RECORD OF SOCIETY OF ACTUARIES
1992 VOL. 18 NO. 1A

HEALTH RATE REGULATIONS, GROUP MEDICAL – UNDER 25 REGULATORY ISSUES

Moderator: JOHN C. LLOYD
Panelists: JANET M. CARSTENS
HARRY L. SUTTON, JR.
GARY E. TRAVNICEK
Recorder: JOHN C. LLOYD

The panel will discuss NAIC, Health Insurance Association of America (HIAA) and state regulation proposed or adopted to regulate small group underwriting and rate guidelines.

MR. JOHN C. LLOYD: Our subject is health rate regulation for group medical insurance in the under-25 life market. When I was first asked to put together a panel on this subject, I immediately had a nightmare in which I was Geraldo Rivera, and an irate panelist hit me with a chair. At best, I was afraid I was going to become the announcer at Wrestlemania. All this concern stems from a recognition that health rate regulation has stirred quite a bit of passion and debate among some actuaries. Much of this debate may have gone unreported, because most newspapers have an editorial policy against using the words "impassioned" and "actuary" in the same sentence.

Rather than discuss the pros and cons of proposals, however, we elected to focus on something other than the debate. Most actuaries are somewhat frustrated by debate, anyway, because the other side always refuses to see the pure reason of your argument. Besides, as we have seen in some of the general sessions, a lot of the reforms center around politics instead of a debate of rating impacts. Therefore, we've elected to focus on the goals and objectives, some specific rating implications, and the diversity of solutions that we've seen put forward.

Our first speaker will be Janet Carstens, who is a consultant in the Minneapolis office of Tillinghast. Prior to joining that firm, Jan worked in the group actuarial department at Western Life. There she focused primarily on small group product development and pricing. Most recently, she has consulted with various health insurance payers on the potential impact of small-group-reform proposals. At this time I'd like to turn it over to Jan.

MS. JANET M. CARSTENS: The caption of a cartoon I saw the other day summarizes the basic premise of small-group-reform legislation: "I can't get work until I get better; I can't get better until I get health care; I can't get health care until I get health insurance; I can't get health insurance until I get work."

Most small-group-reform legislation focuses on either accessibility or affordability. Most people lack coverage because it is either not available or because it is too expensive. In general, what people really want is unrestricted access, state-of-the-art technology, and limited cost. An effective reform proposal involves some trade-off among these three.

The items that I will address include the objectives of small group reform legislation, the means to achieve these objectives and their possible effect on cost, and the results of small-group-reform legislation including potential positive results and potential negative results.

Commonly stated objectives for small-group-reform legislation, not necessarily in order of prevalence, include that it should:

- provide security that coverage will be available and ensure a minimum level of benefits,
- provide security for those currently insured that coverage will continue,
- reduce the number of uninsured,
- make current coverage more affordable,
- limit cost increases and stabilize costs, and
- promote the use of managed care.

The first three of these objectives primarily relate to the accessibility of insurance coverage. The last three primarily relate to affordability. The combination of objectives included in any particular legislative proposal will determine the degree of emphasis on accessibility versus affordability. Most proposals, to date, attempt to address both accessibility and affordability issues, however, the majority of proposals have primarily focused on making current coverage accessible.

Some of the means used to achieve the accessibility objectives include:

- guaranteed issue for groups and guaranteed eligibility for all employees and dependents within a group,
- guaranteed renewability,
- portability provisions,
- elimination of condition waiver exclusions, and
- restrictions on the use of preexisting condition limitations.

Recent proposals that have focused on making current coverage affordable may include:

- a requirement that all insurers and providers participate,
- provider reimbursement based on available funds,
- a defined minimum level of benefits,
- contributions for health-care coverage based on income level (such as an X percent contribution for a family with total income at less than or equal to Y percent of the federal poverty line), and
- the use of subsidies in some form.

Some of the means used to achieve the affordability objectives include:

- rate band limitations with rate increase limitations and restrictions on rating practices,
- subsidies,
- core benefit packages,

- encouragement of managed care, and
- the use of reinsurance mechanisms.

Many of the means, whether they address accessibility or affordability, may produce an additional cost. Following the implementation of many reform proposals, costs may increase at a greater rate than if reform hadn't been implemented, with most of the cost increase occurring in the first few years following implementation. For some means, any cost changes will be affected by changes in demographics following enactment of small-group-reform legislation. These means include guaranteed issue and guaranteed eligibility, guaranteed renewability and portability provisions. The cost for any particular market, given a specific reform proposal, can be anticipated by modeling this expected change in demographics. Common variables used in modeling include

- the percentage of the small employer group population with other coverage, such as individual insurance coverage, coverage through the employer of spouses, Medicaid coverage, or Medicare coverage,
- the percentage of the uninsured employees or dependents of employees of small employer groups,
- the net difference of these first two being the percentage with small group employer insurance coverage,
- the withdrawal rate from employer group coverage due to rate increases, and the possible exclusion from small-group-reform legislation of self-insured plans, individual plans and multiple-employer welfare arrangements that may cause a migration from small-group-employer coverage to these alternative forms of coverage.

Another variable used in modeling is the claim cost ratio of those who withdraw from employer coverage, which could be a function of expected rate increases. For instance, at rate increases slightly higher than trend, it may be that only healthy lives withdraw with a low claim cost ratio compared to the average. At higher rate increases, withdrawals may be a cross section of healthy and unhealthy lives such that the average claim cost ratio of these withdrawals approaches one.

Another variable is the reentry rate into employer group coverage after small group reform, both from those who have private coverage and those who are uninsured. A final variable is the claim cost ratio of those who reenter from private coverage and from the uninsured population. For the uninsured population, the claim cost ratio may depend on underwriting practices in a given location. If historic practice has been to exclude an entire group rather than a single individual, more healthy lives will likely reenter with every high-risk uninsured individual.

For other means of achieving reform, cost changes may become a straight add-on to existing costs. These means include the elimination of condition waiver exclusions, restrictions on preexisting condition limitations, and rate band limitations. The add-on cost for the first two are highly dependent on current underwriting practices. For example, if condition waiver exclusions and preexisting condition limitations have not been used historically, there will be no additional cost. Rate band limitations will have varying effects on specific groups. The average rate will likely increase, but some groups will experience decreases while others may experience substantial increases.

The level of add-on costs will depend on the parameters specified by a specific reform provision. Some examples of these parameters include group size, rate limits, and access provisions. There is a great degree of variation regarding whether legislation applies to employer groups of 1-25 lives, 3-50 lives, etc. As for rate limits, some proposals require community rating, some require rates to fall within a plus or minus X percent spread, and some have no rate limits.

The level of add-on costs will also depend on current underwriting practices as previously stated, and current rating practices that may be used to differentiate rates by health status and claim experience. Some examples of current rating practices include durational adjustments, use of rate tiers and demographic adjustments such as rate variations by age, sex, industry and area.

Other means may be used with the intent to reduce or shift costs either for specific individuals, payers, or for the system as a whole. These means include the use of subsidies, core benefit packages, and an emphasis on managed care. It is important to note that we have seen core benefit packages that are richer than many current benefit packages purchased by small employer groups. These core benefit packages would tend to increase costs for these employer groups as opposed to reducing costs.

The magnitude of potential cost reductions will depend on the source of any subsidies, how much additional revenue is created by the subsidies, and how much cost is shifted back into the system. Some of the proposed sources of subsidies have included an employee head tax, a liquor and tobacco tax, premium taxes which would apply to fully insured business, although we have also seen similar taxes proposed that are intended to apply to administrative services only (ASO) business, and provider taxes that can be viewed as an alternative way to tax ASO groups. The magnitude of potential cost reductions will also depend on the degree of cost-sharing and the level of benefits included in any core benefit package. For instance, the elimination of state mandated benefit requirements may result in reduced costs. The potential for managed care requirements to reduce costs depends on the degree to which care will be managed following reform and, to some extent, the degree to which it is already managed. Finally, some means are meant to be essentially cost neutral such as the inclusion of reinsurance mechanisms in a small-group-reform proposal.

Potential positive results of small group reform legislation include that it should:

- improve the availability of insurance coverage,
- provide coverage for high-risk individuals who have been rejected,
- curb abusive rating and underwriting practices, and
- reduce uncompensated care costs.

Some of the potential negative results of small-group-reform legislation include:

- no significant reduction in the number of uninsured and possibly an increase in the number of uninsured as a function of rate increases,
- no cost reduction and potentially increased costs, and
- the potential elimination of the voluntary private market.

Actuaries have a significant role in the process of evaluating specific proposed legislation. Many actuaries have been or will be provided the opportunity to prepare cost estimates of various reform proposals. This is a valuable service that we can offer to the public. In addition, to comply with the types of reform legislation generally proposed, actuaries will need to:

- ensure underwriting and rating mechanisms are in compliance,
- prepare actuarial memorandums documenting compliance,
- prepare actuarial certifications for regulatory agencies, and
- prepare disclosure requirements of rating practices.

MR. LLOYD: We will have a number of states in which we must deal with small group reform. As Jan pointed out, we need to learn how to quantify the impact on rating, develop models to assess the risk, and then modify our product offerings accordingly. To that end, our next speaker, Gary Travnicek, will discuss some of the implications we will have on the rating side.

Gary is a principal with the actuarial consulting firm of Wakely and Associates in Clearwater, Florida. He is the director of group consulting operations for the firm. In the past few years, his organization has studied the rating implications of small-group coverage to develop and market PC-based software for management of group programs. With that in mind, I've asked him to illustrate some rating impacts we might expect.

MR. GARY E. TRAVNICEK: The target of this presentation will be to discuss a rating characteristic that I believe has taken on increased importance under the recent Small Group Rating Reform legislation. The rating characteristic that I am talking about is aging. While the emphasis of this presentation will be on how the aging phenomenon affects business subject to the legislation, the concepts I will be discussing also affect business that is not subject to the law, in a similar manner.

I expect that this presentation may be somewhat controversial. However, whether you agree with me or not, I hope it will give you food for thought to question whether you are using the right rating philosophy and analytical methods to compete successfully in the small group market.

The subject of aging is like the weather -- everyone talks about it, but nobody does anything about it. Anyone who has studied the changes in claim costs as the duration since issue increases, knows that the aging phenomenon is very real. However, quantifying its effects and then incorporating it into the pricing structure has traditionally been hard to do. Some companies do it directly, others indirectly, but unfortunately, many do nothing.

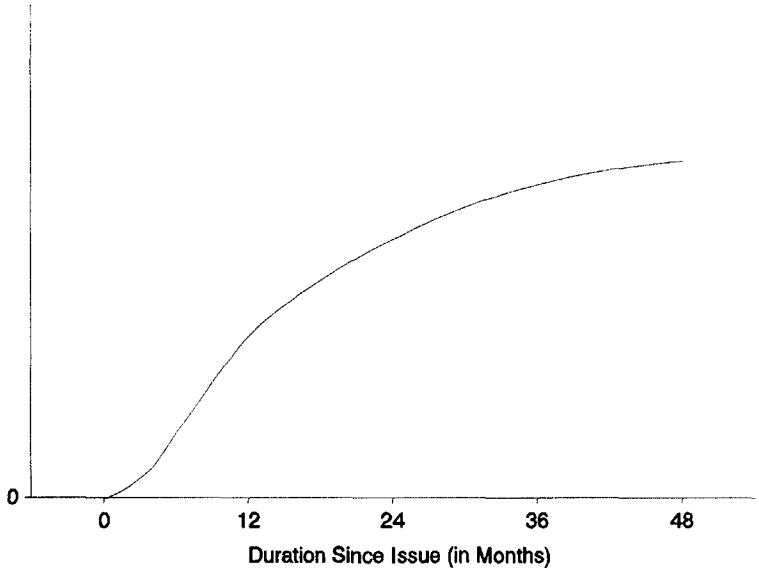
It is hard to imagine ignoring any rating characteristic that has had as much effect on the claims experience as does aging. The recent study performed by Milliman and Robertson (M&R) for the Society of Actuaries in fall 1991, indicated a very real increase in claim costs as duration since issue increases. Claim cost levels in renewal years that are double what they are in the first year are very common. How can this phenomenon not be recognized in the rating process?

I do not know who was responsible for coinage of the term aging. I remember knowing about the effects of aging before the label was applied. The first time that I remember seeing the word in print, was when I read a paper by Howard Bolnick. I do not know if Howard was the first to use it. If you asked Howard, he would probably say that he not only coined the word but was also responsible for inventing the entire phenomenon.

Did aging suddenly become important with the passage of the new rating laws? No, it has always been important, but it was seldom directly recognized and was difficult to calculate. The new legislation makes its quantification more important because new business rates are now indirectly mandated to subsidize renewal business.

What does the aging curve look like? Chart 1 is my opinion of the general shape of an aging curve for a typical insured. The X-axis of this graph represents the duration since issue in months. Duration is relative to issue of an insured -- not of a group.

CHART 1
Aging Curve
Claim Cost Factors



The Y-axis of this graph represents the factor relationship between claim costs as duration increases from issue. I have purposely omitted any factors from the Y-axis because there is no such thing as a universal aging curve that works for all companies. The magnitude and shape of the curve will be different by applicability of preexisting conditions to an insured as well the rules used to underwrite each insured. This means that the aging curve is different for a new hire in a group whose other insureds were medically underwritten, but issued on a "no loss/no gain" basis. You can see how complicated measuring the effects of aging could be in that situation.

The curve is assumed to be independent of medical trend – i.e., changes in inflation, utilization, cost shift, technology improvements, etc. "Trend" is a function of the point in time in which a claim is incurred. It has nothing to do with the duration since issue of an insured. When aging is not separately recognized and quantified, changes in claim costs from period to period are erroneously attributed to "trend" when really much of the explanation for changes in the claim costs could have been quantified and predicted due to a change in the average position on the aging curve of all insureds during the period.

In relative terms, the claim cost factor increases quite dramatically by the end of the first year relative to the time of issue. This increase is due mostly to the inapplicability of preexisting condition limitations to reduce claims after the first year. After the first year, the increase in claim costs reduces due to the slower effects of the wearing off of underwriting. So referring to Chart 1, what I am saying is that, if you look at the increase in the curve from duration zero to duration 12, it is quite steep and thereafter it starts increasing at a decreasing rate. The effect of preexisting conditions has a dramatic effect in that first 12-month period of time.

Should the same aging be expected on all groups as the duration from issue increases? Absolutely not! Claim costs since the issue of an insured increase because of the combined effects of the wearing-off of initial underwriting and the inapplicability of preexisting conditions during the renewal periods. The emphasis in the last sentence was placed on the word "insured" because it is the insured that goes through the aging process -- not the group. The following example illustrates this:

Suppose there are two groups, "A" and "B," that are exact clones of each other in every way: similar census, benefits, geographic area, date of issue, and incurred claims during some experience period. The only difference between the two groups is that all the insureds of group "B" terminated and were replaced by similar clones on the last day of the experience period.

Will the change in aging from the experience period to the renewal period for each group be the same? Definitely not! The replacement insureds of group "B" will probably have to go through preexisting condition limitations. Therefore the claim experience for these people can be expected to be less. This is an extreme example, but it illustrates the point that aging should not be a function of the duration since issue of a group, but rather be based on the duration since issue of each insured.

The M&R study was done on the duration since issue of the group. If that same study were performed on duration since issue of the insured, the steepness of the curve would be much greater than what was illustrated in the study's numbers.

The actual change in aging of a group is dependent upon:

- The average change in aging of all active insureds.
- The turnover rates of insureds within the group.
- The "growth" factor of a group. This factor is related to the net effect of the turnover and the new hire rates within the group. Two groups can have the same growth factor, but could have dramatically different turnover and new hire rates. For example, suppose two groups will grow at 10% during the

next year. They could have dramatically different turnover and new hire rates that net to the same 10% growth. However, the group with the higher turnover and new hire rates will have less expected aging during any renewal period. This is because insureds who were higher up on the aging curve have been replaced by new hires. The fact that you have a lot of people entering the aging curve in that type of situation could, in fact, dampen the effect of aging for the group.

If a group is growing, it means that there are more new hires than terminations. This implies more people are entering the lower end of the aging curve and causing the average aging for the group to actually decrease. This could be important as the economy comes out of the recession.

If a group is stable -- no growth or decline -- then the average change in aging will be zero.

If a group is declining in size, such as during a recession, there will be more terminations than new hires. This usually increases the aging because of both the lack of new hires as well the fact that terminations are usually on a "last in-first out" basis. This means that more people who were relatively low on the aging curve will be leaving which will cause the average aging factor to increase.

Incidentally, this phenomenon occurs on blocks of group business of all sizes. Never assume that aging is not important -- even for large groups. Large groups can change dramatically in size, and the turnover of insureds within these large groups will have an effect on their expected aging.

What were the extremes of different rating philosophies before rating reform? The extremes ranged from "fully pooled community rating" to very unfair "100% experience rating with no pooling." The latter practice was a contributing factor to the rating reform legislation.

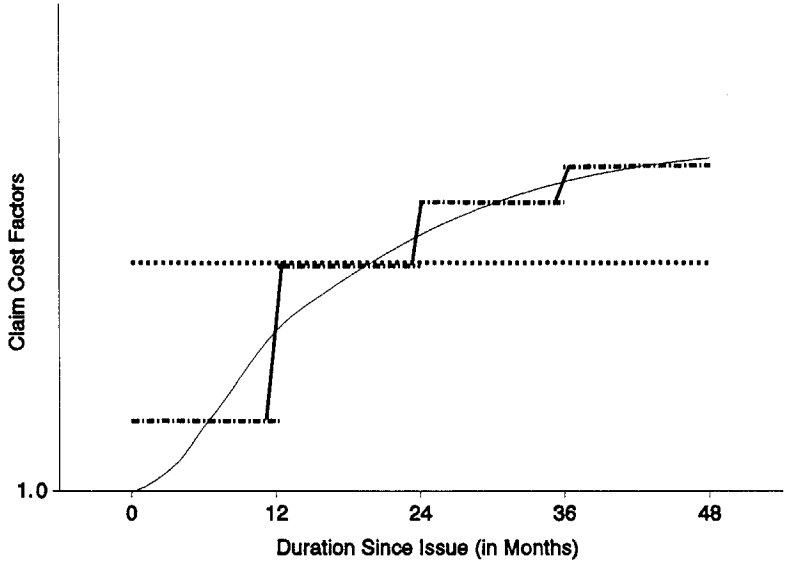
However, another contributing factor was the large rate increases that companies using the term insurance approach rating were giving to groups renewing after the first year. This is called the term insurance approach because of the obvious analogy to the way term life insurance is priced. Referring to the stairstep curve on Chart 2, the rates will go up every year to reflect the change in the underlying costs caused by aging. This rating philosophy has been used because the new business rates were very competitive. Furthermore, it was subject to less selection because no assumptions had to be made about the future aging of the insureds in the group -- on the aging during the current rate guarantee period.

If the claim cost component of the rate level for all groups in their first year was determined using the average claim cost factor for the year, these groups would need a large rate increase for the second year -- even without trend.

Companies that used the whole life approach to rating were at a competitive disadvantage relative to the term companies. The whole life approach means using the

level average aging factor over the lifetime of the group in the pricing of the rate at issue. This is shown on Chart 2 as the straight line.

CHART 2
Aging Curve
"Term" vs. "Whole Life" Approaches



The rates will be more than adequate during the early durations under this philosophy, and deficient in later durations. This method requires more management and financial statement discipline for it to work. Assumptions have to be made concerning the future aging and persistency for this philosophy to be successful.

How does aging affect new and renewal rates under the rating reform legislation? In a nutshell, the new rating reform legislation forces an unnatural or nonactuarial marriage between new and renewal rates for social reasons. The recognition of the actual difference in claim costs between durations is limited in the rating affected by the legislation. This implies that new business rates must be increased above natural levels as a result of aging. Therefore companies that used the term insurance rating philosophy will have to increase their new business rates; otherwise, they would not be able to renew groups at an adequate level.

I would not expect many of the companies that were using the whole life approach to rating to change methodologies as a result of the rating reform. That is because their new business rates will be more competitive than before. However, they will still be at a rate level disadvantage relative to the companies that are using a modified term insurance approach.

To what extent can aging be reflected in the renewal rate increases under the rating reform legislation? In Georgia, no portion of any renewal rate increase is allowed for changes in aging. However, renewal rates are allowed to deviate from the weighted average of all new and renewal rates by plus or minus 25% due to the experience of the group.

In states that have passed the NAIC Model Bill, the answer is "not much." The maximum annual rate increase caused by experience and aging considerations combined, is limited to 15% annually. The aging alone, for most companies between the first and second year, is much greater than 15%.

What aging assumption should be used in Georgia to rate new and renewal business? The level line in Chart 2 shows the whole life or level aging factor assumption that theoretically should be used to price new business in Georgia (assuming there are no lapses and the time value of money is zero). The area below the level aging factor and the curve in the early durations is equal to the area above the level aging factor at the later durations. The Georgia law is different than the NAIC Model Bill because the same aging assumption must be used to price business at all durations; whereas in the NAIC Model Bill there is more latitude in the aging assumption.

What aging assumption should be used in states adopting the NAIC Model Bill? It is impossible to say what the appropriate aging assumption should be for business subject to the NAIC Model Bill without first knowing the company's philosophy. If management wants to assign zero credibility to a group's experience (that is, do not take experience into account when rating the group, but still recognize aging), it should make sure the first-year aging factor assumption is high enough so that subsequent 15% maximum annual increases in rates will not cause a loss over the lifetime of the business. This would put the first-year assumption between the "term" premium assumption (the stairstep line) and the level premium assumption of Chart 2.

If a company does not want to recognize aging by duration, it must use the same aging assumption in the pricing for business at all durations. This would imply the use of the level aging factor. This would then leave the full 15% margin available for credible experience.

Finally, if the company wants to recognize both experience and aging to determine the renewal rate level, the aging factor assumption needed for new business rates would be between the extremes just discussed. That is, the company would use an assumption between the stairstep and level lines of Chart 2.

What are the different extreme philosophies that can be used to renew groups under the rating reform legislation? Not surprisingly, the easiest rating philosophy that assures compliance with the legislation (i.e., fully pooled) also is the most liberal. Any company adopting that philosophy will be subject to more antiselection than a company that uses a philosophy that takes advantage of the limited experience rating allowed by the Model Bill to determine renewal rate levels.

Experience rating renewal business is more complicated, but it will generally lead to lower rates for the majority of the business. Within any "class," the ratio of the highest rate level (presumably for worst renewing groups) divided by the lowest rate

level (presumably the most select of new issues) is 1.67. Allowing the renewal block to be rated within this range implies:

- Lapses on the best groups within the renewal block will be less than under a "fully pooled" approach because their rate level will be less.
- Renewal rate levels in the aggregate will be less due to higher persistency of the best groups.
- Less subsidy will be needed from new business rates because higher aging will be reflected in the renewal rates.
- New business rates should be lower because renewal rate levels will be lower.
- Greater market share will be achieved due to a more competitive rate structure.

What is the theoretical impact that aging can have on financial statements for business subject to rating reform? Excluding trend, census and benefit changes, the renewal rate increase will be limited at renewal to something less than the actual increase in claim costs due to credible experience and aging. If that statement is true, then new business rates must contain an additional margin to fund renewal deficiencies. Unless a company is able to measure the effects of the changes in the distribution of business by duration, it will be very difficult for the company to properly recognize how much true "profit" is attributable to any period.

If the company wants to maintain as competitive a new business rate structure as possible, it should be setting aside the extra margin in the first-year rates to offset the increases in claim costs that will occur as that new business ages. This reserve should then be released slowly as the business ages and completely when it terminates.

Without the reserve, the level of new business rates will be dependent upon the distribution of business at all durations. If that distribution remains constant, there would theoretically not be a problem. However, the reality is that the distribution of business by duration changes from year to year.

For example, without the reserve, if the proportion of new business decreases, the financial statements will indicate a decrease in the profitability of the business because the extra first-year margin will be missing on the decreased proportion of new business. This will put pressure on management to increase renewal rates to higher levels. However, this will automatically trigger an ad hoc increase in new business rates because of the legislative mandated relationship between new and renewal business rates. New business rates will become less competitive. This will then make the problem worse because the lower new business volume is probably the thing that started the last round of rate increases in the first place. This then becomes the beginning of a classic assessment spiral.

Should this reserve be required statutorily? I believe the answer is "no" because the company always has the right to raise new business rates high enough so that renewal business can be rated at an adequate level. While this is a death sentence for new business, it does eliminate the rate adequacy problem.

Since the reserve on each group follows the business from issue, it will not be totally released until the group terminates. If the reserve ever becomes deficient or excessive, this would be a signal to management that a new business rate adjustment may be necessary.

Is the "reserve" difficult to calculate? Mathematically, the answer is "no." From a practical point of view, the answer is "yes," unless the right data are available. It requires that exposure information be available on all insureds. It also requires that assumptions be made for the appropriate aging curve, persistency, and the time value of money.

It is important to quantify as many aspects of the rating process as possible. To the extent rate levels are adopted that recognize the full extent of all rating relationships, the possibility of antiselection is minimized. The rating reform legislation still allows for full recognition of all actuarial rating characteristics (i.e., age, sex, area, etc.) with the qualification that the aging assumption must be consistent (but need not be the same) with what will be used for renewal rates.

Unless a company recognizes and quantifies the effects of aging, the explanation to the board of directors for results that are much better or worse than expected, will be "fluctuation" or "trend." There are many things that happen in group insurance that are not explainable other than to say that the result is due to chance fluctuation. That is acceptable when you have done all that you can to analyze the results. However, many times there is information available to explain a good portion of the fluctuation. The quantification of aging in the analysis and rating process can be done with reasonable effort.

I would encourage you to think about your own new business and renewal rating philosophy. With rare exception, the information necessary to quantify the effects of aging and incorporate it into the rating process is already being captured by the administrative system. By doing so, you should be able to prevent wide swings in financial results and prospectively price for expected changes in aging.

MR. LLOYD: I'd like to thank Gary for showing us some of the complexities that we might have to deal with in rating small groups. I think one thing we should have noted was the diversity of rating variations we might encounter. It is the intention of our next speaker, Harry Sutton, to address that subject.

Harry is familiar to a lot of us. He was with Prudential for over 20 years, and with Towers-Perrin after that. Currently, Harry works with R.W. Moor, a reinsurer of catastrophic coverage for HMOs and organ transplant networks. However, Harry is also a student of health actuarial science and has been involved in a number of task forces and committees to that end. One of his current subjects has been small group reform.

MR. HARRY L. SUTTON, JR.: After I listened to Gary talk, I know I'm no longer an actuary. I'm too old to be a practicing actuary. I'm more of a political actuary. Just by way of background, you who know me know that I'm very biased. I worked essentially in the HMO business for the last 15 years, and part of my work in the small group area has been with legislative commissions and the Academy of

Actuaries -- testifying on federal bills. It's more the structure and mechanics and political philosophy rather than the mechanics that Gary gets into. Every time you talk to somebody like Gary, you know how complex it's going to be to adjust to these changes that come into law. Jan got into a few of these and I would like to differentiate. If you have questions, we can talk about it at the end.

What is small group reform without the subsidy? A lot of states, even Connecticut and Minnesota, proposed legislation, and Ohio and other places have subsidy programs built in; but those plans really don't fit exactly into the small group market. They're typically a separate program with big subsidies or experimental programs. They may come in for discussion because they may completely disrupt the small group market or individual market due to people shifting coverage where they don't have to pay much of the premium.

I'm pretty much going to be limited to the politics and the variations in small group reform, without considering special low-income programs. I'll cover reinsurance briefly, market definitions, underwriting complexity and, in case I forget what I'm going to say, a lot of the politicians think if you have guaranteed issue you can eliminate underwriting and save a lot of administrative cost. That's absolutely not true, at least not if you have a reinsurance pool. I will discuss loopholes, low benefit prototypes, and functioning in a multistate environment, which is just my warning at the end.

The first section here is on rating mechanisms. The most common is what both Gary and Jan discussed, the typical HIAA or NAIC model with full demographic, some variation in industry rating, unlimited geographic rates; but restrictions on adjustments to the rates due to claim experience or duration. In the HMO business we call it community rating by class, which is essentially community rates but adjusting for demographics only, but banding around this to reflect either duration or experience, which Gary was talking about.

These limits may be enough of a problem, but the tendency in the new legislation is to be much more restrictive. The states that I've spent some time in on the legislative process are Massachusetts and Minnesota, which tend to be consumerist states and among the hardest to work in. There is a move to narrow spreads. The Massachusetts law, for example, compacts all demographics and industry loadings into a flat plus or minus 30%, or essentially a two-to-one ratio; so within that structure Massachusetts allows demographic rating, but it's not like Gary was talking about where you have full demographic rating and then a band around that, which essentially could be five- or ten-to-one depending on the size of the groups and how wide the variations to demographics can be.

Some laws have a transition period and other laws haven't. I think sooner or later the legislators and the lobbyists locally have to recognize that you can't shift full-blown into a very restrictive rate setting system without a period of transition to phase your rates into it. That will be bad enough. If you had to change overnight, you'd be in the soup. In Minnesota, legislators are going to pass legislation -- but I don't know what the final form will be -- to approve a five-year phase-into community rating. Essentially, the rate variation (from highest to lowest) starts at five-to-one and goes to two-and-half-to-one in one year and then drops down to one-to-one in the fifth year.

The only variation outside of those ratios -- and those are all ratios for age demographics -- is a 5% variation for geography. Remember, we're talking about rating in only one state. Our geographic variance is probably 15% or 20%, and we're trying to get that changed because there's a real problem with the state bill, because it would require, in effect, rural areas to subsidize the metropolitan areas if you had that small a rate differential.

There are problems with definition of class of business. The states are concerned that carriers are going to play games with classes. In the Massachusetts legislation, a class is a provider system. For example, an HMO is a different class from a PPO, and both could be a different class from a managed indemnity system. Massachusetts doesn't have restrictions between classes exactly like HIAA, but it assumes that an HMO would be lower cost than an unnegotiated indemnity. The HIAA limits are probably too restrictive from the pure indemnity with no control to a straight HMO for the same benefit plan. There are many classes you can have depending on the marketing mechanism, or a purchased block of business outside this framework, but the class limitations may cause problems as we go ahead.

I've got two examples of the effects on rating restriction. Both of these were presented in testimony to the House Ways & Means Subcommittee on Health in 1992. Table 1 shows the effect on rerating of switching immediately from a tiered-rating, commercial-type practice to community rates overnight, it illustrates the rate increases of the various deciles of the business.

TABLE 1
The Effect on Enrollees' Premiums of Converting a
Small Group Line of Business to Community Rates

Percentage Change in the Premium Rate	Percent of Enrollees Affected
+40% or more	10.3
+30% to +40%	14.6
+20% to +30%	13.0
+10% to +20%	8.3
+5% to +10%	6.0
0% to +5%	9.9
0% to −5%	10.6
−5% to −10%	7.1
−10% to −20%	5.7
−20% or −30%	1.1
−30% or more	13.4
TOTAL	100.0%

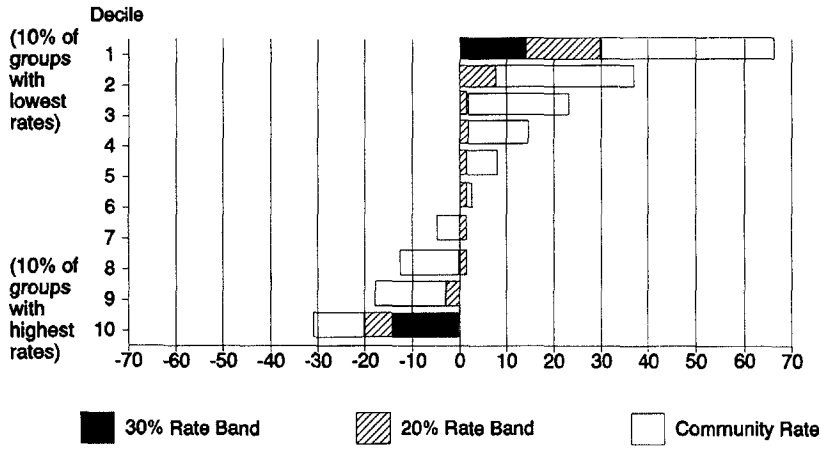
NOTE: Towers Perrin, Insurance General Management Consulting, developed these data. The data reflect the results of a model of a block of small group business. The model assumes aggressive underwriting, age, sex and industry rate factors, and tier rating. The model assumes a common geographic area and benefit for all groups.

You can see at the bottom the big rate decreases. You have a fairly high percentage of groups who have incurred big rate increases of 40%, 50% or 100% at the bottom who would receive sizable decreases. On the other end, about 65% of your in-force

business would have sizable, or some, increases, of 20% or more if you were to switch to a community rate.

Let's switch for a second and I'll show you another illustration, Chart 3. This was a study done in Minnesota by the HMO Association, including Blue Cross. That's why it's titled "Not-for-Profit Health" -- not counting the taxes they're going to be paying! Essentially, because of the historic use of community rating plus types of benefits that are flatter by age, as well as utilization control systems that produce costs that are much flatter by age than indemnity, where deductibles also tend to increase the rate slope by age, the results are much more muted. Minnesota's HMOs proposed a 30% rate band, which is the same as in Massachusetts, by the way, and was proposed by the Blues in Minnesota a couple of years ago.

CHART 3
Minnesota Not-for-Profit Health Insurers Effect of Rate Band Changes on Average Premium Rate by Decile for Groups Under 25 Lives



NOTE: Not-for-profit health insurers include HMOs and Blue Cross and Blue Shield of Minnesota.

Only the decile at each end would have any sizable rate change with a 30% rate band. There would be no need to change the rating system for anybody inside the deciles at either end and even the extreme changes would be on the order of 12% up or down. Thus, a 30% rate band in Minnesota would cause almost no change in the rating systems of either Blue Cross or the HMOs. The HMOs, in terms of risk premium, have over 50% of the business in the state, as most of the HMOs take full risk rather than ASO, although they're swinging to ASO to avoid some of the taxes. However, if you move to a community rate you have a graph similar to the one we just saw where the deciles at the ends would have increases or decreases in the 30-70% range.

The pooling mechanisms have been very confused even after drafting for three years – anything from allocation systems, which are hard to structure (I don't think any state has one yet) to mandate. The first one that's really been implemented is in Connecticut where HMOs, carriers and Blues all are mandatory participants. The newer ones tend to be optional, with carriers who have the financial strength to absorb guaranteed issue, if that's in the law, being allowed to self-insure their own risks for the uninsurables that come into enrollment.

The financial model, and I haven't seen any other ones yet, is the emergence of the pattern of the 150% group loading, 500% for individual reinsurance pool members covering the excess over 5,000 at 90%. The premiums are monumental for the reinsurance program in Connecticut, which is a very high-cost state. For a reinsured group, the individual loading would probably require $100 a month reinsurance premium based on age, but it would be more like $700 or $800 for the five times reinsurance premium for an individual. The issue then is, and Gary didn't really get into this because he's just looking at the rating structure, you have to load your rating structure for the reinsurance premiums, which is a mess because you don't know what percentage to expect of uninsurables.

First of all, you may be starting out, and you don't even know what the premiums are going to be because it's very difficult to figure them out, but when you go into business you're not sure what percentage would come in at 500% and what percentage would come in at 150% and then how much you're going to have to pay. Assuming you're never going to get any of that money back, other than as reduced claims, somewhere you're going to load those reinsurance premiums across the rating system.

Assessment requirements are one of my pets! I love the political environment, because almost every bill I have read says you can't pay more than 4% of small group premium; but if you go over the 4% assessment or whatever it is, after 1% on your total health business, the question is, where does the rest of the money come from and most states don't say. What they mean is you're going to carry a deficit and then they're going to raise the deductible on the reinsurance and keep the premiums up on the reinsurance and then they hope to slide back over and repay the deficit in the reinsurance pool over the next three or five years, which means you're going to get an extra bump in the rates. If you remember Gary's comments, you're going to have more turnover with the low-cost groups getting out and the high-cost groups coming in. At least it appears that way in a voluntary system.

There is one thing that's mystified me in my health care political life, which is about 30 years. I recently worked with two groups, the Minnesota Medical Association and the Citizens League (MN) drafting legislative proposals for Minnesota. We have probably the largest uninsurable pool in the U.S. with 30,000 people in it, of whom maybe 90% are uninsurable. It now accepts dependents who are insurable to go along with their spouses. This is an existing uninsurable pool. Connecticut has probably spent millions setting up an uninsurable pool and still has a 20-year-old uninsurable pool for individuals with only about 2,000 people in it.

My question is how many uninsurable pools do we need. In Minnesota, if the bill goes through, that will be three: the small group pool, the individual insurance pool,

because everybody must continue on an individual basis if you leave the group, and the existing pool for the uninsurables who want to stay there. One of the bills we drafted was to permit small employers to take a rejectable applicant and put him in the state uninsurable pool and pay the premium. All carriers would subsidize with a tax, which is a percentage of total health risk premium as an alternative. Nobody seems to consider that now. The tax is approaching 2% of total health risk premiums.

The size range at the bottom end is from one to three lives. Connecticut is one life. Massachusetts is one life. Other states are proposing three lives. The upper range, the NAIC typical type, is 25. Minnesota is 30. Ohio is 50 and states vary on that. Now, you may have a real problem adjusting. Many consider their small group business to be under 25 and may experience larger group rates. Some companies don't do individual medical underwriting in groups over 25 or 30, sometimes not over 15, but the range at which medical underwriting is used has been rising generally in the past five years, often with short-form questionnaires. So now you may have a typical experience-rated group underwritten in some states that may be in the small group pool in the other states, which is going to cause a mess in corporate strategy.

I think we have coming, although I haven't seen it in too many states, loss ratio requirements for small group. Just to get you horrified a little bit, Minnesota proposes a 75% loss ratio moving up in 1% steps for six years to an 80% loss ratio, none of which could possibly ever be complied with, even in an actuarial certification. In other words, Minnesota is getting very close to some of the loss ratio requirements on individual, and it is tending to raise the loss ratios. North Carolina limited the commissions to 5%, forcing the retentions down by limiting the marketing and the sales overhead down. The states are going to have all kinds of variations.

I have just a word on underwriting complexity. Some of the bills have assumed lower administrative cost under guaranteed issue, since you don't have to underwrite. If you look at Connecticut, which has been in business about a year, the underwriting is very complex. First of all, you have to determine if the person is uninsurable, and then you have to measure the number of people in the group to determine whether it's cheaper to reinsure the whole group at 150%, or one person at 500%. Then if you write substandard business, which some companies do, either small group or individual, is a woman likely to have a normal maternity claim which would run $3,000 or $4,000 depending on the state? Do you really want to put that applicant in the reinsurance pool at a premium of $500 a month? That is, why pay the high premium? Remember if some applicant has a hernia or some minor problem, you can't waiver out the specific claim.

The risk of having a big claim may not be very high, and after a year, when the surgery is completed, the applicant will be an average risk. So maybe you shouldn't put the applicant in the reinsurance pool. Many small group carriers really don't take a lot of substandard business, so they have no idea what the likelihood of a catastrophic claim is for many of these cases; but maybe they will find out.

Is one person a group? I really object to the one-life definition. Massachusetts copied Connecticut, because the blind follow the blind usually, and there's a lot of game playing in Connecticut. At least one carrier I've seen in the state marketing reports

has submitted a large number of one life groups. Since it had reinsured the whole group, then that one life can be reinsured at a 150% loading; whereas if the life were part of a bigger group the carrier would have to pay 500%. Some of the states are tending to require the whole group be reinsured for smaller size groups to avoid the game playing. In Minnesota, it has been proposed to fully reinsure groups up to seven lives. Seven times 50% is 350, so maybe that's close to equalling the 500% on one life. I don't know. It's still not simple!

There is both a loophole and an unsatisfactory provision of many bills. Some states have participation requirements, typically 75%, but Massachusetts, for example, permits 100% for groups of five or less. But laws are often silent about contribution requirements, so not only is it a problem and not defined very well by statute (but possibly by regulation), but it's also a loophole. One of the national bills says the carrier could use its typical participation requirements, but it has to be consistent for all groups of the same size. Well, you could have participation requirements of 100% and therefore limit enrollment to very high-income-level employee groups, assuming you wanted them, like lawyers or doctors, who are normally on most companies' reject lists. You could get engineers and computer companies that were small companies with relatively high incomes and get around guaranteed issue requirements. In other words, you could find a way of picking out which are likely to be good groups.

Continuous coverage is also an underwriting problem. There's a lot of variation there. Most of it only applies to other insurance, but in some states we're talking about integrating with COBRA or conversions. Minnesota is talking about continuous coverage with Medicaid and lower-income people would go in and out of eligibility for Medicaid, so you can't assume they've lapsed and reimpose a preexisting limitation. Continuous coverage definitions vary from 30 days to 120 days in the various bills that I've looked at between federal and state. Minnesota is four months. That's the average period of time between losing your coverage and getting it back according to studies by Employee Benefit Research Institute.

Minnesota is thinking of extending the required gap for group terminations to 18 months because it doesn't have enough money to cover all the people who would be eligible for subsidized state coverage with a gap of only four months. There are legitimate underwriting questions where the laws are silent. I think you can underwrite whether the group is a legitimate employer/employee group. Is the father-in-law of the owner who works 20 hours a week as a treasurer a legitimate employee? Can you still reject him because you don't think he's an employee? The mechanics aren't always familiar to the legislators.

If reform is to work, loopholes must be minimized. You can't permit forced reentry underwriting. If you offer transfer to another class of business at a lower rate, you have to offer it to everybody in the class you're trying to transfer.

Benefit differences are generally not a class. The NAIC has received an application for a different benefit class when a carrier raised the deductible on a comprehensive medical from $100 to $101. The carrier claimed it was a separate class because it was going to have 20% lower experience, so you know the carrier was going to do something. The class was rejected, but I don't know if the rejection held.

An HMO or PPO and tight utilization review programs could be classes. Some states don't really distinguish by provider classes, and others do, particularly where the HMOs have been involved heavily in the negotiating process.

There is a need to control the escape valve. Self-insured plans are a major escape valve. Association Group was a big problem in Massachusetts. The industry lobbied and got an exemption from the bill and then was carved back in. The insurance department says there is no way that you're not going to be regulated. Use of individual insurance contracts could be a problem. An employer could cover all of his employees by individual coverage, individually underwritten, and escape the small-group-reform rating requirements.

Let's summarize national carrier problems. If a carrier operates in many states, the question is how to adjust to all these limitations. Some of them are not serious. I suppose between two lives and 30 or 25 lives is not a real problem. But what about some of these rating systems with restrictive rating bands: whereas HIAA or NAIC says you can have 15% difference in bands for renewal reflecting durational or experience changes, like Gary talked about; others say you can only have 5% difference, which would certainly not cover the aging curve that Gary is talking about.

The use of subsidiary companies to justify reentry underwriting has generally been blocked. I even heard someone mention the possibility of withdrawing from a state when everything is in a mess, to come back five years later and start from scratch, which is probably legal if you dare go out of business for five years. You might save a lot of money if you did that.

A local carrier has a major advantage in a given state. To the extent of lobbying politically and being able to adjust to the local environment in a complicated small group reform, a Blue Cross/Blue Shield group that operates only in one state would have an advantage. The HMOs are often community rated, so HMOs lobby for the tightest rates they can get because they require little adjustment. In Massachusetts, for example, HMOs have to file a community rate, or case rate and use it. While HMOs vary rates in Massachusetts without filing a methodology, the rates are usually uniform.

States define varying, low-option prototypes. Minnesota is $500 deductible, 80%, $3,000 individual out of pocket. The Bentzen bill has $400, 80%, $3,000 per family out of pocket. I saw one filed in North Carolina with a $300 deductible, 60% coinsurance, maximum benefit $25,000 a year, which is going to draw political screams when offered. People may buy them because they're cheap, but then they find out they can't afford to pay the deductibles and coinsurance. You're going to get into political trouble if you sell that.

Can the market survive without more rationality? I can see an argument for federal regulation and federal definition of what's going on here. Many carriers don't operate in every state. Many of them may be able to conform. Think of the actuary in the company that operates in 50 states who has to send a certification in for completely different regulations in each state. While these are only a few of the things to look at, knowledge of the political reality may dictate actuarial approaches.

MR. LLOYD: At this point, I think we can summarize four points we'd like to leave with you. First is that this is a complex rating issue. There's a rumor that the Florida regulations to interpret the law are going to run 300 pages. Second, there is a diversity of approach to reform. As Harry mentioned, it is currently done state-by-state. Third, in any political process, the legislation is a work of compromise by the time it's done. Last, there is significant actuarial work to be done -- both for your company and from a public policy standpoint.

MR. JOSEPH W. MORAN: I had a question and some comments for Gary Travnicek. The M&R study that the Society commissioned in 1991 on variation and small group claim costs by duration did not deal with constant populations. The aging curve that you've graphed, illustrated and discussed is for a population of groups and reflects the dropouts among that population. It wasn't feasible for the study to deal with the comparison of claim costs by duration for a constant population of groups because of the time frame of the database. Because of your comments about the group level consideration of the aging curve, I think that point may have been lost sight of. The presumption is that the pattern of aging within a specific closed block of groups would not be as steep as the pattern of aging within a population of groups from which there are dropouts, because many of the dropouts are stimulated by the opportunity posed by reentry underwriting, at least in the prereform market. The second comment that I wanted to make is that you said that you didn't think there was a need for a statutory requirement for reserves to deal with the aging pattern. I would suggest that within the first year of coverage the aging curve is steep enough as to perhaps warrant consideration of the unexpired balance of the first plan year as a basis for having a shortfall of premiums for the balance of the year versus expected claims for the balance of the year, and maybe even within other durations, the same pattern would apply to a lesser degree. Have you evaluated that factor?

MR. TRAVNICEK: To answer your first question, or just to comment on your comment, the aging curve that I put up was by duration since issue of the insured. It was not on any type of population of group, and since I didn't have any numbers on the Y axis, I was basically showing the shape of the curve. The M&R study had some numbers in it that indicated, depending on the block of business and the type of underwriting that was done and whether preexisting conditions were in the block, that there was a different level of aging. If that same study had been done by the duration since issue of the insured, it would have been significantly steeper. It is the result of the terminations of insureds within the group that are being replaced by new entrants into the group that causes a study when you do it by group to be less than it would be by insured.

That's the thing that really makes this whole thing complicated. You can have two groups out there that are in a different position on the aging curve. Their experience in the past could have been the same, but the difference in turnover in the group was significant.

What you're trying to do is prospective rating. You're trying to rate groups for a renewal period, and if a significant number of those people who had claim experience have been replaced by people recently, the replacements are at a different position on the aging curve. So in order to project renewal rates, questioning changes on aging is something that really should be taken into account.

The second question concerned whether there should be a statutory requirement. As long as the company has the right to raise the renewal rates, it's questionable whether there should be a statutory requirement. As I said in my presentation, raising the renewal rates may be a death sentence on writing new business because you have to raise them as well. I'm not sure I'm really here to answer whether it should be or shouldn't be. I'll leave that up to the regulators as to what they want, but in the absence of any statutory requirement I strongly would encourage company management to consider this.

As I said before, it takes a lot of discipline in your financial statements to recognize the effects of aging. There's a lot of pressure from company executives to show as much profit as possible. When you're writing a lot of new business and you have these extra margins in your new business rates, management would like to see as much money drop to the bottom line as possible; but the truth of the matter is you will need that margin for the renewal periods.

MR. ANTHONY J. HOUGHTON: There are a couple of situations: one with the guaranteed issue requirement and the other, something that says your range of rates maybe can be 75-125% of your index number. I think it's absolutely required for a company to be setting up its rates such that on new issues you have premiums both at the lowest end and the highest end. In other words, if your index number has to be 160, you don't issue everybody at 120 and later have to grow some of them up to the maximum rate. I think you definitely have to have some people come in at the highest rate right at the beginning, especially since some of the people will be uninsurable and they'll go into the reinsurance pool.

What may be less obvious is that, even when there isn't guaranteed issue, I think the same thing is true. I don't think it makes sense to have everybody be issued who meets your qualifications to come in at the lowest possible rate and then some would gradually go to a higher rate. I think you have to start right from the beginning of having your tiers, even though the people you accept may be very heavily weighted toward your lowest premium class. I think you'll want to have some representation in all your tiers, and I don't think that's too hard to justify, because there will be people coming in who will have medical problems that, even with preexisting limitations, still are going to have some other problems after the preexisting, or the collateral things that will not be specifically excluded from preexisting will cost more than the average.

It's important to do that so you get an index number that is not your low new business rate. I always shudder a little when I hear people define new business as being the lowest possible rate. I think from now on there's a new business scale, but they'd all be at the very lowest.

MR. SUTTON: I would think that, when you are putting an applicant in the reinsurance pool, you could use the reinsurance rate to bounce the group rate to the highest rate within your rating system. I had a question for Gary and I'll just throw it out to you. Gary talked primarily about the preexisting limitations as a limitation of claims, and I guess some of us think that the underwriting is more of a factor in getting the bottom end of the curve at the beginning rather than the preexisting limitations. Some companies don't use preexisting limitations very much. HMOs have a right to

limit preexisting coverage. They can't exclude coverage if they're federally qualified, and that's causing some confusion in the market as to whether they will get the already sick people coming into the HMOs with no preexisting clauses; whereas the carriers can still have six or twelve months to exclude them. What do you think about the value of the underwriting in getting to the bottom of the curve as opposed to the preexisting limitations in the beginning?

MR. TRAVNICEK: Well, I think they're both important. I do feel that the underwriting sets the relative level of the curve, assuming eventually you're going to get to some ultimate level. The less underwriting you do, the higher the bottom of the curve would be relative to a program that would be very well underwritten. The preexisting limitations set the steepness of the curve and how quickly it changes shape once the preexisting period is over with. My curve shows that it would increase at a decreasing rate. I don't know how many of you have ever done claim cost studies by duration. You get a type of scatter diagram when you measure your claim cost by duration, but it definitely does tend to show that type of shape.

If you were to eliminate preexisting limitations, and just do a study on business that is not subject to any preexisting conditions -- essentially takeover type of business -- and graph the results relative to the curve I showed, the bottom of that curve would be increased, and then I would think that as duration increases, it would show more of a linear type of movement toward the ultimate level shown by my curve.

MR. CHRIS L. SIPES: Along those same lines, given that several of the states are passing the access model and looking just at the portion of the legislation dealing with new hires and late entrants in which you're having to waive preexisting limitations on those people and in which you're having to accept them if they had group coverage somewhere else, even through their spouse and even though they waived out of the employer's plan initially, it seems to me that, under that scenario, you're taking in new groups without preexisting limitations and new hires or any applicants coming on that it takes out almost all your aging based on preexisting limitations just along the lines you were talking; so that regarding the rating problem that we're facing, as Harry has already showed, we can probably deal with the tiers within a plus or minus 25 or plus or minus 35. I think the real unknown right now is when you change the rules to where for the people you're covering coming in, you no longer have those protections you've had in the past and your aging curve basically disappears, I think. I guess that's what I'm asking about. What's your perception there?

MR. TRAVNICEK: Yes, I think that definitely could happen, but I think the point is, we don't know what's going to happen in the different states. Some states may do that and other states may not. If you're a multistate company, how are you going to adjust your rating when in one environment you have to do something different than in another environment? The point is, you need to study those effects and reflect them in your rating. My comments were not from a political point of view. I was just saying that, if you need to comply under the rules that are established for you, then what you should do is just study the effects that something like aging does have on your business and include it in your rerating process.

MR. JIM H. SRITE: We saw some numbers up here that showed if you went to a modified community rate with maybe a plus or minus 30%, that only 10% on either

end of your cases would really be affected. The states that I've seen, most of them at least, have that range, though it's not just for age. It's also for any rating that you're using to show the effect of aging. When you combine the effect of aging with the effect of your demographic assumptions, it seems to me that we're going to have people out there who have a certain rate and that tomorrow will have a rate not 30% or 40% higher, but 100% or 150% higher. This is because we're having to take into account not only the age/sex differences, but also the aging curve differences. If you accept that, then do we have a responsibility to inform the legislators and regulators of that? Because I don't believe right now they understand what's going to happen to some people in the market.

MR. SUTTON: Well, at the congressional level and at the state level they are beginning to listen. We're not necessarily arguing against even community rating. All we're pointing out is that some groups will get horribly big rate increases if you're trying to compact your whole rating structure into a very narrow range, because it doesn't spell mother without the increases.

If they want very narrow rate bands to do that, the question is, will it defeat their general purpose, as Jan mentioned, resulting in fewer people being covered than you started with after spending millions of dollars to overhaul the system? That's why many states have only come in with the preexisting limits and gradual rerate limitations. Carriers can still underwrite and there's no guaranteed issue -- that keeps the rates lower -- but rerating restrictions will raise average rates.

Again, I agree with your point. HMOs may not have much data by duration. They're looking at aggregate data when we reviewed the range for HMOs. The demographic rates may distort durational data, so it kind of hides the effect and doesn't tell you what the extremes are. Obviously a major difference in the compacting would cause a lot of disruption.