RECORD OF SOCIETY OF ACTUARIES
1991 VOL. 17 NO. 4A

UNDER-25 LIFE GROUP MEDICAL REFORM

Moderator: THOMAS D. SNOOK
Panelists: PAUL R. FLEISCHACKER
JOSEPH W. MORAN
Recorder: THOMAS D. SNOOK

- Model Bills
  - -- NAIC
    - o Underwriting and rating
    - o Accessibility
  - -- HIAA
- State variations
- Effect of RBRVS on provider fees and plan costs
- Congressional proposals
- Community rate implications
- Impact on:
  - -- Insurers
  - -- HMOs
  - -- Consumers
  - -- Blue Cross/Blue Shield plans

MR. THOMAS D. SNOOK: A number of studies have shown that a substantial portion of the uninsured and underinsured are employed by small companies. Part of the blame for this has been placed on the state of the small-group health insurance marketplace. I think we've probably all read the stories in the paper about the single mother with the sick baby who loses her health coverage or has her rates tripled. This is important, and our credibility and reputation as an industry have been called into question.

We have a couple of outstanding panelists. Joe Moran is the vice president and actuary in the group insurance department for New York Life. Joe's responsibilities include, among other things, representing New York Life on various health industry matters, with a special focus on the uninsured problem. He's a member of the Board of Directors of the Connecticut Small Employer Health Reinsurance Pool. He's also been very active with the Health Insurance Association of America (HIAA) proposals in this area. Joe is a member of the Society's Health Section Counsel and is Chairperson of the project oversight group for the Society's research project on the variation in small group claims cost by duration.

Paul Fleischacker will talk about the reform activities at the federal level. Paul is vice president and principal with Tillinghast in New York. Paul provides management and actuarial consulting advice on health care issues to insurers, the Blues, HMOs, PPOs and providers of health care. He's the chairman of the Society Health Section Counsel, a member of the Academy of Health Practice Counsel, a member of the Society of Professional Actuarial Specialty Guides Committee and editor of the *Health Section News*.

I'll be talking about the NAIC's activities in small group reform.

MR. JOSEPH W. MORAN: I'm going to start by talking about the general objective of all of the proposals for a small-group reform of underwriting practices and pricing. About three years ago, when the HIAA first went public with its statement that there should be guaranteed access to coverage for all employees in all small firms, its number one objective was access to coverage for those who don't have it now. I think over the past several years it's become apparent that the primary objective of any market reforms in the small-group health business today is to reduce the fear that people who have coverage now are going to lose that coverage. The politicians all seem to say that that's the hot button and is much more important than making coverage available to the uninsured. As a matter of fact, there's some antagonism in the general public against making coverage available to the uninsured, if it does anything to undercut the continuing availability of coverage for people who have it right now.

Another objective of small-group reform is to contain the escalating costs of small-group coverage. And that includes increased availability and increased use of managed-care mechanisms to help contain costs. But, fundamentally, don't let the costs of coverage be so high that they have to get passed through to the public as price increases. Don't let the price of coverage for the small groups that have coverage be so high that the employers and employees can't afford them.

Tied to that, a second objective is to reduce the unpredictability of next year's price for the continuation of this year's coverage for small firms and their employees. This is prompted by the need to react to the fact that there have been some horror stories about 200%, 300%, and 400% price increases.

Finally, the objective of most actuaries who have been working on this project is to preserve a truly voluntary private market in which an employer can select the carrier that offers the best combination of coverage, provider network, managed care resources, service, and price. In that context, those of us who were on the original HIAA Reinsurance Task Force that was formed back in 1988 felt that there were certain minimum requirements that had to be in place in order to have a guaranteed issue mechanism that would make coverage available to everybody. The first of those requirements was a reinsurance mechanism that would enable carriers to protect themselves against the uneven distribution of high-cost risks. Now this is a little bit different form of reinsurance than what people have traditionally found in the commercial insurance field. This is not a situation where there's an attempt to even out the fluctuations in the cost of insurance for high-cost risk. Reinsurance in the small-group reform rules is a subsidy. It's a mechanism of providing a subsidy to the carriers of groups that include high-cost risks to cover a portion of the cost of that coverage. The subsidy will eventually come in part by assessments against all other carriers in the business, and in part ultimately by assessment against other parties who benefit from the fact that there is a reduction in the number of unemployed. The problem, of course, is that there isn't much agreement yet as to who those parties are who that benefit and who should bear the second-tier subsidies.

One of the items that was at issue very early in the discussions over how to design a reinsurance mechanism to facilitate small-group underwriting reform was: Should there be reinsurance of full groups, or should there be reinsurance of specific individuals within groups? There was a fair amount of antagonism to both of those. For

example, some people felt that any mechanism that relied on group reinsurance would entail putting a direct carrier in a spot where the only way to get any cost relief for a ten-life group that happened to be laced with some high-cost risks was to reinsure all the healthy lives in the group along with the unhealthy ones. And that cut against the grain. At the other extreme, selective individual reinsurance was found wanting as a solution, mainly because it was seen that any design of a reinsurance mechanism that would offer reasonable relief to the carrier of a three-employee group would undoubtedly be designed in such a way that there would be far too many substandard risks in 19- and 20-life groups who would be reinsured because it would be financially advantageous to the carrier.

So what evolved from that conflict of problems and conflict of concerns was an admittedly mongrel design under which both the HIAA proposals and the NAIC proposals entail the use of a combination of group reinsurance and individual reinsurance. In effect, the carrier has a choice between group reinsurance of everybody in a small group, or selective reinsurance of specific individuals within that group at a relatively higher reinsurance price. Now, we recognize that this feature has a natural appeal to what have been described as the actuarial, prurient interests of sharp-pencil underwriters; namely, a chance to beat the system and be the antiselectors sometimes instead of being the victim of antiselection, since it would offer each carrier the option to pick the most advantageous reinsurance choice.

But there was some reason for it. The most unfortunate element is that it tends to make all the reinsurance proposals more complicated than they would be otherwise. And it perhaps tends to breathe some suspicion on the part of other parties. But quite frankly, it does tend to achieve an optimum combination of relatively minimal use of underwriting and relatively limited reliance of cherry picking high-cost risk from within groups for reinsurance. The primary purpose of reinsurance is not to reduce costs to the direct carrier below a reasonable market prevailing price level, but rather to minimize the extent to which the carrier that covers a high-cost risk will have to charge a price above a reasonable price for the employer to pay.

But let's face it; if the number of high-cost risks in the general insured population is increased, the average price per insured person is going to increase. The average cost of insurance per insured person will go up. If that flows through and becomes an increase in the average price of insurance per insured person in small groups, it's going to have a negative impact on the total number of persons insured. The main reason why many people in the working population are not insured is that coverage is too expensive. And anything that raises the price for the healthy risks will increase the temptation to "go naked" without coverage and probably increase the number of uninsureds.

It's not likely that any underwriting liberalization would actually increase the percentage of total doctor bills that go unpaid because of noninsured people. But it probably would tend to increase the body count among the noninsureds. Fortunately, the liberalization of underwriting will increase the number of people insured who need coverage the most.

The real problem is: if the total costs are going to be higher and if the average cost per employee is going to be higher than it is today, who should pay that extra cost?

And that is the most difficult, unresolved problem right now. There's a clear-cut agreement that there should be underwriting reform to make sure everybody has access to coverage. And there's a clear-cut agreement, I think, that no employers should have to pay an outrageous price to get coverage for their employees. But the question is, who should pay for the fact that the highest price (that isn't outrageous) exceeds the expected costs of the coverage to the carrier even with the reinsurance mechanism available?

If all employers were mandated to provide coverage, we can assume that the average cost of insurance for all covered small groups would be more or less the same as the average cost per employee in the entire working population. In other words, it would be comparable to what large employers have to pay. The problem is that as long as there are substantial numbers of healthy risks who don't have coverage, the average cost for the covered population is going to be higher than the average cost of the entire working population. And somebody has to find some money somewhere.

There seems to have surfaced in recent months a rather perverse position that the money to pay the costs of coverage that are attributable to adverse selection in the small-group market should come from the employers, the good guys. The employers who now provide coverage for their employees and who have been participating in the marketplace all along, and don't happen to have any high-cost risks, are still going to be expected to pay an above-average price for their insurance just because some of their low-cost colleagues are staying out of the marketplace. It would be more logical to say that the parties to benefit the most from a drop in the uninsured working population should be the parties who pay for the cost of the availability of coverage to all small employers.

Now, who are those parties? Obviously, the first party to benefit would be the providers; providers who will have fewer uncollected bills to contend with, who will have a higher degree of collection of their charges for services, and who will be able to charge their usual prices for those services. The second major beneficiary of a drop in the uninsured population would be those large employers that could look forward to having less of a cost-shift burden thrust upon them by the providers who would have fewer uncollected bills. In any event, either is a better target for imposing the extra cost of covering high-cost, small-employer risks than the good-guy, small employers who have been providing coverage all along.

One more item that's an open question right now, and seems to be getting lost in the shuffle to an undesirable extent, is this whole design of underwriting reform proposals in the context of a competitive marketplace. In a competitive marketplace, you start with a presumption that the carriers that do the best job of reaching the right objective should be rewarded for their performance. Now if the primary objective is to increase the prevalence of coverage among the high-cost risks in the working population, the reinsurance mechanism and other features of underwriting reform should be designed to encourage carriers to cover more high-cost risks. The acid test of any proposal is: Would it encourage a carrier to undertake an aggressive marketing campaign aimed primarily at selling more coverage to high-cost groups? The HIAA proposal generally comes closest to meeting this test. Unfortunately, other recent proposals, including the NAIC design that will be discussed later, tend to fail this test.

The two features of some of these reinsurance proposals that seem to be the source of imposing penalties for doing what's right are two jokers in the deck, so to speak. The first joker is requiring the direct carrier to assume and absorb a large portion of the actual claim cost for each reinsured risk. Typically these proposals are that the direct carrier retains the first $5,000 of claim costs in any year and 10% of the next $50,000 of claim costs in any year for each highly substandard risk that's reinsured. Now this means that a carrier that just wrote a new case in June and acquires a highly substandard new entry in July might find itself paying out $20,000 in nonreinsured claims before it gets its first chance to rerate the group early next year. Furthermore, if this is a very small group, a three-life group, there's no way that any allowable rerating will ever come close to covering the expected cost of coverage for the one high-cost risk in that group. So this means that the group is going to become a permanent, sure loser for the carrier.

A second joker in the deck is that some of these proposals would make group reinsurance unavailable for most groups, particularly those groups that are already in force at the starting date of the program. Why might group reinsurance be inappropriate for an existing group that's already on the books? The answer is that the character of groups can change rather dramatically. Let's assume there is a carrier of a four-life group in which one employee has previously been determined to be highly substandard and insurable only with an impairment restriction that excludes coverage for heart conditions. If an underwriting reform proposal changes it over to a guaranteed issue, full-coverage basis of operation, that individual gets full coverage under the new law, and imposes the obligation on the direct carrier to provide full coverage, just as if it were a new case issued on guaranteed issue. But some of these proposals would make reinsurance unavailable.

In giving an actuarial appraisal of the pros and cons of various reinsurance alternatives and various reform proposals, these would be two, rather cold-blooded criteria by which to judge them. Do they offer incentives for carriers to acquire at least their fair share (or maybe even more) of all the high-cost risks in the market, by making reinsurance available on a group basis for all groups, and by allowing the carrier to offload substantially all of its direct cost through reinsurance? Keep in mind that the penalty that these laws impose on insurers for complying with objectives is a rather severe one. If one carrier has a relatively large proportion of high-cost risks for whom it can't cover its costs, it has to surcharge its premiums to other groups to cover the extra costs of the small groups that contain high-cost risks.

What does that mean? There will be a higher, competitive price in the marketplace, because the competitor has weaseled out of its obligations to cover its fair share of high-cost risk. The efficacy of reinsurance is subverted as a device to protect the carrier against the financial impacts of having too many high-cost risk eggs in one basket.

Those are a few of my general observations about some of the general features of various proposals to achieve underwriting reforms. I've made no pretense that this commentary represented a primer that described the specific provisions of any of these proposals. There are so many of them that such a commentary would have benumbed you.

MR. PAUL R. FLEISCHACKER: As we all know, the U.S. spends more on health care than any other country. Currently, approximately 12% of our gross national product is dedicated to health care expenditures. In addition, the health care trends that are being used by pricing actuaries still hover around the 20% level. So health insurance costs are continuing to go up at a very dramatic rate. Add to this the problem of the uninsured. In the U.S., there are approximately 37 million uninsured people, of which about 20 million work for small businesses or are dependents of employees of small businesses. Finally, there are the politicians. There have been a proliferation of proposals from various congressional leaders and committees dealing in various fashions with the health care crisis in the U.S. Put together all of these elements, and they certainly could result ultimately in a national health insurance program.

There is considerable debate on Capitol Hill on our health care crisis. I recently received from the National Federation of Independent Businesses a brief summary of pending major legislation in the health care area. It was prepared in July or August 1991 and shows 24 different proposals: 14 in the House and 10 in the Senate, with a couple of them overlapping, as they had been proposed both in the House and the Senate. The proposals range in scope from being very narrow, just addressing certain issues and certain population segments, such as Representative Stark's proposed amendment to extend Medicare coverage to pregnant women and to dependent children under age 23, to very broad proposals, such as Congressman Russo's proposal on a national health insurance system.

I have taken the proposals and broadly categorized them and I'll discuss some of the key features of the major proposals. The federal proposals can be broadly categorized into four groups. The most popular national health insurance model being proposed is similar to the Canadian system. As I mentioned before, Congressman Russo's bill is one that's being proposed. Others adopting certain features of the Canadian system include Representative Oakar, Senator Simon and Senator Carey.

There are a number of play-or-pay proposals. These require employers to either provide private insurance coverage for their employees or pay into a federal fund for a public program. The proposals usually include small-group reform, including rating limitations, elimination or restrictions on preexisting condition exclusions, preemption of state mandates and assurances of availability. Examples of these types of proposals include those put forth by Representative Rostenkowski and Senator Mitchell.

Under the small-employer assistance proposals, small employers are allowed to band together to form a purchasing group to buy health insurance. The proposals typically include exemptions from state laws on forming voluntary associations for the sole purpose of purchasing insurance, exemptions from state mandates and anti-managed-care laws, and in some cases, exemptions from the state premium taxes. An example of this type of bill is that proposed by Representative Chandler.

The final category is what I call incremental. These are proposals where the scope is narrowly defined, such as the Medicare extension I mentioned earlier. Some of them just deal with broadening the deductibility of health insurance premiums. For example, self-employed individuals currently can only deduct 25%, and some of the proposals will increase that to 50% or 100%.

I will be presenting the main features typically incorporated in the broader health care reform proposals. Any one proposal may contain some or all of these features. The first issue addressed is access. This includes the scope of the proposal; that is, the particular market definition of who will be covered. Some proposals focus just on the small group market; for example, employers with 25-100 employees. Others are almost universal or near universal in scope; for example, Congressman Russo's bill.

The next area is mandates. And when I refer to mandates, I'm talking about mandates to the employers as far as providing coverage or making coverage available to the employees. A good example is the play-or-pay bill.

Many of the proposals also address small-group market reform, which get into the issues affecting insurers; for example, the standard minimum benefits that have to be incorporated into a plan, preexisting condition limitations, and rating limitations. I will be discussing this particular area in more detail later.

The final area addressed on access is guaranteed availability or guaranteed issue. This is often incorporated as part of the small-group market reform.

The next issue is cost containment. Some proposals encourage higher cost sharing for the employees through the tax policy by limiting the deductibility of the health insurance premium. Others define the maximum benefits that have to be covered in the policy; for example, maximum deductibles, coinsurance, and out-of-pocket limits that can be imposed on the employees.

Managed care is not specifically addressed in many of the proposals. However, a few do encourage managed care programs via preemption of state anti-managed care laws and the provision through tax policy and employer funding arrangements.

On the issue of capital expenditures, which I think is very important, there are only a few proposals that get into the area of limiting or trying to control capital expenditures. Typically they are patterned after the Canadian system and attempt to relate the growth in health expenditures to the rate of nominal growth in the gross national product.

The final area in cost containment is malpractice and tort reforms. A few proposals provide for reduced malpractice insurance costs to selected types of health care providers. It also discusses, in general fashion, limitations that might be placed on the amount available under medical malpractice lawsuits.

The next main area is price regulation and rating. Some of the proposals, such as Congressman Russo's proposal, would be all-payer-type systems. The rating sections of many of the proposals are quite complex and certainly open for varying interpretations. Some claim to be community rated, but, in effect, allow adjustments for age and gender; that is, some form of demographic rating, but with maximum limits. There also are the community-rated-by-block proposals, where certain types of policies can be blocked and put in a pool by themselves, and rate variations are allowed within and between blocks. But there are typically limits placed on that. For example, under Representative Johnson's proposal, for groups within a particular block, the rates on any particular group cannot be greater than 125%, or less than 75% of the

average index rate for that block. Likewise, in looking from one block to the next, the index rates can't vary by more than 20% from the highest rate block to the lowest rate block. That's fairly typical of the types of provisions you will see when looking at these various proposals. And finally, there is the area of renewal rates and the limits placed on the rate increases. A number of proposals do place limits on the renewal rates; for example, to equal the new business rates or maybe the new business rates plus a certain percentage.

The next issue is who pays. It's ironic, but many of the proposals have not gone into any great detail on financing as it relates to the government cost. Most of the proposals have not been costed out, and the financing has basically not been specified in the proposals. I did note in reviewing some literature on this that there have been a couple of independent cost estimates on the national health insurance proposals, which range from virtually no increase in cost in the expenditures that we currently have for health care, to over a $300 billion increase. I think it's pretty safe to say who is for and who is against national health insurance, given that wide range.

On the employer's side, many of the proposals provide for some requirements. A typical provision would be that the employer pay at least 80% of the cost of the health insurance program, with the balance of the premiums being paid by the individual employee. In the area of tax incentives and credits, some of the proposals get into discussing this particular issue, particularly the deductibility of health insurance premiums for the self-employed individuals.

The next issue is benefits. Virtually all of the proposals address a minimum or core package of benefits that must be offered by the employer and that must be available from the insurance carriers. Most of the proposals contain basic services, such as hospital and physician charges, and some preventive services. Others are broader in scope and cover, in addition to basic and preventive, items such as mental health, substance abuse and durable medical equipment.

I'm going to briefly provide a summary of the provisions from the following seven proposals that affect small-group market reform. Note that this is not a summary of the entire proposal, but only those sections dealing with the small-group market reform. These are taken from the summary I received from the National Federation of Independent Businesses in Washington, DC. The specific proposals are (1) the Health Equity and Access Reform Today (HEART) Act of 1991 sponsored by Representative Johnson; (2) the Small Employer Health Insurance Incentive Act of 1991 sponsored by Representative Chandler and Senator McCain; (3) the Pepper Commission Health Care Access and Reform Act of 1991 sponsored by Representative Waxman and Senator Rockefeller; (4) the Health Insurance Coverage and Cost Containment Act of 1991 sponsored by Representative Rostenkowski; (5) the American Health Security Act of 1991 sponsored by Senator Durenberger; (6) the Health America: Affordable Health Care for All Americans Act sponsored by Senator Mitchell; and finally (7) the Improvements to the Health American Act of 1991 sponsored by Senator Simon.

Before getting into the specific provisions, it's important to look at the major focus of each proposal as it relates to small-group market reform. In the case of Johnson's proposal, it requires employers to offer, but not pay for, a basic health insurance program. Small employers would be provided the same tax incentives given other

employers. The plans offered to small employers would be exempt from state-mandated benefits, and carriers of small business plans would be required to offer the plans to all groups.

The Chandler/McCain proposal enables small employers to become part of a large purchasing group for the exclusive purpose of purchasing health insurance. Such groups would be exempt from state-mandated restrictions.

Under the Waxman/Rockefeller proposal, employers with more than one hundred employees must pay-or-play. As far as the extension to the small groups, that would be phased in over a four- or five-year period, but ultimately would apply to all employers. Small businesses would be allowed to insist that the carriers pay the doctors and physicians according to Medicare payment rules.

Representative Rostenkowski's bill is also a play-or-pay approach and implements a tax to help finance a public health insurance fund. Senator Durenberger's proposal would impose an excise tax on insurance companies not meeting certain minimum health insurance standards. Senator Mitchell's bill, in essence, would replace Medicaid with a plan he calls AmeriCare. It also would include a play-or-pay provision. And finally we have Senator Simon's bill which, in essence, provides amendments to Senator Mitchell's bill. It imposes, more or less, a Canadian-style program and increases the provisions relating to small-business reform.

Table 1 summarizes the provisions dealing with the definition of small businesses and the standards imposed on health plans offered to small groups. Most of the numbers that are under definition relate to the number of employees that are covered under the provision.

TABLE 1
Small-Group Reform Provisions

		Definition	Standards for Health Plans
Johnson	H.R.1565	3–25	NAIC
Chandler/ McCain	H.R.2453/ S.1229	< 101	Comply with state laws
Waxman/ Rockefeller	H.R.2535/ S.1177	Small < 25 Medium 25–99	NAIC; basic health services required
Rostenkowski	H.R.3205	Small < 25 Medium 25–99	Basic benefit package with no cost sharing
Durenberger	S.700	1–50	Medplan
Mitchell	S.1227	Small < 25 Medium 25–99	AmeriCare -- replace Medicaid except long-term care (LTC)
Simon	S.1669	> 100	Canadian-style program

As you can see, most of the bills apply to employers with less than 100 employees. A few need clarification. Under the Chandler/McCain bill, the definition that applies

here relates to the purchasing group concept. The definition states that the purchasing group must consist of employers with not greater than 100 employees and include at least 100 employers. The Rostenkowski bill defines both small and medium-sized employers as stated, but the provisions relating to small-group market reform apply only to the small employers; that is, those with less than 25 employees.

The two that are labeled NAIC, which are the Johnson bill and the Waxman/Rockefeller bill, state that the standards will be established by the NAIC, but they do say the insurance companies must offer a basic coverage plan. Under the Chandler/McCain proposal, the plans must comply with state laws at the time of application for group status. In other words, the insurance companies that want to operate in this market have to apply and submit their programs and be registered to be a group writer. The Durenberger proposal has its own plan called Medplan.

The AmeriCare plan, which is in Mitchell's bill, requires that the carriers offer a minimum of two types of indemnity programs and two managed care programs in the small-group market. The other proposals offer basic packages of hospitalization and physician services.

Table 2 summarizes the provisions dealing with coordination with state laws and required offerings.

TABLE 2
Small-Group Reform Provisions

		Coordination with State Laws	Required Offering
Johnson	H.R.1565	Exempt from state benefit laws, premium tax, restrictions on managed care	Yes -- individuals within any group
Chandler/ McCain	H.R.2453/ S.1229	Exempt from state benefit laws	No
Waxman/ Rockefeller	H.R.2535/ S.1177	No presentation of state information reporting requirements	Yes -- any group
Rostenkowski	H.R.3205	No presentation of state information reporting requirements	Yes -- any group
Durenberger	S.700	Exempt from state mandates	Yes -- any eligible employer
Mitchell	S.1227	Exempt from state laws	Yes -- any eligible employer
Simon	S.1669	Exempt from state benefit laws	Yes -- any eligible employer

In general, all the proposals provide for some exemption from state mandates. In addition, the Johnson bill includes exemptions from premium taxes and restrictions on managed care. The Waxman/Rockefeller and the Rostenkowski bills, in addition, provide for no preemption of state information reporting requirements.

On the required offerings, all but the Chandler/McCain bill have provisions dealing with requirements of carriers to offer small-employer health benefit plans. Generally these all can be characterized as a required offering to all employer groups (as defined in the proposal) on a guaranteed issue basis and accepting everyone in the group (that is, no exclusions of individuals).

Table 3 summarizes the provisions dealing with preexisting condition limitations and rating limitations. As can be seen, four of the proposals have a 3/6-month preexisting condition limitation. That means that limitations may not extend beyond six months after issuance, and the 6-month limit can only apply if the condition manifested itself during the three months prior to issue. For the Johnson proposal, the provision is a 6/12 preexisting condition limitation. Under the Chandler/McCain and the Simon proposals, there is no mention or there are no provisions for preexisting conditions. One other point to note on preexisting condition limitations is that generally these apply only to initial eligibility. In other words, if the employer changes from one carrier to the next, or the employee changes jobs, the satisfaction of any preexisting condition limitations follows that employer or that employee. So, if the preexisting condition limitation period is completely satisfied when they move to a new carrier, they don't have to satisfy any additional preexisting limitation period.

TABLE 3
Small-Group Reform Provisions

		Preexisting Condition Limitation	Premium Charged
Johnson	H.R.1565	Yes -- 6/12	Actuarial limitations
Chandler/ McCain	H.R.2453/ S.1229	No restrictions	No restrictions
Waxmanl Rockefeller	H.R.2535/ S.1177	Yes -- 3/6	After second year, no difference due to health or risk status
Rostenkowski	H.R.3205	Yes -- 3/6	After 1/1/93, no difference due to health or risk status
Durenberger	S.700	Yes -- 3/6	Ranges by class given; rate increases capped for existing business
Mitchell	S.1227	Yes -- 3/6	Same as H.R.2535/S.1177
Simon	S.1669	No mention	Same as S.1227

As I mentioned before, the rating limitation provisions are quite complex and really too detailed to discuss in this presentation. As can be seen in Table 3, most of the

proposals state that the premium charged after a specified period -- some say two years, one says January 1, 1993 -- must be based on a system not designed to treat groups differently based on health or risk status. Two of the bills, namely the Johnson bill and the Durenberger bill, propose limitations on rates. In the case of the Durenberger proposal, it places a cap on the rate increases on existing business.

The next two issues with renewability and the treatment of high-risk groups. (See Table 4). In the case of renewability, all of the proposals, except for the Chandler/McCain bill, which has no restrictions, require the contracts to be guaranteed renewable. Under the Johnson bill, high-risk groups are reinsured through a state-sponsored fund, with the reinsurance pool being funded by a tax on carriers. Three of the proposals indicate that high-risk groups are to be treated the same as any other group. In other words, there is to be no differentiation based on health status or risk status from one group to the next. In the other three bills, there is no restriction or no provision dealing with high-risk employers.

TABLE 4
Small-Group Reform Provisions

		Renewal	High-Risk Groups
Johnson	H.R.1565	Guaranteed renewable	State-sponsored reinsurance fund; tax on carriers
Chandler/ McCain	H.R.2453/ S.1229	No restrictions	No restrictions
Waxman/ Rockefeller	H.R.2535/ S.1177	Guaranteed renewable	Same treatment after second year
Rostenkowski	H.R.3205	Guaranteed renewable	Same treatment
Durenberger	S.700	Guaranteed renewable	No provision
Mitchell	S.1227	Guaranteed renewable	Same treatment
Simon	S.1669	Guaranteed renewable	Not mentioned

Table 5 summarizes the enforcement of the provisions and the tax deductibility of health insurance premiums for the self-employed. On all but two of the proposals (which do not mention anything), there are tax penalties imposed on the carriers and/or employers for noncompliance. For the carriers, the penalties range from 20-100% of all accident and health insurance premiums. So the penalties could be quite large. For those who did address the issue of self-employed in their proposals, they have made health insurance premiums 100% tax-deductible for self-employed individuals.

The perfect solution may be an impossible mission. Change is inevitable. Joe went through several of the problems dealing in general terms with some of the solutions that the industry has proposed. None of the proposals will be a perfect solution that will be acceptable to all of our constituents.

TABLE 5
Small-Group Reform Provisions

		Enforcement	Self-Employed
Johnson	H.R.1565	Yes -- tax penalty	N/A
Chandler/ McCain	H.R.2453/ S.1229	No	100% if part of purchasing groups
Waxman/ Rockefeller	H.R.2535/ S.1177	Yes -- tax penalty	100%
Rostenkowski	H.R.3205	Yes -- tax penalty	Small employer defined as < 25
Durenberger	S.700	Yes -- tax penalty	Not mentioned
Mitchell	S.1227	Yes -- tax penalty	100%
Simon	S.1669	Not mentioned	Not mentioned

MR. SNOOK: I'm going to talk about the NAIC's actions in small-group reform. The NAIC's approach to reform has been in two stages, the first being the rating and renewability model, which was adopted in December 1990. The second stage includes the two access models, which were exposed at the June 1991 NAIC meeting. Public comments have been taken, and are still being worked on. I understand that it expects to adopt something in this area in December 1991.

I'll talk first about the rating and renewability model. I'm going to assume that most of you have some degree of familiarity with this model. I'll just briefly review what it does and then talk about how it might impact the market.

The main target of this model is tier rating, which is the determination of a small group's rates based on its claim experience, health status, or duration. The model's provisions are couched in terms of "classes of business," which is important because this is where some of the gray area lies.

A class of business is defined as a distinct grouping of an insurer's small-group block and can be established on four bases. First, plans that are sold through individuals or organizations that do not market plans in any other class can constitute a class of business. Second, an acquired block of business can constitute a separate class of business. Third, plans provided through an association of small employers not formed for the purposes of insurance is a class of business. And finally, guaranteed-issue business can be broken out into a separate class. Within each of these classes, the insurer can form two additional classes based on underwriting criteria.

As for the rate restrictions themselves, there are three major restrictions. First, the midpoint premium rate of a class of business cannot be more than 20% greater than the midpoint for any other class, for reasons of claim experience, health status, or duration. The NAIC model does not intend to restrict rate variances based on other types of case characteristics, such as geographic area or industry factor.

The second provision is the restriction of rates within a class. Premium rates within a class of business cannot vary more than 25% from the midpoint rate for that class. The third provision states that the rate increase for any one group is essentially limited to medical trend plus 15% for claim experience, health status, or duration.

There is one other significant provision to the model that doesn't directly relate to rating. The insurance coverage is renewable at the option of the group. This does not strictly mean guaranteed renewable, because the insurer does have the option of not renewing an entire class of business. But if it does that, it cannot establish a new class for five years.

There's also a provision in the model for an actuarial certification. The actuary needs to certify that the insurer is in compliance with the model.

According to the latest information I've reviewed, about ten states have adopted this model without any significant modification. The model is also being considered in a number of other states.

A couple of states have made a few relatively minor modifications to the models. For example, Louisiana's law applies to groups with 35 or fewer employees, instead of 25 and fewer.

A few states have gone their own way and have implemented small-group reform that bears little resemblance to the NAIC model (or at least deviates substantially). Kansas, Oregon, Vermont, South Carolina, and North Carolina all have substantial deviations from the model. For example, the Oregon law has a guaranteed-issue provision, and the Kansas law throws out rate limitations pretty much altogether. Kansas does limit rate increases for any one group to 75% annually, but you can make a special filing and apply for an exemption. Probably more importantly, the Kansas law states that you cannot exclude any employer or dependent from a group that you're covering, and also limits some of the preexisting condition limitations.

The problem with these state deviations is, of course, compliance. If a company sells small-group health in most or all states, then it has a lot to worry about. The actuarial certification I mentioned earlier may wind up being tedious, at best.

There are quite a few interesting issues or questions that surround the premium-rating model. I'm just going to throw out a few that have caught my eye recently and discuss them a bit. First, how is a regulator going to be able to determine what portion of a rate variation is due to claims experience? As I mentioned, the model puts the restrictions on rate variations attributable to health status, claims experience, and duration. Well, let's say ABC Life is aggressively looking for some loopholes in the law. It decides that it is going to offer two plans to small groups. It is going to take all its poor-risk groups and write them on Plan A that has a $300 deductible. (I'm using the term *poor risk* pretty loosely here.) And then it will write all other groups on Plan B, with a $500 deductible. Then it sets up a manual rate structure with an enormous premium differential; say $1,000 a year premium differential between the two deductibles.

Clearly, that's not justifiable on plan design alone; the rates also reflect expected experience differentials between Plan A and Plan B. Granted, this is a pretty extreme example, but I think it illustrates a point. Are regulators going to get into the business of having to decide what a reasonable variation in rates is? I don't think that's what they had in mind when they passed this model, or if it is, I don't know how they're going to do it.

The model law is going to put a lot of pressure on the manual rate structure, for a couple of reasons. First, a carrier will want to be sure to get its rates right at issue because of the limit on rate increases. Second, a carrier might want to attribute as much of the variation in premium rates as possible to case characteristics, as opposed to claims experience. So we might see a little bit more refinement of manual rates come through.

Similarly, underwriting becomes very important under this model, perhaps more so than it is currently in the small-group market. Again, a carrier will want to get its rates right when it writes new business. If the rates are wrong, it will really be limited as to what can be done to correct the mistake.

Carriers might become more conservative and more careful and exclude more groups from coverage than they would otherwise. I think, more likely, we'll see carriers underwriting not only on an accept-or-decline basis, but underwriting to put a group in its proper tier at issue, so as to limit the rate increase needed at renewal.

We, as actuaries, might think a little bit about changing the way we calculate rates for small-group health. Traditionally, we calculated group rates on a one-year-term basis. Because of the restrictions on rate increases, we might want to think about prefunding some of the selection wear-off and adverse selection at lapse. In other words, employ a present-value, asset-share type of pricing formula. As far as I know, this is not really the norm in small-group pricing. The question is, will the market permit it? Is the marketing vice president going to approve raising new business rates 10%, just to prefund some wear-off?

I'll make a couple of other smaller points. The model gives an advantage to carriers that have little or no small-group business in force and that want to get into the market; they won't have an existing block of business that the new business rates are going to have to help fund. Of course, the advantage would be temporary; as the carrier writes more business and the block ages, they would lose the advantage. But, there is a short-term advantage.

Individual insurance carriers may also gain something of an edge, particularly in those states that don't really regulate individual health premium rates. Individual insurance is specifically exempt from the provisions of the model law. Also, HMOs may see this as a leveling of the playing field and may become more active in the small-group market.

My last question is on the impact of the model. How will the market be impacted by those carriers that seek and are able to find and exploit loopholes in the law? The model certainly is not perfect, and a company could probably exploit some loopholes.

Companies that want to operate in compliance with the spirit as well as the letter of the law may find themselves at a competitive disadvantage.

Next, let's talk about the access models. As I mentioned, they are out for public comment right now and something is expected to be adopted in December 1991. There is a prospective reinsurance model and an allocation model. The two are very similar; they differ in how they fund or pay for high risks, either individuals or groups.

The two models' major provisions are these. First, they incorporate the provisions of the premium rating model, with a few modifications. Second, a small-group carrier must offer two standardized health plans, which are not defined in the model. They're left up to the state. So there will be that state-to-state variation again that will give some headaches. Third, preexisting condition limitations are limited to twelve months, and a carrier must credit the time an individual was covered under another plan toward the new preexisting limit. A small group carrier must also cover all of the employees and dependents of a group. You can't carve anybody out of the group.

Under the reinsurance plan, (which can be either voluntary or mandatory, depending on how the state wants to write it), a participating company can reinsure either an individual or the whole group. It can be done either way. The reinsurance program will have a deductible of $5,000 and then will cover 90% of the cost between $5,000 and $55,000, and 100% above that. The program will be funded by reinsurance premiums, and then assessments as necessary.

As the models are currently drafted, the assessments are not to exceed 5% of the carrier's small-group premium in the state. If that's still not enough money, the model provides that funding will come from a broad-based funding source. I don't know what that means.

In the voluntary version of the model, a company can opt out of the reinsurance program if it gets approval to do so from the Commissioner of Insurance. Approval will be based on four things: the carrier's financial condition; the carrier's history of rating and underwriting small groups; the carrier's commitment to market fairly; and the carrier's ability to assume and manage the risk. If the carrier does opt out, it must offer those two standardized plans on a guaranteed issue basis. It cannot turn any group away.

The allocation model is fairly similar, but the risk-spreading mechanism is different. I won't go into a great level of detail here. Instead of reinsuring claims on high-risk individuals, individual uninsurables would be allocated to small-group carriers based on their small-group premium volume in the state. And again, like the reinsurance program, a carrier could opt out if approved by the Commissioner and if it offers the standardized plans on a guaranteed-issue basis.

My understanding is that the NAIC is planning to adopt both of these models in some form. It is working on changing them somewhat, but the general direction is still the same. There will be two models and then within each model, a state can make it either voluntary or mandatory. So there are really four different models that the states have to choose from.

In summary, unless an insurer meets certain requirements, including guaranteed issue, the carrier will be expected to help fund either a high-risk reinsurance pool or an uninsurable allocation program.

I'll open the floor to questions for the panel now. I'll start with my own question. Paul, you spoke about the federal proposals that are out there. Last time I looked, the states were still regulating insurance (although pretty precariously). And actually, Allen Feezer, the Chief Deputy Commissioner in North Carolina who chaired the NAIC committee that drafted the access models, mentioned that it is really pushing this reform model because it feels the federal government breathing down its neck. It's kind of a different issue, but it's interesting to see the federal government getting involved here. I was wondering what you see as the realistic picture. Is the federal government really looking to take over regulation of the small-group market from the NAIC and from the states?

MR. FLEISCHACKER: I need to have my crystal ball out on that one. Just thinking about all the problems in the health care industry, and looking at the direction and focus of many of the industry proposals and interest in small-group proposals, and the fact that at the federal level there's been a lot of pressure put on by special interest groups to do certain things to reform the whole area, and taking into account some of the problems that Joe mentioned regarding opinions within the industry, or the lack thereof as to making these reforms work, my own personal opinion is that sometime down the road, barring budget limitations, which is always a problem, I can see some form of national heath insurance, at least addressed to the small-group marketplace. I do not think the industry proposals are really going to solve the problems of the uninsured. They're going to continue to exist. With many of the proposals, the costs are going to continue to go up. That's just going to add to the uninsured problem. Unless somehow the federal government can just ignore that segment of our population, I think sooner or later it is going to have to do something about it.

MR. MORAN: I think the federal government would have been perfectly happy if the states had taken action by now to address this problem seriously and significantly. It is moving into a vacuum and it would be much happier if that vacuum didn't exist. But as long as it's there, it knows that the voters back home want something done about it and, if something has to be done about it, it will address it. I don't think there's an urgent campaign on the part of federal government people to supersede state regulation. They may be frustrated by what they see as ineffectiveness of state regulation of the insurance business in achieving reforms in this area, but I think that, if they had seen the states moving adequately to achieve results, they would not have jumped in as vigorously as they have.

MR. RICHARD H. DIAMOND: I have a question for Joe Moran regarding your criteria for a reinsurance mechanism, that it was to remove any disincentive for a carrier to solicit high-risk groups. One criticism that has been made of the HIAA proposal is that by removing that disincentive, it also removes any incentive to want to control claim costs.

MR. MORAN: That's not true.

MR. DIAMOND: Well, how do you respond to that criticism?

MR. MORAN: The assertion that there is no incentive to control claim costs in a mechanism that involves first-dollar reinsurance implies that the carrier actually has nothing to gain for its customers by doing an effective cost containment job -- that it gains nothing in the way of better products to market and better customer satisfaction. It assumes that financial penalties are the only way to create incentives. And that's a debatable assumption.

The usual way that this economy addresses the question of incentives for business firms is to create the opportunity to operate profitably, rather than to impose penalties. What you are saying is that the only way to achieve an incentive for the carriers to perform cost-containment services is to penalize them for having the business on which this cost-containment effort is to be exerted, whether or not they're successful. The carrier is penalized by a deductible and coinsurance on reinsured risks. The deductible and co-insurance are necessary to achieve a degree of cost containment that wouldn't exist otherwise.

MR. DIAMOND: In a situation where the risk is reinsured and the carrier is just paying the reinsurance premium, which is being passed on to the employer, I guess I don't see where the incentive is. If the insurer spends money on cost-containment activities, that cost is going to get passed on to the employer with no savings resulting. So if you are trying to keep the employer's cost down the best thing is to just pay the claims as they come in. Someone else is paying the bill anyway.

MR. MORAN: You're assuming that the carrier would single out the reinsured risks for different treatment from the mechanism that it's generally using for its claim administration on the great majority of the risks that it covers, using large-claim case management, utilization review and other devices; and that the carrier would be ornery and would shut off from access to its best cost-containment services the employer who happened to have a high-cost risk in the firm. That implies a degree of perverseness on the part of the insurance company people that is hard to visualize.

MR. DIAMOND: I guess I don't see where it would be perverse if they are trying to serve their client. That would be the way to keep the client's cost down.

MR. MORAN: How is the client's cost kept down? A set premium is charged for the risk, and the claim costs that the insurer bears might be diminished a little bit, or might not be, by forgoing a cost-containment effort or a case-management effort, or by forgoing utilization review. Presumably it has a contract that it is supposed to be administering universally that says that if the client does not go through its utilization review procedure, the client is paid $500 less than if it does go through the utilization review procedure. And you're saying for the insured to forgo that $500 penalty because the reinsurer would cover the $500 would be effective service to the customer? I don't get what you're driving at -- the gain that a carrier achieves by not doing its usual cost-containment efforts?

MR. DIAMOND: I think of the administrative cost savings.

MR. MORAN: The cost of the administrative function of performing the utilization review? The fee that the carrier pays the utilization review (UR) agency.

MR. DIAMOND: Some carriers offer coverage both with and without UR services.

MR. MORAN: The reinsured business has to be with UR in most of these proposals.

FROM THE FLOOR: In the modeling that you have done on the HIAA proposal, roughly what impact would this proposal have on the number of uninsured we currently have, if this proposal were to be adopted by all states?

MR. MORAN: I think there may be a misconception as to what elements have been modeled in the work that I've done. I have not directly addressed the question of what portion of the uninsured population is accounted for by noncovered employees of small businesses and their noncovered dependents. So I can't give you a direct answer to your question. One of the models in effect simulates underwriting actions with respect to a large number of small-employer groups. That simulation shows that about 92% of the working population (essentially ignoring the over-65 segment of the small-group working population) probably can get coverage today. They may account for about 85% of all the expected claim costs for all of the employees (and dependents) in the small-group population.

Alternative models come up with slightly different figures, but that's one that's been used in testing the impact of various reform proposals. But it doesn't address the question of how the reform proposal would stimulate employer action in a voluntary market, and particularly the question of participation among small employers in the marketplace before and after reform. How would nonparticipation be impacted by the fact that the price of coverage for low-cost employers would go up a little bit? So I don't have all the right answers for you.

FROM THE FLOOR: Paul, you noted that in several of the proposed bills, the carriers are limited as to what they can do in regard to risk status. I'm concerned about how Congress and eventually the state legislatures interpret the term *risk status*. Is that specifically outlined in the proposed legislation that you've seen?

MR. FLEISCHACKER: I've been looking at summaries of the various proposals, rather than going through them in detail. Most of them talk just in general terms about health status or risk status. I have assumed they meant any kind of underwriting that would take into account the health status or the risk status of the individuals. Most of them are more or less on a guarantee-issue basis, at least up to a certain size level. You can't take any health conditions into account, which means you basically can't ask any kind of health questions. In most situations that's what they're referring to.

FROM THE FLOOR: I had assumed that also, but you and I are actuaries. When I hear the term *risk status*, I think of Congress and various litigious groups looking at that term, and I imagine potential action whenever carriers rate on the basis of age, sex, industry, marital status. I can see all of those being interpreted by someone to mean risk status.

MR. FLEISCHACKER: Some proposals do allow some form of demographic-type rating, at least to a limited extent. All the ones that I reviewed, specifically state that they do not want the carriers to take into account the health or risk characteristics of the group, than these demographic-type factors that can be taken into account.