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BIOHAZARD: THE MEDICAL LOSS RATIO AS CONSTITUTIONALLY PERMISSIBLE GARBAGE (AND HOW TO DISPOSE OF IT)

Since the Affordable Care Act (ACA) became law in 2010, it has been subject to political and constitutional scrutiny. While most critics have focused on the expansion of Medicaid and the individual mandate, the rest of the bill is by no means universally praised. One such controversial provision is the Medical Loss Ratio (MLR). Congress crafted the MLR with the purpose to improve patient care and reduce unnecessary administrative spending and excessive corporate profits. Those companies which do not, in a given year, spend the mandated amount on patient care, as opposed to other expenses, must make up the difference by providing a rebate to their policyholders. The purpose of the rebate is both to provide an incentive for insurance companies to comply with government regulations regarding revenue apportionment and compensate consumers who have been “shortchanged.” This Perspective will (1) show that the MLR is constitutional, (2) but that it is nevertheless poor policy, and (3) suggest some alternatives for Congress to consider should it repeal and replace the ACA.

While no one has yet brought a case challenging the MLR, scholars have published law review articles both attacking and defending the provision’s constitutionality. The authors of these articles disagree fundamentally about which constitutional test to apply when analyzing the MLR: specifically,

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3 Id.
4 See 42 U.S. Code § 300gg–18
within the context of the Fifth Amendment Taking Clause,\footnote{U.S. Const. amend. V. cl. 5.} they debate whether \textit{Duquesne}\footnote{See \textit{Duquesne Light Co. v. Barasch}, 488 U.S. 289 (1989) (holding that the decision of the public utility commission not to consider the investment a utility made in planning to build but never actually building nuclear plants violated the Fifth Amendment.)} or \textit{Penn Central}\footnote{See \textit{Penn Cent. Trans. Comp. v. New York City}, 438 U.S. 104 (1978) (Holding that a local ordinance to preserve landmarks which disallowed a train station from modifying part of its building to start a new business did not constitute a Fifth Amendment taking).} controls.\footnote{See Epstein, supra note 6 and Cordner, supra note 6} \footnote{See Cordner, supra note 6} \footnote{See Stubblebine, supra note 6 at 344 (quoting healthcare.gov)} \footnote{See Epstein, supra note 6 at 261} \footnote{Id. at 262. One might consider health care subsidies which the Affordable Care Act provides to be an example of such special treatment, but while they do benefit the insurer they are being distributed to the policyholders.}

Instead of endeavoring to determine which of these tests should apply to the MLR, I will let sleeping jurisprudential dogs lie and attempt to settle the question by assuming that the \textit{Duquesne} test controls and arguing that the MLR is nonetheless constitutional. Since Cordner argues convincingly\footnote{See Cordner, supra note 6} that, should the \textit{Penn Central} test control, the MLR would be constitutional, our arguments together (if both are accepted), will resolve the question of constitutionality without need to decide which test applies as a technical matter.

I. \textsc{The MLR as Constitutional Ratemaking Epstein’s Argument}

A. \textit{Epstein’s Argument}

The MLR stipulates that health insurance issuers must spend 80\% of the premiums they collect in small group and individual markets, and 85\% of premiums in large group markets, on “providing you with health care and improving the quality of your care (as opposed to what it spends on administrative, overhead, [profits,] and marketing costs).”\footnote{See Epstein, supra note 6 at 261} \footnote{Id. at 262.} Richard Epstein argues the following to show that the MLR is unconstitutional: (1) health insurance companies are not utilities, but are being regulated like they are;\footnote{See Epstein, supra note 6 at 344 (quoting healthcare.gov)} (2) this is unnecessary and inappropriate because the health insurance industry is competitive;\footnote{Id.} (3) the government provides no protections or special considerations to health insurance companies which public utilities enjoy;\footnote{Id. at 262.} (4) the extent of regulation through the MLR, coupled with the government’s ability “to declare rate increases unreasonable, and thus force companies off
the exchanges,” (5) stymies the ability of insurance companies to such a degree that the MLR amounts to a confiscatory taking under the Fifth Amendment.\textsuperscript{17} Epstein concedes that this would not be a taking as applied to any new company which wanted to enter the fold, but that “existing firms...do not have effective exit rights because of the huge amount of capital they have sunk into their businesses, which will have to be sold for salvage value if they quit the business,” resulting in a taking.\textsuperscript{18} This lack of exit strategy would violate the rule that insurance companies “are not required to either submit to confiscatory rates or go out of business.”\textsuperscript{19}

\textbf{B. MLR Ratemaking as Non-Confiscatory}

While cogent, Epstein’s argument contains flaws.\textsuperscript{20} At the time of its publication months after Congress enacted the ACA, Epstein could not rely on empirical data. Instead, he made universal deductive claims that no insurer could earn a fair rate of return under the new regulatory system.\textsuperscript{21} Now, some six years after the passage of the ACA, we do have empirical data and the results are mixed.

While insurance companies have almost universally lost money on policies administered under ACA exchanges,\textsuperscript{22} overall health insurance company profits are soaring.\textsuperscript{23} It is difficult to square the proposition of an

\textsuperscript{17} Id. When Epstein refers to these government declarations, he misrepresents the power they have. According to his own explanation earlier on (256-257) “While HHS does not have the authority to reject rate increases, HHS has, nevertheless, called upon health insurance issuers to rescind putatively unreasonable proposed premium increases.” In fact, this soft scrutiny which lacks rejection power only kicks in when insurers seek “rate increases of ten percent or more” – and even then all HHS can do is require a justification to be submitted and issue an opinion about its reasonableness.

\textsuperscript{18} Id. at 265

\textsuperscript{19} See Markham, supra note 6 at 159 (quoting Aetna Cas. & Sur. Co. v. Comm’r of Ins., 263 N.E. 2d 698, 703 (1970).

\textsuperscript{20} See Markham, supra at 156-158. While he ultimately supports Epstein’s conclusion, he points out four problems with Epstein’s reasoning.

\textsuperscript{21} See Epstein, supra note 6 at 265


\textsuperscript{23} See Jeffrey H. Anderson, Insurers’ Profits Have Nearly Doubled Since Obama Was Elected, The
unconstitutional taking with the observation that profits of the regulated companies have almost doubled industry-wide since the ACA’s implementation.\textsuperscript{24} Even if limiting the analysis to the segment of insurance administered under ACA exchanges,\textsuperscript{25} a causal connection between the potentially confiscatory rates and the MLR itself is missing. Other regulatory aspects of the ACA unrelated to the MLR may account for the losses in the exchanges: namely, the fact that insurance companies must (1) take all comers, and (2) are very limited in their ability to charge more to people who are more likely to get sick.\textsuperscript{26} These market realities and regulations, combined with the fact that neither the MLR nor any other provision of the ACA actually set rates,\textsuperscript{27} demonstrate the MLR’s constitutionality under a public utility ratemaking analysis.

II. THE MLR IS BAD HEALTH CARE POLICY

Despite being constitutional, the MLR remains poor public policy. The MLR was passed because “[m]any insurance companies spend a substantial portion of consumers’ premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing.”\textsuperscript{28} The MLR has not been effective in curbing these expenditures: in addition to the skyrocketing profits alluded to earlier, at least one study shows that the MLR is actually responsible for driving health insurance costs higher.\textsuperscript{29} This is no surprise, because the MLR creates an incentive for insurance companies to raise the amount of dollars it spends on patient care (the denominator in the ratio), which effectively eliminates any incentive for the insurer to bargain with hospitals, doctors, and pharmaceutical companies to lower prices for patient

\textsuperscript{24} Id.
\textsuperscript{26} Id. at 252.
\textsuperscript{27} Recall the discussion above regarding the HHS’ ability to oversee rate increases.
\textsuperscript{28} See note 5 supra
\textsuperscript{29} See Steve Cicala, Ethan M.J. Lieber, and Victoria Marone, \textit{Cost of Service Regulation in U.S. Health Care: Minimum Medical Loss Ratios}, THE NAT’L. BUREAU OF ECON. RSRCH., NBER Working Paper No. 23353 (2017) http://www.nber.org/papers/w23353: (“While intended to reduce premiums, we show this rule creates incentives analogous to cost of service regulation. Using variation created by the rule’s introduction as a natural experiment, we find claims costs rose nearly one-for-one with distance below the regulatory threshold: 7% in the individual market, and 2% in the group market. Premiums were unaffected.”)
care. This lack of competition among the different industry interests in health care keeps prices artificially high.

A. Possible Alternatives

Three possible alternatives to achieve the goals behind the MLR while limiting some of the problems it has produced are to (1) make health care a utility, (2) mandate sliding scale care, or (3) enact transparency forcing regulations to protect free-market competition. Each of these solutions have positives and negatives discussed below.

1. Make Health Care a Utility

The first alternative is to actually set rates. Under this proposed scheme, Congress would delegate authority to HHS to set fair market rates for every medical procedure: there would be a set cost for everything from a preventative care visit to a bypass surgery. While this proposal would do a great job of reining in the cost of health care, determining a cost for each procedure would not only be a cumbersome regulatory impossibility, but would lead to uncertainty about which price category new procedures/techniques would fall into. Such uncertainty may stifle the implementation of new medical technologies. Finally, such a regulatory scheme may affect insurance company profits to such a degree that the taking might be total or near total, which would force us to reconsider Epstein’s constitutional concerns.

2. Adopt Universal Sliding Scale Pay through Income Tax

A second option would be to regulate the cost of not health services but insurance premiums. Under this scheme, everyone would be entitled to the same essential health benefits, but the amount one pays in premiums would be determined based on income. Since the Supreme Court upheld the individual mandate under the power to tax, it is likely that this would be a constitutional solution. This approach is probably doomed politically, though; the idea of such a massive tax increase (even for universal free healthcare) would be wildly unpopular and attacked as socialist.

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30 One problem with this suggestion is whether to organize it on the local, state, or federal level; public utilities commissions are state level, but leaving discretion to the states has political and logistical difficulties.

31 See Epstein supra note 6 at 248. They are already mandated under the current version of the ACA.
3. Enact Transparency Forcing Regulations to Protect Free Market Competition

Under this approach, consumers would know exactly how much their care will cost their insurance company before they consume it.\(^{32}\) Insurance companies could provide rebates to policy holders who elected cheaper/fewer treatments. This approach would balance the values of protecting vulnerable consumers while allowing maximum competitive market efficiency, and it would incentivize both insurance companies and consumers to think about cost when considering their care decisions. Most importantly, this would spark competition to lower prices among doctors, hospitals, and pharmaceutical companies. This solution is likely not only the most effective but the most politically feasible of the three I suggest.

CONCLUSION

The MLR is a constitutional but unwise regulation. As Congress considers new legislation to repeal and replace the ACA, it would be wise to do away with the MLR and push for regulations which mandate price transparency from insurance companies, doctors, hospitals, and pharmaceutical companies to protect free-market competition in an industry that is complicated enough both in the exam room and in the board room to shroud antitrust collusion and bewilder policy holders who are all, as mortals that can get sick, inherently vulnerable.

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\(^{32}\) Of course, there would have to be exceptions for life-threatening emergencies, and when patients are unconscious.

Joe Erkenbrack is interested in corporate accountability, constitutional rights, housing discrimination, environmental justice, and jurisprudence. He graduated in 2009 with a B.A. in Philosophy, and was a social worker immediately before enrolling at Emory. Joe enjoys chess, cooking, and dogs, and playing sports.