

New Health Insurance Premium Rules Will Control Costs For Families, Businesses

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Weaken Provision Worth \$1.9 Billion to Customers**

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Health Care for America Now is a national grassroots coalition of more than 1,000 organizations in 46 states representing 30 million people. HCAN spent \$51 million over the past two years in the fight to win passage of health reform and to keep Congress from being steamrolled by corporate special interests.

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THE AFFORDABLE CARE ACT, signed into law by President Obama on March 23, 2010, was one of the most significant domestic achievements in American political history. Nearly a century after President Theodore Roosevelt first broached the idea of national health reform in 1912, the Affordable Care Act represents an historic step toward ending the insurance industry's stranglehold on our health care, eliminating the worst insurance company abuses and guaranteeing that all Americans have quality and accessible health care they can afford.

Because private health insurance will be expanded to cover millions more people, many with the assistance of tax credits, Congress included provisions in the law to improve the quality and value of private coverage for everyone. **One such provision creates standards that make sure health plans spend a minimum amount of premium revenue on medical care.** These benchmarks are known as medical-loss ratios (MLRs), and they represent the portion of premium revenue insurers pay out to doctors, hospitals and other health care providers for clinical care. The non-medical expenses funded by premiums include salaries, profits, lobbying, advertising, marketing, agent commissions, overhead, and underwriting (the industry term for identifying and excluding or charging very high premiums to applicants with various health conditions). The MLR standards are critical to curbing the industry's anti-consumer practices, controlling rising premium costs, squeezing value out of premiums paid by private and public customers, and ending the relentless profiteering of health insurance companies.

Specifically, the Affordable Care Act requires insurers to spend on patient care at least 80 percent of health plan premiums collected from individuals and small employers and 85 percent of premiums from large employers.¹

Starting in 2011, health plans must rebate to consumers and employers the difference between the minimums and actual spending on health care. If the new law had been on the books in 2009, the six largest for-profit health insurance companies would have been required to refund \$1.9 billion in that year alone for spending too much on profits, CEO pay and administration, according to a report by a Wall Street analyst (see Table 1).²

Despite the rhetoric from health insurers, redirecting this amount of money to benefit consumers and employers would not represent a severe blow to the enormously wealthy health insurance industry. The top five for-profit health insurers alone recorded \$12.2 billion in profits in 2009.³ Without the minimum medical-loss ratios, which still are well below the average MLRs achieved in the 1990s,⁴ health plans would continue to spend excessively on profits, bloated CEO pay packages, lobbying and administrative activities designed to take advantage of consumers.

To enforce the MLR standards and achieve these savings, the Department of Health and Human Services (HHS) must beat back the insurance industry's sophisticated efforts to undercut the law. If the rules are implemented as intended, the Affordable Care Act will hold accountable an industry that abuses millions of customers when

they need health benefits the most. **If insurers are successful at redefining medical care, they will continue ripping off Americans**, many of whom have no choice of health plans because of relentless industry consolidation and market concentration. That is why the insurance industry and its Washington-based mouthpieces, America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA), are fighting so vigorously to undermine the law. They want to expand the definition of allowable medical expenses to include costs that are not directly related to the delivery of care and have not historically been classified as medical. They want

TABLE 1
Potential Insurance Company Rebates to Families, Employers Under MLR Reform, 2009

Company	Plan Type	Rebate
Aetna	Individual	\$69,799,536
Aetna	Small Group	\$20,391,865
Aetna	Large Group	\$52,792,343
Aetna Totals		\$142,983,744
CIGNA	Individual	\$30,712
CIGNA	Small Group	\$297,702
CIGNA	Large Group	\$43,467,632
CIGNA Totals		\$43,796,046
Coventry	Individual	\$14,861,196
Coventry	Small Group	\$40,806,461
Coventry	Large Group	\$25,451,307
Coventry Totals		\$81,118,964
Humana	Individual	\$73,942,383
Humana	Small Group	\$39,945,845
Humana	Large Group	\$16,508,816
Humana Totals		\$130,397,043
UnitedHealth	Individual	\$209,597,661
UnitedHealth	Small Group	\$214,809,191
UnitedHealth	Large Group	\$442,412,670
UnitedHealth Totals		\$866,819,521
WellPoint	Individual	\$237,531,718
WellPoint	Small Group	\$195,384,091
WellPoint	Large Group	\$181,374,972
WellPoint Totals		\$614,290,780
Total Potential Rebates		\$1,879,406,101

Source: Carl McDonald, Oppenheimer & Co.

to strengthen their ability to maximize profits and skirt incentives to reduce cost.

The Affordable Care Act assigned to the National Association of Insurance Commissioners (NAIC) the task of making detailed recommendations to HHS on the MLR standards. The industry is treating this as an opportunity to undercut the law's provisions on this important market reform. Insurance companies have deployed more than 1,700 lobbyists and company executives at periodic NAIC meetings in a bid to preserve the status quo and overwhelm regulators (while drowning out the voices of the 29 members of the NAIC consumer panel).⁵ Insurers have used virtually unlimited resources to hire law firms, lobbyists and consultants to drown the NAIC in paperwork. They have filed almost 160 comment letters totaling more than 600 pages expressing their wishes and concerns about MLR rules, compared to 23 letters from consumers and business owners who would potentially benefit from the health care law, according to Senator Jay Rockefeller of West Virginia.⁶

Insurance company shareholders are betting the companies will wear down political support for the law and ultimately pressure HHS to retreat from the clear intent of Congress—even though HHS has been aggressively implementing other parts of the law. “Managed-care stocks are valued as if the law will be implemented as written,” said one Wall Street analyst. When “reform gets reformed,” he said, the stocks will get a boost.⁷ This rhetoric motivates the industry, and the insurers hope victories at the NAIC will blunt market reforms in the short-term and frustrate full implementation of the law in the long term.

Escalating Insurance Company Greed

The modern era of private health insurance greed began quietly in 1994, when the nation's non-profit Blue Cross-Blue Shield plans changed their national bylaws to enable the companies to convert to for-profit entities.⁸ This event revolutionized the industry's finances to the detriment of the American public. Regional for-profit health insurers

began consolidating into powerful national corporations owned by private investors.⁹ For example, WellPoint the biggest for-profit private health insurer by membership, was cobbled together from formerly non-profit Blue Cross plans in 14 states.¹⁰

Today 99 percent of U.S. metropolitan areas have excessive concentration of power in the health insurance markets.¹¹ Yet even as insurers have built monopoly power, they have been unwilling or unable to leverage their huge market shares to restrain growth in medical costs; rather they have raised premiums and reduced the share of premiums spent on medical care.¹² And that goes a long way in explaining their long history of abusing the public, denying needed patient care and providing dubious rationales for their pricing actions.¹³

Health insurers' medical-loss ratios were 95 percent, on average, in 1993. Over the next 17 years, investor-owned health insurers reduced spending on actual medical care to an average of 81 percent of premiums collected, according to a study by PricewaterhouseCoopers and company filings with the U.S. Securities and Exchange Commission.¹⁴ This occurred because premiums continued growing faster than medical inflation.¹⁵ At the same time, insurance industry consolidation and negotiating power accelerated¹⁶; insurers rigged the system to short-change reimbursements for doctors and hospitals¹⁷; and many major drugs lost patent protection and were replaced by less expensive generic versions.¹⁸ The remaining 19 percent of premiums went to profits, executive salaries, lobbying, marketing, administrative expenses, sales commissions, and the cost of weeding out sick people whose conditions might make them unprofitable to insure.¹⁹ In the individual and small-group markets, insurers routinely operate with medical-loss ratios that are much lower than average. A 2008 study of these markets found many as low as 60 percent.²⁰

Analysts and investors view the medical-loss ratio as an indicator of future industry earnings and as a measure of an insurance CEO's business acumen. When the percentage rises, it suggests the volume

and cost of care ate into profits, and when it declines Wall Street applauds companies and their executives. For example, Barron's recently published an article about Coventry Health Care, concluding that the company's CEO, Allen Wise, is:

...known for his strict attention to costs. Under his guidance, Coventry was able to reduce the medical-loss ratio, or MLR—the percentage of premium revenue used for medical costs—to 80.2% in this year's first quarter in its commercial group, a decline of 70 basis points, or 0.7%, from the year-ago period. Operating margins jumped to 5.4% in the quarter from 1.8% a year ago, while earnings of \$97.3 million, or 66 cents a share, far outstripped analysts' expectations.²¹

Sharp Variances in Medical-Loss Ratios Take Advantage of Millions of Americans

There are significant geographic variations in medical-loss ratios among and within the same insurance holding companies, according to data compiled by Wall Street analysts. Some health plans in some states devoted 94 cents of every premium dollar to health care benefits, while others spent as little as 33 cents.²² Consumers are kept in the dark about these vast differences because such benchmarks largely are obscured in Securities and Exchange Commission filings. Consumers investing thousands of dollars in health plan premiums typically have minimal data to guide their purchase decisions or explain where their premium dollars go. The data in Tables 2, 3 and 4 show the substantial gap in health spending between the Affordable Care Act's new standards and selected health insurance company subsidiaries.

Considerable disparities in patient spending are evident when aggregated large-group, individual and small-group markets are compared. Last year the biggest insurers used about 15 cents out of every premium dollar paid by large employers for administrative costs and profits, while more than 26 cents out of every premium dollar in the individual market went to administrative costs and profits (Table 5).²³ Self-insured employers typically pay less than 10 cents out of each health care dollar, and the federal Medicare program spends less than 3 cents on non-medical services (Figure 1).²⁴

Oppenheimer & Co. analyst Carl McDonald reviewed insurance companies' public filings with state regulators and calculated medical-loss ratios for hundreds of subsidiaries of the six largest for-profit health insurers.^{25,26} He based his analysis on MLR reports filed with state insurance departments.²⁷

Some of the lowest MLRs cited by McDonald are for limited-benefit plans with low premiums, low maximum-benefit levels and high out-of-pocket costs. UnitedHealth Inc.'s Golden Rule subsidiary insures about 600,000 individuals across the country and has a consolidated MLR of only about 63 percent. In Colorado, a WellPoint subsidiary that insures 63,000 customers spent only 33.2 percent on medical care, while another Colorado subsidiary of WellPoint with 71,000 members in employer-sponsored groups had a MLR of 53 percent.²⁸ In Texas, many health insurers, including for-profit Aetna and Blue Cross-Blue Shield (a subsidiary of non-profit Health Care Service Corp.), have medical-loss ratios between 60 and 70 percent.²⁹

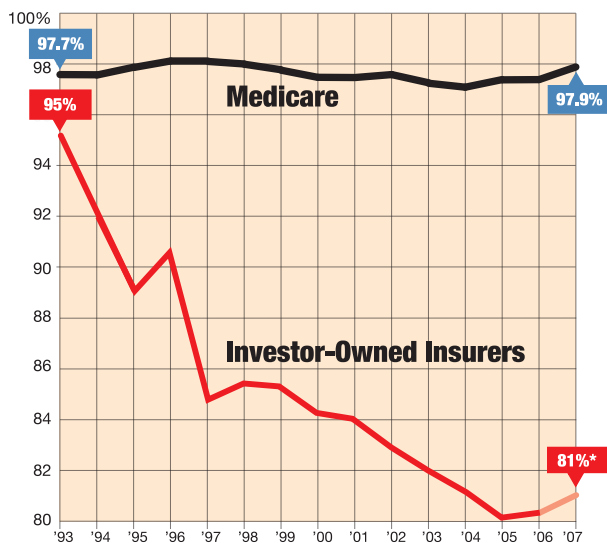
Low MLRs typically mean high profits. The markets where subsidiaries have the lowest MLRs are considered to be "the most profitable tail" of WellPoint's businesses, according to Oppenheimer.³⁰

Today's system allows insurers to pull more administrative revenue, profit and cash flow from states that choose not to protect their residents. Insurers prefer to aggregate their state results and produce a lone corporate-wide medical-loss ratio that obscures the rampant abuse of consumers in states that choose not to regulate effectively. The threat the minimum medical-loss ratios poses to insurers is that "these very profitable regions immediately have to become markets of average profitability, whereas the less profitable markets stay less profitable," McDonald said.³¹ WellPoint, the largest private health insurer by enrollment and biggest seller of individual health coverage, argues that the government should not consider wide geographic variations in MLRs and instead should focus only on consolidated national results.³²

FIGURE 1

Medical Loss Ratios of Private Insurers, Public Medicare Plan, 1993 to 2007

Percentage of Medicare spending on medical care compared with percentage of premium revenue spent on medical care by for-profit insurance companies.



*Estimated
Sources: PricewaterhouseCoopers' Health Research Institute, U.S. Center for Medicare & Medicaid Services

Many subsidiaries of the six largest for-profit health insurers have operated at relatively high medical-loss ratios in the past decade, demonstrating that they can do better for their customers and still be very profitable. And these companies have proved they can and do devote a sharply lower share of premiums to administration and profit when markets demand it. For example, in 2009 UnitedHealth's Florida subsidiary had an 89.7 percent MLR for its large-group business, well above the minimum in the new law.³³ Aetna and WellPoint serve significant numbers of government workers through the Federal Employee Health Benefit Program (FEHBP). The extraordinary negotiating power and oversight resources available to the FEHBP managers in the Office of Personnel Management force insurers to keep medical-loss ratios high: Aetna had a medical-loss ratio of 87.8 for their federal employee plan participants, while WellPoint reported a 94.3 percent MLR for its federal employee customers, according to Oppenheimer. Among the many different health

plans that participate in the FEHBP, the typical MLR is around 95 percent.³⁴ These programs, as well as Medicare and Medicaid plans run by private companies, are profitable for insurers, as proven by the intense competition that exists in those markets. The public Medicare program has consistently spent more than 97 percent of its federal benefit outlays on medical care since 1993, setting the gold standard for most efficient health plan.³⁵ (Figure 1)

In California, major private plans with the highest medical-loss ratios in 2007 ranged from 90.6 to 97.1 percent.³⁶ Those tend to be non-profit and pay their executives less than the large, for-profit health insurers. One of the nation's largest health plans, the non-profit Kaiser Permanente health maintenance organization, had a 92.2 percent MLR in 2009. Since 2004, it has never dropped below 91.6 percent, according to analyst John Rex of J.P. Morgan.³⁷

Consumer Rebates

As noted earlier, company reports filed with state regulators suggest that without changes to their business models, many of the nation's largest investor-owned health insurers will fall short of the MLR standards and face substantial rebate requirements.

Table 1 (Page 4) shows how much money each of the six largest companies would have to rebate to customers if the health care law had been in effect in 2009. If HHS calculated MLRs in the same way that insurers have done for years, UnitedHealth would owe \$867 million in rebates, followed by WellPoint's \$614 million, Aetna's \$143 million, Humana's \$130 million, Coventry Health Care's \$81 million, and CIGNA's \$44 million. That is a total of \$1.9 billion in rebates for only those six companies.³⁸

That amount is a necessary cap on the industry's excesses and will limit the extent to which soaring premiums are used on activities that confer no tangible benefit on enrollees. However, it does not begin to threaten the solvency of these large insurers, as some have implied to regulators. The

five largest for-profit health insurers posted record profits of \$12.2 billion in 2009.

On July 20, 2010, UnitedHealth reported a second-quarter profit of \$1.12 billion, a 31 percent increase from the same period a year earlier. The company's consolidated MLR fell 2.1 percentage points to 81.5 percent—a decline that drove profitability and surprised Wall Street analysts.³⁹

Industry Lobbies to Weaken Medical-Loss Ratio Rules

The \$892 billion-a-year health insurance industry⁴⁰ is lobbying strenuously to prevent federal officials from adopting the MLR standards without major concessions to health plans. Insurers have an army of operatives working behind the scenes at state insurance departments and at the NAIC.⁴¹

“This is the biggest issue right now for the companies,” said Kansas Insurance Commissioner Sandy Praeger, who chairs the NAIC health-insurance committee.⁴² AHIP, BCBSA and its member insurers have two goals: 1) redefine medical-loss ratios to give insurers vast discretion over what expenses they may classify as clinical and administrative costs, and 2) craft as many exceptions, transitions, and delays as possible to avoid meeting even the meager compromised standards that insurers seek.

Exceptions would protect insurers' short-term profitability and are rationalized by threats and overhyped warnings of catastrophe in the individual market. AHIP, BCBSA and some insurance commissioners have commented that companies with extremely low medical-loss ratios would find it disruptive and “destabilizing” to obey the new law immediately and would consider withdrawing from various geographic markets before complying with the new standards on the schedule set by Congress, a form of blackmail used on regulators.⁴³ In some states, regulators will seek exceptions to temporarily shield insurers from the new law in the name of consumer protection. But Americans must ask: is it really in our best interest to bend the law to accommodate insurers selling subpar coverage that would leave enrollees at risk of financial ruin in the event of a medical emergency?

After sponsoring a recent meeting of market analysts, industry representatives, actuaries and regulators, the Robert Wood Johnson Foundation reported that “most of the large, established carriers offering coverage in the individual market will be able to meet the MLR thresholds.”⁴⁴

The long-term success of minimum MLR standards in improving insurance value will be heavily influenced by the ability of regulators to defeat insurers’ transparent attempts to restore the old status quo. Whether the intent of Congress is ultimately respected depends on how state and federal regulators define which expenditures should be classified as legitimate medical costs. Over the past 10 years, health insurers have crowded to Wall Street about how low they’ve driven their MLRs. Now that the new law sets national MLR floors, insurers are scrambling to take those old numbers that pleased investors so much, pretend they never happened, and count as “medical” all the costs they used to consider administrative to burnish their reputations as expert managers.

WellPoint has already “reclassified” more than \$500 million of administrative costs as medical expenses in its bid to stampede regulators into accepting its preferred formula.^{45,46} **WellPoint’s unilateral reclassification would theoretically increase its corporate-wide MLR by 1.7 percentage points without it changing any of its wasteful operations, its lavish executive compensation programs, or its inefficient claims processing.** Other insurers are now claiming that the costs of denying care (so-called “loss adjustment expenses”), fraud prevention, network management, and provider credentialing, all clearly and historically administrative functions, are actual medical care for purposes of the MLR requirement. This is not what the law says and not what Congress intended.

Insurers have used these same reclassification techniques when facing possible state actions setting minimum medical-loss ratios.⁴⁷ In 2007, when California was considering a minimum MLR, one insurer proposed that any services that allegedly improved health outcomes or reduced

health care costs should be included in the medical portion of the ratio, citing a grab-bag of administrative expense categories. As the NAIC consumer panel recently said:

It is important to note that until lawmakers began focusing on MLRs, insurers thought that expenses related to those costs were categorized appropriately as administrative costs not medical costs. Significantly, when the California legislature did not enact a minimum MLR provision, the company took no action to reclassify the expenses.

Indeed, the new law reduces administrative costs for private plans, which should make it easier for them to meet the new MLR rules if they do not already do so. The NAIC consumer panel:

[B]ecause the new law will in 2014 prohibit insurers from denying coverage or refusing to pay claims for anyone with pre-existing conditions, insurers after that date should no longer need to spend as much as they do today on underwriting activities. Similarly, since Congress has passed a healthcare reform package, funds spent on lobbying should be greatly reduced. When underwriting and lobbying-related expenses are reduced, insurers’ MLRs should rise as a direct consequence, which will make it considerably easier for them to comply with the minimum ratios set forth in [the Affordable Care Act]. MLRs will rise even further if the amount of money paid in commissions to brokers declines once the [health insurance] exchanges are in operation [in 2014].⁴⁸

Although they are flush with cash, insurers have nonetheless been sloppy in performing core administrative tasks. One out of every five health insurance claims is processed and paid inaccurately.⁴⁹ Doctors and health plans could save about \$778 million a year in “unnecessary administrative costs” if claims accuracy improved by only 1 percent, and \$15.5 billion a year if inaccuracy were entirely eliminated.⁵⁰

Instead of improving operations, companies have chosen to spend available capital funds to jack up the price of their stocks. Since 2003, the seven largest for-profit health insurers spent \$57.6 billion to repurchase their own stock in order to reduce the number of outstanding shares and raise earnings per share.⁵¹ These maneuvers are especially beneficial to CEOs, whose bonuses and stock options are directly related to their success at boosting share prices.

Insurers would prefer to continue shifting billions of dollars in premiums to Wall Street investors and top insurance executives. Health insurance CEOs have made a profitable science out of denying medical claims for needed care, excluding the sick from coverage and handling claims inefficiently. These practices have created stupendous personal compensation packages for CEOs. The chief executives of the top 10 for-profit health insurers collected more than \$692 million in total compensation from 2000 through 2008.⁵²

The Senate Commerce Committee agrees that HHS and state insurance commissioners must be vigilant and focus on ensuring that consumers benefit from the MLR standards.⁵³ And the NAIC consumer representatives believe “it is critically important that the regulations prohibit insurers from classifying or reclassifying certain administrative expenses as medical expenses, and from taking other actions unrelated to quality improvement that would automatically increase their medical-loss ratios... We believe that allowing insurers to boost their MLRs in such artificial ways would violate Congressional intent. We also believe that because the development of definitions and measurements of insurers’ MLR requirements is of such critical importance to consumers, the process of developing the definitions and standards must be transparent and include consumer group participation and input.”⁵⁴

Smaller Insurers Also Looking for Breaks

Joining in with the largest health insurance companies in appealing for relief from the MLR standards are smaller insurers, such as Assurant Health, which sells individual market coverage

across the country. Assurant Chief Actuary Steve Dziedzic told Florida health insurance regulators that the national MLR requirement in the individual market should be reduced to protect agent and broker commissions and complained that the new law fails to recognize the “complicated set of administrative and distribution costs” the company is obligated to honor. Forcing insurers to alter arrangements—even if those arrangements have contributed to a grossly inefficient and unfair health insurance system—might cause its business to falter and become insolvent, Dziedzic said.⁵⁵ These insurers in essence argue that it is better for Americans and taxpayers to spend more on insurance than it is to drive insurers to become efficient.

Requiring Assurant to adapt to the new MLR rules is clearly in the public interest. Assurant is one of the worst offenders in the way it treats customers who have fallen ill. The company has demonstrated a pattern of arbitrary or abusive coverage denials, according to Connecticut Attorney General Richard Blumenthal. “In the case of *Mitchell v. Fortis Insurance Company* [an Assurant subsidiary], a South Carolina court found that Fortis pre-programmed its computer to recognize billing codes for expensive health conditions, triggering an automatic fraud investigation. The court awarded \$15 million to the plaintiff, who was improperly denied coverage by Fortis for his AIDS treatment.”⁵⁶

Another company with a similar business model is HealthMarkets Inc., which operates MEGA Life and Health Insurance Company, Mid-West National Life Insurance Company and Chesapeake Life Insurance Company. In 2008, HealthMarkets was fined \$20 million by 48 states, whose health insurance regulators documented multiple problems with consumer disclosure, oversight and training of agents, claims handling, and complaint handling practices.⁵⁷ In the same year, Maine officials fined the same company \$1 million for using a flawed method of determining premiums for individual health insurance policies and required the company to refund \$4.6 million in overpaid premiums, plus interest, to consumers.⁵⁸

States Can Surpass Federal Minimums

Under the Affordable Care Act, states retain the power to set minimum medical-loss ratios that exceed the federal standards. New York state lawmakers recently gave state insurance regulators the power to protect consumers from health insurer profiteering. The New York law requires health insurers to spend a greater share of premium revenue on medical claims than in the past. The law raises the minimum MLR from 75 to 82 percent for small businesses and from 80 to 82 percent for individuals (compared with 80 percent for each under the Affordable Care Act). The bill also reinstated the New York State Insurance Department's authority to review and approve health insurance premium increases before they take effect. Since 2000, a "file and use" law limited the state's power to reject health insurance premium increases and allowed health insurers to raise rates as high as they wanted without public accountability.

"Deregulation of health insurance premiums is a failed experiment leading to unjustified premium increases and more people losing their health insurance coverage," Governor Paterson said about the bill. "Health care is a right, not a privilege, and requires sound, balanced regulation to make sure insurance premiums are fair and justified." The law "will help make coverage more affordable and allow more small businesses and individuals to keep their coverage," he said.⁵⁹

The New York law requires health insurers to apply for permission to raise premiums. The Department will have the opportunity to review the rate applications, as well as the underlying calculations, to make sure rates are not excessive, and may approve, modify or disapprove the rate application. The law applies to all rate increases taking effect after Oct. 1, 2010.

Even though some state regulators, such as Steve Poizner, the Republican insurance commissioner of California, have taken aggressive action on individual rate hike requests, they continue to balk at the idea that federal action is needed. Since April 2010, two California insurers have admitted to stunning "math errors" resulting in premium

rate calculations that would have illegally enriched the companies had they not been discovered by regulators. California Governor Arnold Schwarzenegger and Poizner have contorted their political rhetoric to take credit for those discoveries while, incredibly, voicing renewed opposition to federal legislation to set national standards in this area.⁶⁰ Poizner's press secretary, Darrel Ng, admitted that protecting consumers through regulation is incompatible with his boss's ideology. "First of all, our insurance commissioner is Republican and opposes prior approval for health insurance rates at a philosophical level," Ng said.⁶¹

Premium rate review is a necessary complement to strong MLR enforcement. Without rate review, insurers could circumvent the intent of Congress by raising premiums as a way to preserve profit levels and administrative inefficiency within the expanded revenue base. In effect, MLR determines how the pie is divided, but premium review controls the size of the pie. The Affordable Care Act makes available \$250 million in grants to states over the next five years for premium review, beginning with up to \$1 million per state this year.⁶² Premium review funds are available to any state, irrespective of a state regulator's authority to reject or adjust insurance rates, and promise to shine a bright light on information that insurers submit to under-resourced state regulators.

On Capitol Hill, California Senator Dianne Feinstein and Illinois Representative Jan Schakowsky have introduced S.3078/H.R.4757, the Health Insurance Rate Authority Act of 2010, which will empower the HHS Secretary to review and reject unfair premium rate increases in the large number of states where insurance commissioners lack the authority to do so.⁶³ This will allow the Secretary to serve as a backstop for consumers and modify premium increases based on an accurate accounting of insurers' costs.

Health Reform Battleground Moves Down the Hill to HHS

The MLR fight echoes the struggle over the Affordable Care Act that played out for more than a year on Capitol Hill, but now the battleground has moved a few blocks west to the Department of

Health and Human Services. Insurance companies, which are always among the most important players in statehouses, are accustomed to having their way with state regulators. Even big states like California, with the largest funding and staffing of health plan regulators, realized only recently that major insurers such as WellPoint and Aetna for years may have been submitting inaccurate financial data to regulators to justify huge rate increases.^{64,65} The failings of state regulation and, in some instances, the inattention of state regulators make the federal rules crucial to fulfilling the promise of the new health care law.

Despite their cost-containment rhetoric, insurers are trying to build status-quo inefficiencies into future premium calculations by excusing bloated expenses, such as lucrative agent and broker fees and extensive marketing costs. Instead they should

join consumers in finding ways to identify and cut administrative expenses and bring stratospheric executive pay down to earth.

The American Hospital Association, the American Medical Association, Health Care for America Now, consumer representatives to NAIC, and others have urged the insurance commissioners and Sebelius to craft rules that respect the intent of Congress and are based on the historical definition of MLRs. Insurers should not be allowed to game the system.

To protect the historic gains achieved by passage of the Affordable Care Act, it is imperative that the nation's insurance commissioners and the Obama administration stand firm and adopt sensible rules that do not allow the health insurance industry to wield its enormous influence to undo this fundamental reform.

**TABLE 2
State-Specific Individual-Market MLRs of Selected Subsidiaries of Major Health Insurers, 2009**

Insurance Company	Parent Company	State	Lives	Premiums	Medical Expenses	MLR
Humana Employers Health Plan GA Inc	Humana	Georgia	13,467	\$ 14,361,935	\$ 7,789,928	54.2%
Anthem Health Plans of NH	WellPoint	New Hampshire	23,439	\$ 76,196,081	\$ 47,936,019	62.9%
Personalcare Insurance of Illinois	Coventry	Illinois	1,752	\$ 6,263,733	\$ 3,979,823	63.5%
Coventry Health Care of GA Inc	Coventry	Georgia	28,131	\$ 32,734,594	\$ 21,332,112	65.2%
Humana Health Insurance Co of FL Inc	Humana	Florida	81,609	\$ 148,076,760	\$ 99,128,434	66.9%
Healthy Alliance Life Ins Co	WellPoint	Missouri	78,582	\$ 199,963,052	\$ 134,192,471	67.1%
Humana Health Plan Inc	Humana	Kentucky, Arizona, Colorado, Illinois, Indiana, Missouri and Tennessee	18,269	\$ 26,752,412	\$ 19,080,906	71.3%
Anthem Health Plans of VA Inc	WellPoint	Virginia	235,373	\$ 650,500,576	\$ 469,218,427	72.1%
Anthem Blue Cross Life & Hlth Ins Co	WellPoint	California	636,500	\$ 1,118,315,756	\$ 808,793,094	72.3%
Wellpath Select Inc	Coventry	North Carolina, South Carolina	20,747	\$ 41,600,379	\$ 30,759,962	73.9%
Rocky Mountain Hospital & Medical	WellPoint	Colorado	129,264	\$ 336,357,425	\$ 249,132,268	74.1%
Humana Health Benefit Plan of LA Inc	Humana	Louisiana	12,426	\$ 29,325,146	\$ 21,756,956	74.2%
BCBS of GA Inc	WellPoint	Georgia	173,019	\$ 531,962,979	\$ 401,506,043	75.5%
Aetna Health Inc FL Corp	Aetna	Florida	44,443	\$ 122,137,375	\$ 93,577,646	76.6%
Optimum Choice Inc	UnitedHealth	Maryland	4,794	\$ 19,568,641	\$ 15,036,318	76.8%
Health Plan of Nevada	UnitedHealth	Nevada	8,762	\$ 24,737,976	\$ 19,127,566	77.3%
Aetna Health Inc PA Corp	Aetna	Pennsylvania	36,490	\$ 126,429,380	\$ 98,678,116	78.0%

Source: Carl McDonald, Oppenheimer & Co.

TABLE 3
State-Specific Small-Group Market MLRs of Selected Subsidiaries of Major Health Insurers, 2009

Insurance Company	Parent Company	State	Members	Premiums	Medical Expenses	MLR
UnitedHealth Healthcare of TN Inc	UnitedHealth	Tennessee	1,136	\$8,195,441	\$4,139,456	50.5%
Humana Employers Health Plan GA Inc	Humana	Georgia	36,090	\$103,347,153	\$65,702,968	63.6%
Coventry Health Care of KS Inc	Coventry	Kansas	12,261	\$44,519,688	\$28,833,712	64.8%
UnitedHealth HealthCare of AR Inc	UnitedHealth	Arkansas	1,378	\$7,726,008	\$5,098,636	66.0%
Anthem Health Plans of VA Inc	WellPoint	Virginia	173,832	\$813,392,436	\$541,715,642	66.6%
Coventry Health Care of LA Inc	Coventry	Louisiana	7,774	\$27,036,767	\$18,429,269	68.2%
Priority Healthcare Inc	WellPoint	Virginia	11,110	\$42,179,053	\$29,030,366	68.8%
Mamsi Life & Health Insurance Co	UnitedHealth	Maryland	11,445	\$66,386,198	\$46,324,358	69.8%
Humana Health Plan of TX Inc	Humana	Texas	64,102	\$170,154,160	\$119,800,579	70.4%
Personalcare Insurance of Illinois	Coventry	Illinois	9,648	\$37,749,634	\$26,633,489	70.6%
Healthkeepers Inc	WellPoint	Virginia	64,904	\$233,021,967	\$165,271,378	70.9%
Aetna Health Inc DE Corp	Aetna	Delaware	2,698	\$5,190,201	\$3,730,581	71.9%
Coventry Health Care of GA Inc	Coventry	Georgia	22,695	\$138,317,562	\$100,294,701	72.5%
United Healthcare of NC Inc	UnitedHealth	North Carolina	12,300	\$82,090,617	\$59,811,141	72.9%
Peninsula Health Care Inc	WellPoint	Virginia	10,681	\$35,761,228	\$26,294,813	73.5%
HMO Missouri Inc	WellPoint	Missouri	36,818	\$124,384,441	\$91,720,815	73.7%
Healthy Alliance Life Ins Co	WellPoint	Missouri	132,525	\$456,969,951	\$341,259,617	74.7%
BCBS of WI	WellPoint	Wisconsin	3,788	\$24,305,190	\$18,237,685	75.0%
Unicare Life & Health Insurance Co	WellPoint	Indiana	55,836	\$124,193,773	\$94,658,872	76.2%
Cariten Insurance Co	Humana	Tennessee	5,898	\$27,985,336	\$21,436,930	76.6%
Aetna Health Inc TX Corp	Aetna	Texas	28,491	\$101,618,484	\$77,910,270	76.7%
BCBS Healthcare Plan of GA Inc	WellPoint	Georgia	127,702	\$463,050,750	\$357,596,933	77.2%
Health Assurance PA Inc	Coventry	Pennsylvania	93,626	\$336,280,214	\$260,336,571	77.4%

Source: Carl McDonald, Oppenheimer & Co.

**TABLE 4
State-Specific Large-Group Market MLRs of Selected Subsidiaries of Major Health Insurers, 2009**

Insurance Company	Parent Company	State	Lives	Premiums	Medical Expenses	MLR
Mamsi Life & Health Insurance Co	UnitedHealth	Maryland	32,371	\$53,874,438	\$37,344,941	69.3%
CIGNA HealthCare of GA Inc	CIGNA	Georgia	1,819	\$9,737,695	\$7,122,927	73.1%
Aetna Health Inc DE Corp	Aetna	Delaware	6,043	\$26,528,026	\$19,433,508	73.3%
Neighborhood Health Partnership Inc	UnitedHealth	Florida	50,202	\$172,521,369	\$126,909,519	73.6%
UnitedHealth Healthcare Ins Co of IL	UnitedHealth	Illinois	14,967	\$59,331,556	\$44,429,985	74.9%
CIGNA HealthCare of TN Inc	CIGNA	Tennessee	24,014	\$94,974,911	\$71,696,183	75.5%
Priority Healthcare Inc	WellPoint	Virginia	22,319	\$77,140,290	\$58,445,090	75.8%
Peninsula Health Care Inc	WellPoint	Virginia	12,882	\$42,378,462	\$32,493,285	76.7%
Coventry Health Care of GA Inc	Coventry	Georgia	30,433	\$99,663,062	\$76,725,846	77.0%
UnitedHealth Healthcare of New England Inc	UnitedHealth	Rhode Island, Massachusetts, Maine, New Hampshire, and Connecticut	19,415	\$86,943,088	\$66,972,428	77.0%
UnitedHealthcare Plan of The River Valley	UnitedHealth	Ohio	40,898	\$154,905,773	\$120,700,551	77.9%
UnitedHealth Healthcare Insurance Co of OH	UnitedHealth	Ohio	10,151	\$41,547,308	\$32,552,129	78.3%
Anthem Hlth Plans of VA Inc	WellPoint	Virginia	152,927	\$851,283,871	\$675,712,717	79.4%
HMO Missouri Inc	WellPoint	New Jersey	26,856	\$105,206,671	\$84,112,744	80.0%
Carelink Health Plans Inc	Coventry	West Virginia	11,558	\$55,921,437	\$44,733,917	80.0%
Empire Healthchoice HMO Inc	WellPoint	New York	70,144	\$422,659,379	\$338,330,181	80.0%
Optimum Choice Inc	UnitedHealth	Maryland	68,878	\$307,279,680	\$247,492,084	80.5%
Personalcare Insurance of Illinois	Coventry	Illinois	50,782	\$232,416,825	\$187,640,302	80.7%
Coventry Health Care of KS Inc	Coventry	Kansas	29,319	\$98,646,535	\$80,470,547	81.6%
Humana Health Plan of Ohio Inc	Humana	Ohio	61,402	\$205,647,272	\$169,383,535	82.4%
Humana Health Plan of TX Inc	Humana	Texas	74,344	\$209,853,398	\$173,224,486	82.5%
Oxford Health Insurance Inc	UnitedHealth	Connecticut, New York, New Jersey	520,509	\$2,025,729,823	\$1,673,433,783	82.6%
Aetna Health Inc CO Corp	Aetna	Colorado	36,439	\$168,976,997	\$139,605,697	82.6%
Humana Employers Health Plan GA Inc	Humana	Georgia	34,790	\$101,329,472	\$83,749,959	82.7%
Aetna Health Inc PA Corp	Aetna	Pennsylvania	384,102	\$1,680,201,891	\$1,389,059,096	82.7%
Oxford Health Plans NY Inc	UnitedHealth	New York	106,697	\$561,836,618	\$465,082,209	82.8%
Aetna Health Inc NY Corp	Aetna	New York	65,576	\$368,881,420	\$307,069,010	83.2%

Source: Carl McDonald, Oppenheimer & Co.

**TABLE 5
Comprehensive Major Medical Insurance for the Six Largest Investor-Owned Insurance Companies, 2009**

	INDIVIDUAL			SMALL EMPLOYER			LARGE EMPLOYER		
	Premiums	Paid Claims Plus Change in Contract Reserves	Medical Loss Ratio	Premiums	Paid Claims Plus Change in Contract Reserves	Medical Loss Ratio	Premiums	Paid Claims Plus Change in Contract Reserves	Medical Loss Ratio
Aetna	\$1,067,373,961	\$808,241,274	75.7%	\$4,152,377,642	\$3,495,634,331	84.2%	\$10,751,303,688	\$9,378,310,007	87.2%
CIGNA	\$67,909,705	\$59,807,847	88.1%	\$171,979,619	\$158,473,605	92.1%	\$4,281,882,762	\$3,647,976,925	85.2%
Coventry	\$189,101,595	\$136,043,183	71.9%	\$1,691,895,784	\$1,322,747,647	78.2%	\$2,643,919,441	\$2,273,910,960	86.0%
Humana	\$602,807,555	\$410,241,077	68.1%	\$2,127,994,874	\$1,703,155,307	80.0%	\$3,040,915,262	\$2,683,218,711	88.2%
United Health	\$1,749,375,707	\$1,233,295,538	70.5%	\$11,013,011,550	\$8,930,641,286	81.1%	\$17,907,779,538	\$14,910,470,924	83.3%
WellPoint	\$4,429,058,685	\$3,318,569,293	74.9%	\$8,678,606,642	\$7,050,269,009	81.2%	\$11,840,078,917	\$10,051,310,004	84.9%
Total	\$8,105,627,208	\$5,966,198,212	73.6%	\$27,835,866,111	\$22,600,921,185	81.2%	\$50,465,879,608	\$42,945,197,531	85.1%

Source: Senate Commerce Committee

Notes

1. Data is based on Accident and Health Policy Experience Exhibit (A&H Policy Exhibit) filings made by the companies and their subsidiaries with the National Association of Insurance Commissioners (NAIC). In the A&H Policy Exhibits, data about comprehensive medical insurance sold to individuals is under the heading "Individual, Comprehensive Major Medical With Contract Reserves." Data about comprehensive medical insurance sold to small employers (usually between 2-50 employees) is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Small Employer." Data about major medical insurance sold to large employers is under the heading "Group Business Comprehensive Major Medical, Single Employer, Other Employer."
2. NAIC's calculation of Loss Ratio is "Paid Claims Plus Change in Contract Reserves" divided by "Earned Premiums." The change in contract reserves generally does not significantly affect the loss ratio, but is included in the above calculations.
3. Data is limited to fully-insured business, comprehensive major medical insurance. Self-insured, administrative services only, Federal Employee Health Benefit Program, Tricare and Medicare are not included in this chart.
4. Data does not include information about entities regulated by the California Department of Managed Health Care (DMHC), because such entities do not file A&H Policy Exhibits with NAIC. Companies that have substantial amounts of major medical business and file with DMHC include, but are not limited to: Blue Cross of California (a WellPoint subsidiary) and PacificCare of California (a UnitedHealth subsidiary).
5. In 2009, Golden Rule, a UnitedHealth subsidiary, sold the bulk of its individual insurance through associations and other groups, and therefore it is not represented as Individual Business in the A&H Policy Exhibit, but rather is reported as "other associations and discretionary trusts." The above individual number for UnitedHealth, however, includes Golden Rule premiums and claims as reported in Golden Rule's A&H Policy Exhibit. Without Golden Rule, UnitedHealth's individual premiums would be \$629,060,549, its claims would be \$530,783,524 and its loss ratio would be 84.3%. This would increase the total group ratio to 75%.

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