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SMALL GROUP UNDERWRITING

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Recorder: ROBERT BRUCE CUMMING

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  - -- Initial
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MR. WILLIAM F. BLUHM: This is a panel discussion on medical underwriting over five lives. You will be hearing a few introductory remarks from me about the current situation in the small group market. Our three speakers will then describe various proposals that have been put forth to solve the small group market problem.

I'm a consulting actuary with Milliman and Robertson in Minneapolis. Cecil Bykerk is Senior Vice President & Actuary at Mutual of Omaha. Cecil has headed up the health and accident actuarial division since March 1989 at Mutual. He has responsibility for pricing and product development of individual health products, as well as life and health small group products. Before that, he was in the life actuarial division at United of Omaha. He also spent four years as director of the actuarial science program at the University of Nebraska in Lincoln. He is a past member of the Board of Governors of the SOA and is currently on the Industry Advisory Committee to the National Electronic Information Corporation Group Health Rate Review Working Group, which is why he is here. He is also very active with the Technical Advisory Group to the Health Insurance Association of America (HIAA) Board Committee on Small Group Rating Reform and Reinsurance. But he's not going to tell you about that; Dick Hill, the second speaker, will.

Dick has been in charge of Prudential's small group and individual health operations since 1985. He is also an FSA, a CLU, a Chartered Financial Consultant (CHFC), and a Chartered Property and Casualty Underwriter (CPCU). He's Vice President & Actuary at Prudential. Before being with the small group and individual health operations, he had various marketing and management positions in the group department, property and casualty company, and individual marketing area. He is currently a member of the Technical Advisory Group on Small Group Rating Reform and Reinsurance which works with the HIAA Board Committee. He'll be telling you about that.

PANEL DISCUSSION

Our third speaker is April Choi, who is an FSA and MAAA, Director & Actuary at Blue Cross of California. Her area of responsibility is pricing, experience analysis, and financial projection for individual, small group, and federal employee health benefit programs. April will be describing the California situation and the Blue Cross approach.

I have a few introductory remarks, including a little story. Once upon a time, in a land far away, a small group was happy and healthy. The small group wanted to stay happy, and it decided to get together with a number of other small groups who were also happy and healthy. They promised to each other that if any of them weren't healthy anymore that they would all split the cost. Everybody lived happily until somebody else came along and whispered in the ears of the healthy small groups, "Why don't you come and join our group of happy and healthy small groups that is starting up? If you join us you won't have to pay for the small groups in your current group who have gotten sick." To me, that's the essence of the whole problem in the small group market.

The problem gets expressed in a number of different ways. One aspect is the trend in group size required for experience rating. It used to be that only the larger groups were experience rated; they had their prospective rates based on past experience. The size of the group required has trended downward over the last ten or fifteen years to very small groups; sometimes down to two lives.

A second aspect of what's been occurring is medical reunderwriting. There are a number of carriers who look at the medical situation of individuals in setting the prospective rates for renewals.

A third aspect is durational rating, which comes in a number of different forms. In essence, each form does the same thing: the small group gets charged less money when it is newly underwritten, and it gradually loses the benefit of being underwritten, unless it finds cheaper insurance elsewhere.

All of these aspects have combined to create a perceived problem in access to care. The regulators and the public are starting to perceive that the insurance industry, which rates the small group market on a select and ultimate or medical reunderwriting basis, is failing to keep a promise to the people who are getting coverage.

There are a number of things that are going on all around the country to try to solve the problem. A number of different groups have approached the problem. It's being responded to by state legislators, as well as the insurance industry. There are three different sets of responses that address the access and rating problems which we're going to tell you about.

MR. CECIL D. BYKERK: I'll cover a lot of ground in a short period of time, but please bear with me. This is an important issue to small group insurers, but it has broader application than that.

HISTORY

The Industry Advisory Committee to the National Association of Insurance Commissioners (NAIC) started work in July 1989. It worked very closely with the commissioners on

the NAIC Accident and Health (B) Committee Working Group. They issued a preliminary report in December 1989. A final report was presented in June 1990 in Baltimore along with a model law. The working group, made up of the commissioners, not the advisory committee, marked up the model and released it for exposure at the September 1990 meeting in Kansas City. The exposure is now available with an intended adoption in Louisville in December. There have been indications that several, if not many, states will act on it rapidly once it is adopted by the NAIC. You can expect this in early 1991.

The thrust of this work has been with respect to small employers, which is defined as employing no more than 25 eligible employees. There has been some suggestion that this could be expanded to include employers larger than that, depending on regulations and practices in the given state. We sometimes forget to say that this work applies only to health insurance.

Another issue that needs to be looked at very closely is how the model meshes with any individual rate filing guidelines in the state. Everyone agrees that dual regulation is not wanted. The mechanism to accomplish this is of major concern. I would be happy to discuss that at another time since we need to get on with the major issues at hand. I might add, however, that some have suggested that this whole approach should be applied to all individual health insurance as well. There are some very real, practical problems with that, but that is also for a later time.

SCOPE AND REASONS

Before we discuss the strategies and implications of the model, we need to examine the scope of the committee's work, as well as the reasons for it being done. Dick Hill will be talking next about the HIAA's proposal. It is important to note that the HIAA proposal was part of a much broader scope.

There have been a growing number of complaints from small businesses, as well as media articles about large health insurance premium increases, increased inability to purchase new or replacement coverage, and termination of existing coverage. A majority of uncovered persons are workers or persons living in households with workers.

There has been concern that if the complaints aren't addressed, the federal government will step in. The Pepper Commission, of course, has been very active. It has incorporated some of the NAIC's and HIAA's work into its proposals.

One question we might ask ourselves is whether the lack of insurance is due to the failure of small businesses to purchase available coverage or the failure of the insurance market to make fairly priced health insurance widely available.

The advisory committee's proposed recommendations and model law are designed to: curb abusive rating and other market practices, offer a meaningful regulatory policing mechanism, and point out areas outside the scope of the committee's work where additional changes could further improve the efficiency of the existing market. It was the committee's strong feeling that none of this deals with the true, basic problem which is the high cost of health care in America.

The basic premise of the advisory committee was that prior approval of rating was not a desirable approach to solving the rate reform problem. Therefore, the cornerstone of the proposal is "actuarial certification." As you will see, much actuarial theory and application must take place in order to implement the rate limitations provided for by the model.

REGULATORY STRATEGY UNDERLYING MODEL LAW

The regulatory strategy underlying the model law consists of four elements: disclosure requirements, proscription of abusive practices, actuarial opinion and certification, and legal intervention.

Disclosure Requirements

First, let's look at disclosure requirements. Sales material is to contain short, but meaningful summaries of the insurer's rating and other key market practices. Insurers would be required to maintain a complete technical description of their rating and renewal underwriting practices. The advisory committee felt that the disclosure wording should not be specified in the law, but that examples might be available. The committee felt that if tier (experience rated) and/or durational (select and ultimate) rating strategies are contemplated, the insurer should at the point of sale, provide a more detailed nontechnical explanation of how future rate increases will be determined.

Proscription of Abusive Practices

The major points of the recommendations are under the proscription of abusive practices section.

Over the last several years, or decades, the small group marketplace has moved from the individual pooled side of actuarial science to the true group experience-rated side of actuarial science. This has resulted in the loss of coverage for the group or for unhealthy individuals through termination or excessive rate increases.

Growing political and industry consensus has emerged for reform of the small group market in order to curb rating practices that could be deemed abusive.

It is important to note a positive effect of such rating practices, however, which has been to allow the majority of small businesses to pay less for health insurance than may otherwise have been charged. In addition, employers have incentives to encourage healthy lifestyles among their employees.

Some industry representatives have asked why we shouldn't go back to the day of totally pooled small group rates. It was the consensus of the committee that the consequences of a ban or severe constraint on tier and durational rating would be counterproductive by making health insurance more expensive and less available. We must be conscious of both the cost and the availability of coverage.

The committee did acknowledge that in some instances tier and durational rating practices have either knowingly or unknowingly been abused. Abusive practices can be proscribed by adopting rating restrictions.

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The current draft of the model law controls or restricts the rating factors that deal with claims experience, health status, and duration from issue. There is no restriction for demographic differences or plan design. However, it is necessary to determine appropriate actuarial adjustments for them.

The aggregate annual increase in rates is unrestricted. This allows for increases in medical care costs, past deficiencies in pricing, and adjustment for an insurer's expected profit margin. Insurers can therefore adjust rates so that they do not become insolvent due to the rating restrictions imposed. This is a very important point to be made. It is also important to note that these changes do not require prior approval. Solvency may be less assured under individual prior approval regulations.

The model also recognizes that there may be different blocks of business that have significantly differing characteristics. These differences may be due to distinct distribution systems, managed care versus indemnity, assumption of blocks from another carrier, impact of case size on dependent rate strategies, and underwriting using distinct selection criteria. The model allows for "class of business" groupings if the applicable health insurance plans fit one of the following: (1) marketed and sold through differing individuals and/or organizations; (2) acquired from another small employer insurer; (3) provided through an association with some minimum number of small employers which has been formed for purposes other than obtaining insurance; or (4) meet certain open enrollment, guaranteed issue, currently offered and other requirements (this is a special category). However, the insurer may establish no more than two additional groupings under each of these on the basis of underwriting differences.

All of these definitions, restrictions and requirements are necessary in order to prevent gaming of the system. Some people are still unconvinced that this will stop gaming and thus huge rate increases for certain groups. There is one point that must be understood now and as this process is implemented into the small group system: this process will not prevent rate increases of 35% or 40% or even 50%. The underlying trend factor for each insurer's business may drive the annual increase higher than most people would like. It will, however, stop the outliers of 200% or 500% or 1000%.

The rating limitations set out in the model are three in number. The term *index rate* is used in these limitations and is defined as the simple arithmetic average of the applicable base premium rate and the corresponding highest premium rate for each class of business. You'll recall we just defined the different classes of business. The use of index rate and the comparisons made will involve extensive actuarial adjustment. We all have assumed that there is some way to make all of these adjustments, but no one to my knowledge has really developed a system to do it. It will most likely involve the use of manual rates with actuarial adjustment factors for plan design differences, etc.

Now, to the limitations as currently stated in the model. First, the index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more that 20%. In other words, if the smallest index (average) rate is 100, then the largest cannot exceed 120. Special open enrollment business previously described is exempt from this comparison.

Second, within a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more or less than 25% of the index rate. In other words, if the index rate is 100, then the rates must fall between 75 and 125. When combined with the between-classes limit, this means the lowest rate (after adjustments) would be 75, while the highest would be 150, which is 120 times 1.25. The overall rate differences are capped at a 2:1 ratio. Again it is important to remember that adjustments can be made for age, sex, geographic area, and industry. However, substandard differences must fall within the 2:1 limit. The 2:1 limit is a politically driven number. In the early stages of the process, we were looking at ranges of 2.5:1, or even 3:1. As individual states adopt the model, these numbers could easily be ratcheted down. The committee is very concerned about that possibility.

The third limitation deals with the maximum annual increase. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

1. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new period. In the case of the class of business for which the small employer insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate.

2. An adjustment not to exceed 15% annually, adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the insurer's rate manual for the class of business.

3. Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the insurer's rate manual for the class of business can also be made; e.g., census changes, changes in plan design.

For plans outside the limitations on the effective date of the law, a five-year grandfather is provided to reach compliance. The 15% adjustment is eliminated until compliance is reached. After five years, rates must be adjusted to meet compliance. Highest rates could be reduced, lowest increased or both.

Transfers between classes of business are basically prohibited. This is to prevent gaming.

The limitations are very tight and will change the rating practices of most small group writers. More pooling of rates will take place. Small group rating practices will be pulled closer to a middle place on the spectrum of individual pooling and true group experience rating.

The other major proscription involves renewability of coverage. A health insurance plan shall be renewable to all eligible employees and dependents at the option of the small employer, except for the following reasons: (1) nonpayment of premium; (2) fraud or other misrepresentation of the small employer, or with respect to coverage of an insured

individual, fraud or misrepresentation of the insured individual or such individual's representative; (3) noncompliance with plan provisions; (4) the number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan; and (5) the small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

However, a small employer insurer may cease to renew all plans under a class of business provided the insurer gives notice to all affected health insurance plans and to appropriate commissioners at least 90 days prior to termination of coverage. An insurer doing this shall not establish a new class of business for five years without prior approval of the commissioner or transfer any one group or individual to another class unless all groups are allowed to transfer.

Actuarial Opinion and Certification

The third element of the strategy is an actuarial opinion of compliance with sound actuarial rating practices. Due to the proprietary nature of small group business, the committee felt that it was not desirable to have all practices on file in a publicly available form. Therefore, the compliance is handled through the following requirements:

1. Each small employer insurer shall maintain at its principle place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

2. Each small employer insurer shall file each March with the commissioner an actuarial opinion certifying that the insurer is in compliance with this section and that the rating methods of the insurer are actuarially sound. A copy of such certification shall be retained by the insurer at its principle place of business.

3. A small employer insurer shall make the information and documentation described above available to the commissioner upon request. The information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the insurer or as ordered by a court of competent jurisdiction.

Legal Intervention by Regulators

The fourth element of the strategies is legal intervention by regulators.

While the committee felt very strongly that prior approval in the small group health insurance arena would neither encourage availability nor hold down rates, it did recognize that regulators have a legitimate interest and a right to access technical information if there's reason to believe that an insurer is not in compliance with the model law or its regulations. Regulators also need sanctions when there is reason to believe that an insurer somehow is failing to adequately comply. These rights are inherent in the model law. However, consistent with the model drafting process of the

NAIC, no specific sanctions for noncompliance have been offered. Each state may incorporate sanctions that are appropriate to the existing filing laws and regulations of their jurisdictions.

On the opposite side of the coin, it might be noted that the commissioner may suspend all or any part of the limitations as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer insurer and a finding by the commissioner that either the suspension is reasonable, in light of the financial condition of the insurer, or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance. An example of the latter is in the case of a highly substandard block from an insolvent insurer being sold to another insurer.

FUTURE

Well, where do we go from here? I've already mentioned the exposure aspects of this model. Some of the open issues, include: underpricing of new business, preexisting condition clauses which should be viewed in the context of the discontinuance and replacement model, acceptance of all members of the group or none, one-life discretionary group trusts, and reinsurance.

Another advisory committee has been set up by the Working Group of the NAIC Accident and Health (B) Committee. It has been charged with addressing these additional items. John Troy of the Travelers chairs the committee. They have been asked to present a report in Louisville in December.

MR. RICHARD W. HILL: Cecil has given you a good background and brought you up to date on what the NAIC is doing. The direction that the HIAA is recommending, and also the direction that the NAIC is heading, are quite similar. This should make it easier for all of us as we look down the road. I'm going to skip over some of the areas where Cecil gave a lot of detail. If we have to fill in some gaps we can do that during the Q&A session later on.

I'm going to talk about the efforts of the insurance industry, the commercial carriers working through the HIAA, to take an aggressive, proactive approach to these challenging issues in the small employer marketplace.

You may ask, "Why is it important for the industry to put forth these proposals for market reform?" First of all, I think it's always better for the industry to have a positive proposal, something that it can speak about, rather than criticize whatever the other guy suggests. Second, it gives us an opportunity for the industry to be together and have close to one voice on key issues. Third, having a proposal that it can look at serves as a way of educating the public, regulators, and various elected officials about the small employer marketplace and various key issues.

The HIAA recommendations cover three broad areas. The first area is Medicaid reform, which involves increased public funding for the poor. The second area is tax incentives to provide more coverage for lower paid employees (the near poor). The third area involves underwriting and rating reforms which I'm going to talk about.

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Representatives of many member HIAA companies, large and small, have worked with the HIAA staff for over two years with the objective of assuring that all small employers will be able to purchase relatively affordable health insurance for their employees.

I'm on the Technical Advisory Group to the Board Reinsurance Committee of the HIAA. The result of our activities, and the activities of the various committees, is a broad proposal which includes guaranteed availability of coverage, and various rating and underwriting reforms. Details of the proposal are still being worked on. I'll be covering the basics of the proposal, although some of these may be fine-tuned at a later date.

The first precept is that health insurance coverage will be guaranteed for all employers with fewer than 25 employees, excluding one life groups. So there will be full guaranteed coverage for 2-25 lives. That means all groups can obtain basic prototype benefits. All individuals within those groups, including uninsurables and high risks, will also have coverage. Reinsurance will be available for carriers writing both high-risk groups and unhealthy individuals.

The second part of the proposal provides continuity of coverage for both groups and individuals. Groups cannot be terminated because of poor claim experience -- either out-right termination, or termination via excessive rate increases. Once in the health system, individuals will be guaranteed continued coverage even if they change employers. Employees need only satisfy a preexisting conditions exclusion once, not every time they change employers. Employers must permit newly hired employees to purchase coverage in their group medical plan on an employee-pay-all basis during any waiting period prior to the normal effective date of their group coverage. These proposals involving continuity of coverage are designed to fill in various gaps, particularly for those firms that may go from carrier to carrier or those individuals who may change employers fairly regularly. Once in the system they would continue to have coverage.

The third part of the HIAA proposal is designed to curb the abusive rating practices. Rating reforms are designed to limit both the year-to-year rate increases and the overall rate levels for similar groups. The HIAA recommendations here are quite similar to the NAIC's which Cecil described.

Annual rate increases will be limited to 15% plus trend. Trend is being defined as the increase in the lowest new business rates, year to year. This means that if a carrier were to put in high rates of increases for certain blocks of business, it would have to raise its new business rates proportionally. In other words, if an insurance carrier wanted to be extremely competitive year to year on its new business rates, and wanted to, in spite of rising costs of medical care, keep its new business rates flat year to year, it would be prohibited from having much of an increase in its in-force rates. So, it's kind of a rate compression trap.

There will be an overall cap among similar groups that limits the highest rate to about two times the lowest rate. Rates can vary from 35% below to 35% above the average rate for similar groups. Basically we're saying the top rate would be 135%, the bottom rate 65%. The top rate, 135, divided by the bottom rate, 65, is pretty close to two times. This is an area where the HIAA model is considerably more simple than the NAIC

approach, which as Cecil describes, involves several blocks of business. From a bottom line point of view there is very little difference. For today it's easier just to think of a two times relativity, highest rate to lowest rate, for similar pieces of business. There are differences for different benefit levels and that is outside the two times rule.

The intent of these recommendations is to eliminate the abusive tier and durational rating and still allow carriers some flexibility to recognize the aging curve and claim experience in either blocks or individual cases. It eliminates the use of exorbitant rate increases, as I mentioned earlier, to cancel cases or to cancel blocks of business. Also, as I said before, it will force a compression of rates.

Here's a simple example. New business rates go up 10% and your new business rates were the lowest rates you charged. The highest rates you could charge for similar groups would be twice the new business rates. Therefore, if the bottom end only goes up by the trend, the 10% year-to-year, the actual rate increase you could give the very highest rated groups would be that same 10% increase. A group in the middle somewhere, paying an average rate, could get a rate increase of 10% plus as much as 15%, or 25%. This would drive middle groups more towards the upper end of the range and force a compression of your bad, your pretty bad, and your very bad cases. Currently some companies can have a much broader range of rates.

The fourth precept allows carriers to medically underwrite at issue and for new entrants, but only to determine the level of risks and to establish initial rates based on demographic factors. This is an important point. Age, sex, geography, family status, and industry will remain as basic rating factors. Substandard ratings on individuals (for medical conditions or such lifestyle factors as smoking) will also be allowed to price individual risks up to maximum rating limits. This would give the flexibility to rate new business pretty much as we do now and down the road when lifestyle underwriting becomes more important, account for those factors as well.

The fifth part of the proposal involves reinsurance. Since coverage is guaranteed, the proposal calls for a privately funded and administered reinsurance mechanism through which insurers will be able to reinsure high-risk employees or groups.

I mentioned earlier that all groups will be able to get health coverage. However, there's still some discussion as to how they're going to be able to get this coverage. That discussion involves the concepts of guaranteed issue and guaranteed availability. Guaranteed issue would be defined as the insurer having to insure and provide basic coverage to any small group that is presented. Guaranteed availability means that, collectively, all insurers would ensure that any small group could get coverage. There may be designated carriers who would act, more or less, as carriers of last resort to provide this coverage. Right now it appears that guaranteed issue rather than the designated carrier approach is the preferred one. This is largely because many companies are scared of what they have seen happen in many states with automobile reinsurance mechanisms.

There will be requirements to minimize any gaming. For example, only new risks can be reinsured as individuals. Once reinsured, individuals and groups must stay reinsured for

three years. Groups would be reinsured on a 150% basis. If individuals were picked out of groups and reinsured, they would be on a 500% basis. If individuals are reinsured, that would be transparent both to the individual who is reinsured and also to the group, the employer.

By utilizing reinsurance, employers are assured that any group would pay no more than 150% of the average cost of similar groups for basic coverage. The proposal also recommends incentives to practice good claims management. The reinsurance proposal would involve such things as audits and perhaps some sort of cost sharing such as reinsurance that kicks in after a certain deductible or some coinsurance features.

Now for the big question: If you have a reinsurance mechanism, who pays? Obviously, there are going to be more bad risks going into the marketplace than we now have. There would be some excess cost involved for the reinsurance. This is a major area of debate. It is highly unlikely that the losses can be absorbed in the small employer marketplace completely. Therefore, broader based funding of some type will be needed.

The current HIAA proposal calls for three levels of funding. The first is a surcharge of up to 4% on small employer premiums. The second is a surcharge of up to 1% on all medical premiums (and premium equivalents) that should sweep in both insured and self-insured plans. The third is some type of public financing. Including self-insured plans would require an ERISA exemption. Third-tier public financing is a controversial issue, but many companies believe strongly that the uninsured problem is a social issue. A provider tax on everything from hospital care to band-aids has also been suggested as an alternative to both the second- and third-tier-type financing.

The HIAA proposal also contains a provision to protect and educate policyholders and to assist regulators in enforcing rating and underwriting guidelines. There will be full disclosure to policyholders of rerating practices and maximum rate increases. There will be actuarial certification of rating and underwriting practices, as well as benefit relativities. There will be no requirement for filing rates. As I said earlier, these are the basics. There's still a lot of work to be done and a lot of technical areas to be looked into.

For example, we recognize that there are wide differences between states. What we have here is model legislation which we hope most states would look at. In some states there is a heavy managed care environment. Some states are heavily dominated by the Blues. There are substantial differences by state. So, the HIAA is involved in drafting model legislation that could be used as a starting point for most states.

We're also interested in encouraging managed care wherever possible. All prototype plans and proposed solutions for the uninsured would involve managed care. Medicaid, plans for the near poor, and plans for the employer marketplace also would be geared as much as possible towards managed care.

Another concern is high turnover employees, with regard to gaps in coverage, and employees who never stay with any one employer long enough to get any type of coverage. Those are areas that we would have to look into. This is old, and very challenging.

Perhaps the greatest challenge is to prevent gaming of the system. I don't know how many times Cecil mentioned gaming, but he mentioned it several times. We're a very creative industry. Once the rules are established, people will be trying to find ways to get around those rules and to maximize their profit. That will be a major challenge.

April will now discuss how the California Blues and the national Blues are looking at these challenges.

MS. APRIL S. CHOI: At an earlier session we heard what's going on in Massachusetts and Maine. Dick and Cecil have just talked about what's going on at the NAIC and HIAA regarding the small group reform. Let me tell you a little bit about what the Blue Cross/Blue Shield (BCBS) perspective is, what the BCBS Association national policy is, and what the Association's recommendation to the plans is regarding financial access to care for the uninsured. Then, I'll go over what's going on in California and what Blue Cross of California is doing to help address the small group uninsured problem.

Let's begin on behalf of the Association.

BCBSA PERSPECTIVE

In case you're wondering why you would be interested in knowing what the BCBS perspective is: While the Blues are impacted by the access and uninsured problem as are the commercial carriers, they may be impacted differently. We need to work together to tackle these issues. To address the issue of the uninsured, the Association has developed recommendations for government actions, private sector actions, and for the member plans.

BCBSA National Policy

Government actions include no state-mandated benefits, tax credit and subsidies, expanded Medicaid coverage, and state high-risk pools. No state-mandated benefits would preempt state laws that require coverage of specific benefits and providers from all insurance products so the health benefit package can be more affordable. Tax credits and subsidies make insurance more available and affordable for small employers. The next two address the problem of accessibility: (1) Expand Medicaid coverage for people with income below 100% of the federal poverty level, break the link between eligibility and welfare categories, and provide federal assistance on a sliding scale basis for the working poor. Medicaid currently covers only 40% of the population below the federal poverty level. (2) Encourage the development of state high-risk pools where needed to provide coverage to individuals who are considered medically uninsurable and provide for broad financing of these pools.

BCBS recommendation on private sector action includes strengthening the quality of care and effectiveness of health care delivery. To address a problem faced by the small employers, the Association supports moving the small group health insurance market from one that is based on ability to select the best risks to one where competition is based on administration efficiency, service, and ability to control cost. The Association is currently working with the NAIC on ways to assure access to private coverage for all small employers and reviewing a variety of options for achieving this goal.

As the debate on problems in the small group insurance market progresses, the Association emphasizes that, in considering ways to bring about the desired changes, it is important to keep in mind that the current practices did not evolve overnight, but rather developed over time in response to real market pressure. Congress, the states, and the industry will have to work together in balancing the need for change to benefit some individuals and groups against a potential disruptive effect of these changes on other individuals and groups. A transition period will be critical in maintaining stability.

BCBSA Recommendations to the Plan

In 1987, the Association issued a policy statement that offered three recommendations to member plans regarding financing access for the uninsured and medically indigent. They are, provide leadership in local communities regarding uncompensated care, undertake aggressive market development of new products targeted to the needs of the uninsured, and assure effective use of subscriber premiums.

CALIFORNIA LEGISLATIVE ENVIRONMENT

Next, I'll go over what's happening, and some of the features of bills in Sacramento.

What's Happening

There was a mountain of health care bills introduced in 1990 in California, there was no action in 1990, and there's a threat of ballot initiatives in 1992. There are 3-5 million Californians, 12-18% of the population, without health insurance. Two-thirds are either employed or dependents in employed households. The number of uninsured individuals working for businesses is the largest contributor to the problem of uninsured Californians. This year universal health coverage has been a very hot topic in California. There have been numerous health-care-coverage-related bills introduced in Sacramento. Although the 1990 session has ended without any conclusion, it is expected that 1991 will be more intense. Many of the measures will be reintroduced in January. Other than the fear of ballot initiatives, next year a new governor and a new commissioner will come on board. Both Mayor Diane Feinstein and U.S. Senator Wilson, the two candidates for governor, are believed to be more sympathetic to universal health care coverage. The likely commissioner candidate, John Garamendi, has set as one of his goals to find the best way to finance health insurance for all.

There's also the threat of ballot initiatives. The Health Access Foundation, a consumer coalition in San Francisco, supports a bill that calls for implementing a state-run health care coverage system, similar to Canada's socialized health care system. If the legislature does not act, consumers are very likely to take the health access proposal to the ballot in 1992. This is what makes doing business in California so exciting. I assume you are all aware of Proposition 103.

Features of the Access-to-Care Bills

Features of access-to-care bills in Sacramento include: coverage, service, impact on the insurance industry, cost containment, small businesses, and financing.

Some of the bills require voluntary coverage, some require mandatory coverage. The requirements range from covering only the uninsured full-time employees and dependents to all insured and uninsured. In terms of population, the coverage ranges from

100,000 people to the entire state. Covered services range from basic benefits, catastrophic only, to very comprehensive coverage, including long-term care. I'll discuss a little later how this impacts insurance.

Cost containment provisions include controlling hospital rates and physician rates, hospital capital decisions, malpractice reforms and/or expanded data capturing capabilities, such as outpatient data. Small businesses with guaranteed issue and guaranteed renewability will be able to get continuous coverage. With rating restrictions, hopefully they'll have less rate shocks. They can buy into MediCal. They will be required to provide coverage or pay an assessment. Financing provisions include payroll tax, tax on unearned income, alcohol tax, sales tax, federal matching under MediCal, and/or assessments from employers.

Let me give you a little more detail on some of the bills and how they impact the insurance carriers. The last three bills proposed a "play or pay" mandate under which all employers will be required to provide a minimum level of health care benefits to their employees and dependents or pay a fee that would be used to pay for the cost of coverage for uninsured workers. The three bills are AB 3032 sponsored by Speaker Brown and Assemblyman Burt Margolin, SB 328 sponsored by Assemblyman Margolin, and SB 2505 introduced by Senator Maddy and backed by the California Medical Association.

How do these bills impact the insurers? AB 3032 requires guaranteed issue, guaranteed renewability, and rating restrictions. The bill includes an underwriting reform package suggested by the Association of California Life Insurance Companies. In general, most insurers support this bill, except for one provision known as the "gorilla behind the door." It's a backdoor approach to a Canadian style system. If increases in the health care cost in California exceed the overall CPI for three consecutive years, the residents in the state would be allowed to obtain health care coverage through MediCal. This has a significant impact on insurers. This means the state could establish a state health insurance plan and drive out private insurance. The insurers are not thrilled about this provision.

SB 328 requires open enrollment; bars discrimination in enrollment, terminations, renewals, and premiums based on health status; and controls marketing practice to prevent creaming and skimming. In addition, rate increases would require prior approval by the Insurance Commissioner, or the Department of Corporation. It also applies to HMOs. SB 2505 also requires guaranteed issue, guaranteed renewability, and a modified form of community rating. It requires average rates for small group to be no more than the average rates for large group, limits geographic classification to four areas, and exempts insurers from mandated coverage and mandated benefits.

A fourth bill, SB 20A68 sponsored by Senator Patris, is backed by the Consumer Coalition. It will provide universal coverage to all Californians. It's the most ambitious plan. Under this bill, the state will administer the health care system which eliminates the need for private insurance.

BLUE CROSS OF CALIFORNIA'S SOLUTIONS – SMALL GROUP ACCESS PROGRAM

Last, I'll cover what Blue Cross of California is doing. As part of the solution to the small group uninsured problem, Blue Cross of California recently introduced the small group access program for 3-49 lives. I'll go over the goal of the program, how we increase accessibility, the product features, rating, and field reaction.

Goal

The goal of the program is to increase accessibility to health insurance for small employers. We feel that we must be proactive rather than reactive. With more companies being more proactive in addressing the issue, the industry can be part of a private solution to a public policy concern. Blue Cross of California has been working with Sacramento legislators and the Association of California Insurance Companies to help create an environment in which all insurers would share in the responsibility for insuring the uninsured.

If the insurance industry continues to be responsive, it can have a major impact on the ultimate resolution of the problem and alleviate the need for unnecessary legislation. There's certain risk involved in coming up with a small group access program, but the risk of not doing anything is even greater.

Access

To address accessibility we created two pools: the preferred pool and the standard pool. The preferred pool includes people who would easily gain coverage under the current industry underwriting approaches. The standard pool includes groups that would typically be denied coverage. Accessibility is increased by accepting these standard groups.

We anticipate accepting about 90-97% of risks submitted. We ask the agents to give us the good risk groups in return for accepting the marginal risk groups. To balance the risk we limit four preferred employees to one standard employee. We require a long application form for 3-14 employees, and a short application form for 15-49 employees. We no longer have an ineligible industry list.

An example of a preferred group is one with little or no history of serious medical conditions, low turnover, interest in a high-deductible plan, and a 90-180 day waiting period for new employees. The group takes workers' compensation coverage for all employees and has 100% enrollment.

An example of a standard group is one with some acute and chronic health conditions, a thirty-day waiting period for new employees, no adequate workers' comp, and over one-third having coverage elsewhere.

We also decline business if the group is not a bona fide business or if some of the employees have serious medical conditions and are currently being treated.

Product Features
The product features affordability and cost control. We offer managed care products: a selection of PPO plans with three to four deductibles. We also have our own HMO plan, the California Care plan. We allow mixed and matched PPOs and HMOs down to three lives. We have optional dental and group term life insurance.

Rating
We have the same rates for new business as for renewals. We use a five-year age band. We have unisex rates. We have five employee dependent classifications: one adult, two adults, adult and a child, adult and children, and family. We rate six areas by counties.

Field Reaction
When the program was initially introduced the agents were skeptical. The agents now understand that we need a proper balance of the good risks and the bad risks, and we can't take all the bad risks.

I urge you to be more involved in the process of small group reform to help shape what we would like to see. We the actuaries are more knowledgeable of the insurance mechanism, the risk selection. For example, there are misconceptions out there that buying reinsurance would cut down costs, and group insurance would also somehow cut down costs. But we know that only spreads the risks and the costs, it doesn't control the absolute cost.

MR. BARRY T. ALLEN: I'd like to address the panel members who are working towards model bills. Every time I hear health insurance, I'm reminded that you really include, unless specifically exempted, both long- and short-term disability. I wonder if your bills are very specific on whether those are swept in, and if they're not specific, I assume they're swept in. How is that addressed? Do all of these limits address the disability issues?

MR. BYKERK: We should have used the terminology *medical*, rather than *health insurance*. I apologize.

MR. THOMAS J. STOIBER: I really have two questions. The first one concerns the rate increase limitation. Often an actuary rerating changes the slope of the rate table either by age or deductible. It seems to me that you may be within the average limitation. Let's say you're going for a 10% increase over your trend, and yet you change your slope so that the higher ages are now 10% more, and the lower ages are less 10%. Does this create an accumulation of smaller subsets that you have to manage forever?

MR. BYKERK: I think that washes out with the actuarial adjustments that you make. In setting your assumptions you have to back up those assumptions with your own experience. If you're changing the slope, presumably it's because of underlying experience. You can justify that relationship.

MR. STOIBER: So it could be a small group. Let's say you decide that your older ages have worse experience. Older age people could have bigger than this limitation, while the younger would not, and that's considered an adjustment.

MR. HILL: Not if you're doing it just for a small block, and that's a way to get around rules. You're changing the whole scale. The objective of all these requirements is to eliminate abuses, and if you're not doing something that's abusive it could be handled via the benefit adjustment as Cecil said.

MR. STOIBER: You made the statement, Cecil, that the group decided against any kind of restriction or prohibition against tiered and/or durational rating; that is, to allow some of it, because it was too costly. I'm having a hard time understanding that. It seems to me that once you get the policies issued, you're going to be dealing with the same group of people, the total population of insured people. You haven't really changed the health care utilization of that group. If these people are going to be insured continuously, have you really made it more affordable, or more costly? You're just making it more affordable for the new entrants at the expense of the later in-force policyholders. Unless, of course, there's a high commission rate in the first year which you don't have to pay anymore.

MR. BYKERK: I'm not sure I understand that specific remark.

MR. STOIBER: Okay, let's say it a different way. Say the tiered and durational pricing is remaining, because it's less costly. If you went more with the levelized premium approach you would have no tiered and durational rating allowed at all. Right?

MR. BYKERK: That was the concern. If you suddenly go to a level approach, if you do away with tier and durational rating, you're going to force people out of the marketplace. Not because they can't afford it necessarily, but because they don't perceive it as a valuable commodity to them. In which case that will end up driving up rates for other people to stay in.

MR. HILL: Conversely, if you have none of that, it makes it difficult to compete against a new carrier coming into the market with very low rates.

MR. STOIBER: That's the way I understood it. It is an affordability issue at time of issue for new business to compete against old business.

MR. BYKERK: I referred to the area of underpricing but I didn't get into it. There's a great deal of concern on the Committee that needs to be dealt with. We want to make sure that new companies can't come in and lowball the established companies and then get out. Obviously, with a five-year restriction, that can only be done once in five years. But there's concern; there are ways of gaming that: having different companies under the same control. The committee is going to continue looking at that and try to put in restrictions that prevent that sort of hit-and-run game.

Another thing that was not discussed is what's referred to as "fleets." That is, should this cut across all companies controlled by the same organization? There are a lot of problems with that. How do you define control? We know that the problem is there; we've set it aside for the moment.

PANEL DISCUSSION

MR. GREGORY S. BENESH: I've got a question for April. With California being the largest state, what do you think the likelihood is that either an NAIC or HIAA proposal might have any luck at all in California?

MS. CHOI: I think that what was proposed is very similar to the NAIC and the HIAA proposals. So, we probably could end up with something similar to those.

MR. BYKERK: I would like to comment on that a little bit. I think the one major difference is the A-versus-B distinction among carriers. The NAIC hasn't yet addressed that issue. I guess it is addressing that in the new committee structure. Primarily, the A companies are the Kaisers, the Blue Cross/Blue Shields. The B companies are the commercial carriers. I think the HIAA is hoping for something that can get everybody to buy in. Whether it ends up being an A/B-type concept, I don't know.

MR. JOHN SAARI*: I have a question for April. I also have an amplification of her presentation. One of the things that she mentioned was the initiative likelihood from the consumer advocates. It's very likely that we will have competing initiatives; that's also something that makes it very exciting to work and do business in California. They will be sponsored, in all likelihood, by the provider organizations, the California Medical Association and the Hospital Association.

I didn't hear about the relationship between the standard and the preferred in your presentation. I think you have one, and it might be helpful to know what the rates are.

Before you answer, I have one other comment for Cecil and for everybody else who doesn't know what A and B means. It allows you to opt out of the reinsurance mechanism. That's what it is. It's two tracks and on one track you can opt out of the reinsurance mechanism.

MR. BLUHM: I want to ask a question regarding that. Was one of the tracks going to have guaranteed issues, and the other not?

MR. SAARI: No, all carriers would have guaranteed issue. I mean it was guaranteed issue rather than an insurer of last resort. Every carrier would guarantee issue.

MS. CHOI: The answer to your question is the standard rates are 30% higher than the preferred rates.

MR. SPENCER KOPPEL: I have a comment and a question. One is a reaction to the proposals we've discussed. Our clients' reactions have tended to be one of relief. The proposals tend to put the business back in an orderly fashion to something more like insurance than before. There's an element of concern from the insurance company clients regarding a level playing field when there's a self-insured program floating around. In general, there's hope that this will put organization and order back in the

* Mr. Saari, not a member of the Society, is Senior Vice-President Actuarial/Underwriting of Blue Shield of California in San Francisco, California.

business. So, that's been the reaction. We feel that the business can be monitored and managed properly within these guidelines as they're currently structured with a lot of work. The question is for both Cecil and Dick. In the two proposals, I think you both alluded to questions of smoker and nonsmoker rates. I don't know if an actuarial difference in smoker and nonsmoker rates is allowed in the two proposals, or if they're thrown in with health history.

MR. HILL: We're not really sure yet. I'm fighting for it.

MR. KOPPEL: Fighting for what?

MR. HILL: For having a difference. Anything that is predictive at time of issue should be allowed to be recognized as a rating factor that would not be influenced by the other rating guidelines.

MR. BYKERK: I believe the way the NAIC proposal is written at the moment would allow it. Because it is really written from the point of view that you cannot, except within the two-to-one range, adjust for the two or three things. Say it would fall within the characteristics definition that falls outside of those limits. You would have to demonstrate that your experience actually fell within that range.

MR. BLUHM: I'd like to make a comment if I could. My perception is a lot of the regulators and politicians don't perceive that as being an issue. They like being able to rate by lifestyles, having it based on smoking, nonsmoking. So I would perceive it not to be an issue from that point.

MR. DAVID WILLIAM DICKSON: I'd like a little bit of clarification from all three of the panelists on the relationship of the reinsurance versus state high-risk pools. The NAIC model doesn't seem to address the HIAA calling for an industrywide-type reinsurance pool where it's guaranteed issue and everybody participates. The Blue Cross Association mentions encouraging high-risk pools. It doesn't necessarily say anything about guaranteed issue. I will give you a little history in Texas. We just had a law passed that sets up a state high-risk pool. There are two ways to get in it. You're either denied once for insurance from any company, or if your premium is higher than the high-risk pool's premium, even though you're insurable, you can get in it. The highest is going to be 200% of the average of the five largest individual health insurers in the state. In the absence of a guaranteed issue requirement it seems like you will get skimming, people underwriting, dumping people to the high-risk pool. The nice thing about our high-risk pool is it's going to be funded from general revenues, and not assessments to the insurance companies. But I'd like some clarification on that and anybody's opinion on that.

MR. BYKERK: I can give a comment on the NAIC. The initial emphasis that we were asked to look at was the huge rate increases that were happening. That's why we went for rate reform. The issue of reinsurance, guaranteed issue, those kinds of things are what are now being addressed by the subsequent committee. But that was not within the scope of the original technical committee. It is working on the same concept.

PANEL DISCUSSION

MR. HILL: Frankly, I don't think anyone really understands how the reinsurance will work. It's a pretty complicated concept. The key is that we're not talking about a high-risk reinsurance per se. It's a way of carriers being able to provide a lot more coverage. We want carriers to insure risk. We want carriers to feel good about guaranteed issue and be able to lay off the risks that they would lose money on to a reinsurer. It would involve some coinsurance mechanism or whatever. But it's not for just the very bad risk. We envision a fairly decent amount of risks going into some type of reinsurance.

MS. CHOI: The way I look at it is there are several ways to approach a problem of availability. We mentioned that the state pools are addressing the problem of availability, and reinsurance is really for the insurance carriers. The high-risk state pools that I mentioned are for the uninsured individuals. They are only available to those who cannot get coverage elsewhere. Open state pools are open to everybody; it doesn't matter whether you're insurable or uninsurable.

MR. HILL: What is common now in the bottom end of the marketplace in small cases is very often if it's a five-life group and one life is unhealthy, that life is just rejected and four lives are insured. That life might have to go to a high-risk pool of some type. The idea here is through an individual insurance mechanism or group-reinsurance-type approach, all five employees can be accepted and have the same type of coverage and any reinsurance would be transparent. I think that's sort of the major difference in the outcome.

MR. DICKSON: Regarding your example, would all five of those lives be reinsured so that the reinsurance would have some good risks in there too? Otherwise it's not going to work.

MR. HILL: There are different proposals and a lot of discussion, and maybe it might depend on the type of risk that it is; whether it would be group reinsurance where all five lives would go or just one life. If it's one life, it would be on a basis that would be perhaps more expensive. Guaranteed loss is really for the carrier if it sees it as a single life. It would minimize the extent of loss but it would be a guaranteed loss situation.

I just want to mention two other things. One, I think that as an industry we have to recognize that we have very high expense levels. Throughout a lot of our conversations we're trying to find ways to cut back on expenses a little bit, and one way is to insure risks that right now no one would want. If we find a way for these groups to be insured, we should be able to do it in a way that substantially lowers the cost of delivery, which would mean commissions and allied expenses. We feel that it is quite important to cut down the very high expense level in the small group marketplace. The other thing is we don't feel that any of us are going to be able to solve these problems because they're really very heavily provider driven. Perhaps managed care offers the best alternative there; some way to make the providers partners in trying to solve these problems.