



Testimony before the
Pennsylvania House Appropriations Committee

Presented by:
Joel Ario
Insurance Commissioner

Wednesday, February 24, 2010

Escalating Problems in Health Insurance Market
Supplementary Budget Statement
Joel Ario, Pennsylvania Insurance Commissioner
February 2010

Thank you for this opportunity to supplement the department's previously submitted, regular budget information with this statement that focuses on the challenges we face in the health insurance marketplace. Before delving into the details, let me note that, as Insurance Commissioner, I spend well over half my time on health insurance. The reason is simple: the consumer problems we face in health insurance dwarf the problems in every other insurance market.

This is not to say that other insurance markets are perfect. No, there are challenges in each of the other major consumer lines – auto, homeowner, and life – and there are problems to address in other specialized markets as well, whether medical malpractice, surplus lines, commercial property and casualty, or any of the smaller lines. But those challenges are much more manageable than the challenge of expanding access and reducing costs in the health care marketplace.

Cost control is job number one in health reform and I address some of the important areas of cost control in the attached letter. But as I noted in that letter, many of the toughest issues in cost control, especially those related to changing the delivery system, are beyond the ability of the insurance sector to solve alone. Indeed, it will take concerted action by all health care sectors to accomplish the changes we need in areas like moving from a volume-based payment system to an outcomes-based payment system, expanding the use of best practices, and enhancing efficiency with electronic medical records and other technological reforms. Moreover, many of these issues require federal leadership, given that Medicare and Medical Assistance spending account for roughly half of all health care spending.

Let me also note that an area of health insurance in which there is not a pressing need for the Pennsylvania General Assembly to act is the large group insurance market (groups of 50 or more). In that market, insurers already effectively pool risk and employers have bargaining leverage to negotiate better deals than small groups and individuals can. In addition, federal law, especially ERISA, puts substantial limits on what states can do in the large employer marketplace.

This leaves us with the individual and small group markets (2-50 employees). In these markets, consumers are at a severe disadvantage and access to coverage is steadily deteriorating. This is generally true in most states, but it is especially true in Pennsylvania because we are one of only two states that have not enacted small group rating reforms. The health care crisis may be national in scope, but the fact is that 48 states have better consumer protections against large rate increases and other unfair rating practices than does Pennsylvania.

The result of our failure to act is a very unstable, troubled market place in which consumers face a concerted effort by health insurers to use individual health questionnaires and other aggressive rating practices to impose large rate increases on individuals and small businesses, resulting in unaffordable coverage for the very people who need it the most.

More specifically, there are multiple signs pointing to a pattern of rate increases that is well in excess of historical norms. This is truly alarming given that historical norms for the past decade have included annual rate increases in the 10 percent range, leading to a doubling of rates since 2000. In this context, the current rate spikes of 20 percent or more cry out for legislative action.

Fortunately, there are readily available models for legislative action, including the insurance reform bills that passed the Pennsylvania House in 2008 and 2009, both of which embody the rating restrictions, information requirements, and other consumer protections that are commonplace in other states. A similar bill was recently introduced in the Senate, though that bill is more selective than the House bills as to which insurers would be subject to rating limitations.

One reason these bills were stalled in Pennsylvania was the argument that we should wait for the federal government to solve the problem. This was a reasonable argument until recently, but with federal reform stalled, it now appears that our efforts to protect small businesses against exorbitant rate increases will depend on Pennsylvania joining the other 48 states that have adopted small group rating reforms through their legislatures.

The Insurance Department stands ready to work with the General Assembly to achieve such reforms, and to anyone who still doubts the need for action, I offer the following signs of a growing problem for consumers:

1. Abnormally large increases in individual rate filings. In the fall of 2009, the four Blue Cross and Blue Shield insurers in Pennsylvania, with a combined health insurance market share of roughly 60 percent and much higher shares in certain local markets, all filed for abnormally large rate increases in the individual market. For certain specific products, the requests exceeded 30 percent and even 40 percent. After a thorough review process, those requests were reduced and rate increases in the 10 percent range were approved for most products, with the recognition that larger requests will recur in the absence of reform. A number of legislators objected to the original rate requests, and I have attached my December 2009 response to those legislators, which offers an overview of market dynamics and choices facing the General Assembly.
2. Insurers contend that actuarial data supports even larger rate increases in the absence of reform. My December 2009 letter includes a detailed description of one case in which a small business received a 100 percent rate increase based on its claim experience. That business testified to its experience in a Congressional hearing; the insurer did not appear but submitted a letter (copy attached)

- indicating that the rate increase should have been more on an actuarial basis and suggesting that such rating practices would continue until federal health insurance reforms were enacted. Interestingly, that insurer (a commercial competitor to the Blues) expressed support for insurance reforms that would prohibit all insurers from using health status to price insurance as part of a broader package of reforms included an individual mandate.
3. Increased use of underwriting tools. The department has received reports that insurers are making increased use of health insurance questionnaires and other tools to target and substantially increase prices for small businesses with a few expensive claims. The trend includes the Blues, who traditionally have criticized their commercial competitors for “cherry picking” the market but increasingly are taking the position that, in the absence of reform, they have to use the same risk assessment tools and pricing practices as their competitors.
 4. Increased use of deregulated rates by the Blues. Starting with IBC in the mid-1990s, all four Blues have formed for-profit subsidiaries and used them to varying degrees to offer products that are medically underwritten and more price competitive for the best risks. The Department has historically found no basis in Pennsylvania law to treat these for-profit subsidiaries differently than other for-profit companies for purposes of rate review, meaning that small group products issued by these for-profit subsidiaries are not subject to rate review. The department recently reviewed this history in determining whether there was legal authority in current law to prohibit Highmark from moving its small group business to a for-profit subsidiary outside our rate review jurisdiction, and concluded that there was no clear authority for such action and that any attempt to assert such authority would have implications for the other three Blues, all of which previously took similar action.
 5. Increased threats to market stability. One of the leading commercial insurers has recently urged the Department to carefully review rating practices of the Blues, claiming that they are accelerating their use of medical underwriting and rating to the detriment of market stability. The Department is in the process of surveying the nine dominant insurer groups, which collectively account for more than 80% of all business, to determine what their current rating practices are. The survey (copy attached) may lead to regulatory action, but in any event, it will help fill in public information gaps that are unique to Pennsylvania, given our limited rating protections and minimal data reporting that often leave the Department with insufficient information to answer questions from the General Assembly and the public.
 6. Anticipatory rate increases. At the Congressional hearing noted above, there was testimony suggesting that insurers were bidding up prices in anticipation of federal reform so that they would be as favorably positioned as possible when the federal reforms took effect. Even if there is no federal reform bill passed, we can be sure that these recent rate increases will not be reversed.

7. Individual market parallels. There are similar concerns in the individual market. Only the Blues offer products on a guaranteed issue basis; their competitors simply decline to offer coverage to individuals with significant preexisting conditions. However, even the Blues offer better rates to individuals that can pass medical underwriting, meaning that the guaranteed issue business is increasingly becoming a high risk pool with rates that are five or ten times as high as the medically underwritten business. A handful of states have imposed guaranteed issue on all individual market business, but the general result has been increased prices and reduced enrollment. The one striking exception is Massachusetts, where the individual market is expanding and overall coverage is at 97%, primarily because insurance reforms were combined with an individual mandate.

The Insurance Department hopes that you share our concerns about these troubling developments, and we pledge our resources to work with you to achieve reforms that will provide improved consumer protections for Pennsylvania's health insurance marketplace.



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.¹ 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:

¹ 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[±].
- 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.[§]

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.²

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

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

[‡]The source for this data is Quality Compass[®] 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.

[§]“America’s Best Health Plans” is a trademark of *U.S. News & World Report*.



February 16, 2010

Re: Rating & Underwriting Questionnaire for <insert company name>

Dear:

The Department has recently noted several indicators that health insurers are changing their underwriting and rating practices in the individual and small group markets in ways that raise substantial consumer protection issues, especially for those most in need of health coverage. The attached questionnaire, which is being sent to the nine largest health insurers in Pennsylvania, is the Department's first step in gathering the information necessary to fulfill its consumer protection obligations.

The troubling indicators that give rise to this questionnaire include a Congressional hearing featuring a Pennsylvania small business that received a 100% rate increase, letters from consumers and state legislators complaining about rating practices, sample questionnaires and other documentation from brokers concerning individual underwriting in the small group market, reports of anti-competitive practices in pricing bids, consumer complaints about insurers rating children as independent risks under the state's new law allowing children to stay on their parent's policy to age 29, and competitor complaints concerning the scope and pace at which the Blue-branded insurers are expanding their use of medical underwriting and rating.

Depending on responses, the questionnaire may result in no further action for insurers that provide complete information demonstrating compliance with relevant laws. In other cases, the result may be further follow up, up to and including an on-site examination. In all cases, the questionnaire will be helpful to inform the public debate about health care reform. More specifically, the questionnaire will help fill in public information gaps that are unique to Pennsylvania, given our limited rating protections and minimal data reporting that often leave the Department with insufficient information to answer questions from the General Assembly and the public.

Please provide the information requested in the attached questionnaire to Christopher Monahan, Director, Bureau of Market Actions, 1227 Strawberry Square, Harrisburg, PA 17120. Any questions can be directed to Mr. Monahan at 717-787-9100 or cmonahan@state.pa.us, or to Shelley Bain at 717-787-0873 or sbain@state.pa.us. Responses are due by March 5, 2010 and may include confidentiality claims as to specific portions of your answers that are entitled to protection under Pennsylvania law.

Sincerely,

Questionnaire Relative to Industry Rating and Underwriting Practices

Specific Market Practices. For each of the companies in the Aetna Group of insurers, please provide answers and appropriate attachments to the following questions for the time period from January 1, 2008 to the present, noting any changes during that period.

1. Does the company provide claims data to small employers for renewals?
2. Does the company request a renewal quote from the incumbent carrier prior to providing a final quote for a new small employer group?
3. Describe the rating methodology used by the company to establish the premium for an adult child seeking coverage under her parent's policy pursuant to Act 4 of 2009, 40 P.S. §752.1.

Underwriting and Rating Practices (Small Group). For each of the companies in the group, please provide an overview of your underwriting and rating practices, including answers to the following questions, in the Small Group Line of Business (2-50 employees) for the time period from January 1, 2008 to the present, noting any changes during that period. Be specific as to underwriting and rating practices for your Dominant Product (Dominant Product means the one with the highest premium for 2008 and 2009), and also describe any variations for other products.

1. Does the company use health questionnaires for small employer groups? If yes, please provide a copy of any such questionnaires.
2. List all the rating factors the company uses in setting the rates (e.g., age, gender, industry, etc.) and provide the range of each factor.
3. Explain the company's rating methodology, including how each factor is applied and what weight (if any) is given to each rating factor in the development of the rate and the use of any caps or limits on health status or claims experience. Also indicate what, if any, cap or limit your company uses on aggregate or composite rating factors produced by combining all factors in the rating formula.
4. List and quantify any discounts and surcharges that may be included in the rates.
5. Describe any use of flexible rate bands or other practices that can be used to vary rates beyond what has been reported in earlier answers.
6. Indicate the total number of lives covered in the small group market for the group and by company, using estimates if necessary.

Underwriting and Rating Practices (Individual Market). For each of the companies in the group, please provide an overview of your underwriting and rating practices, including answers to the following questions, in the Individual Line of Business for the time period from January 1, 2008 to the present, noting any changes during that period. Be specific as to underwriting and rating practices for your Dominant Product (Dominant Product means the one with the highest premium for 2008 and 2009).

1. Does the company use health questionnaires for individual applicants? If yes, please provide a copy of any such questionnaires.

2. List all the rating factors the company uses in setting the rates (e.g., age, gender, industry, etc.) and provide the range of each factor.
3. Explain the company's rating methodology, including how each factor is applied and what weight (if any) is given to each rating factor in the development of the rate and the use of any caps or limits on health status or claims experience. Also indicate what, if any, cap or limit your company uses on aggregate or composite rating factors produced by combining all factors in the rating formula.
4. List and quantify any discounts and surcharges that may be included in the rates.
5. Describe any use of flexible rate bands or other practices that can be used to vary rates beyond what has been reported in earlier answers.
6. Indicate if the company has any guaranteed issue products in its Individual business? If so, describe any differences in the rating practices applicable to the guaranteed issue business.
7. Indicate the total number of lives covered in the individual market for the group and by company, using estimates if necessary.

Changes in Underwriting and Rating Practices. Please answer the following questions from the perspective of your group as a whole.

1. Explain any changes in rating methodologies used by companies within your group since January 1, 2008. Do you expect to implement any changes in 2010 or 2011? Examples of changes include addition and deletion of rating factors, changes of range or weights of factors, etc.
2. Describe any movement of business from one company to another within the group since January 1, 2008. Do you expect any such movements in 2010 or 2011.
3. Explain any significant differences in the rating processes of the different companies in your group of companies.