Regulatory Approval of Health Insurance Rates: "Prior Approval"

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

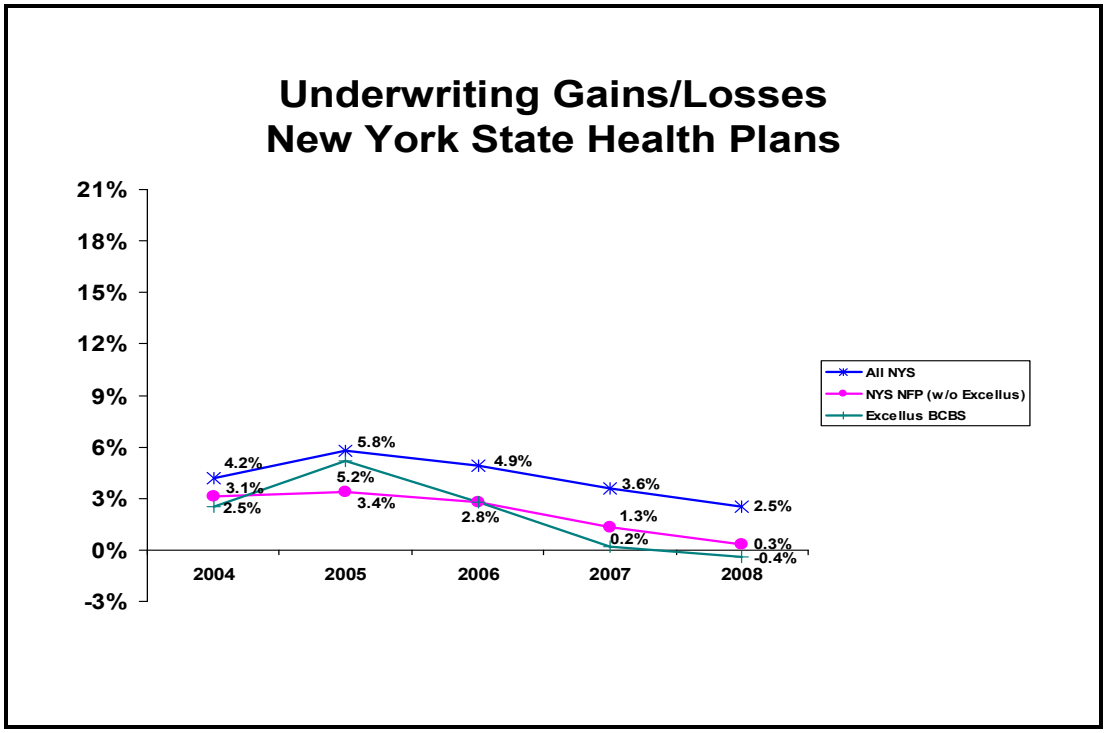
June 8, 2009

Good morning. My name is David Klein. I'm the chief executive officer of Excellus BlueCross BlueShield and our parent company headquartered in Rochester.

I'm proud to say that we're one of upstate New York's largest employers with more than 6,000 employees spread out from Buffalo in the west to Utica in the east, to Plattsburg in the north and Binghamton to the south.

In 2008, we paid about 52 million medical benefit claims worth more than $4.5 billion on behalf of about 1.8 million members. Not counting those expenses, Excellus BlueCross BlueShield and our parent company had a payroll of $347 million in 2008 and purchased another $326 million in goods and services from vendors. Contributing about $877 million in direct and indirect spending, our company has a positive effect on the companies and communities where we do business in upstate New York.

I'm less proud that our nonprofit health plan reported a net income loss in 2008 due to enrollment losses, higher than anticipated medical benefit expenses and investment losses. Over the past several years, our annual overall underwriting gains have shown a modest average of less than three percent.

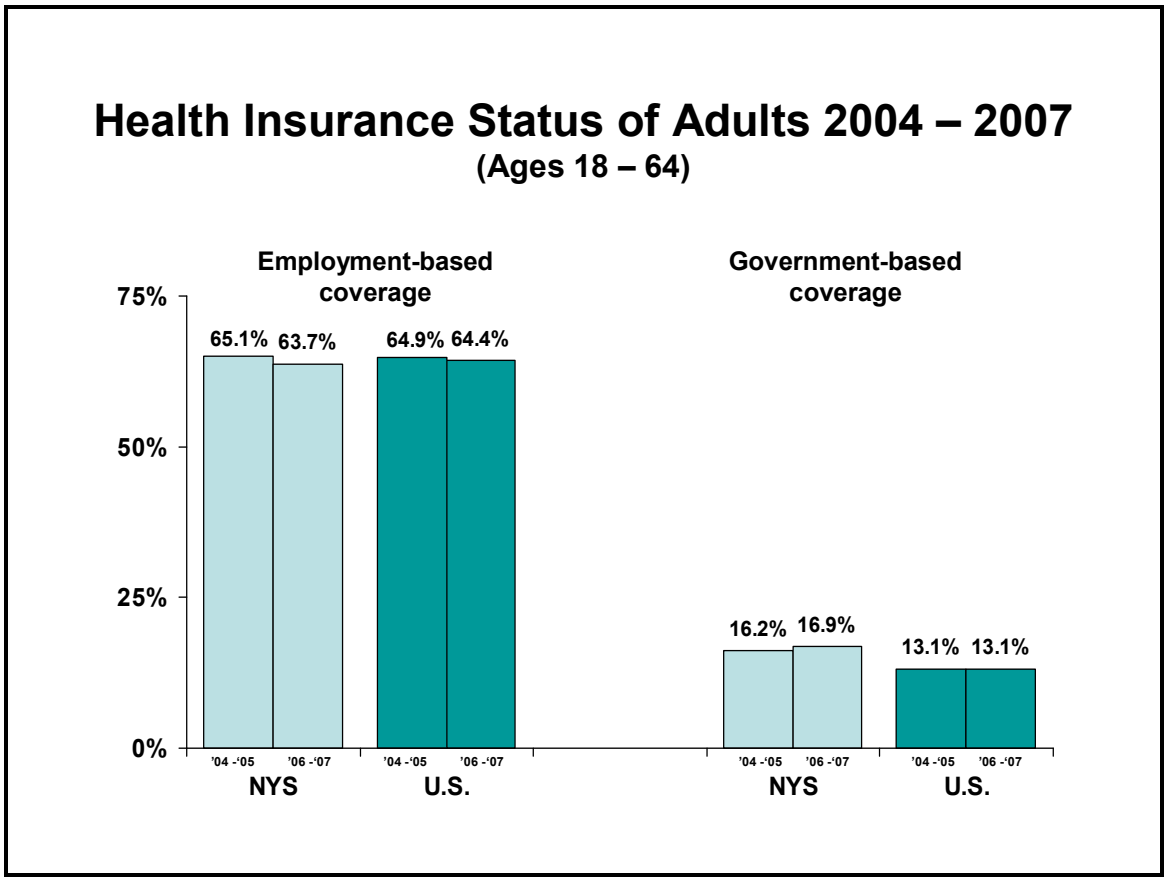


Common goals, unfortunate actions

Looking ahead, I believe there are key common goals most of us share:

1. We want the most number of people possible to have affordable health care coverage that financially supports a high quality and efficient health care delivery system.
2. Because of limitations of public revenues, it's in the state's interest to see as many New Yorkers get health care coverage through the private sector as possible.
3. When people truly cannot afford health care coverage, it's the government's responsibility to use the broadest and fairest sources of tax revenues to pay for their care.

Two years ago in September, I made a series of suggestions to a state panel to create a stronger private-public partnership approach to reduce the ranks of the uninsured to encourage more private health coverage so that there would be less reliance on taxpayer supported government programs. There are slight trends showing employment-based coverage slipping while government-based coverage is rising. Losses of employment based coverage are greater for NYS than for the US generally.



Proposals were made that would have resulted in significant cost reductions for coverage in the individual and small group market. Unfortunately since then, we've seen hundreds of millions of dollars in tax expenses imposed retroactively on those who voluntarily purchase private health

coverage. Today, we're talking about proposed legislation that would impose government price controls at the tail end of the health care financing distribution chain. It's our opinion that this legislation will be destructive to both the financing and the delivery of health care in New York State and thereby work against our common goals. The legislation also poses a very serious threat to the stability of our business and weakens our status as a major employer contributing to our upstate economy.

Government price fixing for any business is a slippery slope for other businesses

We believe the process of government price fixing is flawed from the start in any democratic and capitalistic society. Giving the Superintendent of Insurance the unbridled power to dictate what rates competitive businesses can charge while they are assuming billions of dollars in risk for medical benefit payments on behalf of millions of New Yorkers is a very slippery slope. What businesses will be the next target of price fixing? Grocery stores?

I use grocery stores as an example because it points out what is impractical about government price fixing at the end of any economic distribution chain. How can the government tell a grocery store how much it can charge for a pound of meat if it doesn't also control the costs of the cattle rancher, the trucking industry, the meat packing plant, and all of the other players in the food production system who are involved in putting a pound of beef in a grocery store shelf?

Price fixing health insurance premiums is instantly flawed with no system in place to both ration the number of goods and medical services consumed and fix the prices of those goods and services. I have not heard from any advocates of health care rationing. Nor have I heard of any fans backing the notion of giving the government the authority to restrict what every provider will be paid for each of the medical goods and services they provide.

We've seen the historic disaster that occurred in the early 1970s when the federal government attempted to implement widespread wage and price controls. It simply didn't work. The point is that the major drivers of health coverage premiums represent the prices paid for medical goods and services and the frequency that patients make use of those goods and services.

"Unreasonable" and "excessive" -- troublesome 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 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 is 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. For the record, I'd like to make it clear that our objections to that broad authority are not a reflection on department personnel or Eric Dinallo, whom we highly respect as an individual. It is the legal precedent we're challenging – the "what," not the "who."

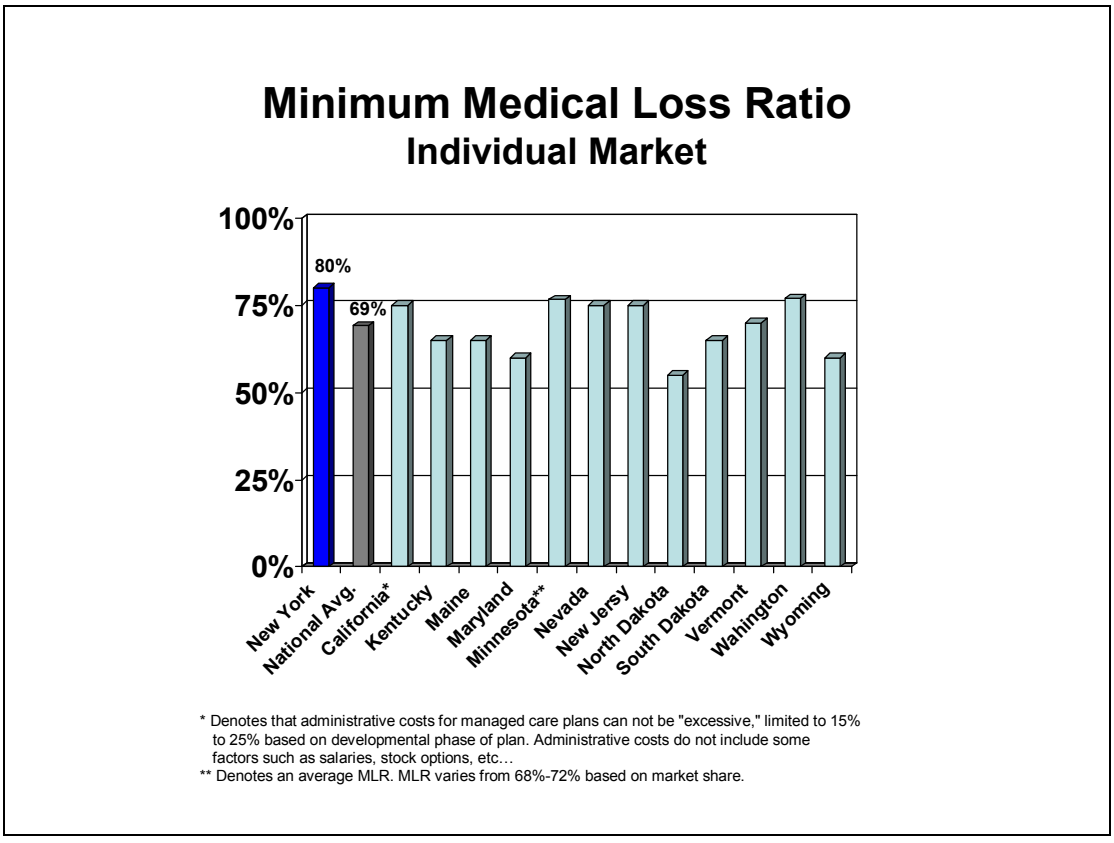
"Prior Approval" of Health Insurance Premium Rates: A Nationwide Perspective

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.

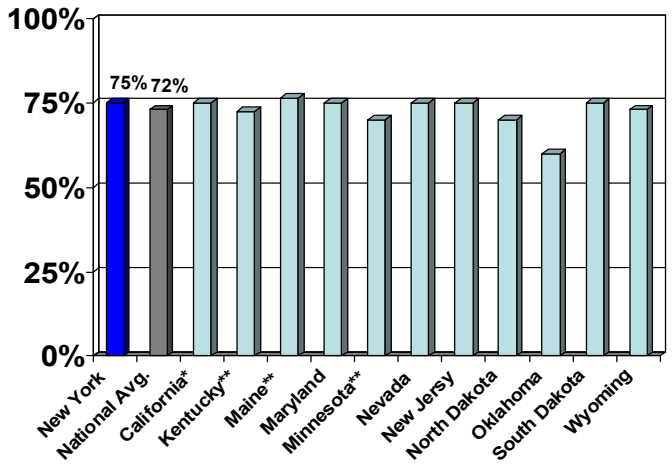
Minimum Medical Loss Ratios (MLRs). A minimum MLR is a requirement that insurers spend, at least, a specified percentage of premium dollars on the payment of claims for medical care rather than on administration, marketing, and profit.

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 insurers 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.



Minimum Medical Loss Ratio
Small Group Market



* Denotes that administrative costs for managed care plans can not be "excessive," limited to 15% to 25% based on developmental phase of plan. Administrative costs do not include some factors such as salaries, stock options, etc…

** Denots an average MLR. Statutory MLRs in these states vary based on number of group members, market share, or length of time between filings.

- **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 are 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)

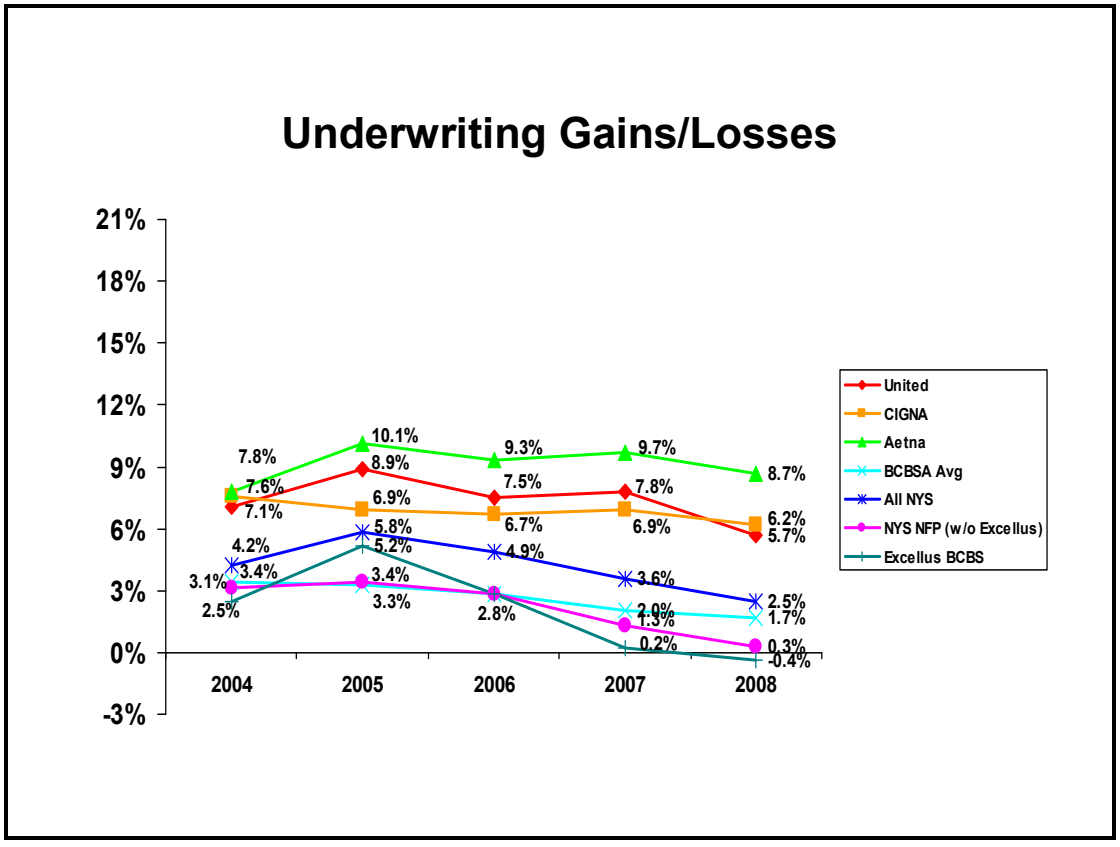
Prior approval is subject to political and artificial suppression of rates

Before the existing system was established – commonly referred to 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. That system was changed to remove some of the subjective nature of rate setting to reduce political influences.

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. And, health plans that are nonprofits have no access to capital outside of what they bring in through premiums versus their counterparts in the for-profit world. We need to achieve narrow margins to survive and to build our infrastructure to provide quality services to our customers. Part way through 2008, when we identified significant negative trends that could lead us to not achieving a margin, we began to take 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.

There were, of course, other actions taken as well, but my point is that the economic vitality of regional health plans will be weakened if the government is permitted to suppress revenues via price fixing. Even if revenues are slighted adjusted downward and don't adequately cover expenses, the effect on plans like ours would be more profound because our underwriting gains don't provide much room for error.



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

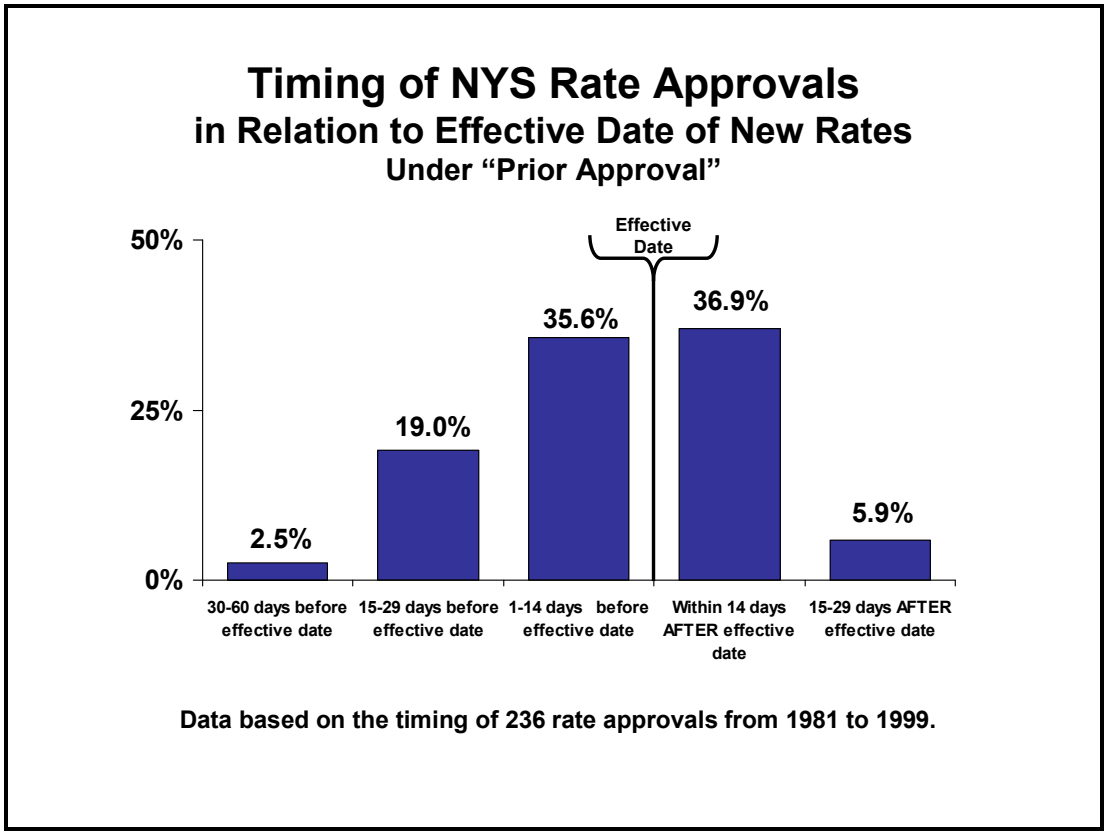
marketplace that has among the highest rate of doctors per capita in the country. But between the state's expensive tort system and its system of prior approval of rates, the downside financial risks of coming here are too great.

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

Applying prior approval to the vast array of different insurance products now in the market also raises serious concerns on whether the Department of Insurance would have the capacity to handle such a review without major delays in getting product and price approvals.

The world of health coverage has changed dramatically since prior approval was last in place. And when prior approval did exist, 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, which led to a rush in making a host of decisions regarding coinsurance and coordination of spouse coverage and a host of other issues.

An analysis done on the timing of 236 rate approvals that took place from 1981 to 1999, one can see that in very few cases were employers and employees given at least 30 days notice.



Evidence of insufficient capacity is found in new product approval cycle times right now as well, 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.

The current system is based on hindsight, the equivalent of 20/20 vision

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.

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. Later, if it is found that a health plan failed to meet those actuarial standards of minimum levels of medical benefit payments, refunds are issued to customers.

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

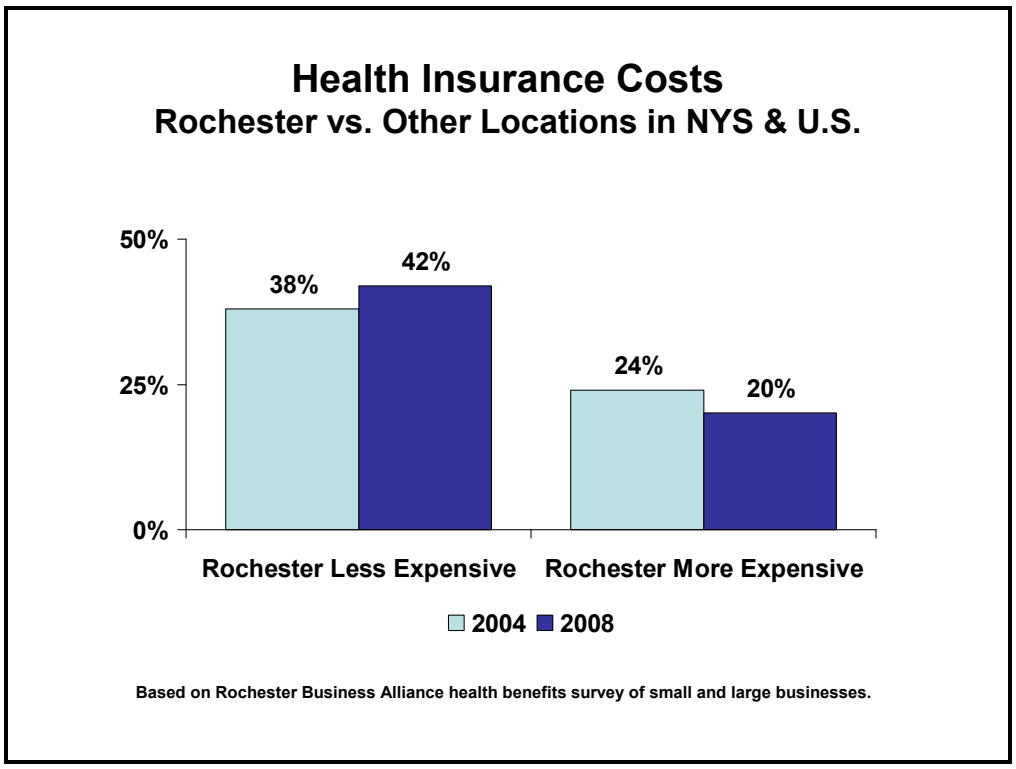
Numerous studies have emerged showing that the government's Medicare and Medicaid payments to hospitals and doctors for their services have followed trends that often fall below the basic costs of providing care, creating negative margins. Low government reimbursement rates lead to significantly higher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

While I have no estimate for you in New York State on the extent of this cost shifting, I believe it would be safe to assume it is significant. Under a system of government price fixing of private health coverage premiums, the squeeze on providers would likely become severe. And, as it does, it will surely lead to a brain drain of needed physician supply as well as delays or abandonment of plans to invest needed capital for real improvements in the delivery system. That scenario, which is also recognized by many hospital executives in New York, is very real and it would have negative consequences to the state's economy the quality of our delivery system.

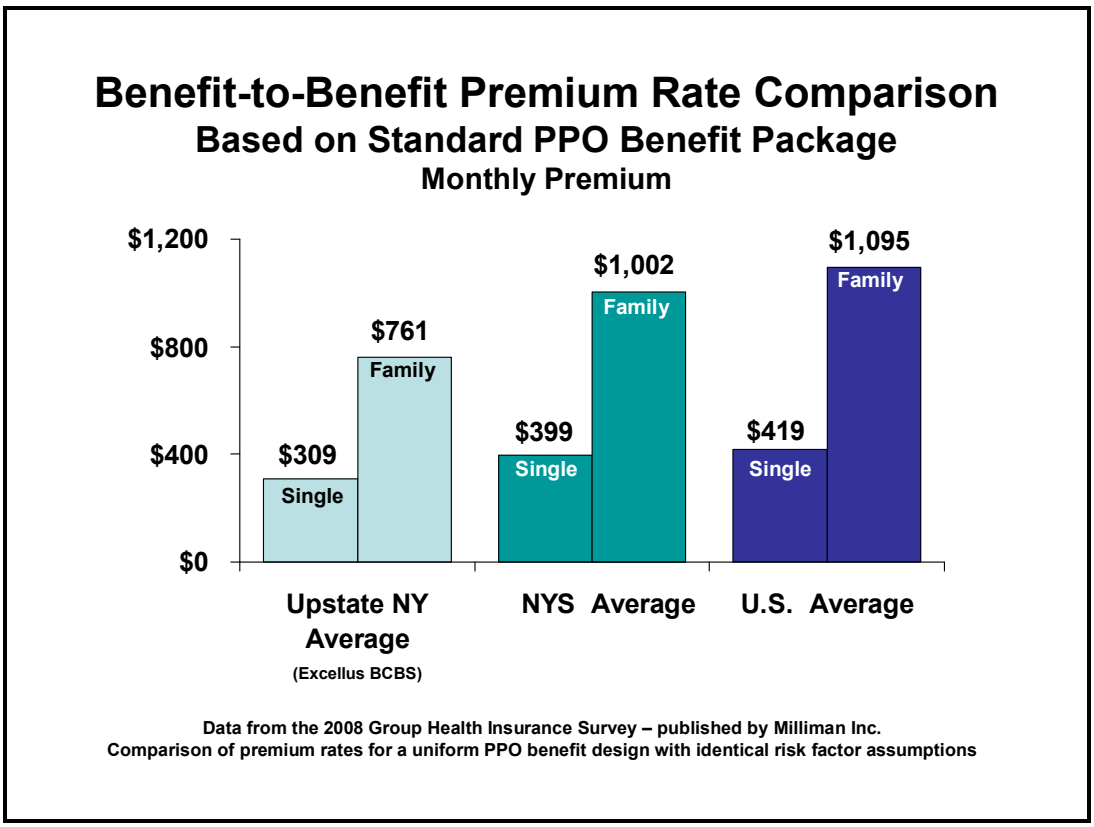
While no one will say they're happy with health coverage costs, upstate New York is better off than in many other places

Everyone would love a system that would provide free care and as much of it as anyone wants, but that system doesn't exist. We understand and share the frustrations about the costs of coverage and the costs of care.

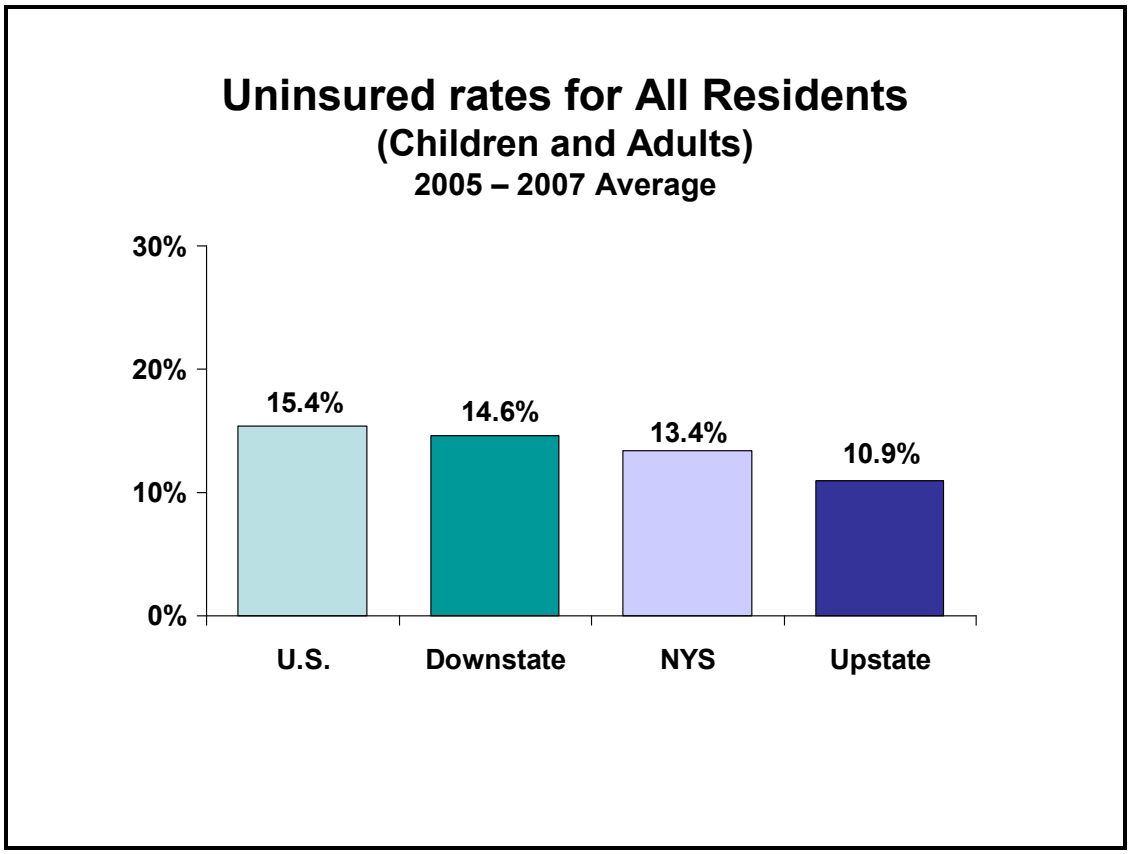
Having said that, I'd like to point out that there is some evidence that the costs of coverage in upstate New York are favorable when compared to many other locations. The Rochester Business Alliance, for example, surveys businesses of all sizes annually each year. One of the questions it asks in the survey is whether they believe the costs of their health coverage are less expensive here or more expensive than other places. In the Rochester area, we have many corporations with employees located across the country. Far more businesses reported that their health insurance costs are lower here than elsewhere.



Because we know that health care costs in upstate New York are principally a reflection of benefit expenses, our costs of coverage are also better than national and state averages. Each year, Milliman conducts a group health insurance survey in which they ask insurers to provide premium rates for a group of 100 employees with an identical PPO benefit design. Identical demographic risk assumptions (age, sex, etc.) are built into the survey as well. When there are three or more premium prices provided from a state, a state average is calculated as well as a collective US average. Last year, our upstate average and New York State's average stacked up favorably to the nation as a whole, among the 30 states counted in the survey. In fact, our upstate premium comparisons for singles and families stacked up better than all 30 state averages reported.



While anything more than a zero percent uninsured rate is undesirable, our upstate uninsured rate stacks up favorably to state and national averages as well. Some may be surprised to hear this, but upstate New York – with a population that exceeds more than 30 other states – has an uninsured rate that's more favorable than nearly 40 other states.



Timing issues to consider with Washington debate

While I believe I've outlined the major points of why government price fixing would work against the goals of fostering a stable and quality health care financing and delivery system, there are also timing issues for you to consider as well. For the first time in more than a decade, serious discussions are taking place in Washington that could dramatically change the health care landscape. Placing price controls on health insurance during this time of uncertainty could prove to 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.

If improvements are needed to enforce the existing law, let's work on them

We've heard the Department of Insurance suspicions that some insurers may be gaming the system in reporting how medical loss ratios and certain claims expenses are recorded in order to avoid or limit payments of refunds. If true, I would recommend that ideas be explored to make the current law work better rather than scrapping it and going back to a far more flawed and potentially damaging system of government price fixing at the tail end of the financial distribution chain.

Thank you.