Excellus

Prepared remarks by David Klein, President and CEO of Excellus BlueCross BlueShield

Joint Legislative Budget Hearing – Health

February 9, 2010

Good afternoon. I have prepared written comments which will be submitted for your consideration and I will confine my testimony to a brief summary of those comments.

My name is David Klein and I am the chief executive officer of Excellus BlueCross BlueShield, upstate New York's largest not for profit health insurer, and our parent company, The Lifetime Healthcare Companies. With offices spanning across virtually the entire region, Excellus is one of upstate New York's largest employers with over 6,000 employees serving our approximately 1.6 million members. As a not for profit plan, we are committed to three core principles: 1) to assure that as many people as possible in the communities we serve have affordable, dignified, access to needed and effective health care services; 2) we recognize the need and obligation to reach out to all segments of the communities we serve, including the poor, aged and underserved, to enhance their quality of life, including health status; and 3) we are committed to being a nonprofit insurer.

As both a local upstate business and a stakeholder in the health care marketplace, Excellus, like many other plans, has not been immune to difficult times in this economic climate. Over the last several years, we have experienced a drop in enrollment, declining revenue, operating losses, depleting reserves and a reduction in our workforce. Additionally, we have shouldered millions in newly-imposed health insurance taxes, instead of imposing midyear rate increases in vulnerable markets. While I believe the worst may be behind us, we continue to face a number of challenges, not the least of which will be a dramatic change in our market in the event federal health care reform is enacted.

With this challenging environment in mind, there are a number of issues included in the Governor's Budget which are of grave concern and will negatively impact the cost of health insurance. These issues include an increase in the HCRA tax paid by our customers, an Early Intervention mandate that is merely a cost shift of an existing state funded program, and provider Medicaid cuts which will force providers to seek greater reimbursement from the private pay market further driving up the cost of coverage. While each of those items are of significant concern, I will limit the bulk of my comments to express opposition to the Governor's proposal to reinstate a failed health insurance premium rate-setting mechanism known as "prior approval" and the devastating impact this proposal will have on both health care delivery state-wide and Excellus' role as a large upstate employer.

In a nut shell, “prior approval” grants the Insurance Department the complete unfettered discretion to approve, or disapprove, rate increases in the small group and individual markets. A version of this proposal was in effect prior to 1995, but was repealed, as part of a larger reform initiative, by a unanimous vote of the Legislature.

On its face, this proposal would appear to be an appealing, populist concept. Indeed, while the industry is one of the most heavily regulated in the State, and New York regulates this industry more heavily than any other state in the country, granting the Insurance Department even greater authority to regulate premiums would, on a superficial level, be an effective tool to control costs. Our past experience indicates, however, that this will lead to a number of severely deleterious results, including: 1) an over politicalization of the rate approval process, 2) creating financial instability in the insurance industry, 3) eventual suppression of health care provider reimbursement rates, 4) dramatic fluctuations in approved premiums, 5) an increase in large group rates or union accounts to subsidize the suppressed rates in the regulated market; and 6) extended delays in the approval process leading to retroactive rate approvals that results in a sticker shock on customers.

Each of these negative consequences is well documented and is reflected in my written testimony. In fact, the Assembly Insurance Committee held a public hearing on “prior approval” last year in which each of the above mentioned negative consequences were repeatedly documented when the State had prior approval in the past. Significantly, the vast majority of witnesses appearing at the Assembly Hearing, including hospitals,

business groups, independent insurance agents, or members of the health plan industry, expressed vehement opposition to this proposal.

The basic cause for these negative consequences is the premise that any increase in premiums is unpopular, regardless of whether it is necessary or warranted. No Administration wants to be accused of raising health insurance premiums on an electorate that is already burdened by high costs. This is especially true in a turbulent economic and political climate like we have today. In turn, without an objective, actuarial standard which assesses the cost of care and providing coverage, the subjectivity of the process leads to artificially suppressed rates, or "price controls". That was clearly our experience prior to 1995 and is very similar to the current suppression of rates in medical malpractice insurance.

While the suppressed rates provide short term relief, it merely delays an inevitably large rate increase or contributes to the financial impairment of a health plan. Indeed, we have the benefit of history- under prior approval, we experienced, first hand, severe fluctuations in rates in the late '80s and early '90s, at first being suppressed for a number of years only to be dramatically increased when our Plan faced mounting losses and financial impairment. The results were unpredictability of costs for our customers, reduced provider reimbursement and financial strain on our business.

The common analogy is to a bag of groceries - capping the cost of a bag of groceries without regard to the cost of each item in the bag, may sound attractive, but at some point

someone has to pay. Likewise, artificial price controls inevitably result when you regulate only one component of the cost structure. Using the groceries example, you can not effectively regulate the price of groceries if you don't also regulate the price of the items in the bag - for example, the cost of meat, the trucking industry costs, the meat packing plant, the grocery store overhead, and all of the other players in food production. Likewise, price fixing health insurance premiums is equally misguided when there is no accompanying control over the actual cost of health care delivery and services consumed.

In contrast to the subjectivity of prior approval, the current process, while by no means perfect, requires plans to set rates using an objective, actuarially-based standard referred to as a medical loss ratio (MLR). At its most basic, MLR is the percentage of a premium dollar spent on claims, such as hospital, prescription drug and medical costs. When determining rates, plans must generate an actuarial projection of the cost of care and ensure rates are such that a minimum standard MLR is achieved. New York's MLR requirements currently exceed the national average in the individual and small group market – 80% as compared to the average 69%, and 75% as compared to the 72% average, respectively. Unless the plan projects that a product will meet these minimum standards, any rate increase is subject to prior approval. Likewise, in the event a plan's experience turns out to be more favorable than the projection and the minimum standard is not achieved, refunds are provided to customers. While there may be a need for improvements, such as accelerating the refunds to customers and clarify ambiguous terms to eliminate potential abuse, the process is highly regulated and can be an effective structure for rate determinations.

In fact, while the Insurance Department has identified twenty-four states that have "prior approval", upon closer examination of each states specific laws, New York's current process, including the oversight provided by the Department to ensure compliance, would result in New York already being considered a "prior approval" state when compared to the process in other states.

As mentioned, I acknowledge that current law is in need of improvement. Instead of reverting back to prior approval, however, a more prudent approach is to look at the current process and make changes to increase regulatory oversight, reduce excess profits, and eliminate the potential gamesmanship by some plans, yet maintain the integrity of an objective analysis. We are certainly prepared to participate in the needed changes to ensure fair and adequate rates in these markets.

In closing, we face incredibly challenging times, both as an employer and a stakeholder in health care. While by no means are we perfect, we have worked to maintain our core principles and also streamline administrative expenses to ensure we maintain adequate reserves and control premium costs. Excellus is proud to be a significant presence in the upstate New York economy and we understand the importance of that role, both as an employer and as a critical member of the health care delivery system. The adoption of prior approval is not only bad public policy, but will threaten our presence as an upstate employer, unnecessarily jeopardize health care jobs and will destabilize an already turbulent marketplace.

Excellus

Regulatory Approval of Health Insurance Rates: "Prior Approval"

Written Testimony of David Klein, President & CEO of Excellus BlueCross BlueShield, before the Assembly Standing Committee on Insurance

February 9, 2010

This written testimony serves as a supplement to my presentation before the Joint Legislative Budget Hearing on Health. Specifically, I wish to provide additional details and data to underscore our opposition to the Governor's proposal to reinstate a failed health insurance premium rate-setting mechanism known as "prior approval."

Specifically, this proposal would grant the Superintendent of Insurance the complete discretion to set premium rates for individuals and small businesses, irrespective of the actuarial need or justification for appropriate rates. As proposed, this language would provide the Superintendent with a level of authority which has not been granted to any other Superintendent of Insurance through either statute or regulation nationwide. Such unchecked authority will inevitably lead to a return to the politicalization of the premium setting process whereby rates will be artificially suppressed without regard to the underlying components contributing to rising health care costs. If the past is any indication, this, in turn, could lead to a number of deleterious results, including: 1) an inability to maintain adequate reserves; 2) a substantial delay in actuarially justified rate increases; 3) an inability to adequately compensate providers; and 4) a negative impact on our role as a major upstate employer. Moreover, the prior approval process will ultimately threaten the ability of health plans to assure New Yorkers that the coverage they prefer and depend on has been adequately funded, not only for routine services, but for events requiring extraordinary financial backing for sustained periods. Each of these concerns actually occurred when prior approval was in effect and is summarized in greater detail below.

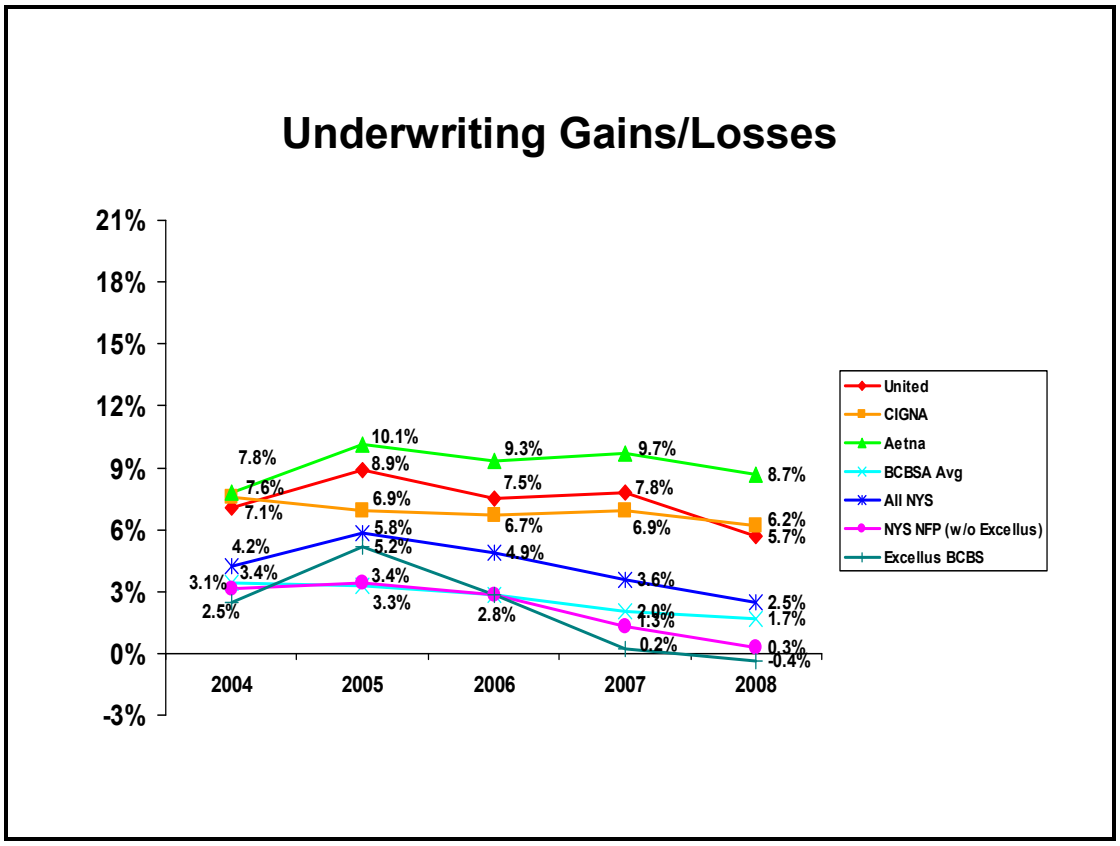
In addition, subjecting one portion of plans' business to price controls will negatively impact other lines of business, such as large labor accounts, as plans will be forced to subsidize rates. Indeed, when prior approval existed prior to 1995, the Insurance Department required a 1% subsidy of large groups to subsidize small group and individual lines of business. This cross subsidization resulted in increased rates on large businesses and jeopardized our retention of that business as large self funded accounts could flee to out of state carriers or third party administrators who are not providing coverage in the small group market.

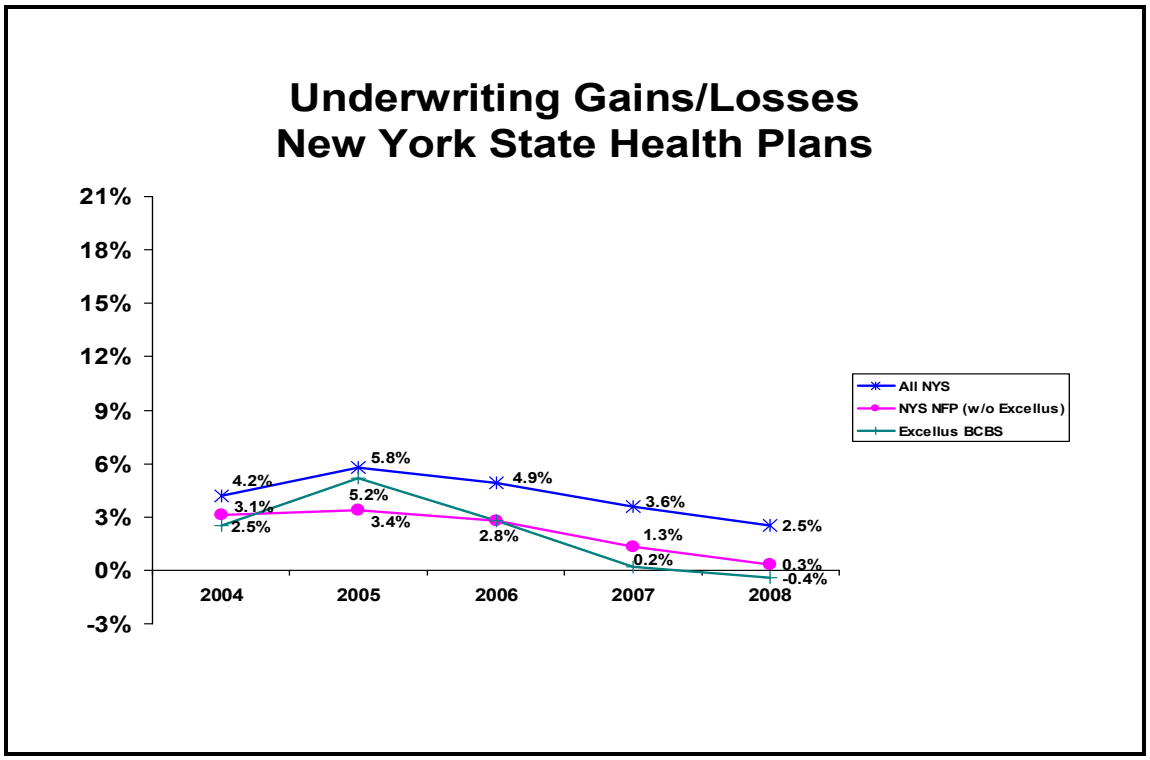
Artificial suppression of rates by even a small amount can be devastating to health plan finances

Contrary to public perception, health plans over time live within narrow percents of underwriting gains. A look at the State's own database demonstrates that, in fact, most health insurers in the State suffered deterioration in financial performance during 2008-09, most with loss ratios well in excess of minimums required by law, and many regional not for profit plans actually generated a loss from operations. Operating losses at nonprofits are of particular concern because not for profits do not have access to the capital markets, but instead rely primarily on premiums and investment income. to build our infrastructure, health information technology and other innovations to provide quality services to our customers.

Difficult economic times have also led us to difficult decisions, including, steps to curb administrative spending – including a temporary hiring and promotions freeze, elimination of open positions and an early retirement incentive program – that resulted in a reduction of nearly 530 positions within the health plan or a 13 percent reduction from a fully staffed workforce.

While we believe the worst is behind us, artificially suppressing our rates will severely impact our operations. The effect on plans like ours would be more profound because our underwriting gains don't provide much room for error.





“Unreasonable” and “excessive” -- arbitrary grounds for denial of rates

Under the terms of the legislation, the Superintendent of Insurance would have the power to deny rates if he or she found them to be “unreasonable” or “excessive,” but those terms are extremely broad and subject to political interpretation that could destabilize the entire health insurance industry. No other state in the country bestows upon its Department unlimited authority to determine what constitutes "unreasonable or excessive" as what has been proposed in New York. For example, while New Hampshire law requires that "rates are neither inadequate nor excessive," the determination is based on whether the rates "bear a reasonable relation to the benefits provided"; thus tying the determination to a quantifiable standard.

Before the existing system was established – commonly misnamed as “File and Use” – the government’s system of prior approval of health insurance premiums dating back to the 1980s and 1990s saw significant swings in rates that had more to do with election cycles than underwriting cycles. Proposed rate hikes during election years tended to be rejected or materially reduced. Later, sticker shock on premium hikes would occur because medical cost and utilization trends continued to grow even though premium rates were suppressed. This practice not only negatively impacted our operations, but also created unpredictability for our customers.

The chart below reflects our own experience with these dramatic fluctuations in premiums:

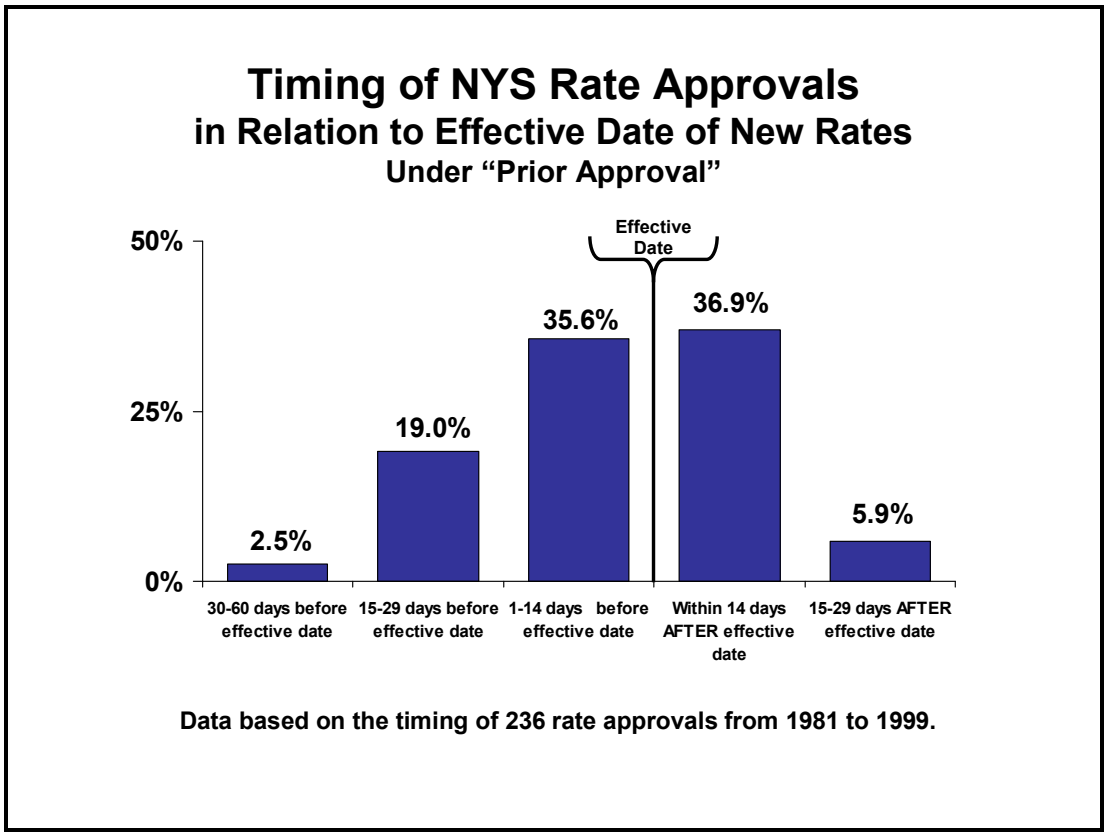
Date	Increase Requested	Increase Approved
1/1/86	4.8%	1.8%
1/1/87	8.7%	0.7%
4/1/88	20.1%	19.8%
1/1/89	18.3%	17.7%

* Excellus rate change request data under prior approval, 1/86-1/89

Prior approval would challenge the capacity of regulators to render timely decisions

Under the prior approval process, health plans experienced long delays in rate approvals, and little, if any ability to prospectively notify members about changes in their rates in the event rates were approved. In reviewing over 200 rate submission applications by the entire industry, NYS Insurance Department Opinion and Decisions regarding rate increase applications and NYS Department of Insurance Press Releases from 1981-99, the average decision came 4 days after the effective date of the rate increase. In contrast, under the current "file and use" process, which sets rates based on an objective actuarially based standard, referred to as a Medical Loss Ratio (MLR) or the percentage of the premium dollar spent on a claim, insurers are required to give members 30 days notice prior to any rate increase. In very few cases were employers and employees given at least 30 days notice under prior approval.

There were significant problems created by the timing of approvals so close to effective dates. Often, employers and their workers would find out at the last minute what was happening with their premium rates that led to a rush in making a host of decisions regarding coinsurance and coordination of spouse coverage, among a variety of other issues.



The world of health coverage has changed dramatically since prior approval was last in place. Applying prior approval to the vast array of different insurance products now in the market raises serious concerns about whether the Department of Insurance would have the capacity to handle such a review without major delays in getting product and price approvals.

Evidence of insufficient capacity is found in new product approval cycle times currently, so the capacity issue will be magnified several times under a full prior approval system. Only new products are currently subject to prior approval and the current backlog at the department is 7-9 months with some product approvals taking up to two years. The issue is not a matter of inefficiency by the Department. It has much more to do with actuarial staffing shortages, which is a national industry problem.

Prior approval system doesn't work for malpractice coverage

Even the Superintendent of Insurance has stated in the past that our state's system of subjecting medical malpractice carriers to prior approval of malpractice coverage premiums has led to artificial suppression of rates. Medical malpractice coverage in New York State is offered by few carriers. This is unsurprising to anyone in the insurance industry because of the existence of prior approval. One would think that national malpractice carriers would be anxious to enter a marketplace that has among the highest rate of doctors per capita in the country. But between the state's expensive tort system

and its system of prior approval of rates, the downside financial risks of coming here are too great.

1991: Déjà Vu- Why no rate increase despite it being clearly justifiable

EMPIRE INDIVIDUAL MARKET 1991 RATE APPLICATION				
DATE	**MLR**	**NET UNDERWRITING LOSS**	**RATE INCREASE REQUESTED**	**RATE INCREASE DECISION**
1991	109.1%	$81,012,261	34%	DENIED

Rate Denial Justification:

Opinion and Decision of Superintendent Curiale dated October 1, 1991 :

"I believe the only real solution to the problems of Empire's subscribers and Empire itself is legislation…"

Sound Familiar… (Excess Medical Malpractice???)

Government "cost shifting" highlights another flaw with government price fixing

Numerous studies have emerged showing that the government's Medicare and Medicaid payments to hospitals and doctors for their services have followed trends that often fall below the basic costs of providing care, creating negative margins. Low government reimbursement rates lead to significantly higher costs being shifted to the privately insured in a negotiated marketplace. A national study done by Milliman on this, issued in December 2008, estimated this cost shift adds an estimated 10.6 percent to the average premium for an American family of four.

This issue has also been recognized by many hospital executives in New York, as evidenced by their testimony before the Legislative hearing addressing this topic in June, 2009. For example:

> "In 2000, private payer payments average 132.2 percent of hospital costs, thereby offsetting the government shortfall.
>
> Hospital finances and those of other health care providers are fragile and would be seriously jeopardized if inadequate premium rates prevented private insurers from subsidizing government underpayments. Our concerns with this

legislation stem from this dependence on private insurers' ability to offset the public programs' below cost reimbursements."

Peter G. Robinson, Vice President and COO, University of Rochester Medical Center

"Prior Approval" of Health Insurance Premium Rates: A Nationwide Perspective

State Laws or regulations pertaining to review authority and enforcement of health insurance premium rates substantially differ nationwide. Contrary to the New York State Insurance Department's claim that more than 24 states have "prior approval," it is not as easy as labeling a state regulatory system as either "prior approval" or "file and use." State laws and regulations contain a number of additional factors that affect such a classification including: minimum medical loss ratios (MLRs), deemer provisions and rate bands.

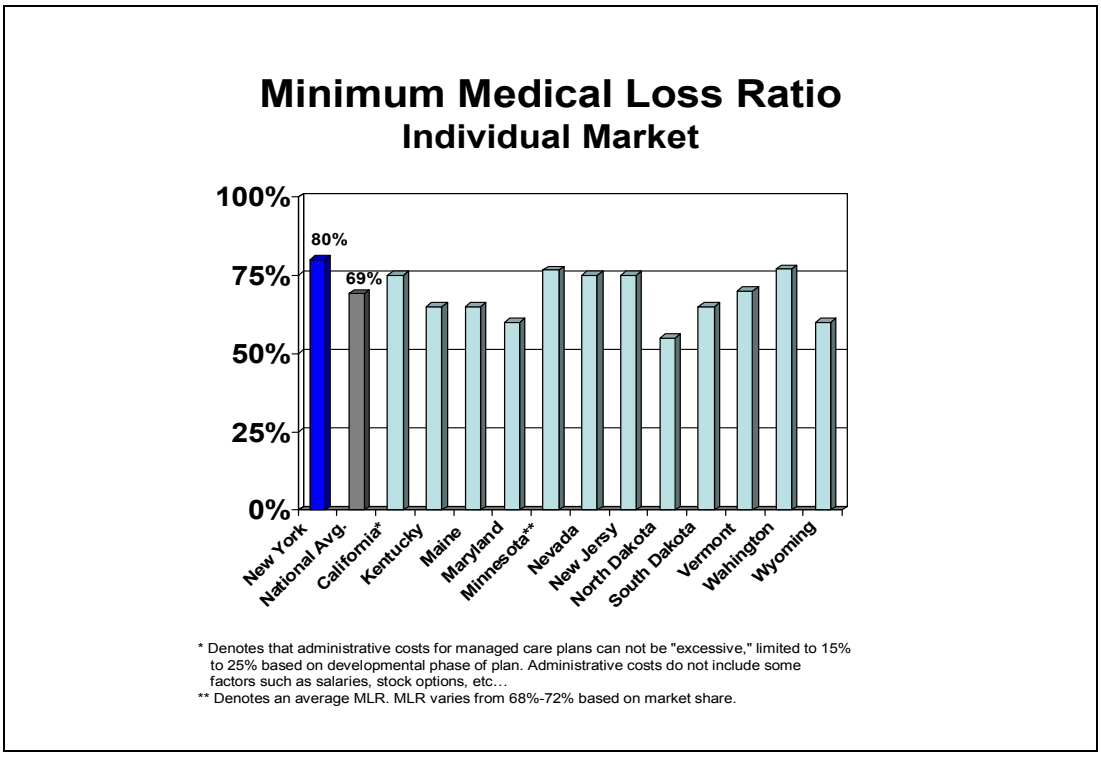
Minimum Medical Loss Ratios (MLRs).

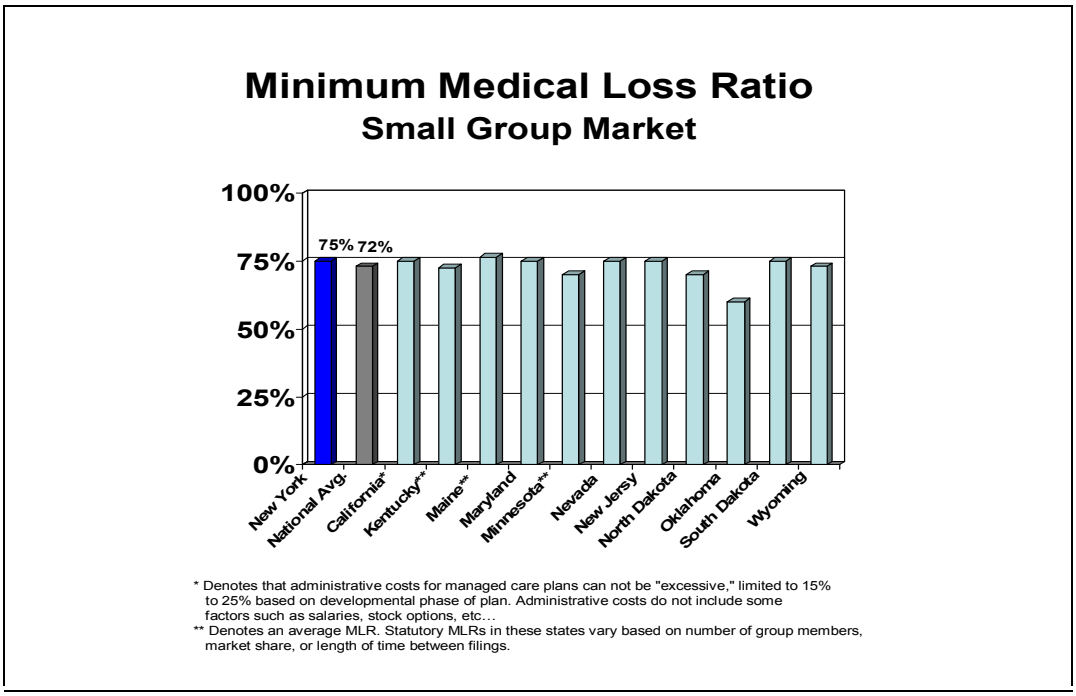
A minimum MLR is a requirement that insurers spend, at least, a specified percentage of premium dollars on the payment of claims for medical care rather than on administration, marketing, and profit.

Both as part of the rate approval process and for ongoing maintenance of rates, many states utilize minimum medical loss ratios in determining appropriate rates. For example, fifteen States, including New York, place statutory MLR requirements on insurers in the Individual and/or the Small Group Markets. The utilization of MLRs in the rate setting process in States that are characterized as having "prior approval," however, varies considerably. For example, in Maine, if an insurer demonstrates that it had a minimum loss ratio of 78 percent over a three year period, the insurer's rate increase is exempt from the prior approval process altogether; while in Minnesota, if the previous year's loss ratio was achieved and the proposed rate increase is accompanied by an actuarial certification, the rate increase is approved based solely on the MLR. Similarly, in Kentucky, if an actuarial certification of the MLR is submitted with the rate application, the proposed rate can be used immediately. In fact, in the seven states that subject insurers to "prior approval," five of these states approve rate increases if an insurer meets a targeted MLR that is comparable to those currently in place in New York. Ironically, in reviewing these varying processes which are characterized as "prior approval", one could argue that New York is already a "prior approval" state.

Moreover, New York is one of only three states that have MLRs that average at or above 75 percent in the Individual Market and one of only seven states with MLRs that average at or above 75 percent in the Small Group Market. No State has an MLR of 85 percent as proposed by the Department. With the exception of Minnesota, which has a complicated

market share test, which may increase a loss ratio under certain circumstances to 82%, New York currently has the highest MLR for the individual market.





- Deemer Provisions. A "deemer" provision is traditionally seen in states that are classified as "prior approval." Under "prior approval," filed rates cannot be used until approved by the state insurance department. A deemer provision allows a submitted rate to be used after a specified time period has elapsed without state insurance department notification. Approximately eleven "prior approval" states have deemer provisions.

State	Rates Deemed Approved After
Arkansas	60 days (Ind. Market)
Colorado	60 days (Ind./SG Markets)
Connecticut	30 days (Ind. Market)
D.C.	30 days (Ind./SG Markets)
Kentucky	30 days (Ind. Market)
Maryland	30 days (Ind./SG Markets)
Nebraska	60 days (Ind. Market)
New Mexico	30 days (Ind./SG Markets)
Ohio	30 days (Ind./SG Markets)
South Carolina	30 days (Ind. Market)
Washington	60 Days (Ind./SG Markets)

- Rate Bands. A "rate band" is a maximum percentage by which an insurer can seek a rate increase or the maximum percentage by which an insurer can seek a rate increase through "file and use." Increases above the maximum percentage are subject to prior approval or actuarial certification. Seven "prior approval" states currently have statutory "rate bands" that vary in form and from five percent to 40 percent.

State	Rate Band
Colorado	5% (Ind./SG Markets)
Florida	10% (Ind./SG Markets)
Ohio	40% (Ind./SG Markets)
Maryland	10% (Ind./SG Markets)
Nebraska	25% (Ind. Market)
North Dakota	15%(Ind./SG Markets)
Pennsylvania	15% (Ind./SG Markets) (HMOs Only)

Finally, it is important to keep in mind that for the first time in more than a decade, serious discussions are taking place in Washington that could dramatically change the health care landscape. These discussions have included major market reforms that could transform individual and small group health insurance. Placing price controls on health insurance during this time of uncertainty could be disastrous to regional health plans that represent high quality services throughout the state along with tens of thousands of jobs. If regional health plans are weakened, coverage will continue to be sold, but it will occur from national plans with employment bases far from New York's borders.

"Prior Approval" of Health Insurance Rates: A Step Backward from the Current "File and Use" System

The current process, misnamed "file and use", sets rates based on an objective actuarially based standard, referred to as a medical loss ratio (MLR), which is the percentage of the premium dollar spent on claims. The medical loss ratio test measures the components contributing to the cost of coverage, such as hospital costs, prescription drug costs and medical costs.

Under the current system, when a health insurance product is initially designed by a health plan, it needs prior approval by the Department of Insurance to sell it at an initial price. In subsequent years, health plans file their premium increases on those products with the department with certain projected actuarial standards that limit profitability and administrative costs for insurers. Once filed, the health plan may use those new rates. A loss ratio test then compares the MLR to a specified minimum standard. If the experience turns out to be more favorable than the minimum standard, then refunds are provided to our customers. In summary this process provides an objective actuarial standard by which to determine rates.

Competition among health plans on the basis of price is alive and well in New York State, so market forces are already doing what prior approval of rates seeks to do in making sure that price gouging isn't taking place. Employers and their workers don't hesitate to go to competitors if they see better rates.

Reforming the Current Approach

We acknowledge that the current law is in need of improvement and we are committed to working to attain comprehensive reform to the current process by supporting the granting to the State Insurance Department additional powers to punish bad actors and clarify a number of terms which would eliminate any potential for abuse of the current process. Such a proposal would be meaningful reform which would provide a balanced approach to addressing the concerns with the current system, without re-instituting excessive government regulation and endangering the stability of a strong health insurance industry that New Yorkers depend on for their own security.

Specifically, we would recommend the following:

- Clarify the appropriate minimum loss ratio on claims for small businesses and individuals to ensure that the appropriate amount of the premium dollar paid by this vulnerable population is used on health care services.

- Clarify any ambiguous terms and require that all actuarial certifications that accompany rate filings affirm that the filing was prepared in accordance with

generally accepted actuarial principles. This creates additional accountability for health plans to ensure that the data submitted to SID is accurate.

- Require timely refunds to customers so that if rate relief is warranted, customers get the relief quickly. Likewise, ensure that customers are provided adequate notice of any proposed changes in rates.

- Expand the regulatory powers of SID, including the power to suspend a plan's right to use the current process if it has been in noncompliance with current law.

These measures represent a realistic and targeted approach to addressing any deficiencies in the current process without re-implementing the failed "prior approval" system. Given the potential dangers of prior approval, this approach is a viable alternative which addresses shortfalls in the current system, but preserves an actuarially objective process.

While most of the rest of the country is just beginning to discuss market reforms, such as guaranteed issue and community rating, New York adopted these reforms for small groups and individuals over a decade ago. The fact that New York health insurance costs are more than we would like is <u>not</u> a function of having prior approval and price controls on insurance rates. The cost of coverage in New York, particularly for small companies and individuals, is driven by the cost of care in our State, increased State taxes, and mandates that actually drive insurance costs higher and limit options needed for New Yorkers. These are the factors we should focus on to reduce the cost of coverage and build on the positive initiatives New York has taken in reforming our system.