TESTIMONY

PENNSYLVANIA
HOUSE OF REPRESENTATIVES
INSURANCE COMMITTEE

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Thank you for the opportunity to provide testimony on the recent re-structuring of Highmark's small group insurance business, and the subsequent changes in premiums. Small groups are defined as covering up to 50 employees.

The decision by Highmark, and the approval by the Pennsylvania Department of Insurance, to move business from the non-profit Highmark entity to a wholly-owned for profit subsidiary, Highmark Health Insurance Company, has resulted in premium increases that are startling in the percentage of the increase and the actual dollar amounts.

Many of these increases are beyond the reasonable ability of groups and individuals to pay. Some believe that physicians are somehow insulated from the cost of medical insurance. This is not correct. Physician practices are businesses, with employees and all the costs of operations as other businesses. There are small groups facing premium increases that will place husband and wife coverage in the range of $40,000 per year. These are premiums at a level that many simply cannot pay.

Following are the rate increases that our small group program has experienced in the past several years:

YEAR	OVERALL AVERAGE INCREASE	INCREASE (TO INSUREDS) RANGES
2006	6.84%	1% to 62%
2007	16.5%	1% to 75%
2008	12.3%	1% to 80%
2009	12.5%	1% to 79%
2010	25.7%	.5% to 79%

Highmark states that it does not medically underwrite individuals as other carriers do. Technically, this is correct. Highmark uses a technique known as "predictive modeling" as part of its rate setting formula. "Predictive modeling" uses previous year's claims to "predict" the claims for the coming year. In essence, it is medically underwriting consumers by using previous claims data; it is a *retrospective* rather

than a *prospective* medical underwriting process. Customers are not denied coverage; but it is offered at premium levels that are so high that the coverage is dropped.

Consumers are provided no data on the premium rating mechanism. Demographic information is provided to Highmark and a premium is generated. Highmark does not provide much in the way of small group data, including aggregated data, citing customer privacy, which makes it difficult to provide an analysis of the number of groups and individuals that have experienced significant premium increases. However, it appears that smaller groups have received selectively higher premium increases with the net effect of driving them out of professional and trade associations plans. These individuals are offered direct-pay conversions to Highmark with admittedly lower premiums but also with substantially reduced coverage limits.

This business model offers large employers and individuals coverage while neglecting small employers. This is a severe detriment to many small employers, their employees, and will leave many people without coverage options.

The practical reality in western Pennsylvania is that there are not many options for coverage in the small group market. Highmark's market share and dominance do not allow for viable alternatives for health insurance coverage for these employers and their employees. Competition from carriers for this business does not exist in a robust manner.

Highmark has stated that this change was necessary to remain competitive with other carriers. It is at odds with the recent federal health care legislation in its ability to provide coverage. It will result in higher numbers of uninsured individuals and families, many of them working and not eligible for public plans. It is particularly difficult to accept these premium increases while Highmark's reserves, currently approximately four billion dollars, continues to grow.

The intent of insurance programs is to provide security from financially devastating expenses in the event of an injury, loss or illness. Insurance is made affordable by spreading risk across a wide spectrum of insureds. These changes are contrary to that intent. Ratings structures by Highmark and other carriers seem to focus on financially penalizing individuals who suffer from an illness rather than spreading risk across a large pool.

Pennsylvania needs insurance reform that would place insurers on a "level playing field" through the use of community rating, a standard policy on pre-existing conditions, benefits packages and limits. "Risk pools" for groups should be constructed by standard, defined, geographic areas to allow greater competition on the same terms by carriers. Consumers also deserve a transparent premium rating process from all carriers, so that they are able to see how rates are determined.

Highmark, and its predecessor companies, was founded on these principals and created by special enabling legislation as a non-profit insurer. As such, it had special obligations to provide coverage to individuals that commercial carriers did not seek to insure. The enabling legislation provided specific favorable tax treatment for Highmark in return for Highmark serving as a insurer of last resort in Pennsylvania. This shift to a for-profit subsidiary creates a situation where the coverage is legally available, but at a price that is not affordable. The company has removed itself from this market through a pricing level beyond the reach of consumers. With these changes to mirror commercial carriers business practices, is it still appropriate for Highmark to enjoy non-profit status, even as a holding company, for a series of for-profit subsidiaries? Highmark is no longer serving the special mission that was the basis of its creation as a company. Those corporate changes, and those that are coming as a result of national health care legislation, call for an intense, thorough review of how health insurance is offered and sold to Pennsylvanians to assure adequate coverage at premiums that fairly represent the cost of insuring those patients.