



Testimony of
Consumers Union of U.S., Inc.,
on the
Consumer Protections Embedded in the
Grandfathering Regulations and
Medical Loss Ratio Requirements
of the Patient Protection and Affordable Care Act
before the
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

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Introduction

Consumers Union, the independent, nonprofit publisher of *Consumer Reports*,¹ is pleased to describe the consumer protections embedded in the grandfathering regulations and medical loss ratio requirements of the Patient Protection and Affordable Care Act (ACA), and to comment on the proposed legislation which would repeal these protections.

¹ Consumers Union is a nonprofit organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union's publications have approximately 8.3 million combined paid circulation and carry no advertising and receive no commercial support. Consumers Union's income is solely derived from the sale of Consumer Reports and ConsumerReports.org, its other publications and from noncommercial contributions, grants and fees. In addition product testing, Consumer Reports and ConsumerReports.org regularly carry articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare.

Expanding Grandfathering Rules Restrain Consumer Protection

The proposed legislation would broaden the definition of what qualifies as a grandfathered plan and calls for a blanket exemption from all ACA requirements. If enacted, this proposal would reduce access to valuable new consumer protections.

The ACA includes popular, new consumer protections such as health insurance that does not discriminate on the basis of pre-existing conditions, ensures families can maintain coverage for their young adults, and places a needed threshold under the coverage purchased by individuals and small businesses – all protections that grandfathered plans would not have to provide if the proposal becomes law.

Consumer Benefits under the ACA Need to be Preserved

The ACA calls for several, critically important consumer protections in private health insurance. Already enacted protections prevent insurers from unjustly dropping coverage when you get sick. The ACA aims to lower health costs by allowing for annual checkups, cancer screenings and other preventive services at no out-of-pocket costs to the consumer. New rights to independent appeals give consumers a standard, reliable way to dispute coverage decisions. New health insurance disclosures coming online in 2012 will enable consumers to make a more informed choice among their health insurance options.

Patients facing a chronic illness have new protections that reduce annual benefit limits and eliminate lifetime limits. We've seen first hand the extraordinary relief this particular provision has provided to parents like Bill and Melinda Strong whose daughter Gwendolyn was diagnosed at birth with a rare-condition called Spinal Muscular Atrophy (SMA).² Almost completely paralyzed, Gwendolyn requires around the clock care, frequent hospital visits, and extensive medical equipment to survive. At age 3, Gwendolyn's care easily reaches into the hundreds of thousands each year, previously putting the Strong family at risk of reaching their lifetime limit. But with the implementation of these new consumer protections, the family now can focus their concerns solely on caring for Gwendolyn and improving her quality of life.

In 2014, consumer protections greatly expand. No one can be denied coverage, you can't be charged more if you have poor health, tax credit subsidies will help consumers afford coverage and new reporting requirements will make it easier for consumers to understand and select a health plan.

Role of Grandfathered Plans in Current Law

But not all consumers have access to these benefits. The ACA creates a way for a plan to maintain a "grandfathered status" and be exempt from several of the new requirements shown in Table 1.

² *The Affordable Care Act: Gwendolyn's Story*, Consumers Union, <http://youtu.be/n70H3AWrax4>

Table 1: Patient Protections that Apply to Grandfathered Plans, Current Law

Provision	Effective Date	Applies to grandfathered group plans?	Applies to grandfathered individual market plans?
Young adults can stay on their parents' health plans until age 26	Health plan years starting on or after Sept. 23, 2010*	YES	YES
Prohibition of pre-existing condition exclusions for children under age 19	Health plan years starting on or after Sept. 23, 2010	YES	NO
Preventive services covered with no cost-sharing	Health plan years starting on or after Sept. 23, 2010	NO	NO
Restriction on annual limits in coverage	Health plan years starting on or after Sept. 23, 2010	YES	NO
Prohibition against unfair rescissions of coverage	Health plan years starting on or after Sept. 23, 2010	YES	YES
Limits on cost-sharing for out-of-network emergency services	Health plan years starting on or after Sept. 23, 2010	NO	NO
Right to internal and external appeals of insurer decisions	Health plan years starting on or after Sept. 23, 2010	NO	NO
Medical Loss Ratio Requirements	2011	YES	YES
Uniform explanation of coverage documents & standardized definitions for health insurance terms	By March 23, 2011	YES	YES
Prohibition of pre-existing condition exclusions for enrollees of all ages	2014	YES	NO
Prohibition of annual limits	2014	YES	NO

Mary E. from Leavenworth, Wash. wrote to us describing how these new benefits are impacting her family.

“I love the fact that our adult children can not only stay on our insurance until they are 26, but my daughter's annual exams are actually covered now. For children that are attending college, this is a big thing for our family. I just can't imagine what we would have done otherwise. The children can't begin to comprehend the savings this has incurred for us, but us parents realize what a benefit it is to our pocket book!”

Mary further explains how she thought her plan was good until she went for an annual check-up. She wrote, “[t]he insurance only covered \$100 and I had to pay the rest. I can't afford that so I only went to the doctor once every three years. Now that preventive care is actually covered, it makes it a lot easier to be able to afford to get checked annually as recommended by your doctor.” This would not be the case if her plan was grandfathered.

The Proposed Legislation Would Broaden the Definition of a Grandfathered Plan

By broadening the definition of plans that can remain as grandfathered plans, many consumers would lose access to the new consumer protections.³ The proposal strips all requirements for maintaining a grandfathered plan at a reasonably similar cost-sharing levels. The proposal would increase the number of consumers who can't access several of the ACA's popular provisions such as phased-out annual benefit limits and access to preventive care with no out-of-pocket cost sharing (Table 1).

Access to preventive care, such as cancer screenings, is important. Data on breast cancer compiled by the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute, shows that patients diagnosed while breast cancer remained localized had a 98.6 percent five-year survival rate.⁴ Patients whose diagnosis came after the cancer had metastasized had a survival rate of just 23.4 percent. Attempts to loosen the definition of a "grandfathered plan" put additional patients at risk of late or missed diagnoses due to financial barriers to preventive care.

Also problematic is that consumers in grandfathered plans do not have federally guaranteed rights to standardized internal and external appeals, potentially leaving insurers, not doctors, to make treatment decisions without sufficient opportunity for outside review.

The Proposal Would Exempt Grandfathered Plans from ALL Protections in the ACA

The proposed legislation not only broadens the definition of grandfathered plan but also expands the list of consumer protections that would no longer apply. The proposal would prevent enforcement of "any requirement or regulation that imposes any standard or requirement set forth in the Patient Protection and Affordable Care Act...on a grandfathered health plan." **Under this proposal not only can a plan change, for example, from a \$500 deductible to a \$10,000 deductible without losing grandfathered status, but popular provisions currently in place and working for consumers will be stripped.** A recent census report shows that new rules allow dependents up to age 26 to remain on their parents' coverage have expanded access to health insurance for approximately 500,000 additional young adults.⁵ These benefits, and several others, are simply gone under this proposal.

Current Law Defining Grandfathered Status Aligned with Consumer Preferences

We believe the regulations set forth by the Department of Health and Human Services (the Department) appropriately address this issue in the spirit of the ACA and in the

³ Interim Final Rule on Grandfathered Plans, June 17, 2010, available at <http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf>

⁴ National Cancer Institute, <http://seer.cancer.gov/statfacts/html/breast.html#survival>

⁵ Department of Health & Human Services, Overview of the Uninsured in the United States: A Summary of the 2011 Current Population Survey, <http://aspe.hhs.gov/health/reports/2011/CPSHealthIns2011/ib.shtml>

interest of protecting consumers. These rules create a reasonable path to maintaining a “grandfathered status,” helping consumers keep the plan they have and like, and allowing for exemptions from providing all of these new benefits.⁶

We constantly receive complaints of rising premiums, lost benefits, and drastic cost-sharing increases. **We’ve yet to hear from any of those same consumers arguing to keep a plan after coverage has been reduced or premiums increased.** Here are a few examples of the thousands of complaints we’ve received:

Sharon M. from Morganton, NC –

My insurance is thru my employer, but it none-the-less [sic] increased outrageously this year. A number of things doubled in cost: such as generic prescriptions and the deductible. Non-generic prescriptions cost 10 times as much as generic prescription. A doctor visit costs nearly twice as much and a specialist doctor costs greater than 300% more. I recently paid \$50 to see a specialist and the insurance company only had to pay \$19.03. Very lop-sided! The yearly co-insurance amount also increased significantly. I can't afford as good of health care as I was accustomed to.”

William E. from Double Oak, TX –

“My employer went from a PPO plan that it paid 100% premium to a high deductible HSA. This has forced us to delay in seeking medical attention except in extreme cases and the low contributions do not cover all of the out of pocket expenses for the year. More needs to be done to make insurance affordable to families and individuals. There is too much focus from congress on repealing the gains in health care reform. The focus needs to be made on making health care affordable and available.”

There is no evidence that shows consumers are clamoring to keep the plans they have when premiums are drastically increased or benefits substantially reduced. Current law is aligned with consumers’ preferences. Table 2 lists the requirements that employers and plans must meet to avoid losing a grandfathered status under current law.

⁶ Op. Cit., Interim Final Rule on Grandfathered Plans

Table 2: Plan Changes Resulting in Loss of Grandfathered Status

Plan Component	Disqualifying Change
Copayment	The greater of an increase of more than \$5 (adjusted for medical inflation since March 23, 2010) or an increase above medical inflation plus 15 percent.
Deductible	An increase above medical inflation (since March 23, 2010) plus 15 percent.
Out-of-pocket Limit	An increase above medical inflation (since March 23, 2010) plus 15 percent.
Co-insurance	Any increase in the co-insurance rate after March 23, 2010.
Annual Limit	Any decrease of an annual limit that was in place on March 23, 2010 or adoption of a new annual limit for plans that did not have one on March 23, 2010.
Employer Premium Contribution Rate	A decrease of more than 5 percentage points below the existing employer contribution rate as of March 23, 2010.
Benefits Package	The elimination of all or substantially all covered benefits to diagnose or treat a particular condition after March 23, 2010.

The rules create ample opportunity for employers to adjust cost-sharing to keep pace with the rising cost of health care. The rules allow a 15 percent increase above medical inflation for co-pays, deductibles, and out-of-pocket limits, creating generous flexibility for employers to maintain their grandfathered plans and avoid offering new benefits.

Given medical inflation of between 3 percent and 4 percent over the last three years, plans can increase cost-sharing by at least 18 percent without losing their grandfathered status.⁷ Furthermore, rules allow plans to maintain annual limit provisions and employers can shift up to 5 percent more of the monthly premium onto employees.

Expanding Consumer Protections has had a Minimal Impact on Premiums

Federal agencies estimated that ending annual and lifetime limits will increase group premiums by about 1/2 of 1 percent and will increase non-group premiums by less than 1 percent.⁸ Prohibiting pre-existing exclusions for children is estimated to have a negligible impact on group premiums and at most a 1 percent impact on non-group premiums.

A recent Anthem BCBS rate filing for individual market products in Connecticut shows that new protections from unjust rescissions have had no impact on premiums, ending lifetime limits have also benefited consumers without raising costs, and increasing coverage to young adults up to age 26 has resulted in just a .2 percent increase.⁹

⁷ Bureau of Labor & Statistics, *Consumer Price Index*, <http://www.bls.gov/cpi/#tables>

⁸ Department of Treasury, Department of Labor, Department of Health and Human Services. "Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections." *Federal Register*, June 28, 2010. Available at: <http://www.urban.org/uploadedpdf/412128-PPACA-impact.pdf>

⁹ Anthem Blue Cross Blue Shield of Connecticut, Individual Market Rate Filing, August 2011, <http://www.catalog.state.ct.us/cid/portalApps/images/reports/005257351.pdf>

Reject Proposals that Undermine Well-Balanced Grandfathering Rules & Reduce Consumer Protections

The proposed legislation not only erases a balanced approach to defining grandfathered plans, but reduces access to consumer protections that provide value for premiums and protect consumers from insurance industry abuses.

Consumers Need Medical Loss Ratio Provisions

Consumers Union strongly opposes any legislation that would repeal the Affordable Care Act's Medical Loss Ratio (MLR) provision. MLR is a measure of the amount of a premium dollar that goes to pay for health care as opposed to administrative expenses. A high medical loss ratio provides consumers with more value for their money. There is already evidence that the rule is working to improve value for consumers and little evidence to suggest it is having a negative impact on jobs.

MLR Rules Are Not New

The MLR requirements are not new. Approximately one-third of states have enacted similar provisions, providing us with significant experience with how MLR regulations affect consumers and brokers.

Consumers, Particularly in Non-group Market, Have Had Poor Return for Premium Dollar

To evaluate the impact of the ACA's MLR provisions, it is important to understand the problem policy makers were addressing in enacting the measure. While many plans had an MLR of 80 percent in the individual market and 85 percent in the large group market even before passage of the law, much variability existed in the marketplace. There have been instances of plans with loss ratios of as little as 46 percent, meaning those plan members only got back less than half of their premium dollar in the form of health care, an extremely poor return for their premium dollar.¹⁰

Current Law Provides Improve Transparency on Health Plan Value

In addition, MLR reporting requirements for plans will provide consumers with new information about how their dollars are being spent. Today, many consumers have no idea how well their dollar is being stretched because they don't know the proportion of their premium dollars that is returned to members in the form of medical care or quality improvement.

¹⁰ Minnesota Department of Commerce, Report of 2010 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets (June, 2011), http://www.state.mn.us/mn/externalDocs/Commerce/Current_Loss_Ratio_Report_052104013421_LossRatioReport.pdf

As part of discharging its duties under the Affordable Care Act, the National Association of Insurance Commissioners (NAIC) now collects a new Supplemental Health Care Exhibit (SHCE) as part of its annual reporting requirement for health plans. The SHCE collects data about premiums and medical claims necessary to calculate the MLR. It will provide a wealth of information about how insurers spend consumer dollars, including the amount of premiums plans take in, the amount plans spend to improve health care quality, total incurred claims, and the amount spent on agent and broker commissions.¹¹ The ACA requires the Secretary of HHS to post information about insurers' MLR on the Internet.¹²

MLR Has Lowered Premium for Consumers

The current MLR rule has already caused insurers to scale back their premium rates. In just one example, Aetna lowered rates by as much as 19 percent for 15,000 Connecticut customers to bring premiums in line with the MLR rule.¹³ The GAO reports that other insurers plan to either reduce premiums or fail to increase them.¹⁴ Another Connecticut carrier acknowledged the MLR rule as a factor in lowering its rate increase request.¹⁵

MLR Has Had No Impact on Consumer Access to Brokers

The NAIC report found that consumers in states with state-enacted MLR requirements continued to have access to brokers.¹⁶ It is important to note that under the ACA formula for MLR, it is easier for health plans to achieve 80 or 85 percent, compared to more traditional formulations.^{17, 18}

¹¹ National Association of Insurance Commissioners, Health Insurance and Managed Care (B) Committee, *Report on Options for Amending the Medical loss Ratio Formula to Address Concerns About Access to Agent and Broker Services* (June 19, 2011) p. 20.

¹² Public Health Services Act, § 2718(a)

¹³ Matthew Sturdevant, *Aetna Seeking 10 Percent Price Decrease As Medical Spending Falls*, May 12, 2011

¹⁴ U. S. Government Accountability Office, *Private health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements*, p. 18.

¹⁵ *Anthem Proposes 12.9 percent rate increase*, The Connecticut Mirror (Sept. 2, 2011)

<http://www.ctmirror.org/story/13806/anthem-proposes-129-percent-rate-increase>

¹⁶ National Association of Insurance Commissioners, Health Insurance and Managed Care (B) Committee, *Report on Options for Amending the Medical loss Ration Formula to Address Concerns About Access to Agent and Broker Services* (June 19, 2011).

¹⁷ U.S. Government Accountability Office, *Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements* (July 2011) p. 5.

¹⁸ Traditionally, the MLR was calculated by dividing the amount paid out in medical claims by premium revenue. The PPACA MLR allows insurers to count quality improvement as part of medical claims, raising the numerator relative to the old MLR formula. At the same time the PPACA formula lowers the denominator by allowing insurers to deduct state and federal taxes. Thus, an insurer's MLR will be higher under the PPACA MLR definition, making it easier to meet the 80 or 85 percent requirement than it would be under the traditional formula.

Targeted Relief is Available to States

The ACA allows the Secretary to adjust the MLR standard for a state if meeting the 80 percent Medical Loss Ratio standard would destabilize the individual market in that state.¹⁹ HHS provides a mechanism for states to apply for adjustments, but they must provide evidence that it will destabilize their market.²⁰ More than a dozen states/territories have applied for adjustments and HHS has granted some and denied others, using a targeted, evidence-based process. Contrary to the criticisms that the adjustment process demonstrates the law does not work, this actually is evidence that the law is working *as intended*. Other flexibility in the law allows for “credibility” adjustments for smaller plans that often experience greater variability in their claims experience than larger plans, effectively lowering the threshold that they face.

Potential Rebates to Consumers

Plans will be required to rebate to consumers if they spend more on administrative expenses than is allowed under the rule. The NAIC modeled the impact of the MLR rule, had it been in effect for 2010, and found that consumers would have seen rebates of nearly \$1 billion dollars in the individual market alone.

Table 3: NAIC Estimates of Rebates Paid to Consumers if the Current MLR Law Had Been in Effect in 2010

Market	Premiums Paid (\$ millions)	Estimated Consumer Rebate (\$ millions)
Individual	\$25,311	\$978
Small Group	\$70,255	\$447
Large Group	\$154,959	\$526
Total	\$250,525	\$1,951

We note that the purpose of the MLR is to make plans more efficient and to have them return an appropriate share of the premium to consumers in the form of medical care and quality improvement. Many analysts believe, and early evidence suggests, that plans will respond in this manner, as opposed to paying the estimated volume of rebates. Consumer benefit is even greater under this scenario, as it accrues to consumers earlier in the process.

MLR Impact on Brokers

We know that brokers and agents have been expressing concern about the impact of the MLR on their commissions. While we understand the fear brokers have about change the health reform law will have on their business it is important to note that evidence on the impact of the MLR on brokers’ *overall compensation* is so far scant.

¹⁹ Public Health Services Act, §2718(a)(2)(c)

²⁰ The Center for Consumer Information and Insurance Oversight, <http://cciio.cms.gov/programs/marketreforms/mlr/index.html>, downloaded September 13, 2011.

The recent NAIC inquiry into the effect of the MLR on broker commissions was inconclusive; so much so, that NAIC declined to support legislation that would carve out brokers' commissions from the MLR. The NAIC found that while some insurers have reduced broker commissions particularly in the individual market, "a significant number of companies" did not reduce commissions in 2011.²¹ It is also unclear how much the MLR is contributing to lower broker commissions. The NAIC found that some carriers have been shifting their compensation structures away from percentage commissions to other payment arrangements, which may have the impact of putting downward pressure on brokers' compensation.²²

Structuring broker commissions as a percentage of premium--in an era of rapidly increasing premiums—appears to have provided brokers with higher commissions that bear no relationship to increase in their workload. As such, a shift to other payment arrangements may well represent a needed correction to fees that have accelerated unreasonably. The large expansion in private coverage expected in 2014 is likely to increase demand for brokers' services. Even today, brokers have new outlets for coverage due to the small business tax credit.

The MLR Should be Retained

Proposals to repeal or weaken the MLR rule should be rejected. These proposals would raise premiums for consumers. In 2014, that means increasing the need for tax-payer financed subsidies. The current law MLR provision is working and should be retained. The current MLR rule is providing a value for consumers in the form of lower premiums and more medical care for their premium dollar.

²¹ National Association of Insurance Commissioners, Health Insurance and Managed Care (B) Committee, *Report on Options for Amending the Medical loss Ration Formula to Address Concerns About Access to Agent and Broker Services*, June 19, 2011, p. 3.

²² *Ibid*, p. 6