A

Supplemental Health Care Exhibit Data Elements

	Earned Premium	
[1]	Total direct premiums earned	SHCE Part 2, Line 1.8
[2]	Change in reserve for rate credits	SHCE Part 2, Line 1.7
[3]	Federal high risk pools	SHCE Part 1, Line 1.2
[4]	State high risk pools	SHCE Part 1, Line 1.3
	Federal and State Taxes and Licensing or Regulatory Fees	
[5]	Federal taxes and federal assessments	SHCE Part 1, Line 1.5
[6]	State insurance, premium and other taxes	SHCE Part 1, Line 1.6
[7]	Regulatory authority licenses and fees	SHCE Part 1, Line 1.7
	Expenses to Improve Health Care Quality	
[8]	Total of Defined Expenses Incurred for Improving Health Care Quality	SHCE Part 1, Line 6.3
[9]	**Deductible Fraud and Abuse Detection/Recovery Expenses**	SHCE Part 1, Line 4
[10]	**Total Incurred Claims**	SHCE Part 1, Line 5
[11]	**Agents and Brokers Fees and Commissions**	SHCE Part 1, Line 10.2
[12]	**Direct Sales Salaries and Benefits**	SHCE Part 1, Line 10.1
[13]	**Member Months**	SHCE Part 1, Other Indicators, Line 4

Appendix B **State Experience with Higher Minimum Loss Ratios**

State	Summary of Response
Colorado	70% MLR for group since 2005 – not really a limit, but a safe harbor for benefits being reasonable in relation to premium. Erosion in small group carriers since 2000, sharply since 2007 when claims experience and health status were removed as allowable rating factors. Target loss ratios have increased to above 70%. A letter from Commissioner Postolowski, provided to the Working Group by an NAIC Consumer Representative, indicated that: (1) consumer access has not changed significantly; (2) MLR requirements may have moderated rate increases; and (3) competition may have provided an incentive to keep benefit ratios high.
Maine	On July 1, 2004 small group carriers had a choice of 75% with prior approval or guaranteed 78% with no prior approval. One company switched from selling small group to individual (65% loss ratio). No other observable impact on commissions or number of producers.
Maryland	Small group 75% MLR since 1993. Observed reducing commissions to small group, starting before healthcare reform. No problem with lack of producers for small group.
Minnesota	Provided state data. No issues about commissions.
New Jersey	From 75% to 80% in 2009. Most individual is sold direct. Small group – no problem with access. High average small group premiums, so may be a special case.
New Mexico	On May 19, 2010, 75% for individual (in process of changing to 80%). 85% for all group. Three years before any refunds are paid.
New York	Until 2010, rebate payable when individual loss ratio < 80% and small group loss ratio less than 75%. In 2011, all community-rated plans 82% (adjustments bring closer to federal level). No access or producer comp issues in small group or individual.
South Dakota	Just changed MLR 1/11/11. Too early to tell what impact the higher MLRs will have. Previous minimums: 65% individual, 75% group
Washington	For individual, 74% (minus 2% premium tax) loss ratio. Since 2000, excess is remitted by company to high risk pool. Companies appear to be reducing agent commissions and terminating contracts to cut costs and move to an on-line system. For small group, there is a trend toward not paying commissions on groups of 1-3 lives.
West Virginia	No problems with consumer access. Some agents are no longer writing for carriers that have limited or ended commissions.

Appendix C

Discussion of Federal Income Tax Impact on MLR Rebates

Under current law, all federal taxes are deducted from premium before calculation of the medical loss ratio (MLR) and rebates. The NAIC recommended that this be limited to federal taxes other than income tax on investment income, since the MLR calculation does not consider investment income. This recommendation was accepted by HHS in their Interim Final Regulation. There have been assertions made by some Members of Congress that they intended the federal tax deduction to apply only to those taxes used to fund the law. However, statutory language prevailed in developing the regulation.

Within this report, the issue of federal income taxes (FIT) is relevant in two regards. First, the Supplemental Health Care Exhibit (SHCE) does not reflect the possible impact of rebates on FIT, since rebates were not required in 2010. Second, one of the options discussed in this report is to substitute broker commissions for federal taxes in the MLR calculation – that is, to deduct commissions from premium but not deduct federal taxes other than the ACA-related taxes that begin in 2014.

Interaction of FIT and Rebates

The Working Group had extensive discussions as to whether FIT would have been lower, and rebates therefore higher, if rebates were actually required for 2010. The thinking was that a liability would be held for anticipated rebates, which would reduce profits and therefore reduce FIT. However, an alternate view was that the rebate rules require FIT to be stated ignoring the impact of rebates. Language in the NAIC Regulation for Uniform Definitions and Standardized Methodologies for Calculation of the Medical Loss Ratio for Plan Years 2011, 2012 and 2013 contains language that can be interpreted to support that position. The federal regulation, which is the one that applies, seems unclear on this point. We believe this is an important issue that must be resolved before rebates are calculated next year and we stand ready to investigate it further through discussions with federal regulators and interested parties if requested. However, it is only a secondary issue for purposes of this report and we concluded that we did not need to resolve it in order to finalize our report on producer compensation.

If the view that the payment of rebates will reduce FIT is correct, then if rebates had been required in 2010, companies would have had lower taxes due to payment of the rebates. These lower taxes would have been deducted from earned premium in the formula, leading to yet lower taxes, leading to yet greater rebates. Companies would have been able to evaluate this recursive formula to develop the actual taxes and rebates due. This concept may be easier to visualize with an example:

Example:

Assume no quality improvement expenses or state taxes and no federal taxes other than FIT, so we have only claims, premium and federal income tax entering the calculation. The MLR is calculated as claims divided by the quantity premium minus FIT. Taxes impact the calculation two ways, in determining the initial MLR and in determining the amount to which the rebate percentage is applied to calculate the rebate. If we have claims of 7,000, premium of 10,000 and FIT of 400, then the MLR is 72.9%, and the rebate initially is 680, (7,000 / (10,000-400) = 72.9%. 80% - 72.9% = 7.1%. 7.1% * (10,000 - 400) = 680.). However the tax is reduced by the deductible rebate paid, so if the tax rate is 30%, then taxes would be reduced by 204, (680 * 30%=204)[1]. But the new taxes of 196 would be deducted from earned premium in calculating the MLR, so that the new MLR would be 71.4% and the new rebate would be $843. Again the higher rebate would result in lower taxes resulting in higher rebates. Evaluation of the recursive formula results in an ultimate tax of 132 and ultimate rebate of 895, 895* 30% = 268, 400 – 268 = 132, 7,000 / (10,000 -1321) = 70.9%. 80% - 70.9% = 9.1%. 9.1% * (10,000 - 132) = 895.) In this case, rebates with a tax rate of 30% are 31% higher after evaluating the recursive formula, (895 / 680 = 132%). Generally the increase in rebates will be about equal to the tax rate.

[1] FIT laws and regulations are very complicated. This illustration uses a simplified calculation of the additional FIT incurred by only applying a marginal tax rate to the change in underwriting gain.

Possible Elimination of Non-ACA Federal Tax Exclusion

Eliminating the federal tax deduction from premium would generally increase the MLR rebates, while incorporating a producer reimbursement deduction from premium would decrease the MLR rebates. It has been suggested that by substituting a producer reimbursement deduction for the federal income tax deduction, perhaps the level of rebates to be paid to consumers would remain at a comparable level to the current statutory level. We evaluated this substitution and found near equality for small group and large group, but a decrease in rebates to be paid for the non-group pool. However as noted above, federal taxes in the SHCE did not incorporate the impact of rebates on the level of taxes, suggesting that the illustrated rebates were lower than they would have been if the recursive relationship had been evaluated. Perhaps a better comparison would be the rebates illustrated in the paper after deducting producer reimbursement versus rebates illustrated as derived from the SHCE inflated by an after tax factor of 25% to 35%. It appears rebates would be reduced with this substitution.

Appendix D

MLR Calculation Details

Bracketed numbers are elements from Appendix A

Table 0

$$\text{MLR} = \left(\frac{[8]+[9]+[10]}{[1]+[2]+[3]+[4]-[5]-[6]-[7]}\right)$$

If MLR < minimum MLR,

Rebate = $[Minimum\ MLR - MLR] * ([1] + [2] + [3] + [4] - [5] - [6] - [7])$,

Else, Rebate = 0

Table 1

$$\text{MLR} = \left(\frac{[8]+[9]+[10]}{[1]+[2]+[3]+[4]-[5]-[6]-[7]-[11]}\right)$$

If MLR < minimum MLR,

Rebate = $[Minimum\ MLR - MLR] * ([1] + [2] + [3] + [4] - [5] - [6] - [7] - [11])$

Else, Rebate = 0

Table 2

$$\text{MLR} = \left(\frac{[8]+[9]+[10]}{[1]+[2]+[3]+[4]-[5]-[6]-[7]-[11]-[12]}\right)$$

If MLR < minimum MLR,

Rebate = $[Minimum\ MLR - MLR] * ([1] + [2] + [3] + [4] - [5] - [6] - [7] - [11] - [12])$

Else, Rebate = 0

Table 3

$\text{MLR} = \left(\frac{[8]+[9]+[10]}{[1]+[2]+[3]+[4]-[5]-[6]-[7]-[11]}\right)$, where[11] is capped at a maximum percentage of earned premium.

If MLR < minimum MLR,

Rebate = $[Minimum\ MLR - MLR] * ([1] + [2] + [3] + [4] - [5] - [6] - [7] - [11])$

Else, Rebate = 0

Table 4

$\text{MLR} = \left(\frac{[8]+[9]+[10]}{[1]+[2]+[3]+[4]-[5]-[6]-[7]-[11]-[12]}\right)$, where [11] + [12] is capped at a maximum percentage of earned premium.

If MLR < minimum MLR,

Rebate = $[Minimum\ MLR - MLR] * ([1] + [2] + [3] + [4] - [5] - [6] - [7] - [11] - [12])$

Else, Rebate = 0

Table 5

$\text{MLR} = \left(\frac{[8]+[9]+[10]}{[1]+[2]+[3]+[4]-[5]-[6]-[7]-[11]}\right)$, where[11] is capped at a maximum PMPM amount multiplied by member months.

If MLR < minimum MLR,

Rebate = $[Minimum\ MLR - MLR] * ([1] + [2] + [3] + [4] - [5] - [6] - [7] - [11])$

Else, Rebate = 0

Table 6
MLR = $\left(\frac{[8]+[9]+[10]}{[1]+[2]+[3]+[4]-[5]-[6]-[7]-[11]-[12]}\right)$, where [11] + [12] is capped at a maximum PMPM amount multiplied by member months.

If MLR < minimum MLR,

Rebate = $[Minimum\ MLR - MLR] * ([1] + [2] + [3] + [4] - [5] - [6] - [7] - [11] - [12])$

Else, Rebate = 0

Table 7
The MLR is calculated as in Table 3, but uses a modified minimum MLR.

Table 8
The MLR is calculated as in Table 4, but uses a modified minimum MLR.

Table 9
The MLR is calculated as in Table 5, but uses a modified minimum MLR.

Table 10
The MLR is calculated as in Table 6, but uses a modified minimum MLR.

Table 11
MLR = $\left(\frac{[8]+[9]+[10]}{[1]+[2]+[3]+[4]-[6]-[7]-[11]}\right)$

If MLR < minimum MLR,

Rebate = $[Minimum\ MLR - MLR] * ([1] + [2] + [3] + [4] - [6] - [7] - [11])$

Else, Rebate = 0

Table 12
MLR = $\left(\frac{[8]+[9]+[10]}{[1]+[2]+[3]+[4]-[6]-[7]-[11]-[12]}\right)$

If MLR < minimum MLR,

Rebate = $[Minimum\ MLR - MLR] * ([1] + [2] + [3] + [4] - [6] - [7] - [11] - [12])$

Else, Rebate = 0

Appendix E

Effects of Removing Commissions/Commissions + Direct Sales from MLR on Rebates

Comparison of Various Alternate MLR Calculations by State

Individual Market
Plan Year 2010 SHCE Data

State	Direct Earned Premium $M	Member Months (K)	Est.MLR Rebate $M	Est. MLR Rebate PMPM	Fees & Commissions Excluded - Est. MLR Rebate $M	Fees & Commissions Excluded - Est. MLR Rebate PMPM	Fees & Commissions + Direct Sales Excluded - Est. MLR Rebate $M	Fees & Commissions + Direct Sales Excluded - Est. MLR Rebate PMPM	Fees & Commissions Excluded, Federal Taxes Included- Est. MLR Rebate $M	Fees & Commissions Excluded, Federal Taxes Included - Est. MLR Rebate PMPM
AK	$57.36	194	$0.48	$2.48	$0.38	$1.98	$0.38	$1.98	$0.64	$3.28
AL	$328.38	2,122	$4.48	$2.11	$2.96	$1.39	$2.50	$1.18	$5.05	$2.38
AR	$242.54	1,428	$8.50	$5.95	$2.39	$1.68	$2.26	$1.58	$5.57	$3.90
AZ	$656.02	3,093	$37.63	$12.17	$9.31	$3.01	$8.40	$2.72	$28.16	$9.10
CA	$2,045.98	11,648	$36.63	$3.15	$11.30	$0.97	$11.18	$0.96	$16.75	$1.44
CN	$12.58	61	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
CO	$660.29	3,615	$24.35	$6.74	$12.39	$3.43	$10.96	$3.03	$24.75	$6.85
CT	$361.54	1,295	$13.51	$10.43	$6.68	$5.16	$6.29	$4.86	$13.70	$10.58
DC	$20.45	62	$0.20	$3.26	$0.14	$2.31	$0.14	$2.19	$0.62	$9.95
DE	$54.22	223	$1.39	$6.24	$0.58	$2.62	$0.54	$2.40	$1.62	$7.25
FL	$2,265.77	10,198	$109.94	$10.78	$45.64	$4.48	$40.58	$3.98	$65.26	$6.40
GA	$896.24	4,261	$41.33	$9.70	$24.86	$5.83	$22.97	$5.39	$38.01	$8.92
GU	$0.07	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HI	$82.87	372	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
IA	$457.53	2,156	$5.37	$2.49	$2.07	$0.96	$1.79	$0.83	$2.70	$1.25
ID	$218.68	1,525	$3.93	$2.58	$2.85	$1.87	$2.85	$1.87	$3.46	$2.27
IL	$1,236.38	5,535	$67.62	$12.22	$21.08	$3.81	$19.07	$3.45	$32.55	$5.88
IN	$449.40	2,189	$24.45	$11.17	$7.99	$3.65	$7.43	$3.39	$19.51	$8.91
KS	$295.90	1,547	$10.59	$6.84	$5.49	$3.55	$5.15	$3.33	$6.91	$4.46
KY	$369.97	1,785	$8.67	$4.86	$1.39	$0.78	$0.83	$0.47	$4.13	$2.32
LA	$472.83	2,037	$9.01	$4.42	$6.75	$3.32	$6.30	$3.09	$10.69	$5.25
MA	$441.51	1,271	$3.14	$2.47	$1.78	$1.40	$1.76	$1.39	$2.92	$2.30
MD	$126.82	644	$14.99	$23.27	$10.13	$15.72	$9.88	$15.34	$17.26	$26.80
ME	$134.27	447	$6.40	$14.32	$4.79	$10.70	$4.79	$10.70	$6.40	$14.32
MI	$765.96	3,997	$24.41	$6.11	$12.48	$3.12	$11.48	$2.87	$19.73	$4.94
MN	$615.59	3,002	$7.89	$2.63	$3.32	$1.11	$3.07	$1.02	$2.14	$0.71
MO	$556.44	2,920	$44.19	$15.13	$19.29	$6.61	$16.25	$5.57	$35.58	$12.19
MS	$197.26	960	$8.42	$8.77	$5.68	$5.92	$5.51	$5.75	$8.92	$9.29
MT	$124.52	644	$6.40	$9.93	$3.26	$5.06	$3.08	$4.77	$3.73	$5.78
NC	$1,022.68	5,018	$19.15	$3.82	$9.92	$1.98	$9.50	$1.89	$15.04	$3.00
ND	$120.56	536	$2.46	$4.60	$1.49	$2.78	$1.44	$2.68	$2.40	$4.48
NE	$290.44	1,334	$5.46	$4.09	$1.12	$0.84	$0.98	$0.73	$2.07	$1.55
NH	$111.09	414	$7.65	$18.49	$4.18	$10.10	$3.77	$9.12	$9.54	$23.05
NJ	$537.86	1,475	$0.75	$0.51	$0.00	$0.00	$0.00	$0.00	$0.43	$0.29
NM	$140.77	743	$1.04	$1.40	$0.74	$1.00	$0.73	$0.98	$1.43	$1.92
NV	$216.46	1,049	$11.96	$11.41	$4.53	$4.32	$4.42	$4.21	$8.60	$8.20
NY	$657.19	1,440	$2.42	$1.68	$2.33	$1.62	$2.33	$1.62	$2.36	$1.64
OH	$481.13	2,882	$39.19	$13.60	$8.67	$3.01	$6.69	$2.32	$12.08	$4.19
OK	$283.65	1,456	$16.06	$11.03	$7.08	$4.86	$6.85	$4.70	$10.54	$7.24
OR	$477.62	2,241	$7.81	$3.48	$4.49	$2.01	$4.36	$1.94	$5.28	$2.36
OT	$110.10	936	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PA	$1,237.08	5,679	$31.13	$5.48	$18.18	$3.20	$17.62	$3.10	$31.83	$5.60
PR	$0.09	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
RI	$67.87	371	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
SC	$345.58	1,613	$34.12	$21.16	$11.95	$7.41	$5.36	$3.32	$21.04	$13.04
SD	$153.11	730	$0.16	$0.21	$0.12	$0.17	$0.11	$0.15	$0.14	$0.20
TN	$571.77	2,833	$25.35	$8.95	$9.39	$3.31	$8.34	$2.94	$14.56	$5.14
TX	$1,747.41	8,849	$172.01	$19.44	$65.47	$7.40	$58.86	$6.65	$117.43	$13.27
UT	$261.47	1,695	$4.15	$2.45	$2.05	$1.21	$1.85	$1.09	$2.48	$1.46
VA	$809.02	3,558	$50.80	$14.28	$18.03	$5.07	$14.49	$4.07	$53.33	$14.99
VI	$0.04	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
VT	$79.33	210	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
WA	$845.27	3,788	$6.56	$1.73	$3.45	$0.91	$3.42	$0.90	$4.50	$1.19
WI	$449.91	2,192	$10.30	$4.70	$1.11	$0.51	$0.41	$0.19	$2.51	$1.14
WV	$69.62	264	$4.39	$16.61	$1.57	$5.93	$1.20	$4.55	$4.02	$15.22
WY	$76.42	296	$1.43	$4.84	$0.45	$1.53	$0.44	$1.48	$0.80	$2.70
Total	$25,310.91	120,837	$978.28	$8.10	$401.28	$3.32	$358.60	$2.97	$699.16	$5.79

Effects of Removing Commissions/Commissions + Direct Sales from MLR on Rebates

Comparison of Various Alternate MLR Calculations by State

Small Group Market
Plan Year 2010 SHCE Data

State	Direct Earned Premium $M	Member Months (K)	Est.MLR Rebate $M	Est. MLR Rebate PMPM	Fees & Commissions Excluded - Est. MLR Rebate $M	Fees & Commissions Excluded - Est. MLR Rebate PMPM	Fees & Commissions + Direct Sales Excluded - Est. MLR Rebate $M	Fees & Commissions + Direct Sales Excluded - Est. MLR Rebate PMPM	Fees & Commissions Excluded, Federal Taxes Included- Est. MLR Rebate $M	Fees & Commissions Excluded, Federal Taxes Included - Est. MLR Rebate PMPM
AK	$125.92	326	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
AL	$1,214.65	4,003	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
AR	$443.09	1,543	$2.89	$1.87	$0.45	$0.29	$0.44	$0.29	$4.27	$2.77
AZ	$993.15	3,721	$21.28	$5.72	$4.65	$1.25	$4.04	$1.09	$19.00	$5.11
CA	$2,707.54	8,763	$2.64	$0.30	$1.47	$0.17	$1.39	$0.16	$0.43	$0.05
CN	$0.16	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
CO	$1,217.01	3,539	$12.72	$3.59	$11.03	$3.12	$10.56	$2.98	$12.14	$3.43
CT	$1,479.14	3,641	$4.73	$1.30	$0.06	$0.02	$0.03	$0.01	$7.52	$2.07
DC	$201.66	533	$6.36	$11.94	$4.32	$8.10	$4.24	$7.95	$6.14	$11.53
DE	$241.03	660	$2.19	$3.31	$0.04	$0.05	$0.04	$0.05	$0.46	$0.70
FL	$3,934.15	10,640	$51.01	$4.79	$2.65	$0.25	$1.23	$0.12	$54.07	$5.08
GA	$1,735.22	6,380	$27.68	$4.34	$15.84	$2.48	$14.80	$2.32	$21.20	$3.32
GU	$33.00	0	$0.00	N/A	$0.00	N/A	$0.00	N/A	$0.00	N/A
HI	$757.33	2,303	$5.30	$2.30	$2.56	$1.11	$2.21	$0.96	$3.93	$1.71
IA	$702.43	2,504	$0.58	$0.23	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
ID	$310.29	1,191	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
IL	$3,179.54	8,876	$41.92	$4.72	$15.80	$1.78	$13.01	$1.47	$25.46	$2.87
IN	$1,169.95	3,643	$13.07	$3.59	$0.11	$0.03	$0.10	$0.03	$16.64	$4.57
KS	$752.02	3,004	$6.16	$2.05	$3.54	$1.18	$2.90	$0.96	$5.67	$1.89
KY	$678.79	2,210	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
LA	$1,252.85	3,817	$0.30	$0.08	$0.14	$0.04	$0.07	$0.02	$0.14	$0.04
MA	$3,111.19	8,149	$4.17	$0.51	$2.20	$0.27	$2.20	$0.27	$3.56	$0.44
MD	$479.07	1,412	$4.03	$2.86	$1.18	$0.84	$1.08	$0.77	$9.77	$6.92
ME	$375.65	1,124	$0.04	$0.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MI	$2,098.67	6,071	$5.47	$0.90	$2.22	$0.37	$1.83	$0.30	$3.48	$0.57
MN	$1,220.34	3,447	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MO	$1,522.74	4,982	$33.14	$6.65	$4.18	$0.84	$2.91	$0.58	$39.67	$7.96
MS	$448.10	1,547	$0.92	$0.59	$0.29	$0.18	$0.01	$0.00	$0.29	$0.18
MT	$213.08	688	$2.09	$3.04	$1.23	$1.79	$1.15	$1.67	$1.23	$1.79
NC	$1,760.14	5,322	$3.85	$0.72	$0.59	$0.11	$0.47	$0.09	$2.92	$0.55
ND	$289.89	995	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
NE	$392.53	1,213	$9.13	$7.53	$2.67	$2.20	$2.24	$1.85	$5.30	$4.37
NH	$519.47	1,288	$0.29	$0.22	$0.16	$0.13	$0.16	$0.13	$0.37	$0.29
NJ	$3,601.23	9,769	$1.40	$0.14	$1.14	$0.12	$1.11	$0.11	$3.10	$0.32
NM	$346.95	979	$2.06	$2.11	$0.63	$0.64	$0.04	$0.04	$2.18	$2.23
NV	$479.21	1,545	$9.28	$6.01	$2.35	$1.52	$2.30	$1.49	$5.63	$3.64
NY	$8,144.55	21,360	$3.71	$0.17	$0.16	$0.01	$0.00	$0.00	$2.80	$0.13
OH	$2,708.61	9,728	$20.58	$2.12	$15.08	$1.55	$14.53	$1.49	$19.41	$2.00
OK	$792.34	2,385	$20.89	$8.76	$0.60	$0.25	$0.57	$0.24	$17.66	$7.40
OR	$924.45	2,815	$0.05	$0.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OT	$14.71	62	$0.23	$3.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PA	$4,711.54	13,333	$5.56	$0.42	$0.49	$0.04	$0.48	$0.04	$5.93	$0.44
PR	$1.91	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
RI	$462.14	1,219	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
SC	$744.68	2,362	$3.86	$1.63	$0.27	$0.11	$0.22	$0.09	$0.34	$0.14
SD	$225.20	709	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TN	$1,524.87	5,135	$8.28	$1.61	$3.29	$0.64	$2.65	$0.52	$6.90	$1.34
TX	$4,447.33	14,203	$43.42	$3.06	$25.17	$1.77	$20.12	$1.42	$32.46	$2.29
UT	$619.58	2,561	$3.54	$1.38	$0.00	$0.00	$0.00	$0.00	$1.61	$0.63
VA	$1,802.48	5,328	$48.33	$9.07	$13.92	$2.61	$12.33	$2.31	$62.68	$11.76
VI	$14.96	37	$1.66	$45.51	$0.53	$14.64	$0.53	$14.64	$1.65	$45.08
VT	$243.39	795	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
WA	$969.38	2,833	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
WI	$1,493.66	4,295	$11.26	$2.62	$5.22	$1.22	$4.40	$1.02	$8.75	$2.04
WV	$298.97	812	$1.28	$1.58	$0.00	$0.00	$0.00	$0.00	$0.49	$0.61
WY	$120.30	311	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$70,255.17	210,113	$447.37	$2.13	$146.24	$0.70	$126.39	$0.60	$415.25	$1.98

Effects of Removing Commissions/Commissions + Direct Sales from MLR on Rebates

Comparison of Various Alternate MLR Calculations by State

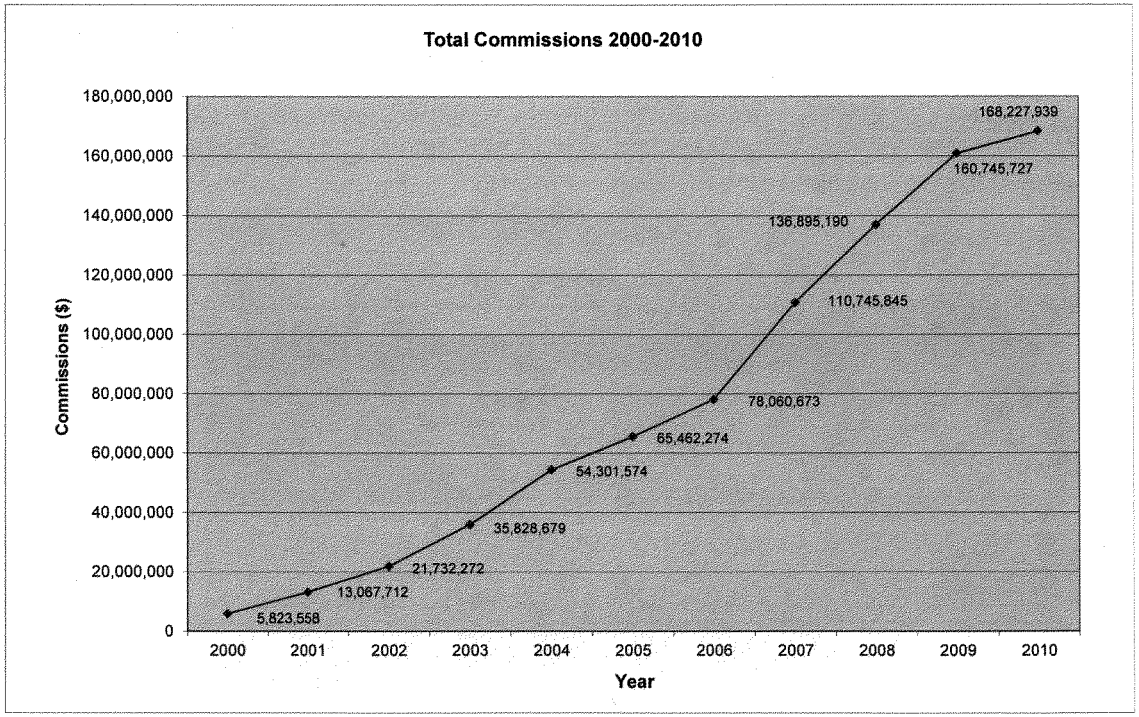
Large Group Market
Plan Year 2010 SHCE Data

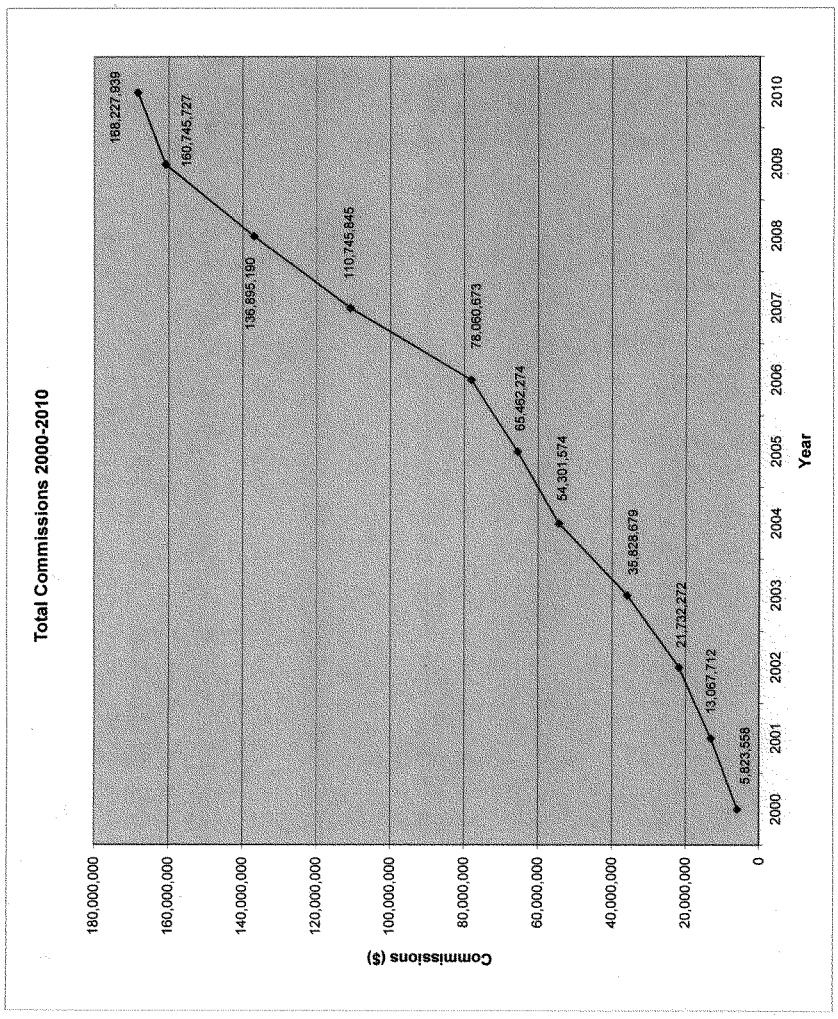
State	Direct Earned Premium $M	Member Months (K)	Est.MLR Rebate $M	Est. MLR Rebate PMPM	Fees & Commissions Excluded - Est. MLR Rebate $M	Fees & Commissions Excluded - Est. MLR Rebate PMPM	Fees & Commissions + Direct Sales Excluded - Est. MLR Rebate $M	Fees & Commissions + Direct Sales Excluded - Est. MLR Rebate PMPM	Fees & Commissions Excluded, Federal Taxes Included- Est. MLR Rebate $M	Fees & Commissions Excluded, Federal Taxes Included - Est. MLR Rebate PMPM
AK	$382.56	673	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
AL	$1,994.19	6,157	$5.49	$0.89	$5.00	$0.81	$1.53	$0.25	$7.36	$1.20
AR	$736.26	2,681	$2.99	$1.12	$1.00	$0.37	$1.00	$0.37	$5.40	$2.02
AZ	$1,921.94	5,743	$10.83	$1.89	$7.81	$1.36	$7.75	$1.35	$12.00	$2.09
CA	$3,800.35	11,515	$39.22	$3.41	$6.97	$0.61	$6.41	$0.56	$32.38	$2.81
CN	$0.03	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
CO	$2,990.59	8,729	$16.36	$1.87	$16.27	$1.86	$16.23	$1.86	$23.25	$2.66
CT	$2,810.24	6,780	$6.06	$0.89	$0.00	$0.00	$0.00	$0.00	$5.60	$0.83
DC	$1,641.19	4,644	$30.45	$6.56	$20.84	$4.49	$20.00	$4.31	$37.95	$8.17
DE	$424.16	1,274	$0.52	$0.41	$0.30	$0.23	$0.12	$0.09	$0.68	$0.53
FL	$8,938.83	24,109	$42.77	$1.77	$13.01	$0.54	$12.61	$0.52	$58.81	$2.44
GA	$3,978.39	12,474	$26.81	$2.15	$11.44	$0.92	$11.42	$0.92	$17.34	$1.39
GU	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HI	$1,376.89	5,482	$4.99	$0.91	$4.99	$0.91	$4.99	$0.91	$5.00	$0.91
IA	$1,383.57	4,308	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
ID	$808.64	2,762	$0.16	$0.06	$0.03	$0.01	$0.00	$0.00	$0.58	$0.21
IL	$8,799.44	25,226	$3.59	$0.14	$0.67	$0.03	$0.65	$0.03	$6.03	$0.24
IN	$2,164.13	5,903	$1.82	$0.31	$0.70	$0.12	$0.43	$0.07	$1.81	$0.31
KS	$1,623.59	5,810	$0.09	$0.01	$0.00	$0.00	$0.00	$0.00	$0.25	$0.04
KY	$1,591.87	4,917	$11.89	$2.42	$3.39	$0.69	$2.55	$0.52	$8.13	$1.65
LA	$1,220.73	3,428	$0.08	$0.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MA	$6,504.85	15,873	$2.99	$0.19	$1.76	$0.11	$1.73	$0.11	$2.29	$0.14
MD	$1,901.61	6,931	$29.49	$4.25	$17.61	$2.54	$17.25	$2.49	$47.93	$6.92
ME	$956.29	2,310	$0.44	$0.19	$0.00	$0.00	$0.00	$0.00	$2.06	$0.89
MI	$7,123.98	22,704	$5.12	$0.23	$4.95	$0.22	$4.95	$0.22	$4.99	$0.22
MN	$2,165.18	8,279	$0.32	$0.04	$0.32	$0.04	$0.30	$0.04	$0.32	$0.04
MO	$3,069.88	7,753	$7.74	$1.00	$1.61	$0.21	$0.33	$0.04	$3.64	$0.47
MS	$650.71	2,073	$2.13	$1.03	$0.17	$0.08	$0.07	$0.03	$2.37	$1.14
MT	$370.18	1,155	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
NC	$2,235.87	6,458	$11.20	$1.73	$3.92	$0.61	$3.87	$0.60	$11.72	$1.81
ND	$453.34	1,437	$0.39	$0.27	$0.27	$0.19	$0.09	$0.07	$0.32	$0.22
NE	$887.76	2,619	$1.87	$0.71	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
NH	$817.65	1,891	$0.63	$0.33	$0.48	$0.25	$0.48	$0.25	$0.81	$0.43
NJ	$5,689.60	15,242	$26.72	$1.75	$6.50	$0.43	$5.87	$0.39	$5.54	$0.36
NM	$690.94	2,094	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
NV	$1,291.21	4,729	$21.79	$4.61	$13.20	$2.79	$9.97	$2.11	$0.38	$0.08
NY	$21,083.63	68,086	$36.81	$0.54	$17.54	$0.26	$11.96	$0.18	$15.34	$0.23
OH	$5,392.52	16,912	$54.10	$3.20	$29.13	$1.72	$29.13	$1.72	$59.45	$3.52
OK	$1,742.31	5,059	$0.24	$0.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OR	$3,099.59	8,685	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OT	$148.49	506	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PA	$10,164.10	31,439	$36.51	$1.16	$2.06	$0.07	$2.06	$0.07	$2.70	$0.09
PR	$19.87	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
RI	$835.82	2,241	$0.16	$0.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
SC	$1,230.75	4,225	$0.18	$0.04	$0.03	$0.01	$0.03	$0.01	$0.03	$0.01
SD	$444.91	1,339	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TN	$1,717.14	6,084	$9.41	$1.55	$1.42	$0.23	$1.39	$0.23	$8.55	$1.41
TX	$7,897.85	25,687	$40.59	$1.58	$3.84	$0.15	$3.84	$0.15	$40.23	$1.57
UT	$1,689.83	6,175	$0.36	$0.06	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
VA	$4,263.73	12,263	$25.94	$2.11	$16.25	$1.33	$14.75	$1.20	$41.55	$3.39
VI	$0.00	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
VT	$331.21	901	$0.40	$0.44	$0.00	$0.00	$0.00	$0.00	$0.89	$0.99
WA	$5,563.02	16,154	$0.26	$0.02	$0.00	$0.00	$0.00	$0.00	$0.26	$0.02
WI	$5,166.02	12,772	$6.10	$0.48	$1.72	$0.13	$1.52	$0.12	$23.22	$1.82
WV	$612.34	1,580	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
WY	$158.85	411	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total	$154,958.60	464,682	$525.99	$1.13	$215.21	$0.46	$195.29	$0.42	$497.15	$1.07

CALIFORNIA INSURANCE DEPARTMENT DATA

Total Commissions 2000-2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
TOTAL COMMISSIONS	5,823,558	13,067,712	21,732,272	35,828,679	54,301,574	65,462,274	78,060,673	110,745,845	136,895,190	160,745,727	168,227,939




Total Commissions 2000-2010
Commissions ($)
Year
180,000,000
160,000,000
140,000,000
120,000,000
100,000,000
80,000,000
60,000,000
40,000,000
20,000,000
0
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
168,227,939
160,745,727
136,895,190
110,745,845
78,060,673
65,462,274
54,301,574
35,828,679
21,732,272
13,067,712
5,823,558

COMMISSIONS BY INDIVIDUAL, SMALL AND LARGE GROUP HEALTH POLICIES 2000 - 2010

Commissions - Individual Health Policies

Insurance Company	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Company A	0	0	0	0	3,354,864	8,611,995	11,761,681	19,487,323	26,622,410	37,299,894	44,882,777
Company B	543,571	4,266,925	7,361,323	7,797,905	8,823,415	9,025,700	10,359,959	18,469,444	22,664,982	18,772,307	16,582,981
Company C	0	0	0	0	0	1,069,361	1,812,962	2,839,083	3,838,041	3,028,258	2,684,293
Company D	0	0	0	0	0	0	0	0	0	0	0
SUB TOTAL:	**$543,571**	**$4,266,925**	**$7,361,323**	**$7,797,905**	**$12,178,279**	**$18,707,056**	**$23,934,602**	**$40,795,850**	**$53,125,433**	**$59,100,459**	**$64,150,051**

Premiums - Individual Health Policies

Insurance Company	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Company A	0	0	0	0	24,655,292	83,385,305	134,269,951	229,038,689	306,010,256	427,057,659	536,145,158
Company B	10,013,480	40,612,344	75,385,729	88,824,145	106,331,491	109,399,634	118,814,921	199,300,124	233,363,301	192,767,815	167,716,758
Company C	0	0	0	0	0	5,205,183	8,119,342	21,522,496	28,837,244	27,238,387	25,240,062
Company D	0	0	0	0	0	0	0	0	0	0	0
SUB TOTAL:	**$10,013,480**	**$40,612,344**	**$75,385,729**	**$88,824,145**	**$130,986,783**	**$197,990,122**	**$261,204,214**	**$449,861,309**	**$568,210,801**	**$647,063,861**	**$729,101,978**
Commissions as % of Premiums	5.43%	10.51%	9.76%	8.78%	9.30%	9.45%	9.16%	9.07%	9.35%	9.13%	8.80%

Commissions - Small Group Policies (2 to 50 employees)

Insurance Company	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Company A	0	0	0	143,865	1,889,000	4,316,902	7,172,646	11,663,400	24,962,563	48,056,348	48,159,672
Company B	2,968,759	4,920,138	11,212,151	18,225,098	22,741,831	20,414,518	20,334,427	25,520,349	25,796,144	23,688,026	29,275,408
Company C	366,768	563,872	287,515	3,785,142	10,154,368	13,961,720	16,429,795	17,199,755	10,793,353	6,593,983	1,956,866
Company D	154,960	271,137	205,514	147,596	38,884	20,427	114,197	2,542,075	8,510,869	10,311,560	12,348,237
SUB TOTAL:	**$3,490,487**	**$5,755,147**	**$11,705,180**	**$22,301,701**	**$34,824,083**	**$38,713,567**	**$44,051,065**	**$56,925,579**	**$70,062,929**	**$88,649,917**	**$91,740,183**

Premiums - Small Group Policies (2 to 50 employees)

Insurance Company	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Company A	0	0	0	1,579,749	26,074,037	62,276,005	114,497,994	177,838,676	354,310,228	680,466,885	685,588,091
Company B	38,934,118	57,424,204	132,186,238	229,448,129	278,756,260	247,938,814	249,188,330	263,559,009	289,770,596	278,358,760	333,438,829
Company C	4,642,761	7,081,387	3,674,664	53,306,070	135,397,714	182,666,637	229,942,020	218,215,059	137,939,829	86,534,547	25,206,371
Company D	2,469,758	5,145,638	4,014,214	3,002,444	909,020	693,910	1,934,319	36,361,854	126,238,451	155,384,765	185,589,176
SUB TOTAL:	**$46,046,637**	**$69,651,229**	**$139,875,116**	**$287,336,392**	**$441,137,031**	**$493,575,366**	**$595,562,663**	**$695,974,598**	**$908,259,104**	**$1,200,744,957**	**$1,229,822,467**
Commissions as % of Premiums	7.58%	8.26%	8.37%	7.76%	7.89%	7.84%	7.40%	8.18%	7.71%	7.38%	7.46%

Commissions - Large Group (more than 50 employees)

Insurance Company	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Company A	0	0	0	4,449	208,399	358,729	647,102	1,590,464	3,403,986	3,617,144	4,187,798
Company B	828,949	1,373,821	1,781,137	2,581,167	3,203,123	3,253,526	4,288,917	6,561,877	6,303,960	6,978,625	6,586,834
Company C	672,434	956,098	366,306	2,788,870	3,745,139	4,384,563	5,070,161	3,539,997	1,934,131	762,371	103,298
Company D	288,117	715,721	518,326	354,587	142,551	44,833	68,826	1,332,078	2,064,751	1,637,211	1,459,775
SUB TOTAL:	**$1,789,500**	**$3,045,640**	**$2,665,769**	**$5,729,073**	**$7,299,212**	**$8,041,651**	**$10,075,006**	**$13,024,416**	**$13,706,828**	**$12,995,351**	**$12,337,705**

Premiums - Large Group (more than 50 employees)

Insurance Company	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Company A	0	0	0	137,370	6,116,132	9,425,142	15,936,955	32,291,210	63,395,958	78,745,911	94,905,087
Company B	47,121,445	69,499,750	91,595,998	122,083,652	178,681,100	203,559,216	231,065,188	245,975,578	220,896,002	229,124,763	266,441,214
Company C	15,905,887	21,863,893	6,135,265	65,936,651	93,911,844	114,820,206	128,766,706	90,483,048	49,970,506	22,911,635	2,978,352
Company D	7,741,860	21,047,296	17,544,666	10,740,566	3,292,986	973,274	1,912,736	27,913,765	42,760,613	33,024,393	30,151,684
SUB TOTAL:	**$70,769,192**	**$112,410,939**	**$117,275,929**	**$198,898,239**	**$282,002,062**	**$328,777,838**	**$377,681,585**	**$396,663,601**	**$377,023,079**	**$363,806,702**	**$394,476,337**
Commissions as % of Premiums	2.53%	2.71%	2.27%	2.88%	2.59%	2.45%	2.67%	3.28%	3.64%	3.57%	3.13%

Total Commissions											
Insurance Company	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Company A	0	0	0	148,314	5,452,263	13,287,626	19,581,429	32,741,187	54,988,959	88,973,386	97,230,247
Company B	4,341,279	10,560,884	20,354,611	28,604,170	34,768,369	32,693,744	34,983,303	50,551,670	54,765,086	49,438,958	52,445,223
Company C	1,039,202	1,519,970	[redacted]	6,574,012	[redacted]	[redacted]	23,312,918	23,578,835	16,565,525	10,384,612	4,744,457
Company D	443,077	986,858	723,840	[redacted]	181,435	65,260	183,023	3,874,153	10,575,620	11,948,771	13,808,012
GRAND TOTAL:	**$5,823,558**	**$13,067,712**	**$21,732,272**	**$35,828,679**	**$54,301,574**	**$65,462,274**	**$78,060,673**	**$110,745,845**	**$136,895,190**	**$160,745,727**	**$168,227,939**

Total Premiums											
Insurance Company	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Company A	0	0	0	1,717,119	56,845,461	155,086,452	264,704,900	439,168,575	723,716,442	1,186,270,455	1,316,638,336
Company B	96,069,043	167,536,298	299,167,965	440,355,926	563,768,851	560,897,664	599,068,439	708,834,711	744,029,899	700,251,338	767,596,801
Company C	20,548,648	28,945,280	11,809,929	119,242,721	229,309,558	302,692,026	366,828,068	330,220,603	216,747,579	136,684,569	53,424,785
Company D	10,211,618	26,192,934	21,558,880	13,743,010	4,202,006	1,667,184	3,847,055	64,275,619	168,999,064	188,409,158	215,740,860
	$126,829,309	**$222,674,512**	**$332,536,774**	**$575,058,776**	**$854,125,876**	**$1,020,343,326**	**$1,234,448,462**	**$1,542,499,508**	**$1,853,492,984**	**$2,211,615,520**	**$2,353,400,782**

Commissions as % of Premiums	4.59%	5.87%	6.54%	6.23%	6.36%	6.42%	6.32%	7.18%	7.39%	7.27%	7.15%
Dollars resulting from different hypothetical commission percentages of 4 companies' premiums											
4%	$5,073,172	$8,906,980	$13,301,471	$23,002,351	$34,165,035	$40,813,733	$49,377,938	$61,699,960	$74,139,719	$88,464,621	$94,136,031
5%	$6,341,465	$11,133,726	$16,626,839	$28,752,939	$42,706,294	$51,017,166	$61,722,423	$77,124,975	$92,674,649	$110,580,776	$117,670,039
6%	$7,609,759	$13,360,471	$19,952,206	$34,503,527	$51,247,553	$61,220,600	$74,066,908	$92,549,970	$111,209,579	$132,696,931	$141,204,047
7%	$8,878,052	$15,587,216	$23,277,574	$40,254,114	$59,788,811	$71,424,033	$86,411,392	$107,974,966	$129,744,509	$154,813,086	$164,738,055

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Communicating for America
Communicating for Agriculture
Communicating for Seniors

The Honorable Sam Graves
Chairman
Committee on Small Business
U.S. House of Representatives
2361 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Graves and members of the committee:

Communicating for America is a national association with tens of thousands of farmers and small business members all across rural America. On behalf of our members, the CA Board of Directors would like to state our support for legislation that ensures insurance agents are allowed to continue helping rural health consumers in the individual and small group market navigate the twists and turns of the health insurance market place and the Patient Protection and Affordable Care Act (PPACA).

The great distances that agents sometimes have to travel to visit customers in rural areas, coupled with reduced access to high speed internet, in many cases points to the exclusion of agent compensation from the MLR calculation. CA members and small businesses in general often don't fit the one-size-fits- all type of policies offered by a few very large health insurance companies. Rural and smaller community health consumers and small businesses need the expertise of many of the smaller companies to meet their needs, as well as the personal attention of an agent who attends church and Friday night football games with their customers.

Health insurance agents also assist with difficult cases involving persons with underlying medical problems who need additional information in order to get coverage. Agents have recommended high risk pools to thousands of their customers, even though they received little or no compensation for steering people in that direction.

Agents help match those hard to cover individuals with the best health insurance plans, at the most affordable price. Sometimes for consumers, particularly in rural America, the best solution is not a large national company with a one-size-fits all online enrollment, especially if certain individuals can be denied coverage. That is where a local agent can help, and why there should be incentives to strengthen their role.

The goal of healthcare reform and the PPACA is to insure more Americans at less cost. Limiting choices for consumers accomplishes neither goal, and reducing agent commissions does not necessarily reduce insurance company profits, nor does it make health insurance more affordable for consumers. CA strongly believes we need legislation that allows greater choices and flexibility for consumers and small businesses and encourages innovative solutions from agents and the private sector. Limiting choice does not serve the needs of

America's small businesses. CA supports legislation that ensures America's small businesses are allowed continued advice of their agents and helps strengthen competition in the individual and small group market.

Thank you for your time, and we would be happy to answer any questions the committee may have.

Sincerely,
Wayne K. Nelson
CA President

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

RANDEL K. JOHNSON
SENIOR VICE PRESIDENT
LABOR, IMMIGRATION, &
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December 22, 2011

The Honorable Mike Coffman
Chairman
Committee on Small Business Subcommittee
on Investigations, Oversight and Regulations
United States House of Representatives
Washington, DC 20510

Dear Chairman Coffman:

The U.S. Chamber of Commerce appreciates you and members of the House Committee on Small Business Subcommittee on Investigations, Oversight and Regulations for recognizing the problems that the new medical loss ratio (MLR) requirements will have on businesses and for holding the December 15, 2011 hearing, "New Medical Loss Ratios: Increasing Health Care Value or Just Eliminating Jobs?" The Chamber agrees that the way health reform law is mandating health insurance carriers to use a specific percent of premiums on direct medical care is driving many carriers out of the small group and individual markets, eliminating jobs and reducing the number of affordable coverage choices.

The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees. For small businesses struggling to remain open, the new health reform law (the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, collectively referred to as "PPACA") and its myriad of requirements impose yet another financial challenge. In addition to imposing new mandates, the law is forcing small businesses and individuals to navigate the new legal requirements with fewer resources and fewer choices.

MLR will reduce valued resources and eliminate jobs

Most small businesses operate without a human resource department to assist with coverage decisions. When deciding which type(s) of health insurance coverage and carriers to offer employees, small businesses have historically relied on insurance agents and brokers for help. However just as these decisions become more complicated, small businesses will be forced to make these choices without the help which they have traditionally relied on and those businesses which have provided this service will be forced to stop.

Employers' coverage decisions will no longer be based solely on what benefit options are available and appropriate. Instead, as businesses struggle to comply with the employer responsibility provision of the PPACA, coverage and carrier decisions will become even more complicated. With a projected 32 million more individuals entering the insurance market in 2014—when health insurance exchanges, new marketplaces of health plans, will also become operational—the brokers will become even more essential. Although brokers may be more essential, the MLR rule will drive them of business.

Despite the urging of The National Association of Insurance Commissioners, HHS refused to exclude broker fees from the administrative portion of the calculation, a decision which will make it difficult for agents and brokers to be compensated for their work. Without commissions, brokers who have helped employers find the policies that meet their needs, negotiated terms, benefits, and premium costs with insurers, and helped navigate the claims process for the client company's employees will not be able to offer these services to small businesses. Companies will either have to do the work themselves or leave their employees to fend for themselves.

Not only is the implementation of the MLR requirement hurting the small businesses that rely on brokers, it is driving those small businesses that provide this service out of business. A recent survey found that 21 percent of independent health insurance agency owners have been forced to downsize their businesses, forcing many brokerage firms to close their doors, lay off workers, and deprive clients of their services.

MLR will lead to fewer choices for small businesses

While small businesses and individuals have fewer resources to assist them in identifying appropriate coverage, the choices available for these purchasers are becoming even more limited.

Prior to the enactment of PPACA, there was very little competition left in the small group insurance market. The four largest health insurance firms accounted for 65 percent of the small group insurance market. However, in many states, especially in rural areas, the largest insurer is the only insurer. In some cases, small businesses have been forced to get a new health plan because their insurer has left the marketplace. In other cases, employers have no other plan operating in their area to call for a rate quote when their current plan premiums skyrocket. Small firms have historically had few, if any, alternatives to their health plan when presented with dramatic rate increases. When plans leave the market, businesses have one less option to choose from, leading to less competition and higher prices.

Attached is a document that shows the number of carriers that have exited the small group and individual market in the states as of October 2011. The chart was compiled using public data. In addition to the immediate decrease in choice that occurs when a carrier leaves the market, it is important to appreciate that this decrease in choice has long term implications. The Health Information and Portability and Accountability Act (HIPAA) generally prohibits carriers from re-entering the market for a period of 5 years, which will keep these carriers out of the market during a critical period of reform. Clearly, PPACA is reducing the number of carrier choices for consumers and employers. Fewer choices mean less competition and fewer alternatives when a carrier increases premiums.

The withdrawal of carriers impacts the inter-play between the small group and individual markets. As states seek to phase in the MLR for the individual market, using the waiver process as outlined by HHS, there is widespread recognition that de-stabilization in the individual market will lead to de-stabilization in the small group market. Indiana is one example of a state where the Insurance Commissioner asked for a phase in the individual and small group market MLR.

The U.S. Chamber of Commerce appreciates this opportunity to submit a statement for the record on such an important issue. We look forward to working with you to identify and enact meaningful reforms to the small group insurance market, making healthcare more affordable and accessible for all Americans.

Sincerely,

Randel K. Johnson

cc: Members of the Committee on Small Business Subcommittee on Investigations, Oversight and Regulations

Louisiana

2011

Carrier	Group Size	Plan Type	Annual Premium	First Year (If Available)	Renewal
184	Group	2-5 enrolled	N/A	$7.50 PEPM	N/A
		6-15 enrolled		$32.50 PEPM	
		16-25 enrolled		$27.00 PEPM	
		26-50 enrolled		$22.00 PEPM	
		51-99 enrolled		5.0%	
		100+		Negotiable	
185	Individual	Medical	N/A	10%	5%
186	Group	2-3 enrolled	N/A	$9 PEPM	N/A
		4-15 enrolled		$40 PEPM	
		16-25 enrolled		$30 PEPM	
		26-50 enrolled		$22 PEPM	
187	Association Group or Individual Health Ins. Plans	***Medical Age 60 & Under***	N/A		4%
		1-49 Policies		10%	
		50-99 Policies		12%	
		100+ Policies		14%	
		Medical Age 61+			4%
		1-49 Policies		5.0%	
		50-99 Policies		6.0%	
		100+ Policies		7.0%	
188	Small Group	Medical	N/A	10.0%	5%
		Tier I			
		2-3 enrolled		$8.00 Per Enrolled	$7.00
		4-15 enrolled		$36.00 Per Enrolled	$35.00
		16-25 enrolled		$30.00 Per Enrolled	$29.00
		26-50 enrolled		$20.00 Per Enrolled	$19.00
		51-99 enrolled		$18.00 Per Enrolled	$17.00
		Tier II			
		2-3 enrolled		$9.00 Per Enrolled	$8.00
		4-15 enrolled		$37.00 Per Enrolled	$36.00
		16-25 enrolled		$31.00 Per Enrolled	$30.00
		26-50 enrolled		$21.00 Per Enrolled	$20.50
		51-99 enrolled		$20.00 Per Enrolled	$19.00
		Tier III			
		2-3 enrolled		$10.00 Per Enrolled	$9.00
		4-15 enrolled		$38.00 Per Enrolled	$37.00
		16-25 enrolled		$32.00 Per Enrolled	$31.00
		26-50 enrolled		$22.00 Per Enrolled	$21.00
		51-99 enrolled		$21.00 Per Enrolled	$20.00
189	Group	***2-50 enrolled***	First $35,000 Next $25,000 Next $15,000 Remainder	10% 7.50% 5% 2.50%	4%
		51+ enrolled		Negotiated but generally 4-5%	

Carrier	Group Size	Plan Type	Annual Premium	First Year (If Available)	Renewal
2010					
Carrier	Group Size	Plan Type	Annual Premium	First Year (If Available)	Renewal
188	Individual	Medical	N/A	20%	5%
186	Group	2-3 enrolled	N/A	$9 PEPM	N/A
		4-15 enrolled		$40 PEPM	
		16-25 enrolled		$30 PEPM	
		26-50 enrolled		$22 PEPM	
187	Association Group or Individual Health Ins. Plans	***Medical Age 60 & Under***	N/A		4%
		1-49 Policies		10%	
		50-99 Policies		12%	
		100+ Policies		14%	
		Medical Age 61+			4%
		1-49 Policies		5.0%	
		50-99 Policies		6.0%	
		100+ Policies		7.0%	
189	Group	***2-50 enrolled***	First $35,000	10%	4%
			Next $25,000	7.50%	
			Next $15,000	5%	
			Remainder	2.50%	
		51+ enrolled	Negotiated but generally 4-5%		
2009					
Carrier	Group Size	Plan Type	Annual Premium	First Year (If Available)	Renewal
188	Individual	Medical	N/A	20%	5%
186	Group	2-3 enrolled	N/A	$9 PEPM	N/A
		4-15 enrolled		$40 PEPM	
		16-25 enrolled		$30 PEPM	
		26-50 enrolled		$22 PEPM	
187	Association Group or Individual Health Ins. Plans	Various Products	N/A	20%	5%
				23.0%	5%
				10.0%	5%
				13.0%	5%
189	Group	***2-50 enrolled***	First $35,000	10%	4%
			Next $25,000	7.50%	
			Next $15,000	5%	
			Remainder	2.50%	
		51+ enrolled	Negotiated but generally 4-5%		