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States Line Up for MLR Adjustments as Insurers Cut Brokerage Commissions

As states line up to request adjustments to a requirement in the health reform law requiring individual plans to spend at least 80 percent of premiums on medical claims or quality improvements, insurers are cutting brokerage commissions to meet the requirement.

Smaller states are asking the Department of Health and Human Services for an adjustment to the medical loss ratio requirement of the Patient Protection and Affordable Care Act (PPACA), arguing that their individual markets will be destabilized if insurers have to meet the ratio too quickly. Maine set the precedent for winning approval for an adjustment March 8 with its plan to keep its individual plan ratio at 65 percent in 2011 and 2012, with HHS to review the adjustment in 2013 (*see previous article*).

On March 11, Florida became the largest state to ask for an adjustment, seeking to hold the ratio at 65 percent for individual plans in that state and at 70 percent for health maintenance organizations until 2014 *(see related item in this issue)*.

In addition, New Hampshire, Nevada, Kentucky, Georgia, North Dakota, and Iowa have applications pending with HHS.

In 2014, millions more consumers are to become insured under the Patient Protection and Affordable Care Act (PPACA), which should enable insurers to sell individual policies at more affordable prices as the risk is lowered that a disproportionately high share of enrollees are less healthy than most people.

PPACA requires fully insured large group plans covering 100 or more employees, as well as Medicare plans, to spend at least 85 percent of premiums on medical claims or quality improvement activities, and small group or individual health insurance plans must spend at least 80 percent, effectively capping profits and administrative expenses. "Grandfathered" plans begun before PPACA was enacted are included in the requirement, while self-insured employer plans are not.

Insurers must file their first medical loss ratio reports April 1. Plans that do not meet the requirements must begin refunding the difference to consumers beginning in 2012, when as many as 9 million people could be eligible for rebates totaling $1.4 billion, according to an estimate in the interim final rule issued by HHS in November 2010.

Florida Will Be 'Battleground' State

Florida will be a "battleground" state for individual waivers, according to a March 16 report by Citigroup managed care research analyst Carl McDonald. Florida's case differs from Maine's, the report said, "since there is actually some competition in the market, while it represents a significant source of rebates for the managed care plans," particularly UnitedHealthcare Group Inc., which owns Golden Rule Insurance Co., the largest individual insurer in the state.

McDonald wrote that Florida's waiver request is not likely to be approved by HHS, as none of the six largest plans that account for 85 percent of the individual market in the state will drop out of the market because of the MLR requirement, and granting the waiver would deprive consumers in the state of rebates estimated at $60 million, based on 2009 data.

HHS regulators will have to decide on trade-offs, McDonald told BNA. "There are going to be some people in Florida [whose coverage is] going to be disrupted," primarily in small plans, he said. It will be difficult for many people with plans that discontinue coverage because of the requirement to find insurance, or they will have to pay more for it, he said. "But it will be a relatively limited number of people in that pool," he said.

"Is the disruption of a few people worth a lot more for a lot of people?" McDonald said, summing up

his assessment of the central issue to be decided by regulators. "That will be the issue for other states as well."

For its part, America's Health Insurance Plans supports allowing states to have transition periods leading up to 2014. "Without a transition to go from today to 2014 there's a potential for significant disruption, including the possibility that some plans could be forced out of markets," AHIP spokesman Robert Zirkelbach told BNA.

Excluding Agent Commissions From MLR

Health insurance agent groups as well as many state regulators are concerned about the impact of the MLR rule on agents and brokers. A current focus of their attention is on whether to change PPACA to exclude commissions paid to them from revenues. That would allow insurers to pay the advisers without adding to administrative costs, thereby meeting the new MLR ratios.

Some health insurers have announced reductions in the sales commissions they will pay agents who sell their products, some are calculating commissions only on initial premiums to avoid inflation, and others are changing the payments from a percentage of premiums to a set monthly per-member fee, according to industry experts.

The National Association of Insurance Commissioners' Professional Health Insurance Advisors Task Force has drafted model federal legislation that would exclude agent commissions from the ratio "to preserve consumer and employer access to professional health insurance advisors." The NAIC draft was criticized by Senate Commerce Committee Chairman John D. Rockefeller IV (D-W.Va.), who said it would cost consumers $1 billion in benefits they are likely to receive as a result of the MLR provision *(see related item in this issue)*.

Joel Allumbaugh, chief executive officer of National Worksite Benefit Group, an employee benefit firm in Hallowell, Maine, says that the exclusion is necessary to keep agents in business. "If you don't get pressure off brokers, you will have fewer and fewer brokers serving the community," said Allumbaugh, who is president of the Maine chapter of the National Association of Health Underwriters, an association that represents health insurance agents and brokers. Individuals and small groups will be the first to be affected by the loss of adviser services, he said.

Agents have received support from members of Congress. On March 17, Rep. Mike Rogers (R-Mich.) and Rep. John Barrow (D-Ga.) introduced the proposed Access to Professional Health Insurance Advisors Act (H.R. 1206), which would exclude commissions from revenues in calculating the MLR. "Insurance agents' and brokers' commissions are never part of an insurer's actual revenue, and should never be counted as an insurer administrative expense," Rogers's release said.

But consumer representatives disagree. "This is a huge issue for consumers, and could raise premiums by far more than the provisions of [PPACA] that have been implemented so far," Washington and Lee University School of Law Professor Timothy Jost, a consumer representative to NAIC, told BNA in an e-mail.

Jost and other consumer representatives wrote NAIC's Professional Health Insurance Advisors Task Force March 7 outlining their concerns about the proposal to exclude agent commissions from insurer revenues. "If you take it out, the insurer is unlikely to contract their administrative costs to make up for it," Jost told BNA. The result could increase health insurance costs by virtually the full amount of the commissions, which would be more than the 1 percent to 2 percent increased cost for health plans currently attributable to the PPACA requirements, he said.

Iowa Insurance Commissioner Susan Voss, president of NAIC, disagreed and told BNA that excluding broker commissions from revenues is unlikely "to increase rates all that much. When I get rate increase approvals from companies I'm looking at numbers on underlying health care costs" that are driving the rate increases, "not increase in commissions" as the underlying factor, she said.

"What we're seeing in the agent and broker community is that industry's paying them less, and I can't imagine, even if we took this out, industry's going to dramatically increase the commissions again," Voss said.

What Plans Are Doing to Adjust to MLR

Nevertheless, Citigroup analyst McDonald said that broker commissions are the top target for health insurers in reducing their administrative expenses to meet the medical loss ratio requirement, which took effect this year. Cutting commissions is "the single biggest thing" health insurers are doing to

adjust to the requirement, he said.

"The plans had been trying for years to figure out a way to lower what they pay to brokers, and this gave them a way to do that," McDonald said. If commissions are excluded from revenues, "that would effectively make the minimum loss ratio meaningless," he said. Brokerage commissions for individual plans have historically been about 20 percent the first year, he said, which has contributed to the low loss ratios for those plans. In contrast, commissions for small group plans "have been in the mid-single digits," he said.

In addition to cutting commissions to adjust to the loss ratio requirement, plans are reducing premium rates, or not raising them as much as they would have, to try to get closer to the minimum, McDonald said.

The MLR requirement should push plans to operate more efficiently, McDonald contended. "In a situation where your margins are capped, the only way you can grow your earnings is either to increase your enrollment or to lower your operating expenses. One of the few ways you can increase your enrollment is to have a lower premium rate than your competitor."

Effect on Large, Small Group Plans

While most of the impact of the medical loss ratio is believed to be on small carriers and individual plans, large carriers in particular states may be liable for rebates, John Steele, managing director of Chicago-based health care consulting firm Healthscape Advisors LLC, told BNA. "In certain states they may be below the rebate thresholds even though in the aggregate they may look like they're OK," he said.

The MLR rule also could put insurers in double jeopardy when combined with premium rate reviews required under PPACA, Steele said. Regulators may be less inclined to approve rate increases by insurers who have low loss ratios, even if higher rates are justified by rising underlying health care costs, he said.

A worry among some industry officials and state regulators is the possibility that the MLR could impact small group plans. At the National Policy Forum sponsored by America's Health Insurance Plans in Washington March 8, AHIP President and Chief Executive Officer Karen Ignagni said of small group plans, "A number of our members are very concerned about transition there." She offered to provide data on the issue to HHS.

Leslie Ludtke, a health policy analyst for the New Hampshire Insurance Department, told BNA that a concern the state has raised in its application for an adjustment to the MLR is that small group plans could be adversely affected by the loss ratio.

New Hampshire, where most businesses are small, requires small group plans to guarantee coverage for self-employed people in "groups" as small as one person, she said. With health care and health insurance costs rising, employer contributions have been declining, she said. That has resulted in younger, healthier people leaving small group plans to buy cheaper coverage in the individual market, Ludtke said. That in turn makes it harder for businesses to keep small group plans, which typically require that participation levels at least reach set minimums, she said.

Possible Unintended Consequences

The impact the medical loss ratio will have on health insurers over time is an open question among industry experts. "If a company has an 85 percent loss ratio, does that mean a consumer gets better quality care than a company that has a 75 percent loss ratio?" asked Nancy Litwinski, a director of the national health care practice in Deloitte & Touche LLP's Tampa, Fla., office. "To have everyone have a standardized medical loss ratio that needs to apply across the country, that's really the challenge for companies."

In 2014, more people will be buying individual insurance plans through the exchange markets, which will likely make it easier for insurers to meet the loss ratios, Paul Ginsburg, president of the Center for Studying Health System Change, told BNA.

But until then, some insurers are likely to leave the market rather than pay rebates, Ginsburg said. "The fact that the MLR started now rather than in 2014 makes it more disruptive," he said. "In 2014, individuals wouldn't have to worry about buying insurance" because PPACA requires insurers to cover everyone, regardless of whether they have medical problems.

Whatever other consequences the MLR requirement may have, some believe a chief bonus will be better public information about health care costs that are covered by insurance as insurers are required to file public information on their ratios.

“It'll be very good for us to see what are the drivers of health care costs,” Iowa's Voss said. “If we're really ramping down on administration, then when a rate increase comes into our office … it will be a really good indicator of what's the next thing that we really have to deal with,” she said. “I really believe it's the underlying health care costs,” she added. “We'll get a better handle on what the drivers are.”

By Sara Hansard

Information on MLR adjustment applications is at http://cciio.cms.gov/programs/marketreforms/mlr/index.html. Citigroup's March 16 analysis of Florida's MLR waiver request is at http://op.bna.com/hl.nsf/r?Open=shad-8f2rbp. The NAIC consumer representatives' letter on agent commissions in the MLR is at http://op.bna.com/hl.nsf/r?Open=shad-8f3kdt.

2009 MLR Statistics

This reflects findings from Citi Investment Research & Analysis of medical loss ratios for major health insurers in 2009 prior to the current regulation that took effect in 2011.

Aetna: 75.7% Individual; 84.2% Small Group; 87.2% Large Group

Coventry: 72.1% Individual; 76.3% Small Group; 84.9% Large Group

CIGNA: 88.1% Individual; 92.1% Small Group; 85.2% Large Group

Humana: 68.1% Individual; 80.0% Small Group; 88.2% Large Group

United: 70.2% Individual; 80.4% Small Group; 83.1% Large Group

WellPoint: 75.2% Individual; 81.3%; Small Group; 85.1% Large Group

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