

# Unhealthy Risk

New York's Misguided Regulations  
And An Insurance Co-Op Collapse

by Bill Hammond

The rapid rise and costly fall of Health Republic Insurance of New York, the largest non-profit insurance “co-op” established under President Barack Obama’s federal health care legislation, is a cautionary tale for policymakers in Albany as well as Washington.

Despite heavy federal subsidies and robust enrollment growth, Health Republic lost money at such a clip that state regulators forced it to shut down as of Nov. 30, on barely two months’ notice.

The collapse disrupted coverage for 215,000 customers, stuck hospitals and other health providers with hundreds of millions in unpaid claims, and left federal taxpayers with a quarter-billion dollars of uncollectible debt.

This was no isolated incident. Of 23 such insurance co-ops launched under the new federal health care law, 12 will be out of business by Jan. 1. That failure rate of more than 50 percent raises obvious questions about the workability of the co-op model and Washington’s management of the program.

Of more direct concern for New York policymakers, however, is an apparent breakdown in state oversight of the health insurance industry.

Health Republic’s growing financial troubles should have been no surprise to insurance regulators at the Department of Financial Services (DFS). The company’s filings to DFS showed steep operating losses, mounting debt, unanticipated costs and heavy reliance on a federal risk-management subsidy that failed to materialize.



Yet the department did not intervene to order an increase in Health Republic's premiums, as other states did in similar situations. To the contrary, DFS repeatedly cut the company's premiums below what the insurer had requested, aggravating the co-op's losses.

The department's most recent cut—trimming some of the plan's proposed rates for 2016—was announced in July, less than two months before DFS moved to shut the insurer down.

At the very least, this chain of events raises the question of whether the department's regulatory judgment was clouded by the political desirability of keeping health insurance prices

artificially low in the short term.

It also highlights an inherent conflict between the department's longstanding regulatory role—which is to assure that health plans are financially sound—and rate-setting authority granted by the Legislature in 2010.

An analysis of premiums before and after the enactment of that law, known

as "prior approval," indicates that the law is having no clear impact on New York's health insurance costs versus national averages. This suggests that consumers might be better off if DFS kept its entire regulatory focus on the financial health of insurance companies while leaving price-setting to market forces.

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***The co-op plan's financial losses were aggravated by the state's insistence on lowering Health Republic's requested premium increases.***



*Health Republic's marketing campaign stressed the low premium rates that ultimately would prove to be its undoing, leaving customers uninsured and providers unpaid.*

## 1. BACKGROUND ON CO-OPS

Co-ops—short for “consumer-operated and oriented plans”—are a byproduct of President Obama’s health care legislation, the Patient Protection and Affordable Care Act of 2010 (more commonly known as the Affordable Care Act or ACA).<sup>1</sup>

The law sought to reduce the nation’s uninsured rate by, among other things, establishing purchasing exchanges in each state, through which individuals and small businesses can choose among a selection of plans, with tax credits available on a sliding scale to lower- and middle-income buyers.

To facilitate comparison shopping, plans sold through the ACA exchanges must offer a standardized menu of benefits and are grouped into “metal levels,” ranging from “platinum” plans designed to cover 90 percent of medical costs, down to “bronze” plans that cover 60 percent.

Concerned that too few private insurers would participate in the exchanges, or that their prices would be too high, some congressional Democrats advocated creating a government-operated health plan to serve as a low-cost “public option.” While that idea failed to win enough support, drafters agreed to establish a private-sector alternative to serve the individual and small-group markets: the co-op program.<sup>2</sup>

Co-op health plans would be set up as non-profit companies governed by their members, and would receive federal start-up funding in the form of low-interest loans.

### New York’s ACA co-op

Health Republic Insurance of New York was founded as a co-op by the Freelancers Union, an organization of independent workers that had previously offered health coverage to its

members. The Center for Medicare & Medicaid Services (CMS) accepted Health Republic into the program in 2013 and authorized financing of \$174 million, the most awarded to any co-op.

That amount included \$24 million to cover startup costs, plus as much as \$151 million in “solvency” loans that would supply the cash reserves an insurance plan is required to maintain to assure it can pay claims. CMS later increased Health Republic’s available solvency loans to \$241 million, of which the company ultimately drew \$209 million.<sup>3</sup>

When New York’s exchange opened in September 2013, Health Republic stood out in two ways – for its unusually broad provider network and for its extraordinarily low premiums.

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***Health Republic Insurance of New York was seeded with \$233 million in federal loans, more than any other health insurance co-op created under Obama’s Affordable Care Act.***

While other plans sharply limited what providers their members could use as a way of controlling costs, Health Republic’s network included Manhattan’s Memorial Sloan Kettering, the world-famous cancer treatment center covered by

few, if any, of its competitors on the exchange.

Health Republic’s prices for 2014, meanwhile, ranked at or near the very bottom of the scale, and were sometimes significantly out of line with those of other plans, as shown in Table 1 on page 4.

For “silver” coverage, the most popular option, Health Republic’s 2014 premiums were the lowest in seven of eight regions of the state (the exception being Long Island, where it was second-lowest.) In the Syracuse area, its silver rate for calendar year 2014 was \$286 a month, 33 percent below the regional average and 20 percent lower than the next cheapest plan.

The combination proved popular with consumers. By June 2014, halfway through its first year of operations, Health Republic had signed up more than 70,000 individuals and 3,300 small

business employees, more than any other plan doing business on the exchange.<sup>4</sup> By the time it was forced to close, its membership had nearly tripled to 215,000.<sup>5</sup>

### Industry Concerns

Early on, some of Health Republic’s competitors—without mentioning the company by name—publicly questioned whether premiums offered through the exchange were excessively low.

In a conference call with investment analysts in April 2014, UnitedHealth Group CEO Stephen Hemsley spoke of an “underpricing dynamic”

in New York.

“We believe several carriers there, including new entrants, are pricing well below cost, and at what we would view as unsustainable pricing levels,” Hemsley said, adding that the company intended to bring the issue up with regulators.<sup>6</sup>

In a similar conference call that same month, Aetna CEO Mark Bertolini said pricing by some co-ops was “irrational.”<sup>7</sup>

That Health Republic was indeed running in the red was confirmed by its quarterly filings with federal and state regulators.

**Table 1: Underpricing the Competition**

*Monthly cost, rounded to nearest dollar, for individual silver-level health coverage, 2014*

Plan	Albany	Buffalo	Mid-Hudson	NYC	Rochester	Syracuse	Utica	Long Island	All regions
Aetna Life	\$504	\$553	\$547	\$615	\$430	\$486	\$504	\$615	\$607
Affinity			\$465	\$477				\$487	\$479
CDPHP-HMO	\$469		\$530			\$526	\$505		\$485
Emblem-HIP			\$397	\$397				\$451	\$404
Empire HMO	\$425		\$501	\$456			\$676	\$420	\$443
Excellus	\$490	\$476	\$490		\$378	\$460	\$490		\$442
Fidelis	\$359	\$355	\$362	\$410	\$356	\$358	\$354	\$378	\$382
<b>Health Republic (HR)</b>	<b>\$294</b>	<b>\$275</b>	<b>\$330</b>	<b>\$387</b>	<b>\$271</b>	<b>\$286</b>	<b>\$278</b>	<b>\$387</b>	<b>\$341</b>
HealthFirst				\$440				\$444	\$444
HealthNow	\$551	\$426					\$576		\$429
Independent-IHBC		\$466							\$466
Metro Plus				\$392					\$392
MVP Health	\$376	\$342	\$461	\$599	\$330	\$430	\$403		\$387
North Shore LIJ				\$423				\$423	\$423
Oscar				\$422				\$422	\$422
Oxford-OHP			\$865	\$865				\$865	\$865
United Health			\$804	\$804				\$804	\$804
Average	\$434	\$413	\$523	\$514	\$353	\$424	\$473	\$518	\$483
HR rank (low to high)	1	1	1	1	1	1	1	2	1
HR vs. average	-32%	-33%	-37%	-25%	-23%	-33%	-41%	-25%	-29%
HR vs. No. 2	-18%	-19%	-9%	-1%	-18%	-20%	-21%	N/A	-11%

Source: NYS Department of Financial Services  
[http://www.dfs.ny.gov/consumer/health/2014\\_and\\_2015\\_approved\\_rates.pdf](http://www.dfs.ny.gov/consumer/health/2014_and_2015_approved_rates.pdf)

Painting a particularly grim picture was its audited financial statement for 2014, filed in May 2015, which showed that the year's premium revenues had fallen short of operating expenses by \$77.5 million, or almost 12.5 percent.<sup>8</sup>

The statement further reported that Health Republic had recently drawn two additional federal loans of \$38 million each to replenish its required cash reserves. The first was back-dated to Dec. 31, 2014, the second to March 30. That brought its total solvency financing to \$209 million and left just \$32 million more available.

The statement listed a "premium deficiency reserve" of \$21.9 million, corresponding to how much the company expected to lose because of low premiums in 2015.

Plus, the company was banking on \$119.9 million in payments from the ACA's "risk corridor" program – most of which is was unlikely to collect, as will be discussed further below.

In another potential sign of trouble, several key numbers in the May filing were significantly worse than those the company submitted in an unaudited statement two months before.

## 2. THE "THREE Rs"

Given the unpredictability of who would buy coverage through the exchange in that first year, and how healthy or unhealthy they might be, Health Republic was far from the only participating plan to set its premiums too low.

Anticipating that problem, the ACA included risk-protection provisions known as the "three Rs": reinsurance, risk adjustment and risk corridors. For Health Republic, however, the latter two programs backfired.

Under risk adjustment, plans that enroll relatively healthy customers must transfer some of their revenue to plans with relatively sick

customers. Despite including Memorial Sloan Kettering in its network – which might have been expected to attract patients with cancer – Health Republic was deemed to have a relatively healthy customer base, and therefore had to give up \$44 million during its first year, aggravating its financial woes.

The third "R," risk corridors, proved especially troublesome for Health Republic.

Under this three-year program, federal officials set a target for what share of premium revenue plans should spend on claims. Plans that underspent the target by more than 3 percent were required to turn over part of the unused funds to the government. Plans that overspent the target, meanwhile, were supposed to be

partially reimbursed for their losses.

In an April 2014 policy memo, CMS projected that plans' surpluses and losses would be more or less equal, and declared its intention to run the program on a "budget neutral" basis (i.e., without the use of federal tax dollars).<sup>9</sup> If funds ran short, officials said they would reduce payouts to plans accordingly and try to make up the shortfalls in subsequent years.

By protecting insurers from the downside risk of excessively low premiums, risk corridors created a classic moral hazard. Health Republic, among others, fell prey to it.

It soon became evident that more plans were running deficits than surpluses, throwing the risk corridor program out of balance, potentially by billions. This raised concern in Congress that CMS would change course and use government money to fill the gap, as the agency signaled its readiness to do in a regulatory statement issued in May 2014.<sup>10</sup> Florida Sen. Marco Rubio took the lead in calling attention to this possibility, saying it would be tantamount to a "bailout" of the insurance industry.<sup>11</sup>

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***The New York co-op's 2014 financial statement painted a grim picture, showing premium revenues nearly \$78 million below expenses.***

A clause specifically barring the use of intra-budget transfers of public funds to backfill the risk-corridor program was included in the federal budget bill passed in December 2014 and signed into law by President Obama.<sup>12</sup> The provision also was included in the government funding bill passed in December 2015.<sup>13</sup>

### **TIMELINE: Health Republic's Drive Down Narrowed Financial "Corridor"**

**Dec. 16, 2014:** Obama signs budget bill banning use of public funds for ACA health insurers' "risk corridor" program

**March 2015:** In public filing, Health Republic reports being owed \$58 million in risk corridor payments for 2014

**May 1, 2015:** Standard & Poor's warns that risk corridors program is underfunded, names Health Republic as one of 15 most-exposed insurers

**May 15, 2015:** Health Republic applies to state DFS for rate hikes averaging 14.36% for individuals, 20% for small groups

**May 31, 2015:** In audited financial statement, Health Republic doubles its estimated risk corridor payments due for 2014, to \$120 million

**July 31, 2015:** DFS trims Health Republic's individual rate hike to 14.03%, approves 20% small-group hike without change

**Aug. 15, 2015:** Health Republic reports \$243 million in risk-corridor payments due through June

**Sept. 25, 2015:** DFS orders Health Republic to stop signing new customers and to wind down after Dec. 31

**Oct. 1, 2015:** Federal government announces it will pay just 12.6% of risk corridors claims, a \$200 million hit to Health Republic's finances

At that point, insurers counting on big risk corridor payouts, Health Republic among them, faced a reckoning.

In a May 2015 report spotlighting the issue, Standard & Poor's (S&P) included Health Republic on a list of companies that stood to lose the most from the shortfall in the risk corridor program. At the time, S&P put Health Republic's liability at \$58 million, based on the company's most recent filing.

In its audited statement a few weeks later, however, the company would more than double that estimate to \$119.9 million.

It was increasingly clear that Health Republic would collect only a fraction of what it was due. Officially, though, the full amount appeared on its balance sheet as a "receivable," helping make the company look solvent on paper. And the more money Health Republic lost on operations, the bigger that theoretical asset grew. When the company filed its June 30 quarterly report, its "receivable" from risk corridors had mushroomed to \$243 million.

The exact amount of Health Republic's risk corridor losses remained unclear when its shutdown was ordered on Sept. 25. Six days later, CMS announced that it would reimburse companies just 12.6 percent of what they were owed under risk corridors,<sup>14</sup> wiping almost \$200 million from Health Republic's books.

### **3. THE ROLE OF STATE REGULATORS**

The Department of Financial Services was created in 2011, when Gov. Andrew Cuomo merged the former Department of Insurance with the Department of Banking.

The department's website summarizes its mission as: "To reform the regulation of financial services in New York to keep pace with the rapid and dynamic evolution of these industries, *to guard against financial crises and to protect consumers and markets from fraud.*" (Emphasis added.)

Among its specific goals is to “ensure the continued solvency, safety, soundness and prudent conduct of the providers of financial products and services.”<sup>15</sup> In keeping with that charge, the department collects and reviews detailed financial reports from all insurers, including health plans, to make sure they are maintaining adequate reserve funds and otherwise operating prudently.

In the case of health insurance sold to small employers and individuals,<sup>16</sup> DFS has a further mandate to regulate prices, which it does in two ways:

First, the state requires health plans to spend a minimum share of their annual revenues on actual claims, as opposed to administrative expenses and profit. This “medical loss ratio,” or MLR, is 85 percent for large-group policies and 82 percent for small-group and individual policies. (Within New York, these rates supersede the ACA’s loss ratios, which are 85 percent and 80 percent, respectively.) Plans that fall short of meeting the applicable MLR must pay refunds to their customers the following year.

Second, DFS directly reviews and approves premiums in advance, and can adjust them as it sees fit. This so-called “prior approval” authority was phased out under Gov. George Pataki between 1996 and 2000, but signed back into law by Gov. David Paterson in 2010.<sup>17</sup>

In principle, DFS could use this authority to raise rates as well as reduce them. In practice, the department’s rate adjustments have gone in only one direction – down, sometimes dramatically so.

**Even as the co-op’s losses mounted, the state Department of Financial Services in 2015 again reduced Health Republic’s rate increases.**

Of the 17 individual rate requests and 20 small-group rate requests submitted in 2014 (for policies covering 2015), the department approved only one without changes: a 15 percent reduction proposed by Care Connect, a plan sponsored by North Shore-LIJ Health System.<sup>18</sup>

Overall, as shown in Table 2, the plans applied for increases averaging 12.5 percent for individuals and 13.9 percent for small groups. DFS’s actions knocked both down by more than half, to 5.7 percent and 6.9 percent, respectively.

<b>Table 2: Squeezing the market</b>					
<i>Requested and approved rate increases for New York health insurance plans</i>					
Year	Market	Requested	Approved	Difference	% Change
<b>Health Republic Insurance of New York</b>					
2015	Individual	15.4%	13.0%	-2.3%	-15.0%
	Small group	5.9%	3.4%	-2.5%	-43.0%
2016	Individual	14.4%	14.0%	-0.3%	-2.3%
	Small group	20.0%	20.0%	0.0%	0.0%
<b>Industry average</b>					
2015	Individual	12.5%	5.7%	-6.8%	-54.4%
	Small group	13.9%	6.9%	-7.0%	-50.4%
2016	Individual	10.4%	7.1%	-3.3%	-31.8%
	Small group	14.4%	9.8%	-4.6%	-32.0%

Source: NYS Department of Financial Services press releases  
<http://www.dfs.ny.gov/about/press/pr1409041.htm>  
<http://www.dfs.ny.gov/about/press/pr1507311.htm>

To drive home how hard it was squeezing plans, DFS noted in its press release that both averages were “below the approximately 8 percent average increase in health care costs.”

The department was somewhat less aggressive in 2015, when it set rates for 2016 coverage. This time, it approved five of 17 individual rates and eight of 19 small-group rates without changes.<sup>19</sup> Still, it lowered the average increases by almost a third, from 10.4 percent to 7.1 percent for individual policies, and from 14.4 percent to 9.8 percent for small group policies.

Although Health Republic’s premiums were already among the very lowest in the state—and though its financial reports showed it was losing money—the fledgling company did not escape the state’s rate-setting knife. During the 2014 approval process for 2015 rates, DFS lowered Health Republic’s individual rate increase from 15.4 percent to 13 percent and its small-group rate increase from 5.9 percent to 3.4 percent.

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***As losses mounted, DFS in 2015 slightly reduced Health Republic’s requested rate hike.***

In July 2015—two months after Health Republic filed its grim audited financial statement—the department still saw fit to slightly lower the company’s requested rate hike for individual policies, from 14.36 percent to 14.03 percent. For small groups, however, the department granted the company the full 20 percent rate hike it sought.

Less than two months later, on Sept. 25, DFS ordered the company to wind down at the end of the year. On the day of that announcement, Health Republic officials cited the department’s rate-cutting as one cause of its struggles. “We didn’t feel as if we got rate adequacy” for 2015 coverage, a company official said.<sup>20</sup>

In contrast to New York’s DFS, some other states’ insurance regulatory agencies have used their rate-setting authority to increase premiums as well as lower them.

Take Oregon, for example. Of 26 rate applica-

tions submitted there this year, its Insurance Division ordered higher-than-requested rates for six plans, approved 16 without changes and lowered only three.<sup>21</sup>

“Our ultimate responsibility to Oregon consumers is to ensure that rates cover the cost of health care,” Oregon Insurance Commissioner Laura Cali said in a news release at the time. “Our final rate decisions reflect our commitment to ensuring that Oregonians can count on the coverage they purchase.”<sup>22</sup>

Had New York’s regulators ordered higher rates for Health Republic from the beginning, the company could have avoided some of the steep losses that made it so dependent on risk-corridor funding. While it’s unclear that such action would have been enough to save the company, DFS’s rate-cutting, in retrospect, was unquestionably counterproductive.

A leading spokesman for New York’s health insurance industry warned of such dangers in July 2014, when the department had cut insurers’ rate requests by an average of more than half. Paul Macielak, president of the New York Health Plan Association, called the rate-setting process “seriously flawed,” described the approved rates as “inadequate,” and said DFS’s decisions were “irresponsible and do not reflect actuarial reality.”<sup>23</sup> Macielak added:

New York’s market is very competitive, and plans submitted rates that were as low as possible while still being actuarially sound. There are serious concerns that DFS’s decisions will create unnecessary turmoil in the market and will lead some plans to make business decisions that might include eliminating or reducing product offerings, withdrawing from regions, or even withdrawing from the marketplace entirely.

The bottom line is, inadequate rates will result in reducing product choice or otherwise destabilizing the market, which is ultimately harmful to the health care system as a whole and to the consumers who rely on it.<sup>24</sup>



#### 4. CO-OP CRASH CONSEQUENCES

The shutdown of Health Republic harms three groups of stakeholders: consumers, providers and taxpayers.

The company's 215,000 subscribers – about one fifth of all New Yorkers who bought private coverage through the state exchange – faced a double whammy: they had to scramble to switch plans on short notice, then, in most cases, pay significantly more than Health Republic's too-good-to-be-true premiums.

At first, subscribers were told their coverage was good through Dec. 31, meaning they could shop for a new plan during the standard open enrollment period for 2016. Then they learned Health Republic was closing Nov. 30, meaning they also needed to arrange a single month's coverage for December.

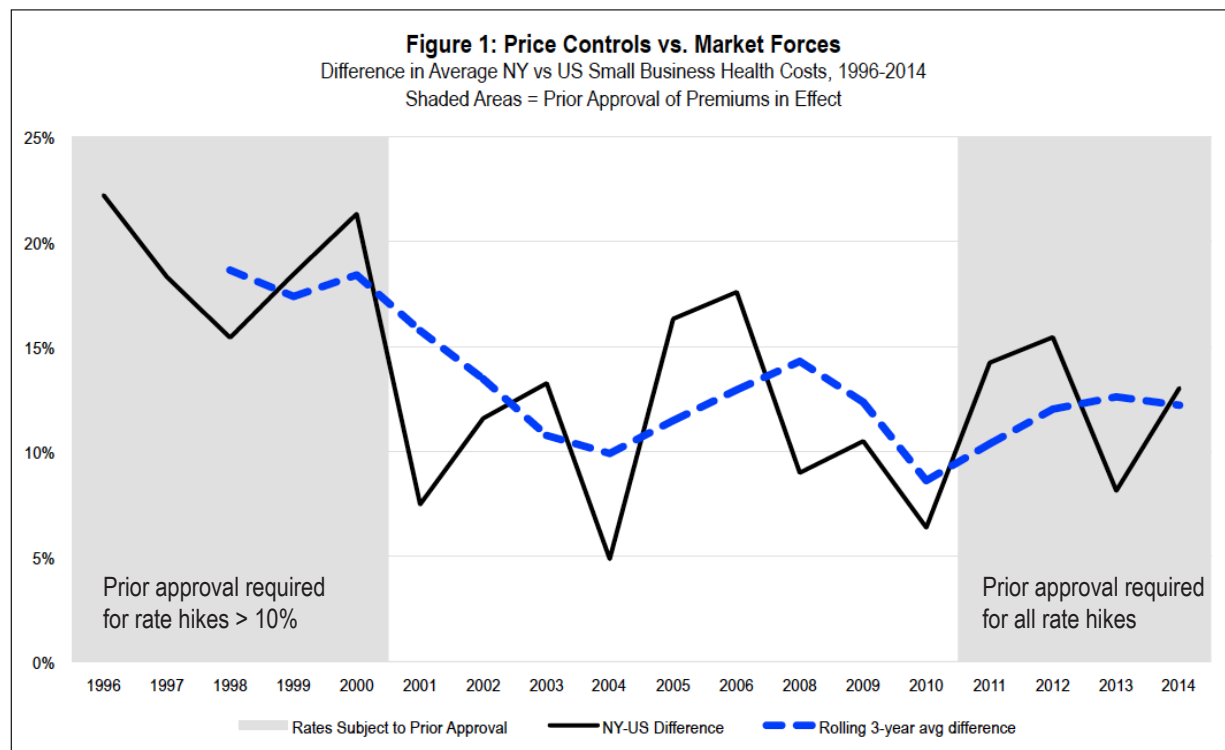
While DFS arranged an "automatic enrollment" option to streamline the process, it's likely that at least some Health Republic customers were

lost in the shuffle or chose to drop coverage.

The hospitals and doctors who treated those customers, meanwhile, are stuck with millions in unpaid bills. The company's June 30 financial filing reported \$184 million in outstanding claims, a number that would have grown since then.

Estimating that hospitals alone are owed \$165 million, the Greater New York Hospital Association is pushing for state lawmakers to create a so-called guaranty fund, financed through a tax on health insurance, which would reimburse providers for attributable to the Health Republic collapse and to any future insurance company failure.<sup>25</sup>

That, of course, would further drive up the cost of health insurance for everyone. As an alternative, the New York Health Plan Association argues that any compensation for Health Republic providers should come from the existing \$4.6 billion a year in taxes and fees that the state collects from (or through) health insurers.<sup>26</sup>



*The affordability gap between health insurance costs in New York and in other states declined after rates were deregulated in 2000 and shows signs of growing again since prior approval was reinstated in 2010.*

Taxpayers, meanwhile, are unlikely ever to be repaid for the \$233 million the federal government loaned to Health Republic.

## 5. THE IMPACT OF “PRIOR APPROVAL”

Beyond the potentially damaging effect on health plan finances, does New York’s prior-approval law achieve its goal of making coverage more affordable in the long term? An analysis of insurance costs with and without the law in place suggests the answer is no.

Under prior approval, which existed in New York before 1996 and was reinstated in 2010,

**Table 3: Price Regulation vs. Market Forces**

NY small-business health costs compared to US average  
Before and after prior approval of premiums, 1996-2014

	Year	Small firm* avg NY	Small firm* avg US	Difference NY-US	Rolling 3-yr avg
Some Prior Approval**	1996	\$2,530	\$2,070	22.2%	
	1997	\$2,494	\$2,108	18.3%	
	1998	\$2,580	\$2,235	15.4%	18.7%
	1999	\$2,932	\$2,475	18.5%	17.4%
	2000	\$3,430	\$2,827	21.3%	18.4%
No Prior Approval	2001	\$3,258	\$3,031	7.5%	15.8%
	2002	\$3,766	\$3,375	11.6%	13.5%
	2003	\$4,103	\$3,623	13.2%	10.8%
	2004	\$3,948	\$3,764	4.9%	9.9%
	2005	\$4,794	\$4,121	16.3%	11.5%
	2006	\$5,010	\$4,260	17.6%	12.9%
	2008	\$4,906	\$4,501	9.0%	14.3%
	2009	\$5,140	\$4,652	10.5%	12.4%
	2010	\$5,272	\$4,956	6.4%	8.6%
Prior Approval Required	2011	\$6,007	\$5,258	14.2%	10.4%
	2012	\$6,304	\$5,460	15.5%	12.0%
	2013	\$6,086	\$5,628	8.1%	12.6%
	2014	\$6,653	\$5,886	13.0%	12.2%

\*Up to 50 employees

\*\* Required only for rate hikes of more than 10%

Source: Agency for Healthcare Research and Quality,  
Medical Expenditure Panel Survey

health insurance companies must submit their premiums for individual and small-group coverage to state regulators for review and approval. Experience has shown that regulators often succumb to political pressure to set rates too low, which can discourage insurers from doing business in New York, reduce choice and, ultimately, make coverage less affordable.

In 1995, then-Gov. George Pataki pushed through a repeal of rate-setting, instituting in its place a system of minimum medical loss ratios. In the name of providing a smooth transition, the law initially capped increases at 10 percent unless approved by regulators. The Legislature did not extend the 10 percent cap after it expired in 2000.

In 2006, the Empire Center studied the impact of that reform by comparing national average small-group health insurance premiums to small-group insurance rates in New York.<sup>27</sup>

The study showed that the affordability gap, or “New York difference,” stayed high from 1996 through 2000, possibly because insurers tended to set rates as close as possible to the 10 percent cap. (See Table 3 at left.) But the difference dropped markedly after the law completely expired, suggesting that market forces kept prices in check more effectively than state regulation.

Updating that same comparison through 2014 shows that the gap fluctuated considerably before dropping to 6.4 percent in 2010, just as lawmakers were voting to bring back prior approval. Since 2011, when the reinstated law took effect, the gap has returned to double digits in three of four years.

So far, there’s no clear trend either way, but certainly no justification for the ham-handed solution of price controls.

## CONCLUSION

The full story of Health Republic's failure remains murky. It's unclear whether DFS, in shutting the company down, was reacting to the company's expected losses on risk corridor funding or some other factor.\*

After initially ordering the company to close by December, DFS accelerated the closure to Nov. 30, saying it had learned the company's finances were "substantially worse than the company previously reported to the state" and promising an investigation of the plans' "inaccurate representations."

Still, what Health Republic did report was worrisome enough: steady losses, heavy debt and mushrooming dependence on a federal risk management subsidy that failed to materialize after Congress stipulated that it could not be backfilled with public funds. Moreover, it was

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\* The author sought clarification from the agency about its handling of Health Republic's financial crisis and its ongoing investigation. A DFS spokesman declined to comment.

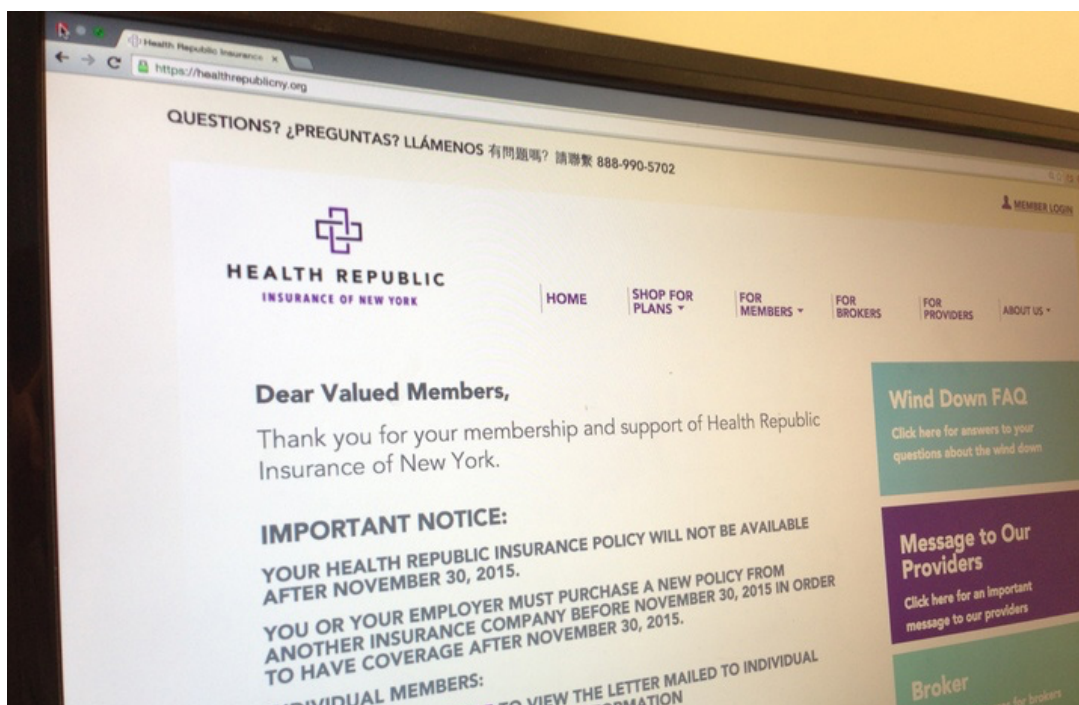
a brand-new company, built on an untested model, navigating the unpredictable tides of a rapidly transforming health-care system.

If DFS spotted these red flags, it took no obvious steps to address them. What it did do was further reduce Health Republic's inadequate premiums, in the name of a regulatory system with no demonstrated record of achieving its stated goal of promoting affordability.

As DFS officials and legislators study what went wrong, they should recognize that prior approval is a dangerous and possibly counterproductive distraction from what should be their primary mission: preventing the next insurance plan collapse.

If the goal is making health coverage more affordable, the surest way to achieve that objective is not for the state to impose price controls, but for it to roll back its own high taxes and costly coverage mandates.

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## ENDNOTES

1. A section-by-section summary of the law can be found at <http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html>
2. See background from the federal Center for Consumer Information & Insurance Oversight at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html>
3. "Loan Program Helps Support Non-Profit Insurers," <https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html>
4. New York State of Health 2014 Open Enrollment Report, <http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202014%20Open%20Enrollment%20Report.pdf>
5. <https://healthrepublicny.org/about-us/our-story/>
6. Transcript of UnitedHealth Group quarterly earnings conference call, April 17, 2014
7. Transcript of Aetna quarterly earnings conference call, April 24, 2014
8. Health Republic Insurance of New York, Corp., Statutory Basis Financial Statements, Supplementary Schedule of Expenditures of Federal Awards and Supplementary Information, Years Ended December 31, 2014 and 2013
9. <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf>
10. Federal Register, Vol. 79, No. 101, Tuesday, May 27, 2014, Rules and Regulations, 30260. <https://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf>
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