



Testimony before the  
House Insurance Committee:  
*"Small Group Reform"*

Presented by:  
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Good morning. My name is Joel Ario and I am Pennsylvania's Insurance Commissioner. Thank you for this opportunity to testify in support of health insurance reforms for the small group and individual market. As we discussed last year, Pennsylvania is one of only two states that does not have any rating laws to protect small businesses against rate spikes simply because one or two employees have an expensive claim.

I will divide my testimony into three parts. First, I will explain why 48 states have acted to protect small businesses. Second, I will discuss some of the key reforms in HB 746 and why they are important. Third, I will offer some comments on how HB 746 could be improved in ways that may broaden support for reform.

### **Small businesses are vulnerable**

In spite of the escalating cost of health insurance, more than 95% of businesses with 200 or more employees continue to offer health insurance to their employees. As business size decreases, so does health insurance coverage, with less than half of businesses with fewer than 10 employees offering health insurance. There are many reasons why small businesses do not offer health insurance as often as large businesses, but the critical difference from an insurance perspective is that small businesses do not have enough employees to create their own stable risk pools. Absent some opportunity to pool their employees with other small businesses, their rates are subject to large increases because of one or two expensive claims. Even without such claims, they are riskier because of the potential volatility of claims costs.

The federal government has addressed this problem to a limited degree by requiring that health insurers offer coverage to all small groups (2-50 employees) on a "guaranteed issue" basis, meaning that no small group may be denied coverage because of health status or any other risk factor. However, federal law does not regulate pricing of small group insurance, leaving it up to the states to protect small businesses from being priced out of the market.

The 48 states that have enacted small group rating protections have done so in a variety of ways – from community rating, where all groups pay the same common rate, to rate bands, where rates can vary within defined limits based on group characteristics such as age or type of industry. Most states allow insurers to use health status or claims experience as a rating factor, but states typically put more restrictions on this volatile type of rating than they do on other rating factors.

It is important to note that rating protections do not, by themselves, increase or decrease the overall cost of health insurance. They simply spread those costs more equitably across a large pool of small businesses so that each business has more stable and predictable rates than it would if on its own. Given the importance of predictable costs in the business world, rating protections have proven popular across the states. Interesting evidence for this point comes from two states (Colorado and New Hampshire) that first banned medical underwriting and subsequently repealed their bans in the name of lowering rates for businesses with young and healthy workers. In both states, the

resulting rate fluctuations led to reinstatement of the bans on medical underwriting, with the business community leading the charge in the name of predictability.

It is an interesting question as to why Pennsylvania is one of two outliers among the 50 states. As a relative newcomer to the state, I believe it is because the four Blue Cross and Blue Shield companies have traditionally used rating practices similar to what is required of all insurers in other states. However, the landscape is changing quickly on that score, with each of the four Blue companies finding creative ways to do what insurers naturally do in the absence of regulation: compete aggressively for the best risks and excluding or prohibitively pricing the bad risks.

The Blue companies do have social mission responsibilities to continue offering certain products on a guaranteed issue basis, but there is nothing in current law that prohibits them from using for-profit subsidiaries and other business strategies to engage in the same aggressive “cherry picking” that increasingly characterizes the commercial marketplace. The future of these trends can be seen in the pricing differences between the “medically underwritten” and “guaranteed issue” products that the Blue companies currently offer in the individual market. Those who pass underwriting pay as little as \$100 per month, while those that fail underwriting often pay more than \$500 per month for similar coverage.

Some have proposed to address these trends by tightening the rules for the Blue companies and leaving other insurers alone. This would be preferable to doing nothing, since inaction will leave all insurers free to accelerate their competition for the best risks at the expense of those who are aging or happen to have a preexisting condition. It is worth noting, however, that no other state has adopted such a bifurcated approach, and that past attempts to impose rules selectively on the Blue companies have not succeeded.

### **HB 746 is a good starting point**

HB 746 contains a number of promising reforms. Let me focus on two of them: rate bands and limits on rating factors, and expanded data gathering and rate review authority for the Insurance Department.

**Rate bands.** Under HB 746, Pennsylvania would join the other 48 states that require insurers to pool risk in the small group market so that all small businesses have more stable and predictable rates. The bill provides a modestly bifurcated approach. Large insurers (those with a 10% or greater market share) would be required to price all small groups within a 2:1 rate band, meaning no group could be charged more than the average rate plus 33% or less than the average rate minus 33%. Small insurers could use a 3:1 rate band, meaning no group could be charged more than the average rate plus 50% or less than the average rate minus 50%. Rating variations within these rate bands could only be based on age, region of the state, and wellness incentives (plus class of business for small insurers). Medical underwriting would be prohibited.

These are reasonable provisions and are consistent with the approaches taken in other states except for the bifurcation between large and small insurers. One practical problem

with this bifurcation is the administrative complexity of calculating market shares for all insurers in each of seven regions on an annual basis. This would likely be costly for insurers to report and for the Department to analyze, and could generate a series of challenges, especially for insurers who may be close to the 10% demarcation line. As suggested below, it would be much simpler to exempt the genuinely small insurers, though exemption would not be sensible for insurers with high single digit market shares since this could amount to billions in premiums on a statewide basis.

**Rate review.** Second, let me single out the provisions in HB 746 that enhance the Insurance Department's data gathering and rate review authority. Currently, we have rate review authority in the individual market, but in the small group market, our authority is limited to the Blues companies and HMOs. HB 746 would give us rate review authority for all individual and small group rates, and would give that authority some teeth by allowing us to ensure that insurers are properly accounting for administrative expenses and following best practices for cost control.

Pennsylvania is a national leader in cost control, with innovative work in many areas including chronic care management and hospital-based infections. We have some good models, but the major payers, including both government and insurers, are the key to successful implementation. All insurers have robust cost control programs for their large employer accounts for the simple reason that employers demand it. But small employers do not have the same leverage and typically lack the specialized personnel to coordinate between the insurer and the workplace. One way to hold insurers accountable for promoting wellness programs and other cost control strategies in the small group market is through the rate review process.

#### **HB 746 can be improved**

HB 746 is based on HB 2005 of the 2007 Session, which was the first small group reform bill to pass either chamber in recent times, albeit in amended form. That was a commendable success and I was proud to join the Chairman and this Committee in supporting that bill. Unfortunately, however, HB 2005 did not fare well in the Senate. This year, we all ought to aim higher and find the accommodations necessary to join the other 48 states with small group protections. To that end, I offer five suggestions for how HB 746 might be amended in ways that both improve the product and broaden support for the bill: focus on rate spikes, promote wellness, phase in reforms, address the individual market separately, and exempt small insurers.

**Rate spikes.** The single most important objective of reform should be to prevent rate spikes for small businesses and individuals. It would be great to achieve universal coverage, but at the least we should ensure that no one who has coverage loses it because of an unaffordable rate increase. In the small group market, the most direct means for achieving this would be a hard cap on annual rate increases at a specified percentage above medical trend. Ten percent would be a reasonable cap, which would require reducing the 15% flex rating allowance that the Blues and HMOs currently have by statute, and then applying this cap to all insurers. Such a cap would address the rate

spikes that occur when an employee incurs a serious claim or when an employer hires a person with a chronic medical condition.

In the individual market, federal law requires guaranteed renewability in the individual market, but as with the small group market, this can be a hollow promise if not combined with effective rate regulation. Individuals should be protected against selective rate increases at renewal, which means rate increases should be done on a tier-wide basis so that individual experience is spread across a broad pool.

**Wellness incentives.** The best way to control costs in the long term is to promote healthy behaviors. All major insurers have robust programs to promote wellness, and large group contracts typically contain wellness incentives such as the PEBTF program that gives individual employees a premium reduction for participating in the state's wellness program. HB 746 allows wellness incentives to be used as a rating factor, and this should be strengthened so that small businesses get the same kind of discounts for meeting defined goals that large businesses typically get through their market leverage.

It is important to note here that claims-based rating does not achieve the same result. On the one hand, claims-based rating penalizes accidents, genetic conditions, and other health claims that are completely unrelated to unhealthy behaviors. On the other hand, claims-based rating also fails to reward smoking cessation and other healthy behaviors that may not show up in reduced claims costs for many years after the behaviors are adopted.

The Insurance Department is working closely with the Department of Health on how to promote employer-based wellness programs, and we are convinced that insurance discounts are one effective means for accomplishing this goal. In addition to model insurer programs, there are a number of model laws from other states to help us devise a program for Pennsylvania. Secretary James and I would be pleased to work with this committee and stakeholders on enhancing wellness incentives.

**Phase in.** The rate bands in HB 746 will bring much needed rate relief to the older and less healthy, who are most disadvantaged by the current unregulated system. However, it bears repeating that rating protections, by themselves, do not increase or decrease overall rates, meaning that some will pay more and others pay less in order for everyone to have more stable and predictable rates. The best way to ensure that the transition to rating reforms does not itself create unnecessary volatility is to phase in the rating reforms by putting an annual cap on any rate increases caused by the rating rules. This cap could be the same 10% limit suggested above for rate increases based on health status. This would have the effect of extending the change over multiple years, particularly for the more aggressive commercial insurers who may have offered the best risks heavily discounted rates.

Recent experience in Oregon offers an illustration of how a phase-in might work. When a 2007 law phased in a new 3:1 rate band, 60% of small employers saw rate decreases or no change in rates in the first year. The remaining 40% saw rate increases, including 3%

with rate increases of 40% or more. A longer phase in would have been better for this latter group.

**Individual market.** HB 746 does not address individual market reform, such as provisions that would extend guaranteed issue to the individual market and also prohibit preexisting condition exclusions. Admittedly, this makes some sense, since only five states (Maine, Massachusetts, New Jersey, New York, and Vermont) currently require guaranteed issue in the individual market, and all of them allow preexisting conditions exclusions. Furthermore, all five have faced the related challenges of above average prices and below average participation.

The only one of these five states that has made significant progress is Massachusetts, which combined what had been a disproportionately small individual market with its small group market and, more importantly, adopted a “personal responsibility” mandate that requires everyone to purchase insurance. The mandate has proven key to making Massachusetts the national leader for coverage, with rates above 95%.

In considering our own individual market, the Massachusetts approach bears watching. It may be the best approach for Pennsylvania as well, since the reality is that no other state has found an effective balance between a market that takes all comers without restrictions and a market that has affordable rates for everyone.

The Governor is not generally a fan of government mandates on individuals, but he has expressed his willingness to consider a health insurance mandate as part of a broader package to expand access to coverage. The concept has a clear precedent in auto insurance, where it is called “personal responsibility” and requires all drivers to purchase auto insurance. As noted, this has proven popular and effective in Massachusetts, the one state to test the idea so far. The idea has bipartisan support in that sister state, with former Governor Romney championing the mandate as a way to hold freeloaders accountable and Democratic supporters seeing it as a matter of community responsibility.

There is a great deal of discussion about the need for an individual mandate as part of federal reform, with concern that many healthy people, especially young ones, will not purchase health insurance on their own, especially if preexisting condition exclusions and other incentives for early purchase are eliminated. There is an even stronger recognition that an individual mandate should have an affordability exception, so that no one with limited income is forced to buy health insurance unless there are appropriate subsidies available. In Massachusetts, the affordability line currently stands at about 400% of the federal poverty level, roughly \$44,000 for a single person. We would be pleased to work with you to craft a similar proposal for Pennsylvania.

**Small insurer exemption.** There currently are more than 200 health insurers licensed in Pennsylvania, and the vast majority of them have small market shares. These small market share insurers are an important source of innovation, and some may become the industry leaders of tomorrow. It would not adversely affect insurance reform to simply exempt such small insurers unless and until they achieve at least a 1% market share.

Under that standard, an insurer would be exempt unless it had annual premiums in excess of \$300 million, quite a generous definition of “small insurer.” At the same time, the nine non-exempt insurer groups would account for 85% of all health premiums. The nine include the four Blue companies, three large national insurers (Aetna, Coventry, and United), and two Pennsylvania-based managed care companies (UPMC and Geisinger). By limiting the reforms to these nine insurer groups, the goals of reform – fair and predictable rates for everyone – could be achieved while preserving maximum flexibility for smaller insurers.

Thank you for this opportunity to testify and I would be happy to answer any questions.