Healthcare Reform’s Mandatory Medical Loss Ratio: Constitutionality, Policy, and Implementation

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May 24, 2011
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ABSTRACT

What do Rush Limbaugh and Richard Epstein have in common? They both oppose the medical loss ratio (MLR) provisions in the recently-enacted healthcare reform legislation. After reading this article, so will you. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law, as Vice President Biden whispered “this is a big [expletive] deal” in the President’s ear. Unfortunately, as can be expected with any major piece of legislation, the ACA has problems. Those seeking to repeal the ACA have focused primarily on the so-called individual mandate, which requires individuals to purchase health insurance. A number of lawsuits challenging the constitutionality of this provision wind their way to the Supreme Court as we speak. I write this article to turn the public’s attention to a much more troubling provision, the medical loss ratio (MLR) mandate, which dictates how private health insurance companies must spend their money. The ACA’s nationwide, mandatory MLR very likely violates the Constitution, in part because the MLR’s “safety valves” do not adequately ensure that health insurance companies can earn the constitutionally-required reasonable rate of return. To make matters worse, it appears that Congress’ decision to set the MLR benchmark as it did was not based on economic analysis of the insurance market, or balancing of interests between insurance companies and consumers, or what MLR will yield a reasonable, non-confiscatory rate of return for the insurance industry, but rather politics. This decision-making process falls far short of the fact-intensive, market-specific, economic-based analysis required by the Constitution when the government sets rates. In addition to being constitutionally troublesome, the ACA’s MLR mandate is bad policy. In this article, I suggest that the cognitive bias known as “anchoring” will simultaneously cause “low MLR” providers to raise their MLRs to comply with the law (the law’s intended effect) and cause “high MLR” providers to drift downward towards the new national MLR standard (an unintended, detrimental consequence of the law). For these reasons, Congress should eliminate the mandatory MLR from any future healthcare reform legislation.
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The business [the insurance companies are] in is health insurance for a profit. They are trying to insure as many people as they can as affordably as they can so that they make a profit and so that the patients get covered. Obama is wiping the profit out. Obama is purposely trying to destroy the private health insurance industry so that government’s the only option people have, five, ten years from now. That’s the objective. And by telling them that they must devote 80% of their profits to X? He’s got no right to do that. It’s totally unconstitutional.  -- Rush Limbaugh, noted conservative pundit, on the medical loss ratio (MLR)\(^1\)

In effect, the onerous obligations under the [ACA] would convert private health insurance companies into virtual public utilities. This action is not only a source of real anxiety but also a decision of constitutional proportions, for it systematically strips the regulated health-insurance issuers of their constitutional entitlement to earn a reasonable rate of return on the massive amounts of capital that they have already invested in building out their businesses. -- Richard Epstein, prominent legal scholar, on the MLR\(^2\)

As a general rule, I do not give much credence to Rush Limbaugh’s interpretation of the law. However, when Richard Epstein shares his view,

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\(^*\) 2011 graduate of NYU School of Law. I would like to thank Deborah Bachrach and Joe Baker for their open-mindedness and support. All errors are, of course, my own.


perhaps there’s something to it. Both Limbaugh and Epstein oppose the medical loss ratio (MLR) provisions in the recently-enacted healthcare reform legislation, and after investigating the issue myself, I can see their point. I write this article to bring public and congressional attention to the often-overshadowed MLR issue. Should Congress revisit healthcare reform in the coming years, I implore our legislators to leave the MLR mandate out of any new law. Imposing a nationwide, mandatory MLR on the health insurance industry is bad policy and likely unconstitutional.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. The New York Times heralded the new legislation as “landmark health care overhaul — the most expansive social legislation enacted in decades.” As Vice President Joe Biden less eloquently put it, “this is a big [expletive] deal.” The ACA is certainly a big deal, but at 906 pages in length, it’s also just plain big. And as can be expected with any big bill that revamps something as critical as healthcare, the ACA has problems. Imposing a mandatory MLR on private health insurance providers may be one of those problems.

In a broad sense, one can evaluate the ACA’s various provisions along two axes: constitutionality and policy. Some provisions are


5 Id.

6 Id. (quoting Vice President Biden whispering congratulations to President Obama).

7 See generally ACA.
undoubtedly both constitutional and good policy. In my opinion, the drastic expansion of Medicaid and the creation of health insurance exchanges fall within this category. Other provisions may embody sound policy decisions but (arguably) overstep the constitutional line. The individual mandate is the paradigmatic example. Still other provisions might be both unconstitutional and bad policy. I fear the ACA’s MLR mandate may be just such a provision.

This paper proceeds as follows. In Section II, I present an overview of the ACA’s medical loss ratio provisions, as well as the current controversy surrounding the new MLR requirements. I then evaluate, and ultimately question, the constitutionality of the MLR provisions in Section III. Section IV sets forth policy-based arguments for and against setting a mandatory MLR in the health insurance industry. In this section, I propose that the ACA will detrimentally “anchor” insurance providers to the arbitrary minimum MLR required by the law. This “anchoring” will simultaneously cause “low MLR” providers to raise their MLRs to comply with the law (the intended effect of the law) and cause “high MLR” providers to drift downward towards the new national MLR standard (an

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unintended consequence of the law). Finally, Section V details the practical steps that insurance providers, state governments, and the federal government should take to implement the new medical loss ratio laws.

II. THE ACA’S MLR MANDATE: OVERVIEW AND CURRENT EVENTS

A. The MLR under the ACA

In general terms, a health insurance company’s “medical loss ratio,” or “MLR,” is the percentage of premium revenue the company spends on “direct care for patients and efforts to improve care quality.”\(^\text{11}\) A short hypothetical will serve to illustrate the MLR calculation. Suppose Health Insurance Company X insures 100 consumers, and each consumer pays the company $10,000 per year for his insurance. It follows that Company X’s premium revenue for the year totals $1,000,000.\(^\text{12}\) If Company X pays out $700,000 to cover its 100 consumers’ annual medical expenses, then the company’s medical loss ratio equals 70%.\(^\text{13}\)

The ACA sets, for the first time, nationwide minimum MLR requirements that all health insurance issuers must meet.\(^\text{14}\) The ACA’s MLR legislation contains several important interlocking provisions. First, the new law requires each health insurance issuer to submit an annual report


\(^{12}\) 100 consumers x $10,000 / year = $1,000,000 / year.

\(^{13}\) $700,000 in direct care for patients / $1,000,000 in total premium revenue = 70%.

\(^{14}\) See ACA § 10101(f) (amending ACA § 1001, which amended Public Health Serv. Act. § 2718, 42 U.S.C. § 300gg et seq.)
to the Secretary of Health and Human Services detailing how the issuer spends its money.\textsuperscript{15} Specifically, the report must include the percentage of total premium revenue the issuer spends “(1) on reimbursement for clinical services provided to enrollees under such coverage; (2) for activities that improve health care quality; and (3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.”\textsuperscript{16} In other words, issuers must report their MLRs to the federal government.

Second, and most importantly, the ACA mandates that every health insurance issuer keep its MLR above a certain benchmark: 85% in the large group market and 80% in the small group and individual markets.\textsuperscript{17} The ACA calculates the MLR as the “ratio of the amount of premium revenue expended by the issuer on [reimbursement for clinical services and activities that improve health care quality] to the total amount of premium revenue [after various exclusions].”\textsuperscript{18} If an insurance company’s MLR falls below the 80% / 85% threshold, the company must send rebates to the people it insures.\textsuperscript{19} As should be readily apparent, the MLR calculation, and therefore an insurance provider’s compliance with the law, depends heavily on the definition of vague terms such as “activities that improve health care quality.” Anticipating this potential problem, Congress required the National Association of Insurance Commissioners (NAIC) to define what

\textsuperscript{15} See ACA § 10101(f) (amending Public Health Serv. Act. § 2718(a)).

\textsuperscript{16} Id.

\textsuperscript{17} See ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(1)(A)).

\textsuperscript{18} Id.

\textsuperscript{19} See id.
“activities…improve health care quality” and thus fall within the numerator of the MLR equation.20

Under the ACA, each state has the option to raise its own minimum MLR requirements above the federal benchmarks.21 Congress directs the states to “seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements” when determining the appropriate MLR.22 This statutory language suggests that Congress sought to accommodate several competing policy goals by enacting a minimum MLR requirement: participation by insurance providers, competition among insurance providers, and value for health insurance consumers. The ACA’s minimum MLR provision went into effect on January 1, 2011.23

Through its complicated language, the ACA’s MLR legislation produces a simple result: capping insurance company profits. Suppose an insurance company has absolutely no expenses, an entirely unrealistic assumption for any business, but useful for purposes of explanation. Under the ACA, that company’s profit margin is capped at 15% in the large group market and 20% in the small group and individual markets. More realistically, if the company spends 10% of its premium revenue on administrative costs, then the ACA effectively limits the company’s profit margin to 5% in the large group market and 10% in the small group and

20 See ACA § 10101(f) (amending Public Health Serv. Act. § 2718(c)).

21 See ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(1)(A)).

22 ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(2)).

23 ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(1)(A)).
individual markets. In an extreme example, consider a company that cannot, or will not, reduce its administrative costs to below 20% of its revenue. The ACA’s MLR provisions ensure that this company will make *no profit* in the small group and individual markets and will *lose 5%* in the large group market, essentially forcing the company out of business. This profit capping represents an extreme, potentially unconstitutional, intrusion into the private health insurance industry, a topic I explore in detail in Section III below.

The ACA does provide a “safety valve” to alleviate some of the foreseeable problems associated with the MLR requirements. Specifically, the Secretary of Health and Human Services (SHHS) has discretion to adjust the MLR benchmark rates in two situations: (1) in the small group and individual markets of a state, if the Secretary determines that the 80% MLR “may destabilize the individual market in such State,”24 and (2) “if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.”25 Neither of these safety valves applies to the large group market, and both vest ultimate authority in the SHHS.

In order to qualify for the MLR adjustment under safety value (1), “a state must demonstrate that requiring insurers in its individual market to meet the 80% MLR has a likelihood of destabilizing the individual market and result in fewer choices for consumers.”26 As of April 12, 2011, nine

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24 ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(1)(A)(ii)).

25 ACA § 10101(f) (amending Public Health Serv. Act. § 2718(d)).

states (Maine, New Hampshire, Nevada, Kentucky, Florida, Georgia, North Dakota, Iowa, and Louisiana) have requested MLR adjustments. Maine’s request was granted on March 8, 2011, and the other eight requests remain pending.

Pursuant to the statute, the Department of Health and Human Services (HHS) promulgated regulations regarding the implementation of the ACA’s MLR requirements. Like the ACA itself, these regulations are long (72 pages) and complicated. According to the HHS, “[t]he medical loss ratio regulation outlines disclosure and reporting requirements, how insurance companies will calculate their medical loss ratio and provide rebates, and how adjustments could be made to the medical loss ratio standard to guard against market destabilization.” The regulations closely

27 See id.


30 See ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(3) (“The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties”)).


track the recommendations formulated by the NAIC “after months of meetings and debate involving industry and consumer representatives.”

As a general matter, consumer advocates praised the regulations, while insurance companies complained.

A comprehensive review of the MLR regulations lies beyond the scope of this paper. However, it is worth mentioning several of the more important and controversial aspects of the regulations. First, the regulations make special allowances for “mini-med” plans, i.e., limited-benefit policies that only cover up to $250,000 a year. In essence, “mini-med” plans can satisfy the 80% MLR requirement by spending only 40% on medical costs. Consumer advocates detest these “mini-med” plans, claiming that they “[leave] often unsuspecting customers to fend for themselves if they develop a costly and serious disease.”

Second, the regulations spell out which expenses “count” as medical spending for the purposes of calculating the MLR. Naturally, the insurance industry pushed for a broad definition of “activities that improve health care

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34 See id.

35 See id.

36 See id.

quality. The broader the definition, the easier it is to meet the minimum MLR requirement. In particular, insurers lobbied to include “the cost of paying claims, signing up doctors to their networks or running customer service call centers,” in the numerator of the MLR equation. Ultimately, the regulations disappointed the health insurance industry. While the regulations permit insurers to count certain quality improvement costs and payments to health care providers (doctors, nurses, and hospitals) as medical expenses, the regulations classify broker commissions as administrative costs, which are excluded from the MLR numerator.

B. Current Controversy: What’s In and What’s Out?

The definitional distinction between medical and non-medical expenses drives the MLR debate. An insurance company’s costs associated with “activities that improve health care quality” count towards the 80% / 85% MLR requirements; non-medical, administrative expenses do not. Three categories of expenses have drawn especially heavy scrutiny: (1) brokers’ commissions, discussed briefly above; (2) federal and state taxes; and (3) anti-fraud efforts.


39 Id.

1. **Brokers’ Commissions**

Insurance brokers “are independent agents who receive commissions from an insurer for selling insurance products.”

Brokers provide a valuable service to both health insurance issuers and health insurance consumers. For example, brokers (1) help employers design the “right” plan(s) for their employees; (2) comparison shop to get the best possible price for their clients; (3) explain the costs and benefits of the plan(s) to the insured; (4) resolve claims-related problems; and (5) refer customers to health insurance providers, thereby allowing the insurance companies to limit marketing-related expenses.

Health insurance brokers lobbied to have their commissions excluded from the MLR equation. Specifically, the brokers expressed concern that if their commissions counted as administrative expenses in the MLR calculation, “insurers would cut their pay to improve medical loss ratios.” The brokers’ concerns appear warranted. Facing the prospect of a mandatory minimum MLR, many health insurance issuers have already reduced broker commissions by up to 50%.

Additionally, state insurance

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42 See id.


44 Id.

agencies worried that they would be flooded with calls for help if the MLR pushed too many brokers out of business. Nonetheless, the brokers lost this battle. The NAIC concluded that “commissions should be counted as administrative expenses,” but at least resolved “to establish a working group with HHS to find some kind of solution to ensure that agents and brokers can remain in the market.”

2. Federal and State Taxes

According to the ACA, the denominator of the MLR equation is “the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees…)” (emphasis added). A smaller denominator makes the MLR requirement easier to meet. Therefore, insurance companies naturally want to exclude as many taxes and fees as possible. The NAIC took the position that “all federal taxes, such as income taxes, except for taxes on investment income and capital gains” should be excluded from the MLR denominator. This relatively broad definition favors the health insurance providers.

On the other hand, the drafters of the bill “maintained that the provision referred only to new federal taxes on insurers that were put in


47 Id.

48 ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(1)(A)).

place through the reform law, and not to other taxes.” By excluding far fewer taxes, this relatively narrow definition would make it more difficult for insurance companies to meet the ACA’s minimum MLR requirements. Some critics of this position claim that such a narrow definition of the tax exclusion would amount to double-taxation of the health insurance industry. Ultimately, HHS sided with the NAIC, defining the MLR tax exclusion quite broadly in the MLR regulations.

3. **Anti-Fraud Efforts**

According to a 1998 HHS report, “losses to fraud and abuse may exceed 10 percent of annual health care spending, or $100 billion per year.” Unfortunately, research indicates that despite this enormous problem, health insurance companies do not devote nearly enough attention and resources to preventing insurance fraud. During the MLR debate,

50 Id.


52 75 Fed. Reg. at 74,878 (“This interim final regulation adopts the NAIC recommendation that Federal income taxes on investment income and capital gains are not taxes based on premium revenues, and thus should not be used to adjust premium revenues, as specified in § 158.162, while all other Federal taxes allocated to health insurance coverage should be excluded from non-claims costs for purposes of the report required by section 2718. Section 158.162 also makes clear that Federal taxes which are excluded from non-claims costs are to be excluded from premium revenue when calculating an issuer’s MLR”).


54 See id. at 10.
insurance providers argued that money spent on anti-fraud measures should qualify as expenses for “activities that improve health care quality.” 55 In other words, insurers want to put fraud prevention expenditures in the numerator of the MLR equation, making it easier to satisfy the minimum MLR requirement.

HHS disagreed, refusing to classify fraud-prevention activities as quality improvement measures except for “fraud detection/recovery expenses up to the amount recovered that reduces incurred claims.” 56 Other “[e]xpenditures and activities that must not be included in quality improving activities” include cost containment activities; expenses related to running a claims adjudication system; “all retrospective and concurrent utilization review”; and marketing expenses. 57

By largely excluding anti-fraud expenses from the MLR numerator, HHS missed an opportunity to incentivize health insurance companies to adopt more advanced, effective fraud-prevention measures. A rational insurance company would likely spend more money to prevent fraud if such expenditures count towards the MLR. That’s a good thing, to the extent that ferreting out insurance fraud produces a net social benefit. Instead, the MLR regulations discourage health insurance providers from spending on fraud-prevention because incurring such costs makes it more difficult for a provider to comply with the MLR mandate. This is particularly troublesome when one considers that the health insurance industry already under-spends on fraud-prevention.


56 75 Fed. Reg. at 74,924-25.

57 See id.
C. Current Events Surrounding the MLR

Passing the ACA did not end the MLR debate. States still have to decide whether to seek an exemption from the new federal MLR requirements, and Republican legislators continue to search for ways to undermine the ACA’s MLR provisions.

1. State Requests for MLR Adjustments

As discussed above, nine states (Maine, New Hampshire, Nevada, Kentucky, Florida, Georgia, North Dakota, Iowa, and Louisiana) have asked HHS for MLR adjustments. HHS recently approved Maine’s request for adjustment, but the other eight requests remain open. HHS clearly and concisely summarized the reasoning behind its decision to grant Maine’s request as follows:

The Maine Bureau of Insurance requested an adjustment of the 80 percent MLR to a 65 percent MLR standard. As of September 2010, nearly 37,000 Maine residents obtain health insurance coverage through Maine’s individual health insurance market. One insurer, MEGA Life & Health Insurance Company, which covers more than a third of the market or approximately 14,000 Mainers, has said it may exit the market if required to meet this higher standard in 2011 and 2012. According to the State, since MEGA offers lower cost policies in Maine’s individual market, if the insurer left the market, consumers may not be able to purchase new policies of comparable price and benefit design. For these reasons, HHS accepted the Maine Bureau of Insurance request for an


59 See id.
adjustment to 65 percent for 2011 and 2012. HHS will allow the adjustment to continue through 2013, as Maine requested, if the State provides additional data at the end of 2012 to support a third year of the adjustment to 65 percent (emphasis added).

One can view this result either favorably or unfavorably, depending on one’s point of view. ACA proponents will say that HHS’ approval of Maine’s request demonstrates that the “safety valve” works. The law contains sufficient safeguards to ensure that the new MLR requirements do not force insurers out of the market, potentially destabilizing it. On the other hand, ACA opponents may claim that the Maine experience illustrates the perils of a national minimum MLR: insurance companies such as MEGA Life & Health would prefer to leave the market entirely rather than comply with the new MLR requirements. If enough insurers follow this approach, the health insurance market, or at least a significant portion of it, will dry up, leaving consumers with limited options. HHS granted Maine’s request for relief, but what about insurance providers in states that do not seek an MLR adjustment? Or what if HHS makes a mistake and denies a state’s valid MLR adjustment request? Finally, consumer advocates who believe the MLR provisions do not go far enough in regulating insurance companies might complain that the MLR adjustment safety valve allows “junk insurance” providers such as MEGA to stay in business while continuing to gouge unsuspecting customers.


The other states requesting MLR adjustments have concerns paralleling those expressed by Maine. Namely, the states worry that the new 80% MLR requirement in the individual market will cause insurance providers to exit the market, which in turn will undermine the integrity of the market. For example, New Hampshire stresses that a single insurance carrier dominates the individual insurance market in the state, and smaller carriers may not participate at all if they are forced to comply with the federal MLR requirement.\textsuperscript{62} Nevada notes that as of Sept. 1, 2010, three carriers “have imposed moratoriums on new business while they determine their ultimate market strategy” and may well exit the market “unless there is some relief granted through an adjustment to the medical loss ratio standard.”\textsuperscript{63} Similarly, Florida contends that implementing the ACA’s new MLR standards will cause insurance companies to “exit the individual market or cease issuing new policies,” “erect barriers to entry into the individual market,” reduce consumer choice, and “severely hamper agent involvement in the individual market to the severe detriment of Florida


It will be interesting to see how HHS decides the many pending MLR adjustment applications in the coming months.

2. Republican Party Efforts to Undermine the MLR

The Republican Party failed to keep the ACA from becoming law, but that hasn’t stopped a number of Republican legislators from continuing to fight against the ACA’s MLR mandate. For example, on February 18, 2011, Republican Congressman Tom Price (Georgia) introduced an amendment to the Full Year Continuing Appropriations Act of 2011, so that “[n]one of the funds made available by division B may be used by the Department of Health and Human Services to implement or enforce section 2718 of the Public Health Service Act [the ACA’s MLR provision].”

Presumably, Congressman Price proposed this amendment to stifle federal government efforts to administer the new federal MLR regime.

On March 9, 2011, in another attack on the MLR provision, Republican Congressman Carter (Texas) discussed the HHS MLR regulation and then noted, “[w]e actually have a bill that is coming before this Congress…It mandates that all new major rules must be approved by Congress before becoming law. This one is pretty simple, and it just supplements what we’re already dealing with. It uses the same definition for major rules and requires Congress to approve all major rules and Federal regulations before they become effective.”

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implies that at least some ACA opponents will go to great lengths to prevent the MLR regulations from taking effect. Whether critics will successfully derail the MLR laws and/or regulations remains to be seen.

3. The Rhetoric Continues

Congressmen on both sides of the aisle have ramped-up the rhetoric in the MLR debate. The following quotations expose the general flavor of the MLR “discussion” swirling around Congress.

Last year, this Congress made a lot of decisions that gave Washington control over our health care system. And a perfect example of that control is that ObamaCare mandates to the companies that provide the health coverage for individuals, helping individuals, how to run their business. Essentially, the Federal Government is in the business of dictating to private companies what they should do to run their business, what kind of coverage they can provide, what kind of prices they can charge, what kind of definition of quality care, and what meets the definition of essential services for individuals. It really is central planning at its finest, and it is certainly not the government's role in a free market system -- Republican Congressman Price (Georgia)\textsuperscript{67}

This [MLR] regulation requires all health plans to pay a minimum of 80 percent of premiums toward health services. Larger insurers should pay a minimum of 85 percent. Industry analysis estimates that as many as 47 percent of the participants in individual and small group plans which have higher administrative costs due to economies of scale will lose their health insurance if this regulation becomes law. So this one regulation, which comes out of what we call the ObamaCare bill, could cause 47 percent of the people who have small to midsize health care plans to lose their health care plan -- Republican Congressman Carter (Texas)\textsuperscript{68}

If you're with the gentleman from Georgia [Price], you are on the side of the big insurance companies, and you'll want to make sure that they make bigger profits, that they get bigger bonuses, that they pass out bigger dividends and more money to their CEOs... That's what this is all about. You're going to hand back to the insurance companies control over what happens with the money that you paid in your premium so they can do whatever they want with it and make whatever profit they want. I think it's wrong -- Democratic Congressman Pallone (New Jersey)⁶⁹

According to Republicans, “ObamaCare’s” MLR regulation could cause half of the entire small group insurance market to disappear. According to Democrats, opposing the MLR requirement equates to favoring greedy insurance company executives. This kind of fear-mongering and name-calling does nothing to shed light on the difficult and important issues at hand: whether or not the MLR law is (1) constitutional and (2) good policy. I take up these topics in the next two sections of the paper.

III. The Constitutionality of the ACA’s MLR Provisions

Prominent legal scholar Richard Epstein has argued that the ACA’s MLR provisions may be unconstitutional.⁷⁰ Although Epstein voiced his concerns in December of 2009 in relation to an earlier, in-progress version...
of the ACA,\textsuperscript{71} the basic structure of his constitutional analysis applies to the version of the ACA that ultimately became law in March of 2010. In this section of the paper, I attempt to flesh-out Professor Epstein’s position, in part by examining and synthesizing several cases in which courts have found unconstitutional government ratemaking. I conclude that the ACA’s MLR provisions at least approach, and likely overstep, the constitutional line.

A. The Constitutional Concern in Brief

Epstein bases his challenge to the ACA’s minimum MLR requirement in the Constitution’s Takings and Due Process clauses.\textsuperscript{72} The first move Epstein makes is to analogize the MLR requirement to government ratemaking.\textsuperscript{73} Using the Supreme Court’s ratemaking cases for support, Epstein then derives the following principle: “[a] basic constitutional requirement is that any firm in a regulated market be allowed to recover a risk-adjusted competitive rate of return on its accumulated capital investment”\textsuperscript{74} (emphasis added). The higher the risk, the greater the constitutionally-required rate of return.\textsuperscript{75}

\begin{itemize}
  \item \textsuperscript{71} See id. at 1.
  \item \textsuperscript{72} See id. at 20.
  \item \textsuperscript{73} See id. at 3 (“[t]hese constitutional provisions have been subject to extensive interpretation in the Supreme Court in ratemaking cases, which must be taken into account in dealing with the legislation”).
  \item \textsuperscript{74} Id. at 3 (citing \textit{Duquesne Light Co. v. Barasch}, 488 U.S. 299 (1988)).
  \item \textsuperscript{75} See id. at 20 (citing \textit{Smyth v. Ames}, 169 U.S. 466 (1899)).
\end{itemize}
Epstein then makes another assumption: “that the health insurance industry is competitive or could easily be made competitive.” Because the industry is competitive, the prevailing market rates (including the MLR) necessarily reflect the “risk-adjusted competitive rate of return” required by the Constitution. It follows that any law mandating an MLR above that already prevailing in the competitive health insurance market violates the Constitution. The ACA does just that and is therefore unconstitutional. In Epstein’s words, “it is impossible for the rate regulation of firms in the competitive health insurance industry to recover the constitutionally permissible rate of return. So long as competitive rates of return remain the constitutional benchmark, rate regulation necessarily fails. The unregulated rates are already at the competitive level. Any system that reduces revenues, raises costs, and increases uncertainty cannot possibly meet the applicable constitutional standard.”

Several aspects of Epstein’s argument trouble me. First, I’m not entirely convinced that the current health insurance market is “competitive.” For one thing, the market is extremely concentrated. According to a 2009 report, one carrier controls more than half the market in 21 states, and two carriers control more than half the market in 39 states. HHS granted Maine’s request for an MLR adjustment primarily because one insurance carrier that controlled over 30% of the individual market threatened to

76 Id. at 21.
77 See id. at 23.
78 Id.

leave. Additionally, the cost of health insurance continues to skyrocket. In 2011, “groups of more than 20 workers have been experiencing premium increases of around 20 percent…while smaller groups are seeing increases of 40 percent to 60 percent or more.” Although not dispositive, market concentration and rising prices suggest that the health insurance market is less than optimally “competitive.” However, once the ACA’s health insurance exchanges take root, the market should be competitive. Therefore, Epstein’s assumption of competitiveness does not doom his constitutional analysis of the ACA’s MLR mandate.

Second, under Epstein’s reasoning, the Constitution would foreclose any rate regulation in any competitive industry. Epstein believes that “the entire rationale for government ratemaking is undermined [when the market is competitive]. The point of ratemaking was to require the firm to accept competitive rates of returns in a market setting where it enjoyed monopoly power.” I don’t believe the Constitution goes this far. Government rate


82 See Kaiser Family Foundation, Explaining Health Care Reform: What are Health Insurance Exchanges (May 2009), http://www.kff.org/healthreform/upload/7908.pdf (explaining that exchanges are “intended to create a more organized and competitive market for health insurance by offering a choice of plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them”).

setting in a competitive market strikes me as unnecessary and unwise. However, such government intervention is constitutional unless the government sets a rate so low as to be “confiscatory”\(^\text{84}\) or “unreasonable.”\(^\text{85}\)

Third, Epstein’s reliance on the public utility analogy contains an internal inconsistency. On the one hand, he cites public utilities cases such as *Duquesne Light Co. v. Barasch* to show that the government must give firms in regulated markets an opportunity to earn a “risk-adjusted competitive rate of return.”\(^\text{86}\) On the other hand, he asserts that government rate setting only makes sense in the context of monopolies such as public utilities, not in competitive markets such as the health insurance industry.\(^\text{87}\) If public utilities (monopolies) fundamentally differ from the health insurance industry (competitive) in the rate regulation context, then relying on public utilities-based doctrine to craft a constitutional rule governing the health insurance industry does not make much sense.

Most importantly, Epstein does not provide guidance on what constitutes a “risk-adjusted competitive rate of return.” The government may exercise significant control over the health insurance industry because healthcare is a vital public interest.\(^\text{88}\) Because the government possesses

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84 *See* 43 Am. Jur. 2d *Insurance* § 42 (2010).

85 *See* 64 Am. Jur. 2d *Public Utilities* § 134 (2010).


87 *See* id. at 21.

88 *See* *Golden Rule Ins. Co. v. Ins. Dept.*, 641 A.2d 1255, 1260 (Pa. Commw. Ct. 1994) (“Our Supreme Court has held that the Commonwealth may regulate the business of insurance, because it is a business affected with a public concern”); *Smith v. Department of Ins.*, 507 So.2d 1080, 1092-93 (Fla. 1987) (“We find a legitimate state interest in regulating these insurance rates, and hold these insurance companies have no
broad power to regulate the insurance industry, including rates, insurance companies have no constitutional right to be regulated under ‘open competition’ laws. However, as mentioned above, the government still cannot impose “confiscatory” or “unreasonable” rates on insurance providers. This begs the question: how do the courts distinguish between permissible rate regulation (here, a permissible MLR law) and an unconstitutional “confiscatory” MLR requirement? The following discussion sheds light on this thorny issue.

B. Constitutional vs. Confiscatory

The words “unreasonable” and “confiscatory” mean nothing without context. Therefore, courts have developed a number of principles to analyze whether or not a government-set rate is “unreasonable” or “confiscatory” and therefore unconstitutional. First, the Constitution does not require the government “to fix rates that will guarantee a profit to all insurers,” but at the same time, the government cannot “constitutionally fix rates so low that if the insurers engage in business they will do so only at a loss.” In the MLR context, this means that the government must set the constitutional right to be regulated and governed by this specific type of ‘open competition’ law”.

93 43 Am. Jur. 2d Insurance § 42 (2010); see also 64 Am. Jur. 2d Public Utilities § 134 (2010) (suggesting that “a system of charges that yields no more income than is fairly requisite to maintain the plant, to pay fixed charges and operating expenses, to provide a
minimum MLR at a level that gives insurers the opportunity to make a fair profit. As noted by Professor Epstein, a “fair profit” should account for the level of risk involved in the business. Rates that merely protect insurers from insolvency or permit insurers to break even do not pass constitutional muster. Of course, neither the government nor anyone else can guarantee that all insurers will make a profit under a particular regulatory scheme.

Procedurally, courts stress that the government should give insurers the opportunity to oppose a rate change. In other words, courts are more likely to find government rate regulation constitutional when the regulatory

suitable sinking fund for the payment of debts, and to pay a fair profit to the owners of the property, is not unreasonable”) (emphasis added).

94 See 73B C.J.S. Public Utilities § 72 (2011) (“Rates which enable a utility to operate successfully, to maintain its financial integrity, to attract capital, and to compensate its investors for the risks assumed cannot be condemned as invalid, even though they might produce only a meager return on the so-called “fair value” rate base”) (emphasis added).

95 See Geeslin v. State Farm Lloyds, 255 S.W.3d 786, 794-95 (Tex. App. 2008) (“We note, however, that rates can be confiscatory without necessarily leading to insolvency. Thus, the proof provision set out in [the statute], by allowing for the imposition of confiscatory rates, fails to provide regulated companies with a constitutionally adequate review of government-set rates. We therefore hold that the proof provision is unconstitutional on its face”).

96 See Guaranty Nat. Ins. Co. v. Gates, 916 F.2d 508, 515-16 (9th Cir. 1990) (“We agree that Chapter 784 is unconstitutional. Neither Chapter 784 nor the Nevada Insurance Code of which it is a part provides any mechanism to guarantee a constitutionally required fair and reasonable return… It follows from this definition that if projected losses and expenses are simply met, the rates are adequate. Thus, section 686B.050(3) guarantees only that an insurer will break even; it does not guarantee the constitutionally required ‘fair and reasonable return’”).

97 See 43 Am. Jur. 2d Insurance § 42 (2010) (“The regulatory authority may not establish a lower rate, in response to an application for a rate increase, without allowing the insurer an opportunity to oppose the reduction”).
mechanism includes a “safety valve” for insurance companies. In *Keystone Insurance Co. v. Foster*, the Eastern District of Pennsylvania rejected a constitutional challenge to a law setting insurance rates.\(^98\) In reaching its decision, the court stressed that the law contained a “constitutional ‘safety valve’” permitting the insurance commissioner to grant rate relief to an insurance company experiencing “extraordinary circumstances,” thereby avoiding “a confiscatory impact on an insurance company.”\(^99\)

Similarly, in *Calfarm Insurance Co. v. Deukmejian*, the California Supreme Court considered the constitutionality of an insurance rate-setting statute.\(^100\) After severing an unconstitutional provision from the law, the court held that “the remaining regulatory provisions should afford insurers an effective means of relief from any confiscatory rate.”\(^101\) One “safety valve” here included statutory language prohibiting the insurance commissioner from approving or permitting “any rate ‘which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter’ - language which makes it clear that the commissioner can grant relief from confiscatory rates.”\(^102\) A second “safety valve” allowed aggrieved insurers to apply for rate relief.\(^103\) As discussed in Section II(A), the ACA’s MLR provisions do contain a “safety valve,” namely the opportunity for states to request an adjustment to the federal MLR standards. The question then


\(^99\) Id.

\(^100\) See *Calfarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805, 815 (1989).

\(^101\) Id.

\(^102\) Id. at 816-21.

\(^103\) See id. at 815.
becomes whether this particular “safety valve” sufficiently protects health insurers nationwide from unreasonable rates.

Third, an insurance company challenging a rate as “confiscatory” bears a heavy burden of proof, and courts should generally defer to the rate setting authority.\textsuperscript{104} Specifically, a “court cannot usurp the function of administrative officials… or substitute its own judgment for that of the officials… and must give deference to their determinations.”\textsuperscript{105} Of course, a court must still reject a government rate determination that “involves a violation of constitutional rights.”\textsuperscript{106} Regarding the burden of proof in rate setting cases, a “party challenging a rate as being confiscatory has the burden of proving that it has been deprived of the opportunity to earn a fair return and that its failure to earn a sufficient return is directly attributable to the inaccuracy of the rate”\textsuperscript{107} (emphasis added). Therefore, an insurance company opposing the ACA’s MLR provisions must show that the new minimum MLR (80% in the small group and individual markets and 85% in the large group market) eliminates the company’s ability to make a fair profit.

Fourth, the government must consider that actual and predicted financial and economic landscape of the marketplace when setting rates,

\textsuperscript{104} See 44 C.J.S. Insurance § 120 (2011); see also Aetna Ins. Co. v. Hyde, 275 U.S. 440, 447-48 (1928) (“Jurisdiction of this court to set aside state-made rates as confiscatory will be exercised only in clear cases; and the burden is on one seeking that relief to bring forward and satisfactorily prove the invalidating facts”);

\textsuperscript{105} See 44 C.J.S. Insurance § 120 (2011) (internal citations omitted).

\textsuperscript{106} Id.

\textsuperscript{107} Id.
which is a fact-intensive inquiry. As eloquently stated in the *Corpus Juris Secundum* encyclopedia of American law, “what constitutes a reasonable rate of return is primarily a question of fact, and there is no immutable standard for its measurement…The rate cannot be based merely on policy, but must be determined from the evidence, and, accordingly, depends largely on the facts and circumstances of the particular case” (emphasis added). As discussed in detail below, Congress made no effort to evaluate the realities of the insurance market when setting the MLR at 80% in the individual and small groups markets and 85% in the large group market. It was a purely political decision. This alone renders the ACA’s MLR provision constitutionally suspect.

Despite judicial deference to rate-setting authorities, courts will strike down insurance regulations when the government goes too far, e.g., by setting unreasonable, confiscatory rates. In *Geeslin v. State Farm Lloyds*, the Texas Court of Appeals struck down the proof provision of a rate-setting statute as unconstitutional on its face. The provision in question required “the commissioner to approve potentially confiscatory rates, absent clear and convincing evidence that such rates would lead to insolvency.” The court reasoned that “rates can be confiscatory without

108 See 64 Am. Jur. 2d Public Utilities § 133 (2010) (“In determining fair rates, the regulatory body considers a representative level of anticipated revenues and expenses and the property employed by the utility to provide service to its customers…The setting of utility rates requires a certain amount of prediction concerning a utility's future revenue requirement…The amount that a utility is permitted to recover from its customers in the rates it charges is determined by its revenue requirement”) (internal citations omitted).


111 *Id.*
necessarily leading to insolvency,” so the provision failed “to provide regulated companies with a constitutionally adequate review of government-set rates.”

The Ninth Circuit reached a similar result in *Guaranty National Insurance Co. v. Gates*. In *Gates*, the court interpreted the Nevada Insurance Code to guarantee “only that an insurer will break even.” The *Gates* court then held the law unconstitutional because a “break even” provision does not “guarantee the constitutionally required ‘fair and reasonable return.’”

In *Aetna Casualty & Surety Co. v. Commissioner of Insurance*, the Massachusetts Supreme Court considered the constitutionality of a law setting rates in the automobile insurance industry. In doing so, the court flatly rejected the government’s argument that it had unfettered discretion to set insurance rates and “if the companies cannot write the insurance at those rates they are free to stop writing it.” Insurers are “are not required to either submit to confiscatory rates or go out of business,” according to the

112 *Id.*


114 *Id.*

115 *Id.*


117 *Id.*
court. The court concluded that the law in question set confiscatory rates and therefore violated the Constitution.

Finally, in Calfarm Insurance Co. v. Deukmejian, the California Supreme Court confronted a rate-setting law “which provides that the commissioner cannot approve a rate increase…unless the insurer is substantially threatened with insolvency.” The court held this “insolvency only” provision unconstitutional because it did not “afford insurers an effective means of relief from any confiscatory rate.” However, the court saved the rest of the statute by severing the unconstitutional provision.

C. Applying Constitutional Principles to the ACA’s MLR Provision

Given what we now know about the constitutional limitations of government rate regulation in the insurance industry, how would a court view the ACA’s MLR mandate? In this segment of the paper, I argue that the MLR’s “safety valve” contains fundamental flaws, and Congress used an unacceptable process to select the benchmark MLRs (80% / 85%). Therefore, the ACA’s MLR provision might fall under a facial constitutional attack. However, the fact that many insurance companies profit while maintaining MLRs above the ACA’s 80% / 85% thresholds suggests that a facial challenge to the MLR will likely fail. On the other

118 Id.

119 See id.


121 See id.

122 Id.
hand, if a particular insurance company can show that the 80% / 85% MLR requirement would force the company to exit the market, or does not permit the company to earn a reasonable, non-confiscatory rate of return, the company’s as-applied constitutional challenge would likely succeed.

1. Flaws in the MLR’s “Safety Valve”

As discussed in Section II(A), the ACA gives the SHHS discretion to adjust the MLR benchmark rates in two situations: (1) in the small group and individual markets of a state, if the Secretary determines that the 80% MLR “may destabilize the individual market in such State,”\(^\text{123}\) and (2) “if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.”\(^\text{124}\) I call these provisions “safety valves” because they provide escape routes from the ACA’s otherwise mandatory 80% / 85% MLR requirement. There are four reasons why these particular “safety valves” do not adequately protect health insurance companies from confiscatory rates.

First, the ACA’s implementing regulation permits only the States, not the insurance providers, to request an adjustment to the MLR.\(^\text{125}\) If a

\(^{123}\) ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(1)(A)(ii)).

\(^{124}\) ACA § 10101(f) (amending Public Health Serv. Act. § 2718(d)).

\(^{125}\) HealthCare.gov, Medical Loss Ratio: Getting Your Money’s Worth, Accommodations to Avoid Market Destabilization, http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html (last visited Apr. 15, 2011) (“Consistent with NAIC recommendations, the regulation establishes a process for States to request such an adjustment for up to three years – an effective State-based transition. In order to qualify for this adjustment, a State must demonstrate that requiring insurers in its individual market to meet the 80 percent MLR has a likelihood of destabilizing the individual market and could result in fewer choices for consumers”) (emphasis added).
state does not request an adjustment, the health insurance providers in the state have no recourse from a confiscatory MLR. This stands in stark contrast to the “safety valves” that courts have credited in cases such as Calfarm Insurance Co. v. Deukmejian and Keystone Insurance Co. v. Foster, in which the insurance companies, not the states, had the power to seek relief from unreasonable rates.126

Second, the ACA’s “safety valves” do not guarantee a non-confiscatory rate of return. Specifically, “[i]n order to qualify for this [MLR] adjustment, a State must demonstrate that requiring insurers in its individual market to meet the 80 percent MLR has a likelihood of destabilizing the individual market and could result in fewer choices for consumers”127 (emphasis added). In Geeslin v. State Farm Lloyds, the Texas Court of Appeals held an insurance rate regulation unconstitutional, in part because it merely protected companies from insolvency, and “rates can be confiscatory without necessarily leading to insolvency.”128 Analogously, rates can be confiscatory without leading to market destabilization. Thus, the ACA’s MLR adjustment provision does not afford health insurance companies the constitutionally-required level of protection from confiscatory rates.


Third, the ACA’s “safety valves” apply only to the individual and/or small group markets, not to the large group market. Therefore, insurance providers in the large group market lack protection from confiscatory rates. In other words, if a large group insurance provider cannot raise its MLR above 85%, as required by the ACA, the provider must either operate at a loss or exit the large group insurance business. Forcing an insurance company to make this choice is unconstitutional.

Finally, the ACA’s MLR adjustment safety valve is only temporary. Specifically, “the regulation establishes a process for States to request such an adjustment for up to three years” (emphasis added). After this three-year transition period, presumably states will no longer be allowed to request an adjustment to the MLR. Therefore, even if the “safety valve” is constitutionally adequate right now (which is doubtful for the reasons set forth above), it will certainly be inadequate several years down the line.

129 See ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(1)(A)(ii)) (permitting the SHHS to adjust the MLR in the small group and individual markets if an 80% MLR would destabilize the individual market); ACA § 10101(f) (amending Public Health Serv. Act. § 2718(d)) (allowing the SHHS to adjust the MLR if the establishment of health insurance exchanges undesirably increase the volatility in the individual market).

130 See Aetna Cas. & Sur. Co. v. Commissioner of Ins., 263 N.E.2d 698, 701-04 (Mass. 1970) (the government “may not constitutionally fix rates which are so low that if the insurers engage in business they may do so only at a loss. The insurers are not required to either submit to confiscatory rates or go out of business”) (emphasis added).

2. Congress’ Questionable Decision-Making Process

Congress’ true motivation for setting the MLR threshold at 80% / 85% stinks. As detailed in Section III(B), the government must consider the economic and financial realities of the insurance market when setting rates. The rate cannot be based merely on policy, but must be determined from the evidence, and, accordingly, depends largely on the facts and circumstances of the particular case" (emphasis added).

On December 13, 2009, several months before the enactment of the ACA and during the heat of the healthcare reform debate, the Congressional Budget Office (CBO) released a memo discussing the ACA’s MLR proposal.133 The memo stated that if Congress set MLRs higher than 80% for the individual and small-group markets or 85% for the large-group market, the CBO would “consider transactions in those markets as part of the federal budget.”134 According to Megan McArdle, business and economics editor of The Atlantic, “[n]eedless to say, it is very doubtful that Congress wishes to consolidate the operations of the nation’s health insurers on the financial statements of the United States government.”135

Not surprisingly, Congress latched on to the 80% / 85% MLR numbers from the CBO memo, passing a bill with the highest possible MLRs that do not trigger CBO’s threat. In fact, the language and structure

132 73B C.J.S. Public Utilities § 72 (2011) (internal citations omitted).
134 Id.
of the ACA itself suggest that Congress harbored doubts about the appropriate MLR until the very last minute. Section 1001 of the ACA would have set the MLR thresholds at 75% in the individual market and 80% in the group market, a less stringent requirement than the ultimately enacted 80% / 85% regime. However, Section 10101(f) of the ACA amended the just-added Section 1001 to raise the MLR requirements to 80% in the small group and individual markets and 85% in the large group market.

Congress’ decision to set the MLR at 80% / 85% was not based on economic analysis of the insurance market, or balancing of interests between the insurance companies and the consumers, or what MLR will yield a reasonable, non-confiscatory rate of return for the insurance industry, but politics. This cannot be stressed enough. Congress did not want the health insurance industry’s financials on government books and set the MLR accordingly. This decision-making process falls far short of the fact-intensive, market-specific, economic-based analysis required by the Constitution when the government sets rates.

3. The Fate of a Constitutional Challenge to the MLR

In spite of all of the defects in the ACA’s MLR provision, it might withstand a facial constitutional challenge because some insurance companies can, and do, make a reasonable profit while maintaining MLRs within the range required by the statute. In other words, as applied to the

136 See ACA § 1001 (amending Public Health Serv. Act. § 2718(b)(1)(A), (B)).

137 See ACA § 10101(f) (amending ACA § 1001, which amended Public Health Serv. Act. § 2718(b)(1)(A), (B)).
insurance industry as a whole, the ACA’s MLR provisions do not impose confiscatory rates.

To succeed on a facial challenge, the challenger must show that the challenged legislation is unconstitutional in all circumstances.\textsuperscript{138} Here, an insurance company facially challenging the ACA’s MLR requirement would have to show that no insurance company could earn a reasonable profit while maintaining an MLR of at least 80\% in the small group and individual markets and 85\% in the large group market. In fact, many insurance companies already operate profitably at or above the newly-mandated MLRs. For example, “[a]ccording to an April 2010 report…, the nation’s largest health insurers in 2009 had medical loss ratios ranging from 68 percent to 88 percent in the individual market; 78 percent to 84 percent in the small-group market; and 83 percent to 88 percent in the large-group market.”\textsuperscript{139} A recent article also mentions that most of Kansas’ top health insurers already meet the MLR requirement.\textsuperscript{140}

Because some health insurance companies can make money under the ACA’s 80\% / 85\% MLR regime, a court would probably reject a facial challenge to the Act’s MLR provisions. However, if an individual insurance company demonstrates that the federal MLR requirement would either force the company to exit the market, or does not permit the company

\textsuperscript{138} See United States v. Salerno, 481 U.S. 739, 745 (1987) (“A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid”).

\textsuperscript{139} Health Affairs, Health Policy Brief, Updated: Medical Loss Ratios (Nov. 24, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=33.

to earn a reasonable profit, the company’s as-applied constitutional challenge would likely prevail. In analyzing the issue, a court would certainly consider the limitations of the MLR “safety valve” provisions and the suspicious manner in which Congress chose the 80% / 85% MLR thresholds as factors cutting against the constitutionality of the Act. In fact, a court may believe that the ACA’s MLR “safety valve” provisions cannot adequately protect any health insurance company from the threat of confiscatory rates, even if some companies can make a profit under the ACA’s MLR requirements. In this situation, the court would likely follow the Texas Court of Appeals’ analysis in Geeslin v. State Farm Lloyds and hold the ACA’s MLR provision unconstitutional on its face for failing to sufficiently protect the industry against unreasonable rates.141

Some might argue that states have been imposing MLR requirements on insurance companies for years, so why can’t the federal government do the same? I can think of several responses to this position. First, I do not contend that the federal government necessarily violates the Constitution by setting a minimum MLR in the health insurance industry, only that the ACA’s MLR provision has constitutional problems for all the reasons discussed above. Second, a governmental entity that sets confiscatory rates violates the Constitution, regardless of whether the rate-setting entity is federal or state. As detailed above, courts will not hesitate

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141 See Geeslin v. State Farm Lloyds, 255 S.W.3d 786, 794-95 (Tex. App. 2008) (“We note, however, that rates can be confiscatory without necessarily leading to insolvency. Thus, the proof provision set out in [the statute], by allowing for the imposition of confiscatory rates, fails to provide regulated companies with a constitutionally adequate review of government-set rates. We therefore hold that the proof provision is unconstitutional on its face”).
to strike down insurance rate laws that fail to guarantee insurers the opportunity to earn a fair profit.

Finally, until now, each state has determined its own MLR by examining the realities of the insurance market in the state: “State-imposed medical loss ratio requirements have varied widely. They reflect differences in rural and urban markets as well as in markets that have different levels of competition.”¹⁴² In other words, each state bases its MLR requirement on the actual circumstances prevailing in the state’s insurance market. This is the constitutionally-proper method for setting insurance rates. In contrast, the federal government set the ACA’s MLR requirement based on political calculations, not by analyzing the economic realities of the insurance markets around the country. This creates a constitutional concern.

IV. MANDATORY MLR IN THE HEALTH INSURANCE INDUSTRY: BAD POLICY?

A. Policy Arguments Favoring a Mandatory MLR

Notwithstanding the constitutional problems of the ACA’s MLR provision, Congress had valid reasons to believe that setting a mandatory, nationwide MLR for the health insurance industry made good sense. The ACA’s statutory language indicates that Congress tried to accomplish several competing policy goals through the minimum MLR requirement: participation by insurance providers, competition among insurance

providers, and value for health insurance consumers.\textsuperscript{143} Of these three goals, ensuring that consumers get “value for their premium dollar” reigned supreme during the healthcare debate.\textsuperscript{144} Specifically, ACA supporters in Congress claimed that the MLR requirement would reduce insurance companies’ administrative costs and stop executives from getting rich at the expense of the American consumer. Pro-ACA legislators repeated this mantra over and over, using slightly different words to convey the same basic concept: insurance companies are greedy and wasteful, and the MLR requirement will rein them in. The following quotations are exemplary of the debate:

This provision provides the Commissioner with the authority to ensure that premiums are used primarily to provide health benefits and not lost to excessive administrative costs or profit.\textsuperscript{145}

Without a minimum medical loss ratio to hold insurance companies accountable there is no limit on the amount of taxpayer resources that private health insurance companies can spend on executive compensation, shareholder profits, marketing, and other activities that do not add value for the consumer.\textsuperscript{146}

\textsuperscript{143} See ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(2)) (discussing the factors states should consider when deciding whether to raise the MLR above federally mandated levels).


\textsuperscript{146} S. REP. NO. 111-89, at 344 (2009).
What a novel idea; you get some bang for your buck and the government would actually do something for you for a change, protecting consumer rights and making sure that companies do what they should be doing. This isn't about profits. The companies are extremely profitable, and this is not going to cramp their style. In fact, *this is about greed* (emphasis added).

[The bill] will require all insurers to reinvest more of our premiums back into health coverage through a "medical loss ratio" of at least 80 percent, ensuring that no more than 20 percent of our premiums go toward administrative expenses and *windfall profits for insurance executives* (emphasis added).

This is going to make health insurance companies put at least 85 percent of their premiums toward actual health services, not administrative costs, marketing campaigns or profits or *bloated CEO salaries*. Advocates have been trying to get these profit restrictions in place in many States, but it is usually too hard to fight these companies on a local level. So while I am disappointed we don't have the public option, the minimum medical loss ratio is a potent measure that will limit insurers' profits and put the brakes on *skyrocketing premiums* (emphasis added).

These worries have some factual basis. As mentioned above, health insurance premiums continue to rise much too quickly, e.g., by 20% or more from 2010 to 2011. On the other hand, health insurance companies


typically operate on a relatively low profit margin. The results of a recent Fortune magazine study put the health insurance industry profit margin at 2.2%, which pales in comparison to the profit margins in other health-related industries such as pharmaceuticals (19.3%) and medical products (16.3%). Additionally, a similar study shows that health insurance companies’ profit margins vary quite a bit across the industry (from WellPoint’s 7.3% to Health Net’s -0.3%).

Imposing a profit cap on a low-profit margin, heterogeneous industry does not make much economic sense. If the health insurance industry suffers from anti-competitive tendencies, then increasing competition will solve the problem. In that regard, the ACA’s health insurance exchanges should enhance competition in the health insurance marketplace. With greater competition, the MLR requirement becomes redundant at best and harmful at worst, for all the reasons set forth in subsection B. below.

B. Policy Arguments Against a Mandatory MLR

As discussed in Section II(A), the ACA’s MLR requirement acts to cap profits in the health insurance industry. Economists have long condemned profit caps and other government price controls for a variety of


reasons.\textsuperscript{153} Opponents of the MLR requirement have adapted, and expanded, these general “anti-price control” arguments to the MLR context.

Some critics believe that requiring insurance companies to meet a high MLR standard will drive many insurers out of the market, thereby reducing competition and consumer choice.\textsuperscript{154} Different regions have different demographics, costs of living, average salaries, etc., so the administrative costs to run a health insurance business will inevitably vary throughout the country. Some insurance providers in high administrative cost markets may not be able to meet the 80% / 85% MLR requirement and will have to exit the markets, or so the argument goes. According to Congressman Carter (R-Texas), “[i]ndustry analysis estimates that as many as 47 percent of the participants in individual and small group plans which have higher administrative costs due to economies of scale will lose their health insurance if [the MLR] regulation becomes law.”\textsuperscript{155} Similarly, the CBO worries that the health insurance industry’s response to the minimum

\begin{footnotesize}
\begin{itemize}
\item\textsuperscript{154} See, e.g., \textit{Health Affairs}, \textit{Health Policy Brief, Updated: Medical Loss Ratios} (Nov. 24, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=33 (“If the medical loss ratios are overly stringent, companies and many state commissioners are concerned that insurers will leave markets with too few enrollees to make it worthwhile, leaving consumers with few coverage options. They also fear that small insurers will be driven out of business because the requirements don’t account for market volatility from one year to the next”).
\end{itemize}
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MLR law “would reduce the types, range of prices, and number of private-sector sellers of health insurance.”

The MLR requirement hits small insurance companies particularly hard. Although the ACA’s MLR provision differentiates between the sizes of the group insured (80% MLR for small groups and individuals vs. 85% MLR for large groups), the law does not distinguish between large and small insurance providers. This is problematic because small companies typically have higher administrative costs (on a percentage basis) than larger companies do. As Merrill Matthews of the Institute for Policy Innovation puts it, “[t]he MLR is nothing but a price control mechanism that will drive even more of the smaller and medium-sized insurers out of the market, dramatically reducing competition. That’s in part because large insurers have better economies of scale to keep administrative costs lower.”

If the MLR requirement puts small insurers out of business, large insurance companies will face less competition and therefore less pressure to keep prices down.

The MLR requirement has real potential to cause insurance companies to exit certain markets. In other words, the concern is more than hypothetical. In Maine, one low cost insurer that covers over 30% of the people in Maine’s individual insurance market “said it may exit the market

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if required to meet this higher [MLR] standard in 2011 and 2012.”

Similarly, Nevada claims that three insurers “have imposed moratoriums on new business while they determine their ultimate market strategy” and might leave the Nevada market unless HHS grants the state’s MLR adjustment request.

A second argument against the ACA’s MLR provision focuses on the law’s likely detrimental effect on insurance brokers. If insurance companies must reduce administrative costs to comply with the heightened MLR requirement, then insurers have a strong incentive to cut broker commissions. This is one reason why brokers lobbied to keep their commissions out of the MLR calculation. If insurers cut payments to brokers, some brokers will go out of business entirely and others will simply stop selling health insurance. If this happens, then the health insurance market, and in particular the consumers, will lose the benefits that brokers bring to the table (insurance plan design, implementation, explanation, troubleshooting, and claim resolution). Congressman Price of Georgia has expressed this very concern: the MLR requirement “compromise[s] the opportunity for brokers to provide the best advice to citizens…these folks are going to be pinched and pushed out of their jobs, the ones that are


actually helping our citizens to weave their way through the morass of health coverage in this country.” \(^1\)

Third, an MLR requirement paternalistically deprives consumers of the freedom to choose the kind of health plan they want. Some insurance companies have high MLRs, and some have low MLRs. \(^2\) Assuming that low MLR plans spend more on plan administration, and higher administrative costs result in better customer support, claims processing, client service, etc., some rational consumers may prefer low MLR plans. The ACA’s MLR requirement effectively eliminates these kinds of plans.

The fact that insurance companies operate over a wide range of MLRs supports the proposition that consumers have heterogeneous preferences when it comes to the MLR (or at least the variables that constitute the MLR). In 2005, the six largest for-profit insurance companies had MLRs ranging from 76.9% (Aetna) to 83.9% (Health Net). \(^3\) In 2010, the five top health insurance companies in Kansas had the following MLRs: American Medical Security, 97%; Blue Cross Blue Shield of Kansas, 93%; Blue Cross Blue Shield of Kansas City, 91%; Coventry, 72%; and Time


\(^2\) See Health Affairs, Health Policy Brief, Updated: Medical Loss Ratios (Nov. 24, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=33 (citing a report showing that “the nation’s largest health insurers in 2009 had medical loss ratios ranging from 68 percent to 88 percent in the individual market; 78 percent to 84 percent in the small-group market; and 83 percent to 88 percent in the large-group market. Because states have defined what constitutes medical care differently, their medical loss ratios differ even more than these numbers would suggest”).

Insurance Company, 57%.\(^{164}\) I view this kind of variety as a positive, while the ACA obviously considers it to be a problem.

On a more basic level, I don’t assume that all “low MLR” plans are “bad” and all “high MLR” plans are “good.” Aetna remains popular despite its relatively low MLR because of its reputation for high quality and customer service. Some consumers are obviously willing to pay a higher price for higher quality. The ACA should not discourage that.

Fourth, this new federal MLR regime will be extremely complicated, and therefore expensive, to administer. The implementing regulations are 72 pages long.\(^{165}\) Despite these detailed instructions, insurance providers will still have difficulty determining exactly what expenses to include where in the MLR calculation. The following phrases taken directly from the regulations illustrate the vagueness inherent in defining the MLR: “designed to improve health quality,”\(^{166}\) “designed to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements,”\(^{167}\) “designed primarily to control or contain costs,”\(^{168}\) and “[e]nhance the use

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\(^{166}\) Id. at 74,875.

\(^{167}\) Id.

\(^{168}\) Id. at 74,924.
of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology."

This complexity and ambiguity will cause several problems. First, health insurance companies will spend lots of time, energy, money, and human capital trying to understand and comply with the nuanced regulations. These resources would be better spent on something else, e.g., covering the costs of a patient’s surgery. Additionally, overly complex and/or vague laws such as the ACA’s MLR provision are ripe for abuse. Opportunistic insurance providers will seek out ways to circumvent the law, e.g., by artificially inflating their MLRs or finding “loopholes” in the regulatory scheme. Thus, the MLR requirement will likely be less effective than its supporters hope.

Finally, the ACA’s MLR provisions will arguably discourage health insurance companies from investing in innovation. Innovating is expensive. If a company spends money to develop technology that counts as “administrative,” e.g., an improved billing system or better claims processing software, the company will have a harder time meeting the MLR requirement. Thus, the company will be less enthusiastic about developing the new technology in the first place. Additionally, since the MLR provisions cap a company’s profits, the company has little incentive to go above-and-beyond what is necessary to meet the MLR. Merrill Matthews explores this reasoning through a hypothetical:

Suppose a new preventive care therapy emerges that makes patients very healthy. Where is the economic incentive for insurers to adopt that therapy if they will be penalized for claims dropping below the MLR? Suppose new software becomes available that would lower

169 Id.
an insurer’s claims by catching fraud. But buying the software adds
to its limited admin allowance, while reducing fraud lowers the
insurer’s claims costs. Either way, it could be forced to pay the
rebate penalty. ¹⁷⁰

At this point, one should realize the difficulty in classifying the
MLR law as normatively “good” or “bad” policy. As with most tough
issues, both sides of the debate make persuasive arguments that cut in
opposite directions. In the next section of the paper, I add another policy
concern that may tip the scales against the ACA’s MLR provision: the
effect of a phenomenon called “anchoring.”

C. “Anchored” to the MLR

Psychologists use the general term “cognitive bias” to describe “any
of a wide range of observer effects identified in cognitive science and social
psychology including very basic statistical, social attribution, and memory
errors that are common to all human beings.”¹⁷¹ In layman’s terms,
cognitive biases are mental errors that influence our beliefs and decisions,
potentially to our detriment. “Anchoring” is one kind of cognitive bias.

Anchoring describes “the common human tendency to rely too
heavily, or ‘anchor,’ on one trait or piece of information when making
decisions.”¹⁷² In practice, the anchoring theory posits that “different starting

¹⁷⁰ Merrill Matthews, Rolling Back ObamaCare: Eliminate the Medical Loss Ratio,
Forbes Blogs (Jan. 18, 2011),
http://blogs.forbes.com/merrillmatthews/2011/01/18/rolling-back-obamacare-eliminate-
the-medical-loss-ratio/.

¹⁷¹ ScienceDaily, Cognitive Bias,

¹⁷² ScienceDaily, Anchoring bias in decision-making,
points yield different estimates [end points], which are biased toward the initial values.”173 The follow example illustrates the anchoring phenomenon. Suppose Seller X decides to sell his house. He lists it for $500,000 and waits for offers. Buyer Y likes the house and begins negotiating the price with Seller X. Because Seller X set the price at $500,000, the negotiations revolve around that number. In other words, $500,000 acts as an “anchor” in the parties’ minds during the negotiation. After several rounds of offers and counter-offers, the parties settle on $480,000.

Now suppose Seller X had initially listed the same house for $600,000. Buyer Y still likes the house, but believes the price is way too high. Nonetheless, Buyer Y enters into negotiations with Seller X, hoping to drive the price down. $600,000 acts as the new anchor point, and the parties negotiate around that number. The parties finally agree on a price of $520,000. The higher starting point ($600,000 v. $500,000) results in a higher end point ($520,000 v. $480,000) due to anchoring. This powerful cognitive bias influences real-world negotiations174 and pricing strategies.175

I posit that the ACA’s new nationwide mandatory MLR (80% / 85%) will act as an anchor to which health insurance companies will gravitate. Importantly, this anchoring will affect all kinds of insurance


175 See Roger Dooley, Anchor Pricing Strategies, Neuromarketing (July 18, 2008), http://www.neurosciencemarketing.com/blog/articles/anchor-prices.htm (discussing how marketers can take advantage of irrational anchoring).
providers, both “good” and “bad,” and consumers will ultimately lose. For ease of explanation, I label companies having a high MLR (above 80% / 85%) as “good” and companies having a low MLR (below 80% / 85%) as “bad.” In other words, “good” companies are those that currently exceed the new MLR requirements, and “bad” companies are those that do not. This assumption is incorrect for the reasons discussed in Section IV(B), but the ACA relies upon it, and so shall I when discussing the MLR’s anchoring effect.

The ACA introduced new, highly visible anchors into the collective mind of the health insurance industry: an 80% MLR in the individual and small group markets and an 85% MLR in the large group market. How will insurance companies respond? A “bad” company can respond in one of two ways. First, it could leave the market, deciding that changing its business to comply with the new MLR doesn’t make economic sense. This may be good for consumers (if the company is indeed “bad”) or bad for consumers (because it reduces consumer choice). Alternatively, the “bad” company might change its business practices to comply with the new MLR. Again, this may be good for consumers (if the company raises its MLR by providing more value and eliminating wasteful expenses), but it may be bad (if the company cuts back on expenses for services that consumers actually want). In any event, the ACA’s MLR provisions were clearly designed with the “bad” companies in mind.

That leaves the “good” companies. How will the new MLR requirement affect them? Anchoring suggests that “good” providers with high MLRs will drift down towards the anchor point (80% / 85%). For example, suppose Insurance Company Z currently operates at an MLR of 90% and sells only to large groups. In dealing with the new federal MLR
regulations and reporting requirements, Company Z becomes acutely aware of the mandatory MLR: 85% in the large group market. Consequently, the company changes its business practices (reimbursement rates, salaries, administrative expenses, etc.) either consciously, to increase profits, or subconsciously, because 85% is the new magic number. Over time, Company Z’s 90% MLR becomes 88%, or 86%, or 85%, because that’s what the federal law requires.

This particular anchoring phenomenon would not pose much of a problem in an insurance industry filled with “bad” companies. In other words, without “good” companies in the current market, downward anchoring becomes irrelevant. However, the health insurance industry is heterogeneous, filled with both “good” and “bad” companies, so downward anchoring poses a real danger to consumers. Citing a 2010 report, Health Affairs notes that “the nation’s largest health insurers in 2009 had medical loss ratios ranging from 68 percent to 88 percent in the individual market; 78 percent to 84 percent in the small-group market; and 83 percent to 88 percent in the large-group market.”176 In other words, the individual market includes both “bad” companies (68% MLR) and “good” companies (88% MLR). The small group market includes both “bad” companies (78% MLR) and “good” companies (84% MLR). And the large group market includes both “bad” companies (83% MLR) and “good” companies (88% MLR).

Nothing indicates that Congress considered this potentially negative consequence when passing the ACA. Congress likely recognized that different insurance companies had different MLRs, some higher than

However, as recounted in Section IV(A), ACA supporters focused the MLR debate on “bad” companies and ignored the impact on “good” companies. In other words, Congress hoped that a minimum MLR would transform an industry comprising “good” and “bad” companies into one containing only “good” companies (or at least some “good” companies and some “average” companies). In reality, the MLR mandate may homogenize the health insurance industry as companies anchor themselves to the new MLR. “Average” insurance providers will glut the market, replacing both “good” and “bad” companies. Normatively, one can question whether this market homogenization benefits consumers. Descriptively, anchoring suggests that it will occur.

Critics of this approach may point out that many states already have MLR requirements, yet the health insurance industry remains heterogeneous, containing both “good” and “bad” companies. If “anchoring to the MLR” is real, why aren’t insurance companies anchored to the state-based MLR benchmarks? This challenge has some appeal but ultimately fails.

State MLR requirements vary widely from state-to-state. For example, “North Dakota requires a 55 percent medical loss ratio for insurers in the individual market, and New Jersey requires an 80 percent ratio.”

These divergent requirements do not provide a fixed, stable anchor to tether the insurance industry’s thinking. The anchoring effect of multiple, conflicting state regulations should be much lower than that of the ACA’s

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single, nationwide MLR requirement. Additionally, state insurance regulations are based on the prevailing market conditions in the state. Therefore, when compared to a federal statute like the ACA, state-mandated MLRs are much more likely to change from year-to-year. This uncertainty and instability would also lessen the anchoring effect of state MLR requirements vis-à-vis the federal MLR provisions.

Congress itself implicitly expressed concern with anchoring in the ACA, albeit in a very different context. Specifically, the government included a “maintenance of effort” (MOE) requirement in the ACA’s Medicaid/CHIP provision. This suggests that Congress worries about anchoring, or more concretely, regression to new government healthcare mandates.

Under the ACA, states must maintain Medicaid and CHIP eligibility levels for children above 133% of the federal poverty level (FPL).\(^\text{179}\) The Georgetown University Center for Children and Families describes the MOE requirement as follows:

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Today, nearly all states provide Medicaid and/or CHIP coverage to children up to 200 percent of the FPL [federal poverty level], with 25 states covering children at or above 250 percent of the FPL. As a condition of receiving federal Medicaid funding, states cannot scale back their income eligibility levels and enrollment procedures in place on March 23, 2010 for children eligible for Medicaid and CHIP\(^\text{180}\) (emphasis added)

In other words, there are currently “good” states (those that cover children up to a high percentage of the FPL) and “bad” states (those that cover children only to a low percentage of the FPL), just like there are “good” insurance companies and “bad” insurance companies in the MLR context. The MOE requirement prevents the “good” states from scaling-back their coverage levels to the new ACA-mandated level (133% of FPL). In other words, the MOE protects against anchoring by requiring the “good” states to stay “good.” If Congress wasn’t concerned about regression or backsliding by “good” states, Congress would have no reason to insert the MOE provision in the ACA. Obviously, Congress is concerned that the ACA’s new requirements will anchor even “good” actors. However, Congress did not include an anti-anchoring MOE provision in the MLR section of the law. The ACA does not prevent “good” insurance providers from backsliding, so the new MLR requirements may not work as well as ACA supporters hope.

V. IMPLEMENTING THE MLR

The ACA’s MLR requirement may be unconstitutional and unwise, but it’s the law. In this section, I provide recommendations to insurance companies, state governments, and the federal government on how to best implement the MLR.
A. Insurance Companies

The ACA changes the way insurance providers must calculate and report their MLRs.\(^{181}\) Companies will not be comfortable with the new requirements right away; it will take some time. To shorten the learning curve, a company should designate certain employees as “MLR experts” and task those individuals to learn the new law inside-and-out. As discussed above, many states imposed MLR requirements on health insurance companies long before the ACA. If a company already has an established MLR compliance department, then the “MLR experts” should be drawn from this department. These individuals have experience dealing with MLR issues in general, so they will be best suited to navigate through the new federal regulations. Additionally, it may make sense for large insurance companies to hire outside counsel or a health care consultant to work on MLR-related issues that are too complex or controversial to handle internally.

Second, management will need to decide whether to adjust the company’s business practices in response to the MLR requirements, and if so, how. In low MLR companies, management will have some tough choices to make. According to the CBO, “[i]nsurers operating at MLRs below such a minimum would have a limited number of possible responses. They could change the way they provide health insurance, perhaps by reducing their profits or cutting back on efforts to restrain benefit costs through care management. They could choose to pay the rebates, but if they raised premiums to cover the added costs they would simply have to rebate

that increment to premiums later. Alternatively, they could exit the market entirely.”

Managers of high MLR companies should consider what changes will benefit the company while still keeping the company’s MLR above the 80% / 85% threshold.

Third, low MLR companies facing a tough transition may want to lobby the states to seek an MLR adjustment from HHS. The ACA’s implementing regulation permits only the States, not the insurance providers, to request an adjustment to the MLR. Therefore, insurance companies need the states’ help to get relief. This strategy worked in Maine. MEGA, a large insurance provider in the state, stated that it might leave Maine’s individual health insurance market if forced to meet the ACA’s MLR requirement.

Maine subsequently petitioned HHS for an MLR adjustment, and HHS granted the request.


183 HealthCare.gov, Medical Loss Ratio: Getting Your Money’s Worth, Accommodations to Avoid Market Destabilization, http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html (last visited Apr. 15, 2011) (“Consistent with NAIC recommendations, the regulation establishes a process for States to request such an adjustment for up to three years – an effective State-based transition. In order to qualify for this adjustment, a State must demonstrate that requiring insurers in its individual market to meet the 80 percent MLR has a likelihood of destabilizing the individual market and could result in fewer choices for consumers”) (emphasis added).


185 See id.
B. State governments

State governments have several important decisions to make when it comes to the federal MLR. First, a state must decide whether to request an MLR adjustment from HHS. As of April 12, 2011, nine states (Maine, New Hampshire, Nevada, Kentucky, Florida, Georgia, North Dakota, Iowa, and Louisiana) have asked for adjustments.\(^{186}\) In deciding whether to seek an adjustment, a state should evaluate and weigh the interests of all the parties affected by the new MLR law, including insurers, brokers, and consumers. The state should publicly solicit comments from all interested parties to obtain the information necessary to appropriately balance the interests. Of course, the state should be wary that self-interested parties may make groundless claims in order to influence the state to pursue a course of action that favors the party but may hurt the state as a whole. If, after balancing the interests, the state determines that raising the minimum MLR will do more harm than good (“destabilize the market”), then the state should petition HHS for an MLR adjustment.

Second, a state must decide whether to increase the state’s minimum MLR above the federally mandated level (80% / 85%). The ACA gives each state the option to raise its own minimum MLR requirements above the federal benchmarks.\(^{187}\) Congress directs the states to “seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements” when determining the


\(^{187}\) See ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(1)(A)).
appropriate MLR. In other words, a state should consider the health insurance marketplace in its entirety when setting an MLR. As with the MLR adjustment decision, the state should gather as much information as possible, balance the interests involved, and choose the best course of action for the state as a whole.

C. The Federal Government

The federal government can, and should, do several things with respect to the MLR. First, the government should act quickly on state petitions for MLR adjustments. So far, HHS’ performance on this front leaves much to be desired. Of the nine requests for MLR adjustments, eight remain pending. HHS received Nevada’s request on February 9, 2011, and more than two months later, the application is still “undergoing review for completeness.” The longer HHS takes to decide these MLR adjustment petitions, the more likely it becomes that insurance companies will leave the market. This market destabilization will hurt health insurance consumers. Substantively, HHS should generally defer to a state’s determination that the new federal MLR standard will destabilize the market in the state. The federal government is new to the health insurance business, and each state presumably knows its own insurance market better than the federal government.

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188 ACA § 10101(f) (amending Public Health Serv. Act. § 2718(b)(2)).


than the federal government does. Thus, HHS should grant the vast majority of state MLR adjustment requests, absent a compelling reason not to.

Second, the federal government should release a short, clear “cheat sheet” summarizing the most important aspects of the new MLR regulations. As mentioned above, the MLR regulations are long (72 pages), complicated, and ambiguous in places. Insurance companies and state regulatory agencies need time to adequately decipher the complex MLR requirements. In the interim, a “cheat sheet” will help those affected by the new MLR to formulate and implement an ideal short-term course of action (e.g., through changed business practices, new statewide regulations, etc.)

Finally, Congress should consider repealing the ACA’s MLR provision. It is constitutionally troublesome and a bad policy judgment. As a practical matter, I don’t expect Congress to pass a stand-alone amendment to get rid of the MLR requirement. However, if ACA opponents succeed in forcing significant changes to the law, I hope the MLR provisions will be on the chopping block. Alternatively, if the courts strike down the ACA as unconstitutional, e.g., because of its individual mandate, I would urge Congress to leave the MLR requirement out of any new healthcare reform legislation.

VI. CONCLUSION

The United States desperately needs healthcare reform, and the ACA provides it. In that regard, the ACA is a spectacular triumph. In my humble opinion, the ACA will drastically improve many aspects of our broken healthcare system by increasing competition (e.g., through the health
insurance exchanges) and covering more people (e.g., by expanding Medicaid). In other words, the ACA is better than nothing. But the ACA is not as good as it could be. The MLR requirement embodies the worst aspects of the law: unconstitutional government intervention into private businesses to the detriment of both health insurance companies and American consumers.