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**THE PRICE OF DEREGULATION:**

**How “File and Use” Has Undermined  
New York State’s Ability to Protect Consumers  
from Excessive Health Insurance Premiums.**

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New York State Insurance Department  
Eric Dinallo, Superintendent

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## Executive Summary

The pitfalls of deregulation have never been more apparent than during the past year, with the near collapse of the credit and financial markets. In New York State, a less visible problem has been growing since the mid-1990s -- deregulation of health insurance premiums. Although the private health insurance system in New York is not on the brink of financial collapse, deregulation of health insurance premiums has resulted in excessive rate increases that force many New Yorkers to pay more for health insurance than they should, and force some to drop coverage altogether.

### **File and Use Has Largely Failed To Protect Consumers and Businesses**

**1. File and Use Allows Health Insurers to Increase Premiums With Virtually No Regulatory Oversight.** Under New York's deregulated "file and use" system, the New York State Insurance Department does not approve premium increases. Health insurers<sup>1</sup> can increase premium rates by any amount simply by meeting minimal filing requirements. The file and use laws only require insurers to self-certify that they "anticipate" the premium increase will meet a minimum "medical loss ratio" – the percentage of premium used to pay claims. (The minimum medical loss ratio is 75% for small groups and 80% for individual direct pay). There is no check or balance on the insurer's estimates prior to the rate going into effect. Under file and use, Insurance Department review is necessarily after-the-fact, allowing improper rate increases to be charged even if health insurers simply make mistakes in calculating filed rates.

**2. Health Insurers Have Failed to Self-Regulate.** Self-reporting of excessive premiums has been deficient. Under prior approval (1990-1995), the Insurance Department reduced **24%** of premium rates submitted by health plans after concluding the rate was excessive. Under file and use (1996-2007), however, health insurers self-reported excessive rates only **3%** of the time (i.e., found their premium rates were too high because the loss ratio did not meet the statutory minimum loss ratio requirement).

File and use does contain a self-policing mechanism that requires insurers to report medical loss ratios at the end of the year and eventually refund excessive premiums. But health insurers have been deficient in this regard as well. Between 2000 and 2007, health plans refunded approximately \$48 million in overcharged premiums without Insurance Department intervention. Insurance Department investigations, however, found that during this same period health plans overcharged policyholders an additional \$105 million - more than twice what the plans "self-policed" under file and use. This number may be understated because of the loopholes discussed below that may hide some excessive rates.

**3. File and Use Hinders Insurance Department Enforcement.** File and use contains loopholes that allow health plans to revise underlying assumptions after the rates go into effect to avoid paying refunds. For example, at the end of a plan year health plans can manipulate their medical loss ratios by increasing their reserves for "incurred but not received," or IBNR, claims

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<sup>1</sup> Unless otherwise indicated, "health insurers" is used generally to refer to an insurer licensed to write accident and health insurance, a corporation organized pursuant to article 43 of the Insurance Law and a health maintenance organization (HMO) certified pursuant to article 44 of the Public Health Law.

(the health plan's estimate of claims incurred during the rate year but not yet received from providers).

**4. File and Use Increases the Number of Uninsured.** Even if enforcement loopholes could be reduced, the file and use refund mechanism will always suffer from a classic case of "justice delayed is justice denied." File and use gives health plans until September 30 after the applicable year to pay refunds -- up to 21 months after rate increases go into effect. So, those businesses and individuals that are able to keep their coverage in place in spite of the excessive premiums must wait almost 2 years for relief. However, no relief is available to consumers or businesses that had to cancel their coverage because they could not afford the inflated rate increase in the first place. Therefore, under file and use, an unjustified rate increase can result in an unjustified loss of health insurance coverage.

**5. File and Use Undermines the Most Vulnerable Insurance Markets.** File and use applies to the four community rated markets in New York State: (1) the individual direct pay market; (2) Healthy New York; (3) Medicare supplemental insurance (Medigap); and (4) the small group market. These markets are vulnerable, as they serve populations that have difficulty affording health insurance. Recognizing this vulnerability, the State provides special treatment to these markets in the form of stop loss subsidies and market stabilization pools. From 2000 to 2008, the State's total subsidy for direct pay and Healthy New York will have been approximately \$826 million. (For 2009, the direct pay and Healthy New York subsidies will be paid through assessments on insurers and HMOs). File and use, deregulated and subject to abuse, directly contravenes the State's efforts to enhance affordability in these markets. While New York is trying to increase health coverage, file and use works to decrease it.

For example, the Insurance Law requires all HMOs in New York State to offer two standardized products in the individual marketplace in order to ensure that comprehensive coverage remains available to those consumers who must purchase health insurance coverage without employer assistance. However, most insurers are reluctant participants in this individual market and have an incentive to price themselves out of meaningful participation. As a result, the file and use mechanism frustrates the policy goals of the community rating/mandatory coverage regime developed by the Legislature. Moreover, as rates increase and become more unaffordable, healthy individuals drop their coverage leaving less healthy persons enrolled. As the health plan spends more on the sick consumers who remain, the loss ratios increase. This forces rates upward again and the cycle of increasing rates continues unchecked. Responsible rate regulation will help limit this death spiral in the individual market.

**6. Insurers' Profits Have Increased While Health Insurance Has Become Less Affordable for Small Businesses and Individuals.** Under deregulation, health insurer underwriting gains, investor profits and surplus have been high. For example, the ratio of dividends to parent companies to premiums has increased from 1.93% (1996) to 7.83% (2007), showing that health plans paying a higher amount of premium dollar in dividends. Indeed, health plans have distributed over \$5.4 billion in dividends since full deregulation in 1999. Similarly, excess surplus-- the amount health plans retain in excess of statutory minimums -- increased from 136% of the statutory minimum (1996) to 257% (2007).

Large profits and excess surplus are two symptoms of unsustainable health insurance rate increases. Certainly, underlying medical trend (the cost of doctors, hospitals, drugs and other services) is a primary cost-driver. Also, a strong surplus position helps protect consumers during

times of economic downturn or pandemic illness, for example. And, the current recession appears to be slowing insurers' profit trends (as it has for most sectors in the economy). Nevertheless, health plan profits and excess surplus do reflect the inflated premiums that have been at least partially responsible for the continuing erosion of employer-based coverage and have made coverage prohibitively expensive for individuals without employer-based coverage.

Inappropriate premium increases significantly impact both employers and individuals. Small business owners cannot afford to provide coverage for their employees, putting them at a competitive disadvantage and making it difficult to attract and keep qualified staff. Individuals without coverage are less likely to receive the care they need, tend to be in worse health when they do receive care, and receive fewer preventive services than the insured.

### **Reinstating Regulatory Oversight of Rate Increases Better Protects the Public.**

File and use has proven inadequate to protect New Yorkers from excessive premium increases. Reinstating the Superintendent's authority to subject health insurance premium rate filings to regulatory scrutiny before the rates go into effect avoids the pitfalls of file and use.

**1. Prior Approval Does Not Rely On Self-Policing By Plans.** As discussed above, reliance on self-policing under file and use provides only token protection. Under prior approval, the Insurance Department will use objective criteria to review rates before they are increased and will not rely on self-interested insurers to certify compliance and police themselves.

**2. Prior Approval Avoids Creating Unnecessarily Uninsured.** Ensuring rates are correct *before* they go into effect provides both consumers and insurers with predictability to plan for the future, and would solve any problems before consumers and businesses are charged excessive premiums. Thus, prior approval will help prevent New Yorkers from losing coverage because they had to drop coverage when an excessive rate increase made health insurance unaffordable.

**3. Prior Approval Allows Regulators to Protect Vulnerable Markets.** The Insurance Department can help limit inappropriately excessive rate increases in direct pay and other vulnerable markets, limiting the adverse selection death spiral. Also, prior approval will help ensure that State subsidies of the direct pay market and Healthy New York achieve full value in the markets for which they were intended.

**4. Prior Approval Creates More Regulatory Certainty.** Because rates will not be increased in a "black box," the Insurance Department can prevent inappropriately excessive rate setting better both before and after premiums are increased. The current loopholes will be more difficult for health plans to exploit.

**5. Prior Approval Protects Against Insolvencies.** There is no credible evidence that prior approval in New York resulted in health plan insolvencies. Moreover, the Insurance Department's central priority is to ensure the solvency of all insurers. The Governor's current legislative proposal allows the Department to approve rates with medical loss ratios less than the statutory minimum to ensure the solvency of health insurers.

**6. Nearly Half of All States Have Prior Approval.** Some 24 states currently have some form of prior approval of health insurance rates.

## **I. Background**

“File and use” and “prior approval” are two very different mechanisms to supervise a filed premium rate after it is calculated by the health insurer. Under prior approval, the Insurance Department reviews the premium calculation before the rate is implemented. Under file and use, the rate increase is implemented without prior Insurance Department review.

### **A. Calculating a Premium Rate – In General**

Calculating a premium rate is an attempt to predict the future cost of healthcare for a carrier’s subscribers. Actuaries estimate the number of future medical claims and calculate a premium that is sufficient to cover those claims, meet the insurer’s overhead costs, and generate a reasonable profit for investors. A common measure of relationship between premiums, claims, expenses and profits is the “medical loss ratio.” For instance, a medical loss ratio of 75% means that 75% of the premiums must be paid towards claims and the remaining 25% would be retained by the insurer for administrative expenses and profits.

At first glance, determining the anticipated medical loss ratio would seem to be a straightforward exercise of simply estimating expected claims’ cost relative to premium. In practice, however, the estimation and prediction of an anticipated loss ratio can involve a complex analysis of a number of variables and complex actuarial assumptions including but not limited to the following:

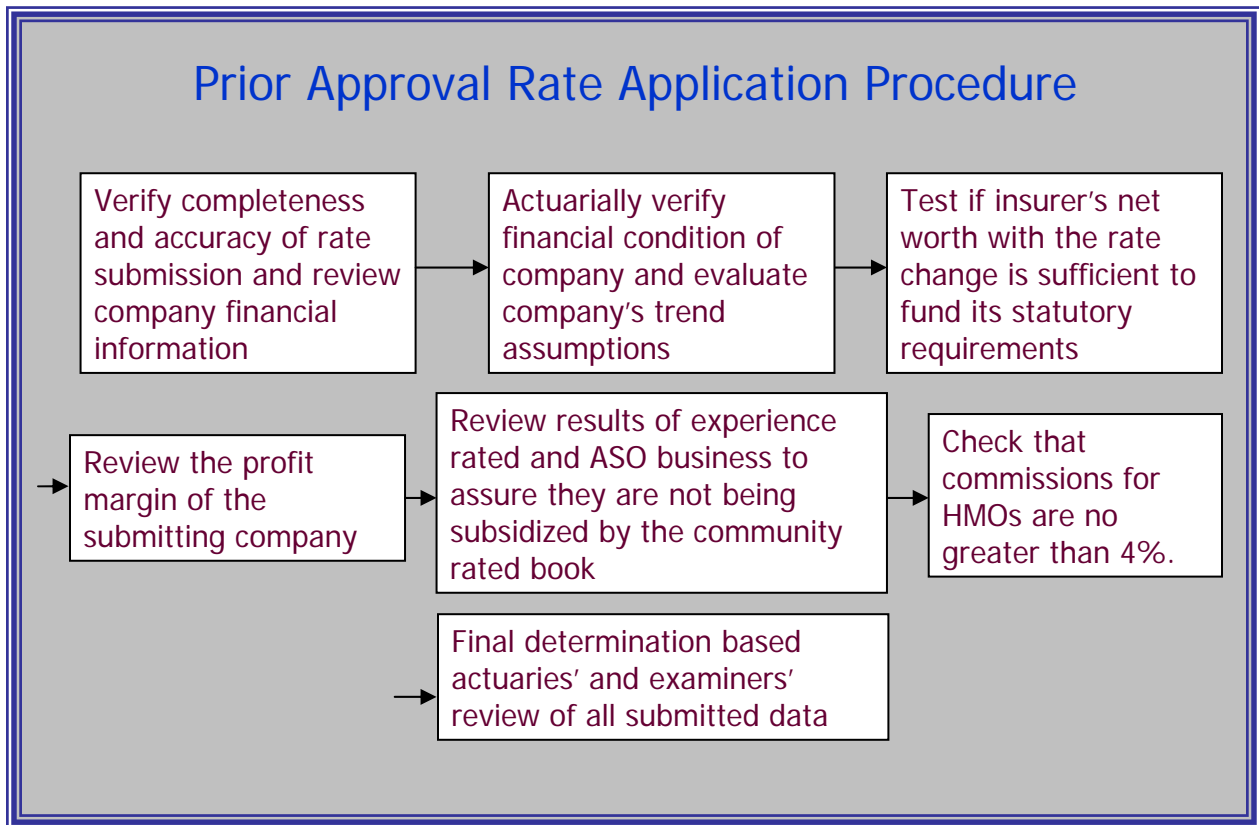
- utilization rates of covered benefits;
- the price of covered benefits;
- the demographics of the insured population (health, age, occupation, etc.);
- utilization of participating provider networks;
- utilization of out-of-network services;
- reserves for IBNR claims;
- receipts from, or payments to, the Market Stabilization Pools established by Insurance Department Regulation 146;
- receipt of State subsidies;
- timing of account renewals;
- the impact of preventive and primary care initiatives;
- administrative expenses of the insurer and the percentage allocation of such expenses to the specific contract or benefits package for which the loss ratio is being determined;
- marketing expenses;
- utilization trends;
- allocation to surplus;
- enrollment trends, including defaults and disenrollment; and
- new and innovative medical procedures and prescription drugs.

**B. Prior Approval**

Under prior approval, each of these factors are reviewed by the Insurance Department before the premium increase goes into effect. Health insurers are required to submit an application package detailing the basis of the proposed rate, including:

- enrollment data, current rates, proposed rates and percentage change for each community rated contract;
- projected income and expenses for the rate period with and without the rate change;
- cost and utilization trend assumptions;
- tests of the accuracy of the company's past trends used in rate making; and
- compensation for senior level executives of Article 43 not-for-profit corporations.

Based on the filing, the Department could accept, reject or modify the proposed rates.



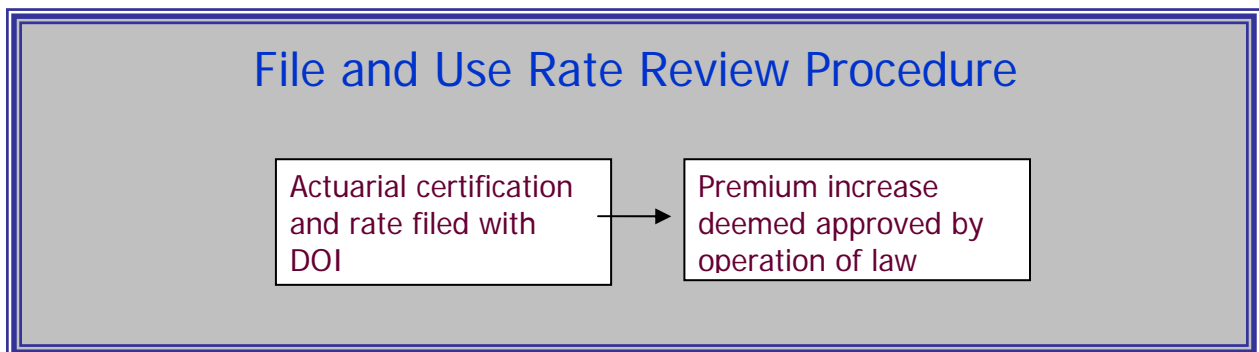
### C. File and Use

Effective January 1, 1996,<sup>2</sup> the Insurance Law was amended to allow health insurers to “file and use” premium increases for community rated contracts. The legislation contained a “phase-in” period from 1996-1999, allowing insurers to exercise file and use for premium increases up to 10%. Beginning on January 1, 2000, insurers could use file and use to implement premium increases of any size.

Under file and use, the Insurance Department does not review the actuarial assumptions and calculations before the rate increases go into effect. File and use essentially removes the Insurance Department from the rate review process, i.e., deregulates health insurance premiums.

The file and use process sets forth a “front end” rate application process and a “back end” review and refund process.

#### 1. File and Use Mechanics (1): “Front End” Filing.



The file and use laws allow health insurers to avoid submitting to the Department almost all of the information required under prior approval. Instead, health insurers can make premium rate adjustments as long as two requirements are met:

- **Minimum Medical Loss Ratio.** The insurer must state that, based on projected claims, the premium rate will meet the minimum medical loss ratios set forth in statute. The file and use law requires minimum loss ratio of 75% for small group policies and 80% for direct pay and Healthy New York policies.
- **Actuarial Certification.** An actuary must certify “that the health insurer is in compliance with the [law], based upon that person’s examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the corporation in establishing premium rates.” (Insurance Law § 4308[g]; *see*

<sup>2</sup> File and use became effective for Article 43 (not-for-profit) corporations and HMOs in 1996; file and use became effective for Article 32 (for-profit) insurers in 1994. The for-profit insurers were not subject to the 10% cap applicable to not-for-profit insurers and HMOs from 1996-1999.

Insurance Law § 3231[e][2][a]). The insurer need not actually supply the underlying records or actuarial assumptions or methods, simply the certification.

Upon meeting these two filing requirements, the new premium rate is “deemed approved” and the insurer may begin charging that new rate with 30 days notice to enrollees.

## **2. File and Use Mechanics (2): “Back End” Refunds**

Because actual claims experience may turn out to be different than the projected claims experience initially used to justify the premium increase on the front end, the file and use laws may require a refund to be made on the “back end.” By May 1 following the applicable year, insurers must file a loss ratio report based on claims incurred up to that point, plus reserves set aside for IBNR claims. If the health plan’s experience has failed to meet or exceed the minimum loss ratio based on the loss ratio report -- i.e., the benefits paid out are less than 75% (for small group policies) or 80% (for individual and Healthy New York policies) of premiums -- the health plan must refund members an amount sufficient to make up for the deficiency.

Insurers are required to issue the refunds to enrollees by September 30 following the May 1 loss ratio report. Consequently, refunds may be issued up to 21 months after the rate increases actually went into effect.

For example: an insurer files with the Department a premium rate increase for a small group policy in November 2006, with a projected loss ratio of 77%. The increase is deemed approved and goes into effect January 1, 2007. On May 1, 2008, the insurer submits a loss ratio report to the Department stating that the loss ratio (based on actual claims incurred plus IBNR claims) is 73%. By September 30, 2008, the insurer must refund enrollees 2% of premiums to make up for the overpayment of premiums.

Between 2000 and 2007, insurers self-reported approximately \$48 million in refunds.

## **3. Markets Subject to File and Use**

File and use applies to the four community rated markets in New York State:

- *Individual Direct Pay Market* is made up of individuals who purchase insurance for themselves or their dependents without contribution from employers. All HMOs are required to offer community rated individual direct pay policies with comprehensive, standardized benefits. Commercial insurers (as opposed to HMOs) are not required to offer individual policies, but if they do, those policies must be community rated. The individual direct pay market had approximately 57,000 enrollees as of 2007, down from 100,000 in 2004.
- *Small Group Market* consists of sole proprietors and employers with 2 to 50 employees. This market had an enrollment of approximately 1.7 million in 2007. Approximately 79% of uninsured New Yorkers are workers and their dependents. Of the

working uninsured, 39% work for firms under 25 employees and 13% work for firms of 25 to 99 employees.

- *Healthy New York* is a program for small businesses with at least one-third of their employees earning less than \$36,500 annually, and individuals and sole proprietors earning less than 250% of the Federal Poverty Level. All HMOs are required to offer Healthy New York plans with standardized benefits that are less comprehensive than the individual direct pay markets. Healthy New York's enrollment was approximately 148,000 in 2007.
- *Medicare Supplement Insurance* is privately purchased health insurance that is designed to supplement Medicare. In New York, Medicare supplement insurance is available to applicants enrolled in Medicare whether by reason of age or disability. Applicants must be accepted at all times throughout the year, and the products are community rated. As of January 2008, approximately 324,800 people were insured under individual and group Medicare supplement insurance plans.

### **Community Rating/Open Enrollment.**

New York adopted a mandatory system of community rating and open enrollment in the individual and small group health insurance markets as of April 1, 1993. Community rating was subsequently extended to Healthy New York.

Under community rating, premium rates must be the same (with minor adjustments for variations in benefits) for all policyholders of substantially similar contracts, without regard to age, gender, health status, or occupation. Open enrollment requires insurers and HMOs to accept all applicants without regard to health history or current health status.

Prior to the adoption of community rating and open enrollment, commercial insurers were able to insure only the healthiest, least costly individuals and small groups. By eliminating the ability of certain insurers to deny coverage to selected individuals or businesses, the law was designed to provide greater access to health insurance markets. And by requiring that premium rates be the same for all individuals or groups under substantially similar policies, the risk of the group would be spread over a larger population, thus making the coverage, on the whole, more affordable for everyone.

Recognizing the vulnerability of these three markets, the State established two mechanisms (in addition to community rating) to help keep rates affordable. The individual direct pay and Healthy New York markets are subsidized by State HCRA funds through a stop

loss mechanism. From 2000 to 2008, the State's total subsidy for direct pay and Healthy New York will have been approximately \$826 million. (In 2009, the stop loss mechanism will be funded through assessments on insurers.) The State also established a Market Stabilization Pool whereby claims costs in the individual direct pay and small group markets are spread among the insurers offering them. These two mechanisms are intended to help keep rates lower and prevent spikes in premium rates that might drive people to cancel insurance coverage.

#### **4. Judicial Entrenchment**

In 2002, the Insurance Department attempted to interpret the Insurance Law broadly to allow the Department to conduct an "enhanced review" on the front end and to disapprove direct pay individual policy rate increases that were "excessive, inadequate or unfairly discriminatory." The New York Court of Appeals struck down the Department's interpretation, finding that the file and use laws clearly state that the rate increase is "deemed approved" if the minimum loss ratio and actuarial certification requirements are met. (*Excellus v Serio*, 2 NY3d 166 [2004]). Consequently, under file and use, even if the Superintendent can prove that the filed rate calculation submitted by the insurer was excessive, inadequate or unfairly discriminatory, the Department is powerless to prevent the rate from being implemented.

## **II. File and Use in Practice: Deregulation Not Working**

File and use has been in place for more than twelve years. During that time, it is evident that file and use is not working for the following reasons:

- **Health insurers have failed to self-regulate.**
- **File and use hinders Insurance Department enforcement of the law.**
- **File and use increases the number of uninsured.**
- **File and use undermines the most vulnerable insurance markets.**
- **Insurers' profits have increased under file and use while health insurance has become less affordable for small businesses and individuals.**

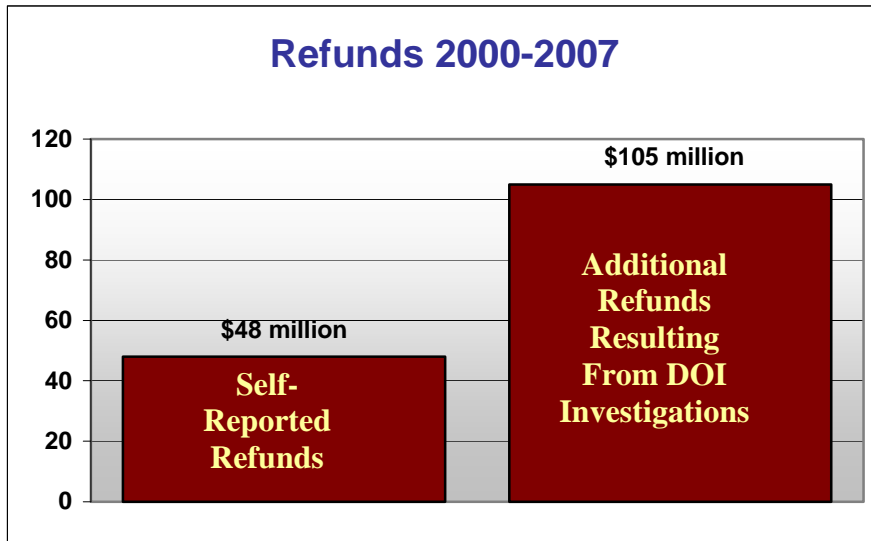
### **A. Health Insurers Have Failed to Self-Regulate.**

Although file and use is intended to be an objective, efficient mechanism to implement rate increases, it is based on the assumption that insurers will act in good faith and self-police. Insurance Department investigations have shown that this assumption is flawed.

Under prior approval (1990-1995), the Department found that **24%** of premium rates submitted by health plans were excessive. Under file and use (1996-2007), health plans self-reported excessive rates only **3%** of the time (i.e., plans found their premium rates were too high because the loss ratio did not meet the statutory minimum loss ratio requirement).

Health insurers have also been deficient in issuing refunds, which is the supposed self-policing mechanism of file and use. Between 2000 and 2007, insurers self-reported approximately \$48 million in refunds. Department investigations, however, revealed improper rate calculations that resulted in over \$105 million in refunds to enrollees -- *in addition* to those required under file and use. Therefore, the file and use mechanism not only allowed

inappropriate rate calculations to be implemented, but it also resulted in inadequate refunds to correct those inappropriate rates.



### Additional Refunds Following DOI Investigation

- Oxford Health Insurance	- \$ 50 million (2008)
- Empire	- \$ 25 million (2005)
- Excellus	- \$ 15.3 million (2006)
- HealthNow	- \$ 11.3 million (2004)
- Healthy NY (3 insurers)	- \$ <u>3.1 million</u> (2008)
<b>Total</b>	<b>\$104.7 million</b>

**Oxford Health Insurance (\$50 million additional refund)** During 2006 and 2007, Oxford included in its small group loss ratio calculations over \$50 million in payments that were supposed to be made into the market stabilization pool. Oxford, however, never made those payments. Nonetheless, by including these payments in its accounting, Oxford increased its medical loss ratio from 70.3% to 75.1% in 2005 and from 70.6% to 75.0% in 2006 (the minimum medical loss ratio for small groups is 75%), thus avoiding having to pay refunds under the file and use law.

Oxford did not explicitly mention the “payments” when it filed its front end rate increase application and anticipated loss ratio under the file and use statutes. It informed the Department later, as it was finalizing its back end loss ratio report from which refunds are calculated. Upon investigation, the Department determined that including the payments in Oxford’s “front end” premium filing was improper and should not be included in its “back end” loss ratio report.

Oxford agreed to recalculate its loss ratio for 2006 and 2007 resulting in \$50 million refunds to policyholders.

**Empire (approximately \$25 million additional refund)** From 2002 to 2004, Empire submitted its loss ratio reports without reflecting payments that it received from the market stabilization pools on Medicare Supplement Insurance. No refunds were due under Empire's initial loss ratio report. Once the stabilization pool payments were determined, Empire included them in the medical loss ratio calculations and agreed to pay approximately \$25 million in refunds based on the recalculations.

**Excellus (\$15.3 million additional refund)** From 2000 to 2004, Excellus submitted loss ratio reports indicating refunds of \$9.9 million. Upon investigation, the Department determined that Excellus had systematically overstated claim reserves. By so doing, Excellus was able to increase its medical loss ratio, thereby decreasing refunds due to policyholders. After a full scale review by the Department, Excellus agreed to pay \$15.3 million in additional refunds to impacted policyholders.

**HealthNow (\$11.3 million additional refund)** From 2000 to 2004, HealthNow submitted loss ratio reports which overstated its claim reserves and combined blocks of business. Overall for these years, HealthNow indicated no refunds in its initial reports. Based on a full scale review by the Department starting in 2004, HealthNow agreed to refund \$11.3 million to impacted policyholders. The Department's review took two years to complete.

**Healthy New York** In 2007, the Department investigated the loss ratio reports of various Healthy New York plans. Recall that Healthy New York program provided direct state subsidies to insurers for the express purpose of making the plans affordable for small businesses and low-income working families.

- HIP Health Plan had mistakenly used a 75% loss ratio in calculating premiums for 2006 and overstated its reserves at the end of 2005. After recalculating the loss ratio for those two years, HIP paid approximately \$1 million in refunds to enrollees.
- MVP Health Plan simply failed to submit a loss ratio report for its Healthy New York contracts and, after Department investigation, agreed to refund \$2,063,080 to enrollees.
- Atlantis Health Plan also failed to submit any loss ratio report. Department investigation determined that Atlantis had not properly calculated stop loss reimbursements, resulting in a \$58,289 refund to enrollees.

File and use laws prevented the Department from discovering these problems before the initial rates went into effect. Had the Department had prior approval authority, these problems most likely could have been avoided, enrollees would not have been overcharged premiums, and members who could not afford the premium increase would not have had to cancel their policies

## **B. File and Use Hinders Insurance Department Enforcement.**

The Department's investigations into health plans' premium increases are, by statute, after the fact. The law puts insurers' premium calculations into a black box that the Insurance Department cannot look into until after the rate goes into effect. Premium increases are "deemed approved" by operation of law, whether or not the underlying calculations are appropriate or inappropriate, excessive, inadequate or unfairly discriminatory – or even mathematically correct.

Also, during the course of the year, insurers may change their cost structure and accounting practices as the loss ratio develops, allowing insurers to tweak their medical loss ratio calculations as the year develops. But the Insurance Department cannot see or track these practices under file and use. Essentially, file and use allows an insurer to decide on the magnitude of a rate increase first, and then develop the assumptions needed to comply with the law.

Specific examples of loopholes under file and use include the following.

### **1. Overstating Reserves**

The "back end" loss ratio report is based on claims incurred plus IBNR claim reserves. IBNR claims occur when, for instance, an enrollee went to the doctor during the applicable year, but the claim was not processed at the time the loss ratio report had to be submitted. For the loss ratio report, insurers must estimate IBNR claims and set aside reserves to cover those projected costs.

File and use, however, allows insurers to estimate the IBNR claims without regulatory oversight, thereby allowing insurers to "pad," or overstate, the reserves set aside for those claims. This effectively increases the medical loss ratio contained in the loss ratio report, which in turn can allow an insurer to avoid paying refunds.

For example, at the end of a year (December 31), the insurer estimates the medical loss ratio for a particular policy will be 73%, which would require the insurer to issue a refund. But if the insurer overstates the IBNR claims in the loss ratio report, it can increase its medical loss ratio to the statutory minimum of 75%, thus avoiding refunds.

Insurers have persistently overstated reserves based on IBNR claims. While superficially prudent, this practice clearly frustrates the ability of the Department to enforce file and use regulations. The chart below compares health plans' initial reserve statements (based on actual claims information plus IBNR projections) versus their restated reserve statements (based on actual claims information after all or most of the claims have been received by the health plan). The initial reserve statements have been consistently overstated by 9% to 20%.

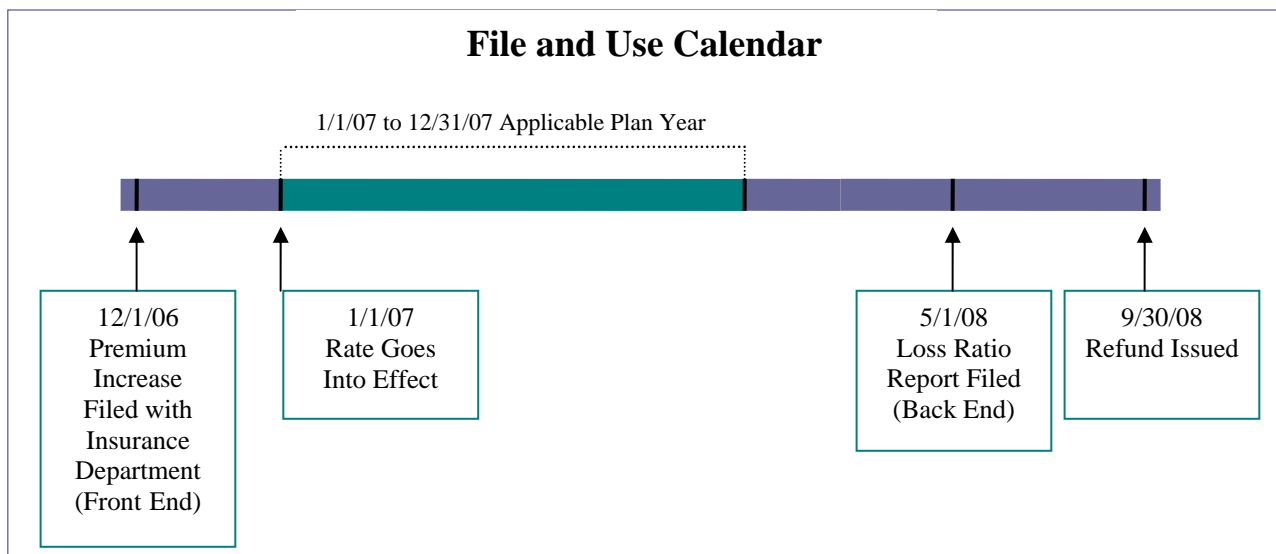
RATIO OF STATEMENT RESERVES (ACTUAL CLAIMS PLUS IBNR CLAIMS) TO RESTATED RESERVES (ACTUAL CLAIMS)	
12/31/2000	109.0%
12/31/2001	114.1%
12/31/2002	115.4%
12/31/2003	109.5%
12/31/2004	121.7%
12/31/2005	113.8%
12/31/2006	108.4%

## 2. Improperly Combining Community Rated Policies

Under community rating, the claims experience of substantially similar policies is pooled together to determine the medical loss ratio of the entire pool. This allows insurers to average both high and low medical loss ratios in order to meet the statutory minimum medical loss ratio. While this may be beneficial to the members of the community rated pool as a whole, it can also be subject to improper manipulation if the carrier creates the pools opportunistically. File and use, however, prevents the Insurance Department from reviewing not only how the insurer developed the overall community rate, but how the insurer priced each policy within the community pool and how the insurer averaged the rates of those individual policies.

### C. File and Use Increases the Number of Uninsured.

The “back end” refund mechanism is intended to compensate policyholders for excessive premiums. Under file and use, however, insurers must pay refunds only to those consumers who remain policyholders when the refund is issued. Policyholders are not eligible to receive a refund if they cancel their coverage any time prior to the date the refund was issued. Furthermore, refunds do not have to be paid until September 30 following the applicable year – up to 21 months after the rate increase actually went into effect.



Consequently, if an individual or small business cannot afford a premium increase and has to cancel their coverage, they are not entitled to a refund. The “self correcting” cure for the unjustified premium increase is no correction at all for those who are affected most drastically by the rate increase. Even if enforcement loopholes could be reduced, the refund mechanism will always suffer from a classic case of “justice delayed is justice denied.” Therefore, under file and use, an unjustified rate increase can result in an unjustified loss of health insurance coverage.

**D. File and Use Undermines the Most Vulnerable Insurance Markets.**

File and use applies to four community rated markets: individual direct pay, small group, Healthy New York and Medicare Supplement insurance (Medigap). Each of these markets serves populations where affordability is an issue. The individual direct pay market guarantees comprehensive benefits and is expensive. The small group market is made up of small employers who have a hard time affording premium increases and often cannot afford to offer their employees any health insurance coverage at all. (As noted above, 79% of the uninsured were workers and their dependents. Of those uninsured, 39% worked for firms of under 25 employees and 13% worked for firms of 25 to 99 employees.) And Healthy New York was explicitly created for individuals with lower incomes.

Because of the importance and vulnerability of each of these markets, New York State provides hundreds of millions of dollars in subsidies. From 2000 to 2008, the State’s total subsidy for direct pay and Healthy New York was approximately \$826 million. The individual direct pay and small group markets have access to the Market Stabilization Pool to help keep premium rates level. These markets are also community rated, which enlarges the risk pool, thereby helping decrease premium rates.

Yet under file and use, rate increases have risen dramatically and remain between 10% and 15% per year.

The bottom line is that premium increases have been significantly higher since the 10% annual cap was lifted in 1999.

<b>Average Rate</b>			
<b>Per Year from:</b>	<b>Large Group</b>	<b>Small Group</b>	<b>Direct Pay</b>
1996 to 1999	5.08%	5.22%	7.59%
2000 to 2008	13.10%	13.96%	14.92%

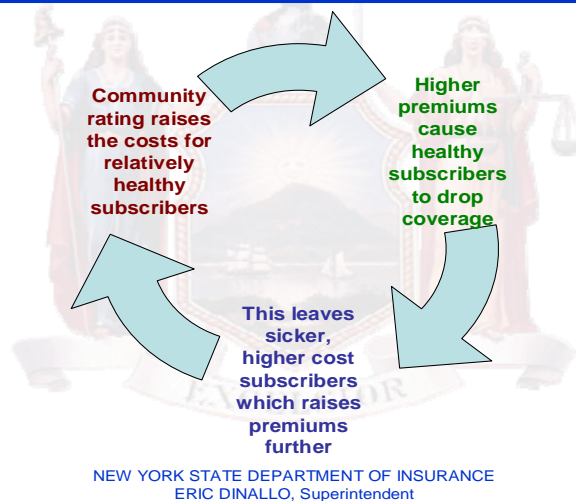
And, as Insurance Department investigations have shown, some of these rate increases have been based on improper rate calculations. File and use has made community rated policies *less* affordable than they would have been if the Insurance Department could have reviewed the rates before they were implemented. File and use is working in opposition to New York State’s efforts to help these markets. While New York is trying to increase health coverage, file and use premium rates decreases health coverage.

## HMO Direct Pay Market “Death Spiral”

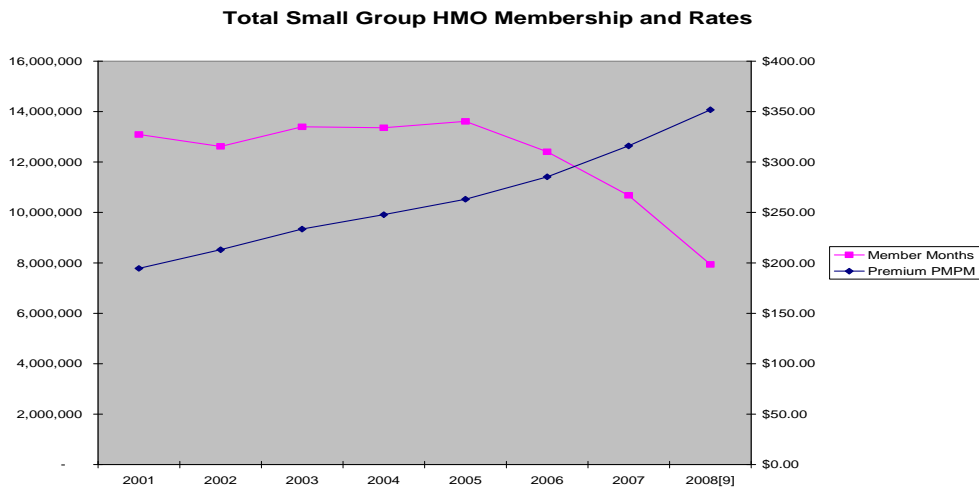
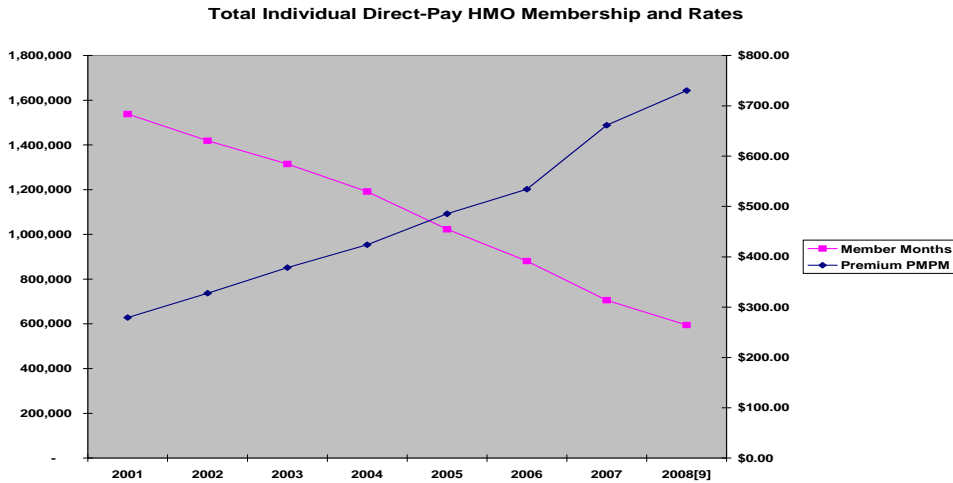
The problems with file and use are particularly pronounced in the HMO individual direct pay market. This market is in a “death spiral” of adverse selection, in part due to file and use rates that have allowed some carriers to effectively exit the market. The premiums are high, so healthy people drop coverage, which leaves less healthy people in the risk pool, which results in higher medical costs, which results in higher premiums, which drives out healthier people, etc., etc.

## Adverse Selection “Death Spiral”

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The premiums continue to rise despite State subsidies and the Market Stabilization Pools. Nonetheless, under file and use, these premiums are “deemed” appropriate, and the Department is powerless to review rate increases, even though this market is in the throws of dysfunction. As premiums have increased dramatically, membership has decreased dramatically as well



The death spiral of the individual direct pay market is unsustainable. But file and use has left the Insurance Department without any regulatory authority to try to help it. Meanwhile, the insurance companies and HMOs continue to be profitable.

**E. Insurers' Profits Have Increased Under File and Use While Health Insurance Has Become Less Affordable for Small Businesses and Individuals.**

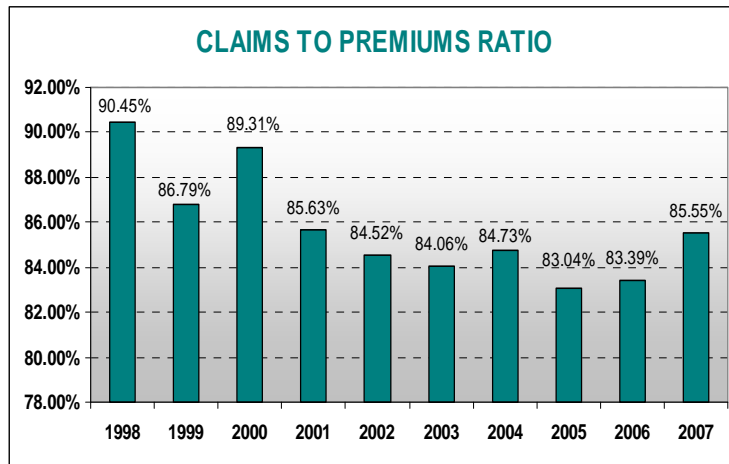
As health insurance has become more expensive and insurers have implemented rate increases under file and use, the financial well being of insurers has improved significantly. While robust profits and surplus are not illegal, they are an indicator of the unsustainable health insurance rate increases. Certainly, underlying medical trend (the cost of doctors, hospitals, drugs and other services) are a primary cost-driver. Nevertheless, large profits and excess surplus do add substantial costs to premiums that have been at least partially responsible for the erosion of employer-based coverage and have made coverage prohibitively expensive for individuals without employer-based coverage.

Increased insurer and HMO profits under file and use can be measured by (1) profits as a percentage of premiums, (2) dividends issued to parent holding companies, (3) the ratio of

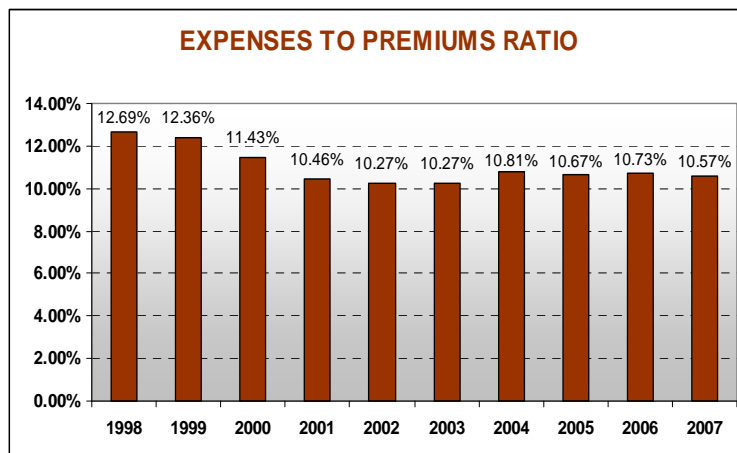
liabilities to assets, and (4) the amount that actual net worth of insurers exceeds the statutory minimum net worth.

### 1. Profits as a Percentage of Premiums Have Increased

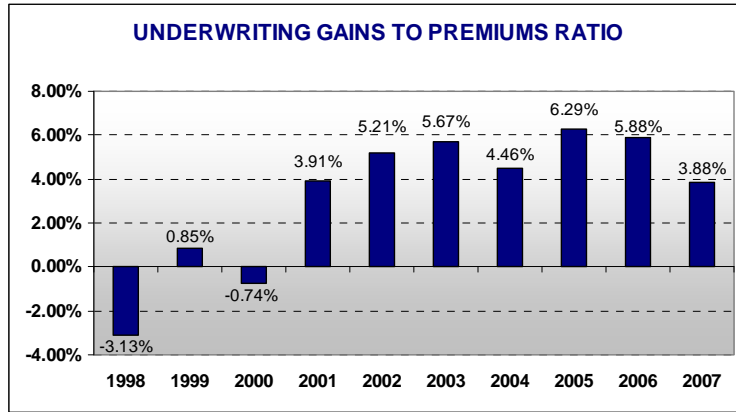
Premiums have steadily increased. But the ratio of claims to premiums has generally decreased, thereby leaving a larger piece of the pie (percentage of premiums) for the insurer to keep for expenses and profits.



Less and less premium has gone to expenses.



Therefore, profits, as a percentage of premiums, have been consistently high.



File and use has caused the premium pie to grow bigger and bigger, which allows insurers' piece to get bigger and bigger too.

## 2. Dividends Have Increased.

The profitability of health insurers under file and use is also apparent in the large amount of dividends that New York Insurers have sent to publicly traded parent companies.<sup>3</sup> In 2008 alone, insurers released dividends of almost \$1 billion.

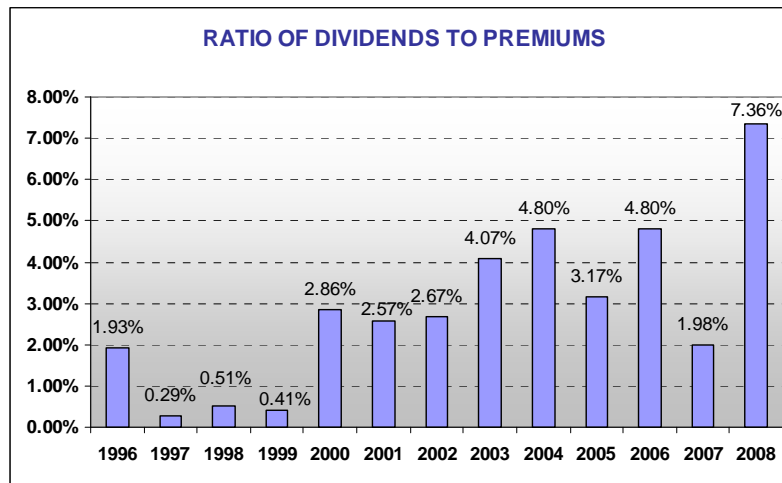
<u>2008 Health Plan Dividends</u>	
- Oxford (HMO)	- \$500 million
- Empire	- \$400 million
- Aetna (HMO)	- \$48 million
<b>Total</b>	<b>\$948 million</b>

<sup>3</sup> Some of the dividends were issued to the insurer's parent corporation, not directly to stockholders. For instance, Empire's 2008 dividend resulted from a release of accumulated surplus associated with Empire losing the New York State Health Insurance Plan (NYSHIP) contract for pharmacy benefit management services. Under the NYSHIP contract, Empire had to maintain a higher level of reserve cushion to reflect the added risk associated with providing the pharmacy benefits. When it lost the contract, those excess reserves were no longer needed and were therefore returned to the parent company for use elsewhere. The Insurance Department has no jurisdiction over the ultimate disposition of the "upstream" dividends by out-of-state corporations, whether via dividends to shareholders, repurchase of stock or for other corporate purposes.

Since 1999, over \$5 billion in dividends have been issued industry wide.

<b>TOTAL DIVIDENDS (ART. 44 AND ART. 42 COMPANIES COMBINED)</b>	
1999	\$115,000,000
2000	403,864,567
2001	286,900,000
2002	603,939,600
2003	647,042,239
2004	695,994,351
2005	691,400,000
2006	507,648,734
2007	501,000,000
2008	948,000,000
<b>TOTAL</b>	<b>5,400,789,491</b>

The ratio of dividends to premiums has also increased dramatically, again illustrating that insurers are taking a bigger and bigger piece of the pie for themselves.



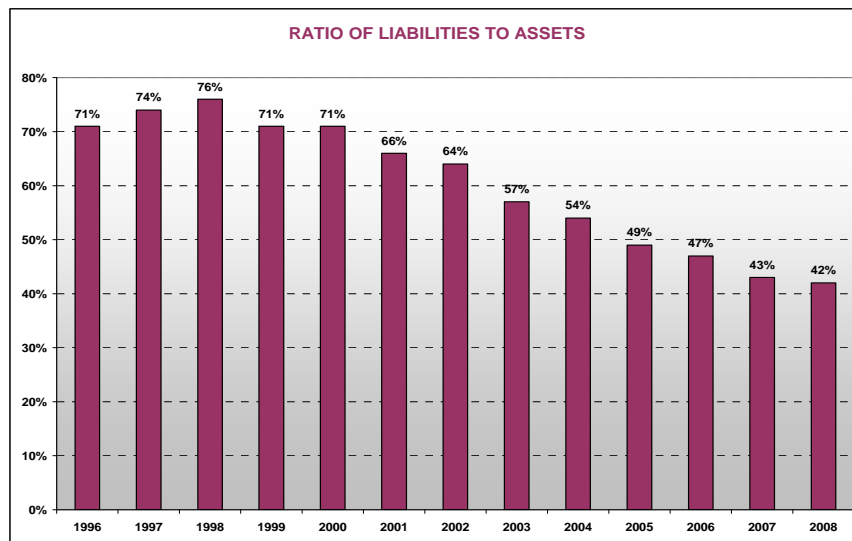
Dividends and profits are dollars being taken from subscribers and providers, and distributed to investors. At a time when the number of uninsured is increasing and premiums are increasing, distributing profits as dividends does not increase affordability of health insurance coverage. File and use, with the lack of regulatory oversight, has contributed to the draining of the health care system at the expense of those whom it was intended to benefit – the insured’s, not the insurers.

**Superintendent’s Limited Authority to Disapprove Dividend Requests.** The Superintendent’s authority to disapprove health insurers’ dividend requests is very limited. The Superintendent must approve dividend requests if he or she finds “that the insurer will retain sufficient surplus to support its obligations and writings.” (Insurance Law §4207[b][1]). Basically, so long as a health plan is solvent, can pay claims and covers its other financial obligations, it can issue dividends of any size. Like premium increases under file and use, the Department has scant authority to make sure money is not pulled out of the health care system in the form of health plan profits.

### 3. Ratio of Liabilities to Assets Has Decreased

While medical loss ratios are a measure of each insurance policy, an analogous measure, the ratio of liabilities to assets, can be used to measure the overall financial health of insurers. Liabilities mainly include claims reserves, general expenses due and accrued, and amounts due to parent corporations and affiliates. Assets mainly include cash and investments, amounts receivable, and premiums in course of collection.

Industry wide, the percentage of insurers’ liabilities has decreased, while the percentage of assets has increased. The declining ratio means that assets have been growing much faster than the liabilities since 2000 (when the 10% cap on file and use applications was lifted), and therefore the net worth of the companies has been growing.



The next table shows that the growth in the net worth has been far in excess of the growth in the minimum regulatory net worth.

**4. Actual Net Worth Has Significantly Exceeded Statutory Minimum Net Worth.**

Minimum net worth requirements are set forth in statute as a measure of solvency. Insurers' actual net worth, however, far exceeds the statutory minimums. Therefore, insurers have been accumulating more assets than the statute requires. While increased assets protect policyholders against unforeseen events, excessive surplus does not necessarily inure to the benefit of policyholders, particularly if those excess assets are dividended out to stockholders or parent corporations.

**ACTUAL NET WORTH vs. STATUTORY MINIMUM NET WORTH  
TOTAL ARTICLE 43 INSURERS AND HMOS:**

<b>Year</b>	<b>Net Worth</b>	<b>Minimum Regulatory Net Worth</b>	<b>% Actual/Required</b>
1996	1,082,119,698	794,918,953	136%
1997	1,126,654,948	901,010,584	125%
1998	1,052,293,268	962,947,124	109%
1999	1,370,332,155	1,089,169,414	126%
2000	1,634,993,697	1,316,451,683	124%
2001	1,985,534,073	1,443,829,688	138%
2002	2,569,859,523	1,638,718,523	157%
2003	3,372,420,201	1,720,305,922	196%
2004	3,866,548,664	1,870,597,057	207%
2005	4,730,873,239	2,010,768,299	235%
2006	5,610,648,690	2,337,945,074	240%
2007	6,434,034,713	2,574,051,101	250%
2008	6,761,187,636	2,631,671,267	257%

As premiums increase, insurers increase their profits and their share of the premium pie, issue larger and larger dividends, and increase their assets and net worth. File and use, meanwhile, prohibits the Insurance Department from balancing premiums, profits and administrative expenses to ensure rate increases are appropriate and fair.

### **III. Reinstating Regulatory Oversight of Rate Increases Better Protects the Public.**

Given the foregoing, file and use is inadequate to protect New Yorkers from excessive premium increases. Reinstating the Superintendent's authority to subject health insurance premium rate filings to regulatory scrutiny before the rates go into effect avoids the pitfalls of file and use.

**A. Prior Approval Does Not Rely On Self-Policing By Plans.** Reliance on self-policing under file and use has had limited success. Health plans self-reported excessive rates only 3% of the time (i.e., plans found their premium rates were too high because the loss ratio did not meet the statutory minimum loss ratio requirement), while the Insurance Department found that 24% of premium rates submitted by health plans were too high under prior approval (1990-1995). Furthermore, insurers self-reported only \$48 million in refunds between 2000 and 2007, whereas Insurance Department investigations resulting in \$105 million in additional refunds during that same time period. As such, self-policing resulted in incomplete compliance and deficient consumer protection.

Prior approval, on the other hand, will result in better compliance and better consumer protection. Prior approval will allow the Department to find inappropriate and excessive rate increases *before* they go into effect. Consumers will be less likely to receive a bill based on insurers' miscalculations or excessive rates. Under prior approval, the Insurance Department will use objective criteria to review rates before they are increased and will not rely on insurers to police themselves.

**B. Prior Approval Avoids Creating Unnecessarily Uninsured.** Even if the Insurance Department could close all of the loopholes in file and use and even if self-policing somehow resulted in full refunds, file and use would still have a fatal flaw: the "back end" refund mechanism is not available to policyholders who cancel their coverage. Therefore, if an excessive rate causes a policyholder to cancel their coverage, that policyholder will not receive a refund, much less have their coverage reinstated. If that rate should not have been charged in the first place, that policyholder would be unnecessarily uninsured. In this regard, file and use is a classic case of "justice delayed is justice denied."

Prior approval will allow the Insurance Department to ensure rates are correct *before* they go into effect, preventing policyholders from becoming unnecessarily uninsured. In today's economic climate, with employers finding it more and more difficult to afford health benefits for their employees, the certainty, predictability and reliability provided by prior approval will become increasingly important.

**C. Prior Approval Allows Regulators to Protect Vulnerable Markets.** The markets subject to file and use – individual direct pay, small group, Healthy New York and Medicare supplemental insurance – are New York State's most vulnerable markets. File and use, however, with its insufficient self-policing and inadequate refunding mechanisms, undermines those markets and contravenes the State's efforts to support those markets.

The Insurance Department can help prevent inappropriately excessive rate increases in direct pay and other vulnerable markets, limiting the adverse selection death spiral. Also, prior

approval will help ensure that State subsidies of the direct pay market and Healthy New York achieve full value in the markets for which they were intended.

**D. Prior Approval Creates More Regulatory Certainty.** Ambiguities and loopholes in the file and use laws will be clarified under prior approval, creating greater predictability and regulatory certainty, both for insurers and consumers. Insurers and the Insurance Department will be able to resolve disputes or problems with rate applications before excessive rates are charged to consumers. Because rates will not be increased in a “black box,” the Insurance Department can enforce excessive rate setting better both before and after premiums are increased. The current loopholes will be more difficult for health plans to exploit.

**E. Prior Approval Protects Against Insolvencies.** As noted above, the Governor’s current legislative proposal allows the Department to approve rates with medical loss ratios less than the statutory minimum to ensure the solvency of insurers. This helps the Insurance Department fulfill its primary function of ensuring solvency of all insurers. Prior approval would not increase insolvencies. To the contrary, prior approval would allow the Department to exercise its full regulatory authority to safeguard the financial condition of all insurers, which in the end, is to protect consumers by making sure the insurer retains enough money to pay out on all claims as required under the consumer’s insurance contract.

**F. Nearly Half of All States Have Prior Approval.** Some 24 states currently have some form of prior approval of health insurance rates (see Appendix 2).

## **Conclusion**

File and use has not worked. Insurers have failed to self-police to the fullest extent, resulting in excessive premium increases, incomplete refunds and deficient consumer protection. File and use has undermined the vulnerable markets it was intended to serve.

Prior approval will allow the Insurance Department to examine rate increases before they go into effect, ensuring that they are fair and objective and that consumers do not become unnecessarily uninsured. Health insurance is too important to leave to deregulation.

**APPENDIX 1**

Governor's Legislative Proposal (A.8280 / S.5470)

## APPENDIX 2

### STATES WITH PRIOR APPROVAL (reprinted with permission from Families USA)

	INDIVIDUAL MARKET	SMALL GROUP MARKET	OTHER HEALTH INSURANCE MARKET
Alaska			Nonprofit Cross Blue Shield plans
Arkansas	✓		
Colorado <sup>a</sup>	✓	✓	
Connecticut	✓	✓	Medicare supplemental policies are reviewed prior to premium rate increases.
Florida	✓	✓	
Georgia	✓ (some products)	✓ (some products)	
Hawaii			All managed care products
Indiana	✓	✓	
Iowa	✓		
Kansas	✓	✓	
Maine	✓	✓	
Maryland	✓	✓	
Michigan	✓		Nonprofit Blue Cross Blue Shield plans and HMO's
Minnesota <sup>b</sup>	✓	✓	
Mississippi <sup>c</sup>	✓	✓	
Nevada	✓		HMOs
New Hampshire	✓	✓	
New Mexico	✓	✓	
North Carolina	✓		
North Dakota	✓	✓	
Ohio	✓ (some products)		
Oklahoma		✓	
Oregon	✓	✓	
Rhode Island	✓	✓	
South Carolina	✓		
South Dakota	✓		
Tennessee	✓	✓	
Texas			Any increase in excess of 50% over a 12 month period requires actuarial justification to be filed. Initial rates and rate increases are filed for approval for Medicare supplemental coverage.
Vermont	✓	✓	
Virginia	✓		Medicare supplemental and long-term care insurance
Washington	✓	✓	
Wisconsin	✓	✓	

<sup>a</sup> Colorado's legislature enacted a law in May 2008 that introduces prior approval to the individual and small group markets. The bill passed too late to be reported in Failing Grades: State Consumer Protections in the Individual Health Insurance Market.

<sup>b</sup> Minnesota regulators report that, although the law does not require carriers to submit rates for approval prior to using them, all insurers in fact submit rates to the Department of Insurance and wait for its approval. According to regulators, this is in part because the rate bands and restrictions are complicated, but also because the carriers would like to avoid the public embarrassment of correcting rates after imposing them because they are adjusted or disapproved by regulators.

<sup>c</sup> According to state regulators, Mississippi is a prior approval state. However, statutes and regulations appear to limit regulators' review and approval powers.