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SMALL GROUP REFORM

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Guest Speaker: RICHARD NIEMIEC*
Panelist: TED A. LYLE

MR. PAUL R. FLEISCHACKER: The officers for this upcoming year will be myself as chair taking over for Alice Rosenblatt; Greg Herrle will be the vice-chair; Dick Helms will be the treasurer; and Frank Morewood will be the secretary. We have four specific committees as part of the Health Section. Our Research Committee is going to be chaired by John Bertko; Communications Committee by Joe Moran; Education Committee by Irwin Stricker; and finally the Program Committee by Bill Thompson. At this point, I'm going to turn it over to Joe Moran. He has an announcement to make on a research study that's just been completed.

MR. JOSEPH W. MORAN: An announcement that was made from the podium at the general session made reference to a newly completed research project, sponsored by the Society and by the Health Section and, in part, funded by the Society. The study is on the variation by duration in small group medical insurance claims costs. This is a subject that is close to the hearts of any actuary in the small group who is either trying to justify the pattern of gradation of premium rates by duration of coverage or fight the use by somebody else of gradation of premium rates by duration of coverage.

For the first time the actuaries who deal with that have more than just their own company experience to refer to in examining the reasonableness and appropriateness of their own or somebody else's price gradation. Three actuaries with Milliman & Robertson have been working for over a year on putting together a research project to study the variation of small group health claim costs by duration. They've now completed a study that has some $2 billion of claim costs over a two-year period analyzed in meticulous detail to show variations by month within the first three years and by year of group duration, and separately compared for groups with various types of case characteristics, size of group, underwriting characteristics, and so forth. The report is now available not just in hard copy form, which is free, but also in diskette form which can save you a lot of wear and tear of having somebody key in 35 pages of tightly packed numbers in about 50 lines and a dozen columns on some of those pages. So you can save keying in a few zillion numbers by buying the diskette from the Society and that will help recover some of the cost that the Society has undertaken in order to have this study conducted. We hope it will be a popular diskette acquisition for most actuaries and that actuaries will turn their imaginations loose on figuring out how to convert this experience study into possible valuation standards for measuring short duration reserves for small group business and maybe even the regulators in dealing with the question of what's reasonable and what's not reasonable in terms of duration gradation patterns. Actuaries should be able to make a lot of use of this report.

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MR. FLEISCHACKER: Getting into the main part of the program, which is a discussion on small group reform, we have two speakers who have done a considerable amount of work in this particular area. Our first speaker is going to be Dick Niemiec. Dick is the senior vice-president of Underwriting, Actuarial and Legal at Blue Cross/Blue Shield of Minnesota. Dick has served on the NAIC Advisory Committee on Access to Health Care and chair of the Actuarial Subcommittee reporting to that Advisory Committee.

Our second speaker is going to be Ted Lyle. Ted is a consultant with Tillinghast in the Minneapolis office. He has worked with the Blue Cross/Blue Shield Association on the development of a small group reform reinsurance model.

MR. RICHARD NIEMIEC: What I'd like to speak on first are the components of both the rating and renewal model and then also the access model or guaranteed issue reinsurance model, as it's also called. What I intend to do is to run through the details of both of these models fairly quickly because there are a lot of details to them and a lot of you have probably seen more of them than you ever cared to but to some of you it may not be as familiar a subject. So I hope I can set the stage for Ted who is going to talk much more about some of the actuarial components of how it operates.

First, I'd like to speak about the rating and renewal model which, as you know, was approved a year ago in December by the commissioners and interestingly, as some of us (Bill Weller and some other people in the room) know it's still under discussion. There is also a group of people who have gotten together recently -- Dick Helms and others -- with Mark Peavy from NAIC. As I go through this, I'll try to indicate some of the points that still appear to be controversial from the commissioners' standpoint. Anyway, for the rating and renewal model, it defines a small group as 3-25 and then sets forth definitions for classes of business, distinct groupings of small employers, which are fairly detailed and based on the following:

- Separate distribution (marketing) networks
- Acquired from another carrier
- Associations
- Open enrollment block
- Underwriting criteria

There was a lot of discussion about them on the Advisory Committee. There is now concern from the commissioners as to gaming. There's also discussion about whether there should be a limit on the number of classes that carriers could have.

Interestingly, from the original Advisory Committee the feeling was, by setting out these criteria and some of the other rules, that you didn't need to set a limit on the number of classes. I am hopeful that we can move forward with this without setting an arbitrary limit on the number of classes a carrier could have. Also key to the rating and renewal model is the idea of case characteristics, such as demographic characteristics of a small employer (e.g., age, sex, area), family composition (single/family, etc.), and group size. There's concern among the commissioners that there might be gaming on the part of some carriers with case characteristics, but I think it's a fairly straightforward approach and I think it's workable.

Continuing on, the three other things you need to know about the model are how the index rate is constructed off of the base rate and the highest rate. There's also a provision in case you have a different new business rate, which wouldn't be your lowest rate. Each of these rates could vary within a class of business by the case characteristics. So there is quite a bit of flexibility. It's far from a community rate, but it's certainly a limitation on what has been going on. The way that it would work is that between each class of business there would have to be a 20% test. Then within a class of business all the rates must be plus or minus 25% off of the index rate for similar case characteristics. Furthermore, there would be limits based on the rate increases to your new business rate, plus an additional 15% for experience plus changes in case characteristics and benefits. Further, if you were outside the rating bands, there would be five years to come within them for existing business and also you could not involuntarily transfer a group into or out of a class of business. There are more provisions.

Then finally it's guaranteed renewable, except for the following provisions that give a little bit of flexibility.

- Nonpayment of rate
- Fraud or misrepresentation
- Noncompliance with plan provisions
- Failure to meet participation requirements
- No longer in business

As you can see, try to avoid gaming if a carrier is going to pull out; then there would be a prohibition against coming back in for five years.

The following are the key things to the operation. One, there needs to be disclosure of rating and renewal practices not only for the market to operate effectively, so the groups would have some idea of what they're buying into, but also for the regulators to know what's going on. That is extremely important. Those of us who worked on it believe that we need to bring as best we can all the players into the market, including the Multiple Employer Welfare Associations (MEWAs). Ted will speak later about that and what some of the implications are. Finally, there would be an actuarial certification and this is part of what we spent time on recently with Mark Peavy. We talked about the testing that a carrier's actuary would have to go through to certify the plus or minus 25%, the 20% between classes of business, and so on.

I think it's fair to report that there is a degree of concern among commissioners and their staff that these things aren't tight enough. I think the key for us is to make sure that this actuarial certification works so that they don't impose other restrictions; for example, the number of classes or even tightening down the rating bands so that they feel they could eliminate gaming. This is the rating and renewal model.

Then what is currently under consideration is the access model. There was supposed to be action on it at the Pittsburgh NAIC meeting but there wasn't. They're looking toward the December meeting. The big concern for the commissioners is that, as you've noticed, there's a lot of action in Congress, including the Senator Benson introduction this week. So NAIC is very concerned that if they don't get something going that goes beyond the rating and renewal model, that Congress will move in.

With this access model, it pretty much carries over the rating and renewal model provisions, so keep that in mind as we go through this. There are two actual models. One is prospective and the other is allocation. There are some things that are common to both of those models. It keeps the group size at 3-25 and talks about two levels of benefits, the core benefit and the standard benefit. The core benefit is important because of the interest in eliminating mandated benefits in a lot of states. There will be a committee that would be set up. The committee is different than the board. The committee would be broader than the board. It includes agents and providers and groups like that and they would be charged with setting the two levels of benefits. Presumably there would be a different set of benefits for HMOs.

There still would be a limitation on total movement in that a carrier would be allowed to impose a 6-12 preexisting condition exclusion, although you would have to give credit for previous group coverage. There could be a 30-day lapse in coverage allowed and it still counts as continuous. In the case of late enrollees, the carrier could impose an 18-month outright exclusion or a preexisting condition exclusion.

Continuing on, the board would be charged to report back to the Commissioner after three years to see whether this act is doing anything to bring more coverage to the small group market. They would need to speak on things like rate stability, availability, affordability, marketing, and then make recommendations for other changes so that there is more coverage in the small group market. That, of course, is the goal of this model. Again, all group players would be regulated, including MEWAs. As I mentioned, the key component of it is to have a waiver of state mandates for the basic product to try to bring some affordability to small group coverage.

The board would be representative of carriers who don't opt out. I'll speak about the opt out provision later on. The rating and renewal requirements carry over. The carrier would be allowed to set minimum participation and contribution requirements. Then as far as the two specific models, the first one is the prospective reinsurance. This is based, to a large degree, on what's going on in Connecticut and now has been carried over into some other states. It would be guaranteed issue for the two products -- the basic and standard benefits. The other products a carrier had could be underwritten.

What has come out of NAIC is that the reinsurance could be voluntary or the state could make it mandatory. A carrier could opt out of the reinsurance and internalize all the risk. Since it's prospective, the carrier would presumably use some sort of medical underwriting to identify what risks they would cede to the pool. A very key consideration on this was that the reinsurance would only apply to new and switching business. It's slightly different in Connecticut and it's a big, big debate relative to volume of the pool, and how much reinsurance you want to allow. Speaking on some of my Minnesota experience more recently, we're trying to work out something between the HMOs, Blue Cross/Blue Shield, and the Federation. Once again, we are visiting this subject. I think that this new and switching is probably a good compromise to us and we'll see how it works out with some of the states that have adopted it, but it's one way to control the volume.

The reinsurance premiums would be set up so that you could insure the entire group or the individual at 150% or 500%. The key to this is that the reinsurance premiums

would have to be absorbed within the rating bands. Cost sharing was an item that was discussed quite a bit. Where it stands is there would be a $5,000 deductible and then 10% retention. Assessment of the losses above and beyond the premium would be first on the carriers in the small group reinsurance pool up to 5% of their total small group premium. Then a not very well-defined, but very controversial issue is what the second tier would be and whether that would be on the rest of the insured market -- the larger groups -- or whether it would carry over to income tax or a sick tax or something like that. That's a very difficult one.

The second model that NAIC is considering is allocation. You probably haven't seen as much of this. It was proposed largely by some of the Blue Cross/Blue Shield plans in some of the states who wanted an option to the prospective model. This is constructed so that it would not be guaranteed issue, of course, unless the carrier opted out. Carriers could opt out of the allocation mechanism and simply guarantee issue. The allocation would work so that someone who is currently uninsured or is terminated by a carrier and then rejected twice goes to the allocation mechanism. The group is allowed to select a carrier from the pool of carriers to be allocated to. The board would set each year, based on market share, a target for the groups that each carrier could receive, and then they would receive allocated groups up to that target.

So that's basically how it works. After two years, a group could have itself reallocated or it could try to move back into the market. So this is an alternative. The advantage that is seen to this is that carriers would manage more of the risk. You don't have a need for the second-tier allocation that I mentioned, where you might have to go to the state for money. There are probably three or four states that are looking at this seriously and the commissioners, as I said, have considered it.

The final item I wanted to talk about is something that Blue Cross/Blue Shield Association has proposed and would point out it's not under consideration by NAIC currently, although some of us think it's a good alternative to the other two. It would be reinsurance. Guaranteed issue would be the same as the prospective, as would the voluntary reinsurance pools. But it would be retrospective and the thresholds might vary by group size. There would be a retention. The difference would be, of course, that rather than prospectively ceding cases, the cases would be eligible for reinsurance if they met a conditions list of chronic and high-cost cases. Any losses beyond what the reinsurance premium would be, would be funded through an assessment on the rest of the small group market and a second-tier assessment.

So these are the things that are being considered right now by NAIC. It's a pretty quick run-through.

MR. TED A. LYLE: I'm going to talk a little bit about the modeling that Tillinghast has done with the Blue Cross/Blue Shield Association. Basically, it's one approach to try to address the question of what the impact of a small group reform mechanism is, and it's just that. It's one approach that we've taken to try and quantify the impact. Before I get into that a little bit, I've had a number of conversations this week with various people, both at this meeting and in a couple of other phone conversations, regarding the objectives of small group reform.

One of the things that really has to be done when you're addressing this question is to lay out very clearly what the issues are that we're trying to address, what the objectives are of any small group reform proposal that we're putting forth, and then try and measure what the objectives are of the implementation procedures that we're going to develop.

In an ideal world, we could get all of the parties to agree as to what the objectives of a small group reform mechanism are. Very practically, this is being addressed on a state-by-state basis. I have had a lot of considerations where various parties do have various objectives and they're still trying to address these. The Health Insurance Association of America (HIAA) has set forth a clear set of objectives. The Blue Cross/Blue Shield Association has a clear set of objectives. But when we bring this down to a state-by-state issue, there are still a lot of parties that feel that they have objectives that they'd like to address, that maybe have not been addressed, or that they're trying to address a little differently.

There are a number of issues that arise. Basically, not all of the parties who are affected by this have the same objectives and I think that should be recognized. Second, even to the extent that people may have common objectives, they may have different ideas as to what is the best way to implement those objectives. Real frankly, those are a number of things that we're starting to run into as we are looking at this on a state-by-state basis. For example, there are a few things that are pretty clear. I think there would be pretty quick and common agreement that a set of objectives should include security for all insured persons that coverage will continue. There should be some sort of security as to what kind of cost increases insureds might expect.

Third, we might say that, and these are all real commonly stated objectives, we should try and preserve the voluntary private insurance market. I think everyone here would agree with that as an objective. It might be a little self-serving, but we can support it saying that it should apply to any appropriate capitalist thought process. These are all pretty reasonable and hopefully obtainable objectives. There are some other objectives that potentially have some higher cost associated with them that people may or may not be fully supportive of.

Providing guaranteed access is a very nice objective and it sounds very good, but intuitively there's a cost. We all started underwriting for a reason. If we're going to remove the impact of underwriting from the system, there's going to be a cost.

There are people who are looking to reduce costs or make coverage be more affordable. The vast majority of people who don't have insurance in the small group market today are saying the reason is affordability. Most of the proposals we're looking at don't really address the affordability issue or address it in a very limited manner and, unless someone steps forward with a pretty nifty funding mechanism or a pretty heavy subsidy from somewhere else, it's real questionable as to whether you can really address the affordability issue; but there are people who are looking for a solution that's going to affect affordability.

There are people who are looking for a solution that's going to have a significant impact on reducing the number of uninsured. Again, in a lot of the proposals that

have been put forth, it's not necessarily clear that we're going to have a significant reduction in the number of uninsured. Even if we're providing open access, it's not clear that people who are expecting this to be an objective of the small group reform mechanism are going to be looking at the results and saying that we've accomplished the goal. I don't think we can have a significant reduction in the number of uninsured, unless either there's an employer mandate or we do something to find a way to address the issue of how to reduce costs significantly. Consequently, I think it's got to be pretty clearly understood any time we're addressing this issue as to which objectives we're going to try and accomplish with the reform mechanisms we're proposing, and what is a reasonable set of expectations of what's going to happen to the market after we implement reform. Hopefully, it's going to be clearly understood by all of the key parties -- regulators, Chamber of Commerce organizations, small employers, as well as commercial insurance carriers, Blue Cross/Blue Shield organizations, HMOs, and other people affected by this -- as to what it is that we're hopefully going to accomplish and where we think we're taking the market.

Even if we came to a set of common objectives, we're still going to have the issue of do we try and address this on a national basis, which is clearly desirable for most commercial carriers, to the extent that we have uniformity on a state-to-state basis. It certainly makes life a lot easier if we have a similar playing field nationwide.

There's part of me that periodically says we're doing some potentially radical things with the small group market. Guaranteed access sounds pretty simple, but it's a pretty big step. There's an awful lot that we don't know about the people who are uninsured because they're uninsured. At times there's a part of me that says it would be really nice to see a bunch of different solutions that are tried in different places and maybe we'll see which is more effective and what some of the pros and cons of various approaches are.

These are trade-offs that end up having to be addressed and there are certain things, even when we're looking at commonly accepted objectives, that are not clear. There are a number of people who would maintain, for example, that carriers are penalized if you're required to pay a portion of the cost of people that we previously considered to be uninsurable who now have gained access to the system. Should carriers be required to pay a portion of that cost directly through the form of some sort of a stop/loss threshold or some kind of a co-insurance cost sharing?

One argument is that carriers should not have to pay that penalty; that seems to be an unfair cost and I think that's a pretty valid argument. On the other hand, there are also people who say by requiring this kind of participation, you're actively encouraging carriers to manage care, and I think you can also sit down and build a pretty logical set of thought processes that would support this argument. If both views are legitimate, then you have to come to some compromise as to what is a reasonable approach to take with this.

Given this and given that there are a lot of other issues, the whole thing is something that's got to be addressed with a tremendous amount of care and diligence. The industry associations have certainly taken that approach and I think we're starting to see this in a lot of states. There really are a lot of organizations that maybe we wish had been looking at this question as closely as we have for the last few years. There

are a lot of people and organizations that are starting to address this just now, and will continue to address these questions in forums on a state-by-state basis throughout the next several months.

Given that, I'm going to run through a summary of the process that we used in putting together some models for the Blue Cross/Blue Shield Association of what the small group market might look like after we've put in a small group reform mechanism. Many insurance companies and HMOs compete in the small group market. There's a lot of experience on people who are currently insured in the small group market, so we know something about that segment of the small group market. We know what the insured business looks like for the underwriting rules that carriers are currently using.

Another thing we know conceptually is, if you basically have pervasive coverage in your entire population we know what the market looks like. This is based on larger employers where pervasive coverage is pretty common.

There's an awful lot that's not known, that's not exactly quantified about the uninsured market in the small group market. The issue anyone who's trying to model this has had to address is how do we try and quantify what is going to be the impact by providing access to people who currently are uninsured. It's been a real tough issue to address; how do you build an effective model to take this into account where we're not going to be talking about universal coverage after implementation of reform? There are a lot of people who don't have insurance now and, assuming that we're not talking about an employer mandate after we've put in a small group reform mechanism, there's still going to be a lot of people who don't have insurance. So the question is, what does the market look like today and then what is it going to look like in a postreform mechanism?

The general approach that we took when we put together the model for the Blue Cross/Blue Shield Association was that we assumed the market after reform would look like an extension of the current market. We started with an assumption that the people who currently are uninsured right now are uninsured basically for one of two reasons. Either they've been denied access because of health status conditions or they just can't afford it. They made a decision that health insurance is too expensive.

We ended up concluding that in trying to put together a model that was going to address access primarily, that we're providing access to a number of people who have been denied access in the past and that basically we will have an extension of the current market with provision for allowing access to these individuals. The model, therefore, is based on current experience from a selected and limited number of Blue Cross/Blue Shield plans. Those plans were selected from a varying number of competitive markets with varying underwriting philosophies.

At the two ends we had a Blue Cross/Blue Shield Plan participating that is, in essence, very close to being a carrier of last resort, which is another term that's not real well-defined when you get into this. In this case, it's a plan that does not underwrite, duration rate, or tier rate. We started from that extreme and at the other extreme we had plans submitting data that were, in essence, operating as many commercial insurance carriers operate; that is, they used rather aggressive

underwriting techniques on the front end and they had tier-rating processes in place for business that was already there -- very much acting like a typical commercial insurance carrier.

So we had a range of Blue Cross/Blue Shield plans submitting data. We took the data and attempted to adjust it to reflect the impact of open access or guaranteed issue. Basically, when we put together the model, we tried to reflect what things would look like in the third year after reform. Recognizing that there is a transition period that you end up going through, we thought it might be appropriate to concentrate on what things would look like in that kind of a time frame.

The basic approach that we took on putting together the model was to build models of the current plan experience. First we collected data from each of the participating plans and built a model of the current plan experience. Then, based on a set of assumptions regarding the position of each specific plan that we were looking at, we did some analysis of their competitive position in their particular marketplace. We looked at the benefit plans that they were offering compared with those that their competitors were offering. We looked at what the average premium differentials for similar benefit plans would be between the Blue Cross/Blue Shield plans and the commercial insurance industry.

We looked at differences in the underwriting practices of that particular Blue Cross/Blue Shield plan compared with what's typical in the commercial industry. From that we made some adjustments to that Blue Cross/Blue Shield experience to model what we thought a typical commercial carrier's experience might be in that state. Then, using the *Tillinghast Group Rate Manual* as a guideline, we did some reasonableness testing to make sure that what we developed is reflective of what we might expect the small group market to look like for a commercial carrier.

We then made some adjustments to reflect what we thought the impact of open enrollment or guaranteed access might be on the market. We then put together, to simulate the impact of underwriting, a presumptive condition list. This was a set of conditions that, if an underwriter were aware that an individual had this condition at the point when the underwriter was making an underwriting decision, the underwriter would probably take some underwriting action. Generally speaking, that underwriting action would be to decline to insure the individual.

We put together this list to quantify the impact of underwriting in the current environment. This was used to measure the impact if we're going to try and measure the impact of guaranteed access. Once we put together this model of what the small group market was going to look like after the implementation of a small group reform mechanism, we then overlaid various reinsurance mechanisms to see the impact of the various methodologies proposed.

I'll step through each of those last items in a little more detail. When we were looking at building a model of a plan's current experience, the information that we were looking at included a distribution of in-force premium rates, and what rating methodologies were in place. We requested individual size of claim distributions, both in total and for claimants with presumptive conditions. Let me add that this was a technical task that took a tremendous effort.

After we had the presumptive condition list put together, we had to go through the claim files and identify all of the individuals who had claim diagnoses relating to these conditions. We then had to go back and extract, for those specific individuals, all of the claims on those individuals in order to put together this distribution.

On a group basis, we did the same thing. We got distributions of premium and claim experience, with the premiums all restated to a set of baseline premium rates. Basically, we adjusted those baseline rates by age, sex, and area. Other than that, we brought them to a baseline set of rates. When we pulled the claims, we did the same thing as with the individual claim distributions. First, we used the raw claims data and we calculated a set of loss ratios relative to the baseline premiums to give us a distribution of group-by-group experience. We then went in and took all of the presumptive condition claims that had been identified and pooled them across the entire book of business.

We did this study by duration. Not surprisingly, when we were looking at duration 1 or 2, there was very little impact of presumptive condition claims. When we get into durations 3 and 4 where the impact of health status starts to wear off, there was quite a significant impact because of the presumptive condition claims.

As I had said before, the model of what a commercial carrier might look like was developed from the plan experience. We then made adjustments to the Blue Cross/ Blue Shield data based upon, for each Blue Cross/Blue Shield plan that we were looking at, their specific rating practices, underwriting practices, and competitive position in terms of benefit levels and premium rates relative to typical commercial insurance carrier practices. Our goal was to try and come up with a measure of what we thought health status differentials might be.

In order to build a total market, we then looked at the relative market share of the commercial insurance model and the Blue Cross/Blue Shield plan model. We then tried to measure what the impact of open access might be on this total market model. As might be expected, in a state where there already is someone who has been providing coverage on a guaranteed issue basis, the cost impact of providing open access is very limited. In states where there is not an insurer of last resort, where there is not an assigned risk pool, where all of the players are, in essence, playing on a level playing field right now, where the norm is that there's aggressive underwriting on the front end and tier-rating practices in place, the cost estimates for providing open access were obviously pretty significant.

In putting this together, parts of the analysis became pretty subjective. We tried to be very careful in putting together these assumptions. We tried to reflect the impact of the underwriting and tier-rating processes that are typically in place and we tried to be conservative in these estimates. When we were looking at experience by duration, we tended to use durations 3 and 4, saying that might be reflective of ultimate experience. Now, this is a questionable assumption, but it's the one we made.

We had expected this to overstate the impact of reform because, by duration 3 and 4, there are a number of healthy lives that have already left the group. They've gotten through somebody else's underwriting and they've gone somewhere else. We also expected this to understate the impact of reform because, even if you're looking

at durations 3 and 4 and we've seen the impact of health status wearing off, we still haven't seen the impact of unhealthy lives who are screened on the front end that were denied access. They're still not included in the data at all. By looking at durations 3 and 4, we concluded that it might be a reasonable estimate of what things might look like in the postreform market.

We then made modifications to look at various reinsurance mechanisms. We tried to anticipate the impact of if there is voluntary versus mandatory reinsurance mechanism. We tried to model the impact of what happens if a number of carriers exit the market for whatever reason. We tried to make adjustments for the changes in the health status of the insured population. One of the real key things we tried to get a feel for is if MEWAs end up being excluded from this process, what is the impact on commercial insurance carriers, Blue Cross/Blue Shield plans, and HMOs that are required to participate.

This analysis becomes pretty subjective and the results pretty severe for the remaining carriers offering insured products. I think everyone here would be very strongly in favor of having a level playing field that would relate to both insured and uninsured entities providing health insurance.

The basic intent of the model was to model various reinsurance mechanisms. Once we had the model put together of what a postreform market might look like, to model a retrospective reinsurance mechanism became very easy. We took our post-reform claim distribution model that we developed to determine the impact of the claim volume and the assessments coming out of a reinsurance mechanism.

For any sort of a prospective reinsurance mechanism where you have to prospectively identify the individuals who are going to go into the reinsurance pool, assuming we're talking about a model where we're going to reinsure individuals only, first we looked at the individual presumptive condition claim distribution data and we used that to identify the portion of claims in excess of any specific stop-loss threshold. We then calculated a statewide average premium rate using a specified assumed loss ratio. From that statewide average premium rate, based on a prespecified ratio, we converted it into a reinsurance premium.

We used that as a threshold amount. If an individual's expected claims exceed that amount, an underwriter is going to tend to reinsure those individuals. So the reinsurance premium levels were converted to stop-loss thresholds and then we used that to determine the portion of cost that would be excess of the stop-loss threshold. We used the presumptive conditions list to identify the people who would end up going into the reinsurance pool. Once we had identified them, we took the claims up to the threshold level and said that was the reinsurance premium. The claims in excess of the threshold level became the assessment level.

To model what would happen if you can prospectively reinsure groups, we took the group and claim distributions which were adjusted for the impact of a two-to-one rate spread. At the time we put the models together, that was the rate spread differential we were looking at. We then calculated the percentage of claims on groups with loss ratios in excess of the reinsurance threshold. We repeated that process using the claim distributions where we had the presumptive condition claims pooled. The

groups we determined were eligible for reinsurance were the difference between the above two calculations; that is, the percentage of total claims on groups with loss ratios in excess of the reinsurance premium that could be identified by the presumptive condition criteria.

From that we calculated the expected level of the assessments from the reinsurance mechanism. We then calculated a threshold level for each group based on the reinsurance premium. The reinsurance premium then became the claims up to the threshold level and the assessments became the claims in excess of the assessment level.

For reinsurance mechanisms that allowed reinsurance of groups and individuals, we did a simple composite of the two models. We worked on the assumption that all individuals indicated would be reinsured; that is, the decision is still made on the expected cost to insure an individual relative to the cost of reinsuring that individual. We then assumed that the volume of claims ceded under the group portion of the study would be reduced; because once you've ceded some individuals, you're not going to reinsure the group.

That's a basic description of the model and process that we've taken. The results of that modeling process were published in a report titled "Report of the Actuarial Subcommittee to the Advisory Committee" in May 1992. There was that report and a response to that report prepared by the HIAA, which I don't know if it has ever been made publicly available. Do you know the answer to that, Joe?

MR. MORAN: I don't know what the exact status of that is. I think it was available at the NAIC meeting, but I don't have a copy.

MR. LYLE: If anyone is interested, we can find out the answer to that.

MR. MORAN: I have a couple of questions for Dick Niemiec. In your description of the allocation mechanism, it was not clear who makes this allocation that says employer X, who is a substandard group, has to go with carrier Y? Who is the body that makes the allocation?

MR. NIEMIEC: The group would have a choice of carriers among all of the carriers; that is, you would have a choice of any carrier until they had reached their targeted allocation.

MR. MORAN: Who makes the determination that a specific carrier has reached its target?

MR. NIEMIEC: The target would be set at the beginning of the year by the board. If it was 100 groups that they had to take, then once they reached 100 they would not take any more.

MR. MORAN: Who makes the determination as to whether a specific group counts against that target?

MR. NIEMIEC: The carrier would be responsible for keeping track of that subject to monitoring and review.

MR. MORAN: By whom?

MR. NIEMIEC: By the board.

MR. MORAN: By his competitors?

MR. NIEMIEC: Well, the competitors might have an opinion, but certainly the board. Joe, you're raising questions about how a carrier might try to game it and say a group that wasn't substandard somehow was. You'd have to demonstrate that you had been rejected by two carriers. I can't just take my block of business and say this is an allocated group. It would have to go through that mechanism.

MR. MORAN: So that means from the employer's level, if it particularly wants to deal with a specific carrier and has borderline underwriting characteristics because of high-cost risks in the group, it first has to approach two carriers that it doesn't want to deal with before it approaches the carrier that it does want to deal with, because that's the only one that will be obligated to issue coverage to it.

MR. ALAN N. FERGUSON: Why couldn't it approach the allocated carrier, the one it wants to deal with, even though it was rejected?

MR. MORAN: If the group is classified as a substandard risk, the carrier that it first approaches can't count that as a substandard group that it's covering on its allocation allotment. It has to reject it.

MR. NIEMIEC: Once it's rejected . . .

FROM THE FLOOR: By whom?

MR. NIEMIEC: By those two carriers -- the carrier it wants and another carrier, then it is an allocated group.

MR. MORAN: And it can go back to the carrier it wants?

MR. NIEMIEC: Yes, as long as the carrier is within its target.

MR. MORAN: What percentage of all groups do you visualize would go through that routine of getting a dummy second declination before going back to the carrier of first choice?

MR. NIEMIEC: Well, I assume that if they want coverage, they will.

MR. MORAN: No. How many groups do you visualize would end up having to get that second declination when they really aren't interested in coverage from the second carrier?

MR. NIEMIEC: In other words, how many groups would be allocated?

MR. LYLE: Yes. If that's the fact of how the market operates, then, yes, groups are going to go back and get that second declination. If you're trying to get access to coverage and the rules are you don't have guaranteed access until you have two declinations, then you get them. I have workers compensation coverage for a nanny and I had to get my two declinations before I went to the assigned risk pool. There is no voluntary market for one life groups in Minnesota for workers compensation coverage. I knew I had to get the two declinations before I could go to the assigned risk pool. People will do what they have to do to get through the rules.

MR. MORAN: Right, and it generates additional nonproductive work.

MR. LYLE: Yes, it does.

MR. NIEMIEC: I'll just add that there are several states that are interested in this. There are some advantages because you don't have the reinsurance mechanism to it. Whether it ultimately, in the rest of the states, is going to be something that's good, I think that's something we're all going to be involved in. I think the point, Joe, is that there are some commissioners who are still very interested in allocation, so it's up to us to make it a workable mechanism. I don't think it helps any of us if there is small group reform in a state that fails.

FROM THE FLOOR: Assuming open access, and I was a small employer with 15 employees, why wouldn't it be to my advantage to either self-insure or partially self-insure with a $3,000 or $5,000 deductible for my employees and then covering between a $200 deductible and that higher deductible until such time as one of my employees became so ill that was no longer a cost-effective alternative to the guaranteed issue? If your answer is the preexisting condition exclusion, I don't think that's a complete answer because I think there are conditions in the aggregate morbidity that extend beyond the preexisting condition exclusion. Also, does the preexisting condition exclusion apply if I did have coverage, albeit, at high deductible levels?

MR. NIEMIEC: I would assume that $3,000 or $5,000 deductible wouldn't meet the basic level of benefits, so then you wouldn't be deemed to have coverage and the preexisting condition exclusion would apply. There wouldn't be continuous coverage. A state could say that $3,000 or $5,000 was the basic level, but I doubt that many would.

FROM THE FLOOR: Assuming the preexisting condition exclusion would apply, do you feel that that's a complete answer?

MR. NIEMIEC: No, because it is a discretionary market, and there are going to be some employers that are going to try and game it. Whether that's a good strategy to stay out and hope that you aren't going to get caught on the preexisting condition exclusion, I don't know.

MR. LYLE: If you're looking for a complete list of ways that employers can game the market, that's one method. There are a lot of other ones that employers could put together pretty easily.

MR. NIEMIEC: These models have to do with how the insurance industry is going to have to reform. The big question is what are small employers going to be willing to do relative to either a mandate to offer or a mandate to contribute to coverage. I think Congress and the states are going to answer that pretty quickly.

FROM THE FLOOR: A question on threshold and also the calculations that you did in the study. It seems to me one of the problems that we always have is we know what the gross submitted charges are, but we have a lot of variation between gross submitted charges, what's actually paid, and what's not the responsibility of the insurer. How do you deal with that, particularly where you have an HMO that's providing services within the threshold? How did you deal with the discounts in your reinsurance study?

MR. LYLE: First off, it was a lot easier to deal with in the reinsurance study that we did than it is in reality. What we did in the study is we based it off of paid charges when we did the modeling. Remember, we were starting with Blue Cross/Blue Shield data. When we did the conversion to what a commercial carrier's experience might be, we were able to reflect what sort of a discount there might be because of that. In reality, that's something that has to be addressed for any sort of a reinsurance mechanism, particularly if you're talking about some kind of a stop-loss threshold and what dollars count against the stop-loss threshold. It becomes a real hard set of issues.

When I've worked through it with other people, there are a lot of different considerations that come up as to how do you count those dollar equivalents. You can come to some resolution for services that are paid for on a fee-for-service type of basis, but then, when you start dealing with some HMOs that are using capitation arrangements, it gets a lot more complex as to what dollars do you start to count. So the rules at that point become quite detailed.

MR. NIEMIEC: My short answer is it would be up to the reinsurance board to set some basis for the equivalence for the HMOs or whatever capitated arrangements. I know we're wrestling with that in Minnesota right now.

MS. DOROTHEA D. CARDAMONE: A question on the NAIC model. When you do the index rating and compare between the classes, are you comparing based on one set of manual rates or are you comparing just based on the gross rates of each of the classes? How do you do the comparison?

MR. NIEMIEC: Well, that's been one of the things we've been discussing most recently with Mark Peavy. What we've talked about is having a sample of groups with different case characteristics, or the commissioner setting some typical groups so that you would be testing similar groups between the classes. Does that answer your question?

MS. CARDAMONE: No. Are they at their own gross rates? If you had different expense loads for two different classes, would you equate them so that they were really one target, or would you set them to take into account the variations in targets?

MR. NIEMIEC: You'd have to take into account the variations in targets.

MS. CARDAMONE: So they are based on the gross premium, not the net claim cost?

MR. NIEMIEC: Yes.

MR. JOHN A. HARTNEDY: Is individual health insurance excluded from this regulation as it's currently being discussed?

MR. NIEMIEC: Is it excluded?

MR. HARTNEDY: Yes.

MR. NIEMIEC: Well, the discussion has been that, if you're selling individual coverage to groups and somehow it's determined that you do that, then you'd be subject to these acts. Frankly, if an employer goes out and buys individual coverage for their employees, I don't know how anybody is going to know about it. The hope is that you don't get the two mixed up and that you don't get people carved out of small groups somehow. But there's no perfect solution about how you separate them and there is concern that you don't mix up the two markets and so you don't screw up the individual by trying to fix small group coverage.

MR. HARTNEDY: That was my concern, that carriers may not even know what either agents or small employers are doing.

MR. NIEMIEC: I think the obligation is on the carrier not to try to come up with a scheme to really market small group coverage under the guise of individual. If a group goes out there and makes the choice, that's going to be tough to check. I think in working with your agents, the implication is that you wouldn't invite the agents to come up with these schemes.

MR. HARTNEDY: I'd be curious on some of the discussion among the committee members. The estimates that I hear that access is going to raise cost, the best that I have heard is 4-7% and the worst is like from Community Mutual who talks in terms of 20-25%. The biggest complaint I also hear is affordability. It does seem, if we get this thing in place, that we'll actually, in fact, end up with less people insured because we're going to raise costs. I know somebody addressed earlier that we don't have the solution to that, but has the committee given any thought to this? It does appear to me that, as soon as we get to access, the last condition will be worse than the first condition. Any comments?

MR. NIEMIEC: I would certainly grant that you could actually end up with fewer people covered. The Advisory Committee's charge was very limited. You have to come up with other solutions, subsidies, and things like that, it seems to me, before you can truly ensure it. You've got discretionary market problems where you could be bringing people in who weren't covered before, and it's going to drive it up. Ted, you may want to comment on the estimates, but they're all over the board depending on conditions.

MR. LYLE: I guess I've heard a much broader range. The best estimates I've heard have been 4% or less and the worst is that it's 70%-plus. I tend to believe it's

something much more in the middle, but I'll go on the line as saying it's between 4% and 70%. I tend to believe the 20% kind of cost increase, but, again, it varies depending on the state.

MR. MORAN: Ted, I want to give you an opportunity to correct what I suspect was a slip of the tongue. In describing the documents that have been produced using your model, you made a reference to a report of the actuarial task force of the Industry Advisory Committee. I believe that the report that you were referring to that Dick issued was the report of the chairman of the committee and did not have the consensus of the committee; that it was a personal report from the chairman as opposed to a committee report.

MR. LYLE: That's correct. That's my understanding.

MR. NIEMIEC: Let me clarify, Joe. I would not say that everyone signed off on it. As you know, there was a lot of discussion on this. Ted referenced that there was a letter back from HIAA. I think, in fairness, all of this is subject to scrutiny. It was done on a very tight time frame. I think the point is how can any of this enlighten the ultimate decision makers -- the commissioners, the legislators and such -- and I think that's our challenge. Certainly anything that Ted did for the Blue Cross/Blue Shield Association, we would accept as open to scrutiny.

MR. MORAN: It's part of an open, ongoing discussion that has not yet been resolved and on which there is not yet a real consensus.

MR. NIEMIEC: Yes, and I would invite people, if we circulate it, to challenge it and to get improvements.

MR. MORAN: Have the problems that were oriented to privacy of information been resolved yet? Some of the assumptions couldn't be described when that material was circulated.

MR. NIEMIEC: It's proprietary data.