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SMALL GROUP PROPOSALS

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MS. ALICE ROSENBLATT: The theme of this conference is an international one, but we will deviate from that. We will talk about certain small group proposals and other regulatory issues in the United States. As the speakers talk about those things, think about the implications and put them in an international setting. I think as we talk about small group reform, there are two ways to think about it. One is that it's one of many steps toward national health insurance. Another is that it is a step to prevent national health insurance in the United States. These are two very different perspectives.

Our speakers will talk about small group reform as well as other regulatory changes enacted or proposed in their states. I'm going to be giving you some background information on each of the three speakers, and then I'll turn it over to Hal Belodoff.

Hal Belodoff is currently Deputy Commissioner of the Massachusetts Department of Medical Security. The Department of Medical Security is charged with handling the state's universal healthcare program. Hal has also worked for the HMO, U.S. Healthcare Inc. as vice president and chief operating officer of both the New York Region and the New England region. He's also worked for Blue Cross/Blue Shield of Massachusetts and for the U.S. Healthcare Financing Administration, the Massachusetts Department of Public Health, as well as the U.S. Healthcare Financing Administration Bureau of Quality Assurance. Hal is a member of the Massachusetts State Bar.

Rick Diamond is an FSA currently serving as life and health actuary for the Bureau of Insurance in Maine. Prior to his work as a regulator, Rick worked for State Mutual of Massachusetts.

Trevor Smith was appointed as Florida's Assistant Treasurer and Insurance Commissioner in January 1989. His previous experience included 19 years with Plan Services in Tampa, as chairman. Trevor has also held key positions with Bankers Life of Nebraska, Connecticut General, and has served as an officer and director of the Professional Mass Marketing Administrators, the Mass Marketing Insurance Institute, and the Independent Administrators Association.

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SECTION MEETING

MR. HAL BELODOFF: This is an unusual opportunity for me. Usually, I'm brought in to speak to legislators or politicians when for policy reasons we want MEGO to set in. "MEGO" stands for "My Eyes Glaze Over" when discussing insurance principles. So, this will be a rare opportunity to speak to an audience whose questions will probably give me MEGO rather than the other way around.

Before getting into a detailed discussion of the small business insurance reform that's taking place in Massachusetts, I think it's important, particularly in light of Alice's comments, to understand the context in which this issue was taking place and the role that it's intended to play in Massachusetts. As many of you know, Massachusetts passed a Health Security Act in April 1988 that is designed to provide universal access to health insurance to presently uninsured individuals by the end of 1992. The Massachusetts program is based on the following principles, which may sound familiar to those of you who have been following what's going on in Washington through the Pepper Commission and other efforts to deal with this as a national plan.

The first principle is one of fundamental fairness both to individuals and to groups that are already providing health insurance. In Massachusetts, those employers who provide health insurance are paying about $350 million a year for the cost of care generated by those who don't have health insurance. Nationally, there's about an $8 billion cost shift taking place; employers who do provide health insurance are subsidizing those who don't provide it. About half of the small businesses that we've surveyed with fewer than ten employees offer health insurance. And so for a competitive fairness and for basic equity, one pizza parlor shouldn't be subsidizing the cost for another pizza shop down the road.

Also, individuals are forced to make very difficult decisions in their daily lives about seeking health care. We've just released a survey last week, done in conjunction with the Harvard School of Public Health, that looked at the use of health care services by those who have health insurance and those who don't. We found that those who do not have health insurance do not seek health care to the same extent as those who do. It's probably not a big surprise to a lot of you, but it was something that broke a conventional wisdom in Massachusetts, given the presence of a large compensated care pool which people equate in their minds with access to care. Why is a program necessary if a hospital pool pays for their care? Of the individuals who were diagnosed as having a serious condition, such as cancer, diabetes, or other chronic conditions, only 18% of those with insurance did not see a doctor in the previous twelve months, compared to 49% of those without insurance. The basic principle of the program is to put insurance protection (in sense of entitlement that comes with an insurance card) under everybody.

The second principle is that the government needs to expand its role in ways supportive of the private sector, principally, through Medicaid expansion and cost containment efforts. Nationally, Medicaid covers only about half of those in poverty, and if Medicaid is brought up to the poverty line, about 11 million of the current 30 million uninsured people would be covered.

Third, the uninsured are not a homogenous group, and it will take a variety of approaches to deal with the various problems posed by each segment. Between two-thirds and three-quarters of the uninsured are either working or are dependents of

people who are working. In Massachusetts, about 53% of the working uninsured work at firms with fewer than 25 employees.

The fourth principle underlying our program is that the program for the uninsured should be based on a series of incremental changes and phased in over time. And if voluntary efforts don't work, mandatory approaches must go into effect. Built into our law is a rather long phase-in period during which we do a variety of voluntary programs designed to test the premise: is a mandate necessary? And insurance reform is one of those, and I'll talk about that more later.

The fifth principle is that the current predominantly employer-based system should be extended as the principal means for providing health insurance to those presently uninsured. The basic concept here is that what we have works for most of the people and should be extended.

And that leads to the sixth principle, which is that the problem of the uninsured can't be solved until the problems of the existing insurance system can be addressed through comprehensive insurance reform. We just can't justify continuance of a private sector system as a solution to this problem if it excludes individuals or prices out groups because of the health risks they pose.

To a large extent our review of the problems of the uninsured lead us right into the area of the problems of small group insurance. And there are two things that we're doing currently in this regard. First, we have a series of what we call our phase-in insurance programs. These are insurance products that are designed to test whether small businesses buy at prices that they consider affordable, and the statute defines affordable as comparable to what large groups could get, and what the experience of the people would be if they were able to buy insurance without medical underwriting restrictions. Unfortunately, we have five programs in effect since last January, actively marketed since April, and the enrollment is going very slowly. The products that we're offering are four HMOs and one PPO, which have a combined enrollment of about 1,000 members after this period of time. The prices that these groups are paying currently are about 20% less than what the small groups could otherwise get on health insurance. Thus, even with a significant price break, they're not beating down our doors to buy the product. We're going out with a much lower cost program this fall or winter in an effort to see if a really low-cost, bare-bones product will have more success than the products we have right now.

The second area that we're working in is small business insurance reform. Last January, we issued a report that documented many of the problems in the small business market. We held eight public hearings and heard testimony from about 200 individuals. We heard stories primarily of the problems of access and affordability. Brokers reported difficulty finding carriers to write certain groups. Blue Cross/Blue Shield's community-rated program was severely selected against, producing an average family rate of about $600 compared to an HMO rate of about $350. So you see the effects of selection against the community-rated insurer. HMOs found that they also had to practice some underwriting. Even though some of them say that they will take anyone who wants to buy their product, in fact, many HMOs stopped writing groups where the competing

carrier's plan was using medical underwriting. Thus, even small groups that wanted HMO plans often found they couldn't obtain them if their indemnity carrier was engaged in underwriting.

We have a small business advisory board consisting of representatives of the small business community and the insurance community. They've developed a series of goals in terms of demands that they felt were necessary to make it possible for small businesses to deal with the insurance problems they were facing. They wanted rate relief in the form of low or more stable rates, they wanted guaranteed issue without any kind of underwriting, and they wanted a system of competition based on risk management rather than avoidance of risk. The challenge facing the department in light of these goals was how to provide rate relief for some without creating rate shock for others. How could we implement guaranteed issue without undermining sound insurance practices? How could we avoid insuring burning houses and yet satisfy their concerns about guaranteed issue? And how could a competitive playing field be leveled without driving out many of the players?

The nature of these highly technical and somewhat empirical questions led us to establish an actuarial advisory group to inform our policymakers. We convened this group consisting of representatives from the Blues, the HMOs, and the Department. We had actuarial and policy people meeting together and judging by their participation, I think the actuaries appreciated the opportunity to participate in policymaking at the earliest stages and not be handed something from the politicians that would be impossible to implement. And, certainly, from our perspective it worked very well to help depoliticize these problems and try to work them out on the basis of how we could meet these goals without breaking the system. I think it's worked pretty well.

A lot of credit for the fact that we're having this meeting here and the discussions we've been having in Massachusetts should go to the Health Insurance Association of America (HIAA) for its work in this area. I call it a sea change that has occurred in the recognition on the part of the private sector. If it wants to be part of the solution it can no longer be part (or be perceived as part) of the problem. The work that the HIAA did in putting small group reform on the table has made it possible for us to have these discussions. About two years ago, a bill was filed in the Massachusetts legislature that called for continuity of coverage for individuals changing employers or employers changing plans. Nobody testified in favor of the bill with the exception of the consumer advocacy group that put it forward. Insurance companies said that it would be the end of insurance, the end of the private market -- gloom and doom! But now, this is one item that all parties have agreed should be an element included in any insurance reform package. We've really come a long way in this area.

In Massachusetts, HMOs have about 30% of the small group market, the Blues about 40%, and commercial insurers about 30%. We met over the summer, and each party submitted a proposal. The commercials submitted a proposal primarily to benefit those who currently don't have insurance. It was largely based on the HIAA proposal and was very much like the Connecticut plan. They've relied on cross subsidies and a rather complex reinsurance scheme with chargebacks to individual groups that caused the

reinsurance premiums to be purchased. It requires the losses of that reinsurance to be shared among the Blues, HMOs, and the commercial players.

Blue Cross/Blue Shield submitted a proposal that would eliminate experience rating. Reinsurance was not a necessary element. The full demographic rating would be provided without any rate compression.

The HMOs submitted a proposal that really wasn't a full-blown proposal, but rather a document saying to keep them in mind when developing the overall proposals. "We're out there. We can't have preexisting conditions. We can't do rating periods. We have very comprehensive benefits and we don't mind selling to anyone who comes, but if we get burned we could pull out of the market." They were very concerned about the mandatory nature of guaranteed issue.

Our department attempted to synthesize these proposals and molded a proposal we thought represented the best of each of the ideas. There are four principal areas in the synthesized proposal which is now under consideration by our actuarial subcommittee. Hopefully, we'll have legislation sometime this fall.

First of the four principal areas deals with rating. We felt it was important to eliminate experience rating but to do so over time. The individual small groups shouldn't be forced to pay the added costs because of the unfortunate circumstances that befall one of its members or dependents. We say this should be eliminated over time, again, with concern over the rate shock impact of forcing rates to be spread more broadly over an entire pool. It would allow, however, full demographic rating by actuarial class with adjustments for geography and industry. This is to minimize the incentives to game the system through marketing. The small business community was pushing very hard for one community rate, but in talking through this issue, it saw, first, that this would produce large rate increases for those younger groups or those with better demographics. Second, it could provide an opportunity for insurers to game the system through selective marketing. We're trying to eliminate gaming and encourage fair business practices.

Over time, we want to have compression in overall rates be no greater than a two-for-one variation top to bottom. And, again, it is to be phased in over time so that no group, as a result of this change in the rate compression, would have more than a 10% increase each year. Is that possible? This is a very tough question to answer. We've done some rough modeling, and we think it would take about four years on an average basis, but this may not be possible for some carriers. More technical work will have to be done on this question. But, the premise is, small businesses are willing to pay something for these changes. Are they willing to pay 40% in one year? No. But at 10%, small groups are willing to pay this increase to get guaranteed issue, consistent coverage, rate stability of the fund, and eliminate experience rating. Even those who have been benefiting from the rating practices that currently exist are willing to pay a price to ensure these benefits.

The second area the proposal addresses is underwriting. We're proposing a guaranteed issue for any product that the Blues or commercials offer. In terms of transferred cases, it would be guaranteed issue for a product of equal or less actuarial value. This is to

prevent situations where people would be trading up to obtain needed service. We're constantly trying to balance individual groups' desires for greater flexibility and the ability to get products they feel they need with insurance principles and practices designed to avoid adverse selection. Continuity of coverage for both individuals leaving their employers and employers switching plans would be a feature of the program. And, obviously, the transition to this system is something that we still need to work out. The unfavorable consequence resulting from the group's ability to trade up, if you will, for benefits is something that we haven't worked out to make the act consistent with guaranteed issue and continuity of coverage. Participation requirements will be okayed by carriers. For groups with fewer than five lives, carriers could require 100% participation.

The third area the proposal addresses is reinsurance. We don't feel it is necessary to have a mandatory private-sector-based reinsurance scheme. We feel that it would be too complex and would take years to implement. In addition, there was very strong opposition in our state by the HMOs and the Blues to share in losses among all the players. I don't think it would be politically possible to force this sharing of losses, nor do we think it's technically necessary. However, individual commercial carriers could set up a reinsurance board and assess members' reinsurance fees. The only restriction that we feel necessary is that the price couldn't be passed on to individual small groups. And that is to prevent selection against those that we're either not reinsuring or those taking part in community-rated programs like HMOs.

The last area is affordability. If you know the old joke that says the three things you need to know about real estate are location, location, location you will appreciate that the three things important to the small business area are price, price, price. Affordability is one area in which we are somewhat limited. Everything else I've been talking about will do very little in terms of making health insurance affordable to large numbers of small businesses. It will bring down the outliers. In other words, it will make insurance more affordable for those who have been rated quite excessively. It will help those who can't afford Blue Cross' community rates because of selection against their pool. In terms of overall affordability, it's not going to make too much of a dent and, as we've seen so far from our demonstration experience, you need to go pretty far in lowering prices in order to get substantial penetration into the small business market on a voluntary basis.

There are three things in this proposal that address price. First is eliminating the premium tax commercial insurers would have to pay for small group products. Second is development of a low-option HMO plan. Our way out of the HMO dilemma was to allow the HMOs to develop a lower cost prototype product that they would have to offer on a guaranteed issue basis. This would offer protection against selection occurring because they weren't allowed to impose waiting periods or preexisting condition limitations. Third is the establishment of a health benefits advisory board that would review all existing mandated benefits with an eye towards elimination of some mandated benefits for the small business market. This board would be required to develop cost estimates for any new proposed mandated benefits.

Again, the sum of these proposals is not going to generate tremendous price relief, and I think that we're all riding the "sea of cost." As one incumbent said when he lost the election, "I was sitting on the beach when the tidal wave came." I think that all these efforts could get swallowed up unless we get a better handle on overall costs. But I guess that's the subject for another day.

MR. RICHARD H. DIAMOND: I'm going to talk about what's been going on in Maine in small group health insurance, but before I do, I want to give you a little bit of background on the group health insurance market in Maine. It is different from the group health market in many other states in that Maine is dominated by small employers. There are not very many large employers in Maine and, consequently, when we talk about the small group market, we're talking about most of the employees in the state. The largest insurance carrier is Blue Cross/Blue Shield of Maine which covers about half of the insured market. The other half is spread among several commercial insurers. Most of the large groups are self-insured. There are a few HMOs that are quite small. They are not a big force in the market at this time.

The problems that have come up in the small group market are mainly related to tier rating and experience rating of small groups. For example, if one member of the group became sick, the rates for the group could more than double for the following year. The result would be that the employer would look elsewhere for coverage. Another insurer would be glad to give the employer insurance, but it would not cover this sick person. The result would be that the person who's had the problem would end up losing his insurance. An alternative would be to go to Blue Cross/Blue Shield, which would not exclude anyone from a group. It would include a preexisting condition exclusion. The person would have coverage but not for the condition he needed the insurance for.

The first action that was taken by the legislature in Maine, about a year and a half ago, was to pass a bill based on a proposal from the Bureau of Insurance. The original proposal essentially banned tier rating entirely. It required each insurer to describe its costs, the costs of all groups. Rating would be allowed by other risk factors, but not based on the experience of the small group (fewer than 50 lives). The commercial insurers were opposed to the proposal. This response wasn't entirely expected. A number of people I had talked to said that tier rating should be eliminated, but, for now, if others were doing it, they also would have to do it to be competitive. Even more surprising is that Blue Cross/Blue Shield objected to the proposal, even though it does not use tier rating. I thought it would have benefitted from a level playing field. For some reason, it was reluctant to support the proposal. The proposal it stayed on the sidelines while that bill was being discussed. The discussions resulted in a compromise. The bill was to apply to groups of 25 or fewer lives. It permitted tier rating but with a cap. The highest tier could be no more than 120% of the average rate for the carrier. The average would be an actual weighted average, not a midpoint.

We introduced another bill in the last legislative session that took place last winter and spring to deal with problems of individual underwriting and preexisting condition exclusions. The specific problem addressed is the situation arising when an employer changed carriers and the sick employee was excluded from the group or else was subject to a preexisting condition exclusion, even though the person had been covered previously

under the plan. We proposed a bill that would prohibit any exclusion of preexisting conditions for somebody who had already satisfied their preexisting exclusion under a prior carrier's plan and would not permit individuals to be excluded from the group. The bill also applied to an employee changing jobs who had been insured by a plan of the prior employer.

In response to that proposal there were two other proposals that were made along the same lines. First, Blue Cross/Blue Shield liked parts of our proposal and not others. It proposed a narrower bill which would apply only to an employer changing carriers and would only prohibit individual underwriting, but would not limit preexisting condition exclusions. Its reason was it was losing groups to commercial carriers that would insure part of a group. To add insult to injury, Blue Cross/Blue Shield would have to offer nongroup coverage under a conversion law to the sick employee who was excluded.

Second, there was a consumer group that proposed a broader bill that said, first of all, if you had any prior coverage, whether it was another group, or individual coverage, or government program, such as Medicaid, and you came into a group, you would have continuity of coverage. There would be no preexisting condition exclusions, and coverage would have to be provided. The bill also applies to individual health insurance. And then beyond that, even if a person didn't have any prior coverage, no preexisting condition exclusion could go more than 90 days. In addition, their definition of preexisting condition was very strict. I think that if you hadn't been to a doctor or had any treatment in 90 days, you were covered.

The legislature put the new bills together and, basically, the result was a compromise very close to the bureau's original bill with the addition of continuity for those coming from individual insurance or government programs into the group program.

The provisions of the bill would be phased in over time. The portion dealing with employers changing carriers was effective October 1, 1990. The portion dealing with individual policies will go into effect December 1, 1990 and the portion dealing with people coming into a group from another employer or another insurance plan will go into effect on April 1, 1991 (if the law does not change in the meantime). This last piece has a retroactive provision which is rather troubling to a lot of people. Basically, anybody who has ever been rejected for insurance or who has a preexisting condition exclusion imposed but is still, otherwise, eligible for that group as of April 1, has to be covered as of April 1. I was not involved in the drafting of that provision or in the compromise that went to that provision, but, as I understand it, it was intended to create some incentive for the insurance industry to reach a compromise on a new bill and identify a task force to determine an acceptable alternative.

The task force which was created by the legislation last year had five charges:

1. Address the rights of continuity for individual health insurance policyholders.

2. Focus on preexisting condition exclusions, riders, medical underwriting, and waiting periods.

3. Review reinsurance and community rating for small business groups and individual policies.

4. Look at exclusions by industry or occupation.

5. Determine the economic impact of the proposed changes (this is the one that gives me nightmares since I'm the one who will have to do it. This will include actuarial projections that account for reserve policies, cost of underwriting, administration, legal costs, marketing costs, such as, advertising and sales commission, investment income, and profit margins, by product line, company, and by industry. It may take me a few minutes to do that.)

The task force had broad representation. Included were employers, labor, consumers, commercial insurers, Blue Cross/Blue Shield, insurance agents, several legislators, and the Superintendent of Insurance. They've been meeting during the summer with little agreement. There is a final meeting scheduled for you in which they hope to agree on a proposal. There are two proposals on the table so far. One is from the HIAA, which Hal talked a little bit about. It contains a reinsurance mechanism, guaranteed issue provisions, and it guarantees continuity once you're in the system. The other proposal made by Blue Cross/Blue Shield is a little different. It would require community rating across the board. Basically, every carrier would have one rate that would apply to everybody. This is the way Blue Cross/Blue Shield does business currently and it is proposing that everyone should do business this way. As part of its proposal, it would eliminate its preexisting condition exclusion. It is also proposing a rather large hospital discount to try to keep the costs down. (I think it is talking about a 30% discount.)

The position taken by the consumer group on the task force is closer to Blue Cross/Blue Shield. It wants no underwriting, no community rating. This group doesn't have a specific proposal, but its aim seems to coincide with Blue Cross/Blue Shield. This may be an indication of the way things are likely to go.

I'd like to tell you the ending of the story, but it hasn't been written yet. That's where we stand currently in the battle.

MR. TREVOR G. SMITH: Let me tell you about the Florida atmosphere. This state, too, has mostly small employers. It has some larger ones and most of them are notable, but not that many jobs. As an interesting index, there are 96,000 employers in our assigned risk pool for worker's comp. And that includes only the businesses that can't get the coverage through the standard market. Eighty thousand of those pay less than $4,000 in premium, reflecting a very high proportion of those risks that are small employers in the assigned risk pool. To give you an idea of how small, I just happened to buy some worker's comp for a little adjunct business of the insurance department. For two clerical people, the coverage cost $1,087. So $4,000 doesn't buy coverage for a lot of people in the state of Florida in clerical positions, let alone other positions. So that means there are a lot of small employers.

The insurance department regulates health insurance benefits for about 50% of the people in the state. The other 50% are either self-insured, as almost all of those small

employers are, or they don't have insurance at all. We hit about half of the market in our regulation, which is astounding to me. Of that insured market, my guess is that the Blues have something in the mid-20% range. I do know it's about 28% on Medigap, Medicare supplement. The Blues also have a very dominant position with individual policies. It runs an HMO and the HMOs in the state don't have high penetration, but they've turned the corner in the last year and a half and now are generally profitable and growing at a rate that's quite satisfactory. That's about the distribution system in our state.

I want to talk to you about five Florida programs. Some of them concern many of you in your own marketplace. Second, I will talk a little bit about the NAIC activities that Florida is involved with and, then, I'll talk about some of the things that perhaps you can do.

There are five programs in Florida that might be of interest. First, this year the legislature passed a program that allowed group health insurance to be sold to small employers without mandated benefits. It doesn't eliminate all of the mandates that are in the law. It eliminates eight of them. The mandates still have to appear on the application in the appropriate place, but the employer can select them. But, some mandated benefits can be eliminated when you sell to small groups, small employers, and, interestingly, small groups of employers. In other words, small employers can band together and buy in a collective fashion. This doesn't have to be an old-fashioned multiple employer trust. It can be considered an employee group even though it consists of several employers banded together. In addition, they can form that group for the purpose of buying insurance under this act. This was to be a pilot program, but in the waning days of the legislature, it became a full-blown program. It eliminates some of those options that otherwise were required for mandated benefits.

The question is whether the two-year experiment is enough time to generate information to determine if this is a good way to give access to people who don't now have coverage. It's hoped that it will. A lot will depend on you, the people who provide the benefits from the private sector. A lot of that is translated through the distribution system to the public. I think there is some hope, but, the truth is, our mandated benefits are not excessively expensive. So there won't be a big price break. There may be some aggressive carriers who will put together a good stripped-down package of benefits, eliminate those frills, and find a low-cost policy that people will buy. I hope that some people will experiment in that area.

We started a program a couple of years ago that's now called the Health Access Program. It was started with some funds from the Robert Wood Johnson Foundation and, also, some funds from the state. Its purpose was to find people who weren't insured and see if it could extend group insurance to them. It started out to cover groups with fewer than 20 people, and now it covers groups with fewer than 25 people. The plan is provided through an HMO, and it's expected to enroll about 5,400 people by March 1. It has been in place in one county for the last couple of years. Now it's expanding to go to another metropolitan area and into some rural areas. Eighty percent of the member employers employ 1-3 people, 19% employ 4-10 and the rest employ 11-19. The average age is 28-years-old. Fifty-six percent of the contracts cover families. Over half of the

enrolled employees take home $20,000 or less each year and 20% make under $10,000 per year. Fifty percent of the group are married; however, of those who are single, 60% of them are single divorced parents with children who have dependent coverage. The employer is paying about 66% of the premium cost while the subsidies are paying about 34% of the cost.

There's some good news and some bad news in this as I see it, but, of course, all the facts aren't in yet. In the last 12 months the per-admission charge to the employer was $7,700 in this geographical area. According to research, 20% of those bills isn't funded because the insured people can't afford it. The conclusion is that about $4.25 million in costs isn't funded. It really isn't uncompensated care because that all gets paid by somebody. But it isn't funded by the people who use the service. It has gone by the boards, generated by this group of people who now are insured. The state subsidy for that period was $1.4 million, so the thesis is that for a $1.4 million investment, you've offset what previously was a $4.25 million drag on the system. Obviously, it's just cost shifting. That's an interesting thesis, and it says that if you penetrate broader to the people who don't have coverage, you help spread costs across the sector better. My concern is, and this is what will have to be tested in the next couple of years, how do you get people off subsidies that are that deep? Thirty-four percent is a large subsidy for a program of this nature. How do you convince those people whose premiums are paid that they ought to pay more themselves, and is that, in fact, fair? Should the people who are paying the premium have to pay more in order to subsidize the other folks as well as pay a higher premium themselves? Or do you just encourage them to go into the pool that allows them to be subsidized equally? That has to be determined, and I don't think there's any clear evidence in any direction right now in what will come out of that. The program is insuring people who didn't have insurance before, but, it's doing it with a subsidy. I'm afraid that while we're penetrating the market that didn't buy insurance before, we're doing it largely on price. We'll see what comes with that and hope that there's some way that we can recover and keep those people buying insurance. Maybe now they'll become convinced they ought to have coverage and be willing to contribute more of the cost.

We're trying a new group concept in Florida as well, thought up a couple years back by someone with more intelligence than myself. The scheme of group insurance today is that the employer buys the policy and brings it down to his employees who, in turn, can insure their spouses and their children. Since we've got such a high level of uninsureds in families and, in particular, children, why don't we just reverse it? A contract could be issued covering kids and they, in turn, could insure their siblings and their parents. It's an interesting approach. It sounds a little crazy, but I'll tell you what we've done with it.

The Child Health Supervision Act has been a part of Florida's coverage for some years. It is mandated coverage for children's health supervision, which means physical exams, shots, etc., periodically from birth to age 16. We've combined with that, and now we've started a corporation. We've stepped out of government about three quarters of a step. We've called it the Healthy Kids Corporation. This corporation is using funds from the private sector, from foundations, from government, from anywhere it can get it, and it will organize a delivery system. It won't be the deliverer, it will be the organizer of a delivery system that gives all children in school child health supervision. Obviously,

we're going to tax the people subject to this law, because heaven knows, that's how we regulate. So the law is applied to uninsureds and self-insurers who haven't had any child health supervision in their policies. And even the half that had it in their policies did not really know how to charge for this. The premiums were all over the lot, and it didn't make much difference because nobody used the benefit. Well, it makes sense to try to intercede with children when they're young and find disorders that can be corrected early and avoid medical expenses later.

There wasn't any champion to this. There wasn't anybody really interested in it. So, the Healthy Kids Corporation will, in fact, be its champion. We'll start by providing the service to all kids in the school system. In time it's hoped that that will be allowed to extend to their siblings and to their parents. So it would be coupled with an insurance product, a private sector insurance product of immediate care, if you will, of acute care that children and, hopefully, their family members need.

And then, hopefully, in time there will be a catastrophic layer laid over the top of this. Now, that should be so inexpensive that it could be funded truly through the school system itself. But this is wild social dreaming. The concept is clearly a social issue and not really much of an insurance issue. Truly catastrophic care will affect me as much as it would a grapefruit picker. In other words, none of us can afford the cost of health care that might be subject to the continuing kind of expense in today's atmosphere. It's not used very often, but its use is necessary and the cost is very slight. If you're going to cover everybody with it and do it with tax revenue, it should be very inexpensive. Well, that's a dream.

What we're doing now is stepping this into four counties in the state (a county is a school district in the state of Florida) and running pilots. We'll do some rural and some metropolitan mixes and try to find out just how this is to run mechanically and, also, how it runs financially. Can you subsidize the people who don't have funding for that child health supervision in a satisfactory fashion, either through the service delivery mechanism or by some sort of subsidy that's generated out of the flow of dollars that comes from the insured system? How can you do this? We haven't figured that out yet, and that's why we're going to experiment. In time we hope it allows us to cover all the children who are in school, extend that to their siblings who aren't in school yet, and also extend it to the parents who don't have any insurance coverage. We hope that each student will have an insurance card in the school system. It will give him coverage from child health supervision and catastrophic care. And it's only possible with this quirk in the law that allows us to have a policy issued, perhaps, with the school district, with the school board or with the county that would trickle down to the children as the insured and then to their dependents, if you will, as we classically think of them, being the sibling and parent.

The comprehensive health pool is for people who can't buy insurance. These people were originally defined as those who were turned down by two carriers or the insurance was priced in excess of what the pool would charge, which was originally 150% of the average rate, as best that could be determined, for health care on an individual policy in the state. Well, the plan cooked along for the first couple of years. It had very poor participation. Nobody seemed to care much about it. In order to generate more

excitement from consumers, the preexisting period was reduced from 12 to 6 months. There was one statewide rate, differentiated by age but not by geography or sex. This became the best buy in Miami, Florida in 1988 and 1989. You couldn't buy anything in the commercial marketplace that came close to this statewide rate, but you could always find some companies that would turn you down. So we had a lot of business out of that geographical area. Finally, we did a quick patch, extended the preexisting period back to 12 months, made the rates geographically differentiated in three different geographical areas, and we differentiated between male and female rates. The plan was still under-financed by many millions of dollars.

This would have been supported by a tax on the insurance industry. However, since it was an offset against their premium tax, it was really an indirect tap on general revenue in the state of Florida. Not many citizens nor our legislators understood that. They estimated what it would generate in 1989. They were $16 million short. They missed it modestly in their estimates. So they decided they had to change some of these loop-holes, and they eliminated the ability to offset the costs against premium tax. The carriers, understandably, were concerned.

At the end of September, the law was eliminated, but a new one was put in its place. Instead of a plan that's designed and written into law, it's allowed to be drafted by people outside the law so that it can be kept in step with the times. For example, there was no provision for cost containment when the plan was written. So, you couldn't include cost containment because it was not written in the law. Now there are all kinds of features. Heavy emphasis is on managed care, critical care, individual diagnosis and procedures. A different range of benefits is included, eliminating some that were loopholes that people crept through. Tiering of rates is an interesting approach. It allows coverage for those who can't buy insurance, not necessarily because they're unhealthy, but because the insurance industry doesn't want to touch them. They're paying a lower premium than a class of people who have a claim history but not a current kind of claim history or claim likelihood. Third, those who are truly uninsurable will pay the highest premium in the third range. Premium rates will step up to some-thing like three times the standard premium for that top bracket.

Now there are advantages and disadvantages. Yes, the people will be helping to fund the plan more, but it's still not going to pay their claims or anything close to it. And it does make it kind of a rich man's club. So we've got to come to some grips with that. The subsidy needed for claims exceeding premium collected plus the expenses will be paid by the insurance industry. This will be done with a table of contributions that probably is unconstitutional, probably will be challenged, and probably will be changed. However, it was a scale that was brought down from a rather high amount of dollars that would be paid by those who have a dominant position in the state, to something that's much smaller in dollars and which squeezes up the bottom. Every carrier with a license in the state which wrote less than $5 million of premium would pay $15,000. That's a tough tax on people who might have zero premiums. So, companies that just happen to hold their own ticket for the fun of it are going to be socked with a heavy charge unless this is changed. We're talking about something that is in effect, although it slid in, and is paid out of general revenue because it is a social issue. Now we're trying to make it be paid by an insurance industry that only insures half the people in the state.

Another thing I want to mention is Multiple Employer Welfare Associations (MEWAs). Florida's had a flurry of MEWAs. Most states have had bad experience with MEWAs. And we've had some really terrible experiences with them, and the tendency of our regulators is to think they are a bad idea.

ERISA allows small employers to combine, generally, by some grouping that is other than for the purpose of buying insurance. It's generally been done by entrepreneurs who have developed it and either have been unable to handle the business or have taken the money and run. There have been examples of this in our state and, I think, across the country. It gives a bad taint to the whole business. The truth is, there is a place for MEWAs, and if they're properly run, they can serve a segment of the marketplace that doesn't seem to be served by the insurance industry and shouldn't be served by governmental resources. This segment can insure itself and shift and buy its interests.

There will be much stronger regulations, I'm sure, in the future. They still do have a place in the state. We had 28 of them over time, and six of those withdrew. They just simply terminated their plans. Six of them converted to insured plans. Eleven of them were in receivership or liquidation. Two of them have the shorts. They're modestly below the line. They aren't even in their balance sheets, which is required. But three of them are okay, and these are three fairly sizeable ones. They're successful because they're watched carefully by the people who have the responsibility for running them. And we, in turn, work with them to make sure they work. Would we do another one tomorrow? Yes, we would if it was a good one. No, we wouldn't if it was like some of the 24 that I mentioned before that have gone by the board. But it is a means of giving more people access to the marketplace. The people who bought into these largely weren't being served by the insurance market. The insurance market either had abandoned them or wouldn't write them from the onset because of the risk they had generated or because of the way they had exhibited their claims history, and they needed coverage. So there's a possibility that this method will reenter the thinking of regulators, and maybe there's a good way to do it. It might be a better idea for the insuring industry, Blues as well as carriers, to think of ways to meet the needs of these groups and recognize they will pay a little bit more. They need close monitoring, but they're a viable group if done right.

Overlying all of this in Florida, we've discovered that the people don't really care how we look at insurance. This was quite a revelation to me, having spent most of my time in the health insurance business and in the group insurance business, in particular. The general public doesn't think about me being the regulator of health insurance. I'm "in" health insurance. They don't think of you as a health insurance actuary. They think of you as an actuary. The buying public really thinks of the insurance business as one continuous entity, and I think we have to, also.

In the state of Florida, worker's comp has a schedule of fees for doctor's services. One schedule for the entire state is the worst thing in the world. The doctors in Miami are paid the same as the doctor in a town up in the panhandle of Florida, and that's ridiculous. It's silly. It means that either one person is paid too much, or the person in Miami must cheat in order to make a living, or he drops out of the system. Well none

of the three is a very good alternative. This year the legislature has introduced personal injury projection on mandatory auto insurance. The biggest element of it would have the same schedule of doctors' fees as worker's comp. This is one bad idea being transferred into another. Using that schedule isn't a bad idea, it's a horrible idea. So finally the Florida Medical Association (FMA) has decided to get its writings circulated. They will start talking to all the decision makers, including the insurance department, and try to figure out how doctors ought to charge and how we can work out something that will be appropriate and economical.

In the new system that Medicare will put in place for doctors fees, Resource Based Relative Value Schedule (RBRVS), average fees will come down enormously. This has caused a great deal of concern with a lot of specialists in this state. And, of course, Florida has a large Medicare population that's going to be subject to the RBRVS. Beyond that, this will leak into all of the delivery and financing systems, I'm sure. So, the doctors are finally speaking out. The FIA plans to come up with an approach by the first of November, so that we can get it into the legislative meetings that take place before our legislature sits next March. We will try to find some way for us to combine all of the interests including good old-fashioned nonoccupational health care, occupational health care through Worker's Compensation, and maybe all the policies. The truth is, everybody in the state probably will buy some health insurance, even if it's just their auto policy or their Worker's Comp policy. They buy some health insurance, and they sure do use it. We've never talked to them about that. We tend to talk to them just about their health care. We think we're talking about their nonoccupational health care and, the truth is, they're thinking about the whole spectrum. We need to think this way, as well.

Let me tell you a little bit about what the NAIC has been doing. I think all of you know the NAIC operates through committees to develop a program and assigns the work to two committees. The Accident and Health Committee has the letter B associated with it. That B Committee looks at issues on health care or accident and health insurance and works on a program for the year. This year it looked at two things that affect all of our interests in the area of health insurance. One was a group health rate review mechanism. It was effectively looking at small group coverage. Small group is defined as employers with fewer than 25 employees. What happens on renewals? How about the ratio rating? What about the tiered rating? That committee was smart enough to draw together an advisory of people from the industry who participated quite extensively in designing a program that would be presented to the NAIC. Over a period of almost two years time, the committee put together and revised a program, bounced the idea off the NAIC, went back to the drawing board, and then came up with a program. This topic will come under the guise of small group underwriting. It would be a good idea for you, as actuaries, to listen to that in more detail.

Basically, three criteria were applied. It limits the range of prices that an insurance company can have among all of its blocks of business that affects this size range of small employers. It allows only so much of a rate increase, based on the experience of the employer in any given period of time. It specifies a maximum increase over the whole duration that the employer is insured by that carrier. So, there is a maximum charge

that can be made relative to the average of the pool of coverage that employer participates in.

The draft is now available to all of you and, if you haven't seen it, you ought to look at it. It will come to a vote in December 1990 at the NAIC Meeting in Kentucky. There will be a model bill that will be presented to the state legislatures through the insurance departments. It is hoped that there will be an across-the-board approach which hasn't happened very often, but, at least it will be considered in every state. This approach would be more uniform and would allow you as carriers to operate a little more efficiently than having to deal with different programs in each state. Programs are already cropping up in a couple of other states (some of them you've already heard about). The NAIC program should be something, I think, you will take a keen interest in.

The other working group is dealing with health insurance access. The advisory group is made up of nonregulators. Their purpose is to come up with an approach that takes some of what Connecticut has done, some of what California is looking at, bring these two different schemes together and decide the best range of possibilities to consider for an NAIC model bill.

There will be a couple more meetings between now and the December NAIC meeting when it will be presented to the B Committee. Perhaps, from there, a draft will be circulated or at least initiated for circulation. This will give all of you a chance to comment on what is proposed. This will be a broader based approach to regulation than a state-by-state, more haphazard approach. Now if we can't get a uniform program through the NAIC with cooperation among all or most of the states, then we can expect something like a Walgreen Bill, or some of the other bills that have been proposed in the federal legislature, to take hold. Walgreen's Bill would eliminate underwriting, eliminate preexisting conditions, and just allow everybody in. You can't do that actuarially. One of your colleagues, Harry Sutton, made a good presentation on this subject. But the pressure is on, and the general thinking is that an NAIC program will keep it out of federal hands.

The committee that's meeting in Chicago for two days this week is made up of the HMO representatives, Blues representatives, and insurance company representatives. They, in turn, will report back to regulators. There's a pretty good amalgamation, similar to what Massachusetts has done, of all the interests in this. This hasn't happened enough in the past. I hope that when you're called you'll respond and try to give some help, too, in your own state. The concept of coming up with something that could be adopted and used in many states makes a whole lot of sense. In fact, I can think of ways we can regionalize what we do as an insurance department, at least in the southeastern part of the country. In 1991, I think we're going to see more action in the Washington legislature to determine what is going to happen to health care. And the legislature isn't going to have any more money to spend than it thinks it has today. It is going to rely heavily on the industry to fund something that the industry may or may not be able to fund. But, it is certainly debatable whether the insurance industry should fund programs entirely by itself without, certainly, the interests of the self-insured and other people. This would include citizens who aren't covered by this marketplace but who are citizens in the state and want to have that kind of delivery system.

So what can you do? Well, simply, as I've mentioned, I hope you'll take an active role. I hope you and your company (or, if you're a consultant, the companies you represent) will become involved in this. A lot of internal development is needed. You need to educate your own people. Not many people in the insurance companies know about health insurance outside of their immediate area. I think you know that, because you've been fighting for resources for years and they never understood you, right?

You've got to educate your regulators, too, and despite all the confrontational filings, rate questions and other things that you have to interface with them on, get together with them on something where you can combine your interests. This is an opportunity for you to meet them on friendly terms and develop something between the two of you that has meaning for the whole social system in your state. Keep your eye on the pools. Make sure, if you're representing the industry, that the industry is funding what it should. There should be some price you pay, I suppose, for having the franchise to sell insurance in a jurisdiction, but I'm not sure it should be all of the social costs for a plan for people who can't possibly fund their losses. I'm not sure that cost should be entirely borne by just the insurance industry. You ought to help make that decision. You ought to participate in it, and you've got to have your resources available to educate the legislators who will make those decisions for you.

But, again, I'd ask you one more time to keep in mind what the society thinks you and I do. They think we know all about health insurance and that we're concerned with all health insurance. I know deep down I haven't spent much time trying to correlate the various deliveries of health insurance to people who get hurt or sick and want to get better. And I think we need that correlation high on our priority lists.

MS. ROSENBLATT: I want to reiterate Trevor's last comments. I think it is very important that we, as actuaries, all take a role in these efforts on small group reform. One of the things I learned from my involvement through Blue Cross/Blue Shield of Massachusetts, serving on the committee that Hal Belodoff mentioned, is the importance of actually modeling what you're going to see. I think a lot of us have preconceived notions about the importance of tier rating, demographic rating, and duration rating. What's very interesting is that once you start doing some computer simulations you find that, perhaps, your company can live with a two-to-one limit. So, I'd strongly recommend that you take some of your scarce resources and spend some time modeling the options.

MR. JAMES EDWARD OATMAN: I have a question for Trevor Smith. I was a little bit surprised to hear you advocate that MEWAs could be a good thing and could have a role is the marketplace. We've seen problems in Florida and throughout the country with MEWAs. Do you see a different set of rules for these than for private insurance as far as capital, rate regulation, and benefit regulation? Why would you want somebody operating in the insurance marketplace selling to small employers under a completely different set of rules than insurers?

MR. SMITH: Well, that's been decided for us to some extent. The federal government has said that small employers can self-insure. They've allowed states to introduce regulation of those self-insured pools, the MEWAs, and some states like Florida have

done so and are continuing to try to make them more workable. Well, it was this year we proposed that, for example, a MEWA had to have other than just "a net worth of zero or more." It had to have three times its December collections as a reserve, in a cash balance on January 1 of every year. Unfortunately, we couldn't get the bill passed, but, I expect we will this year. But, what I was saying was that it's been decided MEWAs can exist, whether we like it or not. We'd better recognize that they can meet some needs, and then be sure we fulfill our role of regulating them. I'm not a great fan of the differences between self-insurance and insurance in terms of regulation. I also am, however, a realist and know that we have to make the best of it and make sure that MEWAs are used properly. The system has been abused in the past with the exception of three and, maybe, the two that are very close in Florida. The rest were really tragedies.

MR. MARK F. HOWLAND: We began July 1989 to introduce demographic rating to all our 2-to-99 business. We converted to that at each group's renewal. There was no phase-in. We've concluded that there was no rate shock. Certain groups did receive a large increase, but when they went out into the marketplace to try to find another community rating company, they didn't find one. So the bargain was gone, but we didn't see that there was a terrible increase in the uninsured problem in our state. It's working extremely well for us. It's been a textbook case of the selection problem and the solution. It used to be that as you drove up I-91 into New England, you needed the left lane for Massachusetts, Vermont, and Maine, and the right lane for New Hampshire. I'm very pleased, therefore, to hear about the report from Mr. Belodoff about how they're considering demographic rating in Massachusetts. I do have a question for Mr. Diamond from Maine. If there is a conversion to community rating across the board, each insurer would definitely have a different community rate. How will that, in fact, level the playing field, and how will it affect the marketplace as you go forward with that process?

MR. DIAMOND: I want to say, first of all, that I'm not necessarily advocating community rating as something that will level the playing field. It's being advocated by others, and I think the point you raise is a good one. There is also a question of how many commercial insurers will stay in the market if that type of approach is taken.

MR. IRWIN J. STRICKER: I heard that in Maine there was some reconsideration of the effective date of a portion of the regulation to beyond April 1, and that there might be some amendments to it. Could you comment on that?

MR. DIAMOND: Yes, the portion of the regulation that requires continuity of coverage for a new employee who had prior coverage elsewhere is not scheduled to take effect until April 1, at which point it will be retroactive for anybody who missed out previously. The task force that's currently meeting is charged with developing proposed legislation by December 1, for consideration by the legislature in its session that starts in January. If the legislature passes something between January and April on an emergency basis, that would override the current law.

MR. JOHN A. HARTNEDY: I'd like to ask Hal a question. I understand you're doing a community rating. I heard Trevor to say that the average age is 28 for a lot of the

people in the small groups who were not insured. If I follow that correctly, what I hear is that community rating will make the situation worse, because community rating is going to tend to pull up the rate for the younger people.

MR. BELODOFF: No, we're not pushing for community rating. In fact, it was in recognition of some of those points that we tried to argue with our small business advisers. Many of the small business people started from a position of community rating. They thought it was the fairest, most equitable system and it would eliminate a lot of the games in the rate increases, durational rating, etc. They saw it as their solution. We felt that it would not work to the overall best interest. It would actually increase incentives for gaming. It would, as you're suggesting, drive up the average cost to small businesses. Our proposal does embodies, full demographic rating, because we do have some overall rate limits on it; but basically any actuarially justified rate classification. Thus, each insurer is getting a fair or actuarially justifiable rate from the group based on the characteristics of each group.

MR. EARL DIRK HOFFMAN: Mr. Smith, regarding the Florida Comprehensive Health Plan and also the Subsidized Plan for Children, you spoke about the need for insurers in the state to help subsidize the children's coverage and, of course, the insurers are assessed for the comprehensive health plan. But, of course, there still is the question of the large self-funded employers and what contributions they make to both of these plans. I know in Minnesota our comprehensive health plan has had to pick up coverage for a couple of bankrupt self-funded plans and yet, we never received any contributions from those plans. Is there anything being done in Florida or is anything being discussed at the NAIC about this?

MR. SMITH: In Florida, it was proposed in the new funding portion of the state comprehensive program that self-insureds be taxed if they bought any kind of insurance. In other words, if they bought stop-loss coverage of any kind, they would then be treated for all of their claims as if they were insured. And heaven knows if that's going to fly. It will probably take a long time in the court to get that ironed out in some fashion. But it's the first pass at getting those people in the same loop. There's no question, they shouldn't be allowed to escape. Sooner or later, I think you've got to convince those who buy coverage in that fashion that's part of the deal. But, they now avoid premium tax in many cases, and they aren't contributing at all to the supported programs. For the Healthy Kids Program, we intend to approach those large, self-insured employers to see if we can't convince them to fund this kind of benefit under their program. Some of them do now, but not all of them. We think we can convince them that it is a nominal cost, it has a long-term benefit, and they are in it for the long term. They aren't like the insurance carrier that says it might lose this plan next year, so why would it want to spend the money now? In the long haul, that child's claim when he's older and sicker is going to be theirs. So we think we can get them to participate in the funding of that program. We're trying our best to get them in the loop, and it's essential that we do, because they are growing, not diminishing.

MR. STEPHEN A. MESKIN: I was really shocked by your statement, Mr. Smith, that you're going to add a tax to a self-employed fund that has any other insurance. Your objective is fine, but you are creating an incentive to reduce the amount of reinsurance

that a self-insured fund might really need. We often have to convince them that they need to get stop-loss, but then you're saying, if you get it we're going to punish you some more.

MR. SMITH: Yes, it is a very tight balance. I'd welcome suggestions on how we could find a way to get those folks to fund the program, or how we can get their participation in something like that fund, because they want to benefit from it too. They want their people to be able to go into that fund and receive benefits, and yet they aren't prepared to pay the subsidy. Now you can do it, obviously, by taxing the delivery of services, but that's even more complicated, and it seems to me that this is a very in-between step.

MR. WOODROW H. MCDONALD: With regard to small groups with fewer than 25 lives and the possible NAIC model, I just wonder if you have any sense from the NAIC of what its members think need to be in that kind of model at this point? For example, do you have any sense as far as the maximums, the 20% cap, or things like that?

MR. SMITH: The NAIC has felt that there needs to be some fairly restrictive range. There ought to be a range of 20%, for example, among blocks of business that a carrier has. They ought to get their blocks in some reasonable balance so that people aren't switching in and out of them. Also, there should be no more than 15% afforded for an employer's experience in a given year, and, over time, there ought to be a 25% spread from the top to the average of a block of business. Those are the numbers. There also are corollary considerations that include a strong emphasis on identification of what can happen at renewal to employers when they buy. Thus, there's going to be something that explains what can happen as a result of that firm's experience over the course of the year, so that there is some understanding of it on the front side. An actuarial verification, or justification, of how that's going to be done needs to be certified each year. It won't have to be filed with the insurance department, but it has to be kept on hand so the insurance department can inspect it if it wants to. There are also some prohibited things such as lapsing individuals, or not allowing an individual to be converted into a new plan, if you take one person, you take them all, etc. There will be continuity provisions as well as limitations on preexisting conditions being applied, and things of that nature.