



COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT  
HARRISBURG

THE COMMISSIONER

December 2, 2009

Honorable Neal P. Goodman, Member  
Pennsylvania House of Representatives  
G7 Irvis Office Building  
Harrisburg, PA 17120

Dear Representative Goodman:

Thank you for your letter expressing concern about large health insurance rate increases proposed by the four Pennsylvania Blue Cross or Blue Shield (Blue) companies earlier this fall. Given the significance of the proposed increases, we required each company to publish notice of its proposed increases in local newspapers, and received numerous letters of opposition.

I am happy to report that we were able to achieve substantial reductions in the proposed increases, most of which were for guaranteed issue products in the individual market, through an extensive review process with each company. I will provide more detail on those reductions in a moment, but I also want to use this letter to offer a broader perspective on the health care crisis we face. More specifically, I want to emphasize that our success with these filings will be temporary unless there is significant insurance reform to bring more rate stability in the short run and broader cost control initiatives to bring down medical inflation over the longer term.

Cost control is job one in health care reform, but it will require fundamental changes in the delivery of health care. For starters, we must move from a payment system based on amount of services delivered to one based on quality of results. Geisinger and others are developing innovative approaches to rewarding outcomes rather than volume, and the federal reforms promote these sort of innovations in a piecemeal way that will need to be broadened and deepened if it is to succeed.

To put it bluntly, effective cost control will take concerted and collaborative action between the public and private sectors, and this has proven difficult to achieve in our current context. To date, both private payers (e.g. insurance companies) and public payers (e.g. Medicare) have found it easier to cut benefits and reimbursements, shifting costs rather than restructuring the delivery system along the lines of what has proven effective at places like the Cleveland Clinic and Intermountain. The Insurance Department stands ready to work with the General Assembly and all stakeholders to support such initiatives, but in the meantime, the rest of this letter will focus on the insurance reforms that are more directly within our regulatory scope.

Insurance reform is needed to spread costs more equitably, particularly in the individual and small group market. Unlike large employers, where risk pools are broad enough to spread the costs of one or two sick workers across a large pool of healthy workers, individuals and small businesses are vulnerable to sharp increases in rates because of one or two major claims. Absent insurance reform, we can expect to see increasing rate disparities in the individual and small group markets, with reasonable rates for the healthiest risks at the expense of those who most need health care and who increasingly are being priced out of the insurance marketplace precisely because of their need for health services.

The Blue company rate filings exemplified this trend in that many of the proposed increases, depending on the specific product, exceeded 20% and some exceeded 40%, not because medical trend was running that high for all customers but rather because the filings were more aggressive in discriminating between good and bad risks. When the companies pointed to medical inflation as a reason for seeking increases, we pointed out that medical inflation, while still unsustainably high, is running under 10% on average. We also pointed out that the requested rate increases were based more on reducing or eliminating past practices that spread risk broadly across product lines rather than on broad increases in utilization. Finally, we found other actuarial problems on a case by case basis.

The bottom line result of our review process was that the Insurance Department did not approve any average rate increases of 10% or more. That is the good news. Now, in the interest of full transparency, comes the bad news.

Future rate increases will be substantial without insurance reform. The rate increases described above were for the individual market, where there already are large differences between the lowest and highest rates. In a 2008 comparison, we found rates for single coverage ranged from \$75 in the medically underwritten market to \$520 in the guaranteed issue market for similar products, roughly a 7:1 ratio. Furthermore, rates have been increasing twice as fast in the guaranteed issue market (9-11% per year vs. 2-6% in the underwritten market).

Similar trends appear in the small group market, as evidenced by the case of Susquehanna Glass, which recently testified in Congress about a 128% rate increase it received because of bad claims experience. I am attaching the explanation offered by Health America for the increase because the letter illustrates why the company was acting rationally under the current system and, therefore, why the system needs to be changed.

In essence, Health America says that Susquehanna Glass should have received a 200% increase under actuarial principles, so the 128% increase was actually not enough. In the company's words: "While 128.6 percent would appear to be a large increase, it will not cover the 200 percent medical cost ratio noted earlier as reflective of the group's actual claims experience." The letter goes on to explain why Health America has to operate as it does in a competitive marketplace.

Health America deserves credit for accurately describing insurer behavior in the current marketplace. The aggressive pricing up of less healthy groups is typical of commercial carriers, and helps explain why the Blue companies are moving their small group business to for-profit

subsidiaries that can compete on the same terms. The Blues will continue to insure everybody; it is just that the rates for the least healthy groups will skyrocket as they compete with the commercial carriers for the best risks. All of this follows traditional insurance principles for pricing groups according to their relative risk, even if that means group rates double in a single year.

The problem, of course, is that traditional insurance practice is not good public policy if we want affordability and stability for everyone. Again to its credit, Health America recognizes this in the last page of its letter where it agrees with the health industry's support for reforms that "would provide all Americans with coverage, with no pre-existing condition exclusions and without any premium variation based on health status or gender in connection with a personal coverage requirement."

In other words, the choice is clear: we can keep the current system in which some individuals and groups get low rates and those that most need health insurance (the older and less healthy) are increasingly priced up and even out of the market, or we can have a system where everyone participates and everyone has closer to average rates because rates are not based on health status or gender.

Congress may answer the question for Pennsylvania, in which case we will be charged with implementing the changes. This would be a welcome development because it would put all of us on the same side in phasing in a system that insurance regulators and insurance companies have collaboratively supported as part of federal reforms (even as there has been some disagreement about how to achieve the broader cost control goals described earlier in this letter).

If, however, Congress fails to enact these reforms, Pennsylvania will face a range of choices as to how to proceed:

- Should we at least address the worst abuses and put some limits on rate increases at renewal? Most states have done this, typically limiting rate increases based on claims experience to 15%.
- Should we also establish rate bands for all small groups? All but two states have done this, with the applicable rate bands varying from 1:1 (community rating) to 3:1 or more.
- Should we have similar rules in the individual market? A few states have guaranteed issue in the individual market, but only one (Massachusetts) has made it work to increase coverage. The key to success in Massachusetts was to combine guaranteed issue with a personal coverage requirement of the sort championed by the insurance industry at the federal level.
- Should we keep the status quo? This would lead to more competition between the commercials and the Blues to cover the best risks, but it would come at the expense of individuals in the Blues guaranteed issue pools and groups like Susquehanna Glass.

Thank you for sharing your concerns about rate increases. I am pleased that we were able to protect some of the most vulnerable Pennsylvanians from unaffordable rate increases in the short run, and I hope this letter helps illuminate some of the choices we face as we seek to provide affordable health coverage to all Pennsylvanians.

Sincerely,



Joel Ario  
Insurance Commissioner

Enclosure

cc: Honorable Anthony DeLuca, Chair  
House Insurance Committee

Honorable Kevin Murphy  
Honorable John Siptroth  
Honorable James Wansacz  
Honorable Todd A. Eachus  
Honorable Richard T. Grucela  
Honorable Eddie Day Pashinski  
Honorable Kenneth J. Smith  
Honorable Keith R. McCall  
Honorable David R. Kessler  
Honorable Phyllis Mundy ✓  
Honorable Tim Seip  
Honorable Edward G. Staback  
Honorable John T. Yudichak  
Honorable Steve Samuelson



November 2, 2009

Senator Mike Enzi  
379A Senate Russell Office Building  
Washington, DC 20510

Dear Senator Enzi:

Thank you for allowing us to provide you with additional information about HealthAmerica's relationship with Susquehanna Glass in Columbia, Pa. The comments of its owner in *The New York Times* article from October 25, 2009, "Small Business Faces Sharp Rise in the Cost of Health Care," require clarification.

The renewal rate of 160 percent quoted in *The New York Times* was incorrect; the actual proposal was 128.6 percent and does not represent a typical increase. In developing the proposed rate renewal, HealthAmerica followed industry standard underwriting guidelines and principles. This included projecting the prior years' medical claims experience for future claim costs and a base premium build-up that includes the impact of any new state and federal mandates. The base rates are then adjusted to account for the specific plan design and benefits, (e.g. copays, deductibles, coinsurance, out-of-pocket maximums, benefit limits, etc).

The plan-specific rates were then adjusted to reflect age/sex demographics, geographic area, industry, and risk category, which are normalized for age/sex and industry. The risk score is a member-level prospective risk score, which reflects the members' anticipated claim costs, on a relative basis, for the upcoming policy period. The new premium rate is not based on the employer group's historical costs nor is it an effort to recoup prior year's losses due to medical claims being higher than paid premium. Rather, the new premium rate is determined by applying standard medical underwriting techniques, which take into account prior years' medical costs to project future medical claim costs. The projection of future claims costs was in large part responsible for the rate proposal for Susquehanna Glass.

Medical underwriting is a critical tool used by health plans to help maintain competitive and fair rate levels. It is necessary to medically underwrite because health care costs vary significantly in a population and may be concentrated in a few individuals. High-cost individuals may be more prevalent in a group of people applying for coverage than in the general population. There may be a tendency to seek out coverage when the need is greater. Medical underwriting assists in distributing medical costs appropriately across all who are insured.

The medical cost ratio for Susquehanna Glass, after all claims were reported, was approximately 200 percent. In layman's terms, the medical cost, not including administrative expenses, were double the premium charged during the 12-month period prior. This history was used to develop the group's renewal rate. While 128.6 percent would appear to be a large increase, it will not cover the 200 percent medical cost ratio noted earlier as reflective of the group's actual claims experience.

To illustrate the medical utilization of this group's members, their top 10 medical claims represent approximately 44 percent of the group's total claims. While HealthAmerica attempts to negotiate competitive discounts with providers, data show that provider claim reimbursement for these claims was approximately 136 percent higher than what Medicare would have reimbursed. This is fairly representative of the subsidization of the public sector by the private sector that exists today. Milliman, Inc., has found that the underpayment by Medicare and Medicaid results in an annual increase of at least \$1,700 for an average family of four.<sup>1</sup> Stated differently, without this underpayment and cost-shift, costs for privately insured patients would be 15 percent lower.

Another inaccuracy is present in the article: "Mr. Rowen said he was told his work force was 'getting too old and very expensive.'" Mr. Rowen was not provided this information by any member of HealthAmerica's staff. Since the primary distribution channel for sale of HealthAmerica's products is through brokers, the renewal rates were delivered to the broker with a copy sent to the group. Limited e-mail correspondence with the broker followed. At no time was the group contacted directly by anyone at HealthAmerica to discuss renewal rates. Attempts to contact the broker since the publication of the article have been unsuccessful.

HealthAmerica transacts business in a very competitive health environment, including increasing costs for provider services, prescription drugs, and more. These medical cost trends further exacerbate medical claims expense. HealthAmerica recognizes the continuing problem of rising health care costs and undertakes activities to positively impact medical cost drivers wherever possible. It is imperative that the focus – both as a nation and as an industry – is on controlling underlying cost drivers and encouraging individuals to take responsibility for their own health and well-being. That is why many of HealthAmerica's activities focus on providing member education on the true cost of medical services and encouraging participation in wellness programs that positively impact health and lifestyle. HealthAmerica will continue to collaborate with members, employers, and providers to provide access to affordable and quality health care.

Because you may not be familiar with Pennsylvania's insurers, you should be aware that HealthAmerica Pennsylvania Inc. and HealthAssurance Pennsylvania Inc. are sister health plans doing business as HealthAmerica. HealthAmerica has received national recognition for efforts in ensuring members have access to quality health care services, including:

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<sup>1</sup> Milliman, Inc., December 2008, *Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers*

- HealthAmerica's commercial health plans were rated higher than the national average in all 15 key measures of medical services and member satisfaction is higher than the Pennsylvania state average in 12 of 15 key measures<sup>‡</sup>.
- HealthAmerica has earned Excellent accreditation by the National Committee for Quality Assurance (NCQA) – the highest accreditation status possible.
- For three years running, *US News and World Report* has recognized HealthAmerica as one of the nation's top health plans. In 2008, HealthAmerica's HMO, POS, and Medicare Advantage plans were ranked among the nation's top 20 best commercial and Medicare health plans.<sup>§</sup>

In collaboration with HealthAmerica's national trade association, America's Health Insurance Plans (AHIP), HealthAmerica remains committed to comprehensive, bipartisan health care reform. Last year, the industry took a strong position for comprehensive insurance reform. The proposal would provide all Americans with coverage, with no pre-existing condition exclusions and without any premium variation based on health status or gender in connection with a personal coverage requirement. HealthAmerica supports the reforms advanced, but agrees with most health policy experts that the decoupling of market reform and personal responsibility does not work. Experience in the states in the 1990s that attempted market reforms of community rating and guarantee issue in the absence of universal coverage demonstrates the unintended consequences. A report examining these eight states found a significant number of individuals deferred coverage until after they encountered health problems. As a result, the states experienced higher premiums for those with insurance, reduced enrollment in individual health insurance coverage, and had no significant decrease in the number of uninsured.<sup>2</sup>

HealthAmerica appreciates your consideration and attention in reviewing this information. Should you have any questions, please do not hesitate to contact me.

Sincerely,



N. Timothy Guarneschelli  
Vice President & General Counsel

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<sup>2</sup> The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets, Milliman, Inc., August 2007

<sup>±</sup>The source for this data is Quality Compass<sup>®</sup> 2008 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass is a registered trademark of NCQA. NCQA is a private, non-profit organization dedicated to improving health care quality.

<sup>§</sup>“America’s Best Health Plans” is a trademark of *U.S. News & World Report*.