IN THE SUPREME COURT OF TENNESSEE
AT NASHVILLE

INDIVIDUAL HEALTHCARE SPECIALISTS, INC. Plaintiff-Appellee, v. BLUECROSS BLUESHIELD OF TENNESSEE, INC., Defendant-Appellant.	No. M2015-02524-SC-R11-CV On Appeal from the Chancery Court of Davidson County Chancellor Ellen Hobbs Lyle No. 11-1042-III

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF APPELLANT

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STATEMENT OF INTEREST OF *AMICUS CURIAE*[1]

America's Health Insurance Plans (AHIP) is the national trade association representing the health insurance provider community. AHIP advocates for public policies that expand affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Along with its predecessors, AHIP has over 50 years of experience in the industry. AHIP's members provide health care coverage and other financial health and wellness benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. As a result, AHIP's members have broad experience working with a variety of stakeholders to ensure that patients have access to needed treatments and medical services at affordable prices. Those stakeholders include agents and brokers, hospitals, physicians, clinics and laboratories, patients, employers, state governments, the federal government, and pharmaceutical and device companies. That experience gives AHIP extensive first-hand and historical knowledge about the nation's health care and health insurance systems and a unique understanding of how those systems work.

AHIP has participated as *amicus curiae* in other cases to explain the practical operation of health insurance markets, including how the Affordable Care Act has affected those markets. *See, e.g.*, *King v. Burwell*, 135 S. Ct. 2480 (2015); *Nat'l Federation of Ind. Business v. Sebelius*, 567 U.S. 519 (2012). Likewise here, AHIP seeks to provide the Court with its unique expertise and experience regarding the operation and regulation of the individual and small group health insurance markets. In particular, AHIP writes to share its expertise regarding the Affordable Care Act's medical loss ratio requirement, which prescribes the proportion of premiums that health

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[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than the *amicus*, its members, or its counsel made a monetary contribution intended to fund the brief's preparation or submission.

plans must spend on certain expenses. That provision and other reforms exemplify an ever-changing landscape in health insurance regulation, which underscores why health insurance providers' contractual rights to modify business terms with their partners and vendors must be enforced according to their plain terms. Health insurance providers typically negotiate for the right to modify commissions in their agent or broker contracts, and this modification right helps the entire industry respond to frequent business and regulatory changes. An interpretation of Tennessee law that creates vested commission rights when contractual language provides otherwise would harm health insurance providers and consumers alike.

INTRODUCTION AND SUMMARY OF ARGUMENT

Health insurance providers commonly negotiate clauses, as BlueCross BlueShield of Tennessee (BCBST) did here, that allow them to modify commissions for brokers and agents for a simple reason: the regulatory and business environments in which the health care industry operates change frequently. Contractual flexibility to modify both new and renewal commissions has been particularly important in the wake of major reforms that applied new federal law to nearly every facet of the market for health insurance, which had previously been left predominantly to state regulation, including the valued relationship between health insurance providers and brokers or agents.

Of particular relevance, the Affordable Care Act included a provision, known as the "medical loss ratio," or "MLR," that effectively limits health insurance providers' expenditures related to administration, customer service, marketing, and other similar functions—including, for now, the commissions paid to agents and brokers.[2] The MLR, like other new federal reforms, is subject to enforcement by Tennessee insurance regulators as well as applicable federal agencies.

[2] Collectively, these costs are referred to as "administrative costs," and they include every cost of a health plan that is *not* a payment to cover the cost of an enrollee's claim (*i.e.*, to cover

The federal MLR, which was one of the first ACA reforms to go into effect in 2011, was a significant departure from Tennessee's differing pre-ACA MLR requirements. The federal MLR requires health insurance providers that do not meet the statutory target for limiting defined administrative expenses to pay rebates to consumers (or in the case of health plans offered in the small group market, to employers). Such rebates effectively double bill health insurance providers for the same costs, requiring them to pay twice for administrative costs exceeding the threshold (once for the administrative function and then again for the rebate), out of the same, unchanged premium revenue. Health insurance providers have worked hard to control administrative expenses to ensure that the vast majority of premium revenue is spent on medical care for enrollees. As part of this effort, many health insurance providers have reduced broker and agent commissions, after fair notice, whether by reducing the commission percentage or converting them to flat fees.

And the MLR is just one part of this changing landscape. A second wave of ACA reforms took effect in 2014. These reforms changed virtually every aspect of health insurance in the individual market, including how premiums are set, what health benefits are covered, and how consumers shop for and enroll in plans. These changes resulted in increased premiums, because the plans offered in the new marketplace were very different from what had been offered before. These new products included a minimum set of "essential health benefits" and were made available to any applicant regardless of health history, a departure from previous business practices that also impacted premiums. The 2014 changes also required health plans to incur substantial administrative expenses to adjust plan design and pricing, and to develop systems to integrate with

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medical treatment provided to the enrollee), an expenditure related to health care quality, or a tax or regulatory fee. *See* 42 U.S.C. § 300gg-18(a)(1)-(2), (b)(1)(A); pp. 8-10, *infra*.

new, web-based health care exchanges. The upshot was that, absent modification, percentage-based renewal commissions would deliver increased compensation to agents and brokers for reasons wholly unrelated to the actual services they provided, at a time when plans especially needed to preserve their ability to cover increased administrative costs without triggering double-cost rebates. The combined effect of these changes—along with new mechanisms for consumers to shop for health insurance that debuted in 2014—spurred many health insurance providers to modify their arrangements with brokers and agents, in accordance with their contracts.

Such modifications were a necessary response to the strict cost restrictions health insurance providers faced under the MLR, beginning in 2011, and to other changes to the marketplace beginning in 2014. By saving on expenditures elsewhere, health insurance providers could continue to provide critically important information and customer service functions to plan enrollees, and were also better able to respond to the initial and ongoing administrative costs arising from new ACA requirements, without incurring the double cost of issuing rebates. Absent the ability to invoke the plain terms of contractual clauses, like the modification clause at issue here, health insurance providers would not have been able to respond as effectively to these regulatory changes while maintaining needed customer service functions and making health coverage as affordable as possible.

The changes mandated by the Affordable Care Act's passage underscore why health insurance providers typically, and sensibly, reserve the contractual right to adjust commissions, as BCBST did here—whether or not they may have needed to exercise that right in the past. Such flexibility is essential to being able to respond to oft-changing business needs and regulatory and market conditions. Commission-modification clauses are critical parts of broker-health insurance provider contracts that should be enforced according to their plain terms.

ARGUMENT

Health Insurance Providers Contract For The Right To Adjust Commissions Because Such Flexibility Is Needed To Address Regulatory Change In The Health Care Industry, Including Changes Like The Affordable Care Act's Medical Loss Ratio.

Before passage of the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029 ("Affordable Care Act," "ACA," or "the Act"), the market in Tennessee for individuals purchasing health insurance, as well as in most other states, was "underwritten" and subject mostly to state regulation. *See* Gary Claxton, et al., Kaiser Family Foundation, *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, at 1–3 (Dec. 2016).[3] That meant that health insurance providers could generally factor in the health status of potential enrollees, and set premiums based on actuarial models that reflected an individual's likely health care needs. *Id.* at 1.[4] The "small group" market—for insurance provided through small employers—was regulated much the same as the individual market, except that Tennessee restricted the degree to which the premium for a small group policy could exceed the market average. *Id.*[5]

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[3] *Available at* https://goo.gl/H8QxMF.

[4] Before ACA, Tennessee operated a high risk pool as a backstop to the individual market, whereby individuals with health conditions that made it impossible to obtain insurance in the individual market could obtain coverage. *See* Karen Pollitz, Kaiser Family Foundation, *High Risk Pools for Uninsurable Individuals* (Feb. 22, 2017), *available at* https://goo.gl/SWffAu. Like other states, Tennessee wound down its high risk pool in 2014 as part of the transition to new individual-market rules under ACA. *Id.*

[5] A group health plan is employer-sponsored health insurance that covers employees (and, often, their families). *See* Kaiser Family Foundation, *Health Reform Glossary*, *available at* https://goo.gl/n3J7AR (entry for "Group Health Insurance"). The group market is generally divided between the small group market, for small employers, and large group market, for larger employers. *See id.* (entry for "Small Group Market"). For most purposes, the small group market in Tennessee includes employers with 2 to 50 employees, Tenn. Code Ann. § 56-7-2802(31). For medical loss ratio purposes, however, the small group rules apply to employers that have between 1 and 100 employees. Tenn. Comp. R. & Regs. § 0780-01-93-.08(1)(b).

Federal regulation in the individual and small group markets was very different before the Affordable Care Act. *See* Len M. Nichols & Linda J. Blumberg, *A Different Kind Of 'New Federalism'? The Health Insurance Portability And Accountability Act Of 1996*, 17 HEALTH AFFAIRS 25 (1998) (describing federal regulation after the enactment of 1990s-era reforms). Before the Act, federal law did not generally regulate the benefits covered by health insurance, how premiums were set, the way that health insurance providers used their resources to cover expenses, or how consumers shopped for health insurance. The Act changed that dynamic. The new federal law governs how health benefit plans are designed, priced, sold, paid for, and administered, particularly in the individual and small group markets.

As relevant here, the new changes became effective in two waves. The first set came into effect over the period of 2010 through 2011, and included the medical loss ratio, which limits the amount that health plans can spend on administrative expenses, broadly defined. *See* 42 U.S.C. § 300gg-18(b). A second tranche of federal regulatory changes became effective in 2014. Among other things, the 2014 changes provided that health insurance providers cannot decline to issue a health insurance policy based on health status (commonly called "guaranteed issue"); restricted the degree to which health insurance premiums can vary based on individual status (known as "community rating"), allowing premiums to vary only for smoking status and by a ratio of 3:1 based on age; and created new health insurance marketplaces known as exchanges. *See* 42 U.S.C. § 300gg(a)(1); *King v. Burwell*, 135 S. Ct. 2480, 2485, 2486 (2015).

States are the primary enforcement or implementation authorities for both sets of reforms, with the federal government as a fallback for enforcement. *See* 42 U.S.C. § 300gg-22(a) (providing that "each State may require that health insurance issuers that issue … health insurance coverage in the State … meet the requirements of this part," which includes the medical loss ratio

and underwriting restrictions, with federal enforcement only when "a State has failed to substantially enforce a provision"); 42 U.S.C. § 18041(c)(1) (requiring the federal government to operate a health insurance exchange on behalf of a state if it chooses not to establish its own exchange).

Both sets of reforms substantially altered the way health insurance providers did business, including significantly affecting the relationship between health insurance providers and insurance brokers and agents. Health insurance brokers and agents serve the important function of assisting consumers and small businesses with "choosing and enrolling into insurance products," particularly in the individual and small group markets. Mark Newsom, Cong. Research Serv., R41439, *Health Insurance Agents and Brokers in the Reformed Health Insurance Market*, at 1 (Jan. 5, 2011).[6] They are generally compensated through a commission payment from the health insurance provider that is selected by the consumer or small business. *Id.* at 1. Because such commissions are counted as administrative expenses under the medical loss ratio, however, they were subject to new federal limits after that provision went into effect. In addition, beginning in 2014, after the second round of ACA reforms, wholesale changes to plan design and premium setting went into effect, along with exchanges that were designed to "mak[e] it easier to shop for different health insurance." *Id.* at 2. These changes fundamentally altered the nature of the individual and small group markets.

Many health insurance providers have exercised their contractual rights to modify broker commissions—in accordance with contracts affording them that right upon appropriate notice—in the wake of these reforms. Their contractual right to do so has been consistently upheld by other courts until now, as BCBST chronicles. *See* Appellant Br. 41–44 (collecting cases). This

[6] *Available at* https://goo.gl/abFQDD.

contractual flexibility, which health insurance providers bargained for and brokers agreed to, is critical to the industry's ability to adapt to constant change in the legal, regulatory, and business environment. It should not be taken away simply because a health insurance provider opted not to exercise it in the past.

A. The Affordable Care Act Made Significant Changes that Affected Administrative Costs, Including Arrangements Between Health Insurance Providers and Agents/Brokers.

1. *Impact of the Medical Loss Ratio on Agent/Broker Compensation*

The ACA provision that most directly affects arrangements between health insurance providers and agents or brokers is called the medical loss ratio, which took effect in 2011. *See* 42 U.S.C. 300gg-18(b); 45 C.F.R. Part 158. Under the MLR, if the proportion of premium revenue spent on "reimbursement for clinical services provided to enrollees" and "activities that improve health care quality" is lower than a specified threshold, then plans must "rebate" a portion of premiums to enrollees. 42 U.S.C. § 300gg-18(a)(1)-(2), (b)(1)(A); *see also* Kaiser Family Foundation, *Explaining Health Care Reform: Medical Loss Ratio (MLR)* (Feb. 29, 2012).[7] Although denoted as a "rebate," the funds paid out to consumers or employers under the MLR are not in any sense a refund of unused premiums. Rather, they reflect a double cost to health plans, without corresponding revenue: After first spending some amount of premium dollars on necessary administrative costs for a particular health plan, a health insurance provider must then spend additional funds on administrative expenses to issue and administer rebate payments which represent a second non-claim cost for that plan (a rebate), even though it has not received any additional premium revenue.

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[7] *Available at* https://goo.gl/t8Svs8.

The threshold for paying rebates in the individual and small group markets in Tennessee is the federally specified amount of 80%—meaning, to avoid paying double costs, health plans must spend 80% (or more) of premium revenue on reimbursement for clinical services (known as "medical losses," thus the MLR name) and health-care-quality activities, rather than on other costs (like provider credentialing, network management, enrollee notifications, customer service departments, claims administration, or agent and broker commissions). 42 U.S.C. § 300gg-18(b)(1)(A)(ii); Tenn. Comp. R. & Regs. § 0780-01-93-.08(1)(b) (requiring plans to calculate the MLR in accordance with federal regulations).[8]

The precise calculation for the MLR and the amount of the rebates involves much detail, but in broad strokes, the formula for the rebate amount in the individual and small group markets is as follows:

A health insurance provider's MLR is: $\frac{\text{\$ expended on reimbursing clinical services + health care quality}}{\text{premium revenue – taxes \& regulatory fees}}$

The rebate is: (0.80 – provider's MLR) x (premium revenue – taxes & regulatory fees)

To put it another way, imagine a health insurance provider with a single enrollee. If that provider received $2000 in premiums, paid $150 in taxes, and spent $1387.50 on reimbursing clinical activities and health care quality, its MLR would be 75% (1387.50/(2000-150)). Because

[8] A different threshold (85%) applies in the large group market, *i.e.*, for insurance plans sold to larger employers. 42 U.S.C. § 300gg-18(b)(1)(A)(ii). States may adjust the threshold upward for all markets, and may also apply to have the Department of Health and Human Services adjust the threshold downward in the individual market (allowing a greater amount of premiums to be spent on administrative costs) if necessary to avoid destabilizing the market. *Id.* § 300gg-18(b)(1)(A). Tennessee has not adjusted the MLR threshold, nor requested an adjustment from the Department of Health and Human Services. *See* Ctrs. for Medicare & Medicaid Servs. (CMS), *State Requests for MLR Adjustment*, *available at* https://goo.gl/yCbwKn.

the required MLR (80%) exceeds the provider's MLR (75%) by 5%, the health insurance provider would owe the enrollee a rebate of 5% of premium revenue (less taxes). That works out to a rebate of $92.50 (.05 * (2000-150)). *See* 75 Fed. Reg. 74,864, 74,883 (Dec. 1, 2010).

As the formula indicates, assuming the same amount of premium revenue, every dollar that a health insurance provider spends on administrative costs lowers its MLR and increases the risk it will have to incur double costs in the form of rebates. Health plans must accomplish everything needed to operationally accept, process and administer their enrollees' benefits and claims within the MLR's permitted 20% ceiling. This includes, among other things, advising enrollees of their benefits and claims, the process of administering and overseeing benefit claims payments, providing customer service and provider information, fraud prevention, case management activities associated with past or ongoing medical care, costs of developing networks of participating medical providers, costs of salaries, rent, information technology, some community benefit expenditures, and (of special relevance here) broker and agent commissions. *See* CMS, *MLR Annual Reporting Form Filing Instructions for the 2016 MLR Reporting Year*, at 22–24 (2016).[9] All of the costs of these health plan activities count against the MLR's 20% administrative-cost cap.

It has been an evolving process for plans to accomplish all these functions within the allowable 20%, further complicated by a rapidly changing regulatory and business climate. In the first year that MLR rebates were paid, health insurance providers paid $1.1 billion in rebates to 12.8 million consumers (or their employers, on the consumers' behalf). CMS, *The 80/20 Rule: Providing Value and Rebates to Millions of Consumers* (June 12, 2012).[10] The individual and

[9] *Available at* https://goo.gl/S5MyG4.

[10] *Available at* https://goo.gl/cBv7RE.

small group markets in Tennessee accounted for $21.8 million of that total. CMS, *List of Health Insurers Owing Rebates in 2012*, at 9 (Nov. 26, 2012).[11] That $21.8 million—or $1.1 billion, nationally—reflects costs that health insurance providers effectively had to pay twice (once for the initial expenditures, and once for the rebate), without any additional premium revenue. As a result of renegotiated business relationships, modifications to activities and expenses, and additional experience with the MLR, rebates dropped to $256 million nationally in the individual and small group markets in 2016, and to about $977,000 in those markets in Tennessee. *See* CMS, *Summary of 2016 Medical Loss Ratio Results* (Dec. 27, 2017).[12]

The federal MLR was a big change in the marketplace. Before it took effect, many states had some form of a MLR, but the requirements were typically far less stringent (requiring MLRs as low as 50%) and double-cost "rebates" were not generally involved. *See* AHIP, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations (as of April 15, 2010)* (hereafter "AHIP Report on Pre-ACA MLRs").[13] In line with the practice in many other states, Tennessee's pre-ACA MLR provision considered loss ratios as a factor in state regulation of the reasonableness of premiums, but deemed ratios of 50%-60% reasonable (meaning it was deemed reasonable to spend substantially higher amounts on administrative costs than under the 80% ACA threshold) and did not impose rebates, but required rate adjustments. *See* Tenn. Comp. R. & Regs. § 0780-01-92-.08(1) (now applicable only to health plans not subject to regulation under the Affordable Care Act).

The departure from the pre-existing state MLR standards directly affected health insurance provider-broker arrangements, in Tennessee and throughout the country. This is because one of

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[11] *Available at* https://goo.gl/1eLvTe.

[12] *Available at* https://goo.gl/aW7KaX.

[13] *Available at* https://goo.gl/e5TcrF.

the many administrative costs that must be managed within the 20% allowed by the MLR is broker and agent commissions. 45 C.F.R. § 158.160(b)(2)(iv) (defining "[n]on-claims costs other than taxes and regulatory fees" to include "[a]gents and brokers fees and commissions"). Such commissions were one of the primary drivers of a health plan's federal MLR in the early years of its implementation, because pre-ACA broker or agent commission rates were, on average, 6% to 8% of premiums. Newsom, Cong. Research Serv., *supra*, at 1. For example, a study by the Government Accountability Office concluded that the more than $1 billion of MLR rebates paid by insurance providers in 2011 and 2012 would have decreased by 75% if broker commissions were excluded from administrative costs. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-14-580, PRIVATE HEALTH INSURANCE: EARLY EFFECTS OF MEDICAL LOSS RATIO REQUIREMENTS AND REBATES ON INSURERS AND ENROLLEES 17 (July 2014) (hereafter "GAO Report").[14]

It is not sustainable for any business to keep paying costs of this magnitude, year over year, in the form of MLR rebates. Unless and until agent and broker commissions are excluded from administrative costs, *see* pp. 16-17, *infra*, modifying those commissions as allowed under their contracts is an important tool that health insurance providers can use to manage those costs so that they can meet MLR requirements and avoid incurring the double cost of issuing rebates.

2. *Impact of the 2014 Market Reforms on Agent/Broker Compensation*

The MLR was not the only major change affecting the broker-health insurance provider relationship following passage of the Affordable Care Act. The ACA reforms that went into effect in 2014 also had major effects. First, there were wholesale changes to how plans were designed and priced, including mandatory coverage of certain benefits, limits on deductibles and co-pays, and requirements to set premiums based on community rating (rather than individual health risk

[14] *Available at* https://goo.gl/WkJT2b.

or needs). *See* Groom Law Group, *Effective Dates for Key Provisions in the Affordable Care Act*, at 3-5 (describing the ACA provisions that went into effect in 2014).[15] These changes transformed the products sold on the individual and small group markets. And broker compensation models based on pre-ACA product design became increasingly unfeasible as they failed to reflect the new market for insurance. For example, to the extent that ACA reforms led to increased premiums (due to requiring coverage of additional benefits, altering premium-setting rules, or any number of factors), fixed percentage-based commissions would lead to increased broker or agent compensation that had no relationship to the nature or amount of services agents or brokers were providing to consumers. In such an environment, other arrangements (such as flat fees) became a better fit for some plans. Moreover, the 2014 changes also came with a set of administrative challenges, requiring plans to expend substantial resources on redesigning plans (and the associated networks of participating service providers) to encompass new benefits, new rules, and new models for premium-setting and cost-sharing. This, too, prompted many plans to rethink the division of resources across administrative expenses, customer service, broker/agent compensation, and other priorities.

Second, the 2014 ACA reforms changed the way that individuals search for and enroll in health plans. The Act required the creation of exchange web portals (*e.g.*, www.healthcare.gov), that provide individuals an electronic way to "compare available private health insurance options on the basis of price, quality, and other factors." 78 Fed. Reg. 42,824, 42,824 (July 17, 2003); *see* 42 U.S.C. § 18031(c)(5) (requiring the development of a template "Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans ... and to present standardized information (including quality ratings) regarding qualified health plans offered

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[15] *Available at* https://goo.gl/TFVQNx.

through an Exchange to assist consumers in making easy health insurance choices"). And the Act also created (and funded) a program for trained personnel—called "navigators"—to assist consumers in selecting and enrolling in a health plan. *See* 42 U.S.C. § 18031(i); Suzanne M. Kirchhoff, Cong. Research Serv., R43243, *Health Insurance Exchanges: Health Insurance "Navigators" and In-Person Assistance* (2014).[16] While brokers and agents can register as navigators, so too can any number of other entities, including non-profits, unions, trade associations, and Native American tribes. 45 C.F.R. § 155.210(c)(2). When acting as a navigator, moreover, brokers and agents—like all navigators—are prohibited from receiving compensation from health insurance providers for enrolling individuals in health plans. *Id.* § 155.215(a)(1)(i)(D). Instead, navigators are paid through government or exchange-funded grants. *See* 42 U.S.C. § 18031(i)(1).

These reforms resulted in more options for consumers when seeking assistance with finding and enrolling in health plans and understanding available premium subsidies. And while brokers retain an important function in assisting clients in selecting the correct health plan, consumers are also now able to increasingly use internet tools or other helpful professionals to find and enroll in the right health plan for them. *See* Julie Appleby, *As Insurers Cut Brokers' Commissions, Consumers May Have One Less Tool For Enrollment*, Kaiser Health News (Nov. 1, 2016) (reporting that approximately 45% of consumers on California's exchange used a broker to select 2016 coverage).[17] Like the changes governing plan design, the availability of other channels for plan information and selection beginning in 2014 affected how health plans could sensibly compensate brokers and agents.

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[16] *Available at* https://goo.gl/VDrWiY.

[17] *Available at* https://goo.gl/vvJhki.

Together, the MLR and the 2014 reforms represented major shifts in the regulatory and business environments for health insurance. To navigate these changes, health insurance providers were required to often re-examine—and modify, if necessary—their business practices and arrangements, including broker and agent commissions.

B. Many Health Insurance Providers Have Exercised Their Contractual Rights to Modify Broker/Agent Relationships in the Wake of Affordable Care Act-Related Changes.

Beginning after the 2011 changes went into effect, and again when the 2014 reforms were implemented, many health insurance providers exercised their long-established contractual rights to modify commissions to account for these changes to the regulatory and business landscape. Health insurance providers have taken a variety of different approaches to adjusting broker commissions, from eliminating commissions entirely to reducing percentages or changing to flat fees. *See* Appleby, *supra* (describing the reduction or elimination of commissions for plans sold on the exchanges); GAO Report at 21 (finding that half of surveyed health insurance providers reported reducing commissions in the first few years after the MLR was implemented, "either by changing their payment method from a percent of premiums to a flat fee, or by reducing the set percentage of premiums that they pay to agents and brokers").

And while health insurance providers have not placed the burden of market adjustments on brokers or agents alone, modifying broker commissions was a necessary and essential means by which health plans were able meet the MLR's requirements. In just the first year of the MLR (from 2011 to 2012), health insurance providers reduced the percentage of premiums spent on commissions by about 10% in the individual market. *See* Michael J. McCue & Mark A. Hall, *The*

Federal Medical Loss Ratio Rule: Implications for Consumers in Year 2, at 5 exhibit 5 (Commonwealth Fund pub. 1744, Vol. 8, May 2014).[18]

Interpreting Tennessee law to require payment of commissions at the same fixed rate in perpetuity—notwithstanding health insurance providers' bargained-for contractual modification rights—will eliminate an important tool health plans rely upon to respond to changing business needs, regulatory conditions and market forces, and thereby harm health insurance providers and consumers, and ultimately brokers, alike. If health insurance providers must pay "vested" commissions at fixed percentages for as long as a consumer renews coverage, plans are highly likely to incur double costs in the form of MLR rebates, because a fixed percentage-based commission likewise takes up a fixed proportion of the 20% administrative-cost ceiling. Alternatively, to avoid incurring the double costs imposed by rebates, plans would be required to reduce or eliminate altogether their other administrative functions, such as staffing customer help lines, updating their web-based network provider directories, investigating fraud and abuse, producing comprehensive and helpful plan documents, and many other functions essential to consumers. As BCBST argues, there is no warrant in Tennessee law to depart from the plain terms of the modification rights negotiated by health plans, Appellant Br. 44–46, and it would cause great harm to the industry and the consumers they serve to impose such rigidity in direct contravention of the plain terms of the contract.

Health insurance providers value the services provided by brokers and agents, who serve an important function in helping consumers and small employers locate and select health plans. AHIP has supported legislative efforts to alter how the MLR calculation affects broker and agent compensation, specifically by excluding commissions from the administrative costs counted

[18] *Available at* https://goo.gl/aFLAzL.

within the MLR formula. *See, e.g.*, Access to Independent Health Insurance Advisors Act of 2015, S. 1661, 114th Cong. (2015); News Release, Senators Isakson, Coons Introduce Bill to Safeguard Americans' Access to Health Insurance Agents, Brokers (June 24, 2015) (listing organizations supporting legislation).[19] Similar legislation has been recently reintroduced, precisely because the existing MLR has "led many health plans to reduce or even eliminate commissions." Dave Kovaleski, *Sens. Isakson, Coons sponsor bill to help consumers get health insurance advice*, Life Science Daily (Jan. 15, 2018)[20]; *see* Access to Independent Health Insurance Advisors Act of 2018, S. 2303, 115th Cong. In addition, the current regulatory approach has also de-emphasized navigators (which have been provided less funding) and promoted the use of agents and brokers through a new help feature on the federal exchange. *See* Robert Pear, *Trump Administration Guiding Health Shoppers to Agents Paid by Insurers*, N.Y. Times (Nov. 11, 2017).[21]

If legislation to remove commissions from the MLR calculation is enacted, health insurance providers will have additional flexibility to address commissions in response to market changes and the ever-changing regulatory environment, without being limited by the regulatory 20% MLR ceiling. But regardless of these potential regulatory changes, health insurance providers must remain free to exercise the contractual modification rights that they negotiated with agents and brokers.

C. Upholding Contractual Modification Rights Is Critical to Health Insurance Providers' Ability to Flexibly and Fairly Respond to Future Changes.

The legislative and regulatory changes described above are unlikely to be the last for the health insurance sector. Against this backdrop, health insurance providers sensibly choose to

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[19] *Available at* https://goo.gl/VvUjMX.

[20] *Available at* https://goo.gl/rWqfGz.

[21] *Available at* https://goo.gl/9TUVXZ.

negotiate contract terms reserving the right to modify broker and agent commissions, as BCBST did here. Such clauses allow health insurance providers to respond to business needs and regulatory changes. Most important, this flexibility to modify commissions allows health insurance providers to keep premiums affordable, preserve essential services for consumers, and calibrate agent and broker compensation to the nature and amount of services they provide (rather than inexorably pegging it to premiums).

Many health insurance providers (like BCBST) negotiated for commission-modification clauses, moreover, with the awareness that major change was coming. Thus, Henry Smith, BCBST's Senior Vice President and Chief Marketing Officer, was well-aware in 2008 (when the 2009 Agreement at issue in this case was negotiated) that major health care reform was in the works, and that BCBST "wanted to maintain some flexibility" in the contracts then being negotiated "since we did not know, at that time, what was going to be in the law that would pass." T.R. Vol. LXIII 2988. And while the precise scope of health care reform was unknown, health insurance providers were generally aware that a provision like a stricter federal MLR was a possibility given that MLR provisions of some kind had been in place in some states for decades, including in Tennessee since 1974. *See* AHIP Report on Pre-ACA MLRs. Thus, commission-modification flexibility has been important to health insurance providers for a long time, and modification rights have accordingly long been a part of standard contracts with agents and brokers.

As BCBST persuasively argues, the plain language of the contract is unambiguous that BCBST, like other insurance providers, secured the right to modify commissions for both new and existing policies. Appellant Br. 40–41. This right is of critical importance to health insurance providers, whether or not it was ever exercised in the past. Modifying commissions is a critical

business tool, given the frequent changes in the health insurance sector. A health insurance provider's past decision not to modify commissions—because continuing existing rates was consistent with then-governing market or regulatory conditions—is not a waiver of the right to modify commissions when those conditions change. *See* Appellant Br. 47–48. Thus, past decisions to leave renewal commissions unchanged, before the period of change sparked by the Affordable Care Act's passage, cannot—and should not—negate the fact that health insurance providers contracted for the right to revise commission rates as needed.

Health insurance providers and brokers are both sophisticated entities, and they bargain for and negotiate the terms that they need—including contractual flexibility to adjust commissions for new and existing policies, to be better able to effectively respond to changing market conditions. Their bargained-for contractual rights to modify commissions should be enforced according to their plain terms.

CONCLUSION

The Court of Appeals' judgment with respect to the rate-reduction provision should be reversed.

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