



Healthcare Association
of New York State

Testimony of the

Healthcare Association of New York State

before the

Assembly Standing Committee on Insurance

on

**Regulatory Approval of Health Insurance
Premium Rates**

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Joseph D. Morelle, Chair, Assembly Committee on Insurance

Thank you, Chairperson Morelle, for providing the Healthcare Association of New York State (HANYYS) the opportunity to testify before the Assembly Insurance Committee regarding regulatory approval of health insurance premiums. I am Jeffrey Gold, Vice President, Managed Care and Special Counsel. HANYYS represents more than 550 non-profit and public hospitals, health systems, nursing homes, and home care agencies throughout New York State.

Prior Approval

We are aware of legislative momentum for reinstating a prior approval standard for contemplated health care premium rate increases. Governor Paterson's proposed legislation, Program Bill #15 (A.8280, Morelle/S.5470, Breslin) would reinstate the prior approval process for the individual and small group market and give the State Insurance Department (SID) regulatory oversight over any proposed rate increase. We recognize that this bill was proposed in an effort to protect consumers from unaffordable premium increases and from potential losses of coverage when individuals and small businesses cannot afford such increases and drop coverage. However laudable that goal, we are concerned that the proposed prior approval mechanism is unwieldy, ineffectual, and will be unable to keep pace with fluid market conditions, particularly in this economic environment.

The Health Insurance Premium/Rate-Setting Process

Under current law, SID does not approve health insurance premium increases before they go into effect. Instead, health plans use a rate-setting procedure, often referred to as "file and use," where premium rate adjustments are "deemed approved" by the Superintendent of Insurance if the insurer seeking the increase meets certain statutory minimum loss ratio requirements and the

filing is accompanied by an actuarial certification of compliance. As we understand it, this process follows actuarial standards and guidance documents issued by SID. Rate increases are thereafter permitted if the health plan certifies that it will meet or exceed certain actuarially based “minimum loss ratio” (MLR) standards. MLR is the measurement of medical costs as a percent of premiums. The higher the ratio or percentage, the greater the amount of premium dollars spent on actual medical costs, i.e., payments to providers and consumers for medical services rendered. MLR is intended to be a method of ensuring more money is going to pay for medical care than is being retained as profit or used for administrative expenses.

If, however, a health plan is unable to certify that it will meet the MLR standards, then the premium rate adjustment is subject to prior approval. Additionally, after failing to certify that it can meet the MLR standards, the health plan must issue a dividend or credit to policyholders who have been overcharged by the plan. In other words, if premiums have been collected but the insurer has failed to pay out a sufficient amount toward medical claims, it is presumed that the premium was too high and a refund is due to policyholders. SID audits health plans to ensure compliance with both the loss ratios and the refund process.

Clearly, there are significant shortcomings in the current “file and use” process. HANYS would support enhancements of “file and use” standards to ensure that health plans are not able to manipulate their MLR and/or rate filings. We believe there is merit in standardizing the definitions and interpretations of medical costs, clarifying any terms that are currently ambiguous or open to exploitation, and enhancing enforcement authority against health plans that fail to meet their statutory or regulatory obligations.

Problems With the Proposed Return to Prior Approval

Under current law, the Superintendent of Insurance must approve premiums for all new small group and individual product offerings. As we stated above, health plans are also required to obtain prior approval of any premium rate adjustments in those instances where the health plan's administrative costs exceed statutory standards. However, the prior approval process existed in New York State in a much broader capacity before 2000, but was abandoned in favor of "file and use." Return to a prior approval process should not occur without extensive consideration of the problems that come with this process.

Inescapably, the prior approval process can easily become subject to the influence of political pressure and adverse public opinion. When, especially in tough economic times, will a premium increase ever be politically viable? Accordingly, the pressure to appease certain constituencies by keeping insurance premiums low and "affordable" can lead to artificially suppressed rates. Insurers argue that artificially suppressed rates can, in turn, lead to health plan insolvency or abandonment of certain markets. Moreover, when a health plan's premiums are artificially suppressed, it can directly inhibit a health plan's ability to adequately reimburse providers. Health care providers are already under extraordinary financial pressures and can ill-afford to be unable to negotiate "market" rates from insurers. In a sense, if payers and providers are expected to negotiate a free market rate, then artificial constraints on market conditions can have adverse and unconsidered effects on provider reimbursement.

Insurers also remind us that in its heyday, the prior approval process tended to be prone to lengthy and inefficient review processes. In this regard, we agree that a process that is non-responsive to a fluid and rapidly evolving market could have deleterious effects on insurers, providers, and consumers.

From a provider's perspective, unpredictability in a health plan's revenue expectations from year to year can retard the willingness of the health plan industry to invest sufficiently in service providers' technology, workforce, and health care infrastructure—which HANYS has long argued are deeply deficient.

Finally, we suggest that it is instructive to look to the experience of other insurance product lines that are subject to prior approval. For example, medical liability insurance rates have historically been subject to prior approval, and have clearly been influenced by special interests and politics. As a result, medical liability insurance rates have been artificially suppressed, new insurance carriers are discouraged from entering the market in New York, and the carriers currently in this state have been repeatedly stating their financial condition is extraordinarily precarious and unsustainable. Some medical liability insurance carriers in New York have been deemed insolvent while others are at real risk of insolvency. We place little value on exposing health insurance premium rate increases to the same kinds of non market-based pressures.

Managed Care Market Conduct Reform

In addition to addressing the issue of regulatory approval of health insurance premiums and reform, HANYS is deeply interested in seeking administrative efficiencies in transactions with the insurance industry, which we highlight below.

HANYS has been an ardent supporter of enhanced regulation and enforcement efforts to achieve increased accountability from the health insurance industry. Managed care market conduct reform is one of HANYS' most important legislative priorities. Specifically, the managed care market conduct reform proposals contained in the Governor's Program Bill #13 (A.8402, Morelle/S.5472, Breslin) represent many of HANYS' managed care priorities and are important steps to enhanced health plan accountability. HANYS is diligently working with the Administration and Legislature to seek its enactment before the end of this legislative session.

- **Administrative Denials:** Administrative denials that are not relevant to insurers' ability to manage care should be barred. Claims that are determined to be medically necessary and are covered health care services for the enrollee should not be denied because of a harmless technical error by the provider. The inadvertent or random failure to adhere to a technical or an administrative rule by providers who are otherwise in substantial compliance with an insurer's rules should not result in a denial of payment for medically necessary covered services. The Governor's Program Bill prohibits insurers from gaining windfalls from harmless errors that result in zero payment to providers.

- **Prompt Payment Law:** Under current law, insurers are required to adhere to certain deadlines and make timely payment of claims. In recognition of increased use and speed of electronic claims processing technology, plans should be compelled, as they are in other states, to pay electronic claims within a shortened timeframe. The Governor's Program Bill would reduce the timeframe for payment of electronically submitted claims from 45 days to 15 days.
- **Coordination of Benefits Questionnaires:** Health plans routinely use coordination of benefits (COB) questionnaires to ascertain whether an enrollee has other insurance coverage. Some plans issue these questionnaires to consumers upon receipt of a claim for services. If the insured fails to return the questionnaire, the insurer either indefinitely pends payment of the claim or denies coverage altogether, leaving the provider without reimbursement. HANYS believes that an insurer should be prevented from delaying or denying payment of a covered claim regardless of whether a person completes and returns the COB questionnaire.
- **Refund Demand Limitations:** This provision of the Governor's Program Bill would apply current statutory protections to and enhance due process for all health care providers. HANYS believes that managed care plans should limit the circumstances under which "take-backs" can occur to billing/coding errors or fraud. The scope of review should be limited as well, so that medical necessity or level of care issues are not revisited. Under the legislation, all providers would be subject to the law that limits

health plans' look-back period to two years from the payment of a claim to demand a refund.

- **External Appeals Program:** HANYS continues to support an expansion of the external appeals program, allowing the appeal of denials for out-of-network care. This is consistent with the principle that health care providers are in the strongest position to advocate for necessary medical care on behalf of their patients. Currently, providers have no explicit right to appeal concurrent denials (i.e., not retrospective) and do not bill health maintenance organization (HMO) patients for covered services that are denied by health insurers. A new provider ability to request an external appeal of a concurrent denial offers a remedy that hospitals have been supporting for years.
- **In-Network and Out-of-Network Benefits:** Consumers have been surprised and outraged to learn that their health insurance coverage was transformed from in-network service to out-of-network because another provider rendering services for the same or related condition was out-of-network. This practice not only costs the patient thousands of dollars, but also puts the hospital in the untenable position of seeking payment from a frustrated and bewildered patient. This legislation is intended to address situations where a consumer is aware and has accepted that one provider is out-of-network but has purposefully chosen an in-network hospital and therefore fully expects that the participating hospital will be considered in-network. HANYS supports the provisions in this legislation to prohibit a plan from changing the status of an in-network provider organization to out-of-network based on the status of the treating provider.

- **Utilization Review:** New York State law establishes timeframes in which utilization review agents must decide whether to pay a claim. However, under the current law, if the plan misses the deadline, the claim is considered to have received an adverse determination, i.e., payment is denied. At that point, the burden is placed on the provider, who must expend time and additional resources appealing the “non-decision.” As currently written, the law does not provide sufficient incentive for the managed care plan to act in a timely manner, because inaction benefits the plan. This legislation would change that and make a failure to render a utilization review decision within the stated time an approved claim and not an adverse determination. HANYS supports this change.

Conclusion

HANYS does not support a return to a prior approval process. HANYS also realizes that there are shortcomings in the current “file and use” process to set health insurance premium rates that need to be fixed. HANYS would support enhancements to the “file and use” standards to address manipulations in MLR and premium rate filings. HANYS would also support measures to provide standardization in the definitions and interpretations of medical costs and to enhance enforcement authority against plans that fail to meet their statutory obligations. While recognizing the objective to enhance consumer protection from unaffordable rate increases, HANYS is concerned about the proposed prior approval legislation, as it would be unable to keep pace with the dynamic market conditions in which health care providers and insurers currently operate.

Reform of managed care market conduct is critical to ensuring consumers have access to quality health care and is a major priority of HANYS. Many of the provisions included in the Governor's market conduct reform bill are meaningful reforms aimed at addressing inadequacies of current practice in the health insurance market, including:

- prohibiting administrative denials and claims-generated coordination of benefits questionnaires;
- strengthening the external appeals program;
- enhancing the utilization review and prompt payment laws;
- limiting the circumstances under which health plans may demand refunds; and
- prohibiting a plan from changing the status of an in-network provider based on the status of the treating provider.

These reform measures are important steps to increasing health plan accountability and ensuring consumer access to high-quality medical care.

Thank you for providing HANYS with the opportunity to testify today on these important topics.