

ACCESS TO PROFESSIONAL HEALTH INSURANCE
ADVISORS ACT OF 2011

NOVEMBER 15, 2012.—Committed to the Committee of the Whole House on the
State of the Union and ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce,
submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 1206]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 1206) to amend title XXVII of the Public Health Service Act to preserve consumer and employer access to licensed independent insurance producers, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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PURPOSE AND SUMMARY

H.R. 1206, the “Access to Professional Health Insurance Advisors Act,” was introduced on March 17, 2011, by Rep. Mike Rogers (R-MI) and was referred to the Committee on Energy and Commerce.

The purpose of H.R. 1206 is to reduce the economic harm and reduced access to agent and broker services caused by the Patient Protection and Affordable Care Act’s (PPACA) medical loss ratio (MLR) provision on the nation’s health insurance agent and broker community.

BACKGROUND AND NEED FOR LEGISLATION

Section 1001 of the PPACA requires health plans to spend 80 to 85 percent of premium revenue on “reimbursements for clinical services” and “activities that improve health care quality.” The MLR requirement excludes Federal taxes, State taxes, and licensing and regulatory fees from the premium portion of the calculation. On December 1, 2010, the Department of Health and Human Services (HHS) issued regulations defining approved activities that “improve health care quality” and altering the statutory definition of taxes for purposes of enforcing the MLR requirement.

By providing HHS the authority to define “activities that improve health care quality,” the underlying MLR provision gives HHS unprecedented control over the design of private health insurance coverage, irrespective of consumer health care preferences. Health care providers also have raised concerns that the MLR requirement severely limits investment in programs and initiatives to reduce fraudulent payments for services, improve health care quality, and advance better care coordination by classifying such investments as administrative costs.

The MLR provision and associated regulation also have major economic consequences for independent insurance agents, brokers, and health benefit specialists. Brokers and agents provide critical support and educational services to individuals and employers seeking affordable health coverage and help ensure plans meet a consumer’s specific needs. Yet, the MLR requirement includes independent agent and broker fees in an insurer’s MLR calculation and classifies fees as an insurer-borne administrative expense. Thus, compensation paid to agents and brokers is penalized by the MLR.

The CEO of the National Association of Health Underwriters (NAHU) has testified that brokers servicing the individual and small-business markets are seeing revenue slashed by 20 to 50 percent. NAHU survey data also indicate that the MLR will force 21 percent of agents to downsize their business as a result.

The National Association of Insurance Commissioners (NAIC) also has recognized the harmful consequences of PPACA’s MLR requirement on the health insurance agent and broker community. The NAIC passed a resolution in November 2011 asking Congress to take legislative action to reduce the adverse impact on agents and brokers associated with the MLR requirement. The NAIC resolution stated:

We are very concerned about the impact the MLR requirement could have on the ability of insurance agents and brokers to continue assisting health insurance consumers at a time of rapid changes that makes their role even more essential. . . . Congress should expeditiously consider legislation amending the MLR provisions of the PPACA in order to preserve consumer access to agents and brokers . . . and [HHS] should take whatever immediate actions are available to mitigate the adverse effects the MLR rule. . . .

H.R. 1206 amends the MLR requirement to exclude remuneration paid to licensed independent insurance producers from the premium portion of the MLR calculation. H.R. 1206 defines licensed independent insurance producers as an insurance agent or broker, insurance consultant, benefit specialist, limited insurance representative, and any other person required to be licensed under the laws of the particular State to sell, solicit, negotiate, service, effect, procure, renew or bind policies of insurance coverage or offer advice, counsel, opinions, or services related to insurance.

H.R. 1206 also requires HHS to defer to a State's findings and determinations as to whether enforcing the MLR requirement will destabilize their respective individual or small group markets for health insurance. To date, HHS has partially or fully denied MLR waivers for 17 of the 18 States that have applied for an MLR adjustment. HHS has denied waivers despite findings from individual state insurance commissioner that without a waiver, the individual health insurance market could destabilize significantly and consumer choice in health plans could be limited severely.

HEARINGS

The Subcommittee on Health held a hearing on June 2, 2011, related to the regulatory burden associated with PPACA. The Subcommittee received testimony from:

- Steve Larsen, Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services;
- Scott Harrington, Ph.D., Professor of Health Care Management and Insurance and Risk Management, Wharton School, University of Pennsylvania;
- Janet Trautwein, CEO, NAHU;
- Randi Reichel, Esq., Counsel, Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C. on behalf of America's Health Insurance Plans;
- Edward Fensholt, Senior Vice President, Lockton Benefits Group;
- Katherine Hayes, Associate Research Professor, Department of Health Policy, George Washington University School of Public Health and Health Services; and
- Terry Gardiner, Vice President, Policy and Strategy, Small Business Majority.

The Subcommittee on Health held a hearing on September 15, 2011, related to the regulatory burden associated with PPACA. The Subcommittee received testimony from:

- Steve Larsen, Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services;
- Janet Trautwein, CEO, NAHU;
- Grace-Marie Turner, President, The Galen Institute;
- Edmund Haislmaier, Senior Research Fellow, Health Policy Studies, The Heritage Foundation;
- Lynn Bates Quincy, Senior Policy Analyst, Consumer Union; and
- Wendell Blaine Potter, Senior Analyst, The Center for Public Integrity.

COMMITTEE CONSIDERATION

On September 11, 2012, the Subcommittee on Health met in open markup session and approved H.R. 1206 for full Committee consideration by a voice vote.

On September 20, 2012, the Energy and Commerce Committee met in open markup session and favorably reported H.R. 1206 by a recorded vote of 26–14.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. A motion by Mr. Upton to order H.R. 1206 reported to the House, without amendment, was agreed to by a record vote of 26 ayes and 14 nays. The following reflects the recorded votes taken during the Committee consideration:

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 133

BILL: H.R. 1206, the "Access to Professional Health Insurance Advisors Act of 2011"

AMENDMENT: A motion by Mr. Upton to order H.R. 1206 favorably reported to the House. (Final Passage)

DISPOSITION: AGREED TO, by a roll call vote of 26 yeas and 14 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Waxman		X	
Mr. Barton				Mr. Dingell		X	
Mr. Stearns	X			Mr. Markey			
Mr. Whitfield				Mr. Towns			
Mr. Shimkus	X			Mr. Pallone		X	
Mr. Pitts	X			Mr. Rush			
Mrs. Bono Mack	X			Ms. Eshoo		X	
Mr. Walden				Mr. Engel		X	
Mr. Terry	X			Mr. Green		X	
Mr. Rogers	X			Ms. DeGette		X	
Mrs. Myrick				Mrs. Capps			
Mr. Sullivan				Mr. Doyle		X	
Mr. Murphy	X			Ms. Schakowsky		X	
Mr. Burgess	X			Mr. Gonzalez			
Mrs. Blackburn				Ms. Baldwin			
Mr. Bilbray	X			Mr. Ross			
Mr. Bass	X			Mr. Matheson			
Mr. Gingrey	X			Mr. Butterfield		X	
Mr. Scalise	X			Mr. Barrow	X		
Mr. Latta	X			Ms. Matsui		X	
Mrs. McMorris Rodgers	X			Mrs. Christensen		X	
Mr. Harper	X			Ms. Castor		X	
Mr. Lance	X			Mr. Sarbanes		X	
Mr. Cassidy	X						
Mr. Guthrie	X						
Mr. Olson	X						
Mr. McKinley	X						
Mr. Gardner	X						
Mr. Pompeo	X						
Mr. Kinzinger	X						
Mr. Griffith	X						

09/20/2012

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a legislative hearing and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of H.R. 1206 is to reduce the economic harm imposed by the Patient Protection and Affordable Care Act's (PPACA) medical loss ratio (MLR) provision on the nation's health insurance agent and broker community.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 1206, the "Access to Professional Health Insurance Advisors Act" would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI of the Rules of the House of Representatives, the Committee finds that H.R. 1206, the "Access to Professional Health Insurance Advisors Act," contains no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, November 7, 2012.

Hon. FRED UPTON,
*Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1206, the Access to Professional Health Insurance Advisors Act of 2011.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Julia Mitchell.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

H.R. 1206—Access to Professional Health Insurance Advisors Act of 2011

Summary: H.R. 1206 would amend current law to exclude compensation paid to insurance agents and brokers from the administrative expenses used to determine the calculation of the medical loss ratio (MLR) for health insurance plans. The bill also would make waivers of certain requirements under the MLR rules easier for states to obtain by requiring the Secretary of the Department of Health and Human Services (HHS) to defer to a state's findings that the application of those rules would destabilize the state's insurance market. Finally, the legislation would extend the availability of such waivers in other ways.

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting H.R. 1206 would increase deficits by \$531 million over the 2013–2017 period and by about \$1.1 billion over the 2013–2022 period. Of this increase in the deficit, \$127 million would be a decline in off-budget Social Security revenues between 2013 and 2022. Pay-as-you-go procedures apply because enacting the legislation would affect direct spending and revenues.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 1206 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—												
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013– 2017	2013– 2022	
CHANGES IN DIRECT SPENDING													
Estimated Budget Authority	0	12	77	89	58	41	39	41	43	46	236	447	
Estimated Outlays	0	12	77	89	58	41	39	41	43	46	236	447	
CHANGES IN REVENUES													
Estimated Revenues	0	–22	–92	–97	–84	–72	–71	–75	–79	–83	–295	–675	
NET INCREASE OR DECREASE (–) IN THE DEFICIT													
Deficit Impact	0	34	169	185	143	113	110	116	123	129	531	1,122	
On-Budget	0	30	154	169	128	99	96	101	106	112	481	995	
Off-Budget ^a	0	3	15	16	15	14	14	15	16	17	50	127	

Note: Numbers may not sum to totals because of rounding.

^a All off-budget effects would come from changes in revenues. (The payroll taxes for Social Security are classified as “off-budget.”)

Background: Under current law, fully insured health plans are required to provide rebates to enrollees to the extent that the insurer's medical loss ratio is below a specified percentage. A medical loss ratio is equal to spending on health care and quality improvements as a fraction of total premiums earned.¹

The MLR is calculated by adding spending for medical claims and quality improvement activities together and dividing by earned premiums. Individual and small group market plans are required to have an MLR of at least 80 percent, and large group plans are required to have an MLR of at least 85 percent.² Administrative expenses, including compensation paid to insurance agents and

¹ Earned premiums are total premiums received by an insurer net of any taxes, licensing, and regulatory fees paid by the insurer and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

² Small group plans are generally defined as plans with 1 to 100 employees, but a state may substitute “50” employees for “100” employees until 2016.

brokers, as well as insurer profits account for the remaining 15 percent to 20 percent (or less) of earned premiums. The Secretary of HHS has the authority to temporarily waive the requirement that insurers achieve an MLR of at least 80 percent in the individual market if she determines that enforcing the statutory MLR would destabilize that market. Such waivers are granted on a state-by-state basis and give states additional time to comply with the required threshold. For 2011, 17 states applied for waivers and 7 states were granted them.³ (Of those 7 waivers granted, 4 included modifications for 2012 as well as for 2011. No additional applications for waivers were submitted for 2012.)

Starting in 2012, plans that do not meet the required MLR standards in the previous year must pay a rebate to each enrollee. Such rebates are equal to the amount by which the applicable MLR standard exceeds the insurer's actual MLR multiplied by earned premiums. According to HHS, insurers have provided enrollees with rebates this year that totaled approximately \$1.1 billion.⁴ Rebates may be provided as a reduction in premiums or reimbursed directly to enrollees. (CBO incorporates estimated rebate amounts in its projections of health insurance premiums.)

To avoid incurring rebates, insurers can increase their MLR by reducing administrative costs or profits, increasing spending on medical benefits or quality improvement activities, or a combination of both. As a result of those changes, premiums could be lower, higher, or about equal to the levels that would occur in the absence of the MLR policy. In CBO's judgment, informed by discussion with outside experts, premiums are probably lower under the MLR policy than they would have been otherwise.

For 2011 and 2012, CBO estimated the magnitude of the reduction in premiums resulting from the MLR policy. That estimate draws on insurance industry data and is based on two factors: actual rebates in 2012, and evidence that insurance carriers reduced administrative costs (in large part by reducing agent and broker compensation).

Beyond 2012, in CBO's judgment, the MLR policy under current law will continue to have the effect of reducing premiums relative to those in the absence of that policy. Over time, however, CBO expects that the reduction in premiums will be attenuated. Starting in 2014, a three-year moving average, rather than annual data, will be used to calculate the MLR, making the MLR targets easier to achieve. In addition, CBO expects that there is an increasing probability that insurers will make changes—such as increasing spending on medical benefits or quality improvement activities—that will push premiums upward.

Overall, CBO estimates that the MLR requirements under current law will reduce premiums by about one-half of a percent, on average, over the next few years, declining to approximately one-tenth of a percent by the end of the 10-year projection period.⁵

³ See: <http://www.cciio.cms.gov/programs/marketreforms/mlr/state-mlr-adj-requests.html>.

⁴ Of that \$1.1 billion, individual market rebates equaled \$394 million, small group market rebates equaled \$321 million, and large group market rebates equaled \$386 million. See: <http://www.healthcare.gov/law/resources/reports/mlr-rebates06212012a.html>.

⁵ While CBO estimates that the MLR policy will reduce premiums relative to those in the absence of the policy, many other factors also affect premiums. On net, CBO estimates that the combination of those factors will result in rising premiums overtime.

Basis of estimate: H.R. 1206 would exclude fees, commissions, and rebates paid to licensed independent insurance agents and brokers (or other individuals licensed by the state to sell or assist in the sale or renewal of insurance) from administrative expenses for the calculation of the medical loss ratio of a health insurance plan. The bill also would change the rules for consideration of state requests for waivers in ways that would make those waivers easier to obtain. In addition, the bill would allow states to request waivers for the small group market. For this estimate, CBO assumes that the legislation would be enacted near the end of 2012 and become effective for plan years that begin at the start of 2014.

Under H.R. 1206, agent and broker compensation would no longer be considered an administrative expense for the purpose of calculating MLRs, making the MLR requirements easier for plans to achieve. By making these targets easier to achieve, H.R. 1206 would reduce the number of plans required to pay rebates and the amount of rebates paid.

CBO estimates that removing agent and broker compensation from the MLR calculation would initially reduce rebates by between 60 percent to 70 percent, declining to between 40 percent and 50 percent by the end of the 2013–2022 period. Because MLR requirements would be easier to achieve under H.R. 1206, insurers would have less incentive to reduce administrative costs than under current law, CBO estimates. Both of these effects are expected to result in an increase in premiums relative to current law.

H.R. 1206 would also increase the probability that more states would be able to waive or obtain modifications to the MLR requirements because the Secretary of HHS would have to defer to a state's own assessment of market destabilization. The estimate incorporates increased waiver activity in the individual market and new waivers in the small group market in a smaller number of states. Because waivers allow plans to face lower MLR thresholds, increased waivers are also expected to increase net premiums.

Overall, CBO assumes that enacting H.R. 1206 would have the effect of increasing premiums by approximately two-tenths of a percent on average over the next few years, declining to less than one-tenth of a percent by the end of the 2013–2022 period.

Overall impact on Federal spending and revenues

According to CBO and JCT's estimates, enacting H.R. 1206 would increase direct spending by an estimated \$236 million over the 2013–2017 period and \$447 million over the 2013–2022 period. Further, H.R. 1206 would reduce revenues by \$295 million over the 2013–2017 period and \$675 million over the 2013–2022 period. Off-budget (Social Security) revenues would account for \$127 million of that revenue reduction over the 10-year period.

Direct spending

Because H.R. 1206 would increase private health insurance premiums, CBO estimates that subsidies for health insurance purchased through the exchanges would rise. Subsidies for health insurance premiums are structured as refundable tax credits; the portions of such credits that exceed taxpayers' liabilities are classified as outlays, while the portions that reduce tax payments are reflected in the budget as reductions in revenues. CBO and JCT esti-

mate that the outlay portion of the increased payments for premium subsidies available through exchanges would be \$236 million over the 2013–2017 period and \$447 million over the 2013–2022 period.

Revenues

The effect of the bill on the cost of subsidies for purchasing health insurance through exchanges would decrease revenues by \$22 million over the 2013–2017 period and \$38 million over the 2013–2022 period, CBO and JCT estimate.

H.R. 1206 also would increase premiums for employer-based health insurance. By increasing the share of employee compensation furnished as tax-excluded health benefits rather than as taxable wages and salaries, CBO and JCT estimate that revenues will decrease by \$637 million over the 2013–2022 period. Decreases in such wages and salaries lead to decreases in both federal income tax and payroll taxes for Social Security and Medicare.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays and revenues that are subject to those pay-as-you-go procedures are shown in the following table. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 1206, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON SEPTEMBER 20, 2012

	By fiscal year, in millions of dollars—											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013–2017	2013–2022
NET INCREASE OR DECREASE (–) IN THE ON-BUDGET DEFICIT												
Statutory Pay-As-You-Go Impact	0	30	154	169	128	99	96	101	106	112	481	995
Memorandum:												
Changes in Outlays	0	12	77	89	58	41	39	41	43	46	236	447
Changes in Revenues ...	0	19	76	81	69	58	56	60	63	66	245	548

Intergovernmental and private-sector impact: H.R. 1206 contains no intergovernmental or private-sector mandates as defined in UMRA and would not affect the budgets of state, local, or tribal governments.

Estimate prepared by: Federal Costs: Julia Mitchell, Sarah Anders, and staff of the Joint Committee on Taxation; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Alexia Diorio.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

This section cites the act as the “Access to Professional Health Insurance Advisors Act of 2011.”

Section 2. Findings

This section includes findings related to the importance of the role of health insurance agents and brokers in our health care system and the need to recognize and protect their continued role.

Section 3. Protecting the ability of licensed independent insurance producers to continue to serve the public

This section excludes remuneration paid to licensed insurance producers from the premium portion of the MLR calculation and requires HHS to defer to State findings and determinations regarding destabilization of their respective insurance markets.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE**PART A—INDIVIDUAL AND GROUP MARKET REFORMS**

* * * * *

Subpart II—Improving Coverage

* * * * *

SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

(a) **CLEAR ACCOUNTING FOR COSTS.**—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year,

submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

(1) * * *

* * * * *

(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes, *remuneration paid for licensed independent insurance producers*, and licensing or regulatory fees.

* * * * *

(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes, *remuneration paid for licensed independent insurance producers*, and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

(i) * * *

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

In the case of a State request for an adjustment pursuant to clause (ii), the Secretary shall defer to the State's findings and determinations regarding destabilization.

(B) REBATE AMOUNT.—

(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

(I) * * *

(II) the total amount of premium revenue (excluding Federal and State taxes, *remuneration paid for licensed independent insurance producers*, and licensing or regulatory fees and after account-

ing for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

* * * * *

(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market *or small group market* due to the establishment of State Exchanges.

* * * * *

(f) *INDEPENDENT INSURANCE PRODUCER REMUNERATION DEFINITIONS.*—*For purposes of this section:*

(1) *The term “independent insurance producer” means an insurance agent or broker, insurance consultant, benefit specialist, limited insurance representative, and any other person required to be licensed under the laws of the particular State to sell, solicit, negotiate, service, effect, procure, renew or bind policies of insurance coverage or offer advice, counsel, opinions, or services related to insurance.*

(2) *The term “remuneration” means compensation paid by or accrued from an insurance issuer or health plan for services rendered under contractual agreement which may include fees, commissions, or rebates.*

DISSENTING VIEWS

We oppose the passage of H.R. 1206, the *Access to Professional Health Insurance Advisors Act of 2011*, a bill to amend title XXVII of the Public Health Service Act, as added by section 1001(5) and amended by section 10101(f) of the *Affordable Care Act* or ACA,¹ relating to the calculation and requirements of the medical loss ratio (MLR) of a health insurance plan. Accordingly, we submit the following comments to express our concerns that H.R. 1206 will undermine a critical consumer protection provided Americans by the ACA and will result in increased health care premiums for individuals, families, and businesses.

THE MEDICAL LOSS RATIO IS A CRITICAL CONSUMER PROTECTION

The ACA created new consumer protections to establish greater transparency in the health insurance marketplace and to encourage health insurers to deliver higher quality health care at lower premiums. The law requires insurance companies to publicly disclose the proportion of premium revenues spent on health care benefits and quality improvement as opposed to profits, marketing and other administrative costs, which is called the medical loss ratio (MLR). For the first time, insurers are also required to meet minimum MLR standards established by the ACA of spending 80 to 85 cents of each premium dollar on medical care or quality to ensure that consumers receive value for their premium dollar.² If an insurance company spends less than 80 cents of each premium dollar on medical benefits or quality (85% for large group market insurers), they must issue rebates to consumers by August 1 each year.³

The ACA required the National Association of Insurance Commissioners (NAIC) to develop a model regulation containing uniform definitions and methodologies for calculating the medical loss ratio.⁴ On October 27, 2010, the NAIC submitted its final recommendations to the Department of Health and Human Services (HHS). The regulation outlines were unanimously approved by every state insurance commissioner including the District of Columbia after months of work via an open and public process in which a wide range of stakeholders participated.⁵ On December 12, 2010, HHS issued regulations regarding the implementation of the MLR requirements based on these recommendations. The NAIC was careful to take into account the impact of the MLR require-

¹ The ACA is comprised of two public laws, P.L. 111-148 and P.L. 111-152.

² The Public Health Service Act, Section 2718, as added by section 1001(5) of the Patient Protection and Affordable Care Act and amended by section 10101(f) of the Health Care and Education Reconciliation Act of 2010.

³ The ACA, Section 1001.

⁴ The ACA, Section 1001.

⁵ Letter from the National Association of Insurance Commissioners to Kathleen Sebelius, Secretary of the Department of Health and Human Services (Oct. 7, 2010) (online at www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf).

ment on the stability of state markets, and the ability of insurance agents and brokers to continue their work with insurance commissioners. There are allowances in the formula for administrative costs for fighting fraud and for quality improvement activities such as flu shot drives.

BENEFITS ALREADY ACHIEVED FROM THE MEDICAL LOSS RATIO PROTECTION

On June 12, 2012, insurance companies nationwide submitted their annual MLR reports for coverage to the Secretary of HHS. Based on this data, nearly 90% of insurers already either met or took steps to meet the medical loss ratio minimums. The remaining insurers provided rebates to nearly 12.8 million Americans this year totaling more than \$1.1 billion. In addition, according to the Congressional Budget Office (CBO), this consumer protection likely reduced health insurance premiums.⁶ This is a big victory for consumers purchasing insurance not only in the individual market but also through their employers.

The NAIC's Health Care Reform Actuarial Working Group issued a report that, among other things, found states with higher MLR requirements have not observed any problems with consumer access to insurance or agents and brokers. Indeed, agent and broker jobs increased by 7,000 since May of last year according to the Insurance Information Institute.

EFFECTS OF H.R. 1206

H.R. 1206 undermines this critical consumer protection that nearly all insurers have already met by excluding broker and agent fees and commissions from the MLR calculation. According to CBO, H.R. 1206 effectively weakens the pressure on insurers to hold down administrative healthcare costs and will increase health insurance premiums. The NAIC report also stated that adjusting the MLR calculations for agent and broker compensation would effectively weaken the MLR by several percentage points.

The exclusion of the agent and broker commissions from the MLR formula would also negate 60% to 70% of rebates expected to be paid in the coming years according to the CBO. This is similar to a projection issued by the National Association of Insurance Commissioners.

H.R. 1206 also changes the ACA by allowing states to apply a weaker MLR requirement for their small group markets, increasing health insurance premiums further according to CBO. The ACA already allows states to apply for adjustments to the MLR requirement for their individual market, but not in the small or large group markets, in cases where the HHS Secretary determines that a state's marketplace is noncompetitive and too highly concentrated such that the MLR requirement would destabilize the marketplace and availability of insurance. H.R. 1206 further changes this by deferring to a state request to undermine this critical consumer protection in both the individual and small group markets, providing

⁶Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Rep. Fred Upton, Chairman, Committee on Energy and Commerce (November 7, 2012) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/hr1206.pdf).

less oversight. So far, 18 states (including Guam) have applied for such adjustments and seven states provided data supporting the request such that it was granted.⁷ If H.R. 1206 had already been in effect, it would have reduced the \$1 billion consumer premium rebates insurers paid out by at least \$360 million, increasing premiums for the 3.8 million people in Delaware, Florida, Indiana, Kansas, Louisiana, Michigan, North Dakota, Oklahoma, Texas, and Wisconsin.

CBO SCORE OF H.R. 1206

CBO released a score on November 7, 2012, estimating that H.R. 1206 would increase deficits by \$531 million over the 2013–2017 period and by about \$1.1 billion over the 2013–2022 period. H.R. 1206 would make it easier for insurers to meet the MLR targets, and provide less incentive for insurers to reduce administrative costs. The result would be a drastic reduction in consumer rebates and an increase in insurance premiums. CBO expects that rebates would initially be reduced by 60% to 70%, declining to 40% to 50% by the end of the 2013–2022 period. H.R. 1206 would increase the probability that states would be able to obtain a waiver or an adjustment to their MLR requirement which would result in an increase in net premiums for both individual and employer-based health insurance plans. According to CBO, premiums would increase on average by about two-tenths of a percent over the next few years, declining to less than one-tenth of a percent over the next ten years.⁸

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⁷The Center for Consumer Information & Insurance Oversight, *State Requests for MLR Adjustment* (online at www.cciio.cms.gov/programs/marketreforms/mlr/state-mlr-adj-requests.html).

⁸Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Rep. Fred Upton, Chairman, Committee on Energy and Commerce (November 7, 2012) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/hr1206.pdf).