Healthcare Excellence and Accountability Response Team
House Democratic Policy Committee

Greater Pittsburgh Automobile Dealers Association
RIDC Park ~ 207 Sigma Drive ~ Pittsburgh, PA 15238

August 22, 2006
9:30 AM

Geoffrey Dunaway, Director for the Accident and Health Bureau
Office of Insurance Product Regulation and Market Enforcement
Pennsylvania Insurance Department

Good morning. I am Geoff Dunaway, the Director of the Accident and Health Bureau for the Pennsylvania Insurance Department. On behalf of Governor Rendell and Commissioner Koken, I'd like to thank the members of the House Democratic Policy Committee for asking the Department to participate in today's hearing. We appreciate the opportunity to meet with you to discuss these important issues related to health insurance coverage.

The availability and affordability of health insurance and health care coverage are major public policy issues and important concerns for all Pennsylvanians. An increasing number of people in Pennsylvania do not have access to health insurance, cannot afford health insurance, or their employers cannot subsidize it to the degree that they had been able to in the past.

As you may know, the Governor's Office of Health Care Reform is leading a comprehensive planning process to expand access to affordable health care coverage, contain costs, and improve the quality of health care in Pennsylvania. The Commonwealth has been awarded a state planning grant from the federal government to help with this planning process.

The Governor has asked a diverse group of Pennsylvanians, through four advisory panels, to provide input and feedback on policy options, cost models, and other proposals related to this grant. These panelists include small business owners, CEOs, physicians, leaders of community organizations, union leaders, hospital administrators, legislators and consumers, from across the Commonwealth. The Governor's Office of Health Care Reform is currently assessing concepts as well as proven strategies for expanding access, containing costs and ensuring quality. After their work related to this grant has been completed, they will be reporting their findings and recommendations.

As requested, this morning I'd like to discuss several health care related issues: Health care trends including spending, premium rates and cost drivers; the Insurance Department's premium rate review authority; an overview of community and demographic rating and how the health insurance market has been shifting and reacting to regulatory oversight.

I'd like to start by taking a few minutes and providing some background information on health care trends including spending, premium rates and health care cost drivers. While the spending and premium data is national, Pennsylvania's experience is very similar to the national data.

Total U.S health care spending has been increasing in both dollar amounts and as a percentage of the Gross Domestic Product (GDP) for many years. The rate of health care spending has been accelerating in recent years. In 1980, $255 billion or 9.1% of GDP was spent on health care. In 1990, spending had risen to $717 billion or 12.4% of GDP. By 2000, health care spending was $1.6 trillion or 13.8% of GDP. By 2015 it is estimated that health care spending will be over $4 trillion or 20% of the GDP.

During this time there has been a similar rise in national per capita health expenditures. In 1990, national per capita health spending was $2,821. By 2000, it had risen to $5,485. In 2005, it was $6,683. Per capita spending is now projected to almost double to $12,320 in the decade from 2005 to 2015.

When considering health care costs it is important to understand that health care spending is not evenly divided across the entire population. A small percentage of the population accounts for a large percentage of the expenditures.

A study released in April 2006 by Watson Wyatt Worldwide, a global human capital and financial management consulting firm, showed that 4% of the population used 49% of health care dollars with an average health care cost per individual of over $10,000 per year. This study also showed that the next 24% of the population spent between $1,500 and $9,999 per individual per year and accounted for 40% of health care dollars spent. The vast majority of people, 72%, spent less than $1,500 per individual per year and accounted for only 11% of health care expenditures.

Steadily increasing health insurance premiums are one of the biggest current public policy concerns. It is one of the main factors impacting access to affordable health insurance. Over the last 15 years health insurance premiums have been on a roller coaster ride. This trend in not unique to Pennsylvania, but is also being experienced nationally.

An analysis of national data shows that health insurance premiums were rising at double digit rates in the late 1980s and early 1990s. In 1991 premiums rose at the average rate of 11.5%. By 1996, thanks to cost reduction strategies, premiums were increasing at less that 1% per year. However, starting in 1997, premiums began to increase again and peaked in 2003 at 13.9% per year. There has been a reduction in the past two years to 9.2% per year in 2005. But, even with this slowing, premiums today are still increasing at almost three times the rate of general inflation.

Health care costs continue to increase much faster than general inflation, even as the rate of increase has been slowing. There are a number of factors driving up these costs. These include an aging population, the increased utilization of services, the cost and availability of technology, enrollee movement to less restrictive forms of managed care and provider consolidation and reimbursement costs.

America and Pennsylvania's population is aging. As the baby boom generation ages there is an increased utilization of services. In addition, HMOs traditionally encouraged the use of preventive services without regard to the cost of the service. This utilization of services, originally encouraged by traditional managed care plans, has remained high while the demand by consumers for more open networks and greater provider choice has grown. These factors have combined to be important cost drivers of higher health care costs.

Technology and its impact on the cost of health care continue to grow by leaps and bounds. It is a great time to be alive if you need advanced medical treatments and services. But these treatments generally come at a higher price.

Another factor is that enrollment in health coverage and managed care plans has been steadily moving away from more heavily managed care options under HMOs to more open models under point of service and PPO options. As noted, consumers are demanding more choice and more open networks and care delivery systems. These more open access models of health care delivery are generally more expensive. There is a trade off between cost and access to providers.

Finally, hospital and other provider costs are increasing. As other sources of revenue, including Medicare and Medicaid, are reduced, providers are pushing health plans to increase their reimbursement rates. These providers have increasing leverage to negotiate higher rates due to mergers and consolidations.

Now that we've reviewed some of these underlying health care cost trends and cost drivers, I'd like to discuss the Insurance Department's rate review authority. The Department's authority to review accident and health insurance premium rates and policy forms is set forth under Act 159 of 1996, known as the Accident and Health Reform Filing Act.

The Department's rate review authority for group health insurance is based on how an insurer is licensed. The Act gives the Department the specific authority to review premium rates for group health insurance policies sold by the Blue Cross/Blue Shield plans and HMOs. However, the Act does not give the Department any statutory authority to review the premium rates for group health insurance policies sold by other insurers including commercial insurers and Preferred Provider Organizations (PPOs).

Act 159 also gives the Department the authority to review premium rates for all individual health insurance products under the Department's regulatory authority. These premium rates must be filed with the Department for review prior to their proposed use. This allows the Department to review these premium rates and determine if they meet statutory requirements before the rates are implemented.

For both group and individual products, Act 159 requires that premium rates or rating methodologies utilized by insurers under the Department's authority are not excessive, inadequate or unfairly discriminatory. The Department has a number of options when we receive a rate filing for review. We can approve or disapprove the filing based on the information submitted in the filing, we can request further information through a data call, publish the filing for public comment in the *Pennsylvania Bulletin* and local newspapers and hold public hearings.

The Department considers a number of factors during its review of rate increase filings including the actuarial analysis and rating factors that the insurer uses to derive the premium rate. The factors considered include the benefits being provided, the current and projected unit cost for services, the utilization of services, administrative costs and risk and contingency factors. Primarily, it is the unit cost for services and the utilization of the benefits being provided that drives the premium for the product with administrative costs and risk and contingency factors being a relatively small portion of the rate.

Premium rate review can assure that proper trends and assumptions are being used by insurers in developing premium rates. However, premium rate review and regulation cannot slow the increases in the underlying health care cost trends factors previously discussed.

One of the issues I've been asked by the Committee to address is the use of community and demographic rating by insurers for small employers of 2 to 50 employees.

State and federal law requires insurers selling in the small employer market to make their coverage available to any small employer that requests the coverage. This is known as Guaranteed Issue or Guaranteed Availability of small employer group policies. However, the requirement does not address the premium cost for the coverage. An insurer can use any actuarially sound rating methodology permitted under state law.

The premium rating structures that insurers utilize impact the availability and affordability of health insurance coverage for small employers and their employees. Community rating and demographic rating are the main rating methods used by insurers for small employer groups.

Community Rating is a rating methodology where premium rates are calculated without regard to the characteristics of a subset of a covered population. Premiums are based on the average health care costs of the community covered, not the age, sex, occupation or health of the individual insureds.

Demographic Rating is a rating methodology in which premium rates are calculated based on the average health care costs of subsets of the covered population, not the overall experience of the community covered. Premium factors are developed based on such characteristics as age, sex, occupation, group location and health status. By applying these factors to the demographics of the specific group the insurer develops specific employer group premiums.

An example might help illustrate the impact of demographic rating on small employer group premiums. The demographic factors for the age of individuals within a group can be twice as higher for the oldest employees compared to the youngest. Through the actuarial review process the Department has generally limited the range for ages to +/- 35%. This means that premium rates based on the average age of the employer group can vary from 65% of the base rate to 135% of the base rate.

There are no specific laws or regulations in Pennsylvania relating to the use of community or demographic rating by health insurers. For many years community rating was the standard rating methodology utilized by the Blue Cross/Blue Shield plans (the Blues) and health maintenance organizations (HMOs) for small employer groups. The Blues and HMOs provided the majority of health insurance coverage in the small employer group market during that time.

However, all other major health insurers in Pennsylvania subject to the Department's policy form regulation were using demographic rating and health

underwriting to determine premiums for small employer groups. The Blues and HMOs became concerned about the use of demographic and other rating methodologies, including medical underwriting, by commercial insurers for small employers groups and the potential for "cherry picking" by these insurers of the best risks among these groups if they continued to use community rating. Nothing in Pennsylvania statute prohibited the Blues and HMOs from implementing demographic rating factors and they started to use these rating factors for their small group business in 2000.

I'd like to discuss "cherry picking", or seeking out the best insurance risks, a little more. It can be a problem for the health insurance risk pool because, as I noted above, a large percentage of health care services are used by a small percentage of health care recipients. If the best risks, those that balance out the higher risks in the health care rating pool, are removed from the pool, there is a dramatic increase in the costs, and therefore the premiums, for the higher risk population. While cherry picking allows these non-rate regulated insurers to choose the best risks and charge lower premiums, it reduces the affordability of premiums those who need the coverage the most.

As I discussed earlier, the Department's premium rate review for group business is based on how an insurer is licensed. When Act 159 was implemented the majority of group health insurance was provided by the Blues and HMOs. The split between regulated and non-regulated group rates has changed over time as more and more group business is being written through commercial insurers that are not subject to Department rate regulation. This trend has included most of the Blues and HMOs now offering group coverage under commercial insurer subsidiaries that are exempt from the Department's rate review authority. We expect that this shift to non-rate regulated insurers will continue in the future.

As I mentioned earlier, while premium rate review and regulation cannot slow the increases in the underlying health care cost trends factors it can assure that proper trends and assumptions are being used by insurers in developing premium rates. This shift of group policies and rate review from regulated to non-rate regulated insurers reduces the Department's ability to assure that proper trends and assumptions are being used by insurers in developing premium rates.

As this information demonstrates, there are a number of interactive factors that are driving health care costs and health insurance premiums. We look forward to working with you on these important issues. I thank you again for the opportunity to appear before you today, and welcome your questions at this time.