

PREMIUM INCREASES BY ANTHEM BLUE CROSS IN THE INDIVIDUAL HEALTH INSURANCE MARKET

HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED ELEVENTH CONGRESS SECOND SESSION

FEBRUARY 24, 2010

Serial No. 111-97



Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

76-009

WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
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PREMIUM INCREASES BY ANTHEM BLUE CROSS IN THE INDIVIDUAL HEALTH INSUR- ANCE MARKET

WEDNESDAY, FEBRUARY 24, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:03 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Bart Stupak [Chairman of the Subcommittee] presiding.

Present: Representatives Stupak, Braley, Markey, DeGette, Schakowsky, Christensen, Welch, Green, Sutton, Waxman (ex officio), Capps, Eshoo, Hill, Burgess, Gingrey, and Griffith.

Staff present: Phil Barnett, Staff Director; Kristin Amerling, Chief Counsel; Bruce Wolpe, Senior Advisor; Sarah Despres, Counsel; Purvee Kempf, Counsel; Naomi Seller, Counsel; Jack Ebeler, Senior Advisor on Health Policy; Stephen Cha, Professional Staff Member; Dave Leviss, Chief Oversight Counsel; Stacia Cardille, Counsel; Ali Golden, Professional Staff Member; Erika Smith, Professional Staff Member; Ali Neubauer, Special Assistant; Karen Lightfoot, Communications Director, Senior Policy Advisor; Elizabeth Letter, Special Assistant; Matt Eisenberg, Staff Assistant; Sean Hayes, Minority Counsel; Alan Slobodin, Chief Minority Counsel; Clay Alspach, Minority Counsel; and Garrett Golding, Minority Legislation Analyst.

OPENING STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. STUPAK. This meeting will come to order. Today we have a hearing entitled "Premium Increases by Anthem Blue Cross in the Individual Health Insurance Market." Before we begin, I ask unanimous consent that the contents of our supplemental memo be entered into the record. This supplemental report is in regards to our investigation in the small business health insurance market. We had a draft last night and I think it was just finalized today. And the company documents with that memo, there is a document binder I think we all have agreed on. So without objection, they will be entered into the record. I should also note for the record that members will be going back and forth 2 floors up. Consumer Protection and Trade Subcommittee is also having a hearing on telecommunications, which many of our members are members of both

subcommittees, and they will be going back and forth for this hearing.

Right now the chairman, ranking member and chairman emeritus will be recognized for 5-minute opening statement. Other members of the subcommittee will be recognized for a 3-minute opening statement. I will begin. Today's hearing is the fifth hearing in this Congress that our subcommittee has examined questionable business practices in the private health insurance market. One of the hearings we had last year examined the problem of under insurance. We heard stories about ordinary citizens who thought they had sufficient health insurance but learned that their policies were inadequate when they needed them most.

We also looked into the problem of small businesses purging, which is when a health insurance company raises premiums to a point it is unaffordable for businesses to continue their health coverage. Lastly, we held 2 hearings on rescissions, which is the private insurance industry practice of terminating coverage after a policy holder becomes sick so the company can avoid paying expensive and much needed health care. Our hearing today will focus on rate increases in the individual insurance market in California. We will examine what is happening when insurance companies have no limitation or accountabilities under rate increases. While most Americans receive health insurance through their employer in a group market or through government-assisted programs such as Medicare and Medicaid more than 15 million Americans receive their health insurance through the private individual market.

The individual health insurance market is unique in that companies are limited in their ability to spread their risk among a larger population. While today's hearing will focus on WellPoint's proposed premium increase in California, this is a national problem. According to a disturbing report released today by the Center for American Progress WellPoint has implemented or proposed double digit rate increases in 11 of the 14 states in which they operate. In Maine, WellPoint raised individual rates by 23 percent this years after 5 straight years of double digit increases for individual policy holders in that state.

Likewise, Indiana residents covered by certain WellPoint policies will endure a rate increase of 21 percent. In Georgia, WellPoint policy holders face a 21 percent increase in 2009 and are anticipating a similar rate increase again this year. And in the west, Colorado expects average rate increases in WellPoint policies of nearly 20 percent and as high as 24.5 percent this year. But as residents of my home state know, the problem is not limited to WellPoint subscribers. Some Michigan policy holders are facing a proposed rate increase of 56 percent in the individual market.

On January 26 this year WellPoint sent out letters advising 800,000 California policy holders of possible rate increases for the coming year. As it turns out, nearly 700,000 WellPoint subscribers received rate increases of as much as 39 percent. WellPoint has tried to justify their rate increases through a high profile media campaign reassuring policy holders, congressional leaders, and the Administration that the proposed rate increases are necessary due to rising medical costs and declining business resulting from economic difficulties, not from padding their bottom line.

Through our investigation, we discovered internal documents that suggest a closer relationship between the proposed premium increases and WellPoint's profits. The documents reveal that WellPoint sought inflated premium increases as a negotiating tool with the California Department of Insurance. WellPoint also appears to be directing policy holders to less generous health insurance plans as a way to lower medical claims while awarding their executives excessive salaries and paying for lavish retreats. In our insurance rescission investigation last year, we learned that if an insurance company believes your illness may be costly, it will go back and re-examine your initial application to find an excuse to cancel your coverage.

As health insurance industry executives brazenly told us this practice will continue until there is national health care reform to expressly prohibit it. In this case here, we are reminded of this sad fact. An internal WellPoint document tells us that the practice of rescission is a "key issue" for maintaining lower medical loss ratios. Our first panel will put a face on the frightening premium increases that have affected California. Lauren Meister received notice that WellPoint increased her rates by 38.6 percent. WellPoint offered her an alternative plan that does not cover the brand name medications she requires to treat a chronic condition.

Julie Henriksen is a single mother with 2 children. WellPoint has proposed to raise her premiums by 30 percent. One of her 2 sons was born with a hole in his heart and required open heart surgery at age 3, and now requires annual care from a cardiologist. If Lauren switches to the alternative plan WellPoint has offered she will have to pay \$5,000 out of pocket before her insurance even kicks in. Jeremy Arnold has experienced rate increases on his WellPoint policy totaling 74 percent between 2009 and 2010. Anthem has proposed to increase his rates 38 percent this year. We will also be hearing from Angela Braly, the President and CEO of WellPoint. Accompanying her is Cynthia Smith, WellPoint's Executive Vice President and chief actuarial. I look forward to their testimony to help this committee understand why WellPoint made the decision to raise premiums this year by up to 39 percent.

Tomorrow the White House will be holding a summit to discuss the President's newly released health care reform proposal. Included in this proposal is language granting the states the authority to regulate rate increases by private health insurers like WellPoint. This hearing could not come at a better time. It provides a frightful reminder that unless Congress and the Administration acts, Americans across the country will continue to experience large premium increases and will be priced out of the market. With limited or no health care coverage, we are all just one injury or illness away from bankruptcy. Next, I would yield to the gentleman from Texas, Mr. Burgess, and welcome him sitting officially as the ranking member now of the Oversight and Investigations Committee. I look forward to working with him throughout this Congress. And, Mr. Burgess, your opening statement, please.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman. We will see if you still feel that way after a few months. I thank you and Chairman Waxman for allowing us to have this hearing today. I want to thank the witnesses who traveled far and wide to come and be with the committee today and to share their stories about the purchasers of health insurance and the people who provide health insurance. You know, it is odd, Mr. Chairman, you look around the room and you don't see the insurance commissioner of the State of California, which really strikes me as odd in a hearing of this nature. If the reason for this hearing is to determine whether a state insurance company has violated a state's regulations then you would think logically that the head of the state's regulatory agency would be present and be with us.

But here today we have Anthem, WellPoint's California subsidiary, in a dispute with the California insurance commissioner. The evidence shows that Anthem submitted, as required, by California state requirements, their actuarial determinations as to why they needed to decrease premiums less than 20 percent as well as raise some premiums as high as 39 percent. The evidence also shows that the California state insurance commissioner did nothing with the actuarial information they were given by Anthem. They did not raise a single complaint for over 4 months. Now why the federal government is involved in a state issue, a state dispute, to me presupposes that the fundamental difference between the line of thinking between national Democrats and national Republicans in the health care debate.

The central argument of the Democratic Party is that we need a national single federal regulator oversee all health insurance companies but Republicans believe fundamentally that insurance is a state issue and based on risk pools how many people get sick at one time versus how many healthy people there are who won't get sick. So the actuaries look at the market place and determine this ratio. And, of course, we are involved right now in this tremendous, tumultuous health care debate or what used to be called a health care debate before the President renamed it health insurance reform, and that is why the timing of this hearing couldn't be more coincidental. And just for the record, I never attribute anything to coincidence if it can be adequately explained by conspiracy.

Tomorrow, the President is holding a bipartisan photo-op on health insurance reform at the White House, a 6-hour photo-op, so it is a significant photo-op, and his Secretary of Health and Human Services has used the state-based issue, the increase of Anthem's in the State of California to increase support as another reason why we need a \$1 trillion or \$2 trillion health reform package. In fact, his Secretary of Health and Human Services has said that the profits of Anthem are outrageous, her words, and that the insurance companies should not make that much money. Why does profit matter if the actuaries have done their work?

I will agree, a 39 percent premium is a huge number, a big, scary number but it may be irrelevant in this debate if the debate is on whether or not the business model of the insurance should be based on what the actuaries are determining is a risk spread. Now

I make no apologies for the insurance companies. They are certainly capable of defending themselves, and, if not, then they deserve what they get but I think a GAO report needs to be commissioned to study how the insurance companies determine how much they are going to charge with their premiums, but if the numbers show that there will be a precipitous decline in the number of people who are in the risk pool then any number, no matter how big, may in fact turn out to be acceptable.

So if we are just focused on solving a dispute between California and Anthem, whose actuary is right, now wouldn't that be a stimulating hearing? We could have dueling actuaries. If Anthem is right, their actuary portrayed an accurate risk for the State of California, or is the California Department of Insurance right to complain 4 months after the fact that Anthem is a bad insurance company. But, you know what, we are really not here to answer those questions. We are here to answer whether there needs to be reform in the health care industry as a whole. And I will tell you as a practicing physician for over 25 years, there needs to be. Costs are a problem. Yet, after months and months of debate, we really haven't figured out how to answer the question of how do we bend the cost curve or actually we have figured out to bend it in the wrong direction.

We haven't determined whether these costs are conclusively attributable to the business practices of health care providers, who are sometimes impugned, or the insurance, who are often impugned, or whether these costs are attributable to what the First Lady is focusing on, lifestyle choices, diet, exercise, and the epidemic of obesity. Or maybe it is just that people are living longer and the cost of treating an older generation were never envisioned when we created Medicare back in the '60s. And, of course, there is the advancing complexity of what we are able to do. The very fact that we have more than one cholesterol-lowering medication on the market is significant. What we can all agree on is there needs to be reforms in the health industry. Let us get rid of pre-existing conditions and lifetime caps. I am for that. Let us work on tort reform. How about increased competition? I could be for that.

Increased flexibility and portability, who would be against that? How about some improvements for people who are stuck in the COBRA system so they are not stuck with such a high premium? I could be for that. But, you know, we are going to turn our attention to the President's summit tomorrow. I hope the President, I hope the President is truly interested in including good ideas regardless from which side of the dais they emanate. I will yield back the balance of my time.

Mr. STUPAK. Thank you, Mr. Burgess. Mr. Waxman, chairman of the full committee. Thanks for being here, and I look forward to your opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Chairman Stupak, thank you for convening this important and timely hearing. On February 4, the Los Angeles Times reported that Anthem Blue Cross, a subsidiary of WellPoint,

intended to raise its rates as much as 39 percent for their 800,000 individual policy holders in California. And I want to single out Duke Helfon and Lisa Garrion, who are reporters who have done excellent work on this issue and brought to our attention the rescissions as well which has been a tactic used by those who cover individuals for insurance policies. By any measure, this was a breathtaking increase in health insurance costs. We are holding today's hearing to find out what is really driving these enormous rate increases.

WellPoint says the rate increases are a result of medical inflation and healthier policy holders dropping coverage. But the thousands of pages of WellPoint documents we have reviewed tell another story. They tell a story not about costs but about profits, not about increasing coverage but about reducing benefits to policy holders, not about removing barriers to coverage but about erecting new ones, not about covering more people who have illnesses, but about cutting them off and seeking out new customers who are healthier and wealthier.

The documents also tell a story of potential huge new premium rate increases still to come. WellPoint says that its rate increases have nothing to do with increasing company profits, but an internal company e-mail says that its rate increase would "return California to target profit of 7 percent." WellPoint says that its rate increases are absolutely necessary, but its internal company documents describe a plan to build in a cushion to allow for negotiations. The company told its board of directors that its average rate ask would be 25 percent but that its final rate increase would only be 20 percent. Other documents raised the possibility that WellPoint may have manipulated its actuarial assumptions to keep its medical loss ratio, a key measure reviewed by California regulators, flat.

The documents we have reviewed show WellPoint is proposing its highest increases on its more generous plans, and at the same time it is actively developing new products called downgrade options that reduce benefits for its policy holders. As we will hear from the witnesses on our first panel, this purging process cuts coverage for WellPoint policy holders when they need it the most, when they get sick, and the WellPoint documents point to a future of even higher rate increases. WellPoint told committee staff that WellPoint voluntarily capped its maximum rate increase at 39 percent. Well, if WellPoint had not done this some policy holders could have faced rate increases of over 200 percent.

Mr. Chairman, we have circulated a memorandum to members describing these documents, and I know they are now part of the record. One question we asked is where does all of this money go? We have learned that in 2008 WellPoint paid 39 senior executives over a million dollars cash each, and the company spent tens of millions of dollars more on expensive corporate retreats. During 2007 and 2008, WellPoint spent \$27 million on 103 executive retreats. One retreat in Scottsdale, Arizona cost over \$3 million. Corporate executives at WellPoint are thriving, but its policy holders are paying the price. Ultimately, what this hearing will show is that the current system is absolutely unsustainable. If we fail to pass health reform, insurance rates will skyrocket and health in-

surance will become so expensive only the most healthy and the most wealthy will be able to afford coverage.

Health insurers like WellPoint may get richer, but our nation's health will suffer. We cannot go down this road forever. It is breaking our middle class and it will bankrupt our nation. We will learn much from today's hearing, Mr. Chairman, and I hope we will apply these lessons when we meet at the White House tomorrow and in the days and weeks to come. We have got to reform the current health care system. Individual insurance seeks not to spread the cost but to exclude people from coverage so that they will not cost the insurance companies more money, and that is not insurance that is going to protect people who need it the most when they get sick. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Waxman. Mr. Gingrey, for an opening statement, please, 3 minutes.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Thank you, Mr. Chairman. And, Mr. Chairman, I want to join with you and all of our colleagues in welcoming and congratulating my OB GYN colleague on our side of the aisle as the new ranking member of the subcommittee, and I congratulate Dr. Burgess. First off, these patients here today, they need reform, as do many patients who find it increasingly hard to afford health insurance or chronically ill patients who cannot find a policy because they are simply too sick to insure. The increases they receive especially in an economy like the one we are currently experiencing are tough to justify, and I would like to thank them for coming today and we look forward to your testimony.

Throughout the past year, many in this Congress have seemed to operate in a bubble seemingly oblivious to the needs or the wants of their constituents because of ideological reasons. We started this Congress with the hope that we would work together to reform our health care system. What we ended up finding was a Congress more prone to closing doors than opening them creating special deals to, yes, buy Democratic votes instead of compromising to find Republican ones. I along with many of my colleagues continue to write the President and Democratic leadership offering my medical advice. Unfortunately, they have yet to respond.

So whether it becomes a paycheck doesn't bring home enough money to afford it or our sickest patients cannot access it, every American should have quality health care. A majority of Americans, and an overwhelming majority of Congress strongly agree with that sentiment. Yet, here we sit without a health reform bill because Washington continues to pursue a bill that they cannot sell to the American people. The Obama plan is the same bill with a few minor changes, notably changes that favor unions, increase cuts to senior's health plans. If it was a popular bill, we would not be sitting here today. If it was a good bill, we would not be sitting here today.

Mr. Chairman, the American people simply do not want the Obama plan. Every day that this Administration and this Congress spends in backroom meetings on the Obama plan is one day too many. I believe I can speak for every member of this committee

when I say that we can fix the problems in our health care system. The only thing standing in the way of that goal is a simple, yet inconvenient truth, the plan President Obama and Democratic leaders want is not what the American people want. Mr. Chairman, I believe that the Democratic majority has a decision to make. If they truly want health care reform, they will need to get rid of the bill that Americans don't want. If they want bipartisan health reform, they will need to invite Republicans to work with them to help create legislation, not just invite them to review that has already been created and now, of course, plused up by another \$100 billion.

Inviting Republican leadership to a televised meeting at the Blair House while secret meetings on the Obama plan continue at the White House is not the change that the American people want or will accept. I look forward to the witnesses' testimony. And, Mr. Chairman, I will yield back as my time has expired.

Mr. STUPAK. Thank you, Mr. Gingrey. Ms. DeGette for opening statement, please, 3 minutes.

OPENING STATEMENT OF HON. DIANA DeGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DeGETTE. Mr. Chairman, I will submit my opening statement for the record. But I want to say I am offended by some of the things that my colleague from Georgia just said, and the reason why I am offended by them, it is one thing for us to disagree about the content of a health care bill. It is another thing to disparage people's motives. Now there are a lot of motives to be disparaged on both sides of the aisle, but I will say every single member of this committee who has worked on this bill from Chairman Waxman to the ranking member to everybody else has worked hard on this bill. Now Mr. Gingrey and his colleagues may not like the bill that this committee passed, but they cannot deny that we spent hours of hearings in this committee and we spent hours of markups considering amendments from both sides. And if you don't like the bill, that is just fine. That is not a partisan problem. That is a problem of not liking the bill, and I understand that.

But I would ask that Mr. Gingrey and everybody else just quit painting everybody with the same broad brush because if we ever hope to restore a spirit of comity to this committee and this Congress attacks like that should not be countenanced on either side of the aisle. I want to say one more thing. There really is a problem here that we are trying to deal with, and I don't think anybody in this room would disagree with that. As the chairman said, there are proposed rate increases by Anthem Blue Cross in California, in Michigan, in Connecticut, in Maine, in Oregon and Rhode Island, and 20 percent in my home state of Colorado. Now today on the floor they are going to have a bill repealing the antitrust exemptions of the McCarran-Ferguson Act.

Only 2 industries currently enjoy those exemptions, and that is the health care industry and major league baseball. I guess we can talk about major league baseball later this year. But if we want more competition, it would seem to me that this would be a good start, and I would hope my friends on both sides of the aisle would

vote for this bill. In the meantime though to deny that there is a problem to say, well, you know, the insurance companies because medical costs are going up have to increase their premiums like this is denying the fact that my constituents and everybody in this room constituents cannot buy insurance policies on the individual market because they cannot afford to pay these rate increases.

And I have people come to me every day and talk to me about this. Some of them are related to me, and I am sure everybody in this room has experienced those same issues. So, you know, my view—and I have worked with Mr. Gingrey. I have worked with everybody in this room. They know that I am not particularly a partisan person, that I try to work on these issues in a bipartisan way. So I would say on both sides of the aisle let us cut it out. If we don't like each other's bills, let us just debate against the bills. Let us stop disparaging their motives. And I yield back.

[The prepared statement of Ms. DeGette follows:]

**O&I Hearing: Premium Increases by Anthem Blue Cross in the Individual
Health Insurance Market
Congresswoman Diana DeGette
February 24, 2010**

Opening Statement

Thank you, Mr. Chairman. I am extremely bothered by the need for today's hearing.

While we are focusing primarily on the proposed increase by Anthem Blue Cross in California, I want to reiterate that this is a nationwide problem—proposed rate increases of 56 percent in Michigan, 24 percent in Connecticut, 23 percent in Maine, 20 percent in Oregon, 16 percent in Rhode Island, and 20 percent in my home state of Colorado.

I am sure many of the people here today have read Secretary Sebelius' report on the recent premium increases, but I want to reiterate two points from the report that are simply unacceptable.

- 1) Almost 75 percent of individuals who look for a plan on the individual market never actually purchase a plan, and 61 percent of those individuals cite high premium costs as the primary barrier for obtaining coverage.
- 2) We cannot deny that health care costs are rising, and it is certainly reasonable for rates to keep pace with rising costs, some of the proposed premium increases are 5 to 10 times higher than the growth rate of national health expenditures.

I believe we need is an overarching requirement on a national level to ensure that insurance companies spend a certain amount on direct medical care as opposed to marketing and Executive Compensation.

We also need to enact the sunshine provisions included in the House-passed health reform bill, which would require insurance companies to provide public justification for any rate increases. If insurance companies are going to impose drastic premium increases, consumers should have a right to the information necessary to make an educated assessment about how their insurance provider does business and decide whether they will remain customers of a particular provider. Let transparency and competition guide consumers so they can determine whether to continue enrolling in such a plan or look elsewhere.

This hearing today simply underscores the need to pass comprehensive health reform in a timely manner. If, for example, health care costs are increasing so much that a 39 percent increase is warranted—as Anthem Blue Cross and WellPoint claim—then we need to find ways to change incentives within the health care system and reduce health care costs as quickly as possible.

Mr. GINGREY. Mr. Chairman, since Ms. DeGette mentioned my name, can I have 30 seconds to respond?

Mr. STUPAK. No, let us move on. We are not going to go back and forth. We will have an opportunity later. Maybe Mr. Griffith can yield you some time, but yield now to Mr. Griffith for 3 minutes for an opening statement.

OPENING STATEMENT OF HON. PARKER GRIFFITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. GRIFFITH. Thank you very much for the opportunity, and I certainly appreciate being here. The good news about health care reform is that everyone would like to see it happen. The discussion of how it might happen has certainly been ongoing and will continue to be ongoing. One of the bills that was passed this year that I think got not as much applause as it should have was the FDA's ability to control tobacco, a huge, life saving bill in and of itself. That in and of itself was health care reform, and I think Chairman Waxman needs to be proud of that. And I know as a cancer specialist, I am certainly proud of it.

One quick comment is that in order to reform health care, we must understand we cannot reform it around a shortage, and the shortage are MDs. There is a difference between coverage and access. We have millions of Americans covered today who can't access health care because we don't have enough providers to take care of them. So if we gave everyone in America a little card that said USA health care our emergency rooms would still be just as busy as they are, just as crowded. We would still have just as much trouble getting our Medicare and Medicaid and our pediatric patients seen, and so any part of reform or improvement in health care must include a major increase in the number of medical schools, a major increase in the number of young men and women who are entering medical school, and we need to increase our mid-level providers, our nurse practitioners. We must increase their ability to see our chronically ill and do education.

Half of all deaths in America over the next hundred years will be lifestyle-related. There will be smoking, overeating, not enough exercise, unrelated to infection or malignant disease. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Griffith. And I should say welcome to the committee. It is your first time with us. Welcome to the committee. Next is Mr. Braley for an opening statement.

OPENING STATEMENT OF HON. BRUCE L. BRALEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. BRALEY. Thank you, Mr. Chairman. Even though the focus of this hearing is on rate increases by Anthem Blue Cross what we are really talking about is a problem that affects people all over this country because it is not a new problem and the point has been raised about health insurance reform versus health care reform. I have always stressed the need for comprehensive global health care reform, and we cannot afford as a country not to move forward with health care reform. Even though this hearing is focused on Anthem Blue Cross in the State of California, this very same issue is facing my constituents in Iowa. Last week, Well

Mark Blue Cross/Blue Shield, the largest health insurer in Iowa, announced it would raise rates an average of 18 percent for Iowans who buy their own health insurance, and that is expected to affect about 80,000 Iowans. Some of them will see their rates go up over 20 percent.

According to Well Mark, this is the largest annual increase since 2006 and the troubling rise in premiums comes on top of an average 9.3 percent increase for individual policy holders last year, and a 54 percent increase in rates for individuals over the past 5 years. So when asked about this, the company spokesman noted that this was not related to anything that we don't already deal with and blamed increase in chronic conditions such as obesity and knee and hip ailments as well as the price of prescription drugs and high tech medical imaging.

And this is what is very fascinating. He also said the real way to make insurance more affordable is to lower health care costs and require everyone to have insurance, which is one of the very points that we have been struggling with in this debate over how we address the problem of providing access to health care coverage for millions of Americans. So I think Iowans want to know exactly why companies like Well Mark and WellPoint are raising rates on these individual plans and what factors went into their decisions because everyone who is affected by this deserves a detailed justification for the increases from their insurance companies. They deserve to know that their elected officials are working to ensure appropriate and adequate oversight and regulation of the insurance industry and working to ensure that they have access to quality affordable health care.

That is why I believe this hearing is a good first start, but it is also one more example about why we need comprehensive health care reform in this country. All Americans deserve access to quality affordable health care coverage as soon as possible, and unless we look at all the contributing factors including unregulated high increases in health insurance premiums, which have been going on for decades in this country, we are never going to get at the root of the problem and that is why I look forward to the testimony of our witnesses. And I yield back.

[The prepared statement of Mr. Braley follows:]

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CHAIRMAN

**Congress of the United States
House of Representatives
Washington, DC 20515**

**Statement of Congressman Bruce Braley
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations**

**"Premium Increases by Anthem Blue Cross in the Individual
Health Insurance Market"
February 24, 2010**

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Thank you, Chairman Stupak, for holding this important hearing today on premium increases by Anthem Blue Cross in the individual health insurance market. While this hearing is focused primarily on the premium rate increases by Anthem Blue Cross in the state of California, this same issue is also affecting my constituents in Iowa.

Last week, Wellmark Blue Cross Blue Shield, Iowa's largest health insurer, announced it will raise rates an average of 18 percent for Iowans who buy their own health insurance. This is expected to affect about 80,000 Iowans. Some Iowans will see their rates go up by over 20 percent.

According to Wellmark data, this is the largest average annual increase since 2006. This troubling raise in premiums comes on top of an average 9.3 percent increase for Wellmark individual policy

holders *last year* and a 54 percent increase in rates for individual policies over the past five years.

I'm seriously concerned about this announcement and about what these premium increases will mean for the thousands of Iowans with individual health insurance plans who will now have to pay more for health insurance. Especially during these tough economic times, working families in Iowa and across the country can't afford these drastic rate increases.

I think Iowans deserve to know why exactly Wellmark Blue Cross Blue Shield is raising the rates on their individual health plans, and what factors went into this decision. Iowans, like all Americans across the country who are seeing their insurance premiums skyrocket, deserve a detailed justification for these increases from their insurance companies.

Most importantly, Americans affected by these rate increases deserve to know that their elected officials are working to ensure appropriate and adequate oversight and regulation of the insurance industry, and working to ensure that they have access to quality, affordable healthcare coverage.

This hearing is a good first step in providing oversight of Anthem Blue Cross, and I look forward to working with my colleagues on the Subcommittee to ensure sufficient oversight of other companies in Iowa and around the country that are also raising premium rates. This hearing is also just one more perfect example of why we need comprehensive healthcare reform in this country, and I intend to continue to work with my colleagues in Congress to ensure that *all* Americans have access to quality, affordable healthcare coverage as soon as possible.

Thank you again for holding this important hearing today. I look forward to hearing the testimony of the witnesses.

Mr. STUPAK. Thank you, Mr. Braley. Mr. Green, for an opening statement, please.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Mr. Chairman, I want to thank you for holding this hearing today on the recent individual health insurance policy increases proposed by WellPoint and Anthem Blue Cross/Blue Shield in California. Millions of Americans do not have insurance through their employers or through public programs and they turn to the individual insurance market to purchase an insurance policy. Individuals who purchase insurance through the individual market must go through sometimes a difficult application process and often they are denied coverage through pre-existing conditions. Even if they are approved for coverage, they cannot afford the premiums in the individual market. We do know that in tough economic times like these health individuals drop their coverage to save money because health premiums across the Board are too high, and because of this occurrence could reduce this risk pools so significantly that extreme premium increases are necessary for those individuals who want to maintain their individual policies.

At least that is the explanation given by WellPoint President and CEO Angela Braly to HHS Secretary Sebelius when asked to explain skyrocketing premium increases in California. There are not enough healthy people in Anthem Blue Cross/Blue Shield individual market and 39 percent premium increase is necessary for Anthem to continue to provide coverage in that area. The data emerges from the National Association of Insurance Commissioners clearly showing that enrollment in Anthem BCBS in California increased from 583,967 individual policies at the end of 2008 to 627,082 individual policies at the end of the third quarter of 2009. That is an increase of over 7 percent in the individual market for Anthem in California alone, so a high rate increase because of reduced pool doesn't make sense.

It appears to me that the insurance industry's dirty little secret drastically increasing individual policy rates without justification and running rough shod over consumers has finally been given the public attention it deserves. Companies and Anthem Blue Cross/Blue Shield has been trying to get away with these outrageous type increases in Michigan, Rhode Island, Washington, and Maine, just a few. Unfortunately, states like Texas have very little we can do to prevent these rate increases going into effect, and are often at the mercy of the insurance companies, and that is historically true in Texas. Today, we are finally telling the insurance industry that the party is over. You have been making astronomical profits in the individual market off the backs of the sick and working folks who don't have an option but to obtain health insurance, but in the individual market it has gone on too long.

Both the House and Senate reform bills contain provisions to give state and HHS Secretary the ability to review health insurance premium increases and the President's proposal takes this one step further by creating oversight of insurance premiums at the federal level. If individuals continue and cannot afford health insurance they end up in the emergency room forcing the health care

system and the taxpayer to pay for their expenses, yet the insurance companies continue to see increased profits while making it nearly impossible for individuals to gain access or to afford a policy.

These hearings highlight we desperately need insurance reform and health insurance reform in our country. All individuals should have access to quality and affordable health insurance. And, Mr. Chairman, we are not seeing that in our country. Otherwise, insurance reform wouldn't be needed, but we know in my particular district 43 percent of my constituents who are working don't have insurance through employers so they don't have a group plan so they have to go to the individual market, and I yield back my time.

Mr. STUPAK. Mr. Markey, for an opening statement.

OPENING STATEMENT OF HON. EDWARD J. MARKEY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF MASSACHUSETTS

Mr. MARKEY. Thank you, Mr. Chairman, very much. Many people think that health insurance reform doesn't matter to them because they already have health insurance. Skyrocketing premiums and insurance company abuses, however, reveal a different story. Medical bills are the leading cause of personal bankruptcies in the United States today. In 2009, 60 percent of all people who declared personal bankruptcy did so because of their medical bills, and 80 percent of those people actually had health insurance. They just weren't covered or what it was that ultimately came to become the disease that affected them or their family. People just discovered they weren't covered.

It is appalling that over the coming weeks and months when many Americans sit down to pay their bills, they will open a letter from their health insurance company informing them that their premiums will increase by 14, 22 or even 39 percent. Last week, I spoke with a small retail business owner named Diane Otnesio from Woburn, Massachusetts in my district. She recently got a letter from her insurance company saying that her health insurance premium is jumping 32 percent from \$494 per month to \$652, and her husband had the same increase. So this is essentially a 30 percent increase, and she says to me personally my small business is struggling to survive and I am expected to pay an extra \$158 for the same health plan. It is making an already difficult economic situation even worse.

People like Ms. Otnesio are doing the right thing and faithfully paying their health insurance premiums, but it is becoming increasingly difficult when some insurance companies are jacking up premiums and experiencing huge profits. In the midst of this economic crisis, WellPoint, the parent company of Anthem Blue Cross, recorded a \$2.3 billion increase in annual profits. That is a 91 percent increase compared to the company profits in 2008. Did that jump in profits mean that WellPoint covered more of their customers' medical costs? No. In fact, their contribution to medical expenses of their customers decreased by 1 percent. Did this rise in profits lead to an appropriate reduction in premiums? No. Anthem Blue Cross is considering raising individual health insurance premiums by as much as 39 percent.

And, sadly, Anthem Blue Cross is not an isolate case. Last week, Health and Human Services Secretary Sebelius released a report showing that health insurance companies in 6 other states proposed outrageous increases in health insurance premiums. There could not be a more important hearing, Mr. Chairman. I thank you for having it. It goes right to the heart of the anxiety that millions of Americans all across our country are feeling right now as we sit here in this hearing room. Thank you.

Mr. STUPAK. Thank you, Mr. Markey. Ms. Christensen, for an opening statement, 3 minutes, please.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. Amid the reports of record breaking profits in the insurance industry almost 3 million more people in this country lost their coverage. So I want to thank you, Chairman Stupak and Ranking Member Burgess, for having this oversight hearing on what proposes to be an extreme increase in insurance premiums. This morning, we are looking at what is happening in California but premium increases every year, year after year, are hurting American families and increasing the ranks of the uninsured, exactly the opposite direction this country ought to be moving in. Over the years, I have worked with WellPoint, and I applaud the work that they have done in diversity and wellness programs and other areas, but I am alarmed by the proposed 39 percent increase in premiums.

Despite the reasons that they offer, I do not see that they support the need for these premium increases, and I cannot support them. WellPoint is among the big 5 who enjoyed a combined profit of \$12.2 billion last year. I don't grudge them the profits. They are in the business to achieve profits, but ordinary folks, your clients and others, are having to make unsustainable sacrifices to keep health insurance and to make ends meet. I cannot see why keeping the premiums where they are, having been raised about 20 percent last year, would be an even comparable sacrifice for WellPoint or its shareholders because as I see it they would still realize substantial profits.

We welcome WellPoint's support for health care reform. Indeed, in a very real way this Congress' failure to pass meaningful legislation such as we passed in this committee last year is a major part of the problem we are discussing today. It is time for our Republican colleagues to stop blocking what we and the other committees passed at the long hearings and markups and which everyone was involved. So anyone who goes to the White House tomorrow without a determination to insure everyone, to provide equitable health care to everyone, including those living in the territories, and reduce health care costs should get out of the way and let others who will do what has to be done sit in their chair.

If there is anything that WellPoint and those of us on this side of the dais can agree on, it is that we might not be here having this hearing today if the President had signed the kind of legislation this House passed last year. I want to welcome those who are here to testify this morning, both the customers of WellPoint and the officials of WellPoint, and I look forward to your testimony.

Mr. STUPAK. Thank you. Mr. Welch, for an opening statement. He stepped out. Ms. Sutton, opening statement.

**OPENING STATEMENT OF HON. BETTY SUTTON, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Ms. SUTTON. Thank you, Mr. Chairman. Thanks for holding this hearing today. I would like to be able to say that I am shocked that we are talking about this, but sadly I am not. While I understand that this hearing focuses primarily on Anthem Blue Cross in the California market unfortunately as we heard here the situation is not unique. Across this country millions of Americans, affecting both individuals and businesses, are being devastated by shocking increases in their health insurance premiums. And let us be clear, health insurance companies have been socking it to the American people and businesses for years. Health Care for America Now recently released a report that found that in 2009 the health insurance industry had record profits.

Let us just think about that. In 2009, a year when the average American family suffered unlike any year in recent history, health insurance companies still had record profits. And according to the report the 5 biggest for-profit health insurance plans had combined profits of \$12.2 billion in 2009, up 56 percent from the year before. According to a Health and Human Services report, over the last 9 years profits at the largest insurance companies increased 10 times faster than inflation, and over the last decade the amount private insurance companies spend on administrative costs, administrative costs, instead of paying claims and covering care, the amount that they spent on administrative costs grew faster than the amount they spent on prescription drugs as well.

Premiums continue to skyrocket but consumers don't receive additional benefits or care. These increased premiums mean families have to make untenable choices. They are forced to sit down and weigh their chances of getting cancer or getting hit by a bus against having to pay an insurance premium that is now suddenly 30 percent higher, sometimes higher than their mortgage. Choosing to pay the higher premium means they may not be able to pay their heating bill or other basic life necessities or send their children to college, or sometimes it means choosing, if you can even call it a choice, to not have health insurance. This is not a situation that should occur in the United States of America.

And this why we have heard a lot about health care reform. The Affordable Health Care for America Act that was passed by the House contained an 85 percent medical loss ratio, which would require insurance companies like Anthem Blue Cross, WellPoint, to be held accountable to consumers when they do not spend enough of their premium revenue on actual health benefits. The days of health insurance companies putting profits before people need to be over. I am sad that we are sitting here to discuss this today but the American people, they need answers, and it is time for WellPoint to explain why they are raising premiums in this way, especially right now. And I yield back.

Mr. STUPAK. Thank you. Mr. Welch is here. Opening statement.

OPENING STATEMENT OF HON. PETER WELCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VERMONT

Mr. WELCH. Thank you, Mr. Chairman. These premium increase requests really are just the latest effort on the part of the insurance industry to preserve and protect its business model, and it is a business model that served them extremely well with record profits and record salaries but has imposed real harsh consequences on individuals in America and our businesses that are trying to provide health care to their citizens. It is not sustainable. There is nothing really to talk about. How possibly can a family or a business cope with an envelope that arrives telling them that the cost of health care is going to increase 40 percent. And Anthem, WellPoint, always has an excuse, always has an explanation, that is "the cost of health care." But essentially what the insurance industry has done, unfortunately, with a good degree of success, is block any systemic reform which this country needs in order to have a health care system that is affordable and accessible.

It is pretty astonishing when you look at what the premium increases has been, 26 percent between 2003 and 2008 for single policies, 33 percent for family policies. The 10 largest health insurers saw their profits balloon from \$2.4 billion to \$13 billion in 2007. And as the member from Ohio was saying, the amount paid to health providers has gone from 95 percent in some cases to 74 percent. That has enabled some companies to pay executive salaries in the range of \$24 million. In my own small state of Vermont when the CEO of Blue Cross left, he got a \$7.2 million golden parachute. That came out of rate increases. It came out of businesses that were struggling with the decision about whether they were going to cut workers or cut their benefits, a decision our employers don't want to make.

So if I have a complaint about the insurance industry, it is not the individual rate increases. It is the consistent effort to stand in the way of health care reform so that the folks in this country, the businesses in this country, can have some confidence that they are going to get affordable and accessible health care. Health care is not about being in service of the insurance industry. The insurance industry should be about being in the service of helping us have access to health care. I yield back. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Welch. Last, but not least, Ms. Schakowsky, opening statement, please.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. When I saw the latest stories out of California about Anthem Blue Cross' decision to raise rates, I knew, my constituents knew, this is not an isolated incident. It is just the most recent example of what the insurance companies are doing to policy holders across the country. This committee has known for some time that arbitrary rate increases are a real threat to health access. Last summer, 12 of my colleagues and I successfully offered an amendment to the health reform bill to prevent excessive premium hikes like the one we now see from Anthem. We passed legislation requiring prior approval of large

rate increases. And I am glad the President has now called for strong rate review regulation in his proposal for comprehensive reform, and I look forward to ensuring that what started as an amendment in this committee becomes law.

I have heard from my constituents in my district asking that we not limit our investigation to California or to Anthem. They have sent me policy statements and renewal notifications highlighting years of high premiums. They have described the tough choices they have had to make, agreeing to high deductibles in an effort to maintain coverage, and yet the increases keep coming and coming. Illinois, like 25 other states, does not require prior rate approval of premium increases, and there is no authority to reject or deny excessive rate increases. So my constituents are turning to me, to Congress, to act to protect them.

In addition to those stories, I have heard cases from my district showing that these trends are not confined to the individual market. From a community health center in my district in the process of renewing their Blue Cross/Blue Shield group policy, they are looking at an across the board double digit premium hike this year, and they are being forced to pay higher co-pays for things like emergency room visits or to see a specialist. Congress has taken repeated action to increase funding for community health centers. That money was intended to provide quality access to health care for our most vulnerable populations, not to pay insurance company premium hikes.

Families are forced to make extremely tough choices when faced with an unexpected 39 percent increase in their budget and their personal stories only emphasize the need for comprehensive health reform that brings greater access and affordability to our health care system. I would like to close by thanking the witnesses for their participation in today's hearing and look forward to their testimony. I yield back.

Mr. STUPAK. Thank you. That concludes the opening statements from all members of the subcommittee. I should note, and I appreciate the fact, that Ms. Eshoo from California is here, and I am sure when we get to questions she will probably have a question or two. And Ms. Capps was also here, who just had to step out. As I said, we have two hearings going, one on the third floor and one here, and members are going back and forth. But members of the full committee of the Energy and Commerce Committee who may not be a member of this subcommittee will be allowed to ask questions at a later time of witnesses. So that concludes the opening statement by members of the subcommittee.

We have our first panel of witnesses before us. They are Lauren Meister, who is from West Hollywood, California, Ms. Julie Henriksen, who is from Los Angeles, California; and Mr. Jeremy Arnold, who is also from Los Angeles, California. It is the policy of this subcommittee to take all testimony under oath. Please be advised by the rules of the House that you are allowed to be advised by counsel during your testimony. Do you wish to be represented or advised by counsel during your testimony, any of our witnesses? All shaking their heads no, so we will take that as a no. Therefore, I am going to ask you to please rise and raise your right hand and take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that the witnesses have replied in the affirmative. They are now under oath and they will begin with an opening statement. I would ask Mr. Arnold if you would not mind going first. Pull that mike up, press a button, the green light should go on, and you need to keep that mike fairly close to your voice in order to project your voice. Begin, please.

**TESTIMONY OF JEREMY ARNOLD, LOS ANGELES, CALIFORNIA;
JULIE HENRIKSEN, WESTCHESTER, CALIFORNIA; AND
LAUREN MEISTER, WEST HOLLYWOOD, CALIFORNIA**

TESTIMONY OF JEREMY ARNOLD

Mr. ARNOLD. Thank you. Good morning, Mr. Chairman, and members of the committee. I am an Anthem Blue Cross policy holder, who has been directly impacted by Anthem's astonishing proposed rate increases in California. Because I work as a self-employed writer and also have an additional part-time job, I have had to purchase individual health insurance. Two weeks ago, Anthem informed me that the premiums on my rate plan PPO 40 policy were going up 38 percent from \$231 to \$319 a month. This follows an increase exactly 1 year ago of 26 percent when my rates went up from 183 to 231 a month. In other words, my premiums are poised to rise to a level that is a whopping 74 percent higher than barely over a year ago.

This is outrageous. My benefits have not improved in any way, and I don't go to the doctor that often. Last year, I went a handful of times and paid about \$1,250 in medical bills. As per the terms of my policy, Anthem paid a balance of about \$1,600 in claims, far below the \$2,700 in premiums I paid Anthem. I did also take prescription drugs, including a generic and a brand name medication, to manage high cholesterol and blood pressure related to a mild heart condition that I developed after I joined Anthem. Those 2009 drug costs were subject to a separate \$500 brand name deductible.

In its notice to me last month, Anthem offered to switch me to a plan with a lower increase in premiums, but one which does not include brand name drug coverage. That is unacceptable to me since I need that coverage to treat my condition. There are other Anthem plans I could try to switch to. Some of these require underwriting in which case my pre-existing condition would probably make me ineligible. Some don't require underwriting but carry high deductibles, lower lifetime maximums, and very poor prescription drug coverage. If Anthem goes ahead with its desired rate increase, I will not only be driven to one of these high deductible policies, I will have to hope that I don't get sick or injured. Hope is not an effective health care policy and hope is not what Anthem is supposed to be selling. I eat right. I exercise. I take care of myself. I am generally a healthy person and I resent being squeezed in this way.

Anthem tries to justify these rate hikes by citing rising medical costs. This is disingenuous. If insurance companies believe that medical costs are out of control, they should fight them rather than simply passing them off to ordinary Americans. Anthem and WellPoint's recent astronomical profits are repellants because they

are at the expense of breaking the backs of people like me. I have no problem with corporate profit making, but I do have a problem with profiteering, especially when it is at a level that penetrates so far into the economic and social well-being of our country that we Americans are discouraged from pursuing dreams and starting businesses and are stuck in undesired jobs simply because we worry about losing our health insurance or being able to afford it for our employees.

This is wrong. It is insane, and it must be fixed by doing whatever it takes to pass meaningful health reform now. It would be simplistic to think that Anthem's corporate greed is the only problem here though it is a huge one that I believe requires stringent regulation. Sharing the blame are indeed hospitals and doctors raising rates far above what is defensible, and a legislature that is too beholding to special interests and consumed with partisan rhetoric to take necessary action. All these parties feed off each other to conveniently and happily line their own pockets or win elections while blaming the other side and caring not a wit about the rest of it.

In conclusion, I want to say to Anthem and the insurance companies, including WellPoint President Angela Braly, to hospitals and medical providers, and to legislators on both sides of the aisle, I ask you all in words that are as true today as they were in 1953 when Joseph Welch first said them, have you no sense of decency at long last, have you left no sense of decency? Thank you.

[The prepared statement of Mr. Arnold follows:]

**Written Testimony to House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations**

By Jeremy Arnold

February 24, 2010

I am an individual health insurance subscriber who has been directly impacted by Anthem Blue Cross's astonishing proposed rate increases in California.

Because I work as a self-employed writer and also have an additional part-time job, I have had to purchase individual health insurance. At the beginning of 2009, the premiums for my Right Plan PPO 40 policy were \$183 per month, or \$2196 per year. In March 2009, Anthem raised those premiums to \$231 per month, or \$2772 per year – an increase of 26%. Anthem last year also increased my prescription drug co-pay for both brand-name and generic drugs. In January 2010, Anthem informed me that my rates were going up again, to \$319 per month, or \$3828 per year – a further increase of 38%. Compared to what I was paying just 13 months ago, therefore, Anthem is attempting to raise my premiums by a whopping 74%.

This is outrageous. My benefits have not improved in any way, and I don't often go to the doctor. Last year I went a handful of times and paid about \$1250 in medical bills. Anthem paid a balance of about \$1600, far below my \$2700 in annual premiums. I did also take prescription drugs, including a generic and a brand-name drug to manage high cholesterol and blood pressure related to a mild heart condition that began after I joined Anthem. Those drug costs were subject to a separate \$500 brand-name deductible.

In its notice to me last month, Anthem offered to switch me to a plan with a lower increase in premiums but one which does not include brand-name drug coverage. That is unacceptable to me since I need that coverage to treat my condition. There are other Anthem plans, some of which require underwriting – in which case my preexisting condition would not be covered – and some of which don't require it but do carry high deductibles, lower lifetime maximums, and very poor prescription drug coverage, in some cases with a separate \$2000 brand-name deductible. If Anthem goes ahead with its desired rate increase, I will almost certainly be driven to a high-deductible policy and will have to hope that I don't get sick or injured. "Hope" is not an adequate health care policy. I am generally a healthy person who eats right, exercises and takes care of himself, and I resent being squeezed in this way.

Anthem tries to justify these seemingly arbitrary rate hikes by citing rising medical costs. This is disingenuous. If insurance companies believe that medical costs are out of control, they should fight them rather than simply passing them off to ordinary

Americans. Anthem's recent multibillion-dollar profits are repellent because they're at the expense of breaking the backs of people like me.

I don't have a problem with corporate profit-making; it's the foundation of American business and innovation, and it drives our economy. But I do have a problem with profiteering, especially when it's at a level that penetrates so far into the economic and social well-being of our country that Americans are discouraged from pursuing dreams and starting businesses, and are stuck in undesired jobs simply because they worry about losing their health insurance or being able to afford it for their employees. This is wrong. In fact, it's insane. And it must be fixed.

It would be simplistic to think that Anthem's corporate greed is the only problem here, though it is a huge one that I believe requires stringent regulation. Sharing the blame are indeed hospitals and doctors raising rates far above what is defensible and who, like the insurance companies, happily line their own pockets while blaming the other side; a legislature that is too beholden to special interests or consumed with partisan rhetoric on both sides of the aisle to take necessary action; and bloated bureaucracy all around. If all parties – legislators, insurance companies, medical providers – have any shred of fairness and decency, they will do whatever it takes to support and pass meaningful health reform now.

Mr. STUPAK. Thank you, Mr. Arnold. Ms. Henriksen, your opening statement, please.

TESTIMONY OF JULIE HENRIKSEN

Ms. HENRIKSEN. Good morning, Chairman Stupak, Chairman Waxman and members of the committee. I first would like to say that I am honored and more so extremely encouraged with the invitation to come before the subcommittee to present my real life situation regarding the most recent premium increase of my Anthem Blue Cross individual health insurance policy. The new found urgency and the spirit of determination with which these hearings are taking place give me a tremendous amount of hope that the issue of health care reform is going to remain an enormous focus of attention until a solution is found satisfactory to all. A little about myself and my particular case. I am 54 years old. I have two teenage sons, Keaton, who just turned 18 years old and is heading to college next year, and Britton, who is 16 years old and a junior in high school. I am self-employed as a consultant in the field of architecture and interior design, specializing in hotel design.

I have worked continuously in this field for approximately 27 years now. I make fairly good money, and both my boys attend private school. I have held a Blue Cross individual family policy since owning my own small business. My current policy is called a PPO share plan designated with a \$1,500 deductible. My monthly premium is \$1,042 covering the three of us. Dated January 26, I received a letter with a booklet attached stating that on March 1 of this year, my monthly premium would be raised to \$1,352 for the same policy. This is an increase of \$310 per month or a 29.8 percent increase.

Just to clarify, my current policy states that I must meet an annual \$1,500 deductible for each two members of my family which totals 3,000, and an annual out-of-pocket expense of 4,500 for two members of my family, which totals 9,000 in addition to the yearly premium of \$12,504 that I pay already. I have to tell you that we have never even met the deductible each year. All three of us are very, very lucky to be very healthy. But what is most concerning to me is that I am held captive in this policy since my younger son, Britton, was born with a heart condition. Not discovered until age 3, he was born with a small hole in his heart about the size of a dime between his right and left atrium.

In addition, he has a condition called a cleft mitral valve, which means that the flap that opens and closes to allow blood to flow from the atrium to the rest of the body does not shut properly. Rather it swings back into the atrium and in so doing allows a small amount of blood to flow back into the heart with each beat. He had surgery when he was 3-1/2 years old, which repaired the hole in his heart. At the same time the mitral valve was corrected to the extent that it is characterized as a mild leak. The flap of the valve needs to move back and forth so it can only be cinched so far to correct a leak. He is seen by a pediatric cardiologist once a year for an ultrasound and an echocardiogram just to make sure that the leak has not changed from mild to moderate or severe. He is extremely healthy and is in no way hindered with any symptoms or restrictions when it comes to sports exercise. In fact, he is on

his school's tennis team and has played sports of all kinds all his life.

The reason that I am held captive, so to speak, is because he has in insurance terms a pre-existing condition. Sadly, I am allowed the so-called privilege of staying with Anthem Blue Cross and paying exorbitantly unreasonable premium hikes each year until I can't pay them anymore. In the same written notice by Anthem, I was offered a downgrade to my policy to an annual \$2,500 deductible for each member with a 5,000 annual out-of-pocket amount for each member at a cost of 1,089 per month, an additional increase of \$47 to my current 1,042. I am allowed to downgrade until the term change in policy takes place and then involves the active underwriting, which I do not want to happen.

I should note here that if I were to accept this new monthly premium of \$1,352, thereby retaining my same current policy, this amount would be shy just \$92 of my monthly home mortgage payment, which I refinanced this past summer. What worries me most is what will it be like for my son when he is 22 years of age, and I am no longer able to claim him as a dependent on my taxes. Will he be excluded from any kind of policy because of his unforeseen heart condition when he was born?

I must tell you that I have never written to any government officials or office before this, and though my letter, just another amongst many in the storm of shock and outcry about Anthem's premium increases, but I felt so compelled to do so for the very reason stated above, and the fact that in this economically depressed environment, I find the act of Anthem Blue Cross raising premium costs to individual policy holders for such high amounts truly unconscionable. Not to make light of the situation, but if I were to send out a letter today in my industry stating that I was raising my hourly consultant rate by almost 30 percent, I would not be working.

To conclude, I find that even with all the disagreements in Congress regarding the latest health care reform proposals amazingly, I really still do have a positive outlook that our government officials can come up with a workable solution to the obvious and urgent need to change the direction of the health care in this country. I thank you for the opportunity to be heard.

[The prepared statement of Ms. Henriksen follows:]

**Testimony of Julie Henriksen
Before the House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
“Premium Increases by Anthem Blue Cross in the Individual
Health Insurance Market”
February 24, 2010**

Good Morning Chairman Waxman, Chairman Stupak and members of the Committee.

I am honored and more so, extremely encouraged with the invitation to come before this subcommittee to present my real life situation regarding the most recent premium rate increase of my Anthem Blue Cross individual health insurance policy. The newfound urgency and the spirit of determination with which these hearings are taking place give me a tremendous amount of hope that the issue of health care reform is going to remain an enormous focus of attention until a solution is found satisfactory to all.

A little about myself and my particular case.....I am 54 years old. I have two teenage sons. Keaton who just turned 18 years old and is heading to college next year and Britton who is 16 years old, a junior in high school. I am self-employed as a consultant in the field of architecture and interior design specializing in Hotel design. I have worked continuously in this field for approximately 27 years now. I make fairly good money and both my boys attend private school. I have held a Blue cross individual family policy since owning my own small business.

My current policy is called a PPO share plan designated with a \$1500 dollar deductible. My monthly premium is \$ 1,042 covering the three of us. Dated January 26th, I received a letter with a booklet attached stating that on March 1st of this year my monthly premium would be raised to \$1,352 for the same policy. This is an increase of \$310.00 per month...or a 29.8% increase. Just to clarify, my current policy states that I must meet an annual \$1500 deductible for each two members of my family, which totals to \$3,000 and an annual out of pocket expense of \$4,500.00 for each two members of my family which totals to \$9,000 in addition to the yearly premium of \$12,504.00. I have to tell you that we never even meet the deductible each year. All three of us are lucky to be very healthy.

But what is most concerning to me is that I am held somewhat captive in this policy since my younger son, Britton was born with a heart condition. Not discovered until age 3, he was born with a small hole in his heart, about the size of a dime, between his right and left atrium. In addition, he has a condition called a “cleft mitral valve” which means that the flap that opens and closes to allow blood to flow from atrium to the rest of the body does not shut properly, rather it swings back into the atrium and in so doing allows a small amount of blood to flow back into the heart with each beat. he had surgery when he was 3-1/2 years old which repaired the hole in his heart. At the same time, the mitral valve was corrected to the extent that it is categorized as a mild leak. The flap of the valve needs to move back and forth so it can only be cinched so far to correct the leak. He is seen by a pediatric cardiologist once a year for an ultrasound and echocardiogram just to make sure that the leak has not changed from mild to moderate or severe. He is extremely healthy and is in no way hindered with any symptoms or restrictions when it comes to sports, exercise, etc. In fact, he is on his school’s tennis team and has played sports of all kinds all his life.

The reason that I am held captive, so to speak, is because he has, in insurance terms, a “pre-existing condition.” Sadly, I am allowed the so-called “privilege of staying with Anthem Blue Cross and paying exorbitantly unreasonable premium rate hikes each year until I can’t pay them anymore!

In the same written notice by Anthem, I was offered a downgrade to my policy to an annual \$2500 deductible for each member with a \$5,000 annual out of pocket amount for each member at a cost of \$ 1,089.00 per month, an increase of \$47.00 to my current \$1,042 premium amount. I am allowed to

downgrade until the term Change in Policy takes place and then involves the act of underwriting which I do not want to happen.

I should note here that if I were to accept this new monthly premium of \$1,352.00 thereby retaining my same current policy, this amount would be shy just \$92.00 of my monthly home mortgage payment. (which I refinanced this past summer).

What worries me most is....."What will it be like for my son when he is 22 years of age and I am no longer able to claim him as a dependent on my taxes?" "Will he be excluded from any kind of policy because of this unforeseen heart condition when he was born?"

I must tell you that I have never written to any government officials or office before this, and I though my letter just another amongst many in the storm of shock and outcry about Anthem's premium increases. But, I felt so compelled to do so for the very reasons stated above and the fact, that in this economically depressed environment, I find the act of Anthem Blue Cross raising premium costs to individual policy holders by such high amounts truly unconscionable. Not to make light of the situation but if I were to send out a letter today, in my industry, stating that I was raising my hourly consultant rate by almost 30% I would not be working!

To conclude I find that even with all the disagreements in congress regarding the latest health care reform proposals, amazingly, I really still do have a positive outlook that our government officials can come up with a workable solution to the obvious and urgent need to change the direction of health care in this country.

I thank you for this opportunity to be heard.

Mr. STUPAK. Thank you. Ms. Meister.

TESTIMONY OF LAUREN MEISTER

Ms. MEISTER. Good morning. Lauren Meister, West Hollywood. Thank you for inviting me to speak today. I have been an individual plan member of Blue Cross of California, now Anthem, for over 17 years. I have always dealt with the company directly, not through an agent. Like many people, in 2008 my income dropped substantially. I was paying a \$500 monthly premium for Anthem's PPO 500 plan. I called Anthem in December of '08 to see what other less expensive plans were available. I expected the plan would have a higher deductible or co-pay but would still have the basic necessary coverage.

The Anthem rep was aware of my budget, my medical history and age. I was turning 49. She recommended Anthem's PPO 1500 plan, which was about \$1,000 less per year, so I switched. Just a few months later, I received a notice from James Oatman, VP and General Manager of Anthem Blue Cross Individual that rates for the PPO 1500 plan were being increased on March of '09, and that the new monthly premium would be 528, even higher than what I had been paying for the PPO 500 plan but with less coverage. I paid the new premium until I spoke with friends about their plans. In October, I called Anthem again and asked them how the PPO 40 plan with Brand RX coverage differed from the PPO 1500 plan, which they had recommended to me in '08.

I was told by this Anthem rep that the PPO 40 plan had a lower monthly premium, no deductible and higher co-pay, but the main difference was it did not cover maternity, which at 49 I probably didn't need anyway, so I switched plans again. At 49, I had been paying for maternity coverage, a costly, unnecessary benefit. I thought Anthem execs should know, so I wrote a letter to James Oatman, and I copied Ms. Angela Brawley, Ben Singer, Director of PR for Anthem Blue Cross of California, as well as Senator Boxer and Congressman Waxman. The only response I received was from Congressman Waxman. In January, 2010, James Oatman finally did send me a letter but this was to inform me that my rates were being raised once again from 373 to 516 per month, an increase of 38 percent.

The letter noted that I would also have the option to change to PPO 40 plan with generic RX coverage only. This alternate plan would increase my premium by only 16 percent as if the 16 percent increase was a great savings. I have allergy asthma and I take brand prescriptions Accolate, Aerobid and Symbicort. Symbicort is fairly new. Accolate will not be generic until probably 2011. Hopefully, I can hold my breath until then literally. For the record, with the proper medication my breathing capacity is nearly 100 percent, but without the proper medication, I may end up needing more health care services, which ultimately will increase medical costs for both me and my provider.

Pre-existing conditions such as asthma limit one's chances of being able to switch to a different health care provider, particularly if the goal is to lower the cost of the premium and still maintain coverage. This is only one of many reasons why we need health care reform. I read that Anthem's explanation for increasing rates

by up to 39 percent was rising medical costs. In one respect, Anthem is right. It shouldn't cost \$20 for a hospital to administer an aspirin, but then Anthem's executive salaries and stockholders do not appear to be suffering, and how much money goes to lobbyists trying to prevent health care reform, the same reform that Anthem indicates is necessary to keep health care costs from rising.

My issue with Anthem is shared by many and is just a symptom of a broken system. We have a system where prevention and wellness are not encouraged nor embraced. For example, because I was turning 50, my doctor prescribed a bone density test for baseline measurement. Anthem Blue Cross did not cover one nickel of the test even though that test could determine if I had a propensity for osteoporosis. Penny wise, pound foolish. It is obvious. The health care industry needs to be regulated. We saw what the regulation did to the cost of utilities in California. We saw what the lack of regulation has done on a global level to our financial and banking systems. Well, it is having the same effect on our health care system.

If the City of West Hollywood where I live can regulate how much landlords can raise the rent each year to keep rents stabilized, why can't the federal government regulate how much insurance companies can raise their rates per year in order to stabilize premiums. I believe that we should all be able to buy health care coverage. If someone can afford to pay for private insurance, great, but, if not, there has got to be a public, not-for-profit alternative without having to move to Canada, England or France. Some representatives from Congress have stated that we don't need a public option. I say to them I just want what you have, nothing more and nothing less. To me, insurance is like marriage. You expect the insurer to be with you in sickness and in health. That is why we buy insurance.

If the insurer can't live up to this expectation then perhaps they need to get out of the business of insuring. I also want to just reply that I am an American, and I support Obama's health plan, and I just wanted to make that clear. Thank you.

[The prepared statement of Ms. Meister follows:]

Testimony of Lauren Meister
Before the House Committee on Energy and Commerce
Subcommittee on Oversight and Government Reform
“Premium Increases by Anthem Blue Cross in the Individual
Health Insurance Market”
February 24, 2010

Good morning. Lauren Meister, West Hollywood. Thank you for inviting me to speak today.

I’ve been a customer of Blue Cross of California, now Anthem, for over 17 years. I have always dealt with the company directly; not through an agent.

Like many people, in 2008, my income dropped substantially. At the time, I was paying a \$500 monthly premium for Anthem’s PPO 500 plan. I called Anthem in December of ’08 to see what other, less expensive plans were available. I expected the plan would have a higher deductible or co-pay but would still have the basic, necessary coverage.

The Anthem rep was aware of my budget, my medical history and age. At that time, I was almost 49. She recommended Anthem’s PPO 1500 plan, which was about \$1,000 less per year than the PPO 500 plan, so I switched.

Just a few months later, I received a notice from James Oatman, VP and General Manager of Anthem Blue Cross Individual (Western Region), that rates for the PPO 1500 plan were being increased in March of ’09 and that the new monthly premium would be \$528, even higher than what I’d been paying for the PPO 500 plan.

I paid the new premium until I spoke with friends about what plans they had. In October (’09), I called Anthem again, and asked them about the PPO 40 plan with brand Rx coverage, and the differences between that plan and the PPO 1500 plan, which they had recommended to me in ’08.

I was told by this Anthem rep that the main difference was that the PPO 40 plan had no deductible a lower monthly premium (\$373), but a higher co-pay (40%), and did not cover maternity, which, at 49, I probably didn’t need.

It was then that I realized that all these months, I’d been paying for a costly, unnecessary benefit, so I switched plans again and wrote a letter to James Oatman (dated October 21, 2009).

I copied Ms. Angela Braly, Ben Singer - Director of PR for Anthem Blue Cross of California, Senator Barbara Boxer and Congressman Henry Waxman. The only response I received was from Congressman Waxman.

In January 2010, James Oatman finally sent me a letter, but this was to inform me that my rates were being raised once again, from \$373 to \$516 per month – an increase of 38%.

The letter noted that I’d also have the option to change to a PPO 40 with generic Rx coverage only. This alternate plan would increase my premium by only 16%, as if a sixteen percent increase was a great savings.

Unfortunately, I take brand prescriptions for asthma: Accolate, Aerobid and Symbicort. Accolate will not be generic until probably 2011. Hopefully, I can hold my breath until then -- literally.

For the record, with the proper medication, my breathing capacity is nearly 100%. But, without the proper medication, I may end up needing more health care services, which ultimately, will increase medical costs for both me and my provider.

Some of you may be thinking, why not find another plan with a different health care provider? Pre-existing conditions, such as asthma, limit one's chances of being able to switch to a different health care provider, particularly if the goal is to lower the cost of the premium and still maintain coverage.

This is only one of many reasons why we need health care reform.

I read that Anthem's reasoning for increasing rates up to 39% was rising medical costs. In one respect, Anthem is right - it shouldn't cost \$20 for a hospital to administer an aspirin. But then again, Anthem's executive salaries do not appear to be suffering. And how much money goes to lobbyists -- lobbyists trying to prevent health care reform -- the same reform that Anthem indicates is necessary to keep health care costs from rising?

My issue with Anthem is shared by many, and is just a symptom of an unhealthy, broken system.

We have a system where prevention and wellness are not encouraged.

For example, because I was turning 50, my doctor prescribed a bone density test for a baseline measurement. Anthem Blue Cross did not cover one nickel of that test -- even though that test could determine if I have a propensity for osteoporosis. Penny wise, pound foolish.

It's obvious to me, the health care industry needs to be regulated.

We saw what deregulation did to the cost of utilities in California. We saw what the lack of regulation has done on a national level to our financial and banking system -- well, it's doing the same thing to our health care system.

The City of West Hollywood, where I live, regulates how much landlords can raise the rent each year to keep rents stabilized.

Why can't the federal government regulate how much health insurance companies can raise their rates per year, in order to stabilize premiums?

I believe that we all deserve affordable, competitively-priced coverage. If someone can afford to pay for private insurance, wonderful -- but if not, there has got to be a public option alternative, without having to move to England, France or Canada.

Some representatives from the Senate and House have stated that we don't need a public option. I say to them, I just want what you have -- nothing more, nothing less.

To me, insurance is like marriage; you expect the insurer to be with you in sickness and in health – that's why we buy insurance. If the insurer can't live up to this expectation, then perhaps they need to get out of the business of insuring.

(I see that Ms. Braly is here today. I'd love to know why no one from Anthem Blue Cross felt it necessary to answer my letter; and perhaps she'd like to respond now.)

Mr. STUPAK. Thank you, and thank you all for your testimony and for coming here today. We are going to start with questions. We will start with the chairman of the full committee, Mr. Waxman, for questions, please.

Mr. WAXMAN. Thank you very much. I appreciate the testimony each of you has given. Ms. Meister, you indicated you are a constituent. I don't know if the other two witnesses are also constituents because you are from LA . I do know that WellPoint is a constituent of mine as well. And I want to do what is right for all my constituents, but it is not right to have insurance companies deal with ever increasing costs by shifting those costs onto the beneficiaries, their customers, because that is what they are doing. If you have a brand name drug, they won't cover it. You have to pay for it if you want it. If you want insurance, they figure out a way to increase your rates to keep the policy you already have. This is the problem with individual insurance.

What we have as federal employees is we can choose between a number of different plans and they can't turn us down and they can't charge us more if we have pre-existing medical conditions. We get coverage because the costs are spread among all the insured. That is true of federal employees, members of Congress, for a lot of people that work for large employers that provide coverage, but the 3 of you are not in that situation. You have your own business. You have part-time jobs. You have your own activities, so you have to go in the individual market. Those are the people for the most part who don't have insurance coverage because they can't afford it, and it looks like you may not have insurance coverage yourselves if you don't pay these increased rates or they give you another alternative.

WellPoint lets you go into another plan that costs more and covers less. What a deal. It doesn't hold down the cost of care. It simply makes you have to pay more of it, but that is not what you want from insurance. You want insurance to cover at least their share of the cost, and you would also like them to negotiate better prices to hold down health care costs overall. I don't see any evidence of holding down costs except shifting them on to you. Let us look at this situation that you are facing.

Ms. Meister, you talked about your current plan. You have a PPO. You have to pay a percentage of your medical costs and you use a brand name drug as well as generic medications after you meet your deductible. Is that a correct statement of the plan you have generally?

Ms. MEISTER. Yes, and the brand drugs only come—they don't come in generic.

Mr. WAXMAN. So you can't get a generic for those where you need the brand name drugs. You told us in your opening statement you take your medication to treat chronic asthma. These are not in generic form, so if you go along with what you are being told by Anthem, you would have to switch to a plan with inferior coverage or attempt to pay the higher monthly premium. That is the way they have got you in the squeeze, isn't it?

Ms. MEISTER. That is correct.

Mr. WAXMAN. Have you decided what you are going to do?

Ms. MEISTER. I have decided that I am going to take the lower coverage with the generic brand and I will pay out of pocket for the brand medication.

Mr. WAXMAN. And, Mr. Arnold, you have the same health insurance plan as Ms. Meister, and they propose to increase your cost by 38 percent as well, or you can switch to a plan that covers generic medications only, is that right?

Mr. ARNOLD. That is correct, or I could switch to a plan that also covers brand name but one that has a much higher deductible over all.

Mr. WAXMAN. And faced with this kind of a problem, you have got a terrible choice to make. Have you decided what choice you are going to make?

Mr. ARNOLD. At the moment, I am in a wait and see attitude because I know that these proposed increases have been put on hold until May 1, but if nothing changes I will probably switch to one of the very high deductible policies.

Mr. WAXMAN. And they would be very happy because they is what they would like you to do. Then you would just have to pay more of your costs. Mr. Chairman, these witnesses made clear that the alternative plans Anthem is offering to its policy holders provide dramatically less coverage for marginally less money, and if the only option available to consumers in the individual market is to pay outrageous monthly premiums or switch to a plan that doesn't meet their needs, then it is another example of why we need reforms in the individual market. All of us here will say we care about this. We want to have insurance reforms. That is what we are told.

But you can't reform the insurance system without providing some standard policy so you can compare policies. You have such arbitrariness in the kinds of policies that you have available to you, and you can't really figure out what your needs are because from year to year it changes and it goes up. What we need is for insurance companies to have to provide insurance for everybody and spread those costs, and to do that we have to make sure that everybody is covered, and to make sure that everybody is covered we have to help people who can't afford their coverage, and we have to tell the insurance companies they can't deny you that coverage.

That is where we find our differences as we try to deal with health reform. We have got to deal with the problem in a broader way than say, oh, let us do away with pre-existing conditions where the Republican proposal doesn't even do that. They would put people with pre-existing conditions in a special group where they would pay higher premiums and they would be treated differently. We have got to standardize insurance and make sure that people have access to it. That is what President Obama has been trying to do.

We are going to go to a summit tomorrow that the President has called for the Democrats and Republicans. I hope we can work on this in a bipartisan basis. This shouldn't be a Democratic or Republican issue, but we will see tomorrow whether we can look for common ground rather than hear the accusations back and forth that we want to socialize medicine or we are going to create death panels or we are cutting back on people and the elderly, and then yet

we find lack of cooperation to find a solution to this intractable problem. I hope we don't let another opportunity go by and wait another 15 years before we tackle the problem again. You can't afford it, and the American people can't afford it either. Thank you, Mr. Chairman.

Mr. STUPAK. Mr. Burgess for questions, please, 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. In the interest of bipartisanship and comity, I feel that I need to respond to some of the lectures that we have been getting this morning. Mr. Chairman, and referring to Mr. Waxman as the chairman of the full committee, I would be offended as chairman of the committee if the committee passes a bill and the Senate passes this bill I didn't like, but fair enough, the Senate passes a bill, a bill I didn't like that was starkly different from this committee's bill, but nevertheless they did what they intended to do, and then the proper process is for the two sides to get together, House and Senate, I am talking about, not Republicans and Democrats, but the House and Senate to get together and reconcile the differences in what is called a conference report, and this is part of our normal procedure.

But now we have a situation where the White House functioned as the conference with no input that I am aware of from yourself or Mr. Stupak or Mr. Rangel or Mr. Miller as chairman of the Education and Work Force Committee, the White House put together this conference report and now we will be required at some point to vote on that and deal with it through a process called reconciliation which is a little arcane, but it means you don't have to have quite so many supporters to get this done. And if the American people were behind what we were doing, it wouldn't be this difficult.

Now you can look at polls however you want, but 60 percent of the American people don't like what we are doing. Twenty percent of the people are in favor of Congress generally and 45 percent of the people are in favor of the President, so with these sorts of numbers it is difficult to do something this massive in the form of restructuring. Now just another issue that you made. You brought up the federal employee health benefits plan. It is employer-sponsored insurance so it doesn't exactly translate to what we are talking about here today, but had we worked more on making the individual market look more like the ARISA protected market under employer-sponsored insurance the multi-state corporations that provide insurance to their employees across the country that aren't holding to things like state lines perhaps we could have delivered something that was meaningful for someone in the individual market.

I have been in the individual market. I know that it is sometimes tough to find the plan you want. I have had adult children in the individual market. I have had to keep up with things that they chose not to but I thought was important. We do have regulation in the individual market. It occurs at the state level right now. It may be a bad thing. Maybe it needs to be at the national level, but, you know, when I just looked through the federal employee health benefits plan book, I get a better deal because my residence is in Texas than I would in California, and certainly a better deal than I would get in New Jersey, so maybe I don't want a national regu-

lator who is going to base everything on an area that is really not germane to where I live, so we do have to be sensitive to the fact that the states are different.

Now we passed a bill twice in the 108th and 109th Congress that would have allowed aggregations of small businesses across state lines, so-called association health plans. The reason there is not pre-existing conditions in the federal employee health benefits plan is not because we set up something that is better for ourselves. It is because the pool is so big, there are so many federal employees, which may be a good thing or a bad thing, we could argue about that, but there are so many federal employees that the pool is so large that pre-existing conditions actually don't enter into the equation. What we could do for writers across the country, for example, or architects across the country, let every architect buy into an association plan where all the other architects buy into it, realtors, whatever kind of association you want to make, and suddenly you have got a pool that has the market share of a company like Verizon that has employees in all states in the union and buys insurance for them.

Mr. Arnold, I think you brought up about the affordability of the premium, and I don't know your income and I am not going to ask you, but have you looked at the House-passed bill and calculated what your premium would be?

Mr. ARNOLD. No.

Mr. BURGESS. The House-passed bill, and I am not lecturing you here, I want to make you aware, the House-passed bill is a good deal for someone who is unemployed and has no insurance. It provides access that has never existed in the past. Your premium under the House-passed bill, and again I don't know how much you make and I am not going to ask you to tell us, but for someone who makes at 350 percent of the federal poverty level the annual premium, the annual premium would be right at \$4,200 a year, so a little bit more than what you are paying right now.

Now 350 percent of the federal poverty level is a good salary. I don't know how it works out with California cost of living. But it is just a little under \$38,000 a year for a single individual. I don't know whether you are married or not, and again I am not going to ask you. But just to point out that, yes, you have brought up a significant point that we need to pay attention to, that your premium has increased significantly under Anthem, and we are going to ask Anthem to justify what they have done in the California market.

But I do want you to understand that with the House-passed bill that not everyone in your situation, depending upon income, someone who earns 400 percent of the federal poverty level, which is \$43,000 a year, would be paying \$5,400 in annual premium as a single individual in the government option, in the House-passed plan. Only 2 rating bands for younger and older, no tobacco rating, so there are some things in the House-passed bill that might not improve affordability in your situation, and that is really what we are talking about here because Anthem has affected the affordability of your policy. I would give anything to know, Ms. Meister, what you are going to be charged for your bone density. I won't ask you, but I will also suggest that I think your doctor was right to

recommend it. And if your doctor recommended it when you were 65 years of age, yes, it would be covered under Medicare but your doctor would only be paid \$40 for the privilege of providing you that service.

Again, I don't know what your doctor was proposing to charge you. I suspect it was more than \$40 but I don't know that. After you turn 65 under the big public option that we now call Medicare if your doctor charged you more than \$40 for that procedure, my cost is \$200—

Mr. STUPAK. The gentleman's time has expired.

Mr. BURGESS [continuing]. Your doctor would be violating the law to charge you the additional. So we will give up some things if we go with the House-based bill. That is why it is so important for us to get it right. That is why it is so important for us to go through regular order and not let the White House subsume the duties of the conference committee—

Mr. STUPAK. The gentleman's time has expired.

Mr. BURGESS [continuing]. Which is, unfortunately what has happened now. I told you you would regret having me here.

Mr. STUPAK. No, Mike. I have sat in this chair a long time and I have listened to you forever, and I know you always go over. I know I have to be diligent. I know I have to keep on you. I feel sorry for these witnesses because they are self-employed. They took time off of their jobs probably at a loss of money to come and give us the courtesy of asking them questions, and you never asked them a question. So I feel sorry for our witnesses.

Mr. BURGESS. I supplied them with valuable information they couldn't have gotten any other place.

Mr. STUPAK. Yes. Well, it is amazing. It is my turn for questions. Let me just say a couple things. This committee, this subcommittee in the last 3 years have held hearings on under insured, on rescissions, on purging of small businesses. And I asked for this hearing. As I said in my opening, Michigan proposed a 56 percent rate increase. And I would have liked to have had this hearing in LA. We have had hearings in Indiana. I will go anywhere in the country to hold hearings on health care because I think that consumers in this country are being bankrupt by health insurance, and I want to see health insurance passed. And the reason for this hearing—and it is a coincidence. When we set this hearing, when we were doing things, we didn't know the White House was going to do a summit on health insurance. But I will go anywhere with this subcommittee. I will go to any district and hold these hearings because I think they are valuable.

And when Michigan proposed a 56 percent increase for our people, I have the e-mails that they finally settled at 30 to 39 percent increase for these small business people, much like the panel we have here today, and people just can't afford it. We are all truly one injury or one illness away from bankruptcy. But let me ask this question. Yesterday we did a hearing on Toyota, and 10 years ago if I would have bought a car and I buy one now today, I get all kinds of extra bells and whistles whether it is a Toyota, a General Motors, whatever it might be. Mr. Arnold, Ms. Henriksen, Ms. Meister, has your insurance given you more bells and whistles as you have seen these increases?

Mr. Arnold, yours went up 74 percent in the last 2 years. Ms. Henriksen, I see premiums increased about by the time you do your premium, your deductible, and your out-of-pocket, that is about \$31,000 before you even start tapping into anything. And, Ms. Meister, you are just trying to keep your drugs that will keep you breathing. Have you seen increases in benefits as these prices have gone up?

Ms. MEISTER. No, less benefits.

Mr. STUPAK. Mr. Arnold.

Mr. ARNOLD. Yes, also less for me. Last year, in fact, when my rates were raised 26 percent, Anthem also increased my prescription drug co-pay for both brand name and generic.

Mr. STUPAK. Ms. Henriksen.

Ms. HENRIKSEN. No, I haven't, and sometimes when I open my statement from them after going to doctor, I am shocked that like, oh, wow, they didn't cover that. You know, it is things like that, but I haven't calculated exactly any changes.

Mr. STUPAK. You mentioned your son that had the heart issue there, the hole in the heart. How long will they continue to hold like a pre-existing condition like you mentioned he is going to turn 22—

Ms. HENRIKSEN. Probably the rest of his life.

Mr. STUPAK. OK.

Ms. HENRIKSEN. He will always have a heart condition.

Mr. STUPAK. Which requires him to see a cardiologist. He doesn't have any problems. He's playing sports.

Ms. HENRIKSEN. He is completely fine. I mean, you know, you can only cinch it so far, and it can't be completely corrected so he will always have a condition in his heart, but he can only stay on my insurance till I claim him as a dependent.

Mr. STUPAK. Well, the other thing in looking at this file and WellPoint and Anthem here in California, and we are looking at one of the e-mails that the vice president for individual pricing states, it says Jim has asked Brian to price five or six downgrade options to be made available in conjunction with the upcoming rate action, meaning this increase they are passing on. In another e-mail the company's regional vice president and actuarial, Brian Curley, proposes that WellPoint create five or six California look-alike plans, look-alike plans for California, with a benefit or two removed to create a downgrade option upon renewal. My question, and I guess I will direct it to Ms. Meister, how does it make you feel to know that part of Anthem's business plan is to reduce or restrict your health care coverage being offered to you on downgrade options to switch it during your annual renewal. How are you going to be able to afford your medication?

Ms. MEISTER. This is what has been happening the last few years. I have had to downgrade because the price has gotten too high so I will have to pay for my medications through my savings through—

Mr. STUPAK. What do you think that cost is going to be for your brand name drug if you are going to go to the generic, so what will that out-of-pocket cost be, do you know, of this drug?

Ms. MEISTER. Yes. Accolate is \$100 and I have to buy that every month, so that—

Mr. STUPAK. \$100 for a 30-day supply. OK.

Ms. MEISTER. That is just for the Accolate, yes.

Mr. STUPAK. Ms. Henriksen, Anthem, I believe you said, offered to switch you to a similar plan to the one you have now which would come with higher deductibles. What is your opinion on the scale backs?

Ms. HENRIKSEN. Pardon me?

Mr. STUPAK. What is your opinion on, well, OK, I can get a different plan. I am going to get less coverage but I am going to have to pay more.

Ms. HENRIKSEN. I figure I don't have a choice. I can't afford the premium that they are stating for the existing policy they have now so I have a call in to my agent and, you know, he is going to go over options for me, but I know from talking to him almost a year ago that because of my son's heart condition I can only downgrade so far until he has to be underwritten, and I don't want to do that. So, you know, I would probably go with the downgrade of the \$2,500 deductible and 5,000 out-of-pocket because it is \$47 more than my existing payment but it is not \$310 more.

Mr. STUPAK. What is the breaking point when you can no longer afford it at all?

Ms. HENRIKSEN. Oh, I think it is insane as it is now.

Mr. STUPAK. You said it was almost as high as your mortgage, right?

Ms. HENRIKSEN. Yes. It is \$92 less than my mortgage payment.

Mr. STUPAK. Mr. Arnold, let me just finish up with you, if I may. I know you have had a 74 percent increase in your premium rates according to your testimony. Obviously, your insurance hasn't gotten better. Do you believe Anthem is trying to push customers off the plans with less comprehensive coverage and in the plans that barely meets their needs so they just drop coverage all together?

Mr. ARNOLD. Yes. I mean I think the reason that the plans are going up are because healthy people are dropping it all together because they are like me. They are getting priced out of it. I mean I am generally a healthy person. I have an existing condition, but it is getting so high that I mean if it went up to \$800 a month I would have to drop it. That I couldn't afford. No way. But that is an extreme. Just to prove a point. I mean 319 a month which they want to raise it to is very, very difficult for me. The 231 that I have had for the last year, I have not been happy with but, you know, I have managed to do it even though last year was a pretty tough year in this economy and my income was lower last year than it was the year before. So, yes, they are trying to push people like me out.

Mr. STUPAK. Thank you. My time has expired. Thank you all for being here. Mr. Gingrey, questions, please.

Mr. GINGREY. Mr. Chairman, thank you. And I will be fairly brief. I wanted to direct my first question to Ms. Meister. Ms. Meister, you mentioned in your testimony kind of in your closing that you want just what members of Congress, members of the House and the Senate have, nothing more, nothing less, and I want to just say to you and to the other witnesses that I agree with you. I agree with you. I think that the American people in every state should have that opportunity and when the health care reform bill was

first marked up in this committee, H.R. 3200, we spent hours and several days, in fact, several weeks marking up that bill and amending it and making some suggestions for amendments on both sides of the aisle. In fact, two amendments that I had in particular that I think you will like, and I would like to ask your opinion on it, was that all Americans have what we have, members of Congress, and that amendment unfortunately went down pretty much straight party line, and I followed up with that and said, well, you know, if there is a public option, and I think you in your testimony talk about a public option, as you know, right now there is no public option in any of the bills, but in this committee there was. H.R. 3200, there was a robust public option, as I am sure you know.

And so my amendment was, OK, if the public option is so good, maybe it is, then let's show good faith in it and have every member of Congress, House, Senate, and indeed the President and the Administration and their families sign up for the public option, and that also failed on straight party line vote. I would like to know your opinion and maybe the other members of the panel, what they think of that, those two recommendations.

Ms. MEISTER. I am very willing to pay for insurance. I just want to pay for something that is affordable and that actually covers me. We have Medicare. I thought the plan that extended Medicare to 55, down to 55, was a good idea, and have those people between 55 and 64 pay for the plan, so I don't know what else to say. I don't want to have to be spending the next 15 years of my life looking forward to being 65 so I can get Medicare.

Mr. GINGREY. Well, yes, and certainly I understand your point there but do you realize that, and I am sure you do, that Medicare currently has an unfunded liability over the next 50 years of \$35 trillion, and so to add that many more millions of people between age 55 and 64 when we can't even meet the obligations that we currently have, you know, that was the problem with that proposal.

Ms. MEISTER. I see the country supported bail out for the banks and for the car companies. I would like to see them bail out the American people.

Mr. GINGREY. And I think you will be pleased to know that I voted against that bail out for the car companies, and I thank you for bringing that up. Mr. Arnold, let me shift to you just a minute in regard to meaningful health reform. You mentioned that. By meaningful health reform, would you include in that medical liability reform?

Mr. ARNOLD. Absolutely, I would. I think that ideas on both sides of the aisle, there are good ideas on both sides. Just to address what you just said a moment ago about the public option and so forth the reason that—well, you explicated the reason. You said it was party line vote. It is politics. The party that is not currently in power doesn't want to give the party that currently is in power and the President a victory of any sort, so parties and politicians and parties—

Mr. GINGREY. Well, Mr. Arnold, reclaiming my time because I just got a very few seconds left. Absolutely, I think that we ought to give the President the opportunity to do it in a bipartisan way and that is why when we have this meeting tomorrow at the Blair House, the health care summit, I feel sure that the members on the

Republican side from the House and the Senate, maybe Dr. Coburn or Dr. Brasso representing health care in particular as a profession will offer that, and I look forward to the President hopefully adopting it because California, as the three of you well know, enacted that legislation back in the late '70s. I think the acronym was MICRA, and it has worked. It has worked. And fortunately the California legislature hasn't ruled any of that unconstitutional so I am glad that you support medical liability reform. Mr. Chairman, I see my time has expired, and I will yield back.

Mr. STUPAK. Mr. Arnold, did you want to finish an answer there?

Mr. ARNOLD. Yes. I would like a brief moment to finish what I was saying. I thank Mr. Gingrey for what he said, and I take him at his word and I would hope that you would encourage all of your parties and colleagues to operate in good faith and not to use words, irresponsible words, like socialism and death panels and so on and so forth that you hear from parties and politicians and from partisan media commentators because they are completely not an accurate description of the issues that are at stake. Thank you.

Mr. STUPAK. Ms. DeGette for questions.

Ms. DEGETTE. Thank you. Thank you, Mr. Arnold, for clarifying your statement. I think what you said is important and I hope everybody listens to it. It seems to me in listening to all three of your testimony aside from the fact that you are buying insurance on the individual market the other problem that each of you has is either yourselves or family member with a pre-existing condition that pretty much limits you from trying to shop around and buy cheaper insurance, is that correct, Mr. Arnold?

Mr. ARNOLD. Yes.

Ms. DEGETTE. Ms. Henriksen, Ms. Meister. And I understand, Ms. Henriksen, when you were talking, I told my staff, I said I feel like this is me because I am like you, I have two daughters, 20 and 26, and like you my younger daughter has a pre-existing condition which she will have for her whole life. Not only does that limit—even though I am in the federal employees insurance system, I am still limited in shopping around because of underwriting, but what I am the most terrified about with her is when she graduates from college and starts trying to buy insurance on her own she is going to have an impossible time buying a policy, especially as a young person who is just starting out in the labor market that will cover her pre-existing condition. I am sure that you have thought about that too with your son.

Ms. HENRIKSEN. That scares me immensely and with businesses eliminating all insurance group plans and things like that in my industry hardly anybody has it. I don't see how he is going to be able to pay for an individual policy with a pre-existing condition when he is working.

Ms. DEGETTE. Right. So here is my question for all three of you. If you could go on some kind of insurance exchange that allowed anybody to go in and buy from different insurance companies, and the people on that exchange so you could choose between competition between different insurance companies and they couldn't exclude you or your kids because of a pre-existing condition, do you think that would help you with your insurance choices? Mr. Arnold.

Mr. ARNOLD. It sounds like it might, yes.

Ms. DEGETTE. Ms. Henriksen.

Ms. HENRIKSEN. Yes. I believe that it is free enterprise, I guess, and you are allowed the privilege of shopping for almost anything else. Why shouldn't it be insurance too?

Ms. DEGETTE. Ms. Meister.

Ms. MEISTER. Yes, because we are being penalized for being individuals and having individual plans.

Ms. DEGETTE. Right. And, you know, Ms. Meister, I want to ask you about something because you said you thought it was as good idea if they extended Medicare down to age 55 and with every passing year that idea sounds better to me too. But were you aware that those proposals didn't just say we are going to pay for people to have Medicare. They would actually have to buy in.

Ms. MEISTER. Oh, yes, absolutely.

Ms. DEGETTE. And you would be willing to buy into that Medicare is what you are saying.

Ms. MEISTER. Absolutely.

Ms. DEGETTE. I just wanted to clarify that. OK. Now I just want to explain one more thing with the 3 of you because I think there has been some miscommunication about insurance companies selling insurance across state lines. Were you aware that right now insurance companies can sell insurance across state lines, but if they do that they have to comply with the laws of the state where they are selling that? Mr. Arnold, were you aware of that?

Mr. ARNOLD. No, actually I wasn't.

Ms. DEGETTE. OK. Ms. Henriksen.

Ms. HENRIKSEN. No, I wasn't either.

Ms. DEGETTE. Ms. Meister.

Ms. MEISTER. No.

Ms. DEGETTE. OK. Well, see, what happens right now different states like California or Colorado or Iowa or Georgia, any of the states, they can sell insurance across state lines, but if they do that they have to give people the insurance coverage that those states require, so if California says you have to cover maternity benefits or you have to cover prostate cancer screening or something else, then they have to do that, but what the proposal that some from the other side of the aisle have made is to say people could sell insurance across state lines but they would only have to comply with the laws of the state where they are incorporated. It would be sort of like how all corporations, not all, but a lot of corporations incorporate in Delaware because those state laws are very favorable to corporations.

So they can incorporate in a state which had very low requirements for coverage. And I want to talk to you about that, Ms. Henriksen, because you got 2 kids. Would it help you to be able to buy a very low cost plan but one that didn't offer very many coverages for you like mammography or some screenings for your kid? Would that help you?

Ms. HENRIKSEN. I guess I would have to see specifically what they were offering.

Ms. DEGETTE. What it was, yes.

Ms. HENRIKSEN. But, like I said, we are so lucky, all three of us, to be healthy. We never go to the doctor. We have very little cost incurred, you know, through insurance so I would be interesting to

see what I could eliminate and what I would then need. I could pick and choose, I guess.

Ms. DEGETTE. Yes, you could pick and choose. But you wouldn't want to buy a plan that would barely cover anything if you got sick.

Mr. HENRIKSEN. No.

Ms. DEGETTE. And, Ms. Meister, would you want to buy a plan that wouldn't cover the specific medications that you needed?

Ms. MEISTER. I would have to work it out and actually figure out the financial side of it and see how much my medications cost me per year and how much I am being covered. I mean even now I have a deductible for the brand. I believe it is \$500. Until that kicks in, it is 4 months into the year.

Ms. DEGETTE. OK. Thank you.

Mr. STUPAK. Thank you. Mr. Braley for questions. We will wait for Mr. Green to get settled there.

Mr. BRALEY. Thank you, Mr. Chairman. I began my opening remarks by talking about the fact that I am not a Democrat who limits my conversation to health insurance reform because I believe that health insurance reform is a key part of comprehensive health care reform. And I am so glad the three of you are here today because you helped put a human face on what is wrong with health care and health insurance delivery in this country right now. We had 17 town hall meetings back in my district last summer and what I learned is that people who oppose health care reform, and especially the health care reform we have been talking about, really don't want to talk about the human face of health care, so I want to spend a few moments talking to you about that.

One of the people who came up to me in my last town hall meeting ripped the House health care bill, and then said after the meeting, Congressman, I need your help. I said what can I do? He said my brother was just diagnosed with non-Hodgkin's Lymphoma, and he lives in the northern part of your district. The closest place for him to get treatment is at the Mayo Clinic in Rochester, Minnesota, but he can't get treatment there because they are not in his insurance plan's provider network. Another young woman interviewed me during the health care debate who was a class mate of my 2 sons, sat down to interview me, and the first thing I noticed about her was she had a cleft palate. And during her interview, she told me that she was so excited because her parents had almost saved up enough money for her last surgery, and I said isn't that covered by your insurance policy? And she said, no, it is defined as cosmetic surgery under my plan.

So a woman, 21 years old, born with a birth defect just like cystic fibrosis or cerebral palsy, which are covered under health care policies, has gone 21 years with a birth defect that limits her ability to eat, to talk and, most importantly, her self esteem. The last one I want to talk about is my nephew's son, Tucker Wright, who I have talked about before in these hearings. Tucker was 18 months old when he was diagnosed with liver cancer, had 2/3 of his liver removed, has had enormous medical costs, and thank God he is still alive, but he will almost certainly reach his lifetime cap under his private health policy by the time he is 18. He will almost certainly have another bout of cancer before he turns 18. His parents

are doing fundraisers to cover their uninsured medical costs. Both of them work full time and have good health insurance, and yet if his parents want to change jobs they would not be able to because of the exclusion for pre-existing conditions.

All three of you have lived this in your own lives so I want to ask you, Ms. Meister, you have chronic asthmas, you talked about that. If you opted to terminate your policy with Anthem and purchase an individual insurance policy to get a more reasonable deductible or premium, you would have to go additional medical underwriting, correct?

Ms. MEISTER. I would imagine so, yes.

Mr. BRALEY. Right, because that is the way this works. And given your chronic asthma, do you think that that would be a problem for you in getting additional coverage?

Ms. MEISTER. Personally, I work out every day. I live a very healthy life so I don't—but on paper that is a different story.

Mr. BRALEY. You have to fill out the same questionnaire.

Ms. MEISTER. They should talk to me like you are talking to me.

Mr. BRALEY. Yes. And, Ms. Henriksen, you talked about your son's problem with the condition with the hole in his heart. When you fill out any application for underwriting purposes, you are required to go through your family's health history and that would appear.

Ms. HENRIKSEN. Yes.

Mr. BRALEY. And does that concern you?

Ms. HENRIKSEN. Oh, completely.

Mr. BRALEY. And, Mr. Arnold, you were the one who concluded your compelling remarks with a smack down to all of us about doing what is right, and you also have been affected by this because these are the types of things that make it frustrating for people to get private insurance because this can be so daunting. Is the experience that you have had consistent with what the other witnesses and some of the people we have been talking about face every day and try to get health care coverage?

Mr. ARNOLD. Absolutely so, yes. Yes. I won't repeat everything that they just said, but what Ms. Meister said about being underwritten again and pre-existing condition either not being covered or causing the base rate on that policy to be marked up by my insurance agent told me 20 to 100 percent because of that condition. These are the kinds of things that can happen.

Mr. BRALEY. Mr. Chairman, health insurance is supposed to help us when we are sick, not punish us for requiring medical care, and I think what we have heard today reinforces the need to get health reform done now. We as a country cannot afford to wait any longer. Passing meaningful health care legislation that eliminates disqualification based on pre-existing conditions is absolutely essential so that every American can have access to quality comprehensive health insurance, and I yield back.

Mr. STUPAK. Thank you, Mr. Braley. I should note that Representative Hill is with us. He is a member of our committee. We had a hearing on rescissions down in his district earlier this year in Indiana. Like I said, we would be happy to go where we need to go to do these hearings because I think it is important that we put a human face on the cost of health insurance. We have votes

coming up. I am going to try to get through this panel if we can. Mr. Green, you are up for questions, please.

Mr. GREEN. I appreciate my colleague from Iowa questions and your responses. I want to look at it from a different tact because you have trouble with rate regulation or insurance regulation in California. In Texas we have never had any regulation. It is literally the free market. And having been involved as a state legislator in trying to deal with fairness for my constituents and purchasing individual policies and having a son who had the same problem is his small business trying to find an individual policy. He couldn't find one because in high school he was diagnosed with colitis and nobody wanted to write him except for \$2,000 a month. He has found it through an HMO or PPO in Real Ranch Valley in Texas so he can get it at least for his 2 boys now and his wife because he just couldn't do it. So problems in individual market and oversight whether it is in California or Texas or Virginia or anywhere and that is the issue. And that is why the lack of oversight or ability to look at what these premium increases that we are getting ready to experience.

My concern, and this is something that members of Congress have to defend when we travel anywhere, and believe me it has made us watch where we are traveling. I want to ask some questions. In addition to paying their top executives handsomely between 2007 and 2008, WellPoint spent over \$27 million to host 103 executive retreats off company premises. The Democrat caucus actually had our retreat here at the Capitol. Fifty-five of these retreats, over half the costs were over \$100,000. To put that in perspective, the median income in the United States in 2008 was \$52,000, and so you can see that over half the retreats were over 100,000 so that was well over the median income. In 2007, WellPoint spent 3.7 million to host 782 attendees at a brokers and agents event at the Phoenician, a lavish resort and spa in Arizona, for 5 days. And if I could put up a picture of that slide.

Later that year, WellPoint sent 154 attendees to the Four Seasons resort in Manlei Bay, Hawaii for a 4-day broker event that cost the company 850,000. That is over 500,000 a person. If we could put that slide there. In 2008 during the height of the recession, WellPoint paid over 1.3 million to host 360 attendees at the Four Seasons Hotel in San Diego, and if we could put that slide up there. Ms. Henriksen, do you think a company that is struggling to keep up with the rising health care costs would be able to send thousands of employees and agents on lavish retreats such as these?

Ms. HENRIKSEN. No, definitely not. I would like to know what they are doing at these retreats.

Mr. GREEN. Mr. Arnold.

Mr. ARNOLD. Of course not.

Mr. GREEN. Ms. Meister.

Ms. MEISTER. No.

Mr. GREEN. What is your reaction to the images and figures because I know what my constituents would be if I was at that locations, and since you are ultimately paying the freight or asked to pay the freight, does it make you wonder if your hard-earned pre-

miums have indirectly gone to paying for the spa retreats and the golf getaways?

Ms. MEISTER. I was thinking I wish I was an executive at WellPoint.

Mr. GREEN. Mr. Chairman, it seems unconscionable that the company with the spending record that would reach deeper into the pockets of the policy holders at a time when so many Americans are struggling to stay afloat, it also seems to me that any company that can afford to send hundreds of their employees to these lavish retreats all over the world can afford to maintain reasonable and affordable premium rates for its customers, and that is what bothers me. On the individual market, we don't see that regulation and oversight on the state level, and that is why maybe on the national level, I know President Obama earlier this week announced that, there are parts of his bill that I have problems with or his suggestion, but one of the things I like is if we are going to sell insurance across state lines to individuals whether they be in Houston, Texas where I represent or San Diego or anywhere else, I would like to see that there is some oversight on what they are doing with that money to justify those premium increases. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Green. Continuing with questions, Ms. Sutton, questions, please, for this panel.

Ms. SUTTON. Thank you, Mr. Chairman, and thank you for your compelling testimony. I think your stories speak to the stories of many Americans across the country, including my constituents. To follow up on my colleague, Mr. Green's questioning, I would just like to talk a little bit about the executive at WellPoint. Not only do we see the lavish retreats that were pictures that were reflected on the screen, we also know that as premium rates increase and become more and more inflated and health insurance coverage slips further out of reach for people just like you, it is important to ask where are the revenues going, not only to retreats but also to executive salaries.

WellPoint has stated publicly that these most recent premium increases were necessitated by rising medical costs and a shrinking risk pool, that it needs these rate increases in order to stay afloat. But I understand that companies do need to turn a profit. We all understand that. But what I don't understand is how WellPoint can claim that these increases, rate hikes that are literally bankrupting its policy holders are necessary to stay in business especially when we see what we see when it is spending millions upon millions of dollars compensating its top executives. Data received by the committee show that WellPoint paid its executives over \$347 million in 2007 and 2008 alone.

In 2008, WellPoint paid \$115 million to 85 senior executives compensating 39 executives over a million dollars each. That year one executive made \$9 million and two executives made over \$4 million. And I guess I would just like to ask you, our witnesses and policy holders, how you feel about a portion of your premium payments bankrolling multi-million dollar salaries in these tough times. Ms. Meister, do you believe a company that can afford to pay a single executive nearly \$10 million in 1 year has the right to de-

mand higher premiums from you so that it can “keep up with the market?”

Ms. MEISTER. No, I don’t. And I agree with something Ms. Henriksen said. She said if I raised my rates like they raise our rates, I wouldn’t have clients, and that is the same in my business. You know, there is reasonable and then there is just outrageous.

Ms. SUTTON. Thank you. Ms. Henriksen.

Ms. HENRIKSEN. Well, not to be funny but it makes me sick to think that all of this money is going to executives in this economy when so many people are struggling. I do make good money, yet my industry is really struggling. There are no new hotels being built. There are no, you know, residential. There is no building going on so I suffer because of that.

Ms. SUTTON. And Mr. Arnold.

Mr. ARNOLD. I, of course, too think it is unconscionable, and I believe the number I read was that in the last quarter WellPoint had a profit of over 4 billion. Even if you cut that in half, it is still an incredibly healthy profit, so it just speaks to, as I said in my testimony, profiteering versus profit making. There is a difference. And profit making is fine. It drives our economy. It is the foundation of American business. But profiteering, when it affects people like us in the way that it has, is just wrong. It speaks to a lack of decency, and lack of decency may not be illegal but it is wrong and that is why I think it requires government intervention and regulation.

Ms. SUTTON. Thank you. I think you all make the case very well, and for one don’t think a company that is paying its executives more than \$100 million a year has any right asking Americans to subsidize these outrageous salaries in the form of increased premiums and stripped down coverage. It is not like you are getting more for what you are paying.

Mr. STUPAK. The gentlelady has yielded back. We have three votes on the floor, and the first vote is the rule to allow debate to begin on the antitrust exemption if we are going to take it away from the insurance industry so it is a rather critical vote and thus far it is down basically party lines. So I am going to recess for—hopefully we are back here in 20, 25 minutes. And I would like this panel to stay if they can. I would love you to stay because you have Ms. Schakowsky and I know Mr. Hills, Ms. Capps, and Ms. Eshoo all probably had questions too. It has been a good panel. We would like you to stay. So let us try to be back in here in about—let us call it 25 minutes. This vote might stay open for a little bit. Twenty-five minutes, so we are in recess till 12:25.

[Recess.]

Mr. STUPAK. Thanks for coming back right away, all the members. Let us resume this hearing. When I left, I think Ms. Schakowsky, you are up for questions if I remember correctly. And thanks to the panel again for staying.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, and thank you panel. You know, it occurred to me that this panel would only take place of the industrialized nations in the United States of America, that in every other industrialized country, they have made the threshold decision that healthcare would be provided in some fash-

ion, maybe through the public sector, often entirely through the private sector, but still to all of their people.

The other thing that occurred to me when we look at all three of you, and I guess I would have to add your son, we are talking about essentially healthy, high-functioning individuals, not a bunch of sick people, which underscores that, you know, it is hard to reach hardly any age at all without having some sort of a pre-existing condition.

I had, and I don't know where they just disappeared to here, this is from Blue Shield of California. It is a little old, 2006, a three-page, four column list. It says "Applicants who have any of these conditions listed below may be declined without medical record review." Things like adoption in progress, how about that? Breast microcalcifications. I mean, lots of women have that. Diabetes with hypertension. We were talking about Diana's daughter who has—pregnancy of self, spouse or significant other. Varicose veins would be a preexisting condition that would deprive people of, you know, no, you can't have this insurance.

I wanted to see if we could put up on the screen, the Committee recently learned that these recent premium increases may only be the tip of the iceberg. Staff, if anyone here to put up the internal—

Mr. STUPAK. There you go.

Ms. SCHAKOWSKY. There we go.

[Slide shown.]

Ms. SCHAKOWSKY. WellPoint analysis of what potential rate increases would do for them. These are various scenarios. The first scenario calculates, they call them, SAFs. Those are really rate caps. If they left it unchanged, that is, the rates unchanged, the second scenario actually proposes to lower the rate caps to 37 percent which is two percentage points lower than the rates that Anthem filed with the Department of Insurance. And the third proposes, and I quote, "to remove these rate caps completely." The scenario would result, they say, in a maximum of 228.4 percent for certain plans. And had this scenario been implemented, over 27,000 customers would have received a 228 percent increase.

The fact that they would even consider and do the scenario to me is just incredibly shocking, but I guess my conclusion is that we cannot just leave the insurance companies in the driver's seat deciding how they will regulate themselves according to rates. What our bill did and what the President's bill does is establish rate review that could actually prohibit some of these rate increases, and I wanted to hear your feelings about that. Let us start with Ms. Meister and just go across.

Ms. MEISTER. Yes, I mean, that is what I said before. We need to have a maximum percentage put on of how much insurance companies can raise their rates each year, just like some cities have rent stabilization.

Ms. SCHAKOWSKY. Right.

Ms. MEISTER. There could be stabilization of insurance rates.

Ms. SCHAKOWSKY. Let me also say some states do that. I am a state that does not, one of the 25 states that doesn't do any rate regulation whatsoever right now. Ms. Henrikson?

Ms. HENRIKSON. I am all for a national committee that would review rates. I feel California has been neglectful in that sense. So I know it is based on where you live and all that kind of thing, but I believe a national rate regulation would be very beneficial.

Ms. SCHAKOWSKY. It would be called a National Health Insurance Rate Commission I think is what we are talking about.

Mr. ARNOLD. Yes, I agree with that, too, and I would also add that I think if there were rate regulation on insurance companies that that would also put pressure on medical providers, hospitals and doctors, who we keep hearing are raising their rates so irresponsibly. If that is true, that would force them to change their ways as well.

And just very quickly, what you said about unregulated insurance premiums keep rising, it is true. I mean, my rates went up 26 percent last year, 38 percent now. Why should I have any reason to believe they won't try and raise them another 40 percent next year? I mean it is logical to think that they would.

Mr. STUPAK. Thank you. A member of the Full Committee, Ms. Eshoo, do you have questions, please, of this panel? And thanks for being here. You are not a member—

Ms. ESHOO. Thank you, Mr. Chairman.

Mr. STUPAK [continuing]. Of the Subcommittee but a member of the Full Committee.

Ms. ESHOO. Thank you, Mr. Chairman, for having this hearing. I appreciate the opportunity to participate, and I am very glad that we have the rules that allow members from other subcommittees to join you. This is a very important hearing.

I want to thank the witnesses. So many members have said you really put the human face on this. And while my questions are not directly for you but rather the executive, I just thought that I would enter for the record, I did write to Ms. Braly, the President and CEO of WellPoint, after the news came out about the rate hikes up to 39 percent. But I think that it is a telling thing that Anthem Blue Cross, the unit, in an email message urged their employees to oppose healthcare reform. And that email is reported to have said that reform proposals would "cause tens of millions of Americans to lose their private coverage." And it seems to me that this panel is right on the edge, given what the increases were. So I think that more than anything else, you have helped to separate, you know, the political rhetoric that has gone across the country, and really what the facts are because this is your life. You are speaking of real-life experiences. I can't think of a better panel to have come in and testified. This case is not over. I think that there are, I know that there are, many of us that to our last breath will fight for the kinds of reforms that need to take place, both in the health insurance industry and healthcare as well because this simply cannot be sustained, not individuals, not families, not local governments, not state governments, not the Federal Government and not businesses, either. So thank you for traveling across the country to testify. I admire your spirit, and I like the way you just keep following up with members and saying it the way it is. That is not often the case with witnesses, so we thank you.

Thank you, Mr. Chairman. I am going to have to leave for my Intel Committee meeting, but I thank you again for your legislative hospitality.

Mr. STUPAK. Thank you. Well, that concludes questions of members of the panel and of the Committee. So I want to thank this panel for coming. Let me just say one thing. Mr. Arnold, in a question that was put to you, a clarification. I don't want to get into the healthcare debate because I think it is more important that we hear from you. We have had enough healthcare debates. We need to act and move legislation along. But there was some questions about your premium, what you would pay and what you would pay underneath the House bill as it was passed. I think Mr. Burgess asked you some questions along that. Those numbers he was quoting you is from Congressional Budget Office, and that would take place in 2016. They wouldn't be what your current premium would be, plus underneath the House bill you would have a full plethora of services. You wouldn't be denied because of preexisting injury or illness. You have preventative care. There is a number of benefits there in the House bill that is probably not covered in your current one. So just to clarify the record, that number is thrown out to be more than your current policy would be in 2016, and we don't know what your policy would be in 2016 from Anthem we are going. So just a clarification.

Again, let me thank this panel.

Mr. BURGESS. Mr. Chairman, with all due respect.

Mr. STUPAK. All due respect, I will let you go for a minute but I am not going to let you pontificate for 10 minutes.

Mr. BURGESS. No pontifications. That was based on the 2009 figures if the bill had passed last year. The Chairman is correct because none of the benefits go into effect for 4 years from the passage of the bill. Taxes of course would go into effect on day one.

And also, just a point of clarification, Mr. Arnold. You made the comment just a moment ago that providers were raising rates irresponsibly. Do you have an example for us of a provider that you have encountered that has raise rates irresponsibly?

Mr. ARNOLD. I don't, but I think your next witness, Ms. Braly, will say over and over again how they are raising their rates.

Mr. BURGESS. And I am ready for that. I just needed to know if you had some information that I needed to be aware of.

Mr. ARNOLD. No, I don't personally have specific examples of that.

Mr. BURGESS. Most doctors in my state, and I suspect California is the same way, our prices are set by the insurance companies which in turn are set by Congress with Medicare rates, and private insurance pays a percentage of what Medicare's maximum allowable fee schedule is, even for those procedures that are not covered under Medicare, like childbirth. So I just wondered if you had some direct experience because I do intend to question Ms. Braly about that extensively.

Mr. WAXMAN. Will someone yield to me?

Mr. STUPAK. Yes.

Mr. BURGESS. I would be happy to yield to——

Mr. WAXMAN. Medicare sets rates for the whole country, and it turns out that Medicare could be less than what private insurance

pays in any particular area. But the private insurance companies negotiate the rates presumably with the doctors and other healthcare providers. They and Medicare are faced with ever-increasing costs in healthcare. That is a fact. It doesn't mean that anybody is doing anything wrong, but the system is costing more and more money, and one of the things we try to do in health reform is not only reform the insurance system so we don't have people who have to fight on an individual basis to get any opportunity to buy insurance at a fair amount, but we try to hold down healthcare costs overall, and that is important. So I just wanted to raise that point. Thank you.

And I join with the Chairman in thanking these witnesses for being here. You have been terrific. Thank you so much.

Mr. STUPAK. Thank you again. We will dismiss this panel and thanks for your testimony. I would now like to call up our second panel of witnesses.

On our second panel we have Angela Braly, President and CEO, WellPoint. Cynthia Miller, Executive Vice President, Chief Actuarial and Integration Management Officer of WellPoint.

Welcome. It is the policy of this Committee—signs down, please.

Ms. BRALY. Pardon me?

Mr. STUPAK. Before we get going, we are not going to allow signs and that while we are trying to conduct this hearing, OK? No, just put them away. Very good. Thank you.

It is the policy of this Subcommittee to take all testimony under oath. Please be advised that you have the right under the rules of the House to be advised by counsel during your testimony. Do you wish to be represented or advised by counsel?

Ms. MILLER. No.

Ms. BRALY. No.

Mr. STUPAK. OK. I am going to ask you to please rise, raise your right hand to take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that the witnesses replied in the affirmative. You are now under oath. We will have an opening statement. It will be 5 minutes long. If you would like to submit a longer statement for inclusion in the record, we will be happy to submit it.

Ms. Braly, if you don't mind, we will start with you.

Ms. BRALY. Yes.

Mr. STUPAK. OK. Just pull that up. There we go. Great.

TESTIMONY OF ANGELA BRALY, PRESIDENT AND CEO, WELLPOINT, INCORPORATED; AND CYNTHIA MILLER, EXECUTIVE VICE PRESIDENT, CHIEF ACTUARY AND INTEGRATION MANAGEMENT OFFICER, WELLPOINT, INCORPORATED

TESTIMONY OF ANGELA BRALY

Ms. BRALY. Thank you, Mr. Chairman, and members of the Subcommittee for this opportunity to discuss rising healthcare costs and the need for sustainable healthcare reform. This is a very important week for all Americans, and I am sure you join me in hoping that tomorrow's health summit will be the beginning of a truly

constructive, positive process in which every American can have confidence.

I am especially pleased to have been invited to speak with you because I understand the burden that rising healthcare costs put on families. Because of our role in healthcare, it is often insurers who have to deliver the bad news regarding spiraling healthcare costs. There is nothing I would like to do better than be able to report to our members that the medical cost trend is going down. That is why I appreciate the opportunity to explain why healthcare costs are rising not only in California but across the country. The increases we are seeing in California are due to factors that we have been sounding the alarm about for years, the rise in healthcare costs and healthy people opting out of the system when other issues arise, such as the tough economic times we are experiencing today.

These factors led to the rate increases you have seen from our company and others in California. Rising healthcare costs are driven by many factors including hospitals and other healthcare providers charging higher rates, new medical technology, underpayment by government programs, the growth in chronic diseases and conditions like obesity, and an aging population. These increases are generally compounded when younger, healthier members drop their insurance leaving those who most need healthcare to foot the bill. These issues are particularly acute in California where our experience has been that medical inflation is in the double-digits. Also in California, we are required to offer coverage through two guaranteed issue programs which by themselves lost almost \$70 million in 2009. Those are important programs that serve an important purpose, but their costs are ultimately borne by other members in California.

Unless a legislative proposal addresses the fundamental issue of rising healthcare costs, it cannot be considered sustainable healthcare reform. Unfortunately, the leading proposals being discussed in Washington don't do enough to control costs and don't do enough to get everyone into the system. We have put forward substantive proposals on both these fronts. My testimony submitted to the Committee includes our specific suggestions on reform, but let me highlight just three.

First, Congress could address defensive medicine and inappropriate care by including meaningful medical malpractice reform in the legislation.

Second, Congress could also require that the principles of evidence-based medicine be used to guide how payments are made. While this may seem like a technical issue, it is these kinds of reforms that can have a lasting impact on quality and cost.

Third, in reforming the health insurance market, Congress must enact policies that ensure a broad and stable risk pool as they impose other requirements on the marketplace.

We know that every facet of the healthcare system, hospitals, clinicians, manufacturers, drug companies, payers, and we as Americans, contribute to the growth and healthcare costs and all need to be called upon to reduce these costs. Out of every dollar the Nation spends on healthcare, less than one penny goes to health plan profits. Isn't it time to ask, what are we going to do about the other

9 cents? Unfortunately, the deals made with the drug companies, hospitals, physician groups, and labor unions left the legislative proposals considered thus far without the most important part, the core solution for lower cost, higher quality healthcare.

Rising healthcare costs frustrate all of us. It is a serious problem facing the country that deserves not only a serious discussion but meaningful action. WellPoint is eager to continue to participate in both. While it may be tempting to shift the blame to insurers for rising healthcare costs, to do so would be the triumph of sound bites over substance. Insurers are among the least profitable part of the healthcare system and the part that helps the most in making a meaningful reduction in healthcare costs. Insurance industry margins are dwarfed by the margins of others in healthcare. Real reform needs to focus on the areas where systematic savings could be realized.

The elephant in the room is the growth of healthcare spending. Despite the attention we have garnered in this debate, we are the tail on the elephant, and we need to address the elephant.

Thank you for the opportunity to be here today. This is a critical time for our country and for the healthcare debate, and I look forward to discussing with you ways in which we can work together to control rising healthcare costs.

[The prepared statement of Ms. Braly follows:]

TESTIMONY

Enabling Health Care Quality, Safety and Affordability

Angela Braly
President and Chief Executive Officer
WellPoint, Inc.

Testimony presented before the
Oversight and Investigations Subcommittee
of the Committee on Energy and Commerce

February 24, 2010



INTRODUCTION

Thank you, Chairman Waxman and members of the Subcommittee for inviting me to testify today. I am Angela Braly, President and CEO of WellPoint, Inc., and I appreciate the opportunity to appear before you to provide information related to the Anthem Blue Cross March 1st individual market rate increases for members in California and to explain the increases being reported in the media. There seems to be a lot of confusion about the issue, and it is a real case-in-point on why we need sustainable health care reform that will specifically address the growth in the underlying cost of health care services and that takes into account the need for insurance market regulatory changes to be actuarially sound.

WellPoint provides health benefits to nearly 34 million members across the country, representing nearly one in every nine Americans. Our subsidiary companies serve these individuals in the United States through programs and services including medical insurance benefits; life and disability insurance benefits; pharmacy benefits, dental, vision, and behavioral health benefit services; long-term care insurance; and flexible spending accounts. We also serve another 24.5 million Medicare beneficiaries in 25 states as a Medicare administrative contractor through our National Government Services subsidiary.

We care deeply about our California customers and the communities we serve as well as all the people we serve across America. And we share the concern raised by this Subcommittee and appreciate the opportunity to explain why rates—which reflect known and anticipated medical costs—are increasing substantially for certain individual members. In addition to being California's largest individual health insurer, we are the largest Medi-Cal provider (California's Medicaid program), and a HIPAA insurer of last resort (for those individuals exhausting COBRA coverage and who do not qualify to be underwritten in the individual market.) We work diligently to improve the health and wellness of all Californians. In fact, our participation in the state's public programs serving low-income and high-risk Californians is substantially larger than other insurers operating in California, including the two largest not-for-profit health plans.

We take our commitment to advancing quality very seriously, and we continue to implement a variety of initiatives to help achieve these goals. For example, Anthem Blue Cross recently led a patient safety collaborative in California, working directly with providers across multiple geographies to partner with the state's three regional hospital associations to employ systematic and sustainable efforts to improve patient safety. These include sharing data, resources, and proven, successful safety practices to reduce the incidence of pre-term births, and to reduce the incidence of sepsis and other hospital acquired infections (ventilator associated pneumonia, central line blood stream infections and catheter associated urinary tract infections). We are aggressively taking these actions because focusing on the quality and cost of care is the only path to creating a sustainable health care system.

We have also improved our administrative efficiencies to reduce overall administrative costs and improve health care quality. For example, we led the industry in the establishment of the

Committee on Operating Rules for Information Exchange (CORE) which has brought together more than 115 health industry stakeholders – health plans, providers, vendors, the Centers for Medicare & Medicaid Services, associations and others – to help streamline administrative transactions to reduce the amount of time providers spend on those transactions allowing them to focus on patients. We continuously work to become more efficient and effective as an organization and in our interactions with other parts of the health care system. We continue to make improvements to ensure that our members receive the most reasonably priced products that we can provide while continuing to focus on initiatives to increase the quality of care and in turn the health of our members.

The past few weeks have seen a great deal of attention directed at the recent rate increase that Anthem Blue Cross announced for the California individual market. While the March 1st rate increases are significant for certain individuals, it is important to note that the rate increases:

- Relate only to the individual market;
- Reflect estimated medical trend that is rising due to increases in medical costs and adverse selection, as explained further below;
- Reflect that Anthem Blue Cross provides coverage in the California HIPAA and MRMIP programs for which rate increases are restricted and whose losses are borne by the individual market;
- Even if the rate increases were to have gone into effect on March 1st, the individual business in California was estimated to generate an after-tax operating margin of 1.5%;
- Even after our proposed rate increases, our products remain competitively priced in the market;
- An independent actuarial firm reviewed our March 1st rate filing (rates were filed with the California Department of Insurance in November 2009), concluding that the March 1 rate increase was actuarially sound and the company's methodology was reasonable. Anthem Blue Cross has nonetheless agreed to defer implementation for two months to allow further review.

These rate increases related to the individual insurance market where individuals purchase coverage directly (not through their employer). This portion of our California membership represents approximately 10 percent of our more than our approximately eight million members in California.

As you know, we exist in a competitive marketplace where many individual purchasers are free to choose from among a number of carriers. For example, a search for coverage in Los Angeles from an online broker would yield over 100 coverage options from 7 large insurers. The rate increases are not the result of a lack of competition, but rather the underlying cost trends.

Raising our premiums was not something we wanted to do – but we believe this was the most prudent choice given the rising cost of care and the problems caused by many younger and healthier policyholders dropping or reducing their coverage during tough economic times. By law, premiums must be reasonable in relationship to benefits provided which means they need to reflect the known and anticipated costs they will cover. All health insurers are in the same position, and even with this increase our company's premiums remain quite competitive. While we believe that an increase in our rates is unfortunate, it is necessary and we welcome the opportunity to explain why rates are going up in a challenging economy.

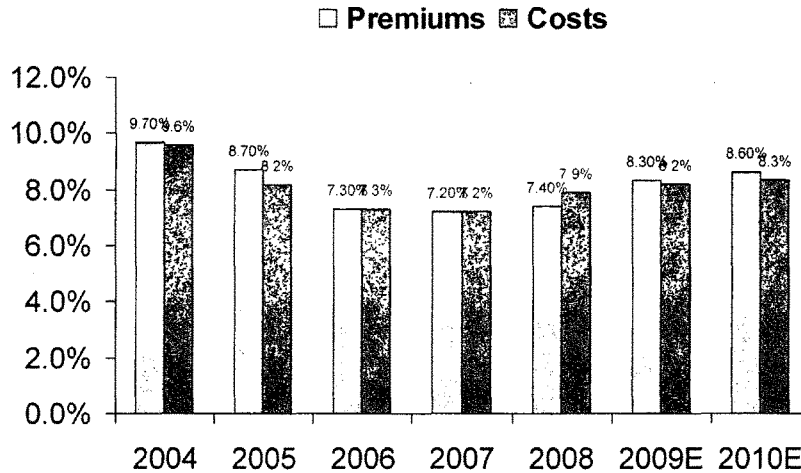
We would also like to emphasize that we are cooperating with a California Department of Insurance review of our March 1st rates. An independent actuarial firm concluded that our rates are actuarially sound and necessary, reflecting the expected medical costs associated with the membership in these plans. Nonetheless, we have agreed to postpone the March 1st increases for two months to allow for additional review.

OVERVIEW

Briefly I would like to discuss the causes for the March 1st rate increase in the California individual market, and will provide more detail later in my testimony. Generally speaking, the cost increase can be broken into two parts: (1) general medical inflation, and (2) a significant change in the risk pool, also called "adverse selection".

- **Higher medical costs as reflected by general medical inflation:** The increases in premium costs are driven by prices charged by clinicians, hospitals, medical device manufacturers, pharmaceutical companies and other suppliers in health care that are accelerating much faster than general inflation as well as increases in consumer utilization. Provider prices increase because of provider rate increases, new technology, and by cost-shifting to the private sector because Medicare and Medicaid do not fully cover provider costs. In effect, the private sector – including our members—are subsidizing the public sector. Experts have found that commercially insured families pay almost \$1800 more each year for their coverage as a result of this cost shift¹. Higher patient utilization is primarily driven by a shift in the demographics of this country, which has an aging population and rising incidence of chronic disease which can be lifestyle related, plus the increasing use of high-cost diagnostic testing by providers.

¹ Milliman, <http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf>



Source: Millman, CMS, Company documents, Barclays Capital Managed Care 2010 Industry Outlook Report

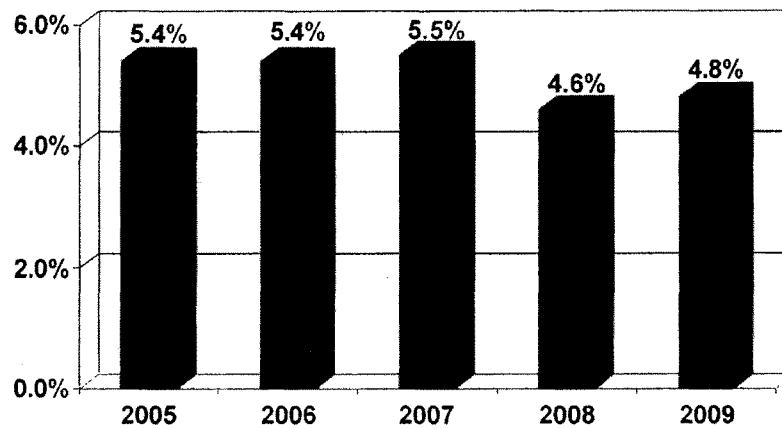
- Adverse Selection:** In a difficult economy, younger, healthier policyholders who lose their jobs and income often sacrifice their health coverage. This means there are fewer policyholders among whom to spread risk and those remaining have higher health care costs. The result is higher premiums for those left in the pool.

These are the drivers behind our claims trend, and when we evaluated our claims trend for our individual market products in order to set our 2010 rates, we determined that a rate increase averaging approximately 25% (excluding aging) was necessary to cover cost trends and adverse selection and was projected to result in an after tax operating margin of 1.5%.

Much has been made of the profit WellPoint, the parent company of Anthem Blue Cross, earned in the last quarter of 2009. However, it is important to review our profits on an adjusted basis as explained below.

Here are a couple salient details to put our fourth quarter results in perspective. We sold our Pharmacy Benefit Management unit to Express Scripts, so excluding that one-time gain to earnings, our real fourth quarter earnings were approximately \$380 million after tax. When our annual income is fully adjusted the percentage of net income to total revenue has remained generally consistent from year to year as shown below.

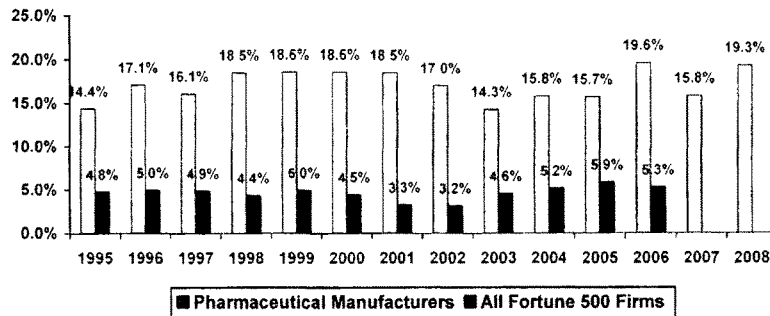
Net Income % of Total Revenue
(Adjusted/Comparable Basis*)



* Adjusted to remove the after-tax impact of realized gains (losses) on investments and other significant non-recurring items. 2009 specifically excludes the one-time gain related to the sale of our Pharmacy Benefit Management companies. For comparison purposes, 2005 includes the reclassified financial results of WellChoice which was acquired on December 28, 2005.

These earnings are in line with other health insurers given our size as the largest insurer in the United States by membership, providing coverage to tens of millions of Americans. Significantly, our net margin in the fourth quarter on a fully-adjusted basis was 3.5%, again completely in-line with our competitors and well below the margins of many other companies in the health care industry including pharmaceutical companies, medical device companies and others.

Profitability of Pharmaceutical Manufacturers, 1995-2008



Note: Percent is the median percent net profit after taxes as a percent of firm revenues for all firms in the industry. 2007 and 2008 data not available from Kaiser. According to Fortune Magazine, the median percent net profit after tax for all Fortune 500 companies in 2007 and 2008 was 5.7% and 3.7%, respectively.

Source: Kaiser Family Foundation and Sonderregger Research Center, Prescription Drug Trends: A Chartbook Update, November 2001, Exhibit 4.11 at <http://www.kff.org/insurance/3161-index.cfm>, updated with data from Fortune, Fortune 500 Industry Rankings: April 14, 2003, Vol. 147, No. 7, p. F-26; April 5, 2004, Vol. 149, No. 7, p. F-26; April 18, 2005, Vol. 151, No. 8, p. F-28; April 17, 2006, Vol. 153, No. 7, p. F-26; April 30, 2007, Vol. 155, No. 8, p. F-32; 2007 and <http://money.cnn.com/magazines/fortune/>; Kaiser Family Foundation, Kaiser Fast Facts, Profitability of Pharmaceutical Manufacturers, 1995-2008. September 16, 2009. <http://facts.kff.org/chart.aspx?ch=218>

Putting this in perspective, if we returned our entire fully adjusted fourth quarter after-tax operating profit back to our members, it would be \$5.13 per member month or about \$60 per year.

Here are a few additional facts to add some context to the current discussion:

- The Anthem Blue Cross profit margin in California is in-line with and below that of many of our competitors;
- Both for-profit and not-for-profit health plans must generate revenue in excess of costs to ensure they are able to not only pay claims, but also to maintain their solvency and operate their business;
- In California Anthem Blue Cross insures more high-cost, low-income individuals than any of our competitors, including the two largest not-for-profit health plans;
- Despite how our rate increase was reported in the media, we still have many affordable and competitive options available in the individual insurance market. Since this is a competitive market, many purchasers often shop around for the best value;

- The average March 1st rate increase is approximately 25% before factoring in attained (actual) age, not the 39% reported;
- The March 1st rate increase will apply only to a person who chooses not to change his or her product. Switching to a less-costly product is an option we offer members and which many choose to do. We offer ten products in the individual market in California—with nearly sixty different benefit and premium levels—that provide consumers numerous options for affordable coverage.

DETAILED DISCUSSION OF CALIFORNIA INDIVIDUAL RATE INCREASE

It is important to note that the proposed March 1st rate increase that is being reported in the media relates only to the individual insurance market where individuals purchase coverage directly (not through their employer), which represents approximately 10 percent of our approximately eight million members in California. Furthermore, the figure of 39 percent being reported by the media represents the largest rate increases and includes the impact of aging and was experienced by only a portion of our members. Specifically, the rate changes range from a 20.4 percent *decrease* to a 34.9 percent increase excluding the impact of age-category changes. Additionally, the rate notices reflect the March 1st rate increase for an individual who does not choose to change his or her product to diminish the impact of premium increases, which is an option we offer to members and which many individuals choose to do.

Clearly, we understand that rate increases create a challenge for many of our members. However, it is important to know that many of our members often have a choice of coverage. We help our members understand their options by making available health plan advisors who work with the member to help ensure they understand their coverage options. Further, our products remain very competitively priced when compared with the dozens of other plans competing in the California individual market, including our two largest not-for-profit competitors. Even after these March 1st rate changes, a 40-year old woman in Los Angeles can obtain coverage with a \$1,500 deductible for as low as \$156 per month.

We would also like to emphasize that we have cooperated and are continuing to cooperate with the California Department of Insurance's review of our rates. As part of our review process, an independent actuarial firm concluded that our rates are actuarially sound and necessary, reflecting the expected medical costs associated with the membership in these plans, and that they satisfy or exceed the medical loss ratio required by California law.

Recently, Anthem Blue Cross agreed to a request by the California Department of Insurance to postpone the March 1st rate adjustment for individual members in California by two months to allow the Department additional time for review. To avoid confusion for our members, we decided to implement the delay for all Anthem Blue Cross individual members regulated at either the California Department of Insurance or the Department of Managed Health Care.

Anthem Blue Cross filed these rates with the appropriate regulators in November of 2009. They are actuarially sound and in full compliance with all requirements in the law. We welcome the scrutiny, and are confident that our rates reflect known and anticipated medical costs and are established consistent with sound actuarial principles and state law.

Our decision to agree to postpone the rate increase does not change the underlying facts. All health plans are in the same situation in trying to deal with the steadily increasing medical costs in the delivery system, which are not sustainable. We are also experiencing a higher proportion of healthy individuals choosing not to enroll, leaving an insured pool that utilizes significantly more health care services. We need to refocus the health care reform debate toward steps that will improve quality and control the underlying medical costs, which is driving the high cost of coverage.

We understand the impact any rate adjustment has on our members and their ability to continue to have health insurance. We are committed to improving quality and reducing costs in the health care system and improving the lives of the Californians we serve and the health of the communities all across the state which can reduce their premium rates. Our members will be receiving a letter shortly that describes these rate changes in detail and whom to contact for additional information about their coverage options.

Rate increases reflect the increasing underlying medical costs in the delivery system which are unsustainable. We hope to continue to work with you and others to help mitigate the factors driving these large rate increases, as described below.

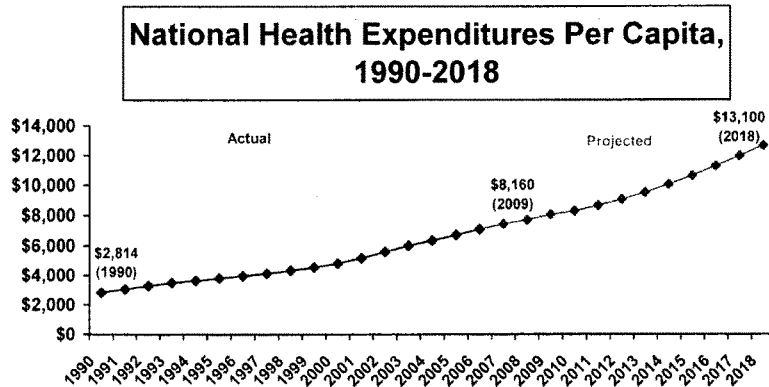
WHY INDIVIDUAL MARKET RATES ARE INCREASING FASTER THAN MEDICAL INFLATION

Health insurance rates increase year-over-year to reflect general medical inflation and other factors. Medical costs increase each year primarily due to (1) prices charged by clinicians, hospitals, medical device manufacturers, pharmaceutical companies and other suppliers of health care accelerating much faster than general inflation, and (2) increases in consumer utilization. Provider price increases above general inflation are driven largely by increased provider cost-shifting to private health insurers due to Medicare and Medicaid not fully covering provider costs, provider consolidation, and higher-priced technologies. Increases in consumer utilization of health services are primarily driven by a shift in the demographics of this country, which has an aging population and rising incidence of chronic disease (some related to lifestyle), plus the increasing use of high-cost diagnostic testing by providers.²

For 2010, we expect hospital inpatient and outpatient costs in California to grow by over 10 percent, driven primarily by hospital reimbursement rates. Additionally, we expect

² Drivers for rising health care costs are detailed in the 2008 PricewaterhouseCoopers report *The Factors Fueling Rising Health Care Costs 2008*.

pharmacy costs in California to grow by over 13 percent. These cost increases that continuously drive premium increases are unsustainable and must be addressed.



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (Historical data from NHE summary including share of GDP, CY 1960-2007, file nhgdp07.zip; Projected data from NHE Projections 2008-2018, Forecast summary and selected tables, file proj2008.pdf); Kaiser Family Foundation, Kaiser Fast Facts, National Health Expenditures per Capita, 1990-2018. March 19, 2009. <http://facts.kff.org/chart.aspx?che=860>.

Other factors result in California rate increases in the individual health insurance market being higher than general medical inflation, including:

- Less healthy risk pool in a challenging economy.** One dynamic in this challenging economy is that individuals are far more likely to keep their coverage if they are less healthy and require ongoing medical services, and a higher proportion of individuals who do not need services disenroll or choose not to enroll. The result is an insured pool that utilizes significantly more services per individual than under better economic times. This in turn leads to higher costs in the pool and to rate increases higher than general medical inflation. For example, if an insurance pool consists of 100 individuals that incur aggregate medical costs of \$10,000 per month, the cost per individual is \$100 per month. However, if 10 individuals leave the pool who incur little or no costs because of the challenging economic times, the \$10,000 now must be spread over 90 individuals. The per-individual cost is now \$111 per month, an increase of 11 percent. This means a health insurer must increase rates 11 percent in order to cover the increase in costs per individual and this is before reflecting general medical inflation. While this dynamic always exists, in a challenging economy it becomes more prevalent as individuals who are paying for coverage without a government or employer subsidy must choose to continue coverage or use the money for other necessities.

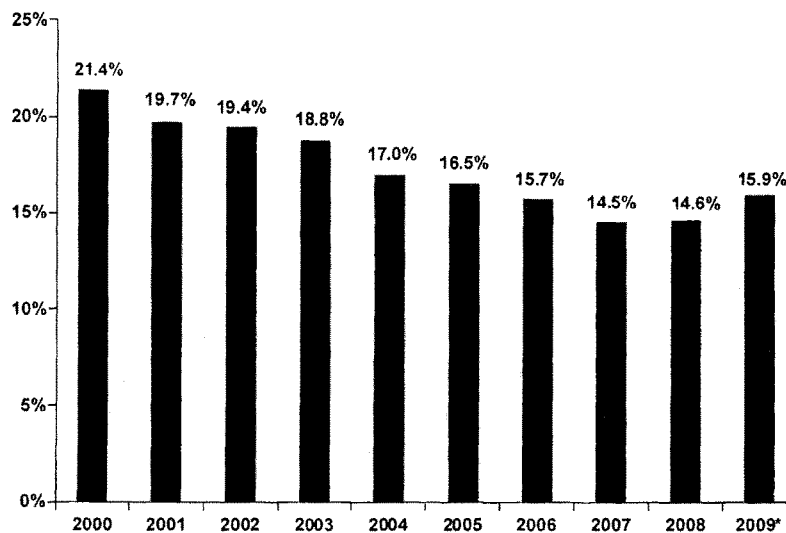
- **Individuals moving to lower-cost options in a challenging economy.** Another dynamic in our current challenging economy is that a higher proportion of healthy individuals move to lower-cost coverage, such as coverage with a higher deductible, than in more robust economic times. Our experience also shows that new, healthy enrollees are more likely to enroll in similar high-deductible plans. For example, in 2009, affordability concerns led a high proportion of Anthem Blue Cross individual members to switch from higher-cost products to lower cost-products, resulting in an average 2009 premium increase after product migration of just 2 percent, considerably lower than the average rate increase of 13.8 percent initially reported in 2009. Meanwhile in 2009, the average claims per member increased by 8 percent, dramatically more than our premium increase of 2 percent. The fact that the weak economy caused more people to move to lower-cost options in 2009 contributed to the fact that the Anthem Blue Cross individual business in California as a whole operated at an approximately \$10 million loss during 2009.
- **Individuals aging into a higher age category.** The reported March 1st rate increases include demographic changes, such as individuals aging into higher age segments. Since rates increase by age, a renewing customer will often face higher rates. These age rate increases occur before reflecting general medical inflation and reflect higher medical utilization associated with aging.
- **“Deductible leveraging.”** Benefit costs for members are typically divided between the premium paid by a member and the member cost sharing (e.g., deductibles and co-payments). When a member does not change plans, deductibles and co-payments, which are a set cost such as a 20 dollar copayment to see a primary care physician and therefore typically remain unchanged at renewal. Because of this, the deductible and co-payments do not increase and are not connected to necessary increases related to medical inflation. Because higher costs due to the increases related to medical inflation must be offset in some way, there is a “leveraging” effect and the medical cost increases disproportionately increase the premium component of benefit costs (as opposed to the member cost-sharing share of benefit costs, which is fixed). This results in premiums for fixed deductible products increasing faster than general medical inflation.
- **Higher Baseline Costs.** In addition, we experienced higher than anticipated unit medical costs and utilization in 2009. Our Anthem Blue Cross individual market rates for 2009 were insufficient to reflect these costs. While we are not pricing to recover 2009 losses, the March 1st individual market rates must reflect these higher baseline costs

All of these rating dynamics are part of necessary, actuarially-sound rating practices and each of these factors contributed to the March 1st individual market rate increases in California in addition to general medical inflation. Other individual market health insurers are facing the same dynamics and are being forced to take similar actions.

MISLEADING ACCUSATIONS OF HEALTH INSURER PROFITS

During the past year I have been listening to the health care reform debate and the accusations that have been made of health insurers, specifically those related to health insurer profits. I was very disappointed to see the health reform debate change from one of possible change and productive results to an attack on the health insurance industry, specifically pointing to our profits and citing this as the primary reason for premium increases, which is very misleading.

WellPoint Selling, General and Administrative Expense Ratio Trend



* Includes 30 bps for the 4Q09 severance charge relating to the sale of certain portions of the company's business and other improvements and productivity.

As noted before, our profit margins as a company have declined over the past five years, our administrative cost ratio has declined, and yet premiums have increased, reflecting higher prices of hospitals, drug companies, and other providers. Additionally, aside from attacks on the entire health insurance industry, the debate has seemed determined to create a divide between for-profit and not-for-profit companies in the healthcare system. As I have already mentioned, in California the Anthem Blue Cross profit margin is in-line with, and below some of our not-for-profit and for-profit competitors and are significantly below other providers, both for-profit and not-for-profit, in health care delivery.

It is also important to note that according to *Fortune 500* magazine, the 2008 profits as a percentage of revenue for health care, insurance and managed care were 2.2 percent. This is significantly lower than other sectors of the health care industry.

Profit as Percent of Revenues	
Source: <i>Fortune</i> List of Profit by Industry, May 4, 2009 - Select Industries	
http://money.cnn.com/magazines/fortune/fortune500/2009/performers/industries/profits/	
Industry	2008 Profits as Percent of Revenues
Food and Drug Stores	1.5%
Health Care - Insurance and Managed Care	2.2%
Medical Facilities	2.4%
Health Care - Pharmacy and Other Services	3.0%
Specialty Retailers	3.2%
Insurance - Property & Casualty	3.3%
Commercial Banks	5.2%
Food Services	7.1%
Utilities - Gas and Electric	8.7%
Oil and Gas Equipment, Services	10.2%
Financial Data Services	11.7%
Medical Products and Equipment	16.3%
Pharmaceuticals	19.3%
Internet Services and Retailing	19.4%
Network and Other Communication Equipment	20.4%

Studies continue to demonstrate that health insurer net (after-tax) profits are a very small percentage of a member's premium. While there are a variety of ways to estimate health insurer net profit as a percentage of premium, regardless of the year, company, or aggregation of the data we have found that net profits fall between a -3.5 percent (loss) and 6 percent (gain), with most falling in the 2 to 5 percent range. To be more specific, the PricewaterhouseCoopers studies concluded that the insurance industry's profit margin is 3 percent. This is consistent with an America's Health Insurance Plans (AHIP) estimate that publicly-traded health insurers averaged a 2.4 percent net profit margin over the last 5 years.

When discussing profits, any comparison of absolute amounts will be misleading. For example, if companies merge, acquire other companies, or sell one of their assets, it stands to reason that its total profits will be significantly affected by that event. For example, WellPoint's fourth quarter 2009 net income was significantly higher due to the gain on the sale of its pharmacy benefit management subsidiary. After adjusting for this sale, WellPoint's fourth quarter 2009 adjusted net income was significantly less.

POLICY CHANGES TO MITIGATE VOLATILE INDIVIDUAL MARKET RATE INCREASES

Several factors contribute to the volatility in the individual health insurance market, including the fact that the individual market is the "market of last resort" for individuals who do not have

access to the employer market or government-subsidized public programs, and participation in the individual market is voluntary (i.e., individuals can forgo coverage). The market exhibits a high “churn” rate, with the average individual or family participating in the market for only about three years on average. This means that while overall enrollment may remain relatively constant, with 1/3 of the risk pool leaving each year, the overall risk of the members can increase quickly. This can lead to wide swings in rates—even if the dynamics seem to shift only slightly.

California’s individual health insurance market is particularly challenging. In contrast to most states that use high risk pools and broad-based funding sources to subsidize HIPAA guaranteed issue products (for those individuals exhausting COBRA coverage and who do not qualify to be underwritten in the individual market), California requires us to absorb the very high costs associated with these individuals without additional funding support. In 2009, Anthem Blue Cross alone experienced an approximate \$58 million operating loss on these HIPAA purchasers who exist in the guaranteed issue product environment in California. Additionally, as a result of being the only PPO and the only statewide option in the state’s high risk pool (MRMIP), in 2009 Anthem Blue Cross experienced an additional operating loss of more than \$10 million in the MRMIP “graduate” program.³

In November 2008, our industry came forward with an interdependent framework of policy proposals that would help control costs and improve health insurance markets for consumers. Included in this framework was an effective, enforceable, personal coverage requirement that would expand and stabilize the individual health insurance market, even when combined with requirements on insurers to accept all applicants with no pre-existing condition exclusions and limit rate variation between higher risk and lower risk individuals. In the proposal, we emphasized that the entire framework rested on a meaningful and effective personal coverage requirement that ensured that virtually everyone would have health coverage. As shown in some of the examples above, even if a small fraction of healthy individuals choose to forgo coverage, it can lead to substantial rate increases and an environment where individuals purchase coverage only when services are needed. Ultimately, an effective personal coverage requirement must (1) be deployed with sufficient subsidies to ensure no one is exempted, (2) include sufficient “checkpoints” to make sure everyone is enrolled for coverage, and (3) contain sufficient penalties to ensure healthy individuals enroll in coverage rather than pay the penalty.

Unfortunately, the proposed personal coverage requirements in the health care reform legislation passed by both houses of Congress failed all three requirements by (1) exempting tens of millions of Americans from the requirement, (2) using the tax filing process as the only checkpoint which misses tens of millions of Americans who do not file taxes, and (3) including penalties that are a small fraction of the cost of coverage. Under this framework, it is only logical that many individuals—primarily those who are healthy—would have not been

³ For a period of time until 2008, members in California’s high risk pool (MRMIP) were limited to being MRMIP members for three years. After three years, individual market carriers were required to accept these members on a guaranteed issue basis.

effectively included by the mandate or would have made the logical choice to pay the penalty unless they needed health care services. The result will be a national health insurance market that is similar to New York, where the average individual market premium is over twice the average individual premium in California.⁴ And this is a finding borne out by analyses completed by our senior actuaries. In fact, these analyses showed that the legislation considered by Congress would increase California individual market premiums for the young and healthy by as much as 106 percent (before premium subsidies for certain eligible individuals).⁵ The personal coverage requirement must be substantially improved for reform to be successful.

⁴ AHIP Individual Market Survey. October 2009.
<http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf>

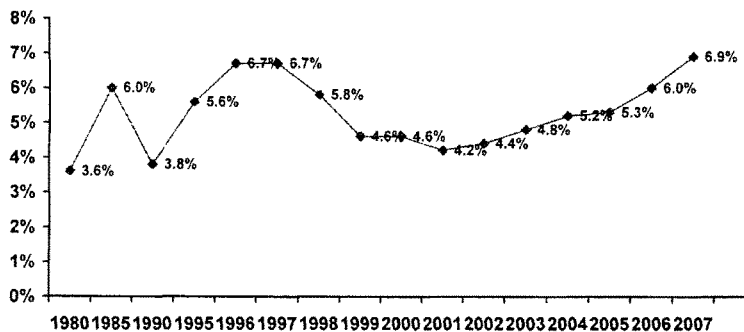
⁵ WellPoint premium impact analysis: http://www.wellpoint.com/newsroom/stats_facts.asp

CONCLUSION

In closing, I want to assure the Subcommittee that WellPoint supports responsible, sustainable health care reform that will specifically address the growth in the underlying cost of health care services and also take into account that insurance market regulation must be actuarially sound. Reform must go beyond the insurance marketplace to address system-wide challenges and associated costs. Changing how we finance health care without changing how we deliver health care is simply not sustainable.

Additionally, we firmly believe that the primary focus of responsible health care reform must be improving quality and controlling the underlying medical costs, which is what is driving the high cost of coverage. On a national scope we continue to see hospital margins rise which impacts our underlying medical costs.

Aggregate Total Community Hospital Margins, 1980-2007



Note: Total Community Hospital Margin calculated as the difference between total net revenue and total expenses, divided by total net revenue.

Source: American Hospital Association and Avalere Health, Avalere Health analysis of 2007 American Hospital Association Annual Survey data, for community hospitals, *Trendwatch Chartbook 2009, Trends Affecting Hospitals and Health Systems*, Table 4.1, p. A-32, at <http://www.aha.org/aha/trendwatch/chartbook/2009/appendbe4.pdf>; Kaiser Family Foundation, Kaiser Fast Facts, Aggregate Total Community Hospital Margins, 1980-2007, September 16, 2009, <http://facts.kff.org/chart.aspx?ch=159>.

We believe that the government must take action in this area to facilitate higher levels of quality and efficiency. We believe that an essential ingredient for practical and sustainable health care reform is improving health care quality, which in turn can help manage costs. There are many opportunities to improve health care in this country, as we are far from having a system that provides the right care at the right place at the right time. Building on the following

principles, WellPoint has identified solutions that will help deliver better health care while helping to reduce costs:

- Promote evidence-based medicine, with focus on outcomes;
- Align payment incentives for improved health outcomes;
- Focus on prevention and managing of chronic illness;
- Provide transparency on medical errors and reform medical malpractice laws;
- Promote safety and efficiency through the adoption of health information technology.

Health plans have provided significant ideas for reform, some of which are incorporated in the legislation being considered in the House and Senate. Unfortunately, neither of the bills currently being considered by Congress will stem health care cost growth and the resulting insurance premium increases, rather higher premium increases are expected to result. We look forward to continuing to play a constructive role by providing members of this Subcommittee and your fellow legislators with assessments of how proposals for reform would impact your constituents. We have decades of real-world experience with different reforms in various local markets that we are sharing with Congress and the Administration, so that our policymakers can make decisions using the best available evidence of what works best.

But as the health reform debate continues, our main focus will remain on improving the lives of the people we serve and the health of our communities. We do this every day by:

- providing clear, actionable, evidence-based messages to our members and their physicians, and by connecting our health care system through health information technology;
- encouraging an informed physician-patient dialogue regarding the risks and benefits of available treatment options and what is best for each patient;
- deploying thousands of nurses, physicians, and other health professionals to support and empower members in their own care; and
- promoting innovation through an unbiased, transparent scientific analysis of clinical research and real-world outcomes.

We recognize that with the largest membership of any private insurer, we have the ability to change health care for the better. We also recognize that, with this ability, we have a responsibility to our members and to all Americans to advance health care quality, safety, and affordability, and to invest in innovative solutions to address the persistent health problems our country faces today and anticipate the challenges of the future. As a family of primarily Blue Cross or Blue Cross Blue Shield plans, WellPoint has decades of experience in our local markets and communities from California to Maine. We believe this blend of national scope and local depth is a unique and powerful combination that contributes greatly to our ability to improve the quality and value of our members' health coverage.

Thank you for this opportunity to explain the factors behind our March 1st rate increases in California's individual health insurance market and my views on the need for meaningful and sustainable health care reform.

I appreciate the opportunity to testify before you today and to respond to your questions.

Mr. STUPAK. Thank you, Ms. Braly. Ms. Miller.

Ms. MILLER. I have no prepared statement.

Mr. STUPAK. Oh, you're not going to do a—OK. Well, let me ask this question. Let me ask about WellPoint's motivations and increasing premiums. I have sort of mentioned it and others have mentioned it. WellPoint's executives, and in a way, Ms. Braly, you asserted the profits were not a motivating factor in raising the premiums in California. In written testimony you indicated that you were disappointed that the critics cited profits as a primary reason that companies were increasing the cost of premiums.

So let me ask you this. Right there is a document book on Tab 13. Please take a look at Tab 13 if we could put it up on the screen. [Slide shown.]

Mr. STUPAK. It is an email that was sent on October 7. It is in response to a voice mail—and in fact, I think you are the one who left the message, senior corporate actuarial wrote the average increase is 23 percent and is intended to return California to a target profit of 7 percent versus 5 percent this year.

So my question is, were you attempting to raise profits to 7 percent then in California by increasing the premiums? Was that the purpose behind this email?

Ms. BRALY. I think Cindy Miller was going to respond to that because the email—

Mr. STUPAK. It was to her, right.

Ms. MILLER. Yes, it is important to understand that that email was during the process of setting the rates, and it only refers to part of our California individual business. I think it makes reference to the fact that we had a 5 percent profit and are in that block.

Mr. STUPAK. In the previous year, right?

Ms. MILLER. In 2009. That in fact did not turn out to be the case. We lost money in the individual market in 2009 on our California business, and the profit that we have targeted in the rate increases that we have asked to implement for 2010 is less than 2 percent.

Mr. STUPAK. But the email basically says we have got to get the 7 percent if—got to increase our premium 7 percent so we can add that 7 percent profit. We have got to increase our premiums, right?

Ms. MILLER. The email was sent on October 7, the rates weren't filed until November 7th, and experience on that block—

Mr. STUPAK. Well, let me ask you—

Ms. MILLER [continuing]. And the medical claims continued to escalate more than we anticipated—

Mr. STUPAK. Sure. Let me ask you one about November 22 then if it was filed on November 7. Go to Tab number 22. On it, it is an email of November 2, and then you said you filed on November 7 from Brian Curley, WellPoint's Regional Vice President and Actuarial wrote, Note, we are asking for premiums that would put us 40 million favorable. One week earlier, Mr. Curley informed Brian Sassi, the President and CEO of WellPoint's Consumer Business is that if we get the increases on time, we will see an op gain upside of 30 million after downgrades and rate cap.

I guess my concern is we say publicly we are not increasing rates to increase our profits, but yet, these emails sort of indicate that

you have to have a minimum increase in order to maintain profit. Go ahead.

Ms. MILLER. Well, again, it is important to remember what I just said which is the lost money in the individual market in California in 2009, and that is not a sustainable business market. So certainly we are talking about profit increases in absolute dollars, but again, when you look at the profit margin that is built into the rates for 2010, it is less than a 2 percent profit margin.

Mr. STUPAK. Well, OK, but look, we have seen your internal corporate documents that you used a variety of accounting mechanisms to sort of manipulate the profit figures. Look, we have seen at least five different accounting measures used to describe profits. The methods include pre-tax income, post-tax revenue, operating gains, underwriting margins and profits. If I remember correctly, WellPoint, at the end of 2009 in the last quarter, the last 90 days, their profit was \$2.7 billion or something like that, right?

Ms. BRALY. Well, let me speak to that because the fourth quarter of '09 was the quarter in which we sold our pharmacy benefit management company. That is a company we had had and invested in for years, and our belief was that by selling that company and partnering with Express Scripts which is a pharmacy benefit management company, we could do the important thing that many of these panelists described which is getting lower-cost drugs for our members by that combination. So if—

Mr. STUPAK. Great.

Ms. BRALY. And those earnings now are, you know, no longer part of our company because we have sold that. And so when you look at our total earnings for 2009 and look at our net margin which is an appropriate measure to look against other elements, we were at 4.8 percent. That was our margin—

Mr. STUPAK. That was your margin? What does that equal in real dollars in 2009?

Ms. BRALY. That was about \$2.385 billion.

Mr. STUPAK. OK. 2.8 billion, that was your profit in 2009 which is a year that everyone would consider was a horrible year economically in this country and hopefully 2010 will be better. But what I am concerned about is our hardworking Americans are asking to increase their premiums to the wealth of WellPoint's investors. I mean, look it, yesterday you had the hearing yesterday in California, right, on the rate increase and Anthem President Margolin, is that how you say that, defended the profit margin during the hearing and he is saying it should be about—the 5 percent is a figure that he said would be acceptable. In fact, he said we have no interest in profit beyond the range I have described to you, 2.5 to 5 percent is reasonable in their appropriate profits. But when your policyholders are taking a hit like the last panel see, everyone of them were self-employed, they are individual, you know. It is that group, basically self-employed people, they have taken 30, 40, 50 percent hit, but it seems like every year you have got to have a profit. Is it reasonable to expect every year companies are going to have profits and we got to have at least 2.5? It would be great if we could guarantee every business to have 2.5 to 5 percent profit. What the heck, you are at 7 percent or more.

Ms. BRALY. You know, actually, over a 5-year period, our profit margin has declined. We continue to get more efficient as a company and as a business, and we are working hard to reduce healthcare costs and improve access to high-quality, affordable healthcare.

So it is important to be a business that sustains, that we have an appropriate profit, and we think a 4.8 percent margin on a relative basis is very efficient. And when you look at that compared to others in the healthcare system, you know, biotech companies are 23 percent profits, pharmaceutical companies are in the 20 percent profit. We have a chart in our written testimony describing that even community-based hospital margins are in the 6.9 percent profit margin. So we are part of the healthcare system that is striving to get to more affordable healthcare for all our members.

Mr. STUPAK. The only way we will get more affordable is to knock off these profits that are being paid for by the average American. I mean, I don't mind you making a profit, but at the end of the year, 2009, a horrible year, you still made \$2.-something billion and that is not enough?

Ms. BRALY. And we serve 34 million Americans across the country, and we feel that it is appropriate for our business to be sustained so that we can be there for those members when they incur those healthcare costs. We want to be solvent as an organization and be able to continue to invest in ways in which we can get to a more affordable, higher-quality healthcare equation.

Mr. STUPAK. Sure, and I don't mean to inject the healthcare debate in this whole deal, that is why so many of us believe in a public option. You are killing the average consumer. They can't afford anymore. We have got to put an option up there. Today we are doing the antitrust exemption. Hopefully that helps.

My time is way over. Mr. Burgess, please, for questions.

Mr. BURGESS. Thank you. I appreciate you all being here today. I appreciate having an actual actuary here at the table. It is a shame that we don't have the state actuary, and you all could compare notes because I presume you prepared some actuarial findings and presented those to the State Board of Insurance, is that correct?

Ms. MILLER. Yes, my team does, by law, is required to do rate filings in which we certify that the rates meet the law and are reasonable. In addition, we have an independent, outside actuarial firm, Milliman, probably the most respected firm in the country, also verify that they thought our rates were reasonable and appropriate and met the law.

Mr. BURGESS. And those went to state regulators?

Ms. MILLER. Yes.

Mr. BURGESS. When was that?

Ms. MILLER. Our filing was on November 7. The independent actuary reviewed the filing in mid-November and issued a letter on December 15 that they believed that rates were appropriate.

Mr. BURGESS. Is it possible for you to provide this Committee with a copy of that letter? Do we have that in our evidence binder somewhere?

Ms. MILLER. I believe so.

Mr. BURGESS. We could get a copy of that letter or we already have it?

Mr. STUPAK. We may already have it. It is not in the evidence binder.

Mr. BURGESS. OK. And then what was the response of the state regulators to the actuarial information they were provided? That this was outrageous? How dare you?

Ms. MILLER. By law, the state is supposed to respond within 30 days to the filing. We heard nothing from the state until actually Christmas Eve, and on Christmas Eve we got several questions from the actuary about one of the products, our Smart Sense product, and the filing for that. We responded to those questions, and then we heard nothing else from the Department of Insurance until the news broke of the rate increases in the LA Times.

Mr. BURGESS. I see. You know, you had to know this was going to be trouble. I mean, a 39 percent rate increase in this climate? You know what we have been doing up here the last year?

Ms. BRALY. Yes.

Mr. BURGESS. You know what is happening at the White House tomorrow?

Ms. BRALY. Yes.

Mr. BURGESS. You knew this was going to be trouble.

Ms. BRALY. Yes.

Mr. BURGESS. You did the report on Christmas Eve. You know what else happened on Christmas Eve? They passed a bill in the Senate. So you knew the landscape into which you were entering, correct?

Ms. BRALY. Correct.

Mr. BURGESS. Did you make a judgment as to whether or not this was the best time to do this?

Ms. BRALY. You know, it is always a challenging issue to raise rates. And to address the issue that many have brought up, you know, our desire is to have more members. Our goal is to continue to serve members and have more members. It is not easy. It is difficult to continue to have to raise rates. The process was under way clearly. The rates had been filed. We had had this certification also——

Mr. BURGESS. I don't want to interrupt you, but I am going to run out of time. You see how mean he is?

On Tab 18, where we talked about the rate increases, we also talked in an email about a cushion to allow for negotiation, margin expansion. Kind of sounds like what we do with appropriators. We ask for twice what we need, hoping they will give us half of what we ask for. So did you file this with a cushion, this 39 percent?

Ms. BRALY. Cindy can speak to that specifically. I think it is important to note that when you look at the individual products in California, because of our participation in the HIPAA and what is called the Mr. Met graduate program, a high-risk pool option. We did have in 2009 a \$68.9 loss when combined with the individuals who buy the products in the open market. Our loss was about \$10 million altogether. So when we price this product for the rates for 2010 that were filed with the Department, they assumed we would have a margin of about 2.4 percent or an after-tax margin of about 1.4 percent.

Mr. STUPAK. And you feel that even though you knew you were going to get significant negative publicity because of those facts, you would be able to justify what the rates were?

Ms. BRALY. The rates, on average——

Mr. STUPAK. You can do it. You can add publicity, right?

Ms. BRALY. It is a difficult situation, and even to break even, the rates would have been in the 20s in terms of overall average, the overall average. And we were concerned which is why we also capped the rates at the top and at 39 percent because we did not want rates for individuals to go in excess of that cap.

Mr. BURGESS. I am going to run out of time, and I must ask because it has come up already. Do you have doctors who are unconscionably raising their rates in your network? My experience with most insurance companies was we took what you gave us. We really didn't negotiate. With all respect to the Chairman, Medicare sets the rates, you guys come in and say we will pay a percentage of Medicare, take it or leave it and that is the end of it. That is the so-called negotiation that we went through. Is California substantially different from Texas?

Ms. BRALY. No, we can talk about what the trend is with the physician trend versus the hospital trend is a much more significant driver, and the pharmaceutical trend is a much more significant driver than that.

Mr. BURGESS. Thank you. The hospital trend and the pharmaceutical trend is a much more significant driver.

Ms. BRALY. Right.

Mr. BURGESS. If you took all physician reimbursement off the table, you would have a one-time savings of from what I read anywhere between 5 and 18 percent. It is not the biggest driver in your book of business, I suspect.

Ms. BRALY. We think the physician trend is around 6 percent in California.

Mr. BURGESS. That sounds——

Ms. BRALY. And so the hospital trend is 10 and the pharmacy trend is 13.

Mr. BURGESS. And of course, all of the expenditures do flow through generally through the physician, that is, if a physician doesn't write the order, write the script, the patient doesn't get the treatment or the prescription.

So although they are a very small part of the actual cash outlay, they do control or they tend to be a driver or a constrictor of costs. I have always wondered why we try to ratchet down physician payments. Doctors are normal people that you say we are going to ratchet it down? We try to do more to catch up, and therefore we see more patients, order more tests, write more prescriptions just because our throughput has to increase in order to pay our overhead. Have you guys ever looked at a corporate level of maybe if we pay doctors differently we could actually get control of this cost curve?

Ms. BRALY. Absolutely. We think the partnership with doctors is the key to changing the reimbursement system so that we are paying for outcomes rather than——

Mr. BURGESS. Now, you know that there is a representative in California named Pete Stark who will not allow that sort of inter-

action to occur, right? That partnership between doctors, insurers and hospitals?

Ms. BRALY. I think that is an important part of the future of the reimbursement system, to partner with doctors, to look at different ways to reimburse—

Mr. BURGESS. But we can't. Under Stark laws, we will all go to jail. So that is off the table. Is there any other way we could do that?

Ms. BRALY. We think there are elements around medical malpractice reform where if doctors understood that they would be protected if they followed evidence-based medicine, that question that you raised, you know, the most expensive thing in healthcare is the pen and the doctor's hand. If we can make the doctors, you know, protected and be willing to and be able to focus on evidence-based medicine, then I think we will get at those procedures or those tests or diagnostic tools that may be used successfully.

Mr. BURGESS. Yes, unfortunately that is one thing that is off the table in tomorrow's discussion. We really aren't going to talk about tort reform, I don't think, other than a very superficial way. We will say caps, they will say no way and that will be the end of the discussion. Thank you.

Mr. STUPAK. Thank you, Mr. Burgess. Maybe we can get a chance to get another round in. Mr. Chairman, Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Stupak. California has a tort reform law. In fact, we have the law that the American Medical Association would like to have for the rest of the country. Are you saying that that has held down costs in California?

Ms. BRALY. Well, clearly the costs in California continue to rise, and we have a number of issues that relate to healthcare costs in California. For example, we have seen—

Mr. WAXMAN. Well, I don't want to know all the issues, but you said if we had a medical malpractice system, that would be one way to hold down costs. California has one. It hasn't been sufficient to hold down costs to keep you from raising the premiums, you asked for 25 percent increase. In your written statement you said raising our premium was not something we wanted to do. So your senior executives as WellPoint determined that a rate increase averaging approximately 25 percent was necessary, is that right?

Ms. BRALY. That is correct.

Mr. WAXMAN. OK. Now, I would like to ask you about a document produced from your internal files at WellPoint. On October 24, 2009, Mr. Shane, a Senior WellPoint Actuary, emailed Mr. Sassi, the head of WellPoint's Individual Market Division, and let me put up that email.

[Slide]

Mr. WAXMAN. Mr. Shane writes that WellPoint executive must reach agreement on a filing strategy quickly, specifically in the area of do we file with a cushion, allow for negotiations, or do we file at a lower level that does not allow for negotiations. This email says that you were considering filing a rate increase that was padded because you expected California to reduce your proposed increase. Is that an accurate conclusion to reach?

Ms. BRALY. I don't believe so, and Cindy described these emails—earlier in the process there was a question of what the medical

trend would be. What we filed did have a margin of 2.4 percent on an operating margin basis or 1.4 percent. And it reflected the trend that we were experiencing in California. So there was not a cushion in the rate that was filed.

Mr. WAXMAN. Well, it is hard to understand these words differently because the words say a cushion allowed for negotiation. You decided you needed 25 percent, but it sounds like you were willing to go to 20 percent. There was a presentation prepared for your board of directors. The presentation outlined WellPoint's strategic plan for individual line of business for 2010, and let me put that slide up on the board.

[Slide]

Mr. WAXMAN. This slide is titled, Key Assumption: Individual Pricing. It distinguishes between your rate ask and the actual rate increase you are assuming for 2010. And according to this slide, the 2010 rate ask is listed as 25 percent to 26 percent, but the assumed 2010 rate increase is just 20 percent. This seems to say that you were asking for a 25 percent increase but expected to see that lowered to 20 percent through negotiations. That sounds like padding. How do you respond?

Ms. MILLER. I will respond to that since my team was responsible for the rate filings. It is important to note that this was prepared before the rate filing, before the rates were finalized, and it recognized the fact, the political reality that departments of insurance have political pressures and often will change rates in response to those pressures. What turned out to happen is that medical costs continue to escalate through the latter part, the last three months of 2009, and the 25 percent rate increase became necessary to achieve, as Angela said, a profit margin of less than 2 percent on an after-tax basis.

Mr. WAXMAN. Well, it sounds like what you are saying is you prepared to ask for a rate higher than what you needed as a negotiating tool. You could have anticipated rates were going to go up, and you had to make a decision. You wanted an average increase of 15 percent, but you were really looking at an average increase of 20 percent. You can see the document says assumes 2-month approval delay, lowering rate increase 5 percent. This says exactly the same thing as a presentation to your board. It says that you are asking for more than you need because you build in a large cushion. Here is what I think is going on. You are raising your rates far above what is necessary. You are trying to squeeze every dollar of profit you can out of policyholders in California and across the Nation, and at a time when families across the Nation are struggling to pay their bills, you are trying to charge them inflated rates that pad your profits and support the salaries and the trips and the treats and everything else.

Ms. BRALY. Mr. Chairman, we have described in 2009 in the individual business in California, our prices were not adequate to cover the losses, for example, in guarantee issue part of the products that are required to be covered, and we had a loss. And our pricing that was filed and certified or reviewed and evaluated by other actuaries confirmed that the——

Mr. WAXMAN. Other actuaries, meaning the state actuaries?

Ms. BRALY. Milliman came in specifically at our request to evaluate—

Mr. WAXMAN. You indicated you were trying to be more efficient to hold down these costs. Is the biggest deficiency that you produce trying to shift people onto plans where they have to come up with more money out of pocket so that you don't have to pay that amount?

Ms. BRALY. No. In fact, we could be making less money when those members shift to products that have less benefits. Our goal is to make sure that we have product offerings for—

Mr. WAXMAN. Well, we heard three witnesses this morning as did you. You were sitting here. All three of them seemed reasonably healthy, but all three of them were told they were going to get a 39 percent increase, not the average of 20 or 25, 39 percent increase. But they were in luck. They could get a plan that would cost less, they just have to pay more out of pocket for their drugs because you wouldn't cover the brand-name drugs or they would have to come up with greater or higher deductibles. Is that efficient?

Ms. BRALY. What we try to do—

Mr. WAXMAN. Is that inefficiency?

Ms. BRALY [continuing]. Is we try to make sure that the customer can get access to a product that they want and afford and provides them the benefits they need. For example, last year—

Mr. WAXMAN. Well, they would like to have what they have been paying for and not have to have increases every year that they have been seeing.

Ms. BRALY. And as reflected, as the pool of insured changes because sometimes healthy younger individuals leave and we have people that stay in the pool that are more expensive. The cost overall of the pool continues to go up. That is the critical—

Mr. WAXMAN. So you would argue that we need a pool that includes everybody, is that right?

Ms. BRALY. Correct, that is—

Mr. WAXMAN. Therefore if you are pooling people together, then you don't need these individual risk analyses because you are spreading the cost. Is that what you are telling us?

Ms. BRALY. We are an advocate for reform that would include the elimination of preexisting conditions provided that there is a mechanism to keep everyone in the pool so that you don't have this phenomenon.

Mr. WAXMAN. That is what the bill does that passed the house. That is what the bill does in the Senate. That is what the President has been calling for. Let us get everybody insured, and let us put them in a pool and then you spread the risk. What the individual insurance markets seem to be doing, if you have got an illness, you are not even going to be considered for consideration. If you are in the plan and you have got some illnesses, we are not going to drop you but we are going to shift you to another plan where you pay more money out of pocket. And you are individualizing insurance so that the individual has no leverage. They have to pay what you ask or drop down to something else.

Ms. BRALY. The actuary analysis is not based on an individual's health status. It is based on who is in the pool. But to your point

about the healthcare reform, I think it is important. The concept and the goal was to eliminate preexisting and get everyone in the pool. But what happened in both of the bills that we have seen is that the effectiveness of keeping someone in the pool really fell apart as the legislation was moving forward. And the great concern is you wouldn't keep everyone in the pool because you don't have the right mechanisms in place to keep them in the pool and they would opt out.

Mr. WAXMAN. What would you do to keep people in the pool?

Ms. BRALY. We would make sure that there was a continuous coverage requirement so if—

Mr. WAXMAN. Somebody says I don't want insurance. What would you do? What would you do to that individual or family that says, I don't want to pay this. I can't afford it. I'm not going to pay it. What do you do to them?

Ms. BRALY. Right, and then there should be an enforceable and effective penalty of some sort that catches all individuals and a requirement to have continuous coverage because people jump in and out of coverage in Massachusetts where there is a mandate. They jump in, consume healthcare, dump their policy, jump out, and the costs continue to escalate because they dealt with coverage and not cost.

Mr. WAXMAN. I think we tried in that House bill to cover everybody and require that everybody get coverage, spread the costs out, and we didn't get a lot of support from the insurance industry for the House bill, let alone the Senate bill.

I have certainly gone way beyond my time. Thank you, Mr. Chairman.

Mr. STUPAK. Ms. Schakowsky for questions, please.

Ms. SCHAKOWSKY. First, Mr. Chairman, on behalf of Representative Eshoo, I would like to add to the record a letter that she wrote February 11, to Ms. Angela Braly. Could I have unanimous consent?

Mr. STUPAK. Without objection—let us see it first.

Ms. SCHAKOWSKY. OK. I will hand it to you.

[The information was unavailable at the time of printing.]

Ms. SCHAKOWSKY. In the letter that representative Eshoo wrote, she quotes from your Anthem Blue Cross unit in an email message urging your employees to oppose healthcare reform, and it is reported to have said that reform proposals would "cause tens of millions of Americans to lose their private coverage. And she makes the point that the 39 percent rate increase flies in the face of this concern for those who would supposedly lose coverage. I wonder if you could respond to that.

Ms. BRALY. I would be happy to. We are very concerned with the legislation that was being proposed because we didn't feel like it addressed that concept of addressing, getting everyone in the pool, and as a result, that, with combined with some other changes that were proposed, including changing the age rating. Our actuarial analysis, which we shared publicly and have available on our Web site—

Ms. SCHAKOWSKY. What is the age rating you use?

Ms. BRALY. It varies by state, and Cindy could probably give the details around California, but constricting the age restrictions, we

found that individuals, young individuals, in California would see in excess of 106 percent rate increase and that was before trend. So that would be in addition to the rising healthcare costs that we saw as well.

Ms. SCHAKOWSKY. You began by talking about how happy you were to be here to talk about rate increases. I want to remind you the name of this hearing. It is Premium Increases by Anthem Blue Cross and the Individual Health Insurance Market. And what I actually expected was not for you to come and lecture us about what we should put in our bill but actually to explain to us, and a good start would have been to answer some of the concerns. I don't know if you were here for the testimony of Jeremy Arnold who talked about a whopping 74 percent increase that he has experienced or Julie Henriksen who I just calculated pays \$24,504 a year. And if I am correct, if I heard you correctly, you never even met the deductible. So you paid this amount, but you really didn't get any benefit from the health insurance because you didn't meet the deductible, or respond, and it would be nice if you would because she wrote you letters talking about how she realized for months she had been paying for a costly, unnecessary benefit, switch plans, and finally did get a letter that her premiums were going to be raised 38 percent, although she could change to a lesser coverage and pay only 16 percent. Isn't that fabulous?

I do have a couple of questions, but I want to tell you something, that I think that a 39 percent rate increase at a time when people, Americans, are losing their jobs, losing their healthcare, is so incredibly audacious, so irresponsible. You know, we see these lavish retreat places. I would be interested to know what your salary is as the CEO, the incredible CEO salaries. I don't know how many people it was said that make over \$1 million a year at your company. How much money do you make?

Ms. BRALY. My salary is \$1.1 million. I receive stock compensation. I received stock compensation with the value of \$8.5 million, and last year an annual incentive payment of \$73,000.

Ms. SCHAKOWSKY. Well, of course, it makes sense then that you would need a big rate increase now that you told us that. You said in your written testimony that Anthem Blue Cross profit margin is in line with and below that of many of your competitors. Can you name any California competitors who have raised their rates up to 39 percent?

Ms. BRALY. Yes, we believe that a number of our competitors have raise rates. In fact, in the individual market, there are products that are available. Our products are competitively priced and in many cases lower priced than many of our competitors, both for-profit and not-for-profit—

Ms. SCHAKOWSKY. They got approved by the commission for more than—

Ms. BRALY. They are outstanding and available now.

Ms. SCHAKOWSKY [continuing]. 39 percent?

Ms. BRALY. We are a very efficient company on a relative basis, and our administrative costs continue to go down. And so we do have very competitive rates in the marketplace. Many times they are less expensive than other products that are currently available.

And there are a number of competitors in California, and our rates are quite competitive in the marketplace.

If I could address your earlier question—

Ms. SCHAKOWSKY. No, I have another question. Has your company met the legal requirement to use 70 percent of premiums collected in the individual market for the payment of medical claims?

Ms. BRALY. Yes, we have submitted those filings and believe they are compliant with the requirement. You have to keep in mind that product is the product sold in a commercial market, that the losses that are incurred in the HIPAA and the Mistermet graduate program are borne in that marketplace as well. So in the end, the individual marketplace lost money in 2009, and would produce an after-tax return of 1.4 percent—

Ms. SCHAKOWSKY. So when you figure your profits, you don't figure it across the company? You look just at the profits made or lost in the individual market?

Ms. BRALY. Yes, and there are some very important reasons actuarially to make sure you price the product for the costs that are being incurred in those products. Cindy, you might talk about the potential—

Ms. SCHAKOWSKY. No, I don't want to hear about it.

Ms. BRALY [continuing]. Adverse—

Ms. SCHAKOWSKY. I don't want to hear because it seems to me that when you have a company that is providing not widgets and not some luxury item but healthcare, that it might make sense to look across the whole company to see what kind of profits because people who are in the individual market are often least able to be able to come up with these very high rates.

What would you think about an 80 or 85 percent medical loss ratio?

Ms. BRALY. You know, our medical loss ratio as an enterprise is 82.6 for 2009. And you know, one thing that is really important about the individual market, we in some states, where there has been regulation that really tries to restrict the ability to raise rates, all the competition has left. We are Blue Cross/Blue Shield. If you look at Maine, in 1993 there were 11 carriers in Maine offering products in the individual market. Now there is us and another company that is not a major national competitor because we are Blue Cross and we have geography licensure, and we don't want to leave the individual market. And so we need to make sure that it is a viable marketplace for our customers so we can continue to cover their costs. So as they incur healthcare costs, we are there to provide and pay for those costs.

Ms. SCHAKOWSKY. I yield back.

Mr. STUPAK. Nothing to yield. Let me go to Mr. Welch of Vermont for questioning.

Mr. WELCH. Thank you very much, Mr. Chairman. Ms. Braly, on our last panel we did hear from some Anthem policyholders who have had very high rate increases. Two of the policyholders had premiums that were being raised 38 percent. The third had a rate notification increase to 30 percent. All of those were markedly higher than the average increase that WellPoint has reported publicly. And the current rate increases put the policyholder in a tough position. They can drop insurance altogether or try to get a much

less comprehensive policy. And I would like to show you and Ms. Miller a document that suggests that these rate increases in fact could be much higher in the future. You can find this chart at Tab o7 of the document binder. And this, as you know, is a WellPoint internal analysis of the potential rate increases which was included as part of the individual leadership pricing memo, a document providing recommendations and analysis about the individual market in California. And I would like to put this document on the screen. Do we have that document up?

[Slide]

Mr. WELCH. OK. Thank you. Ms. Miller, as WellPoint's Chief Actuary, I want to make certain I understand the three scenarios proposed by WellPoint officials in this document. Scenario one, and I don't think this is on the screen, appears to propose that WellPoint make no change in SAFs or rate increase caps, right?

Ms. MILLER. That is correct.

Mr. WELCH. And then scenario two appears to propose a reduction in the rate caps by 2 percent after accounting for age. So am I reading that correctly?

Ms. MILLER. Yes.

Mr. WELCH. And then scenario three which is the focus of attention here, that is the chart that caught my attention. It appears to consider the possibility of removing rate increase caps altogether, and the document states, and I quote, "Remove SAFs completely." And then below that header is a chart that shows that if WellPoint in fact implemented this program, taking away the rate caps, removing them entirely for certain plans, over 27,000 policyholders would be subject to a 228.4 percent increase in their monthly premiums. Is that right?

Ms. MILLER. I don't see the number of policyholders that you are referencing on the one that is in our book. But I do see the 228 percent.

Mr. WELCH. OK. So if we took the caps off, under your internal analysis, if I were a WellPoint policyholder subject to this situation, I could be receiving a 228 percent increase in my premium cost?

Ms. MILLER. Yes, I would like to point out that these are labeled scenarios, not proposals. When we do our actuarial work, you start by looking at the rate increases that are necessary for——

Mr. WELCH. The scenario——

Ms. MILLER. It could have been the starting point, and it is meant to illustrate that if we didn't cap, these would be the increases. We did in fact cap the rates. This was not a proposal. It was just in order to illustrate, you know, how dramatic some of the increases would be if we had to do that.

Mr. WELCH. I get that. You are saying that if you had caps off, by your analysis, you might actually in order to maintain using Ms. Braly language, a viable marketplace would require you to raise my premium by 228 percent. That is where we are headed. I mean, this is the problem. That's where we are headed.

Do you consider, Ms. Braly, that it is a viable marketplace if a machine tool company who has got 15 workers that they have been loyal to and the workers have been loyal to them, and they are trying to hang onto the jobs and they are trying to hang onto health

benefits, they get a notice in the mail saying that they are going to get a 228 percent premium increase. Is that sustainable?

Ms. BRALY. Absolutely not, which is why we need to focus on the rising health care costs, and we think we are an important part of that mechanism in healthcare.

Mr. WELCH. Well, you know, that is pretty self-serving. I mean, if your medical loss ratio is you said about 82 percent, you know, just years ago the medical loss ratio was in the range of 95 percent. So there a business model that is working for you as an insurer so that you can pay your salaries, maintain your bottom line, but it is coming at great expense to other people.

Ms. BRALY. Our administrative expense, you know, really does go to focus on disease management. We have 2500 nurses who work with our customers to make sure they are getting the benefits—

Mr. WELCH. You know, Ms. Braly, I don't mean to interrupt. We have got a situation here that your own internal analysis suggest the obvious conclusion. It is not sustainable. I mean, if left to strict marketplace interpretation of what is "market viability", that being as I understand it, what you would have to charge in order to maintain the financial solvency of your business. If that requires charging that machine tool company 228 percent, that is not a market that is viable to anybody who is on the receiving end of that premium rate increase. So it suggests that the market model that we have is fundamentally broken.

Ms. BRALY. We agree that we need a sustainable solution to this difficult problem, particularly in the individual market where we see these issues extremely in terms of the rate increases which is why we are an advocate—

Mr. WELCH. So basically you are in agreement with the proposition that I just made, that the current insurance model is fundamentally broken where the premiums are going up potentially 228 percent?

Ms. BRALY. I think we need to continue to create an opportunity for both consumers to be better purchasers of healthcare and understand the dynamics which we are doing through investment, as well as continue to innovate around how we fundamentally change the—

Mr. WELCH. When you say the consumer can be a better purchaser of healthcare, when you send out your premium notice, whether it is 40 percent or potentially 228 percent, and when someone calls, do you negotiate the rate for them?

Ms. BRALY. We have a mechanism where we do work with our customers to make sure that they can get another product potentially that they can afford or that has benefits that they want or need or not the benefits that they don't want—

Mr. WELCH. How can you—literally, I mean, again, I am not—

Mr. STUPAK. Go ahead, finish it up, and then that is going to be it.

Mr. WELCH. Well, I think the point has been made here. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Welch. Ms. Capps for questions, please? Thank you for being here today, too.

Mrs. CAPPS. Thank you, Mr. Chairman, it is an honor to be with your Subcommittee. I see a couple of the members of the previous

panel. Before I address the current panel, I just want to say thank you for being such wonderful witnesses. You spoke for a lot of my constituents. I represent a district on the central coast of California, and their stories are so similar to yours, and they were very eloquent. I had to leave, and so I wasn't able to say that to you and allow you to expound even more.

But to this panel, listening to a couple of my colleagues and your responses too them just makes the case for me as one member of Congress that we really do need a lot more competition within the health insurance market.

Here is a story from one of my constituents, in a quote. "We as many others have received a notice from Anthem that our health insurance premium will increase by 30 percent starting March 1. My husband and I are both self-employed. We currently afford a PPO with a 5 deductible. And now Anthem, being so under-standing, is offering a \$7,500 deductible. If anything serious happens to our health, we lose everything to pay our medical bills, even though we technically have insurance." Here is another constituent. "I am a 61-year-old male with individual health insurance from Anthem Blue Cross. I just received a notice of a rate increase from \$616 a month to \$881 a month." Another says this. "The premium on my Anthem Blue Cross health insurance policy is going up from \$545 per month to \$712 as of March 1. I want you to be aware," she writes to me, "of this 30 percent hike in insurance rates.

Ms. Braly, these are hardworking people, I know, who have no choice but to purchase health insurance on the individual market. Yet it doesn't seem like they get much for it. You claim you must raise prices in order to make up for healthy people who drop out of the system. But isn't it true that you have long engaged in the practice of rescission? I am well aware that Anthem has been fined for doing that in years past. And knowing that it may well drop me as a consumer who, in the even that I would become sick, is certainly not an attractive enticement for me to help as a healthy customer to join forces so that you can help to keep your costs down. You don't market yourselves very well. At a time when your company is bringing in record profits, but when the rest of our economy is suffering, I want to know what steps you are going to take now to make quality health insurance products affordable to the people like my constituents who want to be responsible and want to purchase health insurance but just can't do that. Do you want to respond quickly? I have another—

Ms. BRALY. I would. Thank you. Thank you for the opportunity to talk about what we are doing to try to make healthcare premiums more affordable. For example, when we negotiate with hospitals in California, our goal is to have zero increases. Often those hospitals come to us requesting a 40-percent increase, and if there is not competition among hospitals, the regulars have said that it is inappropriate for us to terminate those hospitals from our network because then we would have an access problem. So as a result, we don't have the ability to, you know, not agree to those very high rate increases from the hospitals. So we are going to continue to fight on behalf of our customers to make sure that the healthcare they are receiving is affordable and high quality. And

it is a difficult fight. It is one that we keep doing. It is why we sold our pharmacy benefit management company so we could get access to lower cost drugs because those costs are driving the overall increase in—

Mrs. CAPPS. So you are shifting the blame to the hospitals pretty much. Just summarizing.

Ms. BRALY. We are working together to make sure we can address that.

Mrs. CAPPS. There is nothing within your own system that you can find any flaws with.

Ms. BRALY. We continue to work on our efficiency. In fact, if you look at our administrative efficiency ratio, we continue to improve our efficiency as an organization, while we provide more services in terms of getting to that underlying healthcare cost. We will continue to do that.

Mrs. CAPPS. I am going to just again address the topic that has come up. I saw slides shown of the places where you hold your retreats. This is a sticking point. It is not the whole story, but it is one that because it is so visible, it is pretty galling for people who have had to sacrifice their vacations now for the past two or three years because of the economy and what it is doing to their personal lives. And yet—and I am going to finish and then I am going to give you the rest of the time to respond. You have continued to make these retreats a part of your working relationship and offering these to your employees. Consumers are making sacrifices in order to hold onto their health insurance as the premiums go up and then as they face being denied. These retreats hold more sway with your company than the health and well-being of your subscribers, and I will allow you any seconds I have left to—

Ms. BRALY. Yes, those meetings have been characterized as retreats for our associates, and that is incorrect. Those meetings that were described are meetings that we have with our customers, meetings—

Mrs. CAPPS. Which customers?

Ms. BRALY. Often I meet quarterly with representatives for our customers, our customer advisory groups and—

Mrs. CAPPS. Who are those people?

Ms. BRALY. They are representatives from our customers, so business people who buy the benefits on behalf of group customers—

Mrs. CAPPS. So you are selling your benefits at those lavish resorts?

Ms. BRALY. We are meeting with—brokers and agents. You heard one of the panelists say she was going to work with her agent to understand what her options are.

Mrs. CAPPS. Well, that is where her agent was when she was trying to get a hold of her.

Ms. BRALY. We make sure that our agents and brokers consultants and customers know what our benefits are, know what plans and services we can provide to them. We do some—

Mrs. CAPPS. And you justified that cost as you are raising the premiums?

Ms. BRALY. No, we continue to focus on making sure we are more efficient. We do need to meet with people that are agents, brokers

and customers. We find that they provide input to us in terms of how we improve the services and benefits that we provide to—in the case of——

Mrs. CAPPS. Do you ever meet with your premium holders? Do you ever talk with them?

Ms. BRALY. I do, and I am delighted to, and I appreciate the opportunity when I get. And yes, I——

Mrs. CAPPS. Did you hear their stories in addition to the stories you heard this morning?

Ms. BRALY. It is a challenge, believe me. We are on their side. We want to——

Mrs. CAPPS. They don't feel like it.

Ms. BRALY. And we want them to understand there is so much misinformation about what is driving these premium increases. And I think it is important for people to understand the margins that are available to pharmaceutical companies and in hospitals and where we stand on a relative basis because we are fighting every day to make sure we can make their health benefits more affordable.

Mrs. CAPPS. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you. There was a request earlier that a letter dated February 11, 2010, from Anna Eshoo, member of this Committee and Member of Congress, to Ms. Braly be entered in record. Without objection, it will be entered.

Second round of questions, Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman. You have said a couple of times, you want to make healthcare services for your beneficiaries. You want to provide more services for them. You want to provide more efficient services for them. You want to provide good services for them. Is that what you have been saying?

Ms. BRALY. Yes.

Mr. WAXMAN. You see that as your role?

Ms. BRALY. We see it as a critical role, for us to get them access to affordable quality healthcare. And we, by providing services that we do, we think that creates real value for the customer.

Mr. WAXMAN. Well, some of these documents paint a different picture. There is a document that is titled WellPoint individual 2010 plan. Opportunities not reflected in the forecast. It is a business plan, and under this business plan there is a section called risk management, and it says, our medical loss ratios should improve as we eliminate subsidies and other risk management initiatives. And then you have a number of initiatives. One of the issues is to take preexisting waiting periods and adjust them to be either 12 months or the legal maximum if less. So you want to make sure—they have to wait, if they wait they have a preexisting condition, to wait as long as the maximum will allow. Secondly, reinstatements will only be allowed for a period of 60 days after termination and will require underwriting and payment of back premiums. So that is going to make it more difficult for people to get back into getting access to this good quality care.

Does WellPoint have initiatives to reduce the amount of premium dollars that are used to pay for medical claims?

Ms. BRALY. We have a number of initiatives to try to reduce medical costs, period. And then——

Mr. WAXMAN. Well, how about reduce, not just medical costs, but medical services?

Ms. BRALY. We want to make sure that our members get access to the quality care they need at the right setting at the right time. So if we are avoiding a fraudulent expense or an unnecessary expense, yes, we want to——

Mr. WAXMAN. Well, not fraudulent or unnecessary. You are saying that people have preexisting conditions. You are going to make them wait as long as possible before they can get care and——

Ms. BRALY. No, I was talking——

Mr. WAXMAN [continuing]. There is another document, let me put it up on the screen. It is Tab 14.

[Slide]

Mr. WAXMAN. In this document, WellPoint executives identified key issues confronting the individual market, and they stated, lack of attention to risk management, decreased ability to use pre-existing claim denials and rescind policies and maternity policy have led to our first-year loss ratios climbing from less than 50 percent 5 years ago to over 65 percent. So these documents seem to indicate that senior executives are actively considering steps to reduce the amount of premium benefits that are used to pay for medical claims. If you are going to reduce payment for claims, you are reducing payment for claims for legitimate medical services.

Ms. MILLER. We are trying to make sure that the pool of members that we have is not disadvantaged in the marketplace. One of the reasons that our rates are going up so much in 2010 is that healthy people are making a choice when faced with the hardship of the premium increases they are seeing. We recognize that there are hardships——

Mr. WAXMAN. What does a medical loss ratio mean?

Ms. MILLER. What is medical loss ratio?

Mr. WAXMAN. Yes, what does that mean?

Ms. MILLER. It is the claims, the medical claims paid, divided by the premium.

Mr. WAXMAN. So you are trying to reduce the amount of claims you will pay for people in order to make sure that you are still within the medical loss ratio but you can reduce the claims for people, isn't that right?

Ms. MILLER. No, you can't reduce claims without changing your medical loss ratio. That is not possible.

Mr. WAXMAN. OK. Well, if you are looking for ways in a business strategy to manage the risks, they all sound very nice, managing the risk. And then the ways you do that is to deny people access to care so you don't have to pay for that care for a longer period of time. That sounds like you want to make sure that you have got less money going into paying for care.

Ms. MILLER. No, specifically in the individual market in California, there is a minimum loss ratio requirement that we comply with. In fact, in the HIPAA guarantee issue products that we described, the medical loss ratios or medical cost ratios exceed by far the premium increases that we can——

Mr. WAXMAN. The reason that you have a medical loss ratio is we want to guarantee that insurance companies are using premium

dollars to pay for medical care for the customers and not for overhead, corporate expenses, and profits.

Ms. MILLER. Which is why our—

Mr. WAXMAN. You have to balance that out. But it sounds like your people were looking at business strategies to reduce the amount of payment of the premium dollars for the medical care for the customers.

Ms. BRALY. Actually, if we take some of those risk management ideas, we can potentially reduce the cost for the overall pool and therefore not have such significant—

Mr. WAXMAN. But for the individual involved, that individual is not going to have access to more efficient care. They are not going to have access to good services, they are not going to have access at all because you are going to hold down the cost for the overall pool. But that individual is going to have to go without or pay for the services that you wouldn't otherwise pay for.

Ms. BRALY. And that is one of the critical elements about our reform. If an individual doesn't buy his or her policy when they are well and there is an underwritten market, then if we allow them, like we do in some markets where we have guarantee issue, like New York and Maine, to wait until they are sick to buy the policy, then they won't buy the policy—

Mr. WAXMAN. Nobody wants to do that—

Ms. BRALY [continuing]. Until they are sick.

Mr. WAXMAN [continuing]. But you have got people covered, and your business—and you can't drop them because the law won't let you drop them.

Ms. BRALY. That is correct, and we don't want to.

Mr. WAXMAN. So you have got people covered, and then you want to shift more costs onto them and use more of the premiums for overhead instead of for services. What I think we need is meaningful health reform to guarantee that the insurance companies are using premium dollars to pay for medical care for the customers and not for the overhead, corporate expenses and profits. What is the bill, what do we have? We have 80 percent requirement that the money collected by premiums be used to pay for health insurance claims.

Ms. BRALY. Right.

Mr. WAXMAN. You are at 85 percent. You don't do that now, do you?

Ms. BRALY. We are at 82.6 percent. I want to address that question, though, too. You know, every administrative dollar that we spend, we want to produce a lower cost of care as a result of that. So we make investments in things like—

Mr. WAXMAN. You don't produce a lower cost of care, you produce a certain amount of—to meet the ratio, a certain amount to make sure that you are meeting your expenses and your profits. But people are being denied care, and that is why I think health insurance reform is so necessary, and I dispute your statement, although I don't have time to go into it, that this bill does not bring more people into the pool. And individual has no power to deal with you, but if they are pooled together with others, then those people have the opportunity under healthcare legislation to say we want to make sure that 85 percent of the money that you collect from us

pays our healthcare claims, not more money going to retreats and expenses and salaries. We want it for that purpose, and then you can spread the costs out. Thank you, Mr. Chairman.

Mr. STUPAK. Mr. Burgess for questions, please.

Mr. BURGESS. Thank you. Let me just clarify. On the AMA, American Medical Association site last night, and of course they are not your biggest ally or fan, but they reported a medical loss ratio for WellPoint at 84.8 percent which is right at that 85 percent figure that was mandated in the bill. Is that for the whole company and it is different in California?

Ms. BRALY. They may be looking at statutory financial statements versus gap. The gap statements show for year-end. We were at 82.6 which is enterprise-wide. So I am not sure exactly where they are at 84.8, but there are many products in which—

Mr. BURGESS. They Tweeted it, so I know it is right.

Ms. BRALY. Right.

Mr. BURGESS. Let me ask you a question. I thought Blue Cross was non-profit. We have all this discussion of profits today, I always thought when I was in practice that Blue Cross was a non-profit.

Ms. BRALY. There are many companies who have Blue Cross licenses. We are a for-profit company, but as we have described, the not-for-profit companies continue to have margins sometimes in excess of ours because we have come together as former Blue Cross independent states, and we have created a lot of efficiency and scale at WellPoint. So we are a more efficient Blue Cross plan but we are for-profit Blue Cross plan.

Mr. BURGESS. One of the areas, and I am sorry Mr. Waxman is gone, but one of the areas where I disagree with Mr. Waxman but you agree with him is that we need a mandate, an enforceable mandate, a rigid mandate in this healthcare bill. Mandates are an anathema in a free society, and my submission is that they do not work. We have a tremendous mandate right now with the IRS. Everybody knows you have got to pay your income taxes, and if you don't, you may not be exactly sure of the penalties but you know it is bad and you don't want to find out. And our compliance with the IRS is about 85 percent. Well, we have 15 percent of the people uninsured in a voluntary system in this country, so I don't know how much more compliance we get by going to a mandate, and yet we ask honest people to give up significant freedoms. When we did the Medicare Part D program several years ago, and part of my job as a member of Congress was to go out and talk to people about the changes coming to Medicare, and I can't tell you the number of people who would tell me that you can't make me take that prescription drug benefit. No, ma'am, I am not here to make you take it, it is there for you if you want it. Well, you can't make me take it. I said, no, that is right. You can do what you are doing right now, and that is oK. You can't make me take it. Well, what are you doing right now? Well, I don't have drug coverage. You can keep it. You can keep that non-coverage as long as you want. Now, there was a penalty involved, and we got a lot of criticism for that, that if you didn't sign up in the open enrollment period which at that point was six months after the initiation, that people would pay a 10-percent premium for coming into the system if you will after

they got sick because we were trying to make the benefit look more like insurance and less like an entitlement. And you know, the story with Medicare Part D, although it is not perfect is that it has provided a benefit now to 92 or 93 percent of seniors have a credible prescription drug coverage of some sort and 92 or 93 percent are satisfied or very satisfied. So that is a pretty good track record. Now, we did that without a mandate, and the model that we should follow, in my opinion, is that model which is to create programs people want. If you get a mandate, which is a program you want, but if you get a mandate, then there is not reason for you to try to compete for any of these subscribers' business. And yet, how much better would it be if you said, well, we are going to create programs that people want and will want to stay with us over time. I wish I could have a longitudinal relationship with my health insurance company. I have with my car insurance company since I was 18 years old, but health insurance, you shop around every year to get the best deal when you are in small business or your employer shops around for the best deal, and as a consequence, you don't get to keep your insurer over time. One of the reasons I went with a high deductible policy so I could have a longitudinal relationship with my insurance company. We are far better off if we construct programs that people want, rather than telling them what they have to have.

Now, you have got, and I think it has already come up, that increases in the California individual market can be as much as 106 percent under the confines of the House-passed bill, and that is a pretty significant figure. Now, Mr. Stupak is correct, none of the benefits start for 4 years, so it might not happen to you right away but at some point, the cost of those benefits is going to go up, and the truth is, no one really knows because we do these budget scores but no one really knows. Look how far off the mark we were when we passed Medicare in 1965 with what it costs us today. And Mr. Waxman talks about your medical loss ratio, look at our unfunded liability in Medicare and Medicaid. I mean, that is what is staring people in the face. Yes, we got a lot of problems here we need to fix. They are complex problems that are really hard to do. We need to do them. We have got a much bigger problem staring us in the face which is the unfunded obligation that we have with our existing public options if you will that those bills are going to come due before any of us really had planned. That is really where we need to be focusing right now. We are not doing our part very well right now with Medicare and Medicaid. Before 50 percent of the market that we pay for right now, we are asking to go to 75 percent at the federal level. That is a big ask for the American people. That is why we are getting so much pushback on this bill. They don't think we are doing a good job with what we have got now, and they don't want to give us another 25 percent of that market.

Thank you, Mr. Chairman. I will yield back.

Mr. STUPAK. Thank you, Mr. Burgess. Let me just sort of wrap up a couple questions if I may. Ms. Braly, you indicated that the drivers for this increase, the 39 percent increase you are seeking, doctors were 6 percent, hospital was 4 percent I think you said, and pharmaceutical, 13 percent, right?

Ms. BRALY. No, hospital trend is about 10 percent, the physician trend is 6 and the pharmaceutical trend is about 13 for California for the 2010 rates.

Mr. STUPAK. OK, so that is about 29 percent. So does that leave 10 percent then for administrative costs?

Ms. BRALY. No, Cindy can take you through the different elements that went into the price increases.

Mr. STUPAK. No, I am just trying to keep this simple so average lay people like me can understand how you come up with 39 percent if your projected, and these are all projected, right, Doctor, 6 percent you said, hospital 10 percent, pharmaceutical 13. What is the other driver then?

Ms. BRALY. The trend, I am describing the trend in each of those elements.

Mr. STUPAK. OK. So your 39 percent, you are looking for sort of a guesstimation what you are going to need?

Ms. BRALY. No, Cindy can give you more detail in terms of exactly how we got to the 39 percent because you have rising healthcare costs. You also have what we call adverse selection—

Mr. STUPAK. Well, wait a minute.

Ms. BRALY [continuing]. Due to the fact that a lot of the—

Mr. STUPAK. Ms. Miller has submitted for the record, but what is the driver then, doctor, pharmaceutical, hospital. What else?

Ms. BRALY. Correct. We are also having adverse selection meaning the healthy people and their premium is going away.

Mr. STUPAK. How many healthy people did you have last year in your individual policies?

Ms. BRALY. You know, we look at the whole pool—

Mr. STUPAK. No, just how many people did you have?

Ms. BRALY. We had 800,000 members.

Mr. STUPAK. How many did you have this year in your individual?

Ms. BRALY. You know, we were expecting 25,000 on the aggregate basis between the two regulated companies less that we will have about 25,000.

Mr. STUPAK. OK, but the individual policy, how many less are you going to have?

Ms. BRALY. About 25,000 less we think, we are projecting.

Mr. STUPAK. OK.

Ms. BRALY. What happens in the individual product—

Mr. STUPAK. No, I understand.

Ms. BRALY [continuing]. People are likely to come in and out because they go into group policies.

Mr. STUPAK. And because they can't afford it.

Ms. BRALY. Pardon?

Mr. STUPAK. And because they can't afford it. A lot of people in this country every year go bare because they just can't afford it—

Ms. BRALY. Which is a loss—

Mr. STUPAK [continuing]. Whether they are in a group, they get unemployed or whatever it might be.

Ms. BRALY. We want to have that customer and we want that customer to have coverage.

Mr. STUPAK. OK. You indicated earlier for 2009 your corporate profits were 2.3, almost 2.4 billion because you sold a management company, right?

Ms. BRALY. Well, we sold a PBM, and we had operating earnings as well.

Mr. STUPAK. OK. What was your company profit then in 2008?

Ms. BRALY. Our profit margin was 4.8 percent on a relatively similar base. So actually, you know, the margin was—well, 4.6 in '08, 4.8 is our overall margin in 2009.

Mr. STUPAK. So that is about the same as 2009 then? So what would that be in dollar signs then in 2008?

Ms. BRALY. I am not sure exactly what. We probably had \$62 billion worth of revenue total. So not a dissimilar number.

Mr. STUPAK. So under 2.4?

Ms. BRALY. We can get you the exact—

Mr. STUPAK. So 2010 then, you anticipate again you are going to be around \$15 billion?

Ms. BRALY. \$15 billion? I'm sorry.

Mr. STUPAK. Yes, isn't that what you said?

Ms. BRALY. No.

Mr. STUPAK. OK. Go ahead.

Ms. BRALY. No, in 2010—

Mr. STUPAK. 2010, where do you think you are going to be profit wise?

Ms. BRALY. We are actually going to have lower operating earnings in 2010. It is a reflection of the economy and the loss of our membership primarily in—

Mr. STUPAK. But your profit will probably be what, 4.8 percent?

Ms. BRALY. We expect it to be in the same range potentially, yes.

Mr. STUPAK. So you are already expecting at least for the last 3 years, your profit will be the same?

Ms. BRALY. It has been pretty steady in that range, 4.6, 4.8 would be appropriate, which on a relative basis, the other parts of healthcare and many other industries is very modest.

Mr. STUPAK. Well, you may think it is modest, but if you are looking at a 39 percent increase or in Michigan when they proposed 56 percent increase, that is not very modest to folks.

Ms. BRALY. Yes, we are not Blue Cross/Blue Shield of Michigan.

Mr. STUPAK. I know you are not. I know you are not, but Michigan Blue Cross/Blue Shield is a non-profit, you are a non-profit.

Ms. BRALY. No, we are for-profit.

Mr. STUPAK. You are a for-profit. I am sorry. You are in Maine, though, right, you said? And they have had double-digit increase. You mentioned earlier about Maine being one of the dominant players.

Ms. BRALY. Maine is one of the places where we are one of the few players left in the individual market because others have left the market.

Mr. STUPAK. Right, and less players in the market, the easier to manipulate that market just because—

Ms. BRALY. No, in fact—

Mr. STUPAK [continuing]. Of your sheer size.

Ms. BRALY. No, in fact what has happened is because the regulatory environment in Maine and particularly in the individual

market was regulated the way it was, everyone left except for us. We are a Blue Cross. We are not going to leave. We are going to stay in our geography and continue to serve our members.

Mr. STUPAK. Well, you know, is expected to be 23 percent this year, right?

Ms. BRALY. We filed for a rate increase in Maine. The Maine regulator has denied that, and we are in litigation with the Main regulators about the ability, as provided in the statute, to have an appropriate margin.

Mr. STUPAK. Well, how about in Maine, is your doctor costs there 6 percent or is it less in Maine?

Ms. BRALY. In Maine, the doctor costs are very high, and on a relative basis compared to other parts of the country, it is one of the most highly——

Mr. STUPAK. Yes, but is it 6 percent like California? I'm looking for your drivers in Maine.

Ms. BRALY. No, in fact we have a——

Mr. STUPAK. You have your drivers in California which you said was doctors was 6 percent, hospital, 10 percent——

Ms. MILLER. The driver——

Mr. STUPAK [continuing]. Pharmaceutical 13——

Ms. MILLER. I can take that question, Mr. Chairman.

Mr. STUPAK [continuing]. That is 29.

Ms. MILLER. The driver——

Mr. STUPAK. And so in Maine, what is it there?

Ms. MILLER. Off the top of my head, I don't know the exact trends in Maine. The driver in Maine is that it is guaranteed issue, and there is no requirement for people——

Mr. STUPAK. Well, guaranteed issue——

Ms. MILLER. The people wait until they are sick to purchase coverage, and it drives up the cost of care. Maine has one of the highest healthcare costs in the country.

Mr. STUPAK. Guaranteed issue is you are guaranteed to present the policy and then it is up to the consumer whether or not they can afford it. We call it purging in the business world——

Ms. MILLER. Absolutely, and what happens then——

Mr. STUPAK [continuing]. And in the individual market it is rescission.

Ms. MILLER. Only people who know they are going to incur healthcare costs more than the premium buy the policy, and that is not a sustainable business model. And that is why all the other insurers left the state because they were forced to lose money in that business.

Mr. STUPAK. That is not what the last panel said. They don't take insurance because they expect to gain more than what they paid. In fact, our last——

Ms. MILLER. No——

Mr. STUPAK [continuing]. Panel, they basically pay and never really access it because you have such high deductibles and co-pays and everything else.

Ms. MILLER. Well, obviously there are people who are using the coverage because otherwise, our medical loss ratio would be zero. I mean, that is insurance. You buy it when you don't need it so that it will be there when you do need it, and if everybody waits

until they need it to buy it, we result in the situation that we have today in the individual marketplace where we have escalating insurance costs, which is again why we have talked about the fact that we need sustainable healthcare reform. We need to address not just the insurance market reforms which we agree need to occur, but you also have to address the underlying cost of care. We are only charging the costs that come through to us.

Mr. STUPAK. Well, I still don't see how you justify 39 percent. I got up to 29 percent in your drivers and your trend——

Ms. MILLER. Thirty-nine percent was the high. The average was 25.

Mr. STUPAK. Right.

Ms. BRALY. And Cindy, do you want to talk about each element——

Mr. STUPAK. It is amazing. We had three witnesses say they are all at 39 percent. But you are saying the average——

Ms. MILLER. I don't know how the panelists were selected, and again, we don't like raising our rates that much. We know it is a hardship on these people, but at the end of the day, if you——

Mr. STUPAK. Do you believe that you can actually raise your rates where no one is going to want to take your policy anymore?

Ms. MILLER. Pardon?

Mr. STUPAK. Do you think you are going to finally get to the point where basically you are killing the goose that laid the golden egg? No one is going to be able to afford you?

Ms. BRALY. You know it is really an issue that we have got to get to the underlying costs of care because we want access to healthcare. There are wonderful advances, wonderful technologies, and we want to make sure that we continue to have access and our customers continue to have access, and it needs to be affordable. And so we have to think about how——

Mr. STUPAK. Do you believe there is going to be a point where we can no longer afford it, individually?

Ms. BRALY. I think we as human beings greatly value our access to healthcare which is why we continue.

Mr. STUPAK. I agree, and every family has to make a value judgment. Can I afford it today or not? So when my rates go up 39 percent, as our first panel said, we look at it and pretty soon it is going to be, can I afford it anymore or do I just drop it and hope I don't get sick?

Ms. BRALY. Which is why we are in the market saying we have to get to reducing healthcare costs, making sure people aren't getting unnecessary procedures or redundant procedures. We play that important role in healthcare. To eliminate us from the process eliminates the opportunity to get to that value equation. Without us——

Mr. STUPAK. I don't disagree with you, but for the average family, when they are sitting there and they are saying my rates just went up 39 percent or if you want to use your words, the average in your case, 25 percent, and man, I can't afford it anymore, it is as much as my house payment as the first panel said, and then I look at the end of the year and darn it, you made \$2.358 billion and the salaries are in millions of dollars for the executives, how

can I sustain that because I am the one who paid it, not them. And you are getting to the point where no one can afford it.

Ms. BRALY. And we are serving 34 million Americans across the country, and our goal and desire is to try to get for them affordable health benefits that they can continue to access, the quality care, the drugs that they need and want—

Mr. STUPAK. And it is not working when I came to Congress, like our first panel, small businesspeople, 64 percent of people had health insurance, would buy it. Now we are down to about 34 percent. That is why we have to do something on healthcare in this country because the cost is killing us.

Ms. BRALY. And that is why we—

Mr. STUPAK. And we are just going way over and arguing and probably getting outside the scope of this hearing.

Mr. BURGESS. Mr. Chairman, may I ask one last question of our witness?

Mr. STUPAK. Sure.

Mr. BURGESS. We have a vote in a few minutes on repeal of McCarren-Ferguson. Do you have an opinion as to whether or not that is going to bring down healthcare costs?

Ms. BRALY. You know, belief is it is not going to affect healthcare costs one way or another.

Mr. BURGESS. Is it going to affect your business? Is there any good reason not to do it?

Ms. BRALY. The unintended consequence that we worry about for the McCarren-Ferguson repeal is that there are initiatives to share data, with the evolution of health IT in particular. If we can address some of the quality opportunities through the sharing of data, we hate for those to be eliminated as part of this process.

Mr. BURGESS. But that would be true in anything, infection control ideas. Identifying and aggregating data is going to be critical in that.

Ms. BRALY. Exactly, and that is why as health IT advances and we are investing in that to make sure we can use that data as meaningful information, we would hate for that to be eliminated as an unintended consequence of that repeal.

Mr. BURGESS. What about professional baseball? Would there be any unintended consequences to—

Ms. BRALY. No consequence to us.

Mr. STUPAK. That is the Curt Flood case. You don't even want to go there. With that, let me conclude this panel and thank you both for being here and thank you for your testimony today.

Ms. BRALY. Thank you.

Ms. MILLER. Thank you.

Mr. STUPAK. That concludes all questioning. I want to thank all of our witnesses for coming today and for their testimony. The Committee rules provide that members have 10 days to submit additional questions for the record. I ask unanimous consent that the contents of our document binder be entered in the record, provided the Committee staff may redact any information that is business proprietary, relates to privacy concerns, or is law enforcement sensitive. Without objection, our document binder will be entered into the record.

Also, I ask unanimous consent, the letter from Mr. Dingell to the National Association of Insurance Commissioners and their response dated February 17, 2007, be submitted as part of the record. Without objection, documents will be entered in the record for Mr. Dingell.

[The information appears at the conclusion of the hearing.]

Mr. STUPAK. That concludes our hearing. This meeting of the Subcommittee is adjourned. Thank you all again.

[Whereupon, at 2:12 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

**Statement of
The Honorable John D. Dingell
Subcommittee on Oversight and Investigation Hearing on
“Premium Increases by Anthem Blue Cross in the
Individual Health Market”
February 24, 2010**

Mr. Chairman, thank you for holding this critically important oversight hearing today. I am very concerned about Anthem Blue Cross’s proposed rate increases in their individual policy market, in some cases up to 39 percent. If the rate increase goes into effect in May, enrollees will have to face a set of unconscionable choices: pay dramatically higher prices; switch to another policy that costs less, but probably does not cover the services they need; or drop coverage all together.

I am particularly looking forward to the testimony of the first panel of policy holders. Their stories are ones that will become all too familiar around the country if we do not press forward with comprehensive health care reform.

In fact, already the Anthem Blue Cross of California rate increase is not an isolated event. Just last week Health and Human Services Secretary Kathleen Sebelius released a report that shows similar rate increases in at least half-dozen other states.

The insurance industry, including the two panelists today, and those that defend them, say these rates are justifiable. There are those who blame the recession and regulation and try to paint these insurers as overburdened

good Samaritans promoting free enterprise while protecting the public's health and well-being.

Let's take a closer look at some of these assertions. Yes, we are in the midst of one of the worst recession since the Great Depression. However, Anthem Blue Cross of California had similar double-digit increases in 2005, well before the economy started to weaken. As premiums increased during the last decade, the generosity of these plans decreased, meaning people were paying more for less coverage.

Equally alarming, is the fact that the five largest for-profit insurers, including Wellpoint, the parent company of Anthem Blue Cross, earned \$12.2 billion last year. It was their most profitable year ever. There aren't many other American businesses who can say the same thing about their 2009 profits.

Many people, our Republican colleagues in particular, say that these increases are a symptom of over regulation. Yet, according to a February 18 *Time Magazine* article, "despite the fact that the state has some of the strongest consumer-protection laws in the country, California's regulations regarding the individual health insurance market are not very strict." Insurance companies in California do not have to seek the permission of the state's insurance commissioner to increase rates, and they only have to spend 70 percent of their premiums on claims.

In preparation for this hearing, I sent a letter to the National Association of Insurance Commissioners with questions about rate increases across the country, their causes, and the authorities each state has to prevent

them. What they highlight is an array of state policies, some that do a decent job of protecting consumers and others that practically give the insurance industry complete free reign. In their letter, NAIC also points out the benefit comprehensive health reform would provide with issues like the one we are here to discuss this morning. I would like to ask that my letter and the NAICs response be submitted for the record.

This is further example of why we must pass comprehensive health care reform legislation this year. The Democratic health care reform proposals would immediately put the brakes on these rate increases. For example, the President's proposed Health Insurance Rate Authority will provide assistance to states to help them review unreasonable rate increases. The new health insurance exchanges will create competition among the few insurers who dominate the marketplace, and finally, there will be an end to discrimination based on pre-existing conditions and arbitrary limits on coverage.

Those defending the companies just gloss over the lack of competition, the failure to contain costs, the obscene rate hike requests that exceed the rise of medical inflation – all standard business operations for insurers.

Without health care reform that protects the American people's hard-earned money from simply adding to record profits and covering astronomical overhead costs, the companies will continue to conduct business as usual – hiking premiums and shrinking benefits.

Thank you, Mr. Chairman. I yield back the balance of my time.

Energy and Commerce Hearing

Premium Increases by Anthem Blue Cross in the Individual Health Insurance Market

Opening Statement from Congressman Baron Hill

- I would like to thank the Chairman for organizing this hearing.
- This is certainly a timely and topical subject.
- While the focus of this particular hearing is centered upon rate increases in California, I would like to point out that thousands of Hoosiers, including many of my constituents, have WellPoint insurance and would be directly affected by rate increases.
- I know the Chairman is aware of a letter sent by some of my colleagues in the Indiana State government asking that my home state be included in this investigation and hearing.
- I would like to reiterate that call and hope we can have another meeting of this body regarding proposed rate hikes in Indiana at a later date.
- I, like many, was very taken aback by WellPoint Inc.'s announcement that the company plans to increase premiums by as much as thirty-nine percent on some Hoosiers.
- Thirty-nine percent. I'd like that to sink in for a second as I'm not entirely sure these CEOs know what a thirty-nine percent increase means for Hoosier families.
- It means a lot of them will have to drop the insurance they've dutifully paid into for years.
- It means a lot of them will have to go without necessary medical care.
- It means an added stressor onto already-maxed out family budgets.

- All this, while WellPoint racked up a \$2.7 billion profit in fourth quarter 2009.
- I would ask that the representatives from WellPoint appearing before us today please explain directly to my constituents in Southern Indiana why their insurer who pulled in nearly \$3 billion in profits in a single quarter last year are increasing premiums. Could you help me with that explanation please?
- In closing, I realize WellPoint is now reviewing the proposed changes in premiums, and I would ask that they abandon that plan entirely.
- With that, I understand that WellPoint has cited a weak economy as the reason for the rate hikes.
- I would ask the executives to consider why that same factor – a weak economy – would spell disaster for Hoosier policyholders who could see their premiums increase exponentially.
- Thank you for the time Mr. Chairman.

JOHN D. DINGELL
15TH DISTRICT, MICHIGAN
CHAIRMAN EMERITUS
COMMITTEE ON
ENERGY AND COMMERCE
CO-CHAIR
HOUSE GREAT LAKES
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Congress of the United States
House of Representatives
Washington, DC 20515-2215

February 17, 2010

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Dr. Therese M. Vaughan
Chief Executive Officer
National Association of Insurance Commissioners (NAIC)
444 North Capitol Street NW
Suite 701
Washington, DC 20001

Dear Dr. Vaughan:

The Energy and Commerce Subcommittee on Oversight and Investigations will convene a hearing on February 24, 2010, regarding reports that Anthem Blue Cross, a subsidiary of WellPoint, Inc., is increasing its premium rates by as much as 39% in the individual health insurance market in California. The size of the increase and the stated reasons for the increase has been concerning.

For the benefit of my colleagues and so that I may better understand the insurance rate increases across the country and their purported cause or causes, I request that the National Association of Insurance Commissioners (NAIC) answer the following questions in regards to the practices in each of the 50 states and the District of Columbia:

1. State health insurance commissioners play a critical role in the regulation of health insurance. They are the front line in preventing excessive increases. What is the current process states have in place for health insurance filing and rate review?
2. Do state insurance departments hold hearings during the rate filing and review process?
3. What is the history of rate increases requested and approved for all major health insurance carriers in the individual market during the past five years?
4. What authorities do state insurance commissioners have at their disposal to deny excessive health insurance rate increases?
5. What do state insurance commissioners do formally or informally to prevent excessive rate increases?

Dr. Therese M. Vaughan
February 17, 2010
Page 2

6. What are the underlying causes of the recent health insurance rate increases?
7. In your best professional judgment, do the state insurance commissioners have adequate resources and authorities to prevent the current pattern of rate increases?

Please submit your responses to my office **no later than Tuesday, February 23, 2010**. They will be invaluable in informing congressional hearings on and general debate of this matter. Should you have any questions, please feel free to contact me directly or have a member of your staff contact Virgil Miller or Katie Campbell in my office at 202-225-4071.

With every good wish,

Sincerely,


John D. Dingell
Member of Congress



February 23, 2010

The Honorable John Dingell
2328 Rayburn House Office Building
Washington, DC 20515

Dear Representative Dingell:

This letter is in response to your inquiry of February 17 regarding rising premiums in the individual health insurance market and state efforts to prevent excessive premium increases. State insurance regulators share your great concern over this very important and troubling issue. Most states do require insurers in the individual market to obtain prior approval of proposed rate increases before putting them into effect. This review is based on rigorous, objective actuarial analysis and objective, well-defined standards.

Individual health insurance, where approximately 9 percent of all Americans receive their coverage, is subject to all of the same cost pressures as other forms of health coverage. The rapid rate of health care spending growth continues unabated and places upward pressure on all types of coverage. Marketing, underwriting and administering policies is also much more expensive for insurers in the individual market than in the small- or large-group markets.

Because individuals purchasing insurance on their own must pay the entire premium, they are far more sensitive to premium increases than those who receive coverage from an employer that heavily subsidizes premiums. This greatly increases the volatility and risk of adverse selection that can drive up premiums in the individual market, as the first to drop coverage, particularly in difficult economic times, are the young and healthy who do not foresee an immediate need for medical care. As long as underlying health costs remain high, and individuals can opt in and out of coverage as their needs change, this will continue to be the case.

Because of the continued and persistent volatility of the individual market, the NAIC welcomes Congress' efforts to enact comprehensive health reform legislation. Health insurance exchanges have the potential to facilitate easier comparison of policies and reduce marketing costs associated with individual policies. Extending guaranteed issue and adjusted community rating to the individual market would make insurance more accessible and affordable for those with pre-existing conditions and would virtually eliminate underwriting expenses. Of course none of these reforms will be possible without an effective individual mandate and subsidies that would greatly reduce the volatility of the marketplace and mitigate adverse selection. We continue to support these efforts and to offer our experience and expertise to help reach this goal.

Rate Filing and Review

In 47 states and the District of Columbia, insurers are required to file individual market premiums with state insurance regulators (Attachment A). When filing rates, insurers will submit the base rate that they intend to charge for a given policy form. From this base rate, insurers will reduce or increase the premium charged a given individual using a risk classification system that adjusts for the individual's age, gender, health status and other factors, as permitted by state law. The rate filings would generally include risk classification relativities for age and gender, however factors to adjust for health status are not generally included in rate filings, but are subject to examination during a market conduct review.

In examining rates, actuaries working for the Department of Insurance will review them for compliance with statutory and regulatory requirements and will examine past loss and expense experience of the insurer to determine if the prospective rates are reasonable given the benefits included in the policy. They will also ensure that the prospective rates are sufficient to pay all expected claims and that they are not unfairly discriminatory to any individual or group of individuals. They will also examine the insurer's assumptions, such as the expected growth of medical costs and expected changes in the health of those enrolled in the policy. Many states will also examine the proposed rates to ensure that the policy meets or exceeds the state's minimum loss ratio requirements. If the state determines that the proposed rate does not meet its requirements, it can deny the rate outright or propose a lower level of increase.

Of the states that require individual market rates to be filed, 28 states and the District of Columbia require "prior approval." In many cases, if the Commissioner has not taken action within a certain number of days, the rate filing will be deemed approved. In some cases, certain rates are exempted from filing, such as if rates are not increasing by more than 10 percent. In addition to those states requiring prior approval of rates, 12 have "file and use" requirements. In these states, rates must be filed with regulators prior to their use, and regulators may have authority to deny an insurer's ability to implement these rates. The remainder of states either has "use and file" requirements, require filings for informational purposes only, or only require rates to be submitted with policy forms (the contract that states the benefits, terms, and conditions of policies).

Rate Review Hearings

Many state regulators do have the option to hold public hearings to examine proposed premium increases by health insurers, the NAIC does not have information on the exact number of states that hold hearings. In addition, in many states, insurers are permitted to challenge the denial of a proposed rate increase in a public hearing. We are currently surveying our members on a number of issues, including this one, and will provide you with this information as soon as we have the results. In general, however, public hearings can help provide additional transparency to the process and can help educate the public on this issue.

History of Rate Increases for Major Insurers

The NAIC does not collect national data on premium increases or requests, and is therefore unable to provide the requested historical information. We did, however, conduct an informal survey of the states in October 2009 regarding premium increases in the small group market, in which we asked whether they were seeing similar trends in the individual market. (Attachment B) Of the 16 states that responded to this question, seven reported that premiums in the individual market were increasing at a faster rate than in the small group market. Two states reported that premiums were increasing more slowly in the individual market and the remaining seven reported that trends were similar to those in the small group market. A number of states cited specific premium increase requests in their survey responses:

- Iowa reported an average increase of 12.4 percent for 2009, approximately in line with recent years. State regulators were successful in reducing approximately 50 percent of major medical premium filings.
- Maryland reported requested increases ranging from 7 percent to 24 percent in the individual market.
- Minnesota reported increases ranging from 7 percent-10 percent
- New Mexico reported premium increases that are notably higher in the individual market than in the small group market. One request for an increase of 36.4 percent was modified to 24 percent, while another was reduced from 27 percent to 8 percent.
- Oregon reported that the average requested increase in the individual market was 17.9 percent. Some filings were approved, but others were negotiated down to lower rates, and two were denied.
- Pennsylvania reported premium increases substantially higher than historical patterns would indicate. The three largest carriers in the state requested increases ranging from the high teens to as much as 50 percent. The Department challenged these requests, and the insurers reduced them to less than 10 percent.
- Vermont reported increases below 1 percent in the individual market.
- West Virginia reported that one major carrier slightly decreased premiums, while the other increased them by 16.3 percent.

Authority to Deny Excessive Rate Increases

The authority to deny excessive premium increases varies from state to state, but in every state where that authority does exist, regulators must demonstrate that premiums are not actuarially justified. This normally requires regulators to show that the insurer's medical loss ratio has fallen to an unacceptable level, that the projected increase in premium does not match the projected medical trend for the policy, that the insurer is holding excessive reserves, or that the insurer's assumptions are faulty. Regulators cannot, however, deny premium increases merely because they "seem" too high. While high premiums are undoubtedly a major burden for consumers, and something that we must all be vigilant about, insurers must collect premiums that are sufficient to pay all claims under the policy and maintain sufficient capital reserves to meet legal solvency requirements. For this reason, rate review must be an objective process, guided by actuarial science, careful analysis and defined, well-understood standards.

Formal and Informal Efforts to Prevent Excessive Increases

States have relied upon a number of different strategies to prevent excessive premium increases in the individual market. As I have noted, nearly every state requires rates to be filed by insurers, and a majority do require prior approval of rates. In addition to these efforts, some states have attempted to combat the deterioration of particular blocks of business by limiting the variation between blocks attributed to experience, policy duration, and health status. As a result, the insurer will not be able to isolate poor risk in a single block of business with rapid premium increases because they would be required to raise premiums on a better performing block to comply with the limits on variation between blocks.

Underlying Causes of Premium Increases

As noted above, individual market policies are subject to the same cost pressures as policies in the large- and small-group markets. In our experience, the single most significant contributor to rising health insurance premiums has clearly been the continued growth of health care spending in the United States. This growth affects all types of coverage: group, individual, and government-sponsored plans. Medical technology continues to advance at an amazing pace, bringing lifesaving treatments that are nevertheless very expensive. Multiple treatments for once incurable diseases are now available, which are administered over long periods of time by subspecialists, where less than a generation ago a primary care practitioner would have provided palliative care over a short period of time. Obesity continues to grow at an alarming rate, particularly among the youngest Americans, bring diagnoses of type-2 diabetes at once unimaginable ages. Smoking, while not as prevalent as it once was, still continues to cause serious health problems and add to our national health care expenditures. While rate review can help keep insurers focused on constraining the growth of these costs, it cannot fundamentally address the growth of health care costs, which must be addressed through payment reform, delivery system changes, an emphasis on prevention, and consumer engagement.

In addition to the underlying growth of health care spending, individual market policies are subject to much higher risks of adverse selection than group plans, for the reasons that were explained above. In weak economic times, young and healthy individuals tend to drop or reduce coverage at greater rates than older and sicker individuals, leaving risk pools with higher average costs. This adverse selection compounds the effects of high medical trend costs.

Further compounding cost growth, individuals whose personal characteristics change prior to policy renewal might have larger premium increases. The most significant factor in this regard will be an individual's age, which can cause premiums to vary in the individual market by a factor of 6:1. Insurers typically use bands to apply age rating, and when an individual moves from one age band to the next, their premiums will increase.

Finally, over time the experience of a particular block of business, or policy form, can deteriorate as the healthier enrollees who can pass medical underwriting for another policy change coverage to get a lower premiums. Those left behind, who because of pre-existing conditions cannot change their coverage, face an ongoing spiral of higher premiums. As I have mentioned above, states have attempted to address this problem.

These problems have affected other types of individual policies, such as Medicare Supplement and Medicare Advantage policies, as well. A study released just last week found that if a beneficiary in a federally-regulated Medicare Advantage plan remained in the same plan between 2009 and 2010, their premium would have increased by 22 percent on average across all plans, by 26 percent for private fee-for-service plans, and by 76 percent for regional PPO plans.

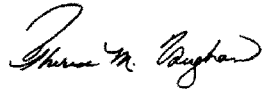
All of these underlying issues, however, are very difficult to address, especially in the individual market, without an effective individual mandate and subsidies. We remain hopeful that comprehensive health reform, which would help address each of these factors, will be signed into law this year.

Adequacy of Authority to Prevent Premium Increases

As I noted above, there is some variation in the extent of authority that states have to deny rate changes. The NAIC worked with the administration and Members of Congress during development of the health reform bills to draft provisions that would encourage all states to grant regulators greater authority to disapprove excessive rates. These provisions would also have provided additional resources to the states to review rates, which can be a very labor intensive and expensive process. Even paying salaries that are well below market rates for actuaries, the California Department of Insurance estimates that adding prior approval of premiums would cost that state alone at least \$15 million per year, with additional start-up costs in the early years. We continue to support these provisions, but would also note that it is crucial that authority to regulate rates at the state level be preserved. Providing the federal government with authority to override state regulatory determinations on rates while solvency regulation remains at the state level risks uncoordinated financial regulation that would greatly increase the risk of insurer insolvency without providing additional protection for consumers. As I noted above, even with a complex bidding process designed to keep Medicare Advantage premiums in check, premiums for seniors in those plans have grown at rates equal to or greater than those in the individual market.

Thank you for the opportunity to comment on this troubling issue. Insurer solvency has been, and must continue to be our primary concern, for, as painful as high premiums are, the pain of finding oneself unprotected because of an insurer has gone insolvent is much worse. State regulators are nonetheless painfully aware of the impossible situation that high premiums in the individual market cause for millions of Americans. At the end of the day, however, while rate review authority is an important tool for regulators, and can help keep insurance companies honest, it can do nothing to reduce claims expenses, which are the biggest component of the premium dollar. I hope that this information has been helpful to you. Please do not hesitate to call upon us if you have additional questions or if we can be of additional assistance.

Sincerely,



Therese M. Vaughan, Ph.D.
CEO
National Association of Insurance Commissioners

ATTACHMENT A-NAIC Form and Rate Filing Chart

NAIC's Compendium of State Laws on Insurance Topics

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The date following each state indicates the last time information for the state was reviewed/changed.

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
AL (2/09)	§ 27-14-8; Ins. Reg. 482-1-024	Prior approval (30 day deemer)		Filing required for informational purposes only.	Accident & Health
AK (2/09)	§§ 21.42.120, 21.42.123, 21.42.125, 21.09.270, 21.39.040, 21.39.210 Order 83-1(exempts certain forms)	File and use with 30 day waiting period with compliance certificate; Prior approval (30 day deemer) without compliance certificate.	Retaliatory	Prior approval; file and use if change is no greater than 10%.	Each Insurer
AZ (2/09)	§ 20-1110 Reg. 20-6-607	Prior approval (30 day deemer)		Filed for review (HCSO and group health forms are not filed).	Individual Health
AR (2/09)	§ 23-79-109; AR Ins. Rule & Reg. 57	Prior approval (30 day deemer)	\$50 policy, rider, application, per submission; \$20 for each rider, application or endorsement filed separately; \$20 for corrections in previously filed forms. \$50 for each rate filing.	Prior approval (30 day deemer)	Individual Health

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CA (2/09)	Ins. §§ 795.5, 10290, 10236.13; Ca. Admin. Code tit. 10 § 2202	Prior approval (30 day deemer)	Indiv./Group Health, Long Term Care: \$580 Policy; \$130 Rider; \$130 New Issue Rate; \$170 Rate Increase. Medicare Supp.: \$330 Policy; \$60 Rider; \$130 Rates; \$130 Rate Increase.	File	Individual Health and Group Health, Medical Supplement, Credit Health
CO (2/09)	§§ 10-16-107, 10-16-107.2, 10-10-109; Ins. Reg. 1-1-6; 4-2-11, 4-4-2; CO Bulletin B-4.18 § 10-16-321; Ins. Reg. 4-3-1	Prior approval	Included in general fee for services.	Prior Approval Prior Approval (60 day deemer); no need for approval if no increase requested (file and use). Prior Approval (30 day deemer)	Long Term Care All Health including Long Term Care and Credit Life and Disability. Medicare Supplement

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CT (2/09)	§§ 38a-182, 38a-183, 38a-474, 38a-481, 38a-513; Reg. 38a-652; Reg. 38a-481-1 to 38a-481-4	Prior approval	Retaliatory	File and use Prior approval (45 days) Prior approval (30 day deemer)	Group LTC credit HMOs, med. supp., credit health Individual health except as noted above.
DE (2/09)	tit. 18 §§ 701, 2504, 2712, 3333	Prior approval (30 day deemer)	\$50 policies, riders applications, endorsements \$50 rate changes	File and use (45 days)	All Health including Med Supp., LTC, HMOs, Health Service Corps.
DC (2/09)	§§ 31-4712, 31-3508 § 31-3109	Prior approval (30 day deemer)		Prior approval (30 day deemer) File and Use (60 day review) Prior approval (90 day deemer)	Individual Accident and Sickness Hospital & Medical Services Subscriber Contracts Health products with mental illness benefit; drug or alcohol abuse
FL (2/09)	§ 627.410	Prior approval (30 day deemer)		Prior approval (30 day deemer)	All Health

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GA (2/09)	§ 33-24-9, 33-8-1, 35-57-5; Reg. 120-2-10-.06, Reg. 120-2-25 (specifies limited exemptions from filings); § 33-57-5; GA Bulletin L&H-2	Prior approval (90 day deemer but could be extended for additional 90 days)	\$25 form \$75 rate	Information filing required for any rate increase or new program; increases must also be filed with Consumer's Insurance Advocate.	All Health
HI (2/09)	§§ 431:10A-113, 431:10A- 309 § 431:14G-105	File—individual health Prior approval—med. supp.	\$20 per form \$50 per rate filing \$20 for form and rate filing	Annual compliance filing Prior approval	Approved plans All managed care plans
ID (2/09)	§§ 41-1812, 41-2136; Ins. Reg. 18.01.44 §§ 011, 040	File and use, certification required	For rate and form filings not filed with SERFF and in excess of 10 per calendar year, \$20 for each rate or form.	File and use, certification required.	Individual Health
IL (2/09)	215 ILCS 5/143, 5/355, 5/408; Reg. tit. 50 § 916.40	Prior approval	\$50 per form; \$200 per form for advisory and ratings orgs.	Rate filing shall be submitted with policy form filing.	Individual Health; Group Medicare supplement; Individual and Group Long Term Care

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IN (2/09)	§ 27-8-5-1	Prior approval (30 day deemer)	\$35	File and use (30 days)	Group Health
	§ 27-13-7-11	Prior approval (30 day deemer)	\$35	Prior approval (30 day deemer)	Individual Health
	§§27-13-20-1 to 27-13-20-2	Prior approval	\$35	Prior approval	HMOs
	§ 27-1-3-15				
IA (2/09)	§§ 514A.13; Reg. 191-30.5, 191-36.9	Prior approval (30 day deemer and 60 days prior to effective date)		Prior approval (30 day deemer and 60 days prior to effective date)	All Health
KS (2/09)	§§ 40-216, 40-2215	Prior approval (30 day deemer)		File and use	Individual and Group Health
KY (2/09)	§§ 304.14-120, 304.17-380, 304.17-383, 304.17A-095; Reg. 806 KAR §§ 14:007, 15:150, 4:010	Prior approval (60 day deemer)	\$100; \$5 all other forms	File and use	All Health

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LA (2/09)	§§ 22:211, 22:620, 22:972; Reg. 78; §10107 (37:XIII.10107) § 22:1078, Reg. 33 §545 and 550 (37:XIII.545 and 550) Reg. 46 § 1917 and 1937 (37:XIII.1917 and 1937)	Prior approval (45 day deemer) Prior approval (45 day deemer) Prior approval (45 day deemer)	\$100 per company per product for insurance policy filings Rates - \$100 per company per type of standard benefit plan No filing fees required for rate for Long Term Care	File and use (30 day deemer) Prior approval	All Health Long term care
ME (2/09)	tit. 24-A §§ 601, 2412, 2736, 2802, 5004, 5011, 5075-A; Ins. Reg. ch. 940, 755, 275, 425, 140; Bulletin 146, 325, 326 and 337	Prior approval (30 day deemer)	Cannot exceed \$20 per rate or form filing	Prior approval	All individual health insurance, group long term care and group Medicare supplement. Also applies to small employer medical plans unless written on an optional "guaranteed loss ratio" basis (used by most plans) under which rates do not require approval but refunds are required if the loss ratio is below 78%
MD (2/09)	Ins. §§ 12-203, 12-205, 2-112; Reg. 31.10.01.02, 31.10.01.02A, 31.04.17	Prior approval (60 day deemer)	\$125 per form and rate	Prior approval (90 days for changes)	All health

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MA (2/09)	§ 175:110; Reg. 801 CMR 4.02	No filing required	\$75 per form \$150 per rate	No filing required	Health group
	§ 176J: 3; Reg. 211 CMR 66.13	File and use		No rate filing, actuarial certification required	Small group
	§§ 176:4 to 176:5; Reg. 211 CMR 41.00	Prior approval (standard plan)		Prior approval	Non-group

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MI (2/09)	§§ 500.2236, 500.2242(a), 500.3474 Reg. 500.801 to 500.806; Order 97-010-M	Prior approval (30 day deemer)	None	File and use	Individual Health
MN (2/09)	§§ 62A.02, 60A.14 § 62A.02, Subd 2(b)	Prior approval (60 day deemer)	\$90 per rate or form filing; \$75 per form or rate if filed electronically	Prior approval (60 day deemer) File and use	All policies Rates related to accident & sickness as defined in §62A.01. Does not include Medicare-related coverage.
MS (2/09)	§ 83-9-3; Ins. Reg. A&H 73-4	Prior approval	\$15 policy \$10 rider, endorsement \$10 application	Prior approval Filed for review and acknowledgment	Med. Supp. and LTC Other Health
MO (2/09)	§§ 376.405, 376.777.7, 354.150, 354.495; Reg. tit. 20 § 400-8.200	Prior approval (60 day deemer)	\$50	No provision	
MT (2/09)	§§ 33-2-708, 33-2-709, 33-1-501; MT ADC 6.6.508A, 6.6.1107	Prior approval (60 day deemer) Prior approval for Medicare Supplement	No fees for filing forms or rates	Prior approval for rates higher than those established. Rates must be accepted prior to use.	Credit insurance Med. Supp.

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NE (2/09)	§ 44-710; Reg. tit. 20 ch. 009	Prior approval	Retaliatory	Rate schedules shall be filed with policy forms.	All other Health
	§44-4501; Reg. tit. 210 ch. 46	Prior approval			Long Term Care
	Reg. tit. 210 ch. 36	Prior approval		Prior approval	Med. Supp.
	NE Bulletin CB-50				
NV (2/09)	§§ 680B.010, 687B.120, 689A.360, 680B.010; NV ADC 687B.229	Prior approval (45 day deemer)	\$25 rates and policy \$10 rider or endorsement	File and use Prior approval	Individual Health Medicare Supplement
NH (2/09)	§§ 415:1, 415:18, 400-A:35; Reg. Ins. 401.02, 401.03	Prior approval (30 day deemer)	Retaliatory	Prior approval (30 day deemer)	All individual health, group med supp., LTC, small employer medical, hospital or surgical
				File and use (30 days)	All other group health
NJ (2/09)	§§ 17B:26-1, 17B:27-25, 17B:27-49, 17B:27E-11, 17B:27-74; Reg. 11:4-16, 11:4-18, 11:4-40	Prior approval (60 day deemer. Re-submission - 30 day deemer) Option to file and use available for certain forms		Prior approval (60 day deemer. Resubmission - 30 day deemer)	Individual Health, LTC
NM (2/09)	§§ 59A-18-12, 59A-18-13, 59A-6-1	Prior approval (60 days)	\$30 policy package \$15 incidental forms \$50 rate filing	Prior approval (60 day notice to policy holder)	All Health

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NY (2/09)	Ins. Law §§ 3201, 4308, 4235(h); 11 NYCRR 52.40	Prior approval (90 day deemer)	None	Prior approval	Individual health and group and blanket forms where jurisdiction applies
NC (2/09)	§§ 58-6-5, 58-51-85, 58-51-95, 58-65-40, 58-68-45, 58-67-50	Prior approval (90 day deemer) HSCO – Prior approval (within reasonable time)	None	Prior approval (all individual rate revisions, group med. Supp., medical service corp. rates)	All Health
ND (2/09)	§§ 26.1-11-06, 26.1-30-19 to 26.1-30-20	Prior approval (60 day deemer)	Retaliatory	Prior approval (60 day deemer)	All Health
OH (2/09)	§§ 3923.02, 3923.021; OH ADC 3901-1-57	Prior approval (30 day deemer)	\$50 forms; no fee for rate filings	Prior approval (30 day deemer)	All Health
OK (2/09)	tit. 36 §§ 321, 3610, 4402, OK ADC 365:10-5-63, 365:10-5-47.1	Prior approval (30/60 day deemer depending on type of filing)	\$50 policy or retaliatory if higher \$25 rider or retaliatory if higher	Rates filed with form.	All Health, Credit Life and Health

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OR (2/09)	§§ 742.003, 746.005, 743.018, 743.730(17)(27)(28), 743.737, 743.760, Reg. 836-010-0011	Prior approval (30 day decmer)		Prior approval	Individual and groups, except groups with more than 50 lives
	§ 836-052-0114	Prior approval		Prior approval	Medicare supp., except specific groups under Reg. 836-052-0114(5)
	§ 836-060-0043			Prior approval (for deviations from prima facie)	Credit life and health
	§ 836-060-0026 to 836-060-0031			File and use (for statutory prima facie)	Credit life and health
	Reg. 836-052-0510	Prior approval			Long term care individuals and groups

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PA (2/09)	§§ 40-18-3809, 40-18-3803; 49 P.S. § 50	Prior approval (30 day deemer)	Retaliatory	Prior approval (45 day deemer)	All Health; some group exempt if meet requirements
RJ (2/09)	§§ 27-18-8, 42-14-18, Reg. R27-23-1101 to R27-23-1102, R27-23-1106 to 27-23-1107	Prior approval (60 day deemer)	\$40 policy and related forms filed together; \$25 revised rate or form; retaliatory on fee-by-fee basis.	Prior approval (60 day deemer)	All Health
SC (2/09)	§§ 38-71-310, 38-71-720; Reg. 69-46; Bulletin 2-93	Prior approval (30 day deemer)		Prior approval (90 day deemer)	Individual Health, Group Med. Supp.
SD (2/09)	§§ 58-11-12, 58-11-17, 58-17-4.1	Prior approval (30 day deemer)		File and use (30 day deemer)	Individual health
TN (2/09)	§§ 56-26-102; Reg. ch. 0780-1-20	Prior approval (30 day deemer)		Prior approval (30 day deemer)	All health except experience rated groups
TX (2/09)	Reg. 28 TAC 3.1, 3.4; Ins. §§ 11153.051, 1701.051 to 1701.054	File and Use with certificate of compliance; Prior Approval without certificate (60 day deemer).	\$50 exempt from review; \$100 not exempt.	File and Use	Individual Health, Long Term Care, Credit Life, Accident and Health, Med. Supp.
UT (2/09)	§ 31A-21-201, 31A-3-103, 31a-3-108; Reg. R590-220	File and use	Included in annual fee	File and use	Individual health, med. Supp., long term care, health benefit plans

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HEALTH INSURANCE FORMS AND RATES

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
VT (2/09)	Ins. Reg. 93-5: tit. 8 §4062	Prior approval (30 day deemer)		Prior approval (30 day deemer)	All health
VA (2/09)	§ 38.2-316; Reg. 14 VAC 5-100-10 to 5-100-80; Reg. 14 VAC 5-130-10 et. seq.; 14 VAC 5-170-120, 14 VAC 5-200-77; 150 and 153	Prior approval (30 day deemer)		File and receive acknowledgment Prior approval	Group health Individual health, all med. supp.
WA (2/09)	§ 48.44.020 § 48.46.060 §§ 48.18.100, 48.18.010, 48.19.010, 48.20.025, 48.21.045, 48.66.035, 48.44.017, 48.44.023, 48.46.062, 48.46.066	File and use File and use Prior approval (30 day deemer)	No fee No fee No fee	Prior approval (60 day deemer) Prior approval (60 day deemer) Prior approval (30 day deemer) Prior approval (60 day deemer) File and use (subject to disapproval)	Healthcare service contractor, large group HMO large group Small group health plan rate changes, med. supp Individual health plan All other health
WV (2/09)	§§ 33-6-8, 33-6-34, 33-16B-1; 114 CSR 26-3 § 33-6-8(b)(2)	Prior approval (60 day deemer) File and use (30 day disapproval)	\$50 per form \$75 per rate	Prior approval (60 day deemer); Rate filings required for new products or rate changes; rate filings shall be filed with forms.	All health Mass-marketed Health

ATTACHMENT A-NAIC Form and Rate Filing Chart

NAIC's Compendium of State Laws on Insurance Topics

FILING REQUIREMENTS

HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
WI (2/09)	§§ 625.13, 631.20; WI Bulletin 4-28-2008; Reg. § INS 6.05	Prior approval (30 day deemer); May file and use with certification; does not apply to long-term care or Medicare Supplement.	None	Use and file (30 days)	Individual health
WY (2/09)	§§ 26-15-110, 26-18-135	Prior approval (45 day deemer)	No fee	File and use	Disability

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the statutes and regulations cited should be consulted. The NAIC attempts to provide current information; however, readers should consult state law for additional adoptions.

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ATTACHMENT B-NAIC Survey on Small Group Premium Increases

Questions	OH	ME	WA	CT	MD	MN	OR
What has your state seen thus far in the rate filings for small business plans? What companies are asking for increases, on what products, how much?	10% to 15%	Average increases are 21%, up from 15% in 2009. Averages by company group: Anthem 20% Aetna 25% Harvard Pilgrim 13%	Regence BlueShield): 13.6%. Asuris NW Health: 13.6%. Group Health Cooperative: 12.7%. (With benefit reduction: 9.6 %.) Group Health Options: 19.8%. (With benefit reduction: 14.6 %.) Regence BlueCross BlueShield of Oregon: 19.5% Kaiser Permanente Health of the NW: 9.8% KPS Health Plan: 10.4% Providence Health Plan: 9.6% PacifiCare of Washington: Negative 10.0%.	14.5% for the HMO small group market.	The top 10 carriers = 15.6% renewal rate increase with a range from 8% to 25% for the 1st quarter of 2010. That compares to an average 16.3% renewal increase with a range from 11% to 25% for the 4th quarter of 2009 (eg.10/2009 over 10/2008). The dominant insurer = 14% with a range from 3% to 25% depending on particular benefit design. HSAs will see renewal increase from 19% to 25% while the more traditional product designs will see renewals from just 3% to 11%.	7-10% The rate increases on high-deductible plans are somewhat higher, maybe 12-15%. .	Ranging from (-5.4) percent to 14.10 percent. Excluding one rate decrease, the average increase is 11.9 percent. The majority of rate increases approved are less than the increase in medical and prescription costs (trend).

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What justifications are companies using for the rate increases? What factors are driving insurance rate increases in your state?	Trend Wearing off of underwriting Higher loss ratio than expected	If loss ratios are less than 78%, premium refunds are required, so justification not required. Increase in cost and utilization.	Medical and drug trend (mid-teens) Utilization Employee costs Mandated benefits (organ transplant and chemical dependency)	Increased utilization Cost trend New mandates or adjustment to current mandates H1N1 costs	Poor past experience due to higher claim costs than expected. Underestimation of annual claim cost trends. Higher utilization, particularly for the high deductible/HSA plans Loss of membership.	Utilization Cost trend	Utilization Trend Membership losses Cost containment: improve provider contracting, direct patients to most appropriate settings, disease and chronic case management, and higher deductible plans.
How are medical loss ratios expected to be impacted by the rate increases?	Ohio does not allow carriers to recoup past losses with a rate increase request.	Major carriers are subject to a guaranteed loss ratio requirement.	Most carriers have the anticipated (or expected) loss ratios around 80%.	Medical loss ratios would be expected to stay the same or increase slightly.	Maryland requires a 75% minimum loss ratio on small group business. Many have exceeded that amount in recent years.	Medical loss ratios should stay about the same.	The average medical loss ratio grew from 86.98 percent in 2007 to 87.9 percent in 2008. Expected higher in 2009.
What actions have been taken by the state in response to the rate increases? Have any been denied or modified?	More information if not found reasonable. Disapprove if not justified. Cannot disapprove small group, but can discuss with	A closed block of about 2,500 lives that has not guaranteed the loss ratio has filed for a 33% increase for a catastrophic medical plan. The AG requested a public hearing	We have not denied any 2010 rate increases in the small group market yet. A few carriers did request an increase lower than the increase projected in the rate filing.	Currently two requested increases for small group premium increases have been modified lower.	Subject to prior approval. After actuarial review, some filings are amended to an MIA disapproval or a reduction in the filed/proposed rate increase.	In past years, some have been denied or modified. This year none have been denied or modified.	Approved without modification.

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Questions	OH	ME	WA	CT	MD	MN	OR
	carrier and work to improve request.	on this and it is scheduled for February 25.					
Have similar rate increases been requested for the individual market?	Generally higher, but justified.	Yes. The following average increases have been proposed in the individual market: Anthem 22.9% MEGA 12.5% Hearings are scheduled on these proposals.	So far, we have only one carrier that has a 5.1% rate change with an effective date of 1/1/2010 for its individual line of business. =	To date, individual rate increase requests have been higher than what is being seen in the small employer market place.	The renewal rate increases will range from 7% to 24% but most individual policyholders will be concentrated around either 15% or 24% rate increases (1/2010 over 1/2009). All proposed increases in the individual market are also subject to prior approval by the MIA with the requisite actuarial justification.	Yes, rate increases of 7-10% are common in the individual market, and somewhat higher for high-deductible plans. Rates cannot change due to the emergence of health conditions, so the trend increase plus any increase in age gives the actual premium increase.	Somewhat higher; ranging from 9.6 percent to 25.8 percent. The average requested increase is 17.9 percent compared to the 11.9 percent average for the small employer rates. The Department has approved some of these filings as submitted, approved some that were modified to a lower amount, and disapproved two of these filings.

ATTACHMENT B-NAIC Survey on Small Group Premium Increases

Questions	KS	RI	PA	IA	WV	FL	MS
What has your state seen thus far in the rate filings for small business plans? What companies are asking for increases, on what products, how much?	Low single digits up to about 13%	13 to 16 percent increase requested in May Tufts – a new entrant - asked for 9.5%	One HMO requested a rate increase of 5.5% on an HMO product (less than 51 subscribers) which was approved as submitted. Currently a 13% rate increase request for a small group product with fewer than 300 subscribers is pending before the Department .	Average of 13%	Mountain State Blue Cross Blue Shield = 7%. Coventry Health and Life Insurance Company and Carelink Health Plans, Inc. (HMO) = decrease of 0.3%. United Healthcare = 6%. Health Plan of the Upper Ohio Valley (HMO) = 1.2%.	Carriers have been requesting increases close to medical trend = 11-14%	Blue Cross = decrease. Humana = 20% for new group. Humana = 25% for group renewals. Humana = 3.6% for individual. United HealthCare = 5% reduction for small group.
What justifications are companies using for the rate increases? What factors are driving insurance rate increases in your state?	Medical trend Network revisions Pool experience	Administrative costs Hospital pricing Specialty utilization	Medical trend Provider contract negotiations Change in mix of business Aging population.	More mandates Utilization Medical trend	Medical trend Utilization Demographics and claims experience Duration of coverage in the individual market.	Companies are using actual experience to justify the proposed rate increases.	Medical trend Increasing loss ratio Utilization
How are medical loss ratios expected to be impacted by the rate increases?	The rate increases appear to be an effort to maintain their original anticipated				Majority of the insurers are in excess of the minimum of 73%	The changes requested typically bring the actual loss ratio closer to the	We except loss ratios to moderate, but do not expect them to necessarily

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Questions	KS	RI	PA	IA	WV	FL	MS
	lifetime loss ratios.					target.	decrease to any material degree.
What actions have been taken by the state in response to the rate increases? Have any been denied or modified?	No specific actions have been taken to modify the filed rate increases.	Carriers told to withdraw for 6 months or go to hearing. Tufts re-filed at 8.5, the others chose to wait.			We have not denied or modified any requested rate adjustment since the insurers have not requested excessive	Justified rate changes have been approved.	The Department often negotiates for lower rates regardless of the requested increase, and has had success in doing so.
Have similar rate increases been requested for the individual market?	Slightly higher, up to about 18%. Kansas routinely seeks additional information from the companies to justify the rates requested and negotiates with the companies to modify the amount requested.		Substantially higher than historical patterns would indicate. Three largest health carriers in the state = high teens and the 20% to 30% range, with some requests as high as 50%. The Department challenged requests. The companies reduced increases to less than 10%.		Mountain State Blue Cross Shield submitted filings a slight rate decrease. Assurant Health recently increased their premiums for 2010 by approximately 16.3 %.	Yes, similar increases have been requested for the individual market.	We are not seeing abnormal increase requests in the individual market, and most are less than 25% (see above). As with small groups, we try to negotiate the requested rates as low as possible.

Questions	VT	ND	OK	CO	NH	NM	NY
What has your state seen thus far in the rate filings for small business plans?	Vermont has three carriers authorized to sell	There has not been a noticeable increase in the	Company A = 1% increase over the 4th quarter 2009.	Increases of 0-20% in the small group market.	One carrier, a NH start-up, had been pricing its	Requested rate changes range from (-1.2%) to	15-20%, which is slightly more than last year

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Questions	VT	ND	OK	CO	NH	NM	NY
What companies are asking for increases, on what products, how much?	in the small group market: Blue Cross Blue Shield of Vermont, CIGNA and MVP. Rate requests of have ranged from negative 5% to 35.7%.	rate increases requested. Only one of these companies had requested an increase (11.4%).	Total request for 2010 of 10%. Company B = overall rate decrease 5%. Company C = overall rate impact of 0% with a maximum change of +10% and a minimum change of -4%. Company D = 4% increase effective 1Q 2010.	Average of 9%.	products based on consultant data. Now that they have some experience, which is worse than expected, they are including an additional 15% experience adjustment in their rates. This means this one company's rates will be going up 30%.	9%.	
What justifications are companies using for the rate increases? What factors are driving insurance rate increases in your state?	Poor claims experience Medical trend Administrative cost increases New mandated coverage's.	Medical trend, driven primarily by inflation and utilization.		Medical trend Attain or maintain MLR target.	Claim costs and claim cost trends that are running at between 10 and 15%.	Medical trend Deductibles Aging of the pool Mental Health Parity coverage	Increased assessments from last year (1-3%) Utilization due to fear of losing their coverage Medical trend
How are medical loss ratios expected to be impacted by the rate increases?	We have not seen any trend to decrease medical loss ratios in filings. In general, medical loss ratios have been steady.			No impact – attain or stay at MLR target.	They're not expected to change at all.	Minimal impact in the first year	
What actions have been	The Department	Department		Most are	So far, they are	Some modified	

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Questions	VT	ND	OK	CO	NH	NM	NY
taken by the state in response to the rate increases? Have any been denied or modified?	denied a 35.7% rate increase because of "rate shock" and an atypical spike in claims supporting the rate increase. The Department denied a 10.0% rate increase after the actuarial opinion determined that the company's allowance for the State's new colonoscopy mandate was unreasonable. The Company amended its rate filing as recommended by the Department to a 1.0% increase.	approved 7.9% for the company that requested 11.4%.		approved, others are in process.	being approved as filed. The Department did not find sufficient information that would be it in a position to disapprove any filing.	for age factor to allow approval	
Have similar rate increases been requested for the individual market?	The range of rate increases has been significantly lower. (0% and 1.0%) In Catamount, rates have not increased for two years.	Have not noticed differences in the rate increases for individual products, but that could happen in the near future.		Similar or slightly higher.	Yes, similar trends.	Notably higher -- ranging from 3% to 36.4%. One request was modified from 36.4% to 24%. Another was modified from 27% to 8%.	