



214 Massachusetts Avenue, NE • Washington DC 20002 • (202) 546-4400 • heritage.org

CONGRESSIONAL TESTIMONY

**Effects of the PPACA's Minimum
Loss Ratio Regulations**

**Testimony before
Committee On Energy and Commerce
Subcommittee on Health
United States House of Representatives**

September 15, 2011

**Edmund F. Haislmaier
Senior Research Fellow
Center for Health Policy Studies
The Heritage Foundation**

Mr. Chairman and members of the Committee, thank you for inviting me to testify before you today.

My name is Edmund F. Haislmaier. I am Senior Research Fellow in Health Policy at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Background

The Patient Protection and Affordable Care Act (PPACA) established new federal rules governing how health insurers spend premium dollars.¹ These rules are commonly referred to as “minimum loss ratio” regulations—meaning that they specify the minimum share of premium income that an insurer must spend on claims costs and “activities that improve health care quality.”

The minimum levels are set in PPACA at 85 percent for large group plans and 80 percent for small group and individual plans. The statute explicitly excludes insurer payments of “Federal and State taxes and licensing or regulatory fees” from the calculation of minimum loss ratios.

PPACA further stipulates that if an insurer spends less than the required minimum in a given year, then the insurer must refund the difference to policyholders. Thus, for example, if an insurer is required to spend 80 percent of premium income on claims costs for a particular product but only spends 75 percent, the insurer is required to rebate five percent of the premium collected to policyholders.

The Department of Health and Human Services (HHS) issued regulations last fall implementing this new requirement, which took effect on January 1, of this year.²

Consequences of PPACA's Minimum Loss Ratio Regulations

The “loss ratio” for an insurance plan is a common actuarial and accounting metric that may be of interest to some consumers when comparing coverage options. It should be noted that there is nothing inherently problematic about government requiring the disclosure of this information to consumers and that basic loss ratio data can already be derived from standard insurer filings with state regulators.

Reporting or publicizing insurer loss ratios does not, in and of itself, create problems. The problems only occur when governments use a comparative measure, such as this one, as the basis for setting and enforcing a required minimum standard. A useful way to understand this important distinction is by considering analogous examples.

¹ New § 2718 of the Public Health Service Act (42 U.S. Code § 300gg–18) as added by PL 111-148 § 1001(5) and then amended by §10101(f).

² 45 CFR 158.

When government requires manufacturers to disclose product information -- such as the fuel efficiency of cars -- consumers can use that information as another point of comparison when making purchasing decisions. The consumer can then decide, say, whether the higher operating costs of a less fuel-efficient car are compensated for by a lower purchase price or other desirable product features, or to opt instead for a more fuel-efficient car that cost less to operate, but has a higher purchase price or lacks other features the consumer might want.

It is only when government takes the additional step of using such comparative information to impose minimum standards that it distorts the market in ways that can disadvantage some consumers. Thus, what killed-off the family station wagon was not government requiring manufacturers to disclose the fuel-efficiency of automobiles, but rather the additional imposition of a minimum "Corporate Average Fuel Economy" (CAFE) standard that manufactures could only meet by no longer producing larger cars.

In the same fashion, the PPACA's requirement that health insurance plans meet new minimum loss ratio requirements will produce negative effects for consumers -- most notably, reduced insurer competition, higher premiums, and more erroneous or fraudulent claim payments.

Killing Start-Ups

The first to go will be new, start-up health insurers. As with many start-up companies, a substantial initial capital investment is required to create a new insurer. That investment is needed to fund initial marketing and sales efforts to attract paying customers, and to build-out the operational and administrative infrastructure for billing customers, paying claims, etc. Similar to other new businesses, a new insurer initially operates at a loss until it achieves enough "scale" -- that is, it acquires enough customers -- that revenues exceed expenses, and it become profitable.

The MLR regulations effectively constrain the amount, and delay the timing, of any excess premium revenues that a start-up health insurer could plan to either reinvest in growing its business (say, through additional marketing) or repaying its initial investors. Thus, the MLR regulations push further into the future a new company's projected "break-even" point, and may also necessitate additional start-up capital beyond what was previously projected.

Of course, it is uncertain whether a particular start-up insurer would succeed, even without having to deal with the constraints imposed by the MLR regulations. However, what is certain is that imposing the new MLR regulations raises the bar for an "in-process" start-up, and increases the risk and initial capital requirements for an "in-planning" start-up venture.

In at least one reported case investors decided to terminate an "in-process" start-up health insurer, at least in part, due to the effects of the new MLR regulations on its business

plan. As a result, 128 Virginia small businesses and their 1,488 workers and dependents were forced to look for new coverage this year.³ What is unknowable are how many attempts to create new health insurers that are still in the planning stage are simply being abandoned once investors determine that the added burden of complying with the new minimum loss ratio regulations make it too expensive or too risky to go forward.

Exiting the Market

A number of established companies that currently provide health insurance can also be expected to exit the market over the next several years. The ones most likely to leave are those with multiple lines of coverage, for which offering health insurance is just part of their larger business. In general, the minimum loss ratio regulations will make offering health insurance less profitable, while other regulations, such as the PPACA's new benefit standards and coverage rules, will make health insurance more expensive for customers and more costly for insurers to administer. Thus, companies with multiple lines of business will likely discontinue or sell to competitors their, soon-to-be less profitable, health plans and focus instead on the other lines of insurance that they offer -- such as life, auto, property, or liability coverage -- or on non-insurance business opportunities.

The smaller the company, or the smaller the share of a company's total business represented by health insurance, the more likely it is that the company will exit the post-PPACA health insurance market. Of course, smart managers aren't going to wait for corporate assets to decline further in value, so it is likely that many of those sales and divestitures will occur sooner rather than later.

For example, on September 30, 2010, Principal Financial Group, Inc. announced that it was exiting the major medical health insurance market and transferring its existing book of business to UnitedHealth Group.⁴ Principal will instead focus on its other lines of business, which include managing retirement and investment plans, and offering life, disability, dental and vision insurance products (none of which are subject to the PPACA's new federal insurance regulations).

To be sure, such business decisions are often the product of multiple considerations, but the fact that the MLR provisions in the PPACA constrain health insurance administrative spending and profitability while its other new insurance regulations increase benefit and administrative costs, will certainly discourage companies with other options from continuing to offer health plans.

³ Michael Schwartz, "Startup health insurer shutting," *Richmond BizSense*, June 4, 2010, at: <http://www.richmondbizsense.com/2010/06/04/startup-health-insurer-shutting> and Michael Schwartz, "With healthcare reform looming, nHealth was losing millions," *Richmond BizSense*, June 11, 2010, at: <http://www.richmondbizsense.com/2010/06/11/with-healthcare-reform-looming-nhealth-was-losing-millions/>

⁴ Principal Financial Group, "The Principal Financial Group to Exit Medical Insurance Business," press release, September 30, 2010, at: <http://phx.corporate-ir.net/phoenix.zhtml?c=125598&p=irol-newsArticle&ID=1477633&highlight=>

An Invitation For Fraud

Even more troubling than its tendency to reduce competition by driving some insurers out of the market, is that the PPACA's minimum loss ratio regulations also create a disincentive for insurers to control payment errors and fraud. Under the statute and regulations, money spent on preventing or recovering erroneous or fraudulent claims, counts as "administrative" expenses, and not "medical" costs, while erroneous or fraudulent payments count the same as appropriate and legitimate ones in determining whether a plan has paid out a sufficient share of premium income on "medical care."

As part of this provision, Congress asked the National Association of Insurance Commissioners (NAIC) to advise HHS on how to account for various insurer expenses in administering the MLR standards. In its recommendations, NAIC attempted to partially remedy this defect in the legislation by recommending that the amount of premium income used to calculate the MLR be reduced by the lesser of either what an insurer spends on "Fraud and Abuse Detection/Recovery Expenses," or the amount of erroneous payments the insurer recovers. HHS incorporated that recommendation into its regulations.

However, even that tweak does not fix the problem. Under these rules an insurer that simply pays claims without first checking whether they are legitimate or accurate will still be financially better off than one that spends money trying prevent or recover erroneous or fraudulent payments. The reason is that, under any possible scenario of administrative expenses and recoveries, an insurer that spends nothing on preventing or collecting erroneous payments will still retain more funds -- which it can use to cover other administrative costs, or to pad its profits -- than an insurer that spends money on preventing or recovering improper claims payments. Indeed, an insurer that doesn't spend anything trying to prevent or recover errors or fraud, will actually report a higher (i.e., "better") medical loss ratio than its competitors, since any overpayments or fraudulent claim payments will count as expenditures "on reimbursement for clinical services" under the MLR provisions of the PPACA.

Bias Toward Higher Premiums

Yet another unintended consequence of the minimum loss ratio regulations is that it creates an inherent bias for insurers to charge *higher* premiums than they otherwise would absent the MLR requirement. This is because if an insurer overestimates expected spending on medical care, it must refund excess premiums to policyholders, but if it underestimates expected claims costs, it cannot keep more revenue the next year to recoup that loss.

There is an inherent tension in any insurance company between the actuaries who want a "margin of safety" built into premiums (which increases rates) and sales and marketing which wants to charge the lowest practical rates in order to attract or retain customers. The MLR regulations will tip that balance in favor of the actuaries. They will argue that underestimating medical costs can now produce losses that cannot be recovered, while

charging premiums that might be higher than necessary will protect the insurer's profitability, at the cost of sending rebate checks to policyholders next year if it turns out that the extra funds were not needed after all.

Favoring For Profit Insurers

Still another unintended consequence of the minimum loss ratio regulations is that they will increase the competitive advantage of for-profit insurers over their non-profit rivals. Because the MLR requirement constrains the share of premium income that an insurer can "retain," it limits an insurer's ability to accumulate the capital needed to expand, either by increasing marketing and sales efforts or by purchasing business from other insurers. Non-profit insurers have no other source of investment capital beyond whatever excess premium income they can accumulate after paying claims costs and administrative expenses. However, for-profit insurers can finance their capital needs by issuing equity shares. Since the proceeds of a share offering are not premium income, the MLR restrictions do not apply.

Thus, the minimum loss ratio regulations will not only spur increased consolidation in the health insurance industry, but will also further drive that consolidation toward a market dominated by a few, very large, for-profit, insurers. It is easy to envision large, for profit health insurers applying the same "roll-up" strategy of raising capital through equity offerings and then using the proceeds to buy smaller competitors that has been successfully applied in other sectors. Such an outcome is probably not something that the authors of the PPACA either intended or envisioned.

Recommendation

These undesirable and unintended consequences of the PPACA's minimum loss ratio regulations offer an object lesson in how greater information transparency is often a better public policy solution than new regulations.

State insurance departments already gather data from insurer regulatory filings on how health insurers spend their premium revenues. Thus, states can, and probably should, publish that data in an easily comparable format so that consumers can use it when shopping for coverage. Such an information transparency approach provides consumers with another useful tool for comparing plans, while also encouraging insurers to offer better value to their customers. More importantly, it achieves those goals without creating the perverse incentives and undesirable side effects of the PPACA's minimum loss ratio regulations.

The best course of action now would be for Congress to simply repeal the PPACA's misguided and badly design minimum loss ratio regulations.

Mr. Chairman, this concludes my prepared testimony. I thank you and the rest of the Committee for inviting me to testify before you on this issue. I will be happy to answer any questions that you or members of the Committee may have.

The Heritage Foundation is a public policy, research, and educational organization recognized as exempt under section 501(c)(3) of the Internal Revenue Code. It is privately supported and receives no funds from any government at any level, nor does it perform any government or other contract work.

The Heritage Foundation is the most broadly supported think tank in the United States. During 2010, it had 710,000 individual, foundation, and corporate supporters representing every state in the U.S. Its 2010 income came from the following sources:

Individuals	78%
Foundations	17%
Corporations	5%

The top five corporate givers provided The Heritage Foundation with 2% of its 2010 income. The Heritage Foundation's books are audited annually by the national accounting firm of McGladrey & Pullen. A list of major donors is available from The Heritage Foundation upon request.

Members of The Heritage Foundation staff testify as individuals discussing their own independent research. The views expressed are their own and do not reflect an institutional position for The Heritage Foundation or its board of trustees.