**Testimony of Dennis M. Donahue**

**On Behalf of**

**The Council of Insurance Agents and Brokers**

**Before the**

**House Committee on Education and the Workforce**
**Subcommittee on Health, Employment, Labor, and Pensions**

**Hearing on: Regulations, Costs, and Uncertainty in Employer Provided Health Care**

**October 13, 2011**

The Council of Insurance Agents & Brokers ("The Council") is grateful to Chairman Roe, Ranking Member Andrews, and other members of the Subcommittee for holding this hearing to examine the impact of regulations, costs, and uncertainty on employer-provided health care. We appreciate the opportunity to testify, in particular, concerning compliance with the grandfathering and minimum medical loss ratio ("MLR") provisions of the Patient Protection and Affordable Care Act ("PPACA").

Specifically, I will share my knowledge regarding some of the costs to employer-based health plans to comply with these provisions, based on my experience as a professional employee benefits consultant and health insurance broker to mid-sized employers who offer health coverage to their employees. The costs and burdens of compliance are considerable.

My job title is Managing Director, National Practice Leader for Employee Benefits, for Wells Fargo Insurance Services USA, Inc. I am testifying today on behalf of The Council, of which I am a member as well as former Chairman of the Council of Employee Benefit Executives. The Council is the premier association for commercial insurance and employee benefits intermediaries in the United States. The Council represents leading commercial insurance agencies and brokerage firms, with members in more than 3,000 locations placing more than $200 billion of U.S. insurance products and services, including group health insurance. The Council's members help employers provide their employees with the health coverage they need at a cost they can afford, serving tens of thousands of employer-based health insurance plans covering millions of American workers. As such, our membership has a thorough understanding of the group health insurance market, and has had a unique opportunity to observe the challenges group health plans have faced thus far in the PPACA implementation process.

Wells Fargo is the fourth largest insurance broker in the United States and the fifth largest in the world. The majority of our commercial insurance customers are small and mid-sized employers, typically 50 to 500 employees. On a personal note, I have 34 years in the

employee benefits industry and I am a national resource for approximately 1,000 employee benefit professionals within our firm.

## Overview

Recognizing that the grandfather and MLR provisions were included in PPACA with a view toward helping consumers of health insurance, I am here today to tell you that these provisions, as they have been implemented, are not cost-free. This is especially so for smaller employers and health plans that lack the staff and resources to devote to ensuring that their plan complies with the myriad restrictions on grandfathered plans, which range from limits on changing co-payment amounts, co-insurance charges and other cost-sharing amounts, to making changes in the types of benefits that are offered. This may sound more straightforward than it is. However, for practically any contemplated change in the design of a health benefit plan, the sponsor of that plan must seek some type of professional guidance if they want to ensure that the change does not jeopardize the plan's grandfathered status. This will likely have to be done annually because plans tend to make changes each year, and all of it costs employers money and time.

At the same, these health plans may lack the resources to pay the higher premium costs that may be associated with losing grandfathered status. In particular, loss of grandfather status means a plan may have to provide new benefits such as preventive services for free. These plans may also have to implement new or different claims appeal and external claims review processes. And there are a number of other changes that would have to be implemented starting in 2014. Employers are concerned about how they and their employees would be able to absorb the costs for these additional requirements.

Our clients have also expressed concern about the effect that the MLR provision may have on health insurance premiums in areas where health insurance carriers are leaving the market because they are unable to meet the MLR requirements.

And finally, there is concern among health insurance agents and brokers about the impact the MLR will have on their businesses and their jobs, as carriers cut back and re-structure commissions to meet the MLR's administrative cost caps. Employers too are concerned, because they do not want to lose ready access to the professional advice they have come to rely upon from their agents and brokers. For these reasons, The Council supports H.R. 1206, the Access to Professional Health Insurance Advisors Act of 2011, a bill introduced by Rep. Rogers to help ensure that the MLR does not lead to the loss of agent and broker jobs, thus depriving consumers of the expertise agents and brokers offer.

## Discussion

### *I. The Impact of PPACA Grandfathering Provisions on Employer Health Plans*

Under PPACA, group health plans that existed on March 23, 2010 (the law's enactment date) are "grandfathered" and are, therefore, exempt from some of the law's new requirements. The U.S. Department of Health and Human Services, Department of Labor, and Treasury Department (collectively, the "Departments") issued a rule last year to implement the

grandfather provision, and that rule basically establishes a list of things a health plan can and cannot do while remaining grandfathered, in addition to imposing new recordkeeping and notification requirements. I think of the requirements as a list of "do's and don'ts," as follows:

| **A Grandfathered Group Health Plan:** | |
|---|---|
| **Cannot –** | **Can –** |
| • Eliminate all benefits to diagnose or treat a particular condition<br>• Increase percentage co-insurance charges<br>• Increase co-pays, fixed amount cost-sharing "significantly" (med. infl. + 15%)<br>• Decrease employer contribution > 5%<br>• New or decreased annual dollar benefit limits<br>• Switch employees' plans or engage in mergers, etc. to avoid compliance | • Change carriers<br>• Change premiums<br>• Make some structural changes to plan (e.g., self-insured to insured)<br>• Change provider network<br>• Change prescription formulary<br>• Add new employees/dependents<br>• Make changes to comply with other laws |

The Departments' rule characterizes the permitted changes as ones that are "routine" in nature for health plans. It is naïve to think that employee benefit plans, especially the medical, are stagnant elections made by employers. Our clients have multi-year objectives that attempt to ward off the rate of continued medical inflation. Plan changes historically evolve as the markets evolved with new cost containment measures, plan designs to promote more cost-effective treatments, the changing of carriers, networks, deductibles, covered expenses, and so forth. But in today's economic environment, it is not unusual for our clients to contemplate cost structure changes beyond those the rule treats as "non-routine." When faced with a decision whether to keep offering insurance to employees or whether to give up in an age of incredible health cost increases, employers do contemplate the possibility of having to increase the employee's contribution by more than 5%, for example, a change that will cause loss of grandfather status.

And as straightforward as some of these decisions might seem, it is never that simple for an employer that is trying to maintain a grandfathered plan. As consultants advising these employers on compliance, we have received countless questions from our clients in the year since the grandfather rule was adopted. Employers now hesitate to do something as basic as moving a group of employees from one health plan to another if the company is re-aligning its staff among different geographic locations or has undergone a corporate re-structuring, for fear of running afoul of the grandfather rule. They seek our advice for this and nearly every other type of change they consider making to their health plans, just to make sure they do not unwittingly end up affecting the plan's status.

The grandfather rule includes recordkeeping and disclosure obligations, as I previously mentioned. These include a requirement that health plans maintain the records necessary to prove their grandfathered status, which entails keeping the paperwork describing each and every health plan benefit and each and every cost or contribution as they existed on March 23, 2010, and for any and every change, for an indefinite period of years thereafter. This is a dichotomy as health plans, and employee benefits in general (as a condition of one's overall compensation package), are viewed by employers as prospective, not retrospective. Tied to employee's

compensation, they are unique and employer-specific in their design. These new recordkeeping rules will be especially burdensome and expensive for employers that have multiple locations and employee classes, all with varying benefit levels for purpose, that continue to evolve as our U.S. healthcare delivery system evolves.

All of this complexity costs employer health plans time and money. And many of our clients say they are daunted by the grandfather rule's requirements. The companies we work with, particularly those with 50 to 100 employees, do not have the administrative resources and expertise to make assessments about whether changes will cause loss of grandfather status, or when it becomes uneconomical to even try to maintain grandfather status. Admittedly, their inquiries and their resulting challenges mean business for my employer; but there is no doubt that our clients spend money on consulting fees for grandfathering compliance matters that they did not have to spend two years ago. That's an administrative expense that does not grow their business, and the Subcommittee is probably aware of the well-known data indicating that small businesses create more than 60% of the new jobs in our country.[1]

One might ask why plans do bother attempting to maintain grandfathered status? The reason is because they may also be unable to afford the cost of the plan if they lose grandfather status. This is the case because a non-grandfathered plan may have to provide new benefits the plan sponsor did not anticipate (having to offer when it sought to design a plan that the employer and its employees could actually afford). Our clients are most concerned about the cost of needing to provide preventive services for free rather than with a co-pay, and the cost of having to implement new or different claims appeal and external claims review processes. Both of these new requirements would have to be implemented now if a plan loses grandfathered status. There are several other new requirements that go into effect for non-grandfathered plans starting in 2014, including having to provide a mandated benefits package and minimum 60% employer contribution for company plans with fewer than 100 employees. Thus, there can be considerable new costs involved if a plan loses grandfather status, especially for small businesses.

## *II. The Impact of the Medical Loss Ratio*

From my perspective as a consultant to employers and as a professional insurance broker, the minimum MLR, which caps the amount of non-claims-related expenses a carrier can have at 15% or 20% depending on the market, is raising concerns among employers about what the MLR may ultimately do to their insurance premiums, and raises concerns about the impact on agents and brokers and the services we provide to employers.

### A. Impact on Employers

Our employer-clients have expressed concern that the MLR mandate will lead to less carrier competition and higher healthcare costs in some markets. In smaller markets where carriers do not enjoy the economies of scale that allow them to meet the administrative caps under the MLR mandate, carriers are abandoning the market altogether. As evidence, we have

[1] U.S. Small Business Administration fact sheet, available at http://www.sba.gov/advocacy/7495/8420.

already seen the exodus of two prominent insurance carriers, The Guardian Life and The Principal, both of which have provided medical benefits to small employers for many decades, have withdrawn their medical plan offerings altogether. Both have signed agreements with their former competitor, United Healthcare, to transition employee coverages. Under the law, carriers must calculate their MLR in each market in each state where they operate. Recent reports, including a U.S. Government Accountability Office study from July 2011, reveal that more carriers are pulling out of, or plan to pull out of, some markets because they cannot meet the MLR mandate in those locations.[2]

Stories like these mirror the concerns our clients are expressing to us, about the future of competition and choice among quality health plans. As we have seen in so many other industries, the simple law of economics tells us here that diminished competition may lead to higher premium prices for employers seeking to provide healthcare for their employees.

**B. Impact on health insurance agents and brokers**

The Council's agent and broker members are generally paid for their services by insurance carriers on a commission basis. The MLR calculation obviously affects these arrangements because it requires commissions paid by carriers to agents and brokers to be categorized as "other non-claims costs." Since a carrier will now pay rebates to subscribers if the carrier fails to limit its non-claims costs to 15% or 20% of premium revenue (depending on the market), the MLR requirement has put stress on agent and broker commissions. The 2011 GAO report found that "almost all insurers [GAO] interviewed were reducing brokers' commissions and making adjustments to premiums in response to the PPACA MLR requirements."[3]

My experience bears this out, as we are seeing carriers cut commissions or try to move to models that shift some or all of the administrative cost directly to the policyholder so that these amounts do not get counted as administrative and distribution costs for the carrier. This is particularly true for brokers servicing the individual and small business markets, which are already seeing their compensation slashed by 20-to-50 percent. It also happens that these markets are where agent and broker services are desperately needed by consumers and entrepreneurs, who find it difficult to navigate a complicated health insurance marketplace that will become even more complicated, unfortunately, as we approach 2014 and small businesses have to figure out what to do in the Exchange context.

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[2] U.S. Government Accountability Office Report to Congressional Requesters, "Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements," GAO-11-711 (July 2011), at 19 (hereafter, "GAO Report"). And these revelations pertain to carriers selling policies in the individual market, a market for which states can at least ask HHS for temporary relief on the minimum MLR where they fear the requirement will destabilize the market. No such relief is available for the small group insurance market that small employers rely on, so there are fears about what may be on the horizon for that market.

[3] GAO Report at 18.

Despite what some observers might suggest, for employers, purchasing health coverage is not like buying an airline ticket. There are a host of variables to be considered that are unique to each employer. Company size, specific workforce health care needs, financial resources, available options, coverage costs, and the need or desire for additional programs such as wellness measures, are among the many factors that must be balanced by employers attempting to find health coverage. Thus, for many employers the personalized needs for compliance, communications and enrollment, can only provide limited support with toll-free telephone numbers and websites.. That will remain true even when the Exchanges start operating in 2014. Without the professional advice of agents and brokers to guide them in the complicated process of selecting health coverage, employers may simply throw up their hands and not offer coverage, or settle for coverage that is less than a good fit for their employees.

Prior to MLR, our services were covered within a component of the premium. While it may seem simple to just assume that small businesses can pay more in fees in lieu of carrier commissions, these new line items may be difficult for small businesses to take on in such challenging economic times. This may also adversely affect employers' willingness and ability to work with agents and brokers for services they have historically outsourced to us.

The foregoing reasons highlight the importance of continuing to have a robust agent/broker presence in the group health market. It is important for policymakers to consider the costliness of regulatory measures that create downward pressure on commissions paid by carriers to agents and brokers, such as the MLR mandate. These measures can lead to fewer agents and brokers in business, fewer employer-broker relationships, lower quality and less tailored health care for employees, and potentially severe PPACA compliance problems and costs for employers that are left to navigate the system without the assistance they need.

All of these concerns have prompted The Council to support H.R. 1206, the Access to Professional Health Insurance Advisors Act of 2011, which was introduced by Rep. Rogers and presently has 129 co-sponsors. By excluding agent/broker compensation from the MLR calculation, H.R. 1206 will help to ensure that the MLR does not lead to the loss of agent and broker jobs, thus depriving consumers of the expertise agents and brokers offer.

## III. Conclusion

It is very important for policymakers to understand the costs and burdens associated with laws and regulations for all parties involved. I hope this hearing and my testimony contributes to that understanding as it relates to PPACA's grandfathering and MLR provisions. Again, I appreciate the Committee's willingness to examine these important issues and the opportunity to testify on behalf of The Council's members.