Regime Change for Health Insurance Regulation: Rethinking Rate Review, Medical Loss Ratios, and Informed Competition

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The recently enacted Patient Protection and Affordable Care Act aims to transform regulation of private health insurance. It would put in place a new federal regulatory regime that prescribes various mandates for covered benefits, imposes tighter restrictions on insurance premiums, sets limits on how premium dollars are spent, and exerts much greater political and bureaucratic control over health insurance. As part of the American Enterprise Institute project, Beyond “Repeal and Replace”: Ideas for Real Health Reform, insurance expert Scott E. Harrington argues that this new regulatory regime misdiagnoses the causes of health insurance problems and will worsen them. His study focuses in particular on the legislation’s new requirements for rate review, minimum medical loss ratios, and rescission of insurance coverage.

The author offers a clear market-oriented alternative to the new law’s agenda of top-down political controls. Harrington proposes reforms that would protect consumers and enhance the value of health insurance coverage, by promoting informed competition, individual choice, and personal responsibility. Instead of building a larger federal bureaucracy to ride herd on the states, his reforms would rely on targeted minimum standards for state regulation of health insurance that enhance existing consumer protections and promote competition among financially sound health insurers.

Scott E. Harrington is an adjunct scholar at AEI and a professor of health care management and insurance and risk management at the University of Pennsylvania’s Wharton School.
The Patient Protection and Affordable Care Act (PPACA), as enacted in March 2010, includes an individual mandate to purchase health insurance, premium and cost-sharing subsidies, the creation of health insurance exchanges, government prescription of benefits, and requirements that insurers provide coverage without respect to health status. The PPACA also establishes a new federal regulatory regime designed to exert political and bureaucratic control and influence on private health insurance rate changes and on how premium dollars are spent. That regulatory regime misdiagnoses the causes of high health insurance costs. Rather than making coverage more affordable and available, it will make it more difficult and costly for health insurers to meet the prescribed requirements for coverage, leading to calls for even tighter regulation and the creation of a public-plan option. In contrast to the PPACA’s agenda of top-down controls, pro-consumer health insurance reforms would encourage the states to adopt and expand policies that protect consumers while promoting informed competition and consumer choice.

Absent repeal or modification of its provisions, the PPACA will expand health insurance coverage by (1) requiring individuals beginning in 2014 to obtain qualified health insurance or pay a fine; (2) subsidizing coverage costs for low- to moderate-income people and for small, low-wage employers; (3) requiring employers with fifty or more employees to offer health coverage or pay fines; and (4) expanding eligibility for Medicaid. The law requires the establishment in 2014 of state-based health insurance exchanges for the individual and small-group markets, with premium subsidies available only for coverage purchased through an exchange.

Also beginning in 2014 (with the exception of any grandfathered plans), health insurers will be restricted to offering within or outside the exchanges one or more of four coverage tiers, along with a catastrophic plan for young adults. They must accept all applicants regardless of health status and without excluding preexisting conditions. Individual and small-group premiums will be allowed to vary only by coverage tier, number of dependents, geographic region, age (within 3:1 ratio), and tobacco use (1.5:1 ratio). PPACA-mandated changes that have already taken effect include the creation of temporary high-risk pools, the prohibition of preexisting-condition exclusions for children, mandated coverage offers for enrollees’ adult children up to age twenty-six, restriction/prohibition of annual and lifetime benefit limits, and prohibition of policy rescissions (declaring the policy void) absent fraud.

In a further departure from the long history of state insurance regulation, the PPACA establishes two new forms of federal price controls on health insurance
companies. First, beginning in 2011, health insurers’ spending on medical care and “activities that improve health care quality” must equal or exceed 85 percent of premiums (net of certain taxes and fees) for large group coverage and 80 percent of premiums for individual and small-group coverage. If necessary, insurers must pay rebates to policyholders to achieve those minimums. Second, although the PPACA does not authorize the federal government to approve or deny proposed rate changes, it requires health insurers to justify “unreasonable” rate increases, and insurers with “unreasonable” increases may be excluded from the exchanges. A new Office of Consumer Information and Insurance Oversight will assist the states in reviewing rates and, in conjunction with state regulators, develop rules for implementing the law’s rating provisions.

This study analyzes three aspects of the PPACA’s insurance regulatory program: minimum medical loss ratio (MLR) requirements, provisions dealing with rate review and required justifications of unreasonable rates, and prohibition of rescissions and minimum requirements for patient appeals of claim denials and coverage determinations. The paper explains why the PPACA’s regulatory program is misguided and harmful, and it outlines market-oriented alternatives that would promote informed competition and consumer choice within a pro-competitive framework of regulation and disclosure.

The PPACA’s regulatory regime misdiagnoses the causes of high health insurance costs.

Section II summarizes health insurance regulation before the PPACA and its proponents’ major arguments for stricter regulation. Section III provides a brief overview of the law’s MLR, rate review, and rescission and appeal provisions, and how they largely misdiagnose health insurance market problems. Sections IV, V, and VI provide detailed analysis of the MLR, rate review, and rescission and appeal provisions, including how the MLR and rate review requirements are counterproductive and should be repealed. Section VII recommends a market-oriented framework of regulation and disclosure that would enhance consumer protection, competition, and choice.
The PPACA imposes substantial regulation of health insurance coverage, pricing, underwriting, and marketing that reaches well beyond previous regulation in most states. This section provides an overview of regulation before the enactment of the new law. It then reviews criticisms of the status quo that have been used to justify expanded regulation under the PPACA.

Pre-PPACA Regulatory Environment

Health insurance companies must be licensed and regulated in each state where they conduct business. “Insured” individual and group health plans, in which a state-licensed insurer provides coverage, are subject to extensive regulation in each state. “Self-funded” employer plans are exempt from most state insurance regulation, and instead are subject to federal requirements under the Employee Retirement Income Security Act (ERISA). State health insurance regulation is administered by state insurance departments or similar agencies that implement statutory requirements and establish administrative rules and procedures. The National Association of Insurance Commissioners (NAIC) achieves some coordination among the states, in part by adopting model legislation for consideration by individual states.

While the details vary widely, state health insurance regulation generally encompasses licensing of companies, agents, and brokers; solvency oversight and regulation; oversight and regulation of pricing, underwriting, and risk classification; regulation of policy terms and conditions, including mandates that health policies provide certain benefits; oversight and regulation of market conduct, including insurers’ claim settlement and sales practices; and information disclosure to assist consumer decision making. Any reasonable system of regulation will involve all of these activities, but to different degrees and in different ways. The following sections highlight specific regulations that are most germane to the PPACA.

Risk Classification. Most states have relatively few restrictions on underwriting and risk classification of the type adopted in the PPACA. A significant majority of states allow individual market insurers to deny coverage, base premiums on health status, and exclude or limit coverage for preexisting conditions. A few states require guaranteed issue of one or more types of policies in this market. About ten states have a “rating band” system that limits permissible variation in rates based on health status. A few states permit rates to vary in relation to factors such as age, location, and coverage, but not health status (partial community rating). New York requires...
insurers to accept all applicants for a given type of coverage and location at the same rate (full community rating).

Small-group health insurance rating and underwriting are restricted in more states. In conjunction with federal law, all states require guaranteed issue. Approximately thirty-five states have rating bands for health status, eleven states have partial community rating, and New York has full community rating. As an alternative to strict underwriting and rating restrictions, thirty-four states had a high-risk pool before the PPACA with guaranteed issue of basic coverage under certain conditions at subsidized (but still relatively high) rates, regardless of preexisting conditions.

Minimum MLR Requirements. According to the NAIC, the trade group America’s Health Insurance Plans (AHIP), and the author’s review of state law, about half the states had prereform requirements that rate filings provide for a minimum MLR (ratio of medical expenses to premiums) for individual health insurance. The minimums generally ranged from 60 to 75 percent; most were 70 percent or below. About half of those states’ requirements were based on 1980 NAIC guidelines. About twenty states had MLR requirements for the small-group or large-group markets, also generally ranging from 60 to 75 percent.

Review of Rate Changes. State oversight of rate changes is highly diverse across states and within states for individual coverage, small-group coverage, and, in some instances, health maintenance organizations (HMOs). The overall regulatory standard typically is that rates be adequate but not excessive or unfairly discriminatory. As is true for property and casualty insurance, a number of broad approaches exist:

- **Prior-approval** laws require rates to be filed with regulators for approval. Many prior-approval laws specify that rates are deemed approved if the regulator takes no action within a specified time of the rate filing (such as thirty or sixty days). Rates generally can be disapproved after initial approval if the commissioner determines that they no longer meet regulatory standards.

- **File-and-use** laws allow insurers to file rates with regulators and use them after a waiting period (for example, thirty or forty-five days) without regulatory approval. Regulators may or may not choose to review the filings during the waiting period. The filings might be challenged under some laws and may be subject to subsequent disapproval if the commissioner determines that they violate regulatory standards.

- **Use-and-file** laws allow insurers to use rates without prefiling or approval. Rates instead must be filed within a specified period, such as thirty days, after they take effect. Some laws permit subsequent disapproval.

- **Filing-only** laws require informational filing of rates within a specified period of their effective date. There are no provisions for subsequent disapproval.

- **No-file** laws do not require filing (or approval) of rates.

According to the NAIC and the author’s review of state law, about half the states had prior-approval regulation for individual health insurance in 2009. Approximately twenty states required prior approval for one or more types of group health insurance (for example, coverage for small groups). About a quarter of the states had file-and-use systems for the individual market, often providing regulators with the ability to disapprove rates after they take effect. A few states had use-and-file laws. The remaining states generally required that rates be filed, at least for the individual market. Many states required actuarial certification that small-group rates comply with relevant law.

Market Conduct. States vary widely in their systems for overseeing market conduct, including auditing of claims and sales practices for compliance with regulatory standards. Violations are subject to fines, cease-and-desist orders, and possible license revocation. Many states have external review systems for disputes between policyholders and health insurers over
coverage decisions and benefits. These states typically require insurers to have an internal review system to be used before external review. Self-funded health plans that are not subject to state insurance regulation generally must meet federal requirements for both internal and external review.

**Information Disclosure.** Most state insurance departments or related agencies have websites that provide information to assist purchasers of health insurance by describing different types of coverage and how to find and purchase coverage. Some states report insurers’ market shares; a few report health insurers’ MLRs. Many states maintain and report complaint data. Some states provide health insurance price information. (A number of private Internet vendors provide extensive price and coverage information for insurers in most states.)

**Advocacy for Stricter National Regulation**

Health insurance markets have been attacked on three broad grounds to justify stricter regulation of pricing, underwriting, risk classification, and trade practices. First, a purported lack of competition and high administrative expenses and profits not controlled by competition and existing regulation are alleged to contribute significantly to high and rapidly growing health insurance premiums. Second, pricing, underwriting, and risk-classification practices permitted in most states are blamed for preventing access to health insurance at affordable rates for persons with preexisting health problems. Third, and related to the second issue, health insurers are alleged to engage in widespread retrospective underwriting and stinting on claims with inadequate state oversight, including thousands of alleged coverage cancelations “for people who become sick.”

**Inadequate Competition and High Premiums.** The costs of private health insurance have grown rapidly in conjunction with overall public and private spending on health care. The Kaiser/Health Research and Education Trust survey of employer-sponsored health benefits reports an average premium (employer and employee combined) for family coverage in 2010 of $13,770, 114 percent greater than for 2000, with an average worker contribution of $3,996. The average premium for single coverage in 2010 was $5,049, with the worker contributing an average of $900. Given greater average cost sharing and less generous benefits chosen (in significant part due to the far lower tax subsidies), average individual health insurance market premiums are lower than in the employer-sponsored market. According to an AHIP survey of 2.5 million policies, the average premium for single coverage in the individual market was $2,985 in 2009, and the average premium for family coverage was $6,328. The average annual individual market premium for single (family) coverage ranged from $1,429 ($2,967) for eighteen- to twenty-four-year-olds to $5,715 ($9,952) for sixty- to sixty-four-year-olds.

Many critics assert that insufficient competition and high administrative expenses and profits are major contributors to high premiums and unaffordable coverage. Health insurance markets in many states and metropolitan areas are characterized by relatively high concentration, that is, a small number of insurers accounts for a relatively large proportion of total sales. Some argue that an attendant lack of competition encourages high administrative expenses and profits, driving up the cost of coverage. Administrative expenses are viewed as especially high for individual coverage, where it is commonly asserted that administrative expenses and profits represent as much as 30 to 35 percent of premiums.

The 1945 McCarran-Ferguson Act, which also codified state insurance regulation as national policy, exempts the “business of insurance” from federal antitrust law provided that the activities are regulated by the states and do not involve boycott, coercion, or intimidation. Some critics claim that the exemption is a source of potentially anticompetitive behavior in health insurance. Criticisms of health insurers escalated early in 2010 with the highly publicized proposed “39 percent” rate increase in California by WellPoint’s Anthem subsidiary. The adverse publicity and attention brought to this issue by the Obama
administration arguably resurrected health care reform legislation following its apparent death after the election of Senator Scott Brown (R-Mass.). The average proposed rate increase for Anthem was 25 percent, with some increases as high as 39 percent. An independent actuarial analysis later indicated errors in the rate filing that overstated the needed rate increase by about 10 percentage points. The company subsequently implemented a 14 percent increase, arguing that the lowered individual market rates in California would cause it to lose $150 million over the next year.

Preexisting Conditions. Health insurers’ underwriting and risk-classification practices represent a second source of widespread criticism. When permitted by law (and when cost-effective), insurers consider the applicant’s health when deciding whether to provide coverage and on what terms. Applicants with preexisting health conditions face higher-than-average premiums and more limited coverage (or are not offered any coverage). While state and federal law generally require insurers to offer coverage to people who have previously been insured for minimum periods of time, federal law and most states allow rates to reflect the person’s health status.

People who develop costly preexisting conditions at a young age may face high premiums or limited coverage in the individual market. People with preexisting conditions who lose employer-sponsored coverage and exhaust their ability to continue coverage under federal and state law may face high individual market premiums and/or exclusion of coverage for one or more preexisting conditions. While the number of people who are uninsured because of preexisting conditions, termination of insurance after job loss, or exhaustion of continuation-of-coverage benefits is not known, those circumstances are widely regarded as problematic.

Policy Rescissions and Claims Practices. Traditional practice in pricing, underwriting, and risk classification, governed by common law, statute, and regulation, is for insurers to rely on accurate disclosure of health-related information by applicants without conducting a detailed investigation of medical history. Companies often practice ex post auditing—conducting detailed and costly reviews of a subset of applications following policy issue—sometimes when patients seek expensive treatment soon after issue. State laws before the PPACA permitted rescission of coverage on the basis of material misrepresentation by the applicant, that is, providing incorrect information that affected the insurer’s decision to offer coverage or the premium charged. Thus, while coverage could not be canceled because someone became ill, it generally could be rescinded if information provided by the applicant was false and affected the insurer’s decision.

During the past few years leading up to the PPACA, health insurance rescissions generated substantial controversy, litigation, and, in some states, new regulation, and they played an important role in the health care reform debate. The Subcommittee of Oversight and Investigation of the House Committee on Energy and Commerce held hearings to highlight questionable rescission practices during June and July 2009. As in his earlier New York Times article and speeches, President Barack Obama asserted in his health care speech before a joint session of Congress in September 2009, “More and more Americans pay their premiums, only to discover that their insurance company has dropped their coverage when they get sick, or won’t pay the full cost of care. It happens every day.” Along with the controversy over preexisting-condition exclusions, the controversy over rescission, and to a lesser extent general claims settlement, contributed to an impression that health insurers’ practices were insufficiently and ineffectively regulated.
PPACA’s Regulatory Program

In addition to the PPACA’s individual mandate, premium and cost-sharing subsidies, creation of exchanges, and community-rating requirements, beginning in 2011 health insurers must spend an amount on medical costs and activities to improve health care quality equal to a minimum of 85 percent of premiums (net of certain taxes) for large-group coverage and 80 percent of premiums for individual and small-group coverage, or pay rebates to achieve those minimums. The PPACA also requires states to have a process for reviewing “unreasonable” rate increases and requires health insurers to justify unreasonable increases to the states and the Department of Health and Human Services (HHS). Health insurers with unreasonable increases may be excluded from the exchanges. Once the exchanges are running, insurers will be required to justify unreasonable rate increases for polices sold within and outside the exchange. The law also prohibits rescissions unless the insurer can prove fraud or intentional misrepresentation of a material fact (or for nonpayment of premiums), and it requires internal and external review procedures for coverage and claim disputes.

Increased Cost Pressure

The general consensus and projections by the Congressional Budget Office and other entities is that the coverage-expansion provisions of the PPACA will increase health insurance costs and premiums. The PPACA’s coverage provisions that have taken effect—prohibiting preexisting-condition exclusions for children, requiring coverage of enrollees’ adult children up to age twenty-six, restricting annual and lifetime benefit limits, and restricting rescissions—have contributed to proposed rate increases and caused some insurers to restrict access to or withdraw product offerings (such as child-only policies).

On one hand, the law’s excise tax on high-cost health plans will have only a modest effect on incentives for middle- and high-income workers to obtain generous health benefits and attendant incentives to use low-valued medical care, given both the relatively high thresholds for the tax and its deferral to 2018. On the other hand, the minimum coverage requirements and permissible benefit tiers will require many people to buy more complete coverage than currently is chosen in the individual market, and they could discourage the expansion of high-deductible plans, likewise increasing utilization and costs. In general, the PPACA’s requirements of guaranteed issue without preexisting-condition exclusions at rates that do not reflect health status rely on the individual mandate to produce balanced risk pools. But the modest financial penalties for violating the coverage mandate could produce significant adverse selection, where many lower-risk people fail to buy coverage unless they get sick, further increasing costs. Higher costs in turn will
increase pressure to expand health insurance regulation to limit premium increases.

**Misdiagnosis of Market Problems**

The PPACA’s health insurance provisions will require an enormous increase in regulation, associated bureaucracy, and risk of unintended consequences. The specific effects of the MLR requirements, rate-review provisions, and market-conduct provisions are elaborated on in sections IV, V, and VI. The overall approach embodied in these rules reflects a misdiagnosis of the causes of high health insurance costs and significant exaggeration of problems that proponents imagine can be addressed effectively by increased regulation.

**Administrative Expenses and Profits.** Much of the criticism of insurers’ administrative expenses and profits is inconsistent with their magnitude and functions in meeting the demand for coverage. According to National Health Expenditure (NHE) data, the projected “net cost” of private health insurance (premiums less benefits, including for self-funded plans) for 2010 was $96 billion, representing 11.6 percent of the $830 billion of projected expenditures for private health insurance and 3.7 percent of the $2,570 billion in projected total health care expenditures.18

Using NHE data, the estimated ratio of private health insurance medical benefits to total premiums (including self-funded plans) has averaged 87.7 percent since 1965, with little or no trend (see figure 1).19 Data from a variety of other sources indicate that health insurers’ profit margins (net income to revenues) typically average about 3 percent (less for nonprofits). Health insurers’ MLRs for insured plans average roughly 85 percent (higher for nonprofits than for-profits), and administrative-expense ratios average about 11 to 12 percent.20 Overall expense and profit-margin data for insured (as opposed to self-funded) health plans reported to state insurance regulators indicate that MLRs ranged from 85 to 88 percent for all types of insured health coverage (including Medicare Supplement and Medicare Advantage plans) and from 83 to 87 percent for comprehensive major medical coverage during 2006–2009.21 Thus, the aggregate data clearly belie the notion that health insurance market expenses and profits are a major driver of high and rapidly growing health insurance premiums.

Insurers’ administrative expenses go toward marketing, provider and medical management, account and member administration, general overhead, and state premium taxes (which average about 2 percent of premiums).22 As explained below, administrative-expense ratios and MLRs can vary widely across insurers in relation to numerous factors.23 Instead of analyzing the sources and functions of varying expense levels, proponents of much tighter regulation and a public-plan option for health insurance commonly compare private insurance to Medicare, for which reported administrative expenses are about 1.5 percent of costs in the fee-for-service program.24 The low expense ratios for Medicare reflect a number of differences from private plans,25 including much higher per-capita claim costs for Medicare, which reduce administrative expenses as a proportion of total costs, and exclusion of general overhead, enrollment, and billing costs.26 Traditional Medicare does
not negotiate with providers, engage in medical management, spend much to reduce fraud and abuse, or incur the state premium taxes or regulatory compliance costs incurred by private insurers.

**Market Structure and Competition.** While relatively high at the state and metropolitan levels, health insurance market concentration varies widely across states and is much lower when measured at the national level.\(^{27}\) Based on data reported to insurance regulators, for example, the top five health insurers writing individual comprehensive major medical insurance covered 4.1 million out of 10 million covered persons nationwide in 2009, representing 41 percent of the market.\(^{28}\) The largest insurer’s market share (WellPoint) was 21 percent; the second-largest insurer’s share (HCSC, a mutually owned Blue Cross Blue Shield entity) was 8 percent.

Relatively high market concentration does not necessarily imply adverse effects on consumers. Health insurance market concentration at both the state and local levels is highly correlated with the market shares of Blue Cross Blue Shield plans,\(^{29}\) which in many cases are nonprofit and operate with high MLRs and very low profit ratios, making it difficult for other insurers to gain market share.\(^{30}\) Nonprofit Blue Cross Blue Shield entities in many states have tax advantages compared with for-profit firms. Nonetheless, large national insurers would be expected to expand in concentrated states if large regional insurers had excessive profits or excessive administrative expenses. Moreover, although often concentrated, the individual and small-group markets in most states still offer many buyers a choice among numerous insurers with smaller market shares, as well as one or more nonprofit insurers.

Some states’ restrictive regulations of health insurance underwriting, rating, and benefits discourage entry of new insurers and expansion of existing insurers. Apart from regulatory impediments, the extent and scope of economies of scale or other entry barriers at the state and local levels are not clear. Effective entry and competition often depend on the ability to use relatively large provider networks and achieve sufficient scale to contract effectively with hospitals and physicians. In many markets, insurers are able to contract with and use the services of large medical service organizations as an alternative to incurring the potentially large upfront costs of developing such networks from scratch.

Consolidation in many health insurance markets has increased market concentration. But it also has coincided with consolidation of hospitals and hospital-provider networks, in some cases increasing insurers’ ability to negotiate favorable rates with providers, and in other cases the opposite, depending on each side’s relative bargaining leverage.\(^{31}\) Assessments of the magnitudes and implications of market concentration also should consider that over half of the employer-sponsored health insurance market is self-funded. Concentration data for enrollees in HMOs and preferred-provider organizations tabulated by the American Medical Association include enrollees in self-funded employer plans in which insurers receive modest servicing fees. Employers generally choose among insurers and numerous third-party administrators for accessing provider networks and claims administration. However, some other insurance-market-concentration estimates do not reflect the share of the actual and potential market involving noninsurance third-party administrators. Larger employers also have the option of administering their own benefits. Third-party administrators and employer self-funding and administration in general represent significant sources of competition for insurance companies in the employer-sponsored market, except for small-group coverage.

**The Antitrust Exemption.** Until 2009, debate over the efficacy of the antitrust exemption for the “business of insurance” focused almost entirely on property and casualty insurance, including medical malpractice liability coverage, and specifically on the role of property/casualty insurance rating organizations, which collect and analyze data on property and casualty insurers’ loss costs, forecast loss development, and disseminate loss-cost projections for hundreds of rate classes in different states. Depending on state law, property and casualty insurers can incorporate those forecasts in their ratemaking. In principle, this system
increases forecast accuracy, thus improving financial stability, and it reduces entry barriers that otherwise would confront small insurers or insurers entering new markets. Cooperative production and distribution of loss-development and loss-cost projections, as opposed to simply sharing historical data, would be unlikely to withstand antitrust scrutiny.

The recent debate about the exemption’s potential anticompetitive effects in health insurance has paid little attention to the exemption’s history and operation. Allegations that large health insurers engage in monopolistic practices while enjoying protection from antitrust laws reflect little understanding of how the exemption actually works and the types of activities it permits. The Supreme Court has interpreted the “business of insurance” narrowly, only encompassing activity that spreads and transfers policyholders’ risk, is integral to the insurer-policyholder relationship, and is confined to entities in the insurance industry. The antitrust exemption does not apply, for example, to insurers’ relationships with medical care providers.

Unlike property and casualty insurers, health insurers do not use services from rate advisory organizations in the estimation of medical claim loss development or projection of future claim costs. Instead, many health insurers and self-funded employers retain the services of independent actuarial consulting firms. There appears to be no evidence that the exemption has impeded health insurance competition or contributed to higher costs, premiums, or profits. Nor is there any evidence that it has contributed to higher market concentration. Health insurer mergers have been subject to federal antitrust jurisdiction, review, and challenge since at least the early 1970s. Mergers and acquisitions of health insurers are also subject to approval by state regulators.

As noted, the exemption does not protect health insurers’ contracting practices with providers, such as the inclusion of “most favored customer” clauses in contracts with hospitals. The Department of Justice filed suit in October against Blue Cross Blue Shield of Michigan, alleging that its negotiation of such agreements with many Michigan hospitals constituted illegal exclusionary behavior in violation of federal law. Although the suit is the Department of Justice’s first challenge of such agreements since the 1990s, they are not protected by the exemption.

**Rescissions and Claims Practices.** The scope of abusive trade practices in health insurance has been greatly exaggerated. It appears that a major objective of the 2009 hearings on rescission practices by the House Subcommittee of Oversight and Investigation was to demagogue health insurance with heart-wrenching testimony by unfortunate victims to generate political support for passage of the broader health care reform legislation before Congress. Going behind the curtain, congressional staffers’ analysis of 116,000 pages of documents from three large health insurers identified a total of about twenty thousand rescissions from several million policies issued by the insurers over a five-year period. Company representatives testified that less than one-half of 1 percent of policies were rescinded (less than 0.1 percent for one of the companies).

Although the rate would certainly be higher among new customers and for new customers that submit large claims, the cases highlighted at the hearings (and subsequent mischaracterizations by the media and the president) fall short of demonstrating the purported systematic and heinous abuse. Congressional staffers highlighted thirteen individual cases, which presumably were among the most egregious. Five of the thirteen cases involved legal rescissions based on misrepresentation or concealment of a condition unrelated to medical claims for which reimbursement was sought. Two cases involved rescission of family coverage based on misrepresentation by the applicant; two involved misrepresentation by the applicant’s health insurance agent. Other examples included a physician misdiagnosis and a diagnosis not disclosed to the patient. One applicant who had previously been treated for Barrett’s Esophagus, a painful and serious condition, did not disclose any “stomach or ulcer symptoms.” Coverage was ultimately reinstated by the insurer in at least five of the thirteen cases.

Allegations that insurers routinely deny, dispute, or delay claims mischaracterize what occurs in the vast majority of tens of millions of claims each year, as is demonstrated by complaint data collected...
and reported online in California and other states. The point is not that abuses and mistakes do not occur; it is that attacks on private health insurance as anticonsumer have been disproportionate to the existing problems. The attacks also largely ignore substantial incentives for fair dealing by health insurers. Like other businesses, health insurers seek to attract and retain customers, including medium and large employers, who in turn must compete to attract and retain qualified employees with salaries and health insurance that pays valid claims. In addition, critics pay little attention to existing state systems of market-conduct regulation and administrative remedies for claims disputes, and the fact that health insurers, especially large ones, face the risk of costly lawsuits—including class actions and large punitive damages—if they engage in abusive practices.
Most states’ minimum MLR rules are designed to deter coverage from being offered where a large proportion of premiums (30 to 35 percent) goes toward administrative expenses and profits rather than medical expenses. The goal is to establish a minimum floor to deter aberrant players from selling low-valued products to unsophisticated buyers. Section 2718 of the PPACA, “Bringing Down the Cost of Health Coverage,” reaches considerably beyond that important and achievable objective.

Section 2718 requires health insurers beginning in 2011 to provide rebates to customers to the extent that the sum of reimbursements “for clinical services” and expenditures “for activities that improve health care quality” to the “total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees)” is less than:

(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary [of HHS] may adjust such percentage with respect to a State if the Secretary determines that the application of the 80 percent may destabilize the individual market in such State.

The PPACA’s requirements differ from existing state MLR requirements, given the inclusion of expenditures to improve quality in the numerator and exclusion of certain taxes in the denominator. However, depending on the final regulations approved by the HHS for calculating and applying the minimums (see below), the requirements will likely be significantly higher than most state minimums. Rather than representing a basic safeguard, they are designed to constrain and modify insurers’ behavior based on proponents’ views on how private health insurance markets should work.

The PPACA’s MLR requirements will not promote the availability of affordable health insurance. They will necessitate costly and bureaucratic enforcement and compliance with adverse effects on the supply of coverage. Apart from apparently being designed to constrain some companies in some markets without wreaking complete havoc, the specific thresholds are not based on economic analysis of what constitutes a reasonable level in view of the economics of providing coverage under diverse conditions of supply and consumer preferences.
Traditionally calculated MLRs—ratios of incurred medical costs (insured losses) to premiums—vary widely across insurers, markets, and plans. For example, according to calculations in an April 15, 2010, majority staff report by the Senate Office of Oversight and Investigations to Commerce, Science, and Transportation Committee chairman Jay Rockefeller (D-WV.), the nationwide MLR for comprehensive major medical coverage in the individual market in 2009 was 73.6 percent for the six largest publicly traded insurers, ranging from 70.5 to 88.1 percent across the insurers.37 For the small-employer market, the overall MLR was 81.2 percent with a range of 78.2 to 92.1 percent. For the large-employer market, the overall MLR was 85.1 percent with a range of 83.3 to 88.2 percent. Among fourteen (of twenty-four) WellPoint subsidiaries with individual market premiums of at least $50 million in 2009, MLRs varied from a low of 62.9 percent to a high of 95.2 percent. MLRs for WellPoint subsidiaries in the small-employer market exhibited qualitatively similar variation. Variation in MLRs was also significant, although less pronounced, among WellPoint’s subsidiaries writing large-group coverage.

The PPACA’s minimum MLR requirements are too high and too prescriptive. They are based on the ideological notion that certain types of expenses are “good” and other types of expenses are “bad,” with the ultimate assessment depending to a great degree on political influence. The requirements reflect the false premise that a higher MLR (lower margin for other expenses and profits) necessarily implies better value for consumers. While that might be true holding equal premiums, quality of care, services, and availability of coverage, those factors generally are not equal. A given consumer, for example, could easily prefer coverage with more cost sharing, tighter utilization review, and a lower expected MLR to more generous coverage with a higher expected MLR and much higher premium (or to not being able to find any coverage).

The NAIC’s Proposed Regulations

The NAIC was charged by section 2718 to develop definitions and methodologies for implementing the minimum MLR and rebate system. Proposed regulations were approved unanimously by the NAIC and submitted to the HHS on October 21, 2010.38 HHS Secretary Kathleen Sebelius issued a statement indicating that HHS would “issue a medical loss ratio regulation that will provide clear guidance to stakeholders in the coming weeks” and “work quickly to promulgate this regulation, using the NAIC recommendations as a basis.”39

The NAIC’s proposed regulations are complex, consisting of forty-one pages of text and forms, including four pages of definitions. Seven pages of text define activities that improve quality for calculating the numerator of the ratio. Two pages describe taxes, regulatory assessments, and fees that can be deducted from premiums to calculate the denominator (a deduction for federal taxes on investment income and capital gains is not permitted).

The regulations propose the following regarding expenses on activities to improve quality:

- Expenses to improve health care quality generally include those “for all plan activities that are designed to improve health care quality and increase the likelihood of desired health care outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. . . . They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality.”

- Qualifying quality-improvement activities are those primarily designed to (1) improve health outcomes and reduce health disparities among specified populations; (2) prevent hospital readmissions; (3) improve safety, reduce medical errors, and lower infection and mortality rates; (4) increase wellness and promote health activities; and (5) enhance the use of health care data to improve quality, transparency, and outcomes.

- Specific exclusions from qualifying activities include expenses for (1) retrospective and concurrent utilization review; (2) fraud prevention, with the exception of “detection/recovery
expense up to the amount recovered that reduces incurred claims”; (3) developing and administering provider contracts, networks, and credentialing; (4) marketing; (5) accreditation (for example, insurers’ expenses for identifying qualified providers); and (6) calculating and administering individual enrollee or employee incentives.

The NAIC proposal stipulates that MLRs and rebates be calculated at the licensed-entity level within a state, as opposed to allowing aggregation across affiliated entities. This increases the likelihood of rebates and market disruptions compared with allowing aggregation, and it would provide an incentive for firms to consolidate affiliates into fewer entities.

The regulations specify “credibility adjustments” to decrease the minimum MLR requirement for smaller plans for which claim experience is subject to greater statistical variation. The term “credibility” refers to the statistical reliability of an insurance pool’s claims experience. Other things being equal, a larger number of enrollees in a plan reduces statistical variation in medical costs, thus producing a more stable MLR. The credibility adjustments make it less likely that plans with small numbers of enrollees would have to make rebates in years in which their loss ratios were lower than the minimums due to chance (but without the ability to surcharge premiums when random experience causes their loss ratios to be higher than expected).

In a letter to the NAIC, the American Academy of Actuaries expressed concern that NAIC’s proposed credibility adjustments could be too small, increasing the likelihood of market disruption. Moreover, and beyond the credibility-adjustment issue, minimum MLR requirements in conjunction with statistical variation in medical-claim costs will inherently exert upward pressure on some insurers’ premiums. As long as there is some chance that an insurer will have to pay rebates as a result of unexpectedly low medical costs, its expected MLR will be higher than the original target, and it therefore will need to charge somewhat higher premiums to expect to achieve that target MLR level.

Consider, for example, an individual market insurer with a target MLR of 82 percent, producing an 18 percent (100 percent minus 82 percent) target margin in premiums to cover nonmedical expenses and provide a reasonable expected profit, with a credibility-adjusted minimum MLR of 79 percent. Given those assumptions, as long as there is some chance that the insurer’s MLR before any rebates will fall below 79 percent due to chance variation in medical costs, the requirement to pay rebates will cause its expected MLR net of any rebates to rise above the 82 percent target. To achieve that target, it therefore would need to increase premium rates, which in turn would increase the chance that it would have to pay rebates. Assuming that the insurer could charge high enough premiums to stay in business and achieve the 82 percent target, its policyholders would end up paying higher upfront premiums because of the law’s legal entitlement for them to receive risky rebates at the back end. The insurer’s expected MLR would still be 82 percent, but upfront premiums would be higher and policyholders’ risk would be greater because of uncertainty concerning rebates.

The NAIC’s proposed credibility adjustments to the minimum MLRs are greater for plans with higher average deductibles in view of greater volatility in medical claims for such plans. However, the regulations apparently include no adjustments to reflect that plans with higher average deductibles tend to have lower MLRs because nonclaim expenses grow at a slower rate than expected medical reimbursement. As a result, some entities that specialize in high-deductible or other high-cost-sharing plans could find it difficult or impossible to meet the minimum MLR requirements.

The NAIC proposal represents a political and practical compromise after extensive debate and lobbying by health insurers, insurance agents, providers, and consumer groups, including participation by consumer representatives in key committee discussions. Even apart from the potential effects on plans with high cost sharing, and although constrained by its charge and the broader political context in which it was approved, the proposal is remarkable for its emphasis on allowing expenses that increase total health care costs and premiums to be included in the MLR calculation, while largely excluding expenses that help reduce health care costs and premiums.
Market Disruption

There is concern that implementation of section 2718 will disrupt markets in many states, especially in the individual market. Insurance commissioners in Maine and Iowa have requested waivers from the 80 percent requirement for individual health insurance. On October 13, 2010, the NAIC leadership wrote Secretary Sebelius indicating the need for a transition period for implementation and expressing concern over factors that could destabilize markets, including the potential effects on insurer solvency, the number of insurers marketing products, consumers’ ability to find easily affordable products should their carrier leave the state market, benefits and cost sharing of existing products, premiums paid by current policyholders, and consumers’ access to agents and brokers. The letter requested deference from the secretary when considering requests for state waivers. The NAIC’s October 21 submittal letter for the proposed regulations reiterated the request for deference and concern with potential market disruptions.

One-Size-Fits-All or Byzantine Regulation

The choice among implementation methods and definitions for the MLR requirements ranges from adopting relatively simple, one-size-fits-all rules, which would produce serious market disruptions and harm consumers, to adopting elaborate rules that attempt to reflect legitimate differences across diverse sellers to reduce undesirable distortions, but with unavoidable complexity, bureaucracy, potential for gaming, and costly compliance and enforcement. Although the NAIC draft leans toward one-size-fits-all, it nonetheless would also result in significant complexity, bureaucracy, potential for gaming, and costly compliance and enforcement.

Given that section 2718’s underlying premise is false, any politically acceptable system of implementation will be problematic. The MLR debate is fundamentally about extensive top-down government control over health insurers versus free markets operating within a pro-competitive regulatory regime. If the NAIC had proposed substantially more flexibility and recognized the desirability of cost control, it would have been slammed by consumer advocates and other interest groups for caving in to the health insurance industry.

Expenses on activities that improve quality notwithstanding, variation in MLRs arises from numerous sources that need bear no relationship to market power or inefficiency, including the following:

1. Chance statistical variation and errors in forecasting medical-cost growth. Statistical variation in medical claims diminishes, but is not eliminated, as the number of enrollees in a plan increases. Allowance for statistical variation and forecast errors is necessary to avoid disadvantaging small insurers and forcing insurers to pay rebates when experience is favorable, without the ability to recoup losses when experience is unfavorable. As noted above, it is not clear that the NAIC proposes sufficiently large credibility adjustments.

2. Differences in the average number of enrollees in a plan. Because insurers’ nonclaim expenses for writing group coverage increase less than proportionately with the number of enrollees, MLRs on average will be lower for insurers that on average write coverage for smaller employers and smaller employers within the small-group category. This favors more distinctions than the PPACAs two categories (individual or small group and large group).

3. Differences in medical-care costs across regions or customer groups within a region. Because insurers’ nonclaim expenses increase less than proportionately with the number of enrollees, nonclaim expenses as a percentage of premiums will tend to decline and MLRs will tend to increase with average medical costs per enrollee in a given region.

4. Differences in average deductibles and cost sharing. Policies with larger deductibles and other forms of cost sharing tend to have lower MLRs because nonclaim expenses increase less than proportionately with the average indemnity per enrollee.
5. **Differences in expenditures on fraud detection and prevention and on utilization review and management.** Unless included in the numerator of the MLR, greater expenditures to reduce fraud or utilization of low-valued care tend to reduce the MLR even if they lower premiums and benefit consumers.

6. **Differences in the use of managed care and the types of contracts with providers.** Depending on the forms of contracts and payments with providers, insurers have different amounts of payments categorized as in-house administrative expenses versus those categorized as payments to providers for medical care.47

7. **Differences in marketing costs, including compensation to agents.** Different distribution systems provide different types and levels of service, with different expense structures and corresponding effects on MLRs.

8. **Differences in customer turnover.** Sales-related expenses are generally higher when a customer is first insured than when the customer renews coverage. Greater turnover of customers tends to produce higher average sales costs and lower MLRs, other things being equal. (This source of variation would likely diminish, assuming full implementation of the PPACA's mandate and guaranteed issue and rating rules in 2014.)

9. **Differences in maturity of customer portfolio.** When coverage is medically underwritten, medical claims experience generally is favorable in the early years of coverage and worsens over time. Moreover, with guaranteed renewable coverage, premiums are commonly relatively high in early years to help limit premiums in later years.48 As a result, companies with different mixes of new and renewal business will have different MLRs. (This source of variation would also likely diminish assuming full implementation of the PPACA in 2014.)

10. **Cyclical variation over time in average premium rates.** Although the causes are not fully understood, health insurance markets have historically exhibited periods of declining MLRs followed by periods of increasing MLRs.

11. **Differences in reporting procedures.** Insurers differ in their practices for estimating reserves for incurred but unpaid medical claims. More conservative estimates increase reported costs of incurred medical claims and MLRs.

12. **Differences in corporate structure.** Insurers vary in the extent to which distinct health plans with different expense structures and expected MLRs are offered by separate corporate subsidiaries, as opposed to being offered through divisions within a single entity. Other things being equal, the NAIC proposal for MLR and rebate calculations at the licensed-entity level favors the latter strategy over the former.

13. **Difference in taxes.** An inability to exclude certain taxes on investment income will depress the NAICs proposed MLRs for firms that generate more investment income in relation to premiums. Other things being equal, insurers that hold more invested assets to provide financial security to policyholders need a higher pretax profit margin and thus lower MLR to compensate for corporate taxes on investment income. At the margin, the disallowance of such taxes works against firms that provide more security to policyholders.

### Incentives and Innovation

The MLR rules that HHS adopts will necessarily provide some incentive for insurers to classify and allocate expenses to “improve” their ratios. Critics will attack such activities as attempts to game the system and defeat its asserted pro-consumer ends. Far more important, the minimum MLR requirements will distort insurers’ incentives for legitimate business decisions, and the implicit limits on profits in minimum MLR regulation will retard innovation.

It is desirable for health insurers to invest in innovation to develop new coverage arrangements, more cost-efficient provider networks, and information
systems to guide consumer choice, including evidence on medically effective and cost-efficient care. Such investment requires upfront expenditures with a reasonable expectation of earning at least fair returns over time from insured plan premiums and from administrative fees for servicing self-funded plans. The percentage of an insurer’s premiums available for nonmedical expenses (including taxes) and profits equals 100 percent minus the MLR. A minimum MLR requirement therefore places a maximum (a “cap”) on the percentage of premiums available for nonmedical expenses and profits. The lower the cap on nonmedical expenses and profit, the lower the potential for profit, and the less incentive there is for innovation. Thus, by reducing the potential returns from investment, the PPACA’s minimum MLRs will deter innovation, especially in an environment of substantial uncertainty associated with the overall law.49

In addition, the MLR requirements in section 2718 could encourage some insurers to enter into arrangements that shift more administrative functions to provider groups, and they could cause some plans to contract with narrower provider networks. The requirements will discourage some coverage designs that could lower premiums but involve relatively high nonclaim costs in relation to insured benefits, such as high-deductible plans. They will discourage potential innovations in coverage design and managed care that might require a lower MLR in conjunction with lower premiums and better overall value for buyers.

**Mandatory Public Reporting of MLRs**

Section 2718 also requires regulators to develop systems for publicly reporting insurers’ MLRs to assist consumers in identifying high-value coverage.50 Given the complexities described above, the development of a system at the insurer level to provide reliable and meaningful information on MLRs to guide consumers’ decisions is exceedingly unlikely. To promote informed competition for consumers, public provision of (or guidance to) information should focus on key attributes that affect value to consumers, including covered benefits, required premiums, cost sharing, access to providers, quality of claims administration, and the insurer’s financial strength.

Given information on those attributes, data on an insurer’s MLR in a state will not provide reliable information to enhance a consumer’s ability to make an informed decision, including helping the consumer to evaluate tradeoffs between the attributes (for example, higher premiums with lower cost sharing versus lower premiums and greater cost sharing). Promulgating MLR metrics will instead provide consumers with unreliable, confusing, and potentially misleading information.
Section 2794 of the PPACA, “Ensuring that Consumers Get Value for Their Dollars,” stipulates:

(a) Initial Premium Review Process-

(1) IN GENERAL- The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

(2) JUSTIFICATION AND DISCLOSURE- The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

(b) Continuing Premium Review Process-

(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS- As a condition of receiving a grant under subsection (c)(1) for rate review, making recommendations to the Secretary, and stimulating creation of research data, a State, through its Commissioner of Insurance, shall—

(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

(2) MONITORING BY SECRETARY OF PREMIUM INCREASES-

(A) IN GENERAL- Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

These provisions fall short of requiring prior approval of rate changes by state or federal regulators. Subsequent legislation introduced by Senator Diane Feinstein (D-Calif.) would require prior approval. A variety of consumer groups and advocates have recommended that the PPACA’s rate review provisions be implemented with elaborate, public-utility-style regulation with regulatory authority to approve rates.\textsuperscript{51}
Even without formal prior-approval regulation, the PPACA’s provisions requiring justification of “unreasonable” rate increases and publication of information about such increases under threat of exclusion from the exchanges creates a de facto environment of federal authority over rate increases both inside and outside of the exchanges. Following announcements of rate increases by a number of health insurers—which insurers attributed in part to provisions of the PPACA regarding restrictions on rescissions, benefit limits, and coverage for dependents up to age twenty-six—Secretary Sebelius explicitly threatened exclusion from exchanges in a September 9 letter to AHIP, stating:

Later this fall, we will issue a regulation that will require state or federal review of all potentially unreasonable rate increases filed by health insurers, with the justification for increases posted publicly for consumers and employers. We will also keep track of insurers with a record of unjustified rate increases: those plans may be excluded from health insurance Exchanges in 2014. Simply stated, we will not stand idly by as insurers blame their premium hikes and increased profits on the requirement that they provide consumers with basic protections.

The PPACA and the administration’s politicization of health insurance rate making, recent rejection by the Centers for Medicare and Medicaid Services of proposed rate increases for a number of Medicare Advantage plans, and earlier blanket rejections by Massachusetts’s insurance regulators of proposed health plan rate increases (followed by negotiated increases with most plans) are a foretaste of what could become commonplace under the PPACA. The rate-review provisions will not improve consumers’ choices, increase quality, or lower costs. They will instead increase insurers’ risk, reduce the availability of coverage and consumer choice, undermine insurers’ financial strength, and increase pressure for even tighter regulation and enactment of a public-plan option. They also bifurcate regulatory authority (or influence) on solvency and rate levels. State regulators have a direct concern with rate adequacy as a means to enhance insurers’ solvency. The PPACA’s rate-review provisions shift some authority for reviewing, monitoring, and influencing rate changes to the HHS, without corresponding responsibility for solvency.

The direct costs of administering and complying with prior-approval rate regulation are ultimately borne by consumers.

The adverse consequences of prior-approval rate regulation and the politicization of insurance rate making have been demonstrated by decades of experience with state regulation of rates for auto insurance, workers’ compensation insurance, and, more recently, homeowner’s insurance in catastrophe-prone regions. The evidence indicates that insurance rate regulation cannot be used to lower average rates without producing significant reductions in quality of coverage, reduced coverage availability, and larger residual markets (such as auto insurance assigned-risk plans), or exit by significant numbers of insurers.

The direct costs of administering and complying with prior-approval rate regulation are ultimately borne by consumers. It produces delays in adjusting rates to trends in losses and expenses. It also produces greater variation over time in insurers’ profitability and willingness to offer coverage and expand to meet growing demand. It has sometimes led to inefficient nonprice competition and slower expansion or even exit of efficient firms. The rate-approval process in some states and time periods has been costly, lengthy, and periodically biased toward rate suppression with associated distortions in supply that harm consumers. Regulators must evaluate loss and expense components of rate filings and determine allowable profit. The substitution of regulatory benchmarks for management judgment in forecasting claim costs and determining “necessary” expenses and profit at best constitutes regulatory micromanagement. Allocating
regulatory budgets to rate regulation reduces the ability of regulators to address other areas, such as insurer solvency or provision of information to enhance competition, where regulation is more likely to benefit consumers.

More important, increased uncertainty about the rate levels that will be permitted by regulators increases insurers’ risk and the amount of capital and premium rates needed to prevent an increase in insolvency risk. At the same time, the threat of regulatory rate suppression reduces incentives for insurers to commit capital to provide financial security to policyholders and otherwise support the sale of coverage. The likely results include both higher prices (to the extent achievable) and increased insolvency risk.

Despite its self-defeating consequences, regulatory rate suppression in the face of high and rapidly growing costs can be politically popular before regulation’s adverse effects become apparent. While ultimately unsustainable, politically motivated rate suppression through prior-approval requirements or related regulation provides incentives for insurers to reduce service, restrain growth, and ultimately withdraw from a market. Despite insurers’ prior investments in building infrastructure and customer bases, persistent regulatory rate suppression that cannot be offset by cost savings from reduced services or other quality reductions will eventually produce widespread exit. In the 1980s and early 1990s, for example, significant numbers of insurers exited the auto insurance market in several states, including Massachusetts, New Jersey, and South Carolina. Some workers’ compensation insurers withdrew from states with unfavorable regulatory climates during the late 1980s and early 1990s.

Regarding rate regulation’s impact on rates, many studies have compared loss ratios, most often for auto insurance, in states with and without prior-approval regulation to examine whether prior approval affects average rate levels in relation to claim costs. The analyses indicate that short-run regulatory suppression of rates in some states and periods resulted in higher auto insurance loss ratios in states with prior-approval rate regulation (for example, during the mid-to-late 1970s and early 1980s). As noted above, a significant number of insurers exited the auto insurance market in states that persistently impeded their ability to charge adequate rates to cover insurance claims.

However, consistent with an inherent inability of prior-approval regulation to reduce insurance rates in the long run, studies have found no persistent difference over time between loss ratios in states with and without prior-approval laws. For example, I analyzed automobile insurance loss ratios, residual market shares, and volatility of premium growth rates by type of rate regulation with annual data by state for the period 1972–98. The estimated average difference in loss ratios between states with and without prior-approval regulation was positive but negligible in magnitude, primarily attributable to the 1970s, and at most weakly significant in a statistical sense (see figure 2 for mean loss ratios by type of regulation by year). Consistent with other studies, I found that prior-approval regulation was persistently
and reliably associated with larger residual market shares (less availability of coverage), even when dysfunctional states with the largest residual market shares were excluded from the comparison. Moreover, prior-approval regulation was reliably associated with greater risk in the form of greater volatility in loss ratios and premium growth. There is no reason to believe that prior-approval regulation or political management of health insurance rate changes would be any different.
Rescission Restrictions and Mandatory Appeal Processes

The PPACA’s “prohibition” of rescissions was used as a key selling point to the public by proponents of the health insurance reform agenda. Section 2712 requires that:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

This blanket rule trumps state statutory and common law to address problems that could have been addressed at the state level. As discussed earlier, traditional practice in underwriting and pricing, governed by states’ common law, statutes, and regulations, has been for insurers to rely on accurate disclosure by applicants without conducting a detailed investigation of medical history, with more detailed and costly reviews of a subset of applications following policy issue—sometimes when patients seek expensive treatment soon after issue. This system lowers underwriting costs and premiums compared to more intensive upfront verification, or to paying all claims regardless of the accuracy or legitimacy of disclosure.

Pre-PPACA state laws permit rescission only on the basis of material misinformation, that is, if correct information would have changed the insurer’s decision to offer coverage or the premium charged. The insurer does not have to prove intentional misrepresentation (lying), but it usually would have to prove intent and knowledge of materiality in the event of failure to disclose a known health condition (concealment) that is not asked about in the application. In the more common context of misrepresentation, requiring an insurer to prove intent will create a significant impediment to rescinding contracts based on false statements in the application. The practical effect of section 2712 in time might be minimal, if the PPACA succeeds in requiring insurers to issue coverage without preexisting-condition exclusions at rates that do not reflect health status. Until then, requiring proof of fraud or intentional misrepresentation will likely increase upfront underwriting costs, claim costs, and premiums, and it could increase denial rates—particularly before the enforcement of even a relatively weak insurance mandate for individuals that is scheduled to begin in 2014.

Section 2719 of the PPACA, “Appeals Process,” requires group health plans and individual health
insurance issuers to have an internal appeals process for coverage determinations and claims disputes that meets existing federal standards for self-funded plans, as updated by either the secretary of labor (for plans subject to ERISA jurisdiction) or the secretary of HHS (for plans not subject to ERISA). Section 2719 also stipulates that group health plans and individual health issuers have an external review process that meets or exceeds protections in the NAIC Uniform External Review Model Act or, if the state does not have the requirements or the plan is not governed by state requirements, an external review process established by the secretary of HHS. The appeal provisions essentially extend current federal and state rules and standards to the entire market. Their primary impact will be in states that currently do not have the requirements that meet the threshold in the NAIC Uniform Review Model Act.
Rather than enhancing basic consumer safeguards and promoting informed competition, the PPACA’s minimum MLR and rate-review provisions are designed to constrain and influence insurers’ behavior based on proponents’ views of how private insurance markets should work. The minimum MLR requirements will distort insurers’ incentives for legitimate business decisions and disrupt markets. The implicit limits on profits in minimum MLR regulation will retard innovation. Put simply, federally mandated minimum MLR regulations are a bad idea. Regardless of the scope of overall modifications to the PPACA, its minimum MLR requirements should be repealed. If politically infeasible, the next best (least worst) change would be to simplify and substantially reduce the minimums.

While the PPACA’s rate-review provisions fall short of requiring prior approval of rate changes by state or federal regulators, the required justification from “unreasonable” rate increases and publication of information about such increases under threat of exclusion from the exchanges creates a de facto environment of federal authority over rates. The rate-review provisions shift some authority for reviewing, monitoring, and influencing rate changes to the HHS, without corresponding responsibility for solvency. The provisions will not improve consumers’ choices, increase quality, or lower costs. They will instead increase insurers’ risk and reduce their willingness to offer coverage, reduce the availability of coverage and consumer choice, undermine insurers’ financial strength, and increase pressure for even tighter regulation and enactment of a public-plan option.

The overall goal of modifications to the PPACA or “repeal and replacement” of the law should be to increase consumer choice, sovereignty, and responsibility, which in turn would broadly expand incentives for cost control. To achieve that goal, a market-oriented agenda for replacing the PPACA should be designed to (1) change the tax treatment of health insurance to encourage cost control and expand portable, individual coverage without increasing the overall federal and state tax burden; (2) expand health savings accounts; (3) expand state-based high-risk plans and enhance portability of coverage for people with preexisting health conditions; and (4) promote informed competition and consumer choice with pro-competitive regulation and disclosure.

The fourth objective can be achieved through targeted minimum standards for state regulation as part of a broad program to replace the PPACA or targeted repeal and replacement of the PPACA’s insurance regulatory provisions. This can be done without creating a large federal bureaucracy to ride
herd on the states or trample state prerogatives. Instead, appropriate changes should rely primarily on the states and provide them with substantial flexibility to meet regulatory objectives given differences among states in consumer needs, preferences, and economic conditions, and given that local regulators can better respond to such differences. Relying to a large degree on decentralized state-level action will also help identify specific approaches that are most effective and promote some degree of regulatory competition. It will keep regulatory mistakes and possibly misguided regulatory regimes from disrupting markets throughout the country.

Regardless of the scope of overall modifications to the PPACA, its minimum medical loss ratio requirements should be repealed.

Specific recommendations for promoting informed competition and consumer choice in health insurance markets through pro-competitive regulation and disclosure follow.

1. Promote inter- and intra-state competition among financially sound health insurers

(a) To reduce potential entry barriers and enhance competition, allow a health insurer that is licensed in any state to be automatically licensed to write coverage in additional states by appropriate notification of the states’ regulators. A minimum level for such a licensing scheme would require the insurer to comply with all state regulation in each state where it writes business, including rate regulation and benefit mandates. A broader, better, and more dynamic approach, which would allow consumers in a state to choose from a different mix of regulations that lowers their premiums, would permit the insurer to designate a home state for regulation of rates and policy terms but require it to comply with solvency and market-conduct regulation in each state where it writes business.

(b) Authorize and assign the NAIC to establish minimum, essential state standards for information disclosure to assist consumer decision making. The standards should build on and leverage existing state disclosure systems. Minimum disclosure standards should focus on coverage, price, quality, and service, including consumer protections, available products and features, market shares of insurers writing health coverage in the state, summary information by the insurer on consumer complaints and their resolution, rate quotes (in conjunction with private information providers), and information on or linkage to insurer financial-strength ratings. Minimum standards should not include mandatory disclosure of MLRs, administrative-expense ratios, or profit data.

(c) Congress should authorize and fund the relevant government agency or agencies to sponsor a study of the effects of the limited antitrust exemption for the business of insurance on health insurance markets, including the extent to which current business practices could be challenged if the exemption were repealed. The study should be limited to health insurance and exclude medical liability insurance.

2. Promote pro-competitive review and oversight of rate changes

(a) Authorize and assign the NAIC to establish minimum state standards for regulatory oversight of rate changes in the individual and small-group health insurance markets. The minimum standard should consist of either a file-and-use or use-and-file system, where filings include actuarial support of rate changes and certification that the changes comply with actuarial standards and state law. With this type of minimum standard and associated administrative rules, regulators in all states would have the opportunity and information to monitor rate changes.

(b) States should be allowed to adopt or retain stricter standards, such as traditional prior-approval regulation or more flexible and targeted systems. Examples of the latter include requiring prior approval only if the
state determines that a market is not competitive (a system used in many states for some types of property and casualty insurance), or for specific categories of rate changes, such as changes in excess of statutory benchmarks or changes that encompass a material change in the insurer’s target loss, expense, or profit ratios.

3. Enhance existing consumer protections against unfair trade practices

(a) Apart from nonpayment of premiums, allow policy rescission only in the case of fraud, intentional misrepresentation of a material fact, and—at the option of the state and with suitable disclosure to applicants and provisions for administrative appeal—material misrepresentation of a medical condition for which reimbursement of care is ultimately sought, regardless of intent. That option would allow a state to permit rescissions where intent is most likely without requiring the insurer to prove that the applicant intended deception or fraud.

(b) Extend existing federal requirements for internal and external appeals of coverage and claims decisions to any group health plans not governed by state insurance regulation.

(c) Authorize and assign the NAIC to establish minimum state requirements for internal appeals for individual health insurance and group health plans not subject to federal requirements that are consistent with federal standards for self-funded plans, and for external appeals based on the NAIC Uniform Review Model Act.

Enacting this agenda would improve consumer protection and choice while promoting informed competition to make coverage more affordable and available, with much less interference in insurers’ legitimate business decisions and practices. It would require far less bureaucracy and lower administrative and compliance costs than the PPACAs’ elaborate, prescriptive, and disruptive regulations.
Notes


9. Its passage followed a 1944 Supreme Court ruling that insurance was interstate commerce and therefore subject to federal antitrust law, which cast doubt on states’ exclusive regulatory role and the legality of then-typical agreements among property/casualty insurers to use rates developed by insurance rating bureaus. Most states responded to the McCarran-Ferguson Act by enacting or modifying laws requiring prior regulatory approval of property/casualty insurance rates, thus qualifying collective rate making for the exemption. The next several decades saw a steady erosion of the role of collective-pricing systems in conjunction with increased price competition, less price regulation, and a significant narrowing of the exemption by the courts.

10. During October 2009 hearings by the Senate Judiciary Committee on possible repeal of the exemption for health and medical liability insurance, Senate Majority Leader Harry Reid testified that “exempting health insurance companies has had a negative effect on the American people” and that “there is no reason why insurance companies should be allowed to form monopolies and dictate health choices.” See Harry Reid, “Statement of the Honorable Senator Harry Reid,” Senate Judiciary Committee Hearing, Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry, 111th Cong., 1st sess., October 14, 2009, available at http://judiciary.senate.gov/hearings/testimony.cfm?id=4111&rwt_id=7320 (accessed November 9, 2010).


13. Once issued, most policies are guaranteed to be renewable at rates that change with the experience of a given risk pool rather than the health status of an individual policyholder. If policyholders that remain healthy tend to seek out new coverage and leave a given risk pool, the rates for those who remain will increase accordingly. A sizable literature has considered the extent to which guaranteed renewable coverage will be stable. Most state and federal law includes regulations that promote guaranteed renewable coverage.

14. According to AHIP survey data, the overall denial rate for the individual insurance market was 12.7 percent in 2009, ranging from about 10 percent for applicants under age thirty-five to roughly 30 percent for applicants aged sixty to sixty-four (AHIP, Individual Health Insurance 2009—A Comprehensive Survey of Premiums, Availability, and Benefits.) The extent to which applicants denied coverage were able to obtain coverage from another insurer or source is not known. The AHIP survey reported that 34 percent of offers were at higher-than-standard premium rates (29 percent of the offers were at standard rates and 36 percent were below standard rates) and that 6 percent of offers included a waiver of coverage for one or more health conditions.

15. A staff review of 68,000 pages of health insurance company documents submitted in response to a March 2, 2010, request from the House Committee on Energy and Commerce indicated that during 2007–2009, the four largest for-profit insurers had “refused to issue health insurance coverage to more than 651,000 people based on their prior medical history” in the individual market (a rate of one out of seven applicants). See Henry A. Waxman and Bart Stupak, “Re: Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market” (memo to members of the Committee on Energy and Commerce, Washington, DC, October 12, 2010), available at www.rncasemanager.com/articles/denials3.pdf (accessed November 9, 2010). The percentage of applications denied for preexisting conditions increased from 11.9 percent of applicants in 2007 to 15.3 percent of applicants in 2009. The report, which was designed to provide support for the PPACA’s prohibition of preexisting-condition exclusions, did not consider reasons for the increase, such as the possibility that increased unemployment led more people to seek individual coverage, or, as suggested in a company e-mail quoted in the report, that reduced ability to deny claims for preexisting conditions and rescind policies may have contributed. The investigation also reported that the insurers had “refused to pay 218,000 claims for medical treatment due to pre-existing conditions.” The report did not mention increases in premiums that would be required to cover preexisting conditions, especially if people are able to wait until they need care to seek coverage.


17. Premiums for policies issued outside of the exchanges will be reviewed to ensure that they are not affecting premiums for policies sold through the exchanges.


19. The NHE data report estimated premium expenditures and the estimated difference between premiums and benefits (denoted the “net cost” of private health insurance in the expenditure accounts). The ratios in figure 1 equal one minus the ratio of net cost to premiums.


22. See Douglas B. Sherlock, “Administrative Expenses of Health Plans”; and American Academy of Actuaries,

23. J. C. Robinson, “Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance.”


26. Administrative expenses generally increase less than proportionately with medical costs. As a result, insurance plans (such as Medicare) with relatively high average medical costs per enrollee (due to the high average age of Medicare enrollees) will on average have lower administrative-expense ratios than plans with lower average medical costs.

27. See Christopher J. Conover and Thomas P. Miller, “Why a Public Plan Is Unnecessary to Stimulate Competition.”


30. In his health care speech before Congress, the president pointed to Alabama as an example of high concentration. The state's largest health insurer, the nonprofit Blue Cross Blue Shield of Alabama, has about a 75 percent market share (Jeremy Gray, “Blue Cross and Blue Shield of Alabama Disputes Obama Remarks,” Birmingham News, September 9, 2009, available at http://blog.al.com/spotnews/2009/09/blue_cross_and_blue_shield_of.html [accessed November 9, 2010]). A company representative indicated that its “profit” averaged 0.6 percent of premiums in the past decade and that its administrative expense ratio was 7 percent of premiums, the fourth-lowest among thirty-nine Blue Cross Blue Shield plans nationwide. The Alabama Department of Insurance indicates that the insurer’s ratio of medical-claim costs to premiums for 2007 was 92 percent, which is higher than the national average. Another study, published in the Journal of Health Economics, found that administrative expenses accounted for 20 percent of premiums, with the remainder going to medical expenses.


32. For a review of the exemption’s history and operation in property/casualty insurance and how it differs from health insurance, see Scott E. Harrington, “An Historical Overview of the Limited Antitrust Exemption for Insurance,” Wharton School, University of Pennsylvania, November 2010.

33. The antitrust exemption did not prevent lawsuits by the AMA and New York attorney general Andrew Cuomo over allegedly flawed databases operated by Ingenix, a UnitedHealth subsidiary, and used by several major health insurance. The top insurer's market share of premiums in 2009 was 17 percent for individual health insurance, 25 percent for group health insurance, and 20 percent for HMO coverage (Missouri Department of Insurance, Financial Institutions & Professional Registration, “Market Share Report,” available at http://insurance.mo.gov/reports/mktsshr.htm [accessed November 15, 2010]). The top five insurers' market shares were 58 percent for individual coverage, 68 percent for group coverage, and 72 percent for HMO coverage. These figures are not qualitatively different from the Missouri auto and homeowner's insurance markets. The top auto and homeowner's insurer shares were 23 percent and 28 percent; the top five auto and homeowner's insurer shares were 59 percent and 64 percent.
insurers in determining reimbursement to out-of-network providers. UnitedHealth settled the cases and agreed to fund an independent database. The AMA subsequently sued Aetna and Cigna for reimbursement of alleged underpayments.

34. The Department of Justice challenged the 2005 merger of UnitedHealth Group and PacifiCare and obtained a consent decree requiring the divestiture of certain portions of the latter organization’s commercial health business for the merger to close. In 2009, the Pennsylvania Insurance Commissioner entered a ruling that derailed a proposed merger between the state’s two largest health insurers, Highmark and Independence Blue Cross.


41. Because large medical claims (for example, diagnosis and treatment of cancer) are less predictable than small claims (routine office visits and diagnostics), plans with a high deductible are subject to greater random variation in average medical costs than plans with low deductibles.


47. J. C. Robinson, “Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance.”


49. As noted above, the NAIC draft allows fraud-prevention expenses to be included in the numerator of the proposed MLR definition only if they save at least as much in medical claims. While better than disallowing all fraud-prevention expenses, that constraint would discourage insurers from making investments in fraud prevention that might involve significant costs in early years but would save more than enough in future years to justify the investment. It also involves issues of proof and verification.

50. The PPACA includes a variety of provisions requiring the secretary of HHS, in consultation with the NAIC and other parties, to develop standards for consumer disclosure, including summary explanations and benefits of health coverage and information on premiums, enrollment, cost sharing, claims practices, and a variety of other factors. For

51. Ibid.

52. The NAIC has proposed a summary form to provide information about “unreasonable” rate increases.


56. Scott E. Harrington, “Effects of Prior Approval Regulation in Automobile Insurance.”