**Allegheny County Bar Association**

**Testimony of Mark T. Vuono**

**Chair of Lawyer Insurance Committee**

**July 20, 2010**

My name is Mark Vuono. I am a partner in Vuono & Gray, a law firm which has been practicing in Downtown Pittsburgh for over 55 years and which focuses its practice on representing small, family-owned businesses. I am here today as the Chairman of the Lawyer Insurance Committee of the Allegheny County Bar Association.

The function of the Lawyer Insurance Committee is to review and endorse insurance products that are offered to our members. This group of volunteer attorneys meets regularly to provide an important screening function, to assure our members that the endorsed products provide a high degree of quality and value. This service is one of the key benefits associated with membership in our organization. Although we endorse life and disability insurance, auto and homeowners coverage and professional liability (malpractice) insurance, the availability of quality, affordable health insurance coverage is literally the primary reason why many of our members belong to our association.

I have served on this committee continuously for more than 25 years, and like Mr. Hunt, do not profess to be an expert with respect to the health insurance industry. Our committee, however, has been dealing with Highmark and its predecessors for longer than I have been involved and we have learned a few things that we want to bring to your attention.

One reason that the Association endorsed Highmark in the past was that it offered coverage to our members without regard to medical history or pre-existing conditions. It was the "community insurer of last resort", offering coverage to all of our members and to the community at large. In exchange for filling this critical role in the marketplace, it enjoyed the tax-exempt status that distinguished it from for-profit insurers. Over the years, it has leveraged its status to become the dominant player in the health insurance marketplace in Allegheny County and has accumulated massive reserves under its not-for-profit umbrella.

In the past, Blue Cross and Blue Shield offered group coverage to our members based on the overall experience of the group as a whole, with each member paying the same price for coverage without regard to the age, gender, or most importantly, medical condition or history of the member or his covered employees and family members. The risks were spread across the entire pool of insureds, just as if our solo and small firm members were employees of a large employer. The committee received reports at least annually (and sometimes more often) of the group's overall claims experience compared to premiums paid and the Blues' overhead and profit. In those days, we literally negotiated the premium rates on behalf of our members. We even had the opportunity to carry over

favorable results from one year to reduce the premiums that our members would pay in future years.

The "small-group" market consists firms covering from 1-50 individuals or families, including not only lawyers, but also secretaries, paralegals and other employees, and the same definition applies to businesses other than law firms. Mr. Hunt referred to the fact that over 60% of our members practice in "small" firms of 6 or fewer attorneys. Of those firms, approximately 35% are sole practitioners, single member law firms. At one time, Highmark proposed to eliminate coverage for sole practitioners or "groups of one." Our Association complained to the Insurance Department, and under pressure, Highmark backed off and reluctantly continued to offer coverage to single-member firms.

The first step away from this arrangement was the Blues' decision to combine all of its association small-group business into a single pool for rating purposes. Although theoretically the larger pool should have resulted in broader risk-sharing and lower rates, it also reduced the availability of information regarding the claims experience of our own members, and thus our ability to monitor and oversee the program on behalf of our members. Highmark did, however, continue to offer coverage to everyone at the same rate, without regard to medical condition.

The next significant step down the slippery slope was Highmark's decision to set different rates for different insured firms on the basis of average age of its insureds. Thus, younger, healthier firms enjoyed a lower rate than older firms. The impact was most noticeable for our older sole practitioners, whose "average" age was the age of the sole attorney in the firm, but not nearly as severe as what has happened most recently.

Later, Highmark began including other "demographic" factors such as occupation, location and gender to their rating process. Significantly, Highmark also considers "firm size" to be a demographic factor that impacts claims experience and therefore the rates that are charged.

Personally, I have never understood why a sole practitioner should constitute a greater (or lesser) health risk than the same attorney practicing in a firm of 2 or 10 or 50 or 100 attorneys. We want to defend the right of our members (or any business owner, for that matter) to choose to pursue his or her professional career as a sole proprietor, without regard to the cost of health insurance.

One unfortunate result of the incorporation of numerous demographic factors into the rating process was our complete inability to understand, let alone analyze or negotiate, the rates being charged to our members. Neither could we shop the coverage to obtain competing proposals from other carriers. The competition from the for-profit marketplace would not offer coverage to sole practitioners, a critically important segment of our membership, nor would they provide coverage without medical underwriting and without regard to pre-existing conditions. Highmark remained the community insurer of last resort.

Several years ago, Highmark advised our committee that, in addition to using demographic factors to determine its premiums, it began using computer-driven "**predictive modeling**" as part of the rating process. Highmark alleged that predictive modeling was not medical underwriting, although it did acknowledge that it was based on historical patient information such as medical procedures received and prescription medications taken. Highmark failed to provide any plausible explanation for how predictive modeling differed from medical underwriting.

The incorporation of predictive modeling into the rating process completely eliminated our ability to understand the rates being charged to our members or to provide the kind of assurances that our members want regarding the products they are purchasing through us. Although we pushed for details, Highmark provided no explanation of the drastic rate increases that our members were experiencing, citing HIPPA and the proprietary nature of its rating process as justifications.

We attempted to obtain information from the Insurance Department regarding the legality and permissibility of Highmark's use of predictive modeling. Although Highmark asserted that predictive modeling was permitted, we were unable to locate any support for the practice in Highmark's public rate filings. The Insurance Department indicated informally that Highmark's rate filings were based solely on demographic factors, not predictive modeling or medical underwriting. We were at a loss to reconcile the rates being charged to our members with the incomplete and inadequate information available to us, or even directly to our members, by Highmark.

Before we were able to resolve this problem, Highmark once again changed the rules of the game when it announced in December, 2009 that it intended to move all of its small group coverage to a for-profit subsidiary, Highmark Health Insurance Services. This announcement included notice that HHIS intended to medically underwrite. At that point, however, our efforts to investigate whether or not predictive modeling is permissible became moot going forward. Once the transfer to a for-profit entity was complete, Highmark would not be subject to any restrictions on medical underwriting or predictive modeling. Although Highmark asserts that it is not medically underwriting at this time, they continue to use predictive modeling to determine their rates, which appears to us to be a distinction without a difference.

Initially, the availability of any group coverage for sole practitioners was uncertain. For the moment, Highmark is continuing to define small groups as 1-50 covered employees, extending coverage to sole practitioners, at least on the surface. We need to look beneath the surface at the reality of what is happening.

This transfer of small-group coverage was approved by the Insurance Department. The approval process, however, delayed the release of rates to our members. When the rates were finally released, the results were shocking. As you can see from the chart below, Highmark disproportionately increased the premiums for sole practitioners. The vast majority of sole practitioners received a more than a 20 percent increase in their premiums, with nine (9) firms receiving **more than a 70 percent increase**. On the other hand, the lowest premium increases went to groups that have two (2) or more employees.

Last year, when Highmark was operating the small group insurance pool under its regulated non-profit company, only 24 groups total, inclusive of solos, received a 30 percent or more increase in premiums.

| **Number of ACBA Groups Insured for 2010** | **% of Increase** | **% of Solos** |
|---|---|---|
| 9 groups | No increase | 0 Solos |
| 106 groups | 0.1 % to 19.9% | 46% Solos |
| 19 groups | 20% to 29.9% | 63% Solos |
| 41 groups | 30% to 39.9% | 66% Solos |
| 24 groups | 40% to 49.9% | 63% Solos |
| 14 groups | 50% to 59.9% | 64% Solos |
| 16 groups | 70% to 79.9% | 63% Solos |

It appears that Highmark selectively increased the premiums of solo practitioners in an effort to drive them out of the Bar Association group health insurance plan.

Since there are no alternative health insurance providers willing to provide group coverage to individuals in Western Pennsylvania, the only option for our individual members is to resign from the Bar Association group plan and convert their coverage to a "direct pay" program provided by Highmark. The Insurance Department's approval of this transfer has resulted in Highmark's for-profit insurance company being permitted to charge our members excessive premiums for health insurance. It seems that Highmark has accomplished indirectly what it tried to do years ago: to effectively deny sole practitioners the benefit of small group coverage and force them into a direct-pay program.

When we met with Highmark to review these rates, we once again received no adequate explanation of why some firms, particularly sole practitioners, had been singled out for such outrageous premium increases. Once again, Highmark relied on HIPPA confidentiality and proprietary business information to preclude us from obtaining the information we need to protect our members.

Although Highmark says that they are still not medically underwriting, they acknowledge that predictive modeling was used to formulate these rates. We are no longer able to oversee the rating process to protect our members. By allowing Highmark to move our members to its for-profit subsidiary, the Insurance Department has enabled Highmark to discriminate against our sole practitioner members without any oversight or protection

whatsoever. The people who are being subjected to these prohibitively high premiums are being priced out of the market and have nowhere else to turn.

You will also hear from some of our members who have experienced directly the effect of Highmark's practices. As Mr. Hunt has stated, these individuals, along with our other small and solo firm members, are representative of small businesses in the broader market. The role of small business in generating job growth and leading our economy out of the recession is well established. These family firms do not have the time or expertise to take on a market giant like Highmark. Our members in the past have turned to us for help and protection, and I believe that we have provided a valuable benefit to them. Recent developments, however, have undermined our ability to prevent the arbitrary and discriminatory rate practices that we have seen.

We therefore turn to the legislature and to the Insurance Department to stand up for small business. We want to know why Highmark, having benefitted from decades of tax-exempt status, should now be permitted to walk away from its role as the community insurer of last resort for small business groups. Why should it be allowed to use an employee's medical history, by whatever label may be attached, to make coverage prohibitively expensive? Why can neither we nor our members receive a credible explanation of how their rates are being calculated? We ask that you demand a plausible and documented explanation from Highmark for why coverage is being effectively denied to our most vulnerable members, small firms who are older and less healthy. We ask that you require that the Insurance Department create a public advocate to speak for our members and other small businesses in Allegheny County and throughout the Commonwealth.

Thank you for granting our request to hold this public hearing and for the opportunity to present this information.