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CURRENT DEVELOPMENTS IN HEALTH INSURANCE RATE REGULATION

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In the past year at least four states, California, Colorado, Georgia and Washington, introduced legislation to require the prior approval of health insurance rates.**1** In connection with implementing price controls on rates, these laws often create new reporting requirements to increase so-called "transparency" of health insurance expenditures. The apparent goal of those sponsoring the legislation is to make health insurance more affordable and thereby decrease the number of uninsured. However, several studies indicate that adding additional layers to existing regulatory oversight in this manner is unlikely to achieve lower premiums for consumers or give consumers the information that will assist them in making knowledgeable, appropriate choices regarding their health care.

OVERVIEW OF RECENT STATE LEGISLATION PROPOSING PRIOR APPROVAL OF HEALTH INSURANCE RATES

In 2007, legislation introduced in California would have required health plans and health insurers licensed by the California Department of Managed Health Care and the California Department of Insurance to file rate increases 60 days prior to implementation.**2** The sponsor of the bill stated the law was "necessary to control health care premium increases that outpace general and medical inflation," and "health plan overhead, including administrative costs and profits, contributes to high costs."**3** In addition to implementing prior approval for rate increases, the legislation sought to elicit financial information such as average rate per enrollee, overhead, loss ratio, reserves, medical expenses, salaries, and bonuses.**4** The legislation failed to pass out of the legislature.

Colorado's Legislation "Concerning Increased Oversight Of Insurance Rates" (a.k.a. "Fair Accountable Insurance Rates"), as introduced, would require health and automobile insurance rate filings that propose a rate increase to be made 60 days prior to implementation.**5** The commissioner of insurance could disapprove the rates "for good cause" after the 60 days expired. Additionally, any rate filing increases filed between March 1, 2007, and January 1, 2009, would be subject to review and disapproval on a retroactive basis.**6** The bill would also require insurers to report whether the proposed rate increase was attributable to an increase in a lengthy list of costs.**7** The bill provides standards for the commissioner to consider during a rate review, including "benefits ratios," and creates a private right of action against insurers who violate the rate filing law.**8** The bill is intended to "require insurance companies to justify their rate increases, giving the Division of Insurance the right to take into account incidence of claims, surplus reserves and other financial factors," and provide "a full financial picture" of insurers.**9** The sponsor stated, "by requiring private insurers to justify proposed increases . . .companies are likely to bring down or at least slow the rate of premium increases that have forced thousands of people to drop insurance coverage in recent years."**10** An amended version of this bill, applying only to heath insurance rates, was signed into law on June 6, 2008 and becomes effective July 1, 2008 for rates that go into effect after January 1, 2009.

In Georgia, Commissioner John W. Oxendine proposed legislation that would have required filing of health insurance rates 90 days in advance of use.**11** While the commissioner could approve the rate filing before the

expiration of 90 days, the commissioner would have the option to extend the review period for an additional 90 days.[12] This review period could conceivably continue indefinitely if the commissioner ordered an examination of a filing.[13] When the legislation was introduced, Commissioner Oxendine stated that, if enacted, the DOI would be "able to make sure insurance companies are held accountable when they file health rate increases" and would "be empowered to hold the line on increases, and make sure that health rates are in line with market realities."[14] The legislation failed to get out of committee.

The Governor of Washington signed legislation on April 1, 2008, that requires insurers to wait 60 days after filing to use rates or rate modifications for individual health plans.[15] The law also requires health plans to maintain a medical loss ratio of 74 to 77% depending on the declination rate. [16] Supporters of the law "hope the bill will put a brake on rising premiums."[17]

UNINTENDED CONSEQUENCES OF PRIOR APPROVAL AND TARGETED LOSS RATIOS

As noted above, in each of these states, the intended effect of the prior approval laws was to reduce or halt increases in health insurance rates. The proponents of the legislation assert not enough of premium dollars are being spent on health care, but instead are going to administrative costs, such as executive salaries, profits and allegedly to pay for computer software to deny claims.[18] Moreover, in an apparent effort to control the cost of insurance, these laws include loss ratio targets and seek disclosure of insurer expenditures. As will be discussed, studies and academic literature indicate that prior approval laws have been shown to result in higher costs, decreased availability and increased numbers of uninsured. Research also shows that insurer loss ratio levels are not an indicator of quality or efficiency of health care delivery. Finally, these legislative efforts are also unlikely to result in providing consumers with a better understanding of price and quality of healthcare providers.

Neither prior approval of health insurance rates nor targeted loss ratios deal with the real drivers of health costs and consequently such laws fail to control premiums in a meaningful manner. A discussion of the many components and factors affecting the cost and delivery of healthcare is beyond the scope of this article; however, many studies conclude that health costs are increasing due to increased utilization by consumers and due to advances in technology that drive provider rate increases.[19] National health insurers report that 79 to 80 cents of every health care dollar is currently used to reimburse doctors, hospitals and other providers for medical services.[20] Of the remaining portion of each dollar, 11 cents goes to administering health plans, 4 cents goes to taxes and 6 cents is profit, which goes to shareholders as dividends, is used for charitable giving and is reinvested in the business.[21]

An in-depth analysis of the impact of prior approval requirements for rate changes in California, by Mercer Oliver Wyman, concludes that prior approval, a form of price control, is likely to result in: higher premium prices, reduced access to health care services as a result of less competition, less consumer choice of insurance products and more uninsureds.[22] The study also examines the experience of three states that implemented rate restrictions on health insurers, Kentucky, Washington and New York. In each state, premiums increased, carriers abandoned the individual market, costs went up due to the long and expensive rate approval process and the uninsured population increased as purchase of individual insurance decreased.[23] Thus, delaying or blocking actuarially justified rate increases does not in the long run appear to provide consumers with more affordable health insurance.

Another method advocated to control rates involves targeted loss ratios. A loss ratio "measures the fraction of total premium revenue that health plans devote to clinical services, as distinct from administration and profit."[24] The argument for codifying targeted loss ratios is based on the theory that a low loss ratio suggests a health insurer is not directing enough of the premium dollar to health care and is instead directing the premium towards administration or profit.[25] This conclusion greatly oversimplifies the issue and disregards the benefits that can be provided to consumers through administrative expenditures, such as disease

management programs or anti-fraud efforts.[26] Importantly, because it is simply a ratio of spending to revenues, the medical loss ratio does not provide a clear picture of either medical or administrative expenditures or waste.[27] It also ignores the differences between and among indemnity and managed care companies and plans and gives no indication of quality.[28]

The demand for greater disclosure by health carriers of where the dollars are spent is connected to the call for targeted loss ratios. However, increased, and often redundant, reporting requirements will not inevitably provide greater understanding for consumers of health insurance. Regulators already mandate myriad reporting requirements for carriers, and they also collect information through existing mechanisms. Regulators conduct market and financial conduct exams of insurers to verify compliance with the laws enacted to protect consumers in their insurance transactions. Furthermore, information on numerous aspects of insurance company operations already exists. States such as Colorado require reporting of complaint ratios.[29] The state also publishes an annual insurance industry statistical report that includes information on assets, liabilities, capital and surplus, net/loss gain, market share percentage, loss ratios and premiums earned.[30] Regrettably, such data is not provided in a manner that is easy to understand or access. Increasing the amount of information available without placing it in a meaningful context will not solve the issue of transparency for consumers.

CONCLUSION

Implementing prior approval of health rates or mandated loss ratios will not result in lower insurance rates. Consumers will not benefit from knowing how much a carrier spends on defense litigation costs, lobbying efforts or shareholder dividends.[31] In the health care context, consumers want to know about prices and quality of providers. The challenge of reform should be on aggregating existing data in a format that is easy to locate and understand for all stakeholders, rather than increasing administrative costs related to oversight and compliance.[32]

Endnotes

1. California A.B. 07- 1554, Colorado H.B. 08-1389, Georgia H.B. 08-923/S.B. 08-380, Washington S.B. 07-5261.

2. California A.B. 07- 1554, § 1.

3. *See*, Bill Analysis, Comments available at: http://info.sen.ca.gov/pub/07-08/bill/asm/ab_1551-1600/ab_1554_cfa_20070515_162540_asm_comm.html(last visited Apr 16, 2008).

4. A.B 07-1554, *supra* note 2.

5. Colorado H.B. 08-1389, §§ 6 & 13.

6. *Id*.

7. *Id*.

8. *Id*. at §§ 7, 8 &, 13.

9. *See* Tim Hoover, Democrats Unveil New Health Bills, THE DENVER POST (Mar. 31, 2008), available at: http://www.denverpost.com/news/ci_8752374(last visited Apr. 16, 2008).

10. *See* Ed Sealover, Bills Add Insurance Rate Hike, Claims Oversight, THE GAZETTE (Mar. 31, 2008), available at: http://www.gazette.com/articles/insurance_34816___article.html/companies_health.html(last visited Apr. 16, 2008).

11. Georgia H.B. 08-923/S.B. 08-380, § 3.

12. *Id*.

13. *Id*.

14. Health Insurance Reform Legislation Will Hold Line on Rate Increases, THE FOREST BLADE, (Jan. 30, 2008), (copy on file with author).

15. 2008 Wa. ALS 303; 2008 Wa. Ch. 303.

16. *Id*. at §5, RCW 48.44.017; The law states: "‘Declination rate' for a health care service contractor means the percentage of the total number of applicants for individual health benefit plans received by that health care service contractor in the aggregate in the applicable year which are not accepted for enrollment by that health care service contractor based on the results of the standard health questionnaire administered pursuant to RCW 48.43.018(2)(a)."

17. *See* Kyung M. Song, Bill To Rein In Individual Health Plans Advances, THE SEATTLE TIMES (Mar. 15, 2008), available at: http://seattletimes.nwsource.com/html/politics/2004258291_insurance04m.html.

18. *See* Tim Hoover, *supra* note 9.; Bob Mook, Democrats Push For Health Care Reform, DENVER BUSINESS JOURNAL (Mar. 31, 2008), available at: http://www.bizjournals.com/denver/stories/2008/03/31/daily15.html(last visited Apr. 16, 2008).

19. *See* e.g. Health Care Costs: A Primer, Key Information on Health Care Costs and Their Impact, KAISER FAMILY FOUNDATION at 12. (Aug. 2007), available at: http://www.kff.org/insurance/upload/7670.pdf(last visited Apr. 17 2008); PricewaterhouseCoopers, Factors fueling Rising Health Care Costs 2006 at 9-11. (Jan. 2006) available at: http://www.ahipbelieves.com/media/The%20Factors%20Fueling%20Rising%20Healthcare%20Costs.pdf(last visited Apr. 17 2008).

20. *See* e.g. How Aetna Spends Each Health Care Premium Dollar, (2006/2007) on file with author.

21. *Id*.

22. Karen Bender & Beth Fritchen, Impact of Prior Approval Requirements for Rate Changes of Small Employer Group and Individual Health Policies, MERCER OLIVER WYMAN at 1. (Jan. 2004).

23. *Id*. at 19.

24. James C. Robinson, Use And Abuse Of The Medical Loss Ratio To Measure Health Plan Performance HEALTH AFFAIRS, Vol. 16, No. 4 (1997) at 176.

25. Id. at 178-179.

26. *See* J.P. Wieske, How High Loss Ratios Undermine Affordable Health Insurance, THE COUNCIL FOR AFFORDABLE HEALTH INSURANCE'S ISSUES & ANSWERS, No. 141 at 1-2, (May 2007).

27. James C. Robinson, *supra* note 24 at 178.

28. *Id. passim*.

29. C.R.S. § 10-16-409; See http://www.dora.state.co.us/pls/real/Ins_Comp_Ratio_Report.Home.

30. Available at: http://www.dora.state.co.us/insurance/pb/supporting%20documents/2006%20Stat%20Rpt.pdf

31. See Colorado H.B. 08-1389, § 6.

32. See James C. Robinson, supra note 24 at 186.