



Treating the Symptom Instead of the Disease The Weak Case for Re-Capping Health Insurance Rates

By Tarren Bragdon

In the face of high and rising health insurance premiums, pressure seems to be growing in some quarters to return to the empty promise of health insurance price controls in New York State.

The state Assembly has already passed its perennial solution: requiring the Insurance Department to approve all annual rate increases over 5 percent.¹ Now Governor George Pataki’s insurance superintendent is joining the pro-control chorus with his own proposal to require approval of increases over 10 percent.²

Advocates argue rate regulation would ensure more reasonable premiums. For example, the Assembly bill memo claims that “prior approval of rates is among the most basic of consumer protections” – which would seem to call into question the existence of free markets for just about anything.

But price controls simply don’t work – in health care or any other industry. Moreover, New York’s own experience demonstrates the fallacy of the argument for more regulation of the health insurance market. In practice, price limits can actually *boost* premiums. As shown below, the removal of rate caps earlier in Pataki’s tenure was followed by a narrowing of the competitive price gap between policies sold in New York and those marketed in other states.

The current law

New York State primarily regulates health plans sold to sole proprietors, individuals directly purchasing their own insurance, and small to mid-size businesses. Health benefits offered by larger
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- Insurance premiums for small firms in New York moved closer to the national average in the three years after the state dropped premium rate approval in favor of a more flexible “file and use” rule.
- In supporting a return to rate caps, Governor Pataki’s Insurance Department is seeking to reverse a key element of the governor’s own de-regulatory agenda.
- When premium increases are capped, insurance companies tend to seek rate increases closer to the limit.
- Tighter regulation of premiums could undermine the profitability of a company whose financial health the state is banking on to finance health care programs.
- The focus should be on health insurance regulations that drive up rates.

Average Premiums for New York Small and Large Companies Compared to National Averages (Employee-Only Premium)

	1996	1997	1998	1999	2000	2001	2002	2003
Mostly State-Regulated Market: Small businesses with less than 50 employees								
New York	2,530	2,494	2,580	2,932	3,430	3,258	3,766	4,103
National average	2,070	2,108	2,235	2,475	2,827	3,031	3,375	3,623
NY Difference*	22%	18%	15%	18%	21%	7%	12%	13%
Mostly Self-Insured (Federal ERISA) Market: Businesses with more than 1,000 employees								
New York	2,119	2,204	2,325	2,372	2,682	3,079	3,120	3,383
National average	2,015	2,056	2,180	2,276	2,613	2,837	3,130	3,430
NY Difference*	5%	7%	7%	4%	3%	9%	0%	-1%

* Cost of NY premium minus comparable national average

Source: Agency for Health Care Research and Quality (MEPS)

employers, which are typically self insured, are not regulated by the state but are covered by the federal Employee Retirement Income Security Act (ERISA).

To use the current rate setting process, health insurers are required to devote a minimum portion of all premiums for individuals and small businesses (groups of 2-50) to pay for medical benefits, such as hospital care, physician visits and prescription drugs. This minimum, known as a medical loss ratio, is set at 80 percent of premiums for the individual market and 75 percent for small group markets. Insurers falling below these thresholds must obtain the State Insurance Department’s approval prior to increasing rates. In addition, if an insurer projects that it will meet the minimum medical loss ratio, but fails to after it has increased rates, the insurer must refund the difference to policyholders.³

The medical loss ratio leaves insurers with a maximum of 20-25 percent of premiums for all marketing costs, taxes, government requirements, administrative costs and profits. It also ties New York health premiums to underlying trends within the health care system. If utilization and health care prices increase, premiums correspondingly increase. If utilization and health care prices moderate, so do premiums.

Insurers file their rates with the State Insurance Department, certify that they meet or exceed the medical loss ratio, and then use these rates in the marketplace. This is called “file and use.”

Less regs, more competition

Prior to 1996, New York State’s Insurance Superintendent approved all initial premium rates and subsequent rate modifications before they became effective. This process became long on politics and short on actuarial and medical trends. Governor George Pataki recognized that when politicians play rate-setter, consumers lose. With premium rates less reflective of underlying medical claim costs and trends, insurers face substantial losses contributing to financial strains on an insurer’s solvency, and the private health insurance market becomes uncompetitive.

In 1995, the governor and the Legislature agreed to repeal the politically-charged rate regulation process and institute a minimum medical loss ratio to make health insurance markets more competitive and premiums more actuarially sound and objectively based.⁴ In order to provide a smooth transition to appropriate rates (which were previously artificially suppressed) the minimum medical loss ratio was linked initially to a 10 percent cap on rate increases. The Legislature did not extend the 10 percent cap after it expired in 2000.

However, Pataki’s own insurance superintendent is

now proclaiming the need to return to pre-2000 premium rate regulation and repeal the reforms championed by his boss.⁵

In a November 2005 letter to legislators, Superintendent Howard Mills laid out a laundry list of why health premiums are increasing, calling it a national problem due to “medical inflation, advancements in medical technology, the rising cost of prescription drugs, the costs of research and development, the lengthening of life spans, and trends in public health such as the increasing incidence of obesity.”

Mills pointedly did not mention the state’s own laws and regulations as factors in high health insurance costs before concluding that premium increases required the “consumer safeguard” of prior rate approval.

“Carriers should be required to justify their rate increases before those rates can be passed on to the consumer,” he asserted.⁶

But New York law *already* requires insurers to justify rate hikes by demonstrating that they do not exceed the medical loss ratio. Mills’ reasoning ignores what has happened since file-

and-use became the regulatory standard six years ago.

As shown in the table on the first page, from 1996 to 2000, when the minimum medical loss ratio was fully phased in, New York small businesses paid on average 15 to 22 percent more for health coverage than the national average for small businesses. But, during the next three years, under the “file and use” standard, that competitive gap shrunk to between 7 and 13 percent.

Large, self-insured New York companies, meanwhile, now pay insurance rates at the national average. It is telling that these large companies’ benefits are not regulated by the New York State Legislature or the Insurance Department.

Setting arbitrary caps on rate increases – such as Mills’ 10 percent proposal – would encourage insurers to file rate increases close to or at the cap, regardless of actual medical trends, rather than face the politically-charged rate approval process. In fact, one recent study noted that this is exactly what happened as “file and use” was being phased in from 1996 to 2000 when the arbitrary 10 percent cap was in place.⁷

When limits were still in place, an insurer in need of a rate increase of greater than 10 percent could avoid the regulatory process and settle for 10 percent (which, at the time, actually was below medical trend for individual policies) thereby risking a potential solvency crisis; conversely, an insurer whose data supported a smaller increase was nonetheless likely seek the full 10 percent, realizing it might need more in future years. In this way, the arbitrary 10 percent limit tended to guarantee an

New York’s experience indicates that setting arbitrary limits on health insurance rate increases simply encourages insurers to play it safe by proposing rate increases at or close to the limits

automatic 10 percent increase for policyholders.

The cost of regulation

Rate regulation allows state officials to put the onus on insurance companies while avoiding any analysis of how the state’s intervention in the health care market has led to higher premiums. The 1993 imposition of community rating and “guaranteed issue” on New York’s individual and small group market clearly is a key factor in the high cost of insurance. Compounding the problem, New York collects over \$2.1 billion in taxes and assessments from private health plans annually – driving up premium costs, pure and simple. The state also imposes 43 mandates forcing insurers to only offer more-expensive plans that cover particular benefits. This is among the highest burdens imposed by any state, and well above the national average.

Large, self-insured companies don’t have these mandates; small businesses are the ones penalized. Premiums for small employers are at least 20 percent higher than those for large employers. Average premiums for New York large employers are now slightly below the comparable national average, while small employers are 13 percent above.

Windfall, or efficiency?

The New York Public Asset Fund owns almost 27 million shares, worth about \$2.1 billion, in the company produced by the merger of WellChoice (the former Empire Blue Cross-Blue Shield) with WellPoint, Inc.⁸ – the state’s largest health insurance company. This

amount is in addition to the approximately \$2 billion in cash proceeds from the Fund’s prior sales of WellChoice stock. The proceeds from the WellChoice sale and from future non-profit health plan conversions are being counted on as a major source of financial support for state Health Care Reform Act (HCRA) programs. Limiting the company’s ability to accurately price insurance products will likely weaken one of HCRA’s underpinnings.

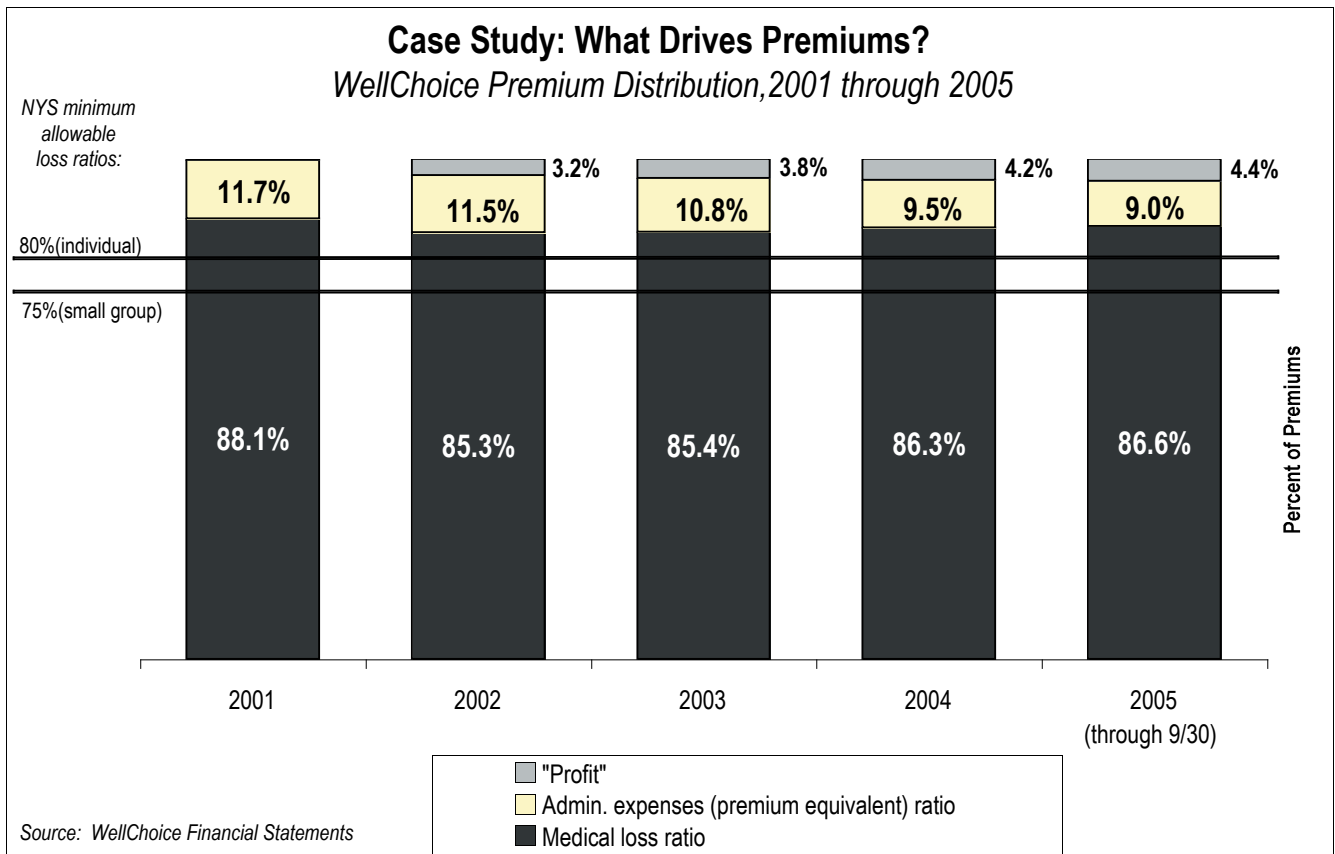
The chart below illustrates the distribution of WellChoice premium revenues among profits, administrative expenses and medical costs (the “loss ratio”) from 2001 to 2005. As shown here, the growth of WellChoice profits during this period was due primarily to the company’s success in squeezing administrative costs.

A recent national PricewaterhouseCoopers study⁹ suggests that the WellChoice trend is not atypical. It found that over a ten year period (1993-2003), the average insurers’ medical loss ratios remained at about 86 percent. The annual growth rate of premiums during this period (7.3 percent) tracked the annual growth rate of medical claims paid (7.2 percent).

From “File and Use” to “File and Abuse”

Requiring the New York State Insurance Department to approve rate increases would shift New York from an actuarially rational “file and use” system to an inherently more politicized approach that might amount to “file and abuse.” The consumer is better protected under the current system which ensures premiums are driven not by political posturing, but by actual health care trends.

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If the State Insurance Department denies insurers actuarially-sound premium increases, then the following become more likely:

- insurers will suffer financial loss for medical claims costs in excess of those supported by approved premium rates; and
- consumers will face large future premium increases as insurers recuperate past losses.

The Assembly proposal also increases the minimum loss ratios from 80 to 90 percent in the individual market and from 75 to 85 percent in the small group market. These 10 percent increases in the medical claims ratios more than equal the entire current portion of claims spent on administration. It is questionable whether New York insurers could remain financially viable under these circumstances.

Mills and Assembly bill supporters have cited the auto insurance rate process as an example of how prior approval is effective. They fail to mention that even with this added pressure on auto carriers to mitigate rate increases, New York's average auto insurance cost was the second highest in the nation as of 2003.¹⁰

Even some New York health care providers--normally at odds with insurers--recognize that actuarially sound premiums are critical. In a letter to legislative leaders opposing the Assembly bill, a representative of one regional hospital network said "artificially suppressing premiums would almost certainly result in artificially suppressed reimbursement for providers leading to a strain on the entire health care system."¹¹

Rate cap record

In an attempt to justify renewed rate caps for the individual and small group market, sponsors of the Assembly bill note that such limits already apply to the state-subsidized Family Health Plus, Child Health Plus and Medicaid Managed Care programs, and to the New York State Health Insurance Plan (NYSHIP), which covers state workers.

However, data from the state Department of Civil Service indicate the rate-approved NYSHIP premium has increased faster than premiums for private employers, particularly since 2000. As of 2003, the latest year for which comparative data were available, the NYSHIP premium was 35 percent higher (a difference of \$1,200 more per year) than the national average for large businesses.

Flexibility – not regulation

New Yorkers need more health insurance flexibility and lower health care taxes. While maintaining a reasonable minimum medical loss ratio and file-and-use, New York insurers should be allowed to provide a fuller range of affordable health insurance plans to consumers. Albany should not restrict New Yorkers' health insurance choices. The state should limit its role to providing consumers with sufficient information and options to decide which one of numerous affordable plans best suits their needs, wants and current lifestyle and economic situation.

Endnotes

¹ A.2518. Sponsored by Assemblyman Pete Grannis (D-Manhattan), Assembly Insurance Committee Chair, and unanimously passed in the New York Assembly on January 31, 2006 (as well as every year since 1998). <http://assembly.state.ny.us/leg/?bn=A02518>. Senate companion bill S2712-B. Principal sponsor: Senator Michael Balboni (R-East Williston).

² S.5286. Sponsored by Senator James Seward (R-Otsego County), Senate Insurance Committee Chair.

³ Section 4308 of the New York Insurance Law. Available at: <http://public.leginfo.state.ny.us/menugetf.cgi?COMMONQUERY=LAWS>

⁴ Public Law 1995. Chapter 504.

⁵ A Senate bill with a 10 percent rate regulation provision (S5286) was introduced at Superintendent Mills request. Principal Sponsor: Senate Insurance Committee Chairman James Seward (R-Milford).

⁶ Superintendent Howard Mills. Letter to Assemblyperson Robin Schimminger. November 9, 2005.

⁷ Bender, Karen and Beth Fritchen. "Impact of Prior Approval Requirements for Rate Changes of Small Employer Group and Individual Health Policies." Mercer Oliver Wyman. January 2004. p. 21.

⁸ WellPoint press release. "WellChoice and WellPoint to Merge." September 27, 2005. http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-newsArticle_general&t=Regular&id=761487&

⁹ PriceWaterhouseCoopers. "Factors Fueling Rising Healthcare Costs 2006." January 2006. page 3. www.ahip.org/redirect/PwCCostOfHC2006.pdf <<http://www.ahip.org/redirect/PwCCostOfHC2006.pdf>

¹⁰ AUTO INSURANCE: Facts and Statistics. Insurance Information Institute. 2003 figures. www.iii.org/media/facts/statsbyissue/auto/ <<http://www.iii.org/media/facts/statsbyissue/auto/>

¹¹ Currie, Brian, Long Island Health Network, letter to Senator Joseph Bruno regarding A.2518, February 10, 2006.

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