RECORD OF SOCIETY OF ACTUARIES
1991 VOL. 17 NO. 3A

HEALTH RATE REGULATIONS, GROUP MEDICAL – UNDER 25 REGULATORY ISSUES

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The panel will discuss the NAIC and HIAA models, as well as state regulations proposed or adopted to regulate small group underwriting and rate guidelines.

MR. HOWARD J. BOLNICK: We have three panelists. First is Karen Brigham, Manager of Health Care Policy for the U.S. Chamber of Commerce in Washington, D.C. We want to be sure that we had the players here, not the observers on the sidelines. The second speaker is Allen Feezor, Chief Deputy Commissioner of North Carolina. And our third panelist is Dick Helms, Second Vice President with Principal Financial Group.

I'd like to do two things. I'd like to tell you a little bit about the problem that our panelists are going to address, and I'd like to give you a couple of clues as to what to listen for as you hear their very different perspectives.

First, in terms of what the problem is, let me give you a few statistics. The U.S. Current Population Survey (1988) showed that there are 31.5 million uninsured Americans. Of that 31.5 million, 23.8 million, roughly a little more than two-thirds, were families headed by a worker. That's kind of a surprising statistic because we don't like to think of people who are working as not having insurance, but that seems to be exactly what's happening.

Another surprising statistic is that out of those 23.8 million Americans who are working and uninsured, about half, or 12 million, are of families where the worker is employed by a small business. That is, a business with fewer than 25 employees.

So we have these statistics floating around that are making people scratch their heads about what's going on in the small group marketplace. And at the same time, there are anecdotes in Congress and the states – people saying, "Gee, my coverage has been cancelled." "Boy, I just got a huge rate increase." "I don't understand what these insurers are doing to me." "I'm sick. I tried to get health insurance. I can't get it." People are complaining about the fine print in insurance contracts – how they thought they had coverage but found out they didn't. So by pairing these statistics

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with these anecdotes, the conclusion is there's something fishy in the small group health insurance marketplace.

And because we're so well loved in political circles, politicians looked to us, the insurance industry, and said, "What's wrong with you?" That's been the genesis of a lot of what we're going to talk about regarding reform activities. But everyone who is involved with reform shares a goal – we're trying to provide access to affordable insurance for all people who work in small businesses. And it's a very important formulation. Access to affordable insurance for all Americans is ultimately what people want. But let's look at it in terms of small businesses.

Here are a few things I'd like you to listen for in our speakers' presentations. First is something a bit ephemeral and difficult to get your hands on; I'll call it a clash of values. People have very different thoughts about the way markets should work. As I've been involved in the whole debate, the one thing I've noticed is we actuaries and insurance people need to be aware of the sets of values that we bring to the table, too.

The second thing I'd like you to be aware of is the trade-off between affordability and availability. As I told you, the goal is to provide access to affordable insurance for everybody working for small businesses. You ought to be aware and listen carefully to some of the trade-offs between cost and access that are floating through the policy debates.

And the third thing I'd ask you to pay attention to is the process itself. We have a marvelous system here in the United States. It's a process of both national and state politics. And the process itself is shaping its feasible outcomes.

So with those hints, I'd like to introduce our first speaker. Karen Brigham is Manager of Health Care Policy of the U.S. Chamber of Commerce in Washington, D.C. She is the chamber's lobbyist on all health care issues. She staffs the chamber's Health and Employee Benefits Committee, which makes and recommends health policy to the chamber's board of directors. Karen's previous work experience was for a legislative consulting firm. She's been the editor of the *American Legislative Exchange Council* magazine and press officer for Florida's former governor, Bob Graham.

MS. KAREN BERG BRIGHAM: It's a pleasure to talk about an issue that is very important to the business community. But before I get started, I'm going to make a disclaimer. I'm going to spend more time talking about politics than the substance of the issue of small group health insurance market reform, which is probably not much of a surprise to many of you. Coming from Washington, we take politics over substance every time.

I want to give you a little background on the chamber and what it is. There's a perception out there that the chamber is "big business." The truth of the matter is our membership runs from the "Mom & Pops," the very smallest businesses, all the way through the Fortune 500 companies. Ninety-two percent of our members have 100 or fewer employees. More than half have 25 or fewer employees. So ours is very much a small business orientation.

Health care reform is the number one issue for our small and large business members. This is a turn of events over the past couple of years. We've done survey work to determine what was really important to our members. Taxes are always at the top of the list, but now health care is right there, neck and neck with taxes. That sends a strong signal.

Howard provided a very good backdrop against what is happening in health care. Health care costs are rising very rapidly. Many businesses are seeing yearly increases on an average of 20%. A lot of smaller businesses are seeing even larger increases. Meanwhile, questions about the quality of the care on which we're spending all of this money are also increasing. There are estimates that as much as $125 billion of our national health care expenditures – and that's in a roughly $600+ billion system – are wasted on procedures that are unnecessary or inappropriate.

Howard outlined the issue of access to health care – the more than 31 million Americans that do not have health insurance. Of the working uninsured, most work in small businesses. So that certainly makes it an issue of concern to us.

I would add just one statistic to those Howard listed. Fifty-seven percent of American businesses do not offer health insurance. That's because of the large number of small businesses in our economy, but that gives you an idea of the magnitude of the issue. So the question becomes, What can be done? There are a lot of days when I wish we could work on health care reform in a vacuum because politics seem to get in the way every time.

There are some very difficult dynamics to contend with. Among them, the large number of diverse interested parties who are involved and invested in this health care debate. That includes us, the business community, and we're just not speaking with one voice on what we want in health care reform. In addition, there's organized labor and organized medicine and the hospitals, the other providers, the insurance industry, consumers the elderly – a very powerful subset of consumers, and government at all levels. We all agree something has to be done about health care, but there's no consensus on what the shape of comprehensive health care reform should be.

Congress is very sensitive to that issue. They have recent experience with a couple of health and benefits issues that has made them a little gun shy in dealing with health care. One is Section 89 of the Internal Revenue Code, with which I'm sure you all are familiar. It required employers to prove, through a series of impossibly complicated tests, that their health benefits plans did not discriminate against lower-paid and part-time workers. Business, primarily small business, revolted, and as a result, Section 89 was repealed in 1989. That was the same year that Medicare Catastrophic was repealed. Congress, in its infinite wisdom, had put into place a new set of benefits for the elderly. The elderly came back to them, in some cases chasing members down the street, saying, "These aren't the benefits that we wanted. And we think your financing mechanism stinks." So as you might imagine, members of Congress are very, very sensitive to this issue. It's been two years, but they haven't forgotten.

And then there's that little matter of the budget. It's not a great revelation that we have a huge budget deficit. Last year, Congress, through the Budget Act, tried to put

in place some reforms in the name of deficit reduction. Among them were some new budget rules including one called "the-pay-as-you-go" principle. It said if you're going to put into place a new entitlement program, you had to either reduce spending in another closely-related program or find a revenue source to pay. That has made the whole process of dealing with health care reform, as well as a wide range of other issues that have any kind of a revenue price tag, very difficult and very controversial.

With that said, I have to tell you small group health insurance market reform is very popular in Congress. There is broad consensus in that everybody agrees that something has to be done. Small businesses obviously believe something has to be done. Even larger businesses think that small group reform is necessary. The providers support it. Organized labor supports it. And best of all, the target, the insurance industry, has agreed that small group health insurance market reform is needed.

When you look back to the Pepper Commission's recommendations released last fall, there wasn't much consensus in the overall recommendations, which were voted out with an 8/7 margin and attacked from all sides. But one issue saw broad consensus: reform of the small group health insurance market. That broad consensus makes many members a lot more comfortable with this issue than some of the other more contentious issues that come up within the context of health care reform.

Next -- and this is the really great part -- it doesn't cost anything. Now of course, we weren't born yesterday. We know that there is no free lunch. But if you're a congressman and you don't have to find a revenue offset, it's free. That definitely makes it a popular issue.

Finally – and after this one you're going to think I'm really crazy – this is not a complicated issue, it's very simple. Let me explain. It's kind of a caveman approach: "Mmm . . . insurance companies . . . bad . . . we make behave." And so they prescribe how insurance companies are going to behave in the small group market. And if they don't, "We club them." In that sense, it is not a complicated issue.

Congress definitely wants to get a piece of the action on this issue and not just let the states take the lead on it. It wants to claim this issue as its own. As a result, there have been a number of proposals that have been introduced. And we're going to see many more. A bill that's going to be introduced very soon by Senate Majority Leader George Mitchell, with Senators Kennedy, Rockefeller, and Riegle, is without question going to include small group health insurance market reform provisions. In fact, it's going to have many elements of the Pepper Commission's recommendations, with a few other bells and whistles. This clearly is an issue that Capitol Hill is going to spend a lot of time focusing on in the 102nd Congress.

Obviously there are some very real issues to be dealt with. And we're concerned that within the efforts to address these important issues, Congress will just gloss over the issue and say, "We're going to fix everything. We're going to tell insurance companies how they're going to act," but not examine the potential side effects of various approaches.

Let me give you a thumbnail sketch of the Chamber's recommendations regarding small group health insurance market reform and give you another disclaimer. You're going to think this is not very technical, not very revolutionary. And it's true, we're not getting into the finer details of how to craft insurance market reform. Our intention is to lay out broad principles. We're more focused on outcomes and what small group reform means in terms of availability and affordability.

Our broad principles include four points. First, we believe that insurers, if they're going to write a policy for a group, should take the entire group so there's no cherry-picking. We haven't addressed the issue of guaranteed issue or guaranteed access.

Second, we believe that insurers should guarantee renewal at pooled rates. We don't define what we mean by pooled rates, but basically the recommendation is aimed at the problems facing a group that may not be dropped explicitly but find its rates have been increased 200% and in effect it is forced out of coverage. That may be an extreme example, but that's what we're trying to respond to.

Third, we believe that no new preexisting condition limitations should be imposed on individuals who have continuously been insured, even when they change insurance carriers or change jobs. And finally, we believe that the insurance industry should develop some kind of a risk-spreading mechanism, whether it's reinsurance or some other variation on that theme, to more fairly spread the higher-risk cases.

As I said, we haven't gotten into the specifics of how exactly insurance market reform should be crafted. We don't have the expertise. We're really focused on the outcomes: what does this mean in terms of expanded availability, increased stability, and what impact this could have in terms of affordability? We see it as a balancing act. And that's the one message we continue to take to Congress. In their fervor to address this issue, we are concerned about unintended consequences in terms of cost and access.

There are many members of Congress who think that small group health insurance reform will make health insurance more affordable for businesses. We know that's not the case. Our goal is to have somewhat of a leavening effect, which suggests that some will be paying more. We have other questions. Does this mean most will be paying more? Does this mean everyone will be paying more? And, beyond the cost implications, what does this mean for access to health insurance? Are we pricing it even further beyond the reach of many of these businesses? Are we encouraging insurance companies to get out of the small group marketplace because it's no longer profitable? Are we really undoing the private health insurance market? That's clearly a consequence that we don't want to see. So again, our message is that this is a balancing act. You have to make sure that in addressing these very real issues, you don't go overboard and exacerbate the very real problems of access and cost.

But we also have even greater concerns about doing nothing. Howard mentioned the anecdotal evidence, and we've had plenty of it pouring into our offices at the U.S. Chamber of Commerce. A lot of these letters are amazing to me. Small businesses are frustrated to learn they've been dropped from coverage or individuals within their

group are not covered for certain items. A number of them have stated in these letters, "Well, maybe national health insurance isn't such a bad idea." This is startling coming from business people who usually have an innate mistrust of government. They're now suddenly countenancing a federal government solution to the problems of access to health insurance. That sends a very strong signal that the frustration level is growing to a point where some of our members are willing to look a little more openly at proposals previously off the table.

So I will leave you with that thought. We don't want to see a middle class revolt that leads us down the path of national health insurance. While there's a lot of talk about national health insurance in the press, on the Hill, most people, even those who would support a national health insurance system, do not see it as politically and financially feasible.

The Pepper Commission put a $220 billion price tag on national health insurance. Clearly, in light of the realities on the budget front, that's not in the cards. But if things within the health care system deteriorate to the point where individuals are so fed up that they're willing to accept some kind of a federal insurance solution, then you can bet Congress will do what they have to do to find the revenues to pay for it.

MR. BOLNICK: Our second speaker is Allen Feezor. Allen is the chief deputy commissioner of insurance in North Carolina. He is Commissioner Long's representative who really runs the National Association of Insurance Commissioners (NAIC) B Committee, Access to Health Care Working Group. This is the group so heavily involved with two pieces of legislation: rate reform and health care access. Allen is the key player this year, having taken over from Trevor Smith, formerly Florida's Deputy Commissioner. Allen has been involved since the group's start.

Prior to getting involved with state government, Allen was senior representative for the Blue Cross/Blue Shield Association in Washington and a consultant to the Blue Cross/Blue Shield Plan. So he has a long history of involvement with the health care industry from the association point of view and now as a regulator. I'd like to introduce you to Allen Feezor.

MR. ALLEN FEEZOR: I would like to spend about 15 minutes trying to do three things: (1) Give a brief overview of what the NAIC has done to date regarding small group reform; (2) Forecast what I think the process will lead to from the NAIC's perspective; (3) Raise a number of concerns about some of the models – some public policy concerns about the course we're proceeding down, maybe a few specific concerns about the rating model. Even though it has been adopted, I think as we look at it, we're probably going to have to do some fine-tuning.

Karen has given you a feel for the Washington environment. And since I spent about 10 years in Washington, I would only make one other observation. The people proposing small group reform are not your Kennedys and Waxmans. Those folks are easy to discount. Yes, they are the Mitchells, the Rockefellers. But in addition, look very carefully at some of the other individuals proposing reform: Ron Chandler and Nancy Johnson from the very heart of insurance country. And there's some rumor, and Karen can confirm this, that even Lloyd Bentsen of Texas is looking seriously at something along this line. Those folks are not enemies of the industry. They are not

liberals. They are friends of the industry, and they are seriously thinking about it. The 1992 elections guarantee some activity at the federal level. Just an observation.

On a closer-to-home level, I think your insurance commissioners as well as your legislators and governors are responding to some of the same public policy pressures that the Congress is feeling regarding the need for something to be done.

Over 40 states have had study commissions either on the problems of the uninsured or on compensated care. The general conclusions, both in the public sector -- Medicaid -- as well as in the private sector, is that the preponderance of evidence suggests that both of these areas are not keeping pace with the demands that are made on them.

Seventy percent of the uninsured are actually employed or dependents or spouses of employed persons. Fifty percent of those are affiliated with small group. What really puts that in perspective for me more than anything else is that 60-70% of the jobs in this country are being created in the small employer and service field. Hence, if we can't get our system, and it is the system, to adequately service that growing portion of our economy, then I'm not optimistic about our long-range survivability.

With that said, I think it was in late 1989 when the NAIC began to push concerned regulators for some action in this area. This gave birth to the NAIC's Health Care Insurance Access Work Group. From my particular perspective, it's unfortunate that it's called access. I think it raises expectations that we will not be able to meet, regardless of how good our models are. I use access as sort of a formula; access equals availability, whether it is with products or services, plus money and perhaps plus incentive. And I think we're doing an excellent job in terms of dealing with the availability of the products. But I'm not sure that we, certainly within this room, can do much about the money or perhaps much about the motivation which creates true access.

While most of the attention and efforts to date have focused on the two products that Howard mentioned -- the rating reform and the guaranteed issue initiatives -- I would quickly say that there are going to be some other elements that this access project will turn to. One is a continuation of conversion. Revisit what's called the discontinuance and replacement laws. And I think ultimately we will have to revisit the role of underwriting; what's acceptable underwriting and what isn't in the health insurance business.

In early 1990, the NAIC formed an industry work group to examine rating practices, particularly those that were generally perceived, at least by public policymakers, as being harmful to the marketplace. You and I know that durational and tiered rating, in many instances, grew out of necessity, particularly in those difficult times in 1987 and 1988 when costs began to take off again.

The work group comprised some of the best experts, including two of the gentlemen sitting to my immediate left. And I think it is a direct tribute to Dick Helms' stewardship, statesmanship and probably his credibility with some rather diverse and at times warring segments of the industry, that he was able to put together what was our

rating reform package in about 10 months time. It was adopted almost intact by the NAIC at last year's December meeting.

If memory serves me correctly, we did do a little compressing of the rating bans and made a couple of other little modifications, but nonetheless, I think their work is a credit to the group.

In mid-1990, the NAIC instituted yet a second work group, chaired by John Troy of Travelers, to look at the method of guaranteed availability or guaranteed issue and renewability of small group products. Iowa, Florida, North Dakota and Arkansas have adopted rating reform models in advance of dealing with the access issue. And in fact, since many of our access or our guaranteed issue models are still unproven, it perhaps is prudent for some states to proceed.

On a personal note, my home state of North Carolina, probably within 10 days, will adopt both a rating reform model based on the NAIC model and a guaranteed issue product. And we're going to try to get them up and running simultaneously.

The Insurance Access Working Group met, as did its sister work group for literally hundreds of hours, trying to design. Actually there was no problem designing a mechanism to guarantee issue. That was the easy part. The real problem was fitting that mechanism on top of current players, or the varying market conditions with the goal of not trying to competitively disadvantage any of the players.

This is where the problem has come in and probably the reason why the Advisory Committee was unable to cut down the number of models to less than six. I think Howard and Dick will probably agree, the discussions and work of that group, as well as the preceding group, were both stimulating, revealing, frustrating, and, at times, contentious.

Despite my urging, and the urging of some of my fellow regulators to try to reduce the number of options to less than six, it was never done. In fact, I would actually say that we probably have received seven models in April at the West Virginia NAIC meeting, when you throw in what I call the "if-it-ain't-broke-don't-fix-it" option, which basically says there are a few states out there with an insurer of last resort willing to insure at community rates. And as long as the market can do that, so be it.

If you have not gotten the report of our industry advisory committee I urge you to get a copy. Actually, while there is a great deal of work to be done on some of the models proposed, all of them embody a great deal of effort. And I think that any of them, given enough time and work, probably could be made effective in any of certain market conditions.

In West Virginia this past April, the NAIC received a report from the industry and then immediately preceded to drop it to two models – what's commonly called the prospective reinsurance with an opt-out, and an allocation better known as assigned risk.

There's a general feeling among the regulator panel that the reinsurance proposals, or certainly the perspective reinsurance with an opt-out, is perhaps the most mature and

the best thought-out of the models. And yet at the same time, there is a fundamental feeling that in some markets, it may be too complicated and too cumbersome for the market to sustain. Consequently, there is a commitment on the part of the committee to come up with a simpler version, and it was hoped that version would be an allocation model. The allocation model was presented in a couple of different forms, but did not prove to be that simple and needed a little work. The goal of the committee that I inherited from Trevor Smith is to get one or both of these models, or some variation of them, out for exposure by the end of the Indianapolis NAIC meeting.

Let me quickly say that we are developing these models with two audiences in mind. The first is our traditional audience of state regulators who need something to address the problems in their state. The second, we are clearly looking over our shoulder at the pressures in Washington. I think that it's fair to say that Florida's Commissioner Gallagher, who chairs the B Committee, the Health Committee, said that the NAIC has to have at least an exposure model to carry to Washington to participate in some of the active debates that are going on.

And yes, I will also say that our report, when it is put out for final vote either in September in Pittsburgh or in December in Houston will probably carry a far more elaborate narrative getting into noninsurance issues.

We're going to put out some models for exposure without the level of testing or examination that I and many of my fellow regulators would prefer. Yet I see that society and the times are demanding that we move ahead. I think perhaps we also may benefit from what Justice Brandeis said: states may be not only laboratories of democracy but also laboratories of experimentation. And it may well be that some other states may profit from mistakes that Connecticut or even North Carolina may make.

Let me talk about public policy questions regarding the rating model adopted in December. I'm not alone in my belief that it is a first step toward greater reform. Some question remains though, if the improved rate stability and rate compression are important enough to small business to accept the likely increase in cost that some, perhaps even a majority, of its members may sustain. Also, if we do the compression and raise the floor, will there be individuals who, compared to their colleagues, have good rates but have gotten more than they can afford to begin with?

As for the guaranteed issue proposals, is the capacity of small group market to absorb the cost of both the rate reforms and the guaranteed issue components? And how much does the latter cost? Our interest and reinsurance pooling mechanisms will have to be flexible enough to allow substantial modifications as we go. I don't think you can do it all in legislation.

I think my biggest fear is that small employers are most interested in small group reform and the fact that it offers a couple of short-term abatements of their current problems. Most of the proposals embody some sort of basic coverage that will reduce cost on a one-time basis. Some strip out the state mandates and, depending upon the state you're in, that would mean substantial one-time savings.

And then I guess I question whether we have really nudged the industry toward cost and risk management. Have we, perhaps, simply gotten a new form or a new playing field for risk selection? By calling these things access models, I think we have raised expectations. My fear is that some members of Congress and of state legislatures who are desperate because of all they've heard, have great expectations that may not be met.

If our industry cannot find a way to fully and fairly service all of its markets, then I think the days of the private health care payment industry are limited. And small group reform, as ugly a child as it may be, represents our greatest hope for maintaining the vitality of the private insurance mechanism. On that, I hope we all agree and will all work toward some sort of reform.

MR. BOLNICK: I wish there were 50 state insurance departments that had the understanding and thoughtfulness about the issues that you do.

Dick Helms will give us the somewhat sobering perspective of the insurance industry. Dick is second vice president of Principal Financial Group. Principal Financial is one of the country's largest writers of insurance for small businesses. Dick is responsible for pricing and financial work for products in the group life and health division. Dick, as Allen mentioned, has been heavily involved with the two industry advisory committees that have given advice to Allen's working group. He also chaired the Rate Reform Group whose work led to an NAIC Model Law, adopted in December 1990.

MR. RICHARD L. HELMS: Karen and Allen have provided, I think, a good flavor for the complexity of the public policy and political issues surrounding this problem. I hope to get into the complexity of the technical and design aspects of the problem. I'm going to focus on the pitfalls of designing solutions for these small employer problems. As I do so, it should become clear that what Howard indicated at the beginning is true: The answers to these problems are not simple and they depend very much on your social policy viewpoints and on balancing of competing goals and so forth. I think it's fair to say there is no single solution to this problem.

The first pitfall I want to discuss is tight rating and underwriting restrictions in a voluntary market. Small employers have detailed knowledge of the health status of their employees, as you would expect. This is unlike the situation with large employers. Small employers can also add unhealthy lives to the payroll. Friends or relatives can be added relatively easily to the payroll for the purpose of obtaining insurance. This kind of antiselection in the small employer marketplace is what leads to the underwriting practices of the insurance industry (underwriting for acceptance of the group, preexisting conditions, and so forth).

Underwriting leads to a select group initially, and better-than-average claims experience for new cases. Then, in order to write the greatest amount of new business (carriers obviously want to write more business) carriers discount new sale rates from average renewal rates. This discounting is justified by the experience of those freshly underwritten cases.

Finally, in order to protect their existing cases from going through the underwriting screening of a competing carrier and getting their lower new sale rate, the carrier is

forced to do some form of experience rating. That comes in many guises. Some carriers say they do experience rating; others say they don't but they really do it in a different format. Some may use loss ratios. Some look at the individual claims to determine health status. Some carriers will close one trust for the old business, open a new trust for the new business, and let the experience of each block drive the rates. Another method is reentry underwriting, allowing existing cases to go through the underwriting health screening again. But under any of those guises, I think it is experience rating in one form or another.

All of these things tie together very tightly. Solutions that say, "Let's just ban underwriting or ban experience rating," are too simplified. You cannot do those things without getting at the root cause, the antiselection that takes place in this voluntary small employer marketplace. You could perhaps implement an employer mandate and make these solutions more feasible. I'm not necessarily advocating a mandate; I just think if you want to eliminate underwriting or experience rating, a mandate probably has to be part of the solution.

The second pitfall is related to the first. Community rating is, in my mind, the ultimate in rating restrictions, and I think it would be a disaster in a voluntary market. Let's talk about two kinds of community rating. The first is community rating by class, where you can still rate by age, sex, industry and geography, but not by experience or health status of the individuals. That type of community rating is the less onerous of the two. But it still raises a huge disincentive to cost containment for employers and employees.

It also increases the cost, as has been pointed out, for many of the groups that have better than average experience. The 80/20 rule says that 80% of the claims come from 20% of the claimants. The distribution of cases is such that the majority of small employers probably have rates that are below the average. And the minority are above the average. I think it is quite likely that community rating would lead to an increase in rates for most small employers. It also penalizes carriers who are willing to write substandard groups, and provides a disadvantage for established carriers in the marketplace. Carriers with a greater percentage of new business (new carriers in the marketplace) can have a lower community rate than other carriers and have a competitive advantage.

If community rating includes demographics, geography and so forth, it has all of the disadvantages I've already mentioned, only they are magnified. In addition, it encourages redlining, discriminatory sales practices, and the like. So this simplistic solution that pops up every now and then is really not a simplistic solution at all.

Another pitfall is leakage from the reforms. Small employers don't have to enter the insurance marketplace in order to provide coverage to their employees. They could use self-insurance. They would be unwise to do so, but if we raise the rates for the healthy groups, more of those healthy groups will be tempted to go it alone. If they can't do so on their own, there are self-insured Multiple Employer Welfare Associations that are beyond the scope of state regulation and some of these reforms.

There is also the individual marketplace. Many small employers provide coverage for their employees through individual contracts instead of a group contract. If the

reforms deal with group and not individual contracts, there's an opportunity for leakage. If the reforms try to deal with individual contracts, then you have the problems of dual regulation because individual insurance is already tightly regulated in many states. It's not an easy issue. Plugging this hole may involve legislation to reform ERISA, and that opens up a can of worms for large employers. They're not at all in favor of tinkering with existing ERISA exemptions.

Another pitfall is the cost of reform. Rate reform raises the rates for small groups with good experience. And there are large numbers of such groups. As for the reforms on access, they try to bring in the uninsured. In the absence of any kind of a mandate, you would expect it's going to bring in the uninsurable uninsureds (the others would get coverage if they could afford it). They will have higher average costs than the existing insured marketplace. That raises the average cost for the entire marketplace. And that effect is magnified to the extent that there is leakage, going back to the prior pitfall. The more leakage, the more the cost effect becomes magnified.

Another cost of reform could be carrier participation. A number of carriers in recent years have left the small employer marketplace. Additional carriers may leave if the protections from some sort of guaranteed issue mechanism are not viewed as adequate. Without adequate pooling, some of the smaller carriers, in particular, will feel that their very existence is threatened by guarantee issue and may exit the marketplace.

There are many interrelated and sometimes competing design elements in access models that Allen has mentioned briefly. I'm not going to talk about the details but will discuss some of the competing design elements. In the guarantee issue models with a reinsurance mechanism, there can be prospective reinsurance or retrospective reinsurance. Your viewpoints on those models may very well depend on the type of business that you've been in. The commercial insurance industry has tended to view prospective reinsurance more favorably. They're all engaged in the business of front-end underwriting which enables easier identification of the cases and individuals that should be reinsured. Many commercial carriers are experts in this business, and that colors their view on the acceptability of prospective versus retrospective. Other carriers, especially HMOs and some of the Blues, have been less involved in front-end underwriting. They are more likely, therefore, to favor retrospective reinsurance. This involves post claims underwriting to identify what's reinsurable and what isn't.

There is an issue of carrier retention of risk versus spreading the risk. If you have guarantee issue and you want to provide the maximum protection for small carriers from guarantee issue and the antiselection that results, then you would allow them to reinsure all of the risk that they can't pass on to the employer. That is, all of the risk that doesn't fit into the rating bands should be reinsured. But if you do that, there is no incentive for those carriers to manage high-cost claims.

Once a claim is reinsured, the carrier lacks incentive to spread the money necessary to manage those claims. If we introduce some incentives to manage reinsured claims, like a front-end deductible or some coinsurance, we reduce the protection for the carrier from guarantee issue. So there are two very desirable, but competing

goals. There is a balancing act to be performed here. This is a big issue for the small carriers in particular.

Employer choice is another issue. The allocation model that Allen mentioned requires uninsurable employers to be rejected for everyone before going through the allocation mechanism to be assigned to a carrier. But that has high visibility for those employers. Some people are worried about the stigma that it carries. Is it that desirable public policy to identify the employers that can't get coverage elsewhere and have to go through the assignment mechanism? The best solutions to this concern are the more complicated ones that involve guarantee issue and a reinsurance mechanism.

There are also carrier equity and enforcement issues. For example, carriers that already have an open enrollment block or have tried to write substandard business and feel they have a bigger volume of substandard cases compared to their competitors would worry about getting into a reinsurance mechanism. Is the funding of the mechanism fair? Are the rules of the mechanism fair? Are all of the carriers going to be playing on a level playing field?

These concerns lead some to ask for an opt-out provision. But an opt-out provision that enables a carrier to internalize the risk and not participate in the reinsurance mechanism introduces equity and enforcement issues. Are the opt-out carriers and the reinsurance carriers all playing by the same rules? Are both groups getting their fair share of the uninsurable risks? How should that be determined?

Second-tier assessment is another issue. There is a rationale, when allowing uninsurables access to the small group marketplace, for sharing the cost with the large employer marketplace. Large employers routinely screen out some of the unhealthy through their screening process for employment. Some of those people end up in the small group marketplace. If that's happening, then shouldn't the large employer marketplace bear part of the burden? Another argument is that the small employer marketplace simply cannot afford all of the cost. If we force them to bear all of the cost, as Allen indicated, we may very well just add to the problem of the uninsured by causing some healthy groups to drop coverage that has become unaffordable.

So there is an argument for sharing the cost across the large employer marketplace. But how can we do that? We can access the large employer insured marketplace, but we can't get to the self-insured through existing regulations. That brings us back to the ERISA question and whether it should be modified.

I've tried to give you a sense that there are a lot of complexities to this problem. There must be a balancing of competing issues involved in trying to develop solutions.

I'll leave you with one final thought. The insurance industry has been criticized for not doing anything to reform the small employer marketplace. I think the industry has, in fact, been pretty active in trying to develop solutions to this problem. The Health Insurance Association of America (HIAA) has been working on it. The Blues, through their associations, have been working on the problem. The NAIC has had the two task forces previously mentioned which have brought all of these players together, including the HMO industry. The people that have been involved in this have been trying to carefully weigh all of these issues and craft solutions that will

work. I think they've designed some things that have a chance to work. But the issues are extremely complex, and we just need to bear in mind that there aren't going to be simple solutions.

MR. BOLNICK: One last note before I open the floor to questions. I'd like to talk just for a moment about the actuary's role in this whole process. Dick is an actuary. I'm an actuary. A lot of the people who have been involved with the process through HIAA and NAIC are actuaries. And I think we should all be proud of the input that actuaries are giving this process. We come at it as technicians – the operations people. But we need to identify the best way to work with the policy people. How do we work together to find the answer that works for society? Something for all of you to think about.

MR. JOHN A. HARTNEDY: I heard Allen and Dick express real concern about pushing rates up. Yet, Karen makes the comment that what we're supposed to do is cover the people who are uninsurable.

My question to anyone who would like to address it is this: The estimated percent of uninsurable individuals is between 1% and 2%. We hear comments like 4% of our insureds will give us 50% of our claims. And it doesn't seem to be that much of a problem until we limit cancelable; all of a sudden, people who are uninsurable are being dumped into the marketplace. That has happened before. But the initial model seems to have gone a long way to fix things.

My concern is why are we pursuing this access model when there are states moving toward high-risk pools? Good underwriting can noticeably hold costs down. The biggest complaint that I hear is affordability, and that will affect most of the people who do not have insurance. Uninsurability is an important, but small complaint. The issue is affordability. I've heard estimates that this will increase insurance costs between 4% and 11%. I find that to be extremely optimistic. I'm very concerned about trying to bring in the uninsurables. Why do we continue to pursue that so aggressively?

MR. BOLNICK: I think that's an excellent question. Allen, would you care to address it?

MR. FEEZOR: First, we don't know what the costs are going to be. Second, there's some offsetting built into most of the current models. I talked about the back-to-basic movement, stripped-down coverages – that probably is cost avoidance as opposed to cost reduction. There is some thinking about doing away with mandates which may be an offset of 4%, 6%, 10%. The cost of mandates in Virginia and Maryland is 16% and 21%. That may be a fair swap. In addition, they're supposed to be removing some barriers that some states have chosen in terms of managed care. So there are a variety of things that may be trade-offs which may ameliorate those cost increases.

If your fundamental question is why not pursue the high-risk pool for individuals, I guess it gets back to trying to pursue the problems of the uninsured on an individual basis. It's inefficient from a marketing standpoint. I think trying to attack it at the

small group, which is the fastest growing segment of our employment, makes the most sense.

But you raise an important concern. There is a need for portability between individual and small group policies. I felt some glee when Karen, who represents both large and small employers, talked about the need to guarantee portability for individuals leaving small employers going to large employers. Currently, if we adopt these reforms, we probably will be visiting a greater commitment on the part of small employers in terms of accepting portability from another transferring employee. Then large businesses will be more willing to do it.

MR. BOLNICK: Your thoughts, Dick?

MR. HELMS: I'll just add two quick thoughts. One, dealing with this problem through the state risk pools does involve public money. And that presents political problems. In addition, that may not be desirable even if it was politically feasible. In effect, it sets the state up as a competitor to private industry. So I think we at least have an argument for trying to solve the problem ourselves.

MR. BOLNICK: Karen, do you have any comments?

MS. BRIGHAM: Well, obviously cost is the big issue. In every survey that we've done of our small business members, the biggest reason they don't offer health insurance coverage is cost. So that's certainly something we're very sensitive to and that's why we view this whole reform effort as a balancing act. How do we keep as many people in the system, and hopefully, add some people, while at the same time avoiding driving many more people out because of the increased cost?

We have traditionally, within our broader health care reform policy, supported high-risk pools for uninsurable individuals. And it's just been over the past two years that we've developed policy in the area of small group health insurance market reform.

MR. HARTNEDY: One other comment. All of the models presuppose that states will pursue high-risk individual pools, particularly for the under-three-life group. My guess is that some states will begin to copy Maine's actions in terms of allowing high-risk individuals from small employers, or what I call "microemployers," those with fewer than five employees, to be ceded to the high-risk individual pool and then try to write the remaining book of business at a standard or near-standard rate.

FROM THE FLOOR: I think what you just said is really true in the state of Texas. From a purely actuarial point of view, it makes a lot of sense to hold down the rates in the small group area, but it would require public money. It's also seen as the insurance industry avoiding the issue. And allowing them to continue to keep the best risk in the small group market while ceding to the government if you will, the worst risks. That's a very difficult perception problem to overcome.

The high-risk pools are sometimes viewed as elitist unless there's public funding of the premiums. The premiums are usually paid by individuals, and the only individuals who can afford them are those who are well off. So a public policy question exists about uninsurables who cannot afford the premiums of the high-risk pool.

First, I'd like to congratulate all the panelists. This is a very difficult topic to address and this is one of the best forums I've heard. I have a concern regarding the reinsurance pools that are going to be proposed. Blue Cross/Blue Shield of Texas, unlike some other Blues, does small group underwriting. We send out health questionnaires and we accept or reject the whole group, which is what Ms. Brigham wants. But we're very adept at doing up-front underwriting. We know that our competitors are as well.

But that's not our objection to the prospective method. Yes, we could prospectively choose which groups ought to go to the high-risk pool. But I think it gets back to Allen's comment that the reinsurance pool actually provides another opportunity for selection. A savvy insurance company could accept more business during a time in the cycle when it knows its margins will be higher. It would just loosen its underwriting standards. When its margins are squeezed, it would tighten its underwriting standards. And so the proportion of the business that it would be sending to the high-risk pool or the reinsurance pool at any time would vary. So I see the possibility for game playing by carriers. They might decide upfront who's going to the pool and who isn't.

The other thing, just from an actuary's point of view, is that I look for a solution that's simple. And to me, the prospective method is more complicated than a simple retrospective stop-loss method where you wouldn't cede any accidents to the pool, but you have a variable stop-loss point based on the size of the group and you'd have varying stop-loss charges based on how much managed care business you were doing. The bottom line is we're adept at underwriting. We could do the prospective method. But for these reasons I've mentioned, we would favor the retrospective method.

MR. JOSEPH W. MORAN: I wanted to pick up on one of Allen Feezor's comments. He used the word "incentives." That word seems to have been lost in the shuffle in most of the discussion in the last few months regarding the design of reinsurance mechanisms as part of a guaranteed insurability design. I think the acid test of any proposed structure should be, "Do carriers have incentives to increase the number of high-cost risks that they cover, and to get as many high-cost risks on the books as possible?"

One design feature that wasn't mentioned because of the time constraints was the concept of reinsurance deductibles. It was an amendment added to the Connecticut reinsurance design. That suddenly shifted the balance of incentives away from carriers being completely protected against any adverse financial impact from having a disproportionate number of high-cost risks, to suddenly having a situation in which any carrier with a disproportionate number of high-cost risks in a small group pool sustains a financial penalty.

Would anybody like to comment on the question of penalties versus incentives in the design of reinsurance programs and whether they think it has a significant impact on the efficacy of any design?

MR. HELMS: The answer is not clear because there are competing issues. Incentives to manage high-cost claims conflict with incentives to insure as many high-cost

groups or individuals as possible. Also, the best ways to provide incentives to cover high-cost groups will increase the size of the reinsurance pool. Then you have the problem of spreading the cost of that. And should it overflow out of the small group marketplace into the large group marketplace? It's just a complex problem, and you have to balance competing objectives in order to design the solution.

MR. HOBSON D. CARROLL: I'm concerned that in all the discussions over the past couple of years which deal with this issue, the focus always seems to be one-sided against the insurance companies. The insurance companies are doing this . . . the insurance companies are doing that . . . we've got to stop the insurance companies . . . etc. Insurance in the small group area is a two-way street. And there seems to be a need for some responsibility on the part of the small employers.

In my experience in the small group business, small employers do not pay much of the cost of small group health insurance -- maybe a third to a half of the total cost. The rest is paid by the employees. And for the small employers to complain about affordability when they're not paying most of the cost anyway seems to be a little shortsighted.

One of the solutions may be to require 100% noncontribution, particularly on the dependent coverage, because a lot of the uninsured have working family members who are insured. They just don't have the dependent coverage. There are children and women out there who have working husbands or single mothers who can't afford to pay for the dependent cost because the employer is not contributing a thing.

And the other part is that if insurance companies are going to have to guarantee that we're not going to ratchet, not tier, and not use appropriate durational factors, when is the employer going to be required to stay with the insurer for some amount of time, long enough to make pooling work?

MR. FEEZOR: I think you raise an excellent point. I mentioned some sort of standardization of employer contribution or employee participation as a way to keep insurers from gaming. But you're absolutely right. I wouldn't be surprised if, in the evolution of these reforms, we don't get square into the middle of a lot of employer/employee relation legislation. If somebody asked, "What is the single most important thing this country could do to deal with the 31 million uninsured?", I would say resurrect reconstructed tax incentive so that unless an employer made a contribution to dependents or spouses in family coverage, the contribution made toward the employee coverage could not be taken as a deduction. And I think you would see a quick and substantial shift toward enrollment.

MR. BOLNICK: Anyone else care to comment?

MS. BRIGHAM: Discussions about mandating coverage or mandating coverage at certain levels for individuals, employees and spouse and dependent coverage are unrealistic. We are talking about forcing these small businesses onto a runaway train of health care inflation without really getting at the underlying problems that are driving it. The discussions in Washington are clearly centering on employer mandates as a way to expand access to health insurance. The Mitchell Bill will be introduced tomorrow. It is premised upon a fair play-or-pay mandate. Employers would be

required to offer a specified set of benefits or alternatively pay payroll tax of a certain percentage. That payroll tax would fund a public insurance program which would compete directly with private health insurance.

We certainly have concerns over an employer mandate and what that means in terms of labor costs for small businesses. But we are also concerned about what it means for the continued viability of the private health insurance system if we set up this public competitor to private health insurance. Over time it will certainly have to be subsidized and could precipitate some of the antiselection problems that we've been discussing.

MR. BOLNICK: I'm very happy that all of you participated in this presentation and had a chance to hear an extremely varied approach to the problem. Hopefully you all got a sense of what some of the issues are and a little bit of encouragement to be part of the solution.