United States Senate

COMMITTEE ON COMMERCE, SCIENCE,
AND TRANSPORTATION

WASHINGTON, DC 20510–6125

WEB SITE: http://commerce.senate.gov

November 2, 2009

H. Edward Hanway
Chairman and Chief Executive Officer
CIGNA Corporate Headquarters
Two Liberty Place
1601 Chestnut Street
Philadelphia, PA 19192

Dear Mr. Hanway:

In the course of investigating how the health insurance industry spends consumers' premium dollars, the Senate Commerce Committee has found serious inconsistencies in the way CIGNA and its subsidiaries provide business information to the public and to their regulators. I am writing to request that you immediately provide information clarifying the amount of premiums you receive and the claims you pay for your group health insurance products.

Health insurance premiums have increased by more than twice the rate of inflation over the last decade. Consumers are seeing their health care premiums skyrocket, and many are concerned that fewer premium dollars are actually being spent on their medical care. The business side of health insurance refers to the percentage of premium dollars actually used to provide medical services as a "medical loss" on insurers' balance sheets, because paying medical claims reduces insurers' profit margins. This seems to run counter to the very purpose of health insurance. With nearly half a trillion dollars in premium subsidies proposed to be paid to private health insurance companies by taxpayers as a part of health care reform, it is critical that consumers have a guarantee that the overwhelming majority of subsidy dollars are going toward actual medical care.

I believe insurers have an obligation to use consumers' premium dollars in a way that maximizes the benefit to their policyholders. I also believe that consumers have the right to know what insurance companies are doing with their money. The medical loss ratio, the percentage of every dollar paid to an insurer in premiums that it uses to deliver health care, is a very basic measure of the value a consumer is getting from his or her health insurance. Just as a car buyer might use gas mileage to choose one car model over another, medical loss ratios are a tool that can help consumers compare various health insurance options. For this reason, I proposed setting an appropriate minimum medical loss ratio for insurers during the Senate Finance Committee's markup of the health reform bill, and intend to raise the issue again when health care reform is debated on the Senate floor.

To learn more about medical loss ratios in the commercial health insurance market, on August 21, 2009, I wrote to CIGNA and fourteen other large health insurance companies

requesting information about their medical loss ratios broken down by state and by the individual, small, and large group market segments. Collectively, these fifteen companies control more than half of the entire fully-insured marketplace, and represent a driving force in market behavior and price setting. The purpose of this request was to compile medical loss information in a way that would be useful for consumers shopping for individual health insurance policies or for business owners shopping for group policies for themselves and their employees.

In reviewing the responses CIGNA and other companies have made to my August 21 letter, I have been surprised to learn that insurance companies consider segment-specific medical loss ratio information "proprietary" and "business sensitive" and deliberately withhold it from the public. Instead of disclosing medical loss ratios to help consumers and small business owners make informed health care choices, health insurance companies have hidden them behind a wall of corporate secrecy.

Because CIGNA and other large, for-profit insurers have been reluctant to share their medical loss information with the Committee on a voluntary basis, the Committee staff has been analyzing premium and claims data these companies have already filed with the National Association of Insurance Commissioners (NAIC). As described in more detail below, the analysis shows that in the individual and small group segments, insurers spend a significantly smaller portion of each premium dollar on patient care than they do in their large group business. It also shows that the large for-profit health insurers appear to be squeezing out more profits for Wall Street investors by spending a lower percentage of premium dollars on patient care than other insurers.

In the course of this investigation, the Committee has also found serious inconsistencies in the way CIGNA and its subsidiaries provide business information to the public and to their regulators. Specifically, CIGNA appears to have submitted state insurance regulatory filings that do not accurately describe your business activities in the small and large group business segments. This failure to submit accurate medical loss ratio information to state insurance agencies not only appears to violate the law; it also undermines the efforts of policymakers, consumer advocates, and regulators to determine whether consumers are getting a fair value for their health care premium dollars.

In order to correct this problem, I request that you immediately submit accurate financial information both to this Committee and to state authorities.

A. Background on the Medical Loss Ratio

One of the basic financial measures used in the health care industry is the percentage of health insurance premiums that insurers use to provide health care to their customers. This

percentage is commonly known as the "medical loss ratio."[1] For example, if an insurer uses 75 cents out of every premium dollar to pay its customers' medical claims, the company has a medical loss ratio of 75%. A medical loss ratio of 75% indicates that the insurer is using the remaining 25 cents of each premium dollar to pay expenses that do not directly benefit policyholders, such as salaries, administrative costs, advertising, agent commissions, and profits.

Regulators, consumers, policy makers, investors and even insurance companies themselves use medical loss ratios to assess how insurers manage their assets and provide health care services to their customers.[2] But these groups analyze medical loss ratios for different purposes. Regulators, consumers and policymakers study them to determine if insurers are spending an appropriate portion of premium dollars on medical services. Investors and the insurance companies they own use medical loss ratios determine the companies' profitability.

Regulators and Consumers

State insurance regulators use medical loss ratio information to make sure that insurers operating in their states are financially solvent and that consumers are getting sufficient value for their health insurance premiums.[3] According to a recent review of state insurance laws by America's Health Insurance Plans (AHIP), 32 states currently require insurance companies to report medical loss ratios in either their individual or group major medical insurance markets.[4]

Many of these states have taken the further step of implementing "minimum medical loss ratios" to limit the portion of premium dollars insurers can use for administrative expenses and profits. In a recent study on the impact of minimum medical loss ratios in the small group market in Texas, the Center for Public Policy Priorities made the following observation:

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[1] Some insurers use different terms to describe this ratio, such as "medical cost ratio," "benefits expense ratio" or "medical care ratio." According to one health care expert, "traditionally, actuaries had called this fraction the *medical loss ratio* (M.L.R.), because it represents what insurers "lose," so to speak, to doctors, hospitals and other providers of health care. Because that terminology comes across as indelicate, however, the preferred term now is the mellower *health benefit ratio* (H.B.R.)" Uwe E. Reinhardt, *How Much Money Do Insurance Companies Make? A Primer.* New York Times Economix Blog (Sept. 25, 2009) (online at http://economix.blogs.nytimes.com/2009/09/25/how-much-money-do-insurance-companies-make-a-primer).

[2] American Academy of Actuaries Loss Ratio Working Group, *Loss Ratios and Health Coverage* (November 1998) (online at http://www.actuary.org/pdf/health/lossratios.pdf).

[3] *Id.*

[4] America's Health Insurance Plans, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations* (Sept. 8, 2009). This document was provided to the Committee by at least 3 different insurance companies. *See also* Families USA Health Policy Memo, *Medical Loss Ratios: Evidence from the States* (June 2008) (online at http://www.familiesusa.org/assets/pdfs/medical-loss-ratio.pdf).

> Some states set minimum medical loss ratios by law to prevent insurance companies from charging excessive rates and retaining large margins for profit and other non-medical expenses. Establishing a minimum standard for the proportion of premiums spent on medical care provides consumers with an assurance that the majority of their premium dollars are used to help them finance their health care – the reason people buy health insurance.[5]

Thirteen states require insurance companies to maintain minimum medical loss ratios in their individual markets.[6] These minimum ratios range from a low of 50% in Pennsylvania to a high of 80% in neighboring New Jersey.[7] Thirteen states require companies to maintain minimum medical loss ratios in their small group markets (generally, businesses with fewer than 50 employees), with minimum ratios ranging from 60% to 82%.[8] Five states require companies to maintain minimum medical loss ratios in their large group markets.[9] These minimums range from 65% to 85%.

At least five of these state minimum ratio laws require insurers to return premium payments to consumers if their medical benefits payments fall below the state-mandated minimum percentages.[10] In response to the Committee's inquiry to the 15 largest health insurers whether they had issued rebates in compliance with these refund laws over the past 5 years, 4 insurers reported they returned amounts totaling $73.2 million. The fact that the insurance companies do, on occasion, dip below required minimum loss ratios suggests that minimum loss ratio standards keep the percentage of premium dollars spent on healthcare higher than it would be without such a requirement.

From the perspective of an individual consumer or business shopping for insurance coverage, medical loss ratios provide useful information about the relative value of health plans with similar benefit structures. Just as a car buyer might use gas mileage to choose one car model over another, "medical loss ratios are one additional tool consumers can use to compare similar products and better understand what they get for their premium dollar."[11]

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[5] Center for Public Policy Priorities, *How to Improve the Health Insurance Market Using Medical Loss Ratios* (No. 09-400) (May 15, 2009) (online at http://www.cppp.org/files/3/400_MLR_report.pdf).

[6] America's Health Insurance Plans, *State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations* (Sept. 8, 2009).

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] *Id.* According to AHIP, these five states are Maine, New Jersey, New York, North Carolina, and South Carolina.

[11] Center for Public Policy Priorities, *How to Improve the Health Insurance Market Using Medical Loss Ratios* (No. 09-400) (May 15, 2009) (online at http://www.cppp.org/files/3/400_MLR_report.pdf).

Investors

The health care consulting group, PricewaterhouseCoopers, reports that: "MLRs [medical loss ratios] are closely watched barometers of financial performance for investors."[12] But unlike regulators and consumers, who are looking for medical loss ratios high enough to demonstrate that a health insurance product is a good value, potential investors are looking for low ratios. Low and declining medical loss ratios signal to the market that an insurer is successfully containing its medical costs and is likely to operate profitably in the future.[13] A guide to investing in health companies on the Investopedia website counsels investors that the medical loss ratio "is the key ratio investors consider. It basically tells the investor how much the medical expenses are as a percentage of premiums…Investors like to see a low medical cost ratio."[14]

On June 24, 2009, a former CIGNA executive, Wendell Potter, testified before the Commerce Committee that CIGNA and other for-profit insurance companies are under intense pressure from Wall Street to contain their medical costs. At the end of every quarter, Mr. Potter testified, insurance executives provide their financial results on investor conference calls.

> On these calls, Wall Street investors and analysts look for two key figures: earnings per share and the medical loss ratio…To win the favor of powerful analysts, for-profit insurers must prove that they made more money during the previous quarter than a year earlier and that the portion of the premium going to medical costs is falling. Even very profitable companies can see sharp declines in stock prices moments after admitting they've failed to trim medical costs. I have seen one insurer's stock price fall 20 percent or more in a single day after executives disclosed that the company had to spend a slightly higher percentage of premiums on medical claims during the quarter than it did during a previous period. The smoking gun was the company's first-quarter medical loss ratio, which had increased from 77.9% to 79.4% a year later.[15]

According to Mr. Potter, for-profit insurers employ several different strategies to exert continuous downward pressure on their medical loss ratios. In the individual market, for-profit

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[12] Pricewaterhouse Coopers' Health Research Institute, *Beyond the Sound Bite: Review of Presidential Candidates' Proposals for Health Reform*, 38 (Nov. 2007).

[13] American Academy of Actuaries Loss Ratio Working Group, *Loss Ratios and Health Coverage*, 7 (November 1998). "From the investor's perspective, the lowest loss ratio is best because it means more risk margin to provide for profit and for potential adverse experience fluctuations."

[14] Investopedia, *Investing in Health Insurance Companies,* (online at http://www.investopedia.com/articles/stocks/09/investing-in-health-insurance.asp) (accessed Oct. 26, 2009).

[15] Senate Committee on Commerce, Science and Transportation, *Hearing on Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (June 24, 2009), Testimony of Wendell Potter.

insurers engage in post-underwriting rescission, where insurers "look carefully to see if a sick policyholder may have omitted a minor illness, or a pre-existing condition when applying for coverage, and then they use that as a justification to cancel the policy."[16] In the small group market, Mr. Potter described how insurers "purge" small businesses with high health care expenses by increasing premiums to unsustainable levels.[17]

The Health Insurance Industry's Conflicting Loss Ratio Numbers

For-profit health insurance companies such as CIGNA struggle to please two different audiences with sharply divergent interests. On the one hand, they try to demonstrate to regulators and consumers that they use a high percentage of premium dollars to provide health care. At the same time, as Mr. Potter explained to the Committee, insurers know that Wall Street will reward them for containing their benefit expenses and lowering their medical loss ratios.

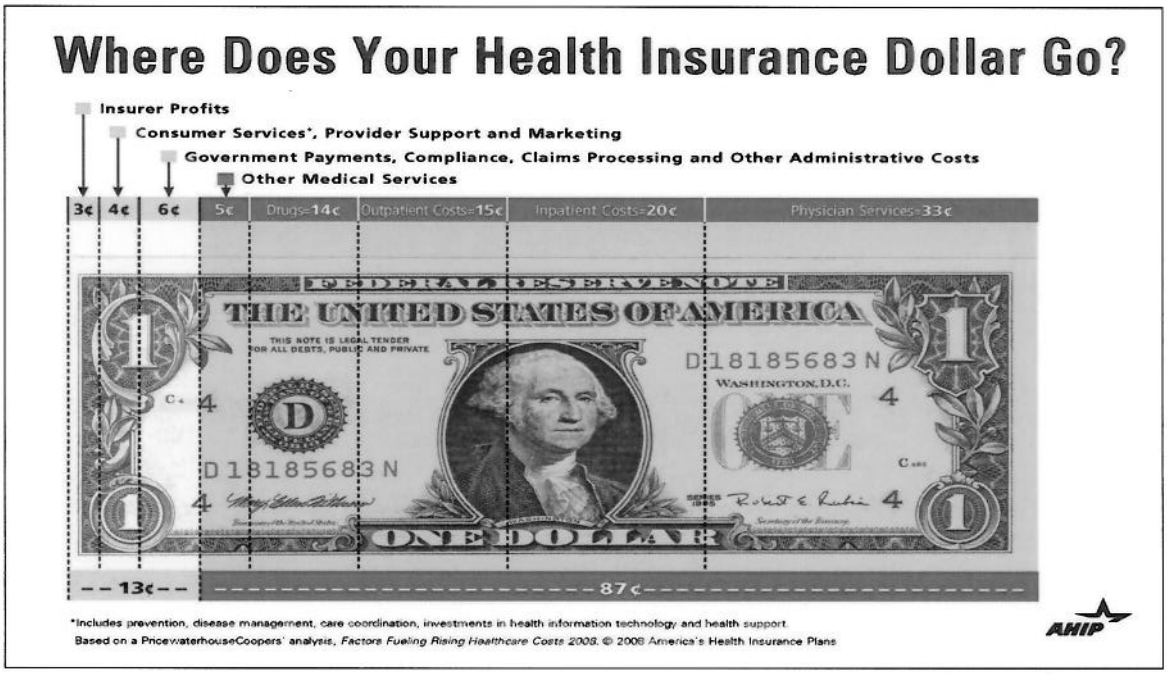

FIGURE I – AHIP Presentation of the Expenditure of a Premium Dollar

During the health care reform debate this year, the health insurance industry has provided one set of premium-benefit numbers to the public and to Congress, and presented a different one

[16] *Id. See also,* U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Termination of Individual Health Policies by Insurance Companies,* 111th Congress (June 16, 2009).

[17] *Id. See also,* U.S. House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on the High Cost of Small Business Health Insurance: Limited Options, Limited Coverage*, 111th Congress (Oct. 20, 2009).

to their investors. In an expensive public relations effort, the health insurance industry's association, America's Health Insurance Plans (AHIP), has repeatedly cited a report it commissioned from PricewaterhouseCoopers that purports to show that in 2008, 87% of health insurance premiums were spent on health care costs, while 13% were spent on administrative costs.[18] As part of this public relations effort, AHIP has repeatedly published graphics showing that the industry spends 87% of every premium dollar on health care (see Figure I above).

However, the industry's representation that insurance companies spend 87 cents of every premium dollar on medical care is contradicted by its own financial reporting. A review of the Securities and Exchange Commission (SEC) filings of the six largest, publicly-traded health insurers, including CIGNA, shows that not a single one of those companies spent 87 cents of every dollar on medical care for their customers in 2008 (see Table I below).

Company	2008 Medical Loss Ratio
Aetna	81.5%
CIGNA	84.8%
Coventry	84%
Humana	84.5%
UnitedHealth	82%
WellPoint	83.6%

TABLE I – 2008 Medical Loss Ratios Presented by For-Profit Insurers to Their Investors

Given that CIGNA and the five other companies listed in Table I above collected more than $70 billion in premiums from their commercial insurance customers in 2008, the difference between AHIP's 87% figure and the companies' actual figures equates to billions of dollars that the health insurance industry claims to spend providing health care, but actually uses to bolster its profits or pay other non-benefit expenses.

Further evidence that AHIP's 87% premium-benefit figure misrepresents the true ratios within the health insurance industry is an analysis published by PricewaterhouseCoopers Health Research Institute in 2007. The analysis shows that, over the past 15 years, the medical-loss ratios of publicly traded health insurance companies have dropped from the 90-95% range to the low 80s.[19] According to this PricewaterhouseCoopers report, it has been almost a decade since the industry-wide medical loss ratio was higher than 85% (see Figure II).

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[18] PricewaterhouseCoopers, *Factors Fueling Rising Healthcare Costs 2008*, Prepared for AHIP (Dec. 2008).

[19] PricewaterhouseCoopers' Health Research Institute, *Beyond the Sound Bite: Review of Presidential Candidates' Proposals for Health Reform*, 39 (Nov. 2007).

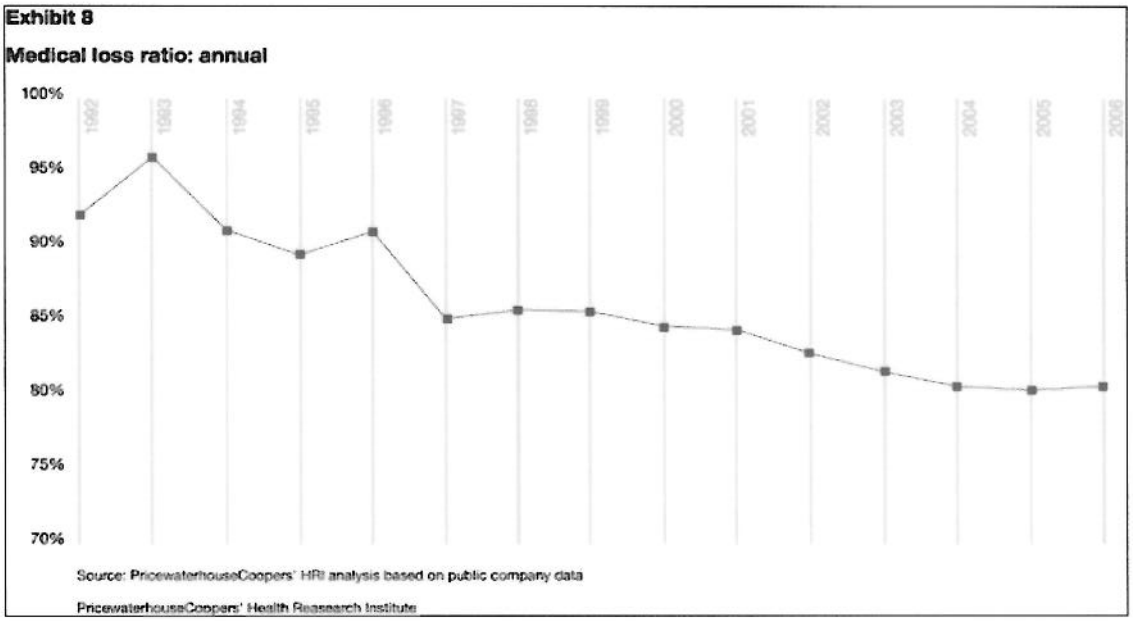

FIGURE II – PricewaterhouseCoopers Analysis of Medical Loss Ratio

In his June 24 testimony before the Commerce Committee, Mr. Potter cited this PricewaterhouseCoopers analysis as evidence of "just how successful the insurers' expense management and purging actions have been over the last decade in meeting Wall Street's expectations." [20] A reduction of a few points in the industry's medical loss ratio "translates into a difference of several billion dollars in favor of insurance company shareholders and executives and at the expense of health care providers and their patients."[21]

Medical Loss Ratios as a Tool for Consumers

Although medical loss ratios are a widely used indicator of performance in the health insurance industry, they do not provide consumers with information about the quality or effectiveness of the care they will receive through a particular health insurance product. In fact, health insurers have been quick to point out to Committee staff the shortcomings of the medical loss ratio, repeatedly directing the Committee's attention to an academic article in which the author calls the medical loss ratio an "accounting monstrosity."[22]

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[20] Senate Committee on Commerce, Science and Transportation, *Hearing on Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (June 24, 2009), Testimony of Wendell Potter.

[21] *Id.*

[22] James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, Health Affairs, Vol. 16, No. 4, 186 (July/Aug. 1997) (online at http://content.healthaffairs.org/cgi/reprint/16/4/176).

The author of this article, as well as other health care experts, make a number of valid points about the limitations of the medical loss ratio. For example, the fact that an insurer is spending a higher fraction of its premium dollars on health care than a competitor does not necessarily mean the company's policyholders are getting higher quality health care. In addition, the medical loss ratio does not always credit the expenditures health insurers make on wellness programs, disease management, fraud detection, and other efforts that ultimately lead to lower health care costs and greater efficiency.[23]

While it is clear that consumers need to consider other measures of quality and efficiency when they are making decisions about buying health insurance, the medical loss ratio gives individuals and small businesses a tool to evaluate health plans competing for their business. For this reason, some states require the public reporting of insurers' medical loss ratios for the individual and small group markets, and some state insurance commissioners even provide medical loss ratio information directly to the public.

The Minnesota Insurance Commissioner, for example, publishes an annual report listing the medical loss ratios of every insurer selling individual and small group insurance in the state. Thanks to this publication, a small business in Minnesota has easy access to information about insurers in the state selling health care coverage to small businesses (see Figure III).[24]

Company	2008 Premiums	2008 Claims	Loss Ratio
** BCBSM, Inc.	$ 653,722,304	$ 575,861,930	88%
* Blue Plus	$ 48,759,855	$ 41,201,622	84%
Federated Mutual Insurance Company	$ 49,392,832	$ 38,008,412	77%
* First Plan of Minnesota	$ 3,182,079	$ 2,370,060	74%
* HealthPartners	$ 278,518,347	$ 235,252,391	84%
HealthPartners Insurance Company	$ 27,331,492	$ 24,499,173	90%
John Alden Life Insurance Company	$ 2,272,757	$ 2,386,327	105%
Medica Insurance Company	$ 420,079,849	$ 365,607,299	87%
Noridian Mutual Insurance Company	$ 1,907,774	$ 1,869,102	98%
* PreferredOne Community Health Plan	$ 47,807,129	$ 41,005,321	86%
PreferredOne Insurance Company	$ 2,049,719	$ 1,621,953	79%
Principal Life Insurance Company	$ 3,318,219	$ 2,182,137	66%
Sanford Health Plan	$ 314,961	$ 228,064	72%
Time Insurance Company	$ 3,135,076	$ 4,315,288	138%
Union Security Insurance Company	$ 296,327	$ 205,685	69%
Total	$ 1,542,088,720	$ 1,336,614,764	87%

FIGURE III – 2008 Minnesota Small Group Medical Loss Disclosure

[23] *Id.*

[24] Minnesota Department of Commerce, *Report of 2008 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies, Nonprofit Health Service Plan Corporations and Health Maintenance Organizations* (June 2009, revised Aug. 1, 2009) (online at http://www.state.mn.us/mn/externalDocs/Commerce/Current_Loss_Ratio_Report_052104013421_LossRatioReport.pdf).

Other state insurance commissioners that provide segment-specific medical loss ratio information to consumers include West Virginia and Colorado, which compile this information in annual reports. Maine and Washington make certain health insurance company filings available in online comparison tools that any member of the public can access. Many other state insurance commissioners include some portion of insurers' medical loss ratio information in their annual statements.[25]

Although AHIP and the insurance industry publicly focus on companies' overall medical loss ratios, regulators and consumer advocates look at medical loss ratios at the market-segment level because loss ratios vary dramatically by product type. Specifically, they collect and analyze data subdivided according to the the individual, small group and large group markets. As Mark Hall, Professor of Law and Public Health at Wake Forest University, has noted, these three market segments are "distinct segments, each of which is governed by fundamentally different economics and regulation."[26] They constitute different product lines, are sold by different sales forces, and are serviced by different corporate divisions, "as distinct in their economic and legal characteristics as are mobile homes, condominiums, and single-family homes."[27]

Each of these business segments has different premium-benefit structures due to varying costs of marketing, underwriting, and administration. In general, according to the American Academy of Actuaries, "loss ratios for plans in the individual market will typically fall below those in the small group market, which in turn will fall below those in the large group market."[28]

One of the significant administrative expenses related to selling individual and small group policies is the cost of reviewing applicants' health histories, or "medical underwriting." According to Professor Hall, medical underwriting and other administrative steps insurers take to limit their risks can consume up to 20-25% of premiums in the individual market and 10-15% of

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[25] *See, e.g.,* Washington State Office of the Insurance Commissioner, *Insurance Commissioner's Annual Report 2008* (2008) (online at http://www.insurance.wa.gov/publications/annual_reports/2008ReportAppendix/AnnualRpt2008.pdf); Maine Bureau of Insurance, *2008 Financial Results for Health Insurance Companies in Maine* (2008) (online at http://www.maine.gov/pfr/insurance/consumer/financial_results_health_insurers.htm); State of West Virginia Offices of the Insurance Commissioner, *Accident and Health Insurance Market Report for 2008* (Nov. 2008) (online at http://www.wvinsurance.gov/LinkClick.aspx?fileticket=dNz-c9pDQEg%3d&tabid=207&mid=795).

[26] Mark A. Hall, *The Geography of Health Insurance Regulation*, Health Affairs, Vol. 19, No. 2, 173 (Mar./Apr. 2000). (online at http://content.healthaffairs.org/cgi/reprint/19/2/173.pdf).

[27] *Id.*

[28] American Academy of Actuaries, *Critical Issues in Health Reform: Minimum Loss Ratios* (July 2009) (online at http://www.actuary.org/pdf/health/loss_july09.pdf).

premiums in the small group market.[29] Thus, comparisons of medical loss ratios that include a breakdown of loss ratios by individual, small and large group markets are more meaningful for consumers and small businesses looking to purchase health insurance.

B. The Commerce Committee's Investigation

Although some state regulators collect and make medical loss ratio information available to their citizens, in most insurance markets in the United States, individual consumers and small businesses do not have ready access to medical loss ratio information about the insurance products offered for sale in their areas. Similarly, while insurers routinely share their company-wide medical loss ratios with their investors, they do not make available the medical-loss ratio information that would be most useful to consumers – the ratios of policies offered in particular market segments and geographic areas. For example, WellPoint informed the Committee that it "does not typically make medical loss ratios available to the purchasers of health benefits. This is because a medical loss ratio is an accounting tool that is not a measurement of quality or efficiency."[30]

In an attempt to find out about medical loss ratios in the individual, small and large group markets and to learn how the health insurance industry collects, uses, and publicizes medical loss ratio information, I wrote CIGNA and the 14 other largest health insurance companies on August 21, 2009, requesting medical loss information broken down by state and business segment. Collectively, these fifteen companies control more than half of the entire fully-insured marketplace. Dividing the commercial health insurance market into the individual, small group and large group segments, the letter asked the companies to provide information showing what fraction of premiums they spent providing medical care to their customers, and describing how they spent the portion of premiums that did not go to providing medical care.

Some of the companies that received the August 21 letter – generally those that are non-profit entities and operate primarily in a single state – provided complete responses to the Committee's request on a timely basis. Most of the for-profit national health insurance companies, including CIGNA, however, have still not voluntarily provided complete responses to the Committee's request.

CIGNA and other large for-profit companies have cited a variety of reasons for their reluctance to provide the requested information, but all of them have stressed the "confidential and proprietary" nature of medical loss ratio information broken down by state, and by the individual, small group and large group market segments. While the companies have acknowledged that they are required to report medical loss ratio information by market segment

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[29] Senate Committee on Finance, *Hearing on 47 Million and Counting: Why the Health Care Marketplace is Broken* (June 10, 2008), Testimony of Mark A. Hall.

[30] Letter from Stephen Northrup, Vice President, Federal Affairs, WellPoint, to Chairman John D. Rockefeller IV, U.S. Senate Committee on Commerce, Science and Transportation (Sep. 8, 2009).

in a number of states where they do business, they argue that disclosing this information in states where they are not currently required to report it would cause them competitive harm.

Publicly Available Information About Insurers' Medical Loss Ratios

While the Committee is continuing discussions with CIGNA and other companies about voluntarily providing the information requested in the August 21 letter, we have learned that much of the information these companies claim to be confidential and competitively sensitive is available to the public through forms the companies file with state insurance regulators. In particular, all companies that sell major medical insurance subject to the regulation of state insurance commissioners annually file a form called the "Accident & Health Policy Experience Exhibit."[31] This form, which was developed by the National Association of Insurance Commissioners (NAIC), requires companies to disclose the premiums they have earned and the claims they have paid in their individual, small group, and large group businesses.[32]

Because the largest for-profit health insurers have been reluctant to share their medical loss ratio information with the Committee – claiming this information is "confidential" and "business sensitive" – we have compiled this information from the numbers they have publicly filed on their NAIC Policy Experience Exhibits. Although this company-provided data has some limitations, it provides a clear picture of how medical loss ratios differ by market segment.[33]

In 2008, for example, American consumers and employers paid health insurers almost $200 billion in premiums for major medical health insurance coverage provided to 58 million Americans in the individual, small group, and large group markets. As Table II below shows, the medical loss ratio for the individual segment (79%) was lower than the group segments, and the small group ratio (82%) was lower than the large group ratio (86%). In other words, while insurers used 14 cents out of every large group premium dollar for non-benefit expenses, they used 21 cents out of every individual premium dollar for non-benefits expenses.

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[31] NAIC's instructions for the 2008 Accident & Health Policy Experience Exhibit define Comprehensive/Major Medical as "Policies that provide fully insured indemnity, HMO, PPO, or Fee for Service coverage for hospital, medical, and surgical expenses." *Official NAIC Annual Statement Instructions: Health*, 502 (Aug. 2008).

[32] The instructions to this exhibit divide "Single Employer" group policies into "Small Employers," as the term is defined in a particular state, and "Other Employers." *Official NAIC Annual Statement Instructions: Health*, 503 (Aug. 2008). States generally follow the definition of "Small Employer" defined in the federal Health Insurance Portability Act (HIPAA), which is an employer with between 2 and 50 employees. 42 USC § 300gg-92.

[33] See the notes to Exhibit 1 attached to this letter.

Market Segment	Premiums	Paid Claims	Ratio
Individual (8.4 million lives)	$20.4 billion	$16.1 billion	79%
Small Group (17.8 million lives)	$60.3 billion	$49.4 billion	82%
Large Group (32.1 million lives)	$109.7 billion	$94.1 billion	86%

TABLE II - 2008 Medical Loss Ratios by Market Segment – All Insurers

A separate analysis of the premium and claims information reported by the six largest for-profit insurers, however, shows that these companies spend less of every premium dollar on health care than the rest of the market. The six largest for-profit companies – Aetna, CIGNA, Coventry, Humana, UnitedHealth Group, and WellPoint – had a cumulative medical loss ratio in the individual market of 74%, five points lower than the industry as a whole. They reported medical loss ratios of 80% and 84% in the small and large group markets, respectively, both of which are two points lower than the industry-wide ratios.

Market Segment	Premiums	Paid Claims	Ratio
Individual (2.9 million lives)	$6.8 billion	$5.1 billion	74%
Small Group (8.3 million lives)	$27.9 billion	$22.3 billion	80%
Large Group (13.2 million lives)	$40.9 billion	$34.4 billion	84%

TABLE III - 2008 Medical Loss Ratios by Market Segment – Largest For-Profit Insurers

As Mr. Potter, the former CIGNA executive, explained in his Commerce Committee testimony, reducing medical loss ratios by even a few points "translates into a difference of several billion dollars in favor of insurance company shareholders and executives."[34] To illustrate this principle, if these six companies' medical care expenditures had tracked industry-wide 2008 medical loss ratios, they would have spent $1.7 billion more on providing health care than they actually did.

C. CIGNA's Failure to Disclose Its Group Business to the Commerce Committee and Its Insurance Regulators

Attached to this letter is a table (Exhibit 1) showing the premium dollars collected, claims paid, and medical loss ratios reported by the six largest for-profit health insurance companies for the calendar year 2008 to the National Association of Insurance Commissioners. This table presents the information broken down by the individual, small group and large group market segments.

[34] Senate Committee on Commerce, Science and Transportation, *Hearing on Consumer Choices and Transparency in the Health Insurance Industry*, 111th Cong. (Jun. 24, 2009), Testimony of Wendell Potter.

A review of the data presented in this table (Exhibit 1) shows that CIGNA has failed to report its financial information in a manner that is consistent with the other five companies included in the table. According to the information you have filed with your insurance regulators, CIGNA and its subsidiaries did no business in the small group segment in 2008, and only a minimal amount of business in the large group segment.[35] Instead, CIGNA reports more than $5 billion worth of business in a catch-all "other group" category.[36] This reporting does not appear to accurately reflect your company's operations in these two market segments, and it directly contradicts statements you made to the Committee in a recent letter about your small business market.

There is an abundance of publicly available information demonstrating that CIGNA markets and sells insurance products in the small and large group segments. Through basic online searches, Committee staff has obtained CIGNA marketing materials advertising small group policies as well as a 2008 press release quoting CIGNA's "senior vice president of CIGNA HealthCare's individual and small group segment."[37] A review of information on state insurance regulator websites also shows that CIGNA has disclosed small or large group business in certain state filings.[38] For instance, in its filing with the New Jersey Department of Banking and Insurance, CIGNA HealthCare of New Jersey claimed $36.9 million in large group premiums and $1 million in small group.[39]

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[35] The Committee's conclusions are based on a manual review of the 2008 Accident & Health Policy Experience Exhibits for the following CIGNA subsidiaries: Connecticut General Life Insurance Company, Allegiance Life & Health Insurance Company, CIGNA Insurance Services Company, CIGNA Life Insurance Company of New York, Life Insurance Company of North America, Alta Health & Life Insurance Company, CIGNA Insurance Group, CIGNA Worldwide Insurance Company, CIGNA Healthcare of Pennsylvania, CIGNA Healthcare of Arizona, CIGNA Healthcare of North Carolina, CIGNA Healthcare of Florida, CIGNA Healthcare of Ohio, CIGNA Healthcare of Texas, Great West Healthcare of Illinois, CIGNA Healthcare Centennial State, Great West Healthcare of Texas, CIGNA Healthcare of Maine, CIGNA Healthcare of New York, CIGNA Healthcare of New Hampshire, CIGNA Healthcare of New Jersey, CIGNA Healthcare of Utah, CIGNA Healthcare of Massachusetts, CIGNA Healthcare of Indiana, CIGNA Healthcare of Delaware, CIGNA Healthcare of the Mid-Atlantic, CIGNA Healthcare of Illinois, CIGNA Healthcare of Colorado, CIGNA Healthcare of Tennessee, CIGNA Healthcare of St. Louis, CIGNA Healthcare of Connecticut, CIGNA Healthcare of South Carolina, and CIGNA Healthcare of Georgia.

[36] An examination of CIGNA's 2006 and 2007 Accident & Health Policy Experience Exhibit filings shows that CIGNA's reporting followed the same pattern in those two years.

[37] Business Wire, *CIGNA Rolls out New Suite of Health Plans for Individuals and Small Employer Groups* (Oct. 28, 2008).

[38] According to the websites of the following state insurance commissioners, CIGNA has reported or listed as available specific small or large group business: Maine, West Virginia, Texas, New Jersey, South Carolina, Florida.

[39] New Jersey Department of Banking and Insurance, *2008 Preliminary Commercial Loss Ratio Market Share Report* (Aug. 25, 2009) (online at http://www.state.nj.us/dobi/lifehealthactuarial/2006comhealth_loss.pdf).

As mentioned above, CIGNA's failure to disclose that it has small group business is also at odds with a letter you wrote to the Committee on September 2, 2009, in which you provided details about CIGNA's small group business, which you defined as employers with 2 to 50 employees. You explained that "CIGNA's historical presence in the small group market has been limited, and currently this business represents approximately 50,000 members."[40]

Thus, based on the plain language reading of the NAIC Exhibit's instructions and on the way your competitors disclosed their market segment information on these forms, it is clear that the information you provided in these Policy Experience Exhibits is inaccurate. CIGNA sold small and large group policies valuing as much as $5 billion to consumers in 2008, but failed to report this activity to state regulators.

This failure to provide accurate business information not only shows that your company is failing to comply with the requirements of state insurance laws; it also undermines the efforts of regulators and policymakers to protect consumers from unfair insurance industry practices. A number of states have made the policy decision to provide special protections to certain types of businesses seeking to purchase health insurance for their employees. To enforce these protections, they have required you and other insurance companies to disclose information about how you do business in their jurisdictions. Your company appears to have flouted these requirements and made it more difficult for regulators and consumers to hold you accountable for your conduct.

In order to understand why CIGNA has failed to disclose accurate information about its business practices to its insurance regulators and to the public, I request that you provide the Committee with the following information and answer the following questions:

- Please explain why CIGNA and its subsidiaries appear to have misclassified as much as $5 billion dollars worth of health insurance business;

- Please produce accurate data showing your company's nationwide medical loss ratio for the major medical insurance products it currently offers, or has offered in the past, for each of the last ten years in:

  a. The individual health insurance market;
  b. The small group health insurance market; and
  c. The large group health insurance market; and

- Please explain how CIGNA intends to amend its state insurance filings, for both the calendar year 2008 and previous years, to accurately reflect your business activities in the individual, small, and large group market segments.

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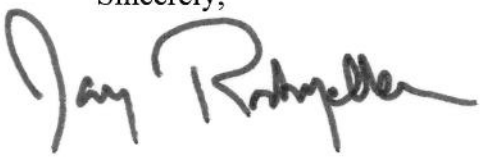
[40] Letter from H. Edward Hanway, Chairman and Chief Executive Officer, CIGNA Corporation, to John D. Rockefeller IV, Chairman, U.S. Senate Committee on Commerce, Science, and Transportation (Sept. 2, 2009).

I request that you provide this information to the Committee by November 9, 2009.

The Committee is making this request under the authority of Senate Rules XXV and XXVI. If you have any questions, please contact John Williams or Lisa Hone with the Committee staff at (202) 224-1300.

Please also note that I am sending a copy of this letter to New Hampshire Insurance Commissioner Roger Sevigny, the current president of the National Association of Insurance Commissioners.

Sincerely,



John D. Rockefeller IV
Chairman

Enclosure

cc: Kay Bailey Hutchison
Ranking Member

Roger A. Sevigny
President, National Association of Insurance Commissioners

Exhibit I - Premiums, Claims, and Loss Ratios

Comprehensive Major Medical Insurance for the 6 Largest Public Insurance Companies (2008)

	Individual			Small Employer			Large Employer		
	Premiums	*Paid Claims*	***Loss Ratio***	*Premiums*	*Paid Claims*	***Loss Ratio***	*Premiums*	*Paid Claims*	***Loss Ratio***
Aetna	$843,692,044	$617,705,102	**73%**	$8,875,867,031	$7,290,075,280	**82%**	$5,459,969,978	$4,476,646,659	**82%**
CIGNA	$61,571,932	$53,460,251	**87%**	$0	$0	--	$12,609,503	$8,117,238	**64%**
Coventry	$121,003,570	$79,610,830	**66%**	$942,048,835	$742,735,050	**79%**	$2,108,245,345	$1,743,470,356	**83%**
Humana	$464,653,831	$333,424,223	**72%**	$2,556,931,493	$1,974,696,888	**77%**	$2,831,401,783	$2,332,915,906	**82%**
UnitedHealth	$585,335,682	$485,607,210	**83%**	$8,464,932,032	$6,684,677,470	**79%**	$13,421,315,270	$11,220,132,212	**84%**
WellPoint	$4,760,267,838	$3,494,528,874	**73%**	$7,106,213,785	$5,615,930,436	**79%**	$17,148,822,998	$14,622,518,775	**85%**
Total	**$6,836,524,897**	**$5,064,336,490**	**74%**	**$27,945,993,176**	**$22,308,115,124**	**80%**	**$40,982,364,877**	**$34,403,801,146**	**84%**

Notes

*Data is based on Accident and Health Policy Experience Exhibit (A&H Policy Exhibit) filings made by the companies and their subsidiaries with the National Association of Insurance Commissioners (NAIC). In the A&H Policy Exhibits, data about comprehensive medical insurance sold to individuals is under the heading "Individual, Comprehensive Major Medical With Contract Reserves." Data about comprehensive medical insurance sold to small employers (usually between 2-50 employees) is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Small Employer." Data about major medical insurance sold to large employers is reported under the heading "Group Business Comprehensive Major Medical, Single Employer, Other Employer."

*NAIC's calculation of Loss Ratio takes into account "Change in Contract Reserves," which is not specifically identified in this chart, and does not usually affect the loss ratio significantly.

*Data is limited to fully-insured business, comprehensive major medical insurance. Self-insured, administrative-services only, FEHB, Tricare and Medicare are not included in this chart.

*Data does not include information about entities regulated by the California Department of Managed Health Care (DMHC), because such entities do not file A&H Policy Exhibits with NAIC. Companies that have substantial amounts of major medical business and file with DMHC include, but are not limited to: Blue Cross of California (a WellPoint subsidiary) and PacifiCare of California (a UnitedHealth subsidiary).

*In 2008, Golden Rule, a UnitedHealth subsidiary, sold the bulk of its individual insurance through associations and other groups, therefore it is not represented as Individual Business in the A&H Policy Exhibit, but rather is reported as "other associations and discretionary trusts." If the premiums and claims reported by Golden Rule were included as individual major medical insurance, UnitedHealth's total premiums in the individual insurance category would increase to $1,590,952,160; its claims would be $1,121,724,504. Including these numbers in UnitedHealth's individual business line drops the company's loss ratio to 70.5%, and decreases the total individual loss ratio from 74% to 73%.

*NAIC data includes full year financial data for companies acquired by Humana rather than just the data following their acquisition. The NAIC data does not include Humana's Puerto Rico operations.