AN ARIZONA POLICY PRIMER

The Maze: Health Insurance Rate Regulation in Arizona

ARIZONA HEALTH FUTURES

NOVEMBER 2003

ARIZONA HEALTH FUTURES
Policy Primers: *a nonpartisan guide to a better understanding of key terms and issues in the Arizona health policy landscape.*

Health Insurance Rate Regulation in Arizona

In a climate of double digit health insurance premium rate increases and skyrocketing health care costs, Americans are quick to look for a scapegoat.

For some, health plans present a tempting target.

Is it true that "gaming" of a convoluted and opaque regulatory environment permits unjustified premium increases? Or are other factors involved, and if so, to what degree?

In this *Arizona Health Futures* Policy Primer, we take a look at private health insurance rate regulation in Arizona and its role in addressing health care access and affordability. We specifically seek to "demystify" the often arcane rules and terminology that swirl around any conversation of health insurance plans and regulation, and to tease out the policy issues that lie buried within a maze of ambiguous statutes and rules.

St. Luke's Health Initiatives
A Catalyst for Community Health

A caveat: This policy primer is not a pretext for the condemnation of health plans. As a matter of record, all of the actors on the American health care stage have sat – or are sitting – on the catbird seat: "greedy" pharmaceutical companies, mega hospital complexes engaged in expensive expansion, for-profit health care providers, "spoiled" physicians and rapacious consumers who are used to getting high tech care and having someone else pay for it.

The American health care "blame game" may be a cottage industry in and of itself, but in the end it contributes to the "perfect storm" metaphor that dominates the national conversation, and does little to shed light on the policy issues we all ultimately must face together. —Editor

Health Insurance: How is it Different?

Private health insurance is an inherently different product than auto, property, life and other forms of insurance, or *indemnity* products. It has a unique history and set of societal functions:

Health insurance is not an insurance product in the traditional sense – indemnification for extraordinary events one hopes to avoid – but a reimbursement mechanism for ordinary events one fully expects to occur.

- **TRADITIONAL SOCIETAL ROLE** – Until the 1930s, the U.S. had no health insurance system. The stereotypical physician carried a black bag, made house calls, and was usually the most educated and respected person in town. He (and until recently, there were few female physicians) was also a businessman who created his own pricing structure and payment plans. Hospitals, for the most part, were charities that provided free or reduced fee care in addition to fee for service. This all began to change with the advent of The New Deal and the creation of Blue Cross/Blue Shield plans.[1]
- **EMPLOYMENT-BASED** – Unlike most other types of indemnity insurance products, private health insurance in the U.S. is usually tied to employment. Companies negotiate group rates for their workers. Individual consumers, on the other hand, generally fend for themselves when buying coverage for their car or home. Beginning with World War II, when wage controls limited employers' ability to compete for scarce workers, the federal government promoted employer-based health benefits through favorable tax treatment. Companies began to offer health benefits in lieu of wage increases, and the practice became firmly established in American society.
- **GRADATION OF EVENTS** – Health insurance is unique in that it does not indemnify a particular event. For example, life insurance indemnifies a death. Property insurance indemnifies a flood, burglary or fire; auto insurance pays for costs associated with a vehicle accident, etc. Policyholders pay premiums with the full hope of avoiding the occurrence of the *sentinel event* being insured. In contrast, health plan enrollees pay premiums while fully expecting to purchase pharmaceuticals and visit physicians for primary care and various procedures. In this respect, health insurance is not an insurance product in the traditional sense (indemnification for extraordinary events one hopes to avoid), but a *reimbursement mechanism* for ordinary events one fully expects to occur.
- **MEDICAL CARE AS A PUBLIC GOOD** – Some public policies treat medical care as a fundamental social benefit for everyone (like public education), while others frame it as a private good subject to market forces. This debate leads to inconsistent policies in terms of financing and delivery. While medical care and technologies are increasingly framed as consumer "goods," they remain fundamentally imbued with a dimension of ethical "good" in a way that cars, buildings and personal property are not. Laws provide for emergency medical care to everyone, regardless of ability to pay. Government does not pay to fix your car if you cannot pay for it yourself.

Mandates + Regulations = $$$

In any discussion of the pros and cons of regulations governing rate setting in health care, it's important to underscore that health care is already one of the most heavily regulated industries in America.

Carriers must maintain loss reserves sufficient to assure payment of policy-holders' outstanding claims, should the company become insolvent.[2] Before expanding its book of business, an insurance company must increase its loss reserves. Some insurance executives believe that the real or perceived threats of bioterrorism will precipitate even higher required loss reserves in the future.

Further, government mandated benefits alone increased 25-fold over the 1970-1996 period, an average annual growth rate of more than 15 percent.[3] Over 1,500 mandated benefits exist at the state and federal levels.

Federal regulations in health care have increased significantly in past years and often duplicate or conflict with rules and regulations at the state level. The Health Insurance Portability and Accountability Act (HIPAA) alone is projected to add billions of dollars in new compliance costs. All of the additional paperwork, information systems, mandated benefits and related factors translate into rising premiums.

According to a recent study by PriceWaterhouseCoopers for the American Association of Health Plans, government mandates and regulations account for approximately 15 percent of rising premium costs (see sidebar to the right).

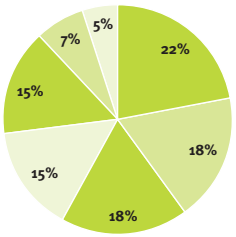
Regulation and Insurance Rate Setting

The regulation of health insurance rates in Arizona is considerably different in practice – if not in theory – from the regulation of rate settings in products such as automobile and property coverage, where companies are required to disclose their rates to the state, regulators are empowered to disapprove excessive prices, and statutes provide a legal standard to judge what is "reasonable."[5] Rate filings become public record, and carriers inspect each other's documents to offer competitive pricing.[6]

In order to provide a context for discussion of how health insurance rate regulation differs from other insurance products, we provide the following condensed summary of general insurance rate regulation in Arizona. The chapter of the Arizona Insurance Code that governs auto and property coverage exempts health plans, which have their own chapters. The following five features apply to auto and property insurance, but not to health insurance:

- **STATUTES PROVIDE STANDARDS FOR REASONABLE RATES.** Arizona statutes state that the purpose of insurance rate regulation "is to promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate or unfairly discriminatory." Rates are presumed not to be excessive, and the market is presumed to be competitive unless evidence proves otherwise. Rates are considered to be excessive if "they are likely to produce an underwriting profit that is unreasonably high." Considerations include loss experience, hazards, expenses, reasonable profit margins, trends, investment income from loss reserves, claims and earned premiums.[7]

THE FACTORS DRIVING RISING COSTS IN HEALTH CARE (2001-2002)[4]



22% Drugs/Technology

18% Provider Expenses

18% General Inflation (CPI)

15% Government Mandates/ Regulation

15% Consumer Demand

7% Litigation/ Risk Management

5% Fraud/Abuse/ Other

ADVERSE SELECTION AND THE VOLUNTARY MARKET

Many programs designed to control health plan pricing have failed due to *adverse selection*, a perennial problem of the voluntary insurance market. While insurance companies hope to enroll members with low risk of disease, individuals with the greatest risk are most likely to purchase insurance. Prices rise when members' costs exceed those used to calculate the premium. Healthy people then tend to leave the plan, gambling on their low probability of illness. This forces insurers to charge higher premiums to remain profitable, which in turn pushes more healthy people out of the pool. Since Americans can choose whether to accept or decline coverage, this "death spiral" continues until the pool is dominated by sick members and high rates.[12]

- **THE ARIZONA DEPARTMENT OF INSURANCE (ADOI) CREATES GUIDELINES.** The Insurance Commissioner compiles statistics for carriers and rating organizations. Carriers report annual expenses and loss experience. The Department uses this data to determine whether rating systems are reasonable and lawful.[8]
- **INSURANCE COMPANIES FILE PAPERWORK DESCRIBING RATES.** Insurers are required to disclose premiums to the ADOI. If regulators lack information to determine whether the filed rates comply with legal standards, they may order carriers to provide more information or hire actuaries to make sense of the rating system.[9]
- **THE ADOI MAY CHALLENGE EXCESSIVE RATES.** Rate filings are presumed to be valid, and the ADOI rarely questions them.[10] Most often, a filing serves to inform regulators with regard to rates rather than actually seeking permission to charge certain fees. Still, ADOI has, on occasion, rejected unreasonable rates.
- **THE RATES ARE PUBLIC RECORD.** The ADOI website includes tools to help consumers shop for auto and property underwriters, including pricing information. Consumer information is available for health insurance as well, but it does not including premium pricing information, since carriers are not required to disclose prices to the state.

The Underwriting Cycle

Health insurance company gains and losses follow a distinct pattern. For several years, consumers' premiums are higher than insurers' medical and administrative expenditures. For the next several years, premiums are lower than expenditures. This is known as the *underwriting cycle*. There have been 11 such "tops and bottoms" since 1965; currently the industry is thought to be at another top after going through a bottom period in the mid 1990s.

Several unique features of the health insurance industry drive the cycle. Health plans can't always predict such factors as the future claims experience of members, health cost trends and the investment climate for their reserve portfolio. There is a lag time between setting a group's premium rate and the group's actual claims experience. Further, carriers will undercut prices to compete for market share, then raise rates once they have achieved higher enrollment numbers. Losses experienced at the bottom of the cycle often have to be made up in the top of the cycle in order to maintain required capital reserves.[11]

Any discussion of health insurance rate regulation needs to take the underwriting cycle into account.

Rate Regulation in Arizona

While federal laws require health insurers to protect patients' privacy, pay for certain medical procedures and refrain from discriminatory practice, the matter of rate regulation is left to the states. They choose whether to regulate health plan premiums, co-payments, deductibles and other costs.[13]

According to one industry analyst,"this is not rate regulation in the sense that we know it for homeowners or car insurance, but is instead a more subtle and ambiguous kind of regulation."[14] Although most states, including Arizona, have enacted modest price guidelines, *no state sets an actual ceiling for rates or increases.* This kind of "fuzziness" in approach has the potential for "gaming" the system. "Complexity and variation in statute and practice may…create opportunities for insurers that are prepared to exploit them, and states should be aware of their practices."[15]

In theory, the open market for private health plans is said to control health plan prices, although some consumer groups maintain that the industry goes unchecked, and consequently prices are out of control. The reason, they say, is that insurance rate laws in Arizona and elsewhere are vague, haphazard, ineffective and illogical.[16] "Individual health insurance market reform has, by and large, not been successful in any state," according to one observer.[17]

While some of Arizona's rate-regulating statutes are unique, others mirror national norms. They are adapted from model acts promulgated by the National Association of Insurance Commissioners (NAIC), whose membership consists of insurance regulators from all 50 states. This legislation provides guidelines for carriers to create disclosure documents and explanation-of-benefits forms. The Life and Health Division of ADOI is charged with reviewing these forms before they can be issued to consumers. ADOI's Rates and Forms Unit receives over 17,000 forms annually.[18]

Rate Regulation of Large Employers

The level of price regulation is generally proportional to the perceived vulnerability of policyholders. For large employers, which are defined by Arizona and the majority of other states as having more than 50 employees, there is virtually no regulation of health plan rates. The presumption is that a large employer should be sufficiently sophisticated and knowledgeable enough to negotiate rates with a carrier, and the state shouldn't interfere with the process. These groups achieve bargaining power by leveraging their relatively large budget.

Carriers are still required to file policy forms 30 days before issuing them to policyholders, which describe such provisions as benefits and eligibility. They may choose to include premium information, although carriers are not required to disclose their rates to ADOI. Once received, ADOI regulators review the form to ensure compliance with rules governing mandated benefits, truthful advertising, etc. Although failure to meet regulatory requirements is a basis for disapproving the form, excessive rates are not in themselves grounds for disapproval. ADOI has no authority to judge, or even to see, large-group rates.[19]

Rate Regulation of Small Employers

Rate regulation for small employers, on the other hand, is more prevalent. Small businesses, which are defined as having between two and 50 employees, dominate the Arizona market. Fully 94 percent of businesses in Arizona have 50 employees or less, and 97 percent have 100 employees or less. This compares to a national average of 41 percent for companies with 100 employees or less.[20]

Almost every state has enacted special rules to protect small businesses from excessive rates, and Arizona is no exception. Unfortunately, the rules have failed to curb skyrocketing insurance premiums, and workers in smaller firms typically pay higher premiums and receive fewer benefits. According to ADOI, Arizona small businesses uniformly describe affordability as the biggest impediment to offering health insurance to their employees.

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The Department reports, "The limited laws directed at controlling rates do not appear to have been effective and are difficult to administer."[21]

"Limited Laws"

The "limited laws" to which ADOI refers were created with passage of Arizona's Accountable Health Plan (AHP) legislation (Senate Bill 1109) in 1993. The major thrust of this legislation was to increase access and availability of group health insurance for small employers and to help make it more affordable. There were four central components:

1. **GUARANTEED ISSUE.** Insurers offering health insurance to medium and large employers were required to also offer it to small employers.
2. **TAX EXEMPTION.** Premiums charged to small groups were exempt from Arizona's two percent health premium tax.
3. **RATE BANDS.** Premium rates charged to small employers were restricted to a "rating band."
4. **RATE INCREASES.** Renewal rates charged to small employers were restricted to a three-pronged formula (described below).

Regulating the Individual Health Plan Market

Six percent of Arizonans (five percent nationally) with private medical insurance purchase it in the individual market. They may be retired, self-employed or work for an employer that doesn't provide health benefits. Since Arizona does not limit charges for individual indemnity plans, carriers may charge substantially more based on an applicant's health status, age, etc.

There is a disconnect between statutory rate review authority and how rates are actually reviewed in practice. Arizona, like many other states, has an administrative code that calls for reasonable prices and authorizes regulators to reject excessive rates. However, in practice regulators lack the power to reject the rates.

How so? A statute titled "Disapproval of Disability Policy Form" provides that "The Director may disapprove any disability policy form if the benefits provided in the policy form are unreasonable in relation to the premium charged."[23] The term "disability policy form" refers to various contracts and documents that govern a health insurance policy. Administrative regulations require carriers to file an actuarial memo describing the ratio of benefits to the premium.[24] In practice, however, carriers file forms that show a range of benefits and premiums along a sliding scale. This disconnect might result from insufficient staff resources to conduct reviews, or from cultural norms within insurance regulation. The administrative code also requires rate increases to be accompanied by a statement justifying the increase.[25] Factors to judge "reasonableness" include the carrier's past loss experience, projected future claims experience, medical inflation, risk exposure, industry trends and so forth.[26] With such a list of broad, even vague, factors, it's not surprising that a request by ADOI for a carrier to reconsider its rates rarely takes place.

Some states have more objective criteria than Arizona's subjective "reasonableness" standard.[27] For example, New Mexico prohibits carriers from increasing renewal rates solely because of declining health. Utah requires individual health plan premiums to be partially based on premiums in the small group market.[28]

In effect, the first component was designed to increase and protect availability of health insurance for Arizona small employers. The next three components were focused on affordability for this market.

Guaranteed Issue and Renewal

Carriers who sell health insurance to medium and large employers must also offer at least one policy to small employers, whether the product is a health maintenance organization (HMO), preferred provider organization (PPO), point of service plan or conventional insurance. They cannot refuse to provide coverage or renew a policy. Most states impose a guaranteed issue requirement, and ADOI reports that this keeps insurers in the small group market that otherwise might withdraw.

While laws guarantee the availability of insurance, availability has not been accompanied by affordability.[22] Plans offered to small employers are more expensive than those sold to large groups, due to the fact that insurers have fewer persons in the group over which to spread the risk and administrative costs such as marketing and administration. In effect, if the insurance is not affordable, availability is a distinction without a difference.

There is also speculation that guaranteed issue, limitations of pre-existing conditions and rating restrictions haven't made much of a dent in either availability or affordability in the small group market because insurers

respond to the reforms by raising prices, and employers then are forced to increase employee contributions or cut the benefit altogether. However, the complexity of forces affecting the small group market make pricing structures by insurers difficult to establish with any precision.[29]

Tax Exemption

All Arizona health carriers are subject to a two percent tax on premiums. AHP laws waive this tax for premiums charged to small groups under the rationale that carriers will pass on the savings by lowering small group prices. This exemption is not typically offered by other states and yields roughly $9 million in combined annual savings to carriers that participate. To qualify, carriers must separate small group premiums on their tax returns, and some may consider the savings too modest in relation to the administrative hassle and costs. In any event, ADOI reports that "The premium tax exemption does not appear to have a significant impact on the affordability of coverage for small groups."[30] If the tax break were eliminated, however, there is speculation that insurers would add two percent to their small group rates to compensate.

Rate Bands

The ADOI refers to rate-setting laws as having "a complicated technical structure."[31] Others, most notably consumer groups, brokers and small employers have at one time or another referred to the laws as ambiguous, difficult to interpret and administer, and ineffectual.

For example, the AHP laws have rate setting and rate renewal provisions that establish a *rating band* for small group coverage. This is designed to "keep premiums affordable." Specifically, the law states:

> The premium rate that an accountable health plan charges during a rating period for a health benefits plan issued to a small employer *shall not vary by more than 60 percent from the index rate* for health plans involving the same or similar coverage, family size and composition, and geographic area.[32](emphasis added)

But what is the *index rate*? The law defines this as "the arithmetic average of the applicable base premium rate and the highest premium rate that could have been charged…"[33]

The *base premium rate*, in turn, is defined as "the lowest premium rate that could have been charged…"[34]

Rate Increases

The rate-increase laws have been called vague and complex. Arizona is one of 29 states using the NAIC's model act for price upsurges. The Arizona law states that "The percentage increase in the premium rate that is charged to a small employer for a new rating period may not exceed the sum of the following: (1) The percentage change in the base premium rate. (2) Fifteen percentage points. (3) Any adjustment due to a change in coverage, family size or composition, geographic area or demographic characteristics."[35]

Long Term Care

Indemnity for nursing home care and home health care is Arizona's first foray into establishing rate ceilings and tight regulatory controls. The Governor recently signed a 2003 bill empowering the ADOI to disapprove excessive rates (HB 2153). The legislation conforms Arizona law to national model standards. It directs insurers to disclose rates, requires their actuaries to include specific estimates of claims and losses, and fines carriers for extreme rate hikes. The ADOI is in the process of creating an administrative rule to accompany the new law.

Why the tighter regulation of long term care (LTC) and not the small group and individual markets? In a word, deceptive advertising. Nursing home care in the U.S. costs approximately $60,000-$70,000 annually. LTC insurance indemnifies costs not covered by Medicare, Medicaid or Medigap policies. Arizona's legislature reports that advertisements across the country promised that the premiums would never increase because of policyholders' age or deteriorating health. However, consumers quickly learned that this statement was not a guarantee and watched their rates multiply the closer they came to needing long term care.[36] Insurers initially undercut prices, then later imposed significant increases that made LTC insurance unaffordable to people who had been paying the premium for years, according to an Arizona Senate fact sheet.[37]

SMALL GROUP RATE INCREASES: STATE TALLY

No state actually puts a lid on premium hikes. Twelve states provide that rates generally be "reasonable" in relation to the benefits provided. Arizona and 28 other states follow the NAIC model formula and allow rates to increase 15 percent, plus the increased index rate and other adjustments described earlier. Another 10 states set forth other guidelines that allow a certain percentage in increase, plus adjustments for claims experience or administrative overhead.

Regardless of the different definitions and approaches, in practice these provisions function equally. While there are variations here and there, they have not had a dampening effect on skyrocketing health premiums across the country.

Provision	# States
NAIC Formula	29
Reasonableness Standard	11
Other	10

The Rate Laws in Practice

There are several points to be made about Arizona's small-group rate setting in practice:

1. **THE BASE PREMIUM RATE IS LARGELY UNREGULATED.** It is defined by the carriers, which can change it to reflect changes in the benefit package, the age of those insured, number of children, demographic characteristics, etc. Since the index rate is calculated on the base premium rate, it, too, can be said to be "unregulated."
2. **RATE REVIEW IS MINIMAL.** Rather than actually filing their small group rates with the ADOI, carriers simply file a statement prepared by an actuary certifying that the rates are legal and mathematically sound. ADOI staff report that the requisite calculations to determine whether rates meet the prescribed guidelines are so complex that insurers and their actuaries interpret the laws in varying ways. While "varying interpretations are not necessarily synonymous with noncompliance… they make compliance very difficult to determine."[38]
3. **ARIZONA'S RATE BAND IS HIGH.** Of the 37 states applying premium rate bands to the small group market, Arizona's band of 60 percent is the largest. In most states, the swing is plus or minus 25 percent from the index rate, or median possible premium rate.[39] This index applies only to premiums and has no effect on deductibles, co-payments or other costs. Carriers may change the index each time they file their annual actuarial certificates.[40]
4. **ADOI LACKS THE RESOURCES FOR THOROUGH RATE REVIEW.** ADOI employs one part-time health actuary. There is no reason to suppose that carriers are "gaming" the system and raising rates beyond what would appear to be "reasonable" according to law and general expectations, but the fact of the matter is that ADOI lacks the resources to find out. According to some researchers, "The shortage of actuarial expertise in many departments of insurance appears especially to shape the nature and scope of rate review."[41]

The bottom line is that Arizona's rate band for small group health insurance does not have the effect of restricting or otherwise controlling rates. Carriers set rates that, while legal, are increasingly unaffordable to many small employers. Even where insurance is affordable, small employers face a variety of practical factors (lack of competition in a shrinking small group market, administrative hassles, compliance issues, etc.) that interfere with obtaining coverage.

For these reasons, ADOI is led to conclude, among other things, that "Arizona small group health consumers would benefit from a legislatively established rate-setting structure that is less subject to interpretation and more easily enforced."[42]

Other Strategies

In addition to rate regulation statutes already discussed, states have implemented a number of different rate strategies to deal with premium increases and coverage:

Community Rating

Under traditional "experience rating," insurance companies charge each group a different rate according to how much care that group utilizes. With "community rating," a formula limits the degree to which carriers may consider factors such as a group's health status, age and past claims. "Pure" community rating takes the additional step of requiring insurers to spread the cost evenly across all groups, regardless of age and health status, in its book of business. Each group pays the same amount, regardless of group characteristics or claims history. Accordingly, healthier groups end up paying higher premiums, essentially subsidizing less healthy groups.

Community rating has been mandated only in the small group market. While it normalizes prices among consumers, it does not restrict the amount that can be charged. Most

studies suggest that community rating and similar reforms have actually raised prices in the small group market because insurers respond by raising rates.[43] In other cases, such as New York and Kentucky, after community rating was implemented, the plans fell victim to adverse selection.[44]

Minimum Loss Ratio

Nine states require carriers in the individual market to spend a minimum percentage of premiums as direct health care benefits. This is called the *minimum loss ratio*. These range from 60 percent in Maryland to 75 percent in New Jersey. The intent is to prevent carriers from absorbing excessive profits or using resources on unnecessary marketing and/or administrative costs. The majority of these states allow exceptions for carriers to charge more if the increase can be "reasonably justified" by anticipated future costs. The minimum loss ratio is often governed by a complex formula that includes loopholes and other exceptions, and it has failed to lower premiums in most states that have imposed it. However, New Jersey's strict regulation has held up over time. In fact, that state has ordered carriers that profited beyond the ratio to reimburse millions of dollars to group and individual policyholders.[45]

Formal Hearings

Nine states report holding hearings to contest high premium rates. Even in those states, however, the practice is rare and is reserved for the most extreme rate filings. In Georgia, a Governor's consumer advocate is invited to attend the hearing; in four other states the Attorney General is involved. Arizona, like most states, neither rejects expensive premiums nor holds formal hearings to discuss them. ADOI staff can only initiate an informal negotiation process, suggest that the rate seems excessive, and hope that the carrier will reconsider its filing. Since Arizona carriers are not required to disclose rates, negotiation can only take place when carriers voluntarily include prices in their filed policy forms. ADOI reports that many insurers make a good faith effort in this regard.[46]

New Jersey's strict minimum loss ratio regulation has ordered carriers that profited beyond the ratio to reimburse millions of dollars to group and individual policyholders.

Why Regulate Rates **At All?**

Whether it's health care, gasoline or some other critical "good," a climate of high prices induces a public outcry and calls for stronger regulation and price control. Clearly the experience of other nations demonstrates that tight price controls can help to control costs, but this occurs in different political and cultural climates than the U.S., which has historically relied on market forces to regulate the ebb and flow of prices over time. What works in, say, Canada, is not directly exportable to this country, despite its "logic."

There is little to suggest that a strong regulatory climate, especially with regard to limiting investments and setting limits on rates, holds down costs over time, at least in the U.S. For example, rapidly rising hospital costs in the late 1960s and early 1970s led to increased regulatory controls that turned out to be less of a factor in controlling costs than changes at the macro-economic level, the advent of managed care and other forces. Some of this regulatory apparatus is still in place today, but its role and effect in the changed marketplace are unclear.[47]

Against this backdrop, some insurance executives and business groups argue that the public will ultimately benefit if lawmakers step back and allow the open market to determine health premium prices. Unfettered competition would keep rates low and quality high, according to industry leaders.

Of course, the line between reasonable regulation of health insurance products and price controls is subject to interpretation. Even though states clearly have a broad authority to regulate, they often refrain from exercising their powers. Up to this point, Arizona is among those states that have taken a more hands-off rather than hands-on approach to health insurance rate regulation. Whether this will continue to be the case in the face of rapidly rising premiums remains to be seen.

A review of health insurance rate regulation in Arizona suggests these policy considerations.

Policy Considerations

- **TRANSPARENCY IN PRICING.** For any market to function efficiently, there should be transparency in pricing and product information between consumers and suppliers. If insurers were required to disclose rates, the state could quantify this information, track trends, and use the data to better inform consumers of their choices in selecting plans. More transparency in pricing among providers, such as hospitals and physicians, would be useful as well.
- **ADOI RESOURCES.** ADOI lacks sufficient staff with actuarial expertise to review rates for compliance with existing state statutes. Regulation without means of enforcement is no regulation at all. If that is the state's intent, we should at least be clear about it.
- **CLARITY IN THE RATE-SETTING STRUCTURE.** ADOI recommends that "Arizona small group health insurance consumers would benefit from a legislatively established rate-setting structure that is less subject to interpretation and more easily enforced."[48] A discussion at the policy level of how to achieve greater clarity in the regulations would be helpful to the degree that it begins to define what the public considers to be reasonable rates, what are considered to be excessive rates and for what reasons.
- **TAKE LARGE GROUPS INTO ACCOUNT.** Although large employers wield bargaining power, many workers still cannot afford to buy into their health plan. Low income workers in large companies are currently joining the ranks of the uninsured faster than workers in small companies. By focusing only on the small-group and individual market, the current rate regulations overlook the former.
- **CONSIDER THE UNDERWRITING CYCLE.** Any discussion of rate setting in response to perceived excessive rates should be viewed by policymakers in the context of the underwriting cycle. For example, a cycle peak in the late 1980s established part of the momentum for national health care reform, while a cycle valley in the mid 1990s influenced a managed care backlash and moves to increase mandated benefits. While history is not a certain guide for the future, it is at least a cautionary one.
- **BE CLEAR ABOUT ACCESS AND COST.** There is no necessary tradeoff between increasing access to care and lowering costs, but there is often a practical one. If policymakers seek to increase access by making premiums more affordable through some type of rate control strategy, they may in fact end up restricting access if companies pull out of the market, reduce benefits or increase the likelihood of adverse selection. It is important to be clear on what the goal is. It's not impossible to both increase access and reduce costs – it's just extremely difficult.
- **CONSIDER ALTERNATIVES TO RATE REGULATION.** While achieving clarity and transparency in Arizona rate regulation is desirable, policymakers may also want to consider other ways to control costs – and increase access. One possibility is the development of a state purchasing pool for small businesses. Studying the experience of Arizona's own Healthcare Group and pools in other states, such as Ohio, would be useful. Another possibility is the development of a high risk pool. Assuming a stable and sufficient funding source could be identified, Arizona's high risk population could receive coverage while stabilizing rates in the rest of the market.

Sources

1 See Paul Starr, *The Social Transformation of Medicine*, NY: Basic Books, 1983 for an excellent history of medicine and health care, among other sources.

2 A.R.S. 20-508.

3 Gail A. Jensen and Michael Morrisey, "Employer-Sponsored Health Insurance and Mandated Benefit Laws," *The Milbank Quarterly*, Vol. 77, No. 4, 1999.

4 PriceWaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs*, April 2002.

5 Arizona Revised Statutes (A.R.S.) 20-357; 20-341; 20-358; 20-356. States are beginning to consider similar types of disclosure and standards for health insurance. For example, California legislation was introduced in 2003 to require state approval before carriers could raise health insurance rates. The bill was modeled after a successful 1988 ballot measure that mandated pre-approval to increase prices in auto and property-casualty insurance. The bill was referred to committee and rolls forward to the 2004 session.

6 A.R.S. 20-357; Interview with Arizona Department of Insurance Policy Analyst, Vista Brown, Sept. 30, 2003.

7 A.R.S. 20-341; 20-383(B); 20-356; 20-384(B).

8 A.A.C. R20-6-604.3; A.R.S. 20-371(A).

9 A.R.S. 20-357; 20-358(D); 20-148; 20-159.

10 Interview with ADOI officials, Sept. 3, 2003.

11 See Richard Kipp, et. al., *Health Insurance Underwriting Cycle Effect on Health Plan Premiums and Profitability*, Milliman USA, April 10, 2003.

12 Tom Baker, "Containing the Promise of Insurance: Adverse Selection and Risk Classification," 9 Connecticut Insurance Law Journal, 2002/2003, p. 371; David M. Cutler and Richard Zeckhauser, "Adverse Selection in Health Insurance," National Bureau of Economic Research, Inc., Working Paper 6107, July 1997.

13 15 United States Code 1012.

14 Thomas Snook, Milliman USA, e-mail correspondence, Sept. 9, 2003.

15 Adele M. Kirk and Deborah Chollet, "State Review of Major Medical Health Insurance Rates," *Journal of Insurance Regulation*, p. 16, July 1, 2002.

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