Regulatory Approval of Health Insurance Rates: "Prior Approval"

Prepared remarks by Mark Wagar, President of Empire BlueCross BlueShield, before the Assembly Standing Committee on Insurance

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Good Morning.

My name is Mark Wagar and I am President and CEO of Empire BlueCross BlueShield. On behalf of our company, I want to thank you for allowing me the opportunity to testify this morning regarding Governor's Program Bill #15 (S.5470/A.8280) which would re-institute the price control process of "prior approval" of health insurance rates. As a leader in the New York health care market for over 75 years, Empire is committed to providing affordable health insurance coverage to our over 5 million members. Likewise, as the State's largest insurer, Empire has maintained a significant corporate presence throughout New York with over 4,200 employees statewide; including approximately 250 employees in Lower Manhattan, 570 in Brooklyn, over 1,600 in Albany, 450 in Syracuse, 920 in Orange County and 350 on Long Island.

While our corporate structure has changed from that of not-for-profit insurer, to that of a for-profit company, and finally to its current day status as a WellPoint subsidiary, we remain committed to maintaining a leadership role in New York's health care community. In my opinion, it is Empire's historical leadership which has been the hallmark of the company's uniqueness. For example, Empire embraced its traditional role as "insurer of last resort", offered coverage to individuals when no other insurer would, assisted hospitals in financial distress, and, more recently, promoted efforts to improve the health of all of our members, especially vulnerable populations. Throughout our history we have dared to be different and to do, as they say, "the right the thing".

I am here today to express my deep concern and opposition to Governor's Program Bill #15 (S.5470/A.8280) and to share with you Empire's first-hand experience with the detrimental effects of the "prior approval" process. Specifically, Program Bill #15 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; 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 our New York operations. Moreover, the prior approval process will ultimately threaten the ability of Empire and other insurers 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. The current process already requires prior approval of both product structure and rates by the Department of Insurance whenever a new health insurance product is introduced, or material changes are made to the product. These rates are based on a prospective actuarial projection of the cost of care, assumptions as to the age and health of the people who enroll, and a retrospective reconciliation of the projection. The rates are then subject to the loss ratio test that measures the components contributing to the cost of coverage, such as hospital costs, prescription drug costs and medical costs. If the experience turns out to be more favorable than the minimum medical loss ratio required by existing law, then refunds are provided to customers.

In addition, subjecting one portion of our business to price controls will negatively impact our other lines of business, such as our large labor accounts, as we will be forced to subsidize rates. Indeed, when prior approval existed prior to 1995, the Department required a 1% subsidy of large groups to subsidize small group and individual lines of business. Similarly, as losses result from inadequate premiums, we will inevitably be forced to reduce investments in service, health information technology and, potentially, a reduction in New York workforce.

Empire's Historical Experience.

As I previously mentioned, Empire has a unique perspective, in that we have experienced the detrimental effects of the prior approval process firsthand. Specifically, prior to 1996, all individual and small group premium increases were subject to the prior approval process. What transpired was a complete populist approach to rate setting with severe fluctuations in rate approvals based on the popularity and political acceptability of the request. The result, in many cases, was that claims incurred on policies exceeded the amount of premiums received for such policies. The impact was severe as many insurers, including Empire, became financially impaired, with inadequate rates as a contributing factor in jeopardizing its solvency.

For example, during the early 90's Empire experienced significant underwriting losses in the small group and individual markets (community rated products). Indeed, the Medical Loss Ratios (MLRs) for these products (as reflected below) were at dangerous levels primarily due to inadequate rate relief.

Figure 1

SELECTED EMPIRE COMMUNITY RATED PRODUCT MEDICAL LOSS RATIOS (MLR)				
DATE	**PREMIUMS EARNED**	**AMOUNT SPENT ON CLAIMS**	**MLR**	**NET UNDERWRITING LOSS**
1989	$1,607,485,452	$1,463,069,965	91.0%	$11,180,829
1990	$1,704,988,587	$1,625,617,784	95.3%	$72,114,650
1991	$1,826,740,401	$1,805,803,528	98.8%	$152,021,250
1994	$1,447,053,562	$1,356,896,563	93.7%	$100,217,928
1995	$1,171,163,669	$1,036,638,975	88.5%	$47,863,499
AVG	**$1,551,486,334**	**$1,457,605,363**	**93.5%**	**$76,679,631**
Total Underwriting Loss:		**$383,398,156**		

Despite these losses Empire regularly received inadequate rate relief under the prior approval process. The problems experienced with inadequate rates for the company were no more dramatic than in the individual market. As evidenced by the rate history below, despite consistent loss ratios well above 100% where the company was hemorrhaging losses, due to political pressures at the time, the Insurance Department was unable to grant adequate rate relief.

Figure 2

EMPIRE INDIVIDUAL MARKET MLRS AND RATE INCREASES				
DATE	**MLR**	**NET UNDERWRITING LOSS**	**RATE INCREASE REQUESTED**	**RATE INCREASE APPROVED**
1990	108.3%	$56,817,427	16.4%	15.3%
1991	109.1%	$81,012,261	34%	Rejected
1992	Records destroyed as a result of 9/11.	Records destroyed as a result of 9/11.	28.7%	14.2%
1993	Records destroyed as a result of 9/11.	Records destroyed as a result of 9/11.	N/A	N/A
1994	110.3%	$48,124,071	N/A	N/A
1995	94.6%	$33,592,339	43.0%	21.8%
AVG	**105.6%**	**$54,886,525**	**30.5%**	**17.1%**
Total Underwriting Loss for Available Data:		**$219,546,098**		

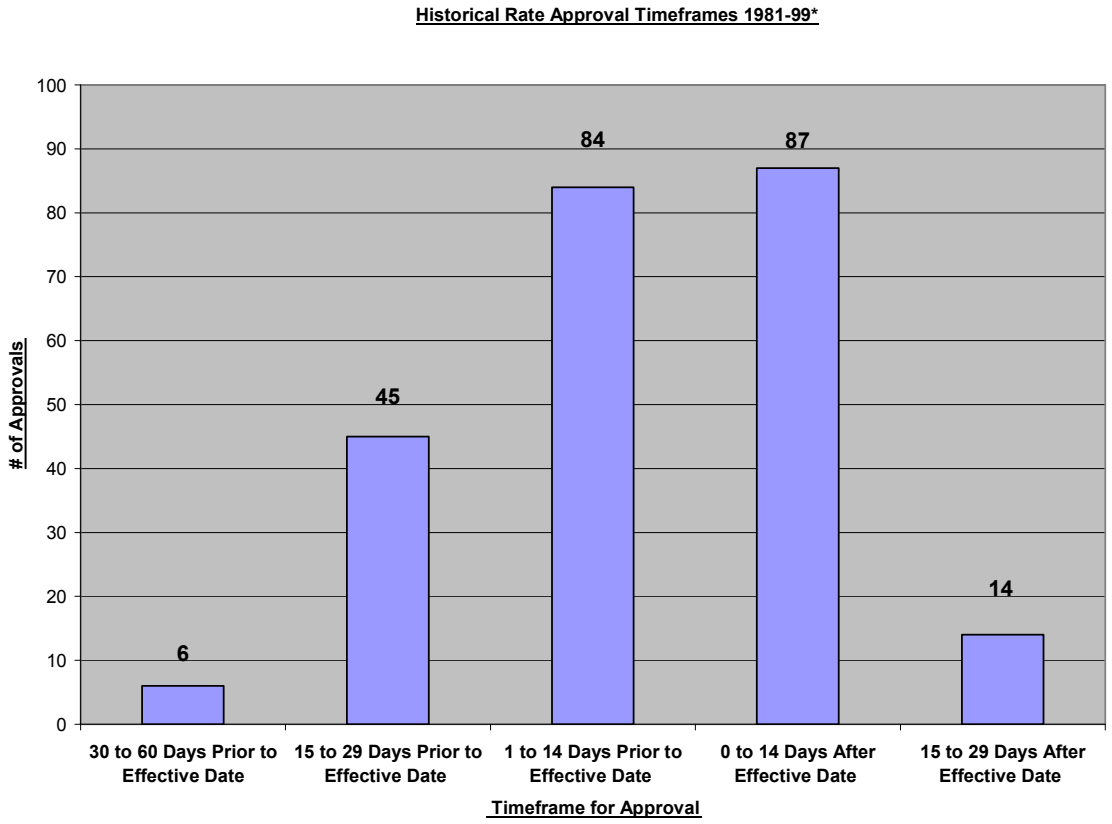
The most dramatic example of the problems with prior approval occurred in 1991. In a scenario eerily similar to the current medical malpractice crisis, despite a loss ratio in excess of 100% (which means we were paying out more in claims than taking in premiums) the Department denied proposed rate increases in the individual and small group markets. Instead of approving what was clearly a justifiable rate increase, the Department called on the Legislature to enact reforms, to quote the rate denial opinion of then Superintendent Curiale: "I believe the only real solution to the problems of Empire's subscribers and Empire itself is legislation..." Such reforms were not enacted and a subsequent decision was rendered by the Superintendent in 1992 as Empire's financial situation continued to deteriorate. The Superintendent stated, "I have concluded that the company [Empire] must be granted immediate rate relief. The decision to approve any

rate increase for this group of Empire policyholders was not an easy one. However, my action today was necessary and allows Empire to remain financially viable, thereby assuring that claims payments and critical coverage will continue…" **This history of the rate application becoming a "political albatross" is exactly the reason we passionately reject a return to prior approval.**

The Timing of Approval

Under the prior approval process, health plans, including Empire, 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. For example, Empire's 1991 and 1995 rate increase application decisions came 1 and 3 days, respectively, after their effective date thus forcing the rate to be applied retroactively. This was not unusual: 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.

Figure 3



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 Ration (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. During the period laid out in Figure 3, only 6 out of 236 rate decisions reviewed under the prior approval process were made at least 30 days prior to the effective date of the increase.

"Prior Approval" of Health Insurance Premium Rates: An Archaic System that is Unable to Meet the Needs of New York's Current Marketplace

It has long been held that those that do not learn from history are destined to repeat it. Empire's experience under the prior approval process was catastrophic, contributing to Empire's financial impairment as well as its inability to adequately reimburse providers. Compounding this experience is the evolution of the health insurance marketplace over the last 13 years. In 1995, the last year in which the prior approval process was in place, each insurance carrier had 3-4 products with 3-4 plans in each resulting in approximately 250-500 plans in the market across the state. With only 250-500 plans subject to the prior approval process, the State Insurance Department experienced difficulty with the volume of applications. For instance, then Superintendent Corcoran cited this difficulty in a letter to BlueCross BlueShield of Central New York stating that "We fully realize the Plan's need for an early decision, but you should also be aware that during the last quarter of 1988 we processed and acted upon thirty-four premium rate applications."

Today, Healthconnect, a leading online network for buyers and sellers of health insurance, reports that, in the downstate region alone, there are over 1400 different plans or product options being offered. Empire alone currently offers 154 plans in the New York market and has 32 “new” filings that have been submitted to the Department and are awaiting action. These delays are primarily the result of an understaffed actuarial department; indeed, we have actually offered to reimburse the Department to retain an outside actuarial firm to help expedite the filings.

Needless to say, by reinstating prior approval and subjecting over 1400 products in the downstate market (let alone the rest of the state) to this cumbersome, time consuming and arbitrary process would substantially multiply the challenges and delays experienced when the Department struggled with the timely approval of just 34 filings in 1988. The result would be not only retroactive approvals of almost every existing product, but even further delays in getting new innovative products into the marketplace.

This is not meant as an indictment on Department personnel as many are hard working and highly qualified state employees; it is merely a reflection of the realities of the industry and the volume of products in the marketplace.

"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. The premium is based on a prospective actuarial projection of the cost of care and a retroactive reconciliation of the projection. 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 manner to determining rates.

The current process has been subject to allegations that insurers are "gaming" the system by taking advantage of ambiguous terms and that the New York State Insurance Department does not have sufficient oversight powers to regulate the industry. 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, most with loss ratios well in excess of minimums required by law, and many smaller plans actually generated a loss from operations.

While we believe existing law provides more than enough authority and latitude for enforcement, evidenced by our leading national MLR requirements, should the State Insurance Department find any plan in deliberate efforts to skirt the most stringent state laws and regulations in the nation, 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, Empire 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 fillings 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 with Empire's help and advocacy. The fact that New York health insurance costs are more than we would like is not 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.

Thank you for the opportunity to present this information before you today. If you have any questions or need additional information, I stand ready to work with you on this issue.