

Exhibit A



April 1, 2013

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Joe Barton
Chairman Emeritus
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight & Investigations
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Marsha Blackburn
Vice Chairman
Subcommittee on Oversight & Investigations
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Michael C. Burgess, M.D.
Vice Chairman
Subcommittee on Health
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen and Vice Chairmen:

This letter responds to your correspondence of March 14, 2013, to   asking for information about the impact of the Affordable Care Act on health care premiums. Like the Members of the House Energy & Commerce Committee and so many other Americans, we have significant concerns about rising health care costs and their impact on the affordability for the businesses and individuals who rely on our insurance products for their health coverage needs. The Patient Protection and Affordable Care Act (PPACA) contains provisions to expand access to health coverage to many new populations and individuals, but it also imposes many new mandates and requirements on health insurers, new taxes and fees, and mandated benefits that will increase overall health costs, which is of significant concern to 

The following section addresses the specific questions posed by the Committee to [REDACTED] and provides additional information.

- 1. Since the passage of the PPACA, has your company done any analysis of the effect of the law on premiums generally, including analyses on the effect of the PPACA on premiums in the individual market, the small group market, or large group market, either nationally or by State? If so, please provide any documents setting forth this analysis.***

[REDACTED] has not completed any analysis of the effect of the law on premiums generally or more targeted analyses on the specific market segments and geographies identified in Question 1. Our analyses are ongoing and evolving, given our local and regional health plan footprint and the rolling implementation of so many new PPACA requirements. However, we are keenly aware that the provisions in the PPACA have added costs to our health plan products—and therefore increased the premiums we must charge to meet actuarial soundness standards and requirements—since the law’s enactment in March 2010.

Starting with plan years on or after September 23, 2010, all health insurers were required to provide coverage for preventive services at no cost sharing to enrolled members. [REDACTED] recognizes the value of prevention and ensuring that our members get timely access to evidence-based care and preventive services. In fact, prior to the PPACA, [REDACTED] provided our fully insured members with 100 percent coverage for certain high-value preventive services, such as annual flu immunizations. But the PPACA’s expansion of the list of required preventive services has increased health costs with downstream impacts on premiums.

Similarly, other immediate reforms under the PPACA—the expansion of coverage to dependents under age 26, the elimination of annual and lifetime limits, and providing coverage of out-of-network emergency room services at 100 percent—have increased costs. In isolation, none of these provisions has significantly increased health costs or premiums but, cumulatively, we believe these immediate reforms increased [REDACTED]’s health plan premiums by 2.3 percent on average across all market segments and geographies since their implementation.

Looking ahead to 2014 with the major reforms to the individual and small group markets, changes to rating standards, expansion of mandated benefits at specified actuarial value (i.e., metallic plan) levels, and new taxes and fees, [REDACTED] expects significant increases in premiums for a large percentage of our membership depending on their current health plan product and their specific circumstances. Those impacts will be addressed in greater detail in our responses below. But, the bottom line is that the PPACA does not contain many provisions that will reduce

costs and improve affordability, especially in the short term. As a result, health care costs and premiums will continue to rise for the foreseeable future at a pace that exceeds general economic growth, which will strain budgets for all health care payers, including employers, individuals and governments.

2. Since the passage of the PPACA, has your company done any analysis of the effects of guaranteed issue, community rating, or requirements to provide essential health benefits on premiums or costs, separately or on an aggregate basis, either nationally or by State? Specifically, have you done an analysis of how the law will affect different age cohorts? If so, please provide any documents setting forth this analysis.

At this time, [REDACTED] has completed only a general analysis of the effects of the guaranteed issue, community rating, and essential health benefits (EHB) requirements. We have not prepared an analysis of these issues by State or nationally, or an analysis of the impact of the law on different age cohorts.

Given [REDACTED] longstanding experience in serving the small group market, we share the Committee's concerns about the impact of PPACA on small employer premiums. While some small groups with a large proportion of older and less healthy employees could see a reduction in premiums, we anticipate that most small employers will experience substantial increases in premiums.

Our general estimates of the ratings impact on fully insured small groups under the PPACA's requirements are:

- Community Rating: +/- 25 percent depending on group characteristics.
- Compression of Rates under 3:1 Age Bands and Elimination of Gender Ratings: +30 percent to -15 percent depending group age and gender composition. As the Committee knows, most states employ age bands that are typically significantly wider (e.g., 5:1 or 6:1) than required under PPACA.
- Coverage of EHBs: +5 percent depending on EHB benchmark plan selection in a given state.
- Single Risk Pool: +15 percent due to requirement to move to a single risk pool for each licensed entity.

See attached slide for details.

In the individual market, we anticipate that the premium increases could be more pronounced due to more dramatic risk pool changes, as some states will shift their high-risk pool population into the individual market. Moreover, some individual market policies today have an actuarial value (AV) below the bronze level (i.e., 60 percent AV), and will therefore see additional increases in order to move to the minimum required level of cost-sharing.

3. *Since passage of the PPACA, has your company done any analysis of the effects of the law's new taxes and fees (for example, the taxes on health insurance providers or medical device makers) on premiums or costs, separately or on an aggregate basis, either nationally or by State? If so, please provide any documents setting forth this analysis.*

As with Question 1, ██████████ has not prepared any broad analysis of the national or State-level impact of the many new taxes and fees that are levied across the health care system, including those imposed on large and small employers (including self-funded groups), health insurers, and pharmaceutical and medical device manufacturers. In general, we have relied on publicly available estimates of the impact of these taxes and fees from benefit consultants, actuaries and investment analysts who have developed sophisticated quantitative models and from company reports.

However, as we start to price for policy years that crossover from 2013 into 2014, we are now incorporating various PPACA fees and taxes into rates, including the costs associated with the Transitional Reinsurance Program, Patient Centered Outcomes Research Institute (PCORI) fees, and the health insurer excise tax.

Pricing for 2013 policies that bridge into 2014 requires consideration of the following ACA impacts:

- **Transitional Reinsurance Program:** Per the final 2014 Payment and Benefit Parameters rule issued by the Department of Health & Human Services in March 2013, all commercial plan sponsors (including self-funded plans) are required to pay a fee of \$5.25 per member per month (\$63 per member per year) for 2014. In the small group and individual market, for a typical plan, this equates to approximately 1.6% and 3.2% of premium respectively, prorated for the number of months that the policy extends into 2014. In the individual market the cost of the reinsurance program would be more than offset by reinsurance recoveries, but this is not the case for the small group market.

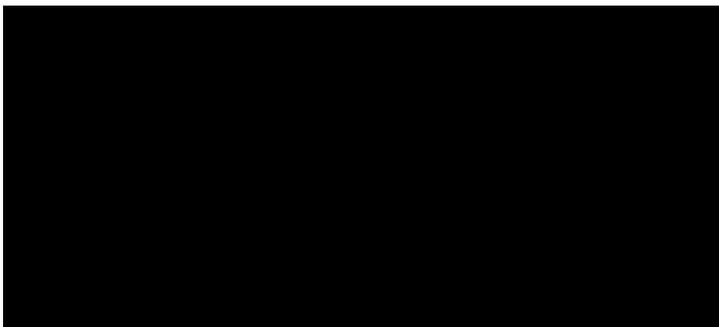
- PCORI fee: For plan years starting on or after October 1, 2012, all commercial plan sponsors (including self-funded plans) are required to pay a fee of \$1 per member per year. This amount will increase to \$2 per member per year for plan years starting on or after October 1, 2013.
- Health Insurer Excise Fee: For calendar year 2014, health insurance issuers will be required to pay a non-tax deductible excise fee based on an issuer's relative share of national premiums in 2013. Self-funded plans and Medicare supplemental plans are notable exclusions from the excise fee. In addition, for profit issuers such as [REDACTED] will pay a rate that is twice the amount of not-for-profit issuers. As a result of the health insurer excise fee, we have incorporated an additional 2.5% into fully-insured individual and small group rates for plans that crossover from 2013 into 2014, prorated for the number of months that the policy extends into 2014.

Conclusion

We trust this letter responds to your March 14 inquiry. Again, we share the Committee's concerns about the future affordability of health insurance premiums and the potential increases that many consumers, businesses, and other health care payers will experience in 2014 and beyond.

We encourage the Committee to consider reforms that would, at a minimum, eliminate taxes and fees, provide greater flexibility in rates, and institute a meaningful transition period in order to protect consumers and businesses from significant rate shock in 2014. In the longer-term, we recommend that policymakers focus on market-based reforms to the U.S. health care system that reward value over volume and greater integration in the care of patients. In the absence of such reforms, health care costs will continue to rise at rates faster than economic growth and our nation's ability to pay.

Respectfully,



Response to House Energy & Commerce Committee

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cc:

The Honorable Henry A. Waxman, Ranking Member

The Honorable John D. Dingell, Chairman Emeritus

The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and
Investigations

The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Major Reform Impacts for Groups

Rate Driver	SG Fully-Ins	LG Fully-Ins	ASO
Community Rating	+/- 25% depending on group characteristics	N/A	N/A
Compression of Age/Sex	+30% to -15% depending on group ages	N/A	N/A
Coverage of EHBs	+5% (estimate)	N/A	N/A
Risk Pool Changes	+15% (estimate)	TBD due to unknown shift to self-insured	N/A
Commissions	TBD (state-by-state)	Pass through	Pass through
Taxes / fees	+2 – 7% PCORI, Insurer Tax, Reinsurance, Exchange User Fee	+2 – 5% PCORI fee, Health Insurer Tax, Re-insurance	<2% PCORI fee, Re-insurance