Testimony of

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Mr. Chairman, Ranking Member Thune and members of the committee, thank you for the opportunity to be here this afternoon.

I also want to thank you, Mr. Chairman, for your tireless efforts to ensure that the Affordable Care Act contained language to address what had been a steady decrease in the medical loss ratio (MLR) over more than a decade. As a result of the MLR provision in the law, Americans with private health insurance have saved billions of dollars that otherwise would have gone to unnecessary overhead and excess profits.

It has been almost five years since I first appeared before this committee and spoke about the medical loss ratio, which was then an obscure term known by few other than insurance company executives, Wall Street financial analysts and shareholders. As I said then, the average family had almost no understanding of how influential Wall Street had become in the decisions made by insurance company executives about how much of policyholders' premiums would actually be used to pay medical claims.

I noted that financial analysts and shareholders of publicly traded health insurers are as interested in the medical loss ratio as they are in earnings per share. To win the favor of influential analysts, executives of for-profit insurers had to demonstrate during every quarterly earnings call that their companies made more money during the most recent quarter than a year earlier and that the portion of the premium going to pay medical claims—the MLR—was declining. If they had to acknowledge that the company had to spend a slightly higher percentage of premiums on medical claims than anticipated, they knew that some of their investors would be disappointed enough to sell their shares, which would inevitably result in a drop in the stock price and the value of the company.

During my last 10 years as an industry executive, one of my main responsibilities was to handle financial communications to the media. In preparing for quarterly earnings reports, the first numbers I looked for were the earnings per share and the medical loss ratio. I could predict with some certainty whether the company's stock price would go up or down the day we announced quarterly earnings by looking at just those two numbers. I once saw a competitor's stock price drop 20 percent in a single day when the company reported that its MLR for the quarter had increased by just one and a half percent.

A study conducted by PriceWaterhouseCoopers in 2008 showed how successful executives at publicly traded companies had been in reducing the percentage of premium revenue on medical care. The accounting firm found that the medical loss ratios of the seven largest for-profit insurers fell from an average of 85.3 percent in 1998 to 81.6 percent in 2008. By reducing the MLR 3.7 percent over those years, the insurance companies avoided paying out billions of dollars for medical care and were able to use that money to reward executives and shareholders—at the obvious expense of their policyholders.

In my previous testimony, I detailed some of the actions insurers took to reduce the chances that analysts and investors would be disappointed, including dumping policyholders when they got sick. By requiring insurers to spend at least 80 percent of what policyholders pay in premiums on medical claims or to improve the quality of care they receive, as the Affordable Care Act does, the influence of Wall Street has been reduced.

As you know, a primary goal of the MLR requirements in the ACA was to help consumers realize fuller value of their health insurance payments. Since those requirements went into effect in 2011, that goal has indeed been realized.

Consumers benefit from the MLR requirements in two significant ways. First, insurers are now operating more cost-efficiently to stay in compliance with the law. As a result, many policyholders are paying lower premiums than they would have been charged otherwise. Second, if an insurer fails to comply and spends less than 80 percent on medical care—or 85 percent in the large group market—it has to issue rebates to its policyholders.

Individuals and families who are not able to get coverage through an employer have seen the greatest benefit. According to the Kaiser Family Foundation, the average MLR in the individual market increased from 78 percent in 2010 to 83 percent in 2012. Researchers at the Foundation estimated that had it not been for the MLR requirements in the ACA, premiums in the individual market would have been $856 million higher in 2011 and $1.9 billion higher in 2012.

During my two decades in the insurance industry, my colleagues and I never tired of saying that steps needed to be taken to remove costs from the U.S. health care system. Although the industry spent considerable time and resources lobbying against the MLR requirements—and later to try to shape the regulations pertaining to the requirements—the 80/20 rule, as it is often called, has done what the industry said was needed. During the first two years that the rule has been in effect, according to a report published earlier this month by the Commonwealth Fund, at least $3 billion in costs were removed from our health care system, with American consumers being the beneficiary.

Approximately half of those savings were in the form or rebates: $1.1 billion in 2011 and $513 million in 2012. Insurers sent out fewer rebate checks in 2012 than in 2011 because most of them quickly implemented the changes necessary to stay in compliance with the law. Had the MLR requirement been in effect in 2010, by the way, consumers across all the market segments would have received close to $2 billion in rebates, according to the Commonwealth Fund. Imagine how much consumers would have saved if the requirement had been in effect during earlier years.

The other way consumers have benefited is the reduction in overhead in the insurance industry. The Commonwealth Fund calculated that $1.75 billion in overhead was eliminated during the first two years alone. Most of those savings

came in 2012 as health insurers continued to reduce their administrative and sales costs, such as brokers' fees, without increasing their profit margins.

It's important to note that although broker commissions decreased by almost $300 million across all market segments in 2012, that represented only about 3.5 percent of total broker expense that year.

As you may know, I had the privilege of serving as a consumer representative to the National Association of Insurance Commissioners when that organization was working in 2010 to draft the MLR regulations. The insurance industry flooded the commissioners with comment letters as part of an intense lobbying effort to persuade the NAIC to give insurers broad latitude to comply with the law. They argued that many of the activities they had always categorized as administrative in nature—such as their spending to reduce fraud and to meet accreditation requirements—should be counted among quality improvement expenses. And lobbyists for insurers and brokers joined forces in an intense campaign to get broker fees exempted from the MLR equation. Despite being outspent and out-lobbied by what could be considered an order of magnitude, the NAIC's consumer representatives were successful in pushing back against the industry. Most of the industry's requests were rejected by the commissioners as being unreasonable and contrary to the intent of the law.

It's worth noting that some critics predicted that the MLR requirements would result in a mass exodus of insurers from the marketplace. That has not happened. In fact, insurers have continued to do quite well financially since the MLR rules went into effect. According to an analysis by the Commonwealth Fund, insurers' total profits for all markets have declined by only 0.1 percent of premiums.

Another benefit of the MLR requirements to consumers as well as to policymakers and regulators is the enhanced transparency they have brought to the insurance industry. We now have much better insights into how insurers spend the premiums they collect from policyholders as a result of the additional reporting requirements.

We have learned, for example, that nonprofit insurers have done a much better job of complying with the 80/20 rule than their for-profit competitors. As Commonwealth Fund researchers noted in a report last year, publicly traded insurers appear to aim their pricing closer to the minimum loss ratio, no doubt because that is what Wall Street demands they do. Their adjusted MLR marketwide has been "virtually identical" to the 80 percent limit.

The researchers found that only eight percent of nonprofit insurers owed a rebate in the individual market in 2011 compared with 47 percent of for-profit insurers. Additionally, the average amount of the rebates owed by the nonprofits were considerably lower than those owed by the for-profits.

Still, all consumers, whether enrolled in a plan operated by a nonprofit or for-profit company, continue to benefit from what has become one of the most important cost-saving provisions of the Affordable Care Act.

The MLR requirements ensure that consumers can now have greater confidence in knowing that most of what they pay in premiums will be used to pay for medical care or improve the quality of that care, and that no more than 20 percent of their premiums will go to unnecessary overhead or to reward insurance company executives and shareholders.

Overall, the 80/20 rule has had a very positive impact on the pocketbooks of millions of consumers, and it will continue to help ensure that Americans can realize the full value of their health insurance payments.

Thank you.