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SMALL GROUP REFORM

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Panelists:	JOHN PAUL GALLES*
	TED A. LYLE
	JAMES T. PARKER†
	JAMES H. SRITE
	WILLIAM J. THOMPSON
Recorder:	JANET M. CARSTENS

MS. JANET M. CARSTENS: The five panelists who spoke at the previous seminar will give a brief summary of their presentations. The panelists will provide five different perspectives of health care reform.

Our first speaker is Jim Parker. Jim is vice president of government relations for Community Mutual Insurance Company. His experience with Community Mutual Insurance Company, and with previous employers in a similar capacity, has allowed him to develop public policy expertise with health insurance. Jim is going to talk about legislative issues.

Our second speaker will be Jim Srite. Jim is vice president and group actuary at John Alden Life Insurance Company. He has served on several state committees responsible for designing the benefit plans required under small group reform legislation. Jim is going to give us a small group insurance company perspective.

Our next speaker will be John Paul Galles. John is the executive vice president of National Small Business United. He is the chief operating officer of the Association, and is responsible for the planning, implementation, and evaluation of policies and activities. He is a frequent speaker and is often quoted on special concerns of small business regarding health care. John is going to give us the employer perspective.

Our next speaker will be Bill Thompson, who directs the health consulting practice of the Hartford office of Milliman & Robertson. Bill consults to insurance companies, HMOs, Blue Cross and Blue Shield plans, employers, and regulators on a variety of health care issues. He has been active with small group reform initiatives in a number of states and has worked on reinsurance pools in Connecticut, North Carolina, Florida, Minnesota, and Massachusetts. Bill is going to give us the reinsurance perspective.

Our last speaker will be Ted Lyle. Ted is a vice president with Tillinghast and manager of the health care consulting practice in the Minneapolis office. Ted consults on all aspects of group life and individual and group health insurance products. He

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was involved in the legislative reform processes in Minnesota and Ohio, and has assisted clients with small group reform compliance issues. Ted will give us the compliance perspective.

MR. JAMES T. PARKER: As Jan mentioned, I approach the subject of small group reform from the viewpoint of someone who deals directly with the legislative and government relations processes. I will therefore give a perspective which may differ from that of someone dealing with implementation and methodology. I would like to summarize the reasons why, from the perspective of my company and many other insurers, our participation in the process of small group market reform has been extremely valuable.

Small group reform, in many ways, is a reflection of larger issues. It reflects unique issues associated with employer-based financing of health care, and since most individuals receive their health insurance coverage through their employer, two implications exist. First, employers face a continually changing employee base and a continually changing risk base. Their cost for health coverage will therefore vary from year to year, depending on the pool of employees that they have at any particular time. Second, as employees change employers with more and more frequency, the underwriting of individuals has become more and more prevalent.

The second larger issue that I think is important is that small group reform reveals a tension between two divergent approaches. The approach of the traditional insurer is to retain maximum flexibility in terms of underwriting and rating. The second approach is to view health benefits as simply a form of prepaid financing of health care services. It is probably fair to say that those of us who write in the small group market take the traditional insurance viewpoint. Those that we sell our products to, over time, have come to view small group products more as prepaid financing vehicles of health care services than as insurance products.

The third larger issue is that small group market reform has been very valuable in easing political tensions between competing ideological perspectives. On one extreme, we have those who strongly support rapid movement to a single-payor approach of delivering health care services to our population. On the other extreme there are those who believe in a free-market approach -- one that perhaps would not include a role for insurance as we know it today. Insurance would simply be relegated to covering those catastrophic events that people would not have the means to finance out-of-pocket. These two very different political ideological perspectives provide an opportunity for a great amount of political tension, which has been building rapidly over the last decade as the cost of health care coverage has increased. Small group market reform has filled the middle ground between those two extremes. Reform has allowed insurers, employers, consumer activists, and others to come to the table and discuss incremental steps that can be made to improve the small group market without clashing over larger issues.

Finally, small group reform has been primarily a state-level project. It has now been adopted in some 30-plus states, each of which has taken a uniquely different approach to implementing reform. This can be viewed as a hindrance to compliance for those carriers who operate in a number of states, but it can also be viewed as a valuable laboratory for policymakers. A great deal of thought has gone into the small

group reform process. Since we now have had it implemented in several states, we need to take the time to look at how it has been received in those states and determine what lessons can be learned from the various approaches. Perhaps what's most important is states have implemented small group reform in ways that fit the needs of their local communities and local populations. Has small group reform and our participation in that process been valuable? We think, absolutely, without question.

MR. JAMES H. SRITE: Our company specializes in small group products. We have approximately 150,000 groups in force, with an average case size of three lives. Therefore, when we talk about small group, we talk about our specialty. I have been with John Alden about three years now, and about 18 months ago, I made a very serious career mistake. My boss came to me and said, "You know, the NAIC recently adopted a small group rating and renewability model law, and I think it may become important to our business. Would you be interested in heading up our effort to implement the things we need to do to comply with state laws?" Being young and naive, I agreed and said, "Sure, that sounds like a lot of fun." At the time, I do not think any of us had any idea how quickly state laws would be enacted. Literally 18 months ago, there was one state that had passed some kind of reform, and as Jim mentioned, today more than 30 states have passed laws. Several of those states have already implemented their second round of reform, in some cases before the first round has really begun.

I will summarize the implementation and competitive issues surrounding small group reform. So far, the implementation has not had a dramatic effect on our business. I think that can vary, depending on the situation at your company. Our biggest cost so far has been an opportunity cost. I estimate that we have spent approximately 50,000 man-hours trying to comply with these laws. We have done so without severely impacting our business, but it has interfered with developing products and providing other services to our customers. This is very frustrating because, when you are implementing these changes, you know that most of what you are doing will probably not be applicable next year because these laws are changing so quickly. The majority of our experience to date is with the NAIC-type laws that typically have rating restrictions, with which you are probably familiar, and guaranteed issue requirements for special plans only.

One of the most frustrating things we have found in dealing with implementation of health care reform laws has been the timing of the different provisions. It is very typical to have a law become effective, and then about a year later, have the regulations come out that tell you how you are supposed to implement that law. The regulations may differ from your original interpretation of the law. Many of the laws also have various phase-in provisions. You can therefore choose to do things in a measured approach, or you can take things into compliance with the law immediately.

From a company's perspective, there are approximately five main areas that are affected by implementation. The first area is rating. The new rating restrictions often require you to develop new rates. We now have to file and certify to rates that we, in most cases, did not have to previously file or certify.

Our next area is underwriting. Underwriting has changed from a risk-selection process to a risk-direction process. Currently, we have to take almost all risks under one of our plans. The issue becomes whether we take those risks in our regular plan, take them with a load, or put them in a special plan. Underwriting is changing a great deal, and might continue to change to the point where underwriting, as we know it, may go away altogether.

Probably the area most affected so far has been the systems area. In our case, with 150,000 groups in force, it is not possible to use a manual process. We must have a systematic approach to be able to comply with these laws. Certainly, the rating requirements cause you to make changes to your systems since you have to track who has reinsurance, and you might need to double adjudicate the claims -- once for the purpose of benefit payment and once for the purpose of reinsurance reimbursement.

The next area affected by implementation that may be the only one that rivals the systems area, is forms and contracts. The majority of health care reform legislation requires that special plans be offered which implies that you need to develop new contract forms and file the forms with the states. Typically, the states are requiring more information: a description of how our rating practices work, a form that makes the employer aware of the availability of special plans, and many other forms that have to be completed, usually filed with the state, and approved. The one good thing in this area, so far, has been that states seem to be fairly proactive in responding to the filings and have been trying to review the forms promptly.

The last area that is really affected is the marketing area. I would say the key points here are education and communication. It can be a big competitive advantage to be familiar with health care reform legislation, to be supportive of these laws, and to be informed so that you can communicate to your agents and brokers.

From the standpoint of implementation, we found that while it is a big chore, it is possible to come up with an approach that will work for most of the current state legislation. It may be more difficult to be in the game in the future with the advent of health care purchasing cooperatives and other relatively new concepts.

From the standpoint of competition, we believe the competitive environment is shifting dramatically. In the past, competition was based on risk selection, unique techniques and product differentiation. In the future, we believe competition will be based more on service and a company's reputation, particularly as we move toward health care purchasing cooperatives, where the employee is merely looking at a booklet and choosing between plans. If employees are not familiar with your company's name, you may not be chosen. We also believe that knowledge and support of the laws are important.

With respect to new entrants to the market, there are some things that would encourage entry: the playing field is being leveled somewhat, and there is more standardization. However, I believe that the onslaught of legislation and the uncertainty surrounding the environment will mean there will be fewer new entrants to the market. This could serve to stabilize the market compared with what it has been in the past.

In closing, I would say that health care reform legislation has provided some good benefits. Some of the abusive rating practices have been eliminated, and companies, agents, and the public have been made more aware of changes that we might need to make as an industry and as a country. From that standpoint, I think the legislation has been positive. It has been a challenge for the insurers, and I think will continue to be a challenge for the next two to three years.

MR. JOHN PAUL GALLES: I will provide you with some feedback on what employers are feeling about health care reform. Health care reform has been the number one issue of our organization for the past six years. We are anxious for reform, for improved access and cost control, and for a little more clout in a system that delivers very little clout to the small business community. Our health care system has become so segmented that small businesses have been trapped by the barrage of laws, mandated benefits, requirements and regulations that all of you have to live with every day. To a large degree, small businesses have blamed the health insurance community for the problem. They are not aware of all of the rules and regulations you have to live with. They have heard about actuaries, but they do not know who they are.

The advent of health care reform will bring you much closer to small business owners and their employees. The use of the term "managed care" suggests that you may have to help small business employers obtain more knowledge about the health care they are purchasing, the benefits they are receiving, the cost of their claims, and the difference in claim expense that might exist from one community to the next.

Small business owners have reacted to health care reform in a number of different ways. Some employers are angry about the kinds of coverage they have been provided with, premiums that have skyrocketed, and with employees who cannot get coverage. These employers are trying to hire talented people, who will help them produce a profit from the goods or services they provide within a given marketplace. They look to insurers to help them provide health care coverage. They are frustrated with the system today: frustrated with preexisting condition limitations, lack of portable coverage, and with many of the underwriting practices. They support the elimination of preexisting condition limitations. They also support some change in the way rating provisions apply to them since they have been buffeted by companies literally buying their business with a very low premium rate, and then raising that premium over the next six months to two years by percentages that range from 25-80%.

Small business owners also are frustrated that they have to pay premiums that are 40% higher than those of larger employers. Think about the segmented marketplace that has been created. Of the $900 billion we are supposedly spending on health care, nearly 40% is absorbed or provided by state and federal governments through Medicare and Medicaid. Another 30% of the marketplace is self-insured and is supposedly managing its own costs. The remaining 30% is the small group and individual market. A lot of the individuals are going without health care coverage, and many of these individuals are small business owners as well. Of the 20 million business entities in the United States, nearly 15.5 million are sole proprietorships, independent contractors, or consultants. Some of them are trying to find coverage and simply cannot. A lot of reform legislation is crafted for small groups that are

2 to 25 or 3 to 50 lives. Neither one of those definitions includes those very small businesses consisting of independent contractors or sole proprietorships. We seek a leveling of the playing field in a number of ways, but one way in particular is that we want those people who purchase health care on their own, or through their businesses, to get a full deduction in the same way that corporate entities are given that deduction. Sole proprietors have been limited to a 25% deduction for quite some time.

We believe it is time for small businesses, for the segments of small business, to come together, and we are anxious for the opportunity to create health care purchasing cooperatives. We are anxious to form partnerships with insurance providers, HMOs, PPOs, hospital groups, and accredited health care plans that will be licensed under the new reform system we expect to occur.

There is a timetable for all of this. We hope there will be some health care reform legislation by spring of 1994. We think that this will be the most important challenge of the Clinton administration. Frankly, we are concerned that if health care reform does not occur, we may see even more government interaction and maybe a Canadian-style system. We must be successful in meeting the challenge that faces us in the short term.

MR. WILLIAM J. THOMPSON: I will briefly review some of the topics we discussed at the seminar with regard to reinsurance pools. The basic objective of a reinsurance pool is to help carriers manage the costs of some of the new high-risk individuals that are going to be covered under the guaranteed issue requirements of many of the small group reform laws. The carrier is able to transfer some of the cost of these high-risk individuals into a pool. In some situations, it may enable carriers to stay in the market if they might otherwise have considered exiting the market because they were concerned about the extra risks they were receiving.

Under the NAIC model, one of the initial decisions a carrier has to make is whether to be a risk-assuming or a reinsuring carrier. Compare the differences. First of all, whichever decision you make has no affect on your obligation to provide coverage to all eligible small groups if you are going to stay in the small employer market. It does affect how much risk you are going to take for these groups. If you retain 100% of the risk, you are not playing in the reinsurance pools, and you are a risk-assuming carrier. If you are a reinsuring carrier, you can reinsure individuals or you can reinsure entire groups to the pool. Reinsuring carriers would be liable for any additional assessments that are charged against the pool due to experience being worse than anticipated, administrative costs that were not covered in the rates, or other additional costs. I believe it is Florida that charges some assessment to the risk assuming carriers, so you may not get away from assessments entirely. As a reinsuring carrier, you have a new layer of underwriting that comes from a decision on whether to cede a risk (an individual or a group) to the pool. The introduction of the reinsurance pools has created new underwriting departments in some companies that had not previously done much underwriting, so the company can manage their block of business.

There are a number of issues that a company should consider when deciding whether to be a risk assuming or a reinsuring carrier. The list of issues includes: the size of

the market in a particular state; your market share; the quality of your business with respect to the producers you have in the state; whether you have a good managed care network operating in the state (so that you believe you already have a good control of the risk and do not need to reinsure much of it); and, what sort of rating restrictions a state allows or prohibits. In a state with community rating where you cannot do much of anything in terms of adjusting for higher-risk groups, you may want to consider reinsurance more than you would in a state where you can recognize more of the risk characteristics of a particular group. How the assessment formula works – do you expect high assessments or modest assessments – might also have an effect on your decision.

Reinsurance pools identify certain standard statutory plans into which all lives are reinsured. You may sell a group a benefit plan that is not the same as the statutory plan. When it comes time to pay a claim, you pay benefits under the plan that you have sold. When it comes time to decide whether you have any reinsurance recoveries coming, you determine those based on the statutory plan. You, therefore, have to effectively pay the claim twice, once to make the benefit payment and once to determine if you have any recoveries and the value of the recoveries. Double claim adjudication can be a major problem for some carriers that are reinsuring. Connecticut has adopted a rule that allows the use of a formula to estimate the effect of the difference between plan benefits to avoid the actual double adjudication. The formula uses a series of factors and it is a creative exercise for some of us.

Underwriting for reinsurance raises a new set of questions. How do I decide whether to reinsure an individual or a group? What sort of conditions should I reinsure? Do I reinsure an individual who came in with a heart condition, and last year had a successful open-heart surgery, and is now actively back at work on medication and doing well? This person may have had $50,000 or $100,000 worth of claims last year, but is he still a high risk? It may be that this is not the type of risk you need to cede. Underwriting needs to be creative with respect to deciding who will be the high-risk people next year, and over the next couple of years. Establishing your underwriting rules is an important decision. You also need to establish a monitoring mechanism within your organization to be able to track whether or not you are doing an effective job.

A decision also needs to be made on how to pass the reinsurance costs back to the employer groups. If you operate in a state that requires community rating, all your expected reinsurance costs become part of your general expense of doing business, and everybody pays. If you operate in a state that allows rating bands, you are able to reflect experience to some extent. You can, therefore, pass some or all of the reinsurance costs back to the employer through the premium rates. However, there are some portions of the reinsurance costs that you will not be able to pass along to employers, and you need to recognize those as well. The extra administrative expense associated with dealing with a reinsurance pool will be affected by specific state requirements.

At the end of the year, if the reinsurance pool lost money, there will be assessments charged back to various companies. If you expect there are going to be assessments, they will typically be charged back based on your total small group premiums. This is an additional cost that you may need to factor into your rating structure. The effect

of some of these reinsurance pools seems to be to raise premium levels for small groups by approximately 5%, which is the NAIC cap on assessments. Some companies have figured that they will be charged this extra assessment or even more.

When trying to determine how successful you are in ceding risks to the pool versus everybody else who is ceding risks, you need to look at your company's loss ratio. Compare your reinsurance recoveries to the premiums that you have paid to the pool and compare that to the average pool loss ratio. If you have a higher loss ratio, you beat the system. If you have to pay a high assessment, your experience was probably better than average, so there is antiselection operating. No matter where the reinsurance premiums are set, companies will try to beat the system.

MR. TED A. LYLE: I spoke yesterday on the development of acceptable rating strategies and the preparation of actuarial certifications under small group reform legislation. One of the issues we have encountered is that virtually every state has put their own twist into the legislation they are enacting, which makes it very difficult to put together something that works everywhere. We have found that you can start out looking at things on an overall basis. If you look at a piece of reform legislation, you can estimate the cost associated with the particular guaranteed issue rules, the limitations on preexisting conditions, and the prohibition of condition exclusion riders. Then, you can estimate the effect of the limits on your ability to vary rates by group. You can perform an overall analysis to determine the impact on your total costs. From there, you can develop a rating strategy that looks at the specific rating variables allowed within each state. In most states, there is some degree of commonality in the items being required. For example, condition exclusion riders are almost uniformly prohibited, and we see very similar requirements with regard to limits on pre-existing conditions.

The key in determining acceptable rating strategies is to determine what sort of rating variables are still allowed in any particular state. Once we determine allowable case characteristics, other rating variables that are allowed in the rate spread, and what sort of spread is allowed, we can then put together a rating formula based on this information. In many states, we are still allowed to vary our rates by age, sex, contract type, geographic area, industry, benefit plan, provider panel, health status, duration, experience, and group size. A number of these rating variables are traditional rating variables that we can continue to use. We hit some variances by state in terms of what is allowed in case characteristics as opposed to what is allowed in the rate spread.

There are quite a few variations in terms of what rate spread is allowed. We also are seeing a trend towards a narrowing of the rate spread. Many reform packages have transition rules to accomplish this narrowing. California, for instance, which on implementation will allow a plus or minus 20% spread, I believe reduces this spread to 10% in 1996. In spite of the differences arising with state-by-state variations, you end up with a philosophical issue to address. If you are looking for the maximum flexibility on a state-by-state basis, you are going to have very different rating requirements for every state that you are operating in. On the other hand, if you are looking for commonality and not necessarily to walk the line of what is legally allowed in every state, you can, for the most part, come up with a limited number of basic rating strategies that will allow you to operate nationwide.

Disclosure statements can have a very onerous impact, since we now have to disclose as part of the sale process, in almost all instances, what the renewal rating practices are going to be. This may affect you if, for example, you are doing something less restrictive than the law allows with your renewal rating. For example, I drafted a disclosure statement last fall for a client in Florida. The rating requirements under their old law (they have just passed a re-reform) allowed a spread of plus or minus 20%. In this particular instance, we were using a tier rating approach. Basically, the rating intent was that on renewal we would be giving groups a trend increase, plus a rate change for changes in demographics, plus 5% on each of the first two durations, which is less onerous than the law allows. The client intended to draft its disclosure statement to follow its intended rating practices. After some discussions, the client decided to draft its disclosure statement saying its renewal practices were to give groups a trend increase, plus a rate change for demographic changes, plus up to a 15% increase on renewal. This was more onerous than the intent, but was what the law allowed. This put the client at a slight disadvantage, because it had higher going-in rates than it would have had if it used it's actual renewal rating practice. In other words, this client was putting something more onerous in its disclosure statement than what it actually intended to do. However, this gave the client an option to put in a corrective action if it ever ran into a rating problem. This provided wiggle room at the expense of the marketability of the new business rates. One of the things disclosure statements will do is tie you down to what you will be allowed to do with your renewal rates. If you are doing something less restrictive than the law allows, and you state that in your disclosure statement, you will probably be confined to those renewal rating practices. This affects the drafting of those statements.

There are a number of issues related to the preparation of actuarial certifications. It is difficult to put a certification together and feel absolutely certain you have done everything that you should be doing. Quite often, when we read either the statutes or the regulations dealing with certifications, there is something that says the certification relates to this paragraph or subsection of a law. When you read the subsection, it infers the certification relates to the entire article or act. It also is unclear exactly to what you may be certifying. In some cases, the certification is dealing with compliance with the rating and underwriting standards. In other instances, you might be certifying to meeting minimum loss-ratio standards, that the disclosure requirements have been met, that the preexisting condition provisions are correct in the underwriting requirement, or that all of the home office documentation requirements have been met. I am very comfortable with the state regulating or legislating that a company has to comply with these items. However, I am not quite sure they necessarily belong in an actuarial certification. Nonetheless, we do have states that include these items with the preparation of an actuarial certification. In the states that do include these requirements, you have to go through the regulations very closely to satisfy yourself that you are in compliance.

There are a number of smaller issues that may come up with respect to compliance. Again, I will use Florida as an example. As part of their actuarial certifications that were due March 1, Florida required that you identify any groups that did not fall within the rate bands. I had at least one client who could not identify those groups because it had not historically tracked employer size. The client potentially had some groups that fell outside of these bands, but they could not identify them. We then

had to decide whether to issue a qualified opinion. To our reading, Florida law does not really make provisions for giving qualified opinions. We convinced ourselves that we could put in our certification that the company could not identify those groups; but that they in fact had a plan in place (which they did) to identify those groups and to make sure they were brought into compliance within the transition period. We felt that by disclosing this in our certification we were not giving a qualified opinion. The end result is that there are a number of very serious professional questions that must be answered when putting these certifications together.

MR. JAMES T. PARKER: Since none of us can be really certain what is going on in Washington, I will not spend a lot of time discussing it. First, I think it is clear that, conceptually, the theoretical idea of managed competition has clearly won the political middle ground. Policy leaders, the administration, and the leadership of Congress, for the most part (with some exceptions), have agreed to managed competition. What does that mean?

Part of the problem with managed competition is that it means different things to different people. For those who come from a private sector, free-market stance, it still means competition; we are just letting the regulators tinker with it a little bit. For those who come from a single-payor perspective, it means we are basically going to inch closer to single payor; we are just going to let the competitive types think that they are still in the game. As you can see, that is perhaps the attractiveness of managed competition. It represents a political victory to a lot of different camps.

There are a number of key issues that will attach to whatever proposal the aministration delivers to Congress. It is clear the proposal will include a National Health Board which will have a variety of functions. The Health Board will include those dedicated to directing policy at the national level and creating a mechanism through which data can be established and retrieved on the health care delivery system; this includes that policymakers feel is extremely lacking at this point. The Health Board also will act as a national vehicle for discussing issues as they arise in the future. Perhaps most key to the concept of managed competition are health care purchasing cooperatives, and accountable health plans. Let me talk first about accountable health plans.

It is clear that under the proposal there will be an attempt to standardize, to a great degree, the requirements for carriers who seek to participate in the system in the future. Perhaps some of these requirements can be viewed as an outgrowth of small group market reform, and simply a standardization of the reforms that have taken place to this point. They will almost be guaranteed to include a requirement of guaranteed issue, extreme limitations on the use of preexisting condition limitations (if limitations are allowed at all), tight rating parameters (if not community rating), and other associated issues that deal with carrier performance. Measurements of quality, perceptions of customer satisfaction, the degree to which a carrier can electronically process claims, the degree to which carriers have contractual arrangements with their providers that are viewed as minimum and adequate will all be issues that will cumulatively determine whether or not a carrier is qualified as an accountable health plan.

The health care purchasing cooperative is perhaps the one area where there is the most interest, and the most in the way of unanswered questions. It appears that health care purchasing cooperatives will exist in every state, with at least one per state. States that wish to establish more than one cooperative will be able to do so. The Clinton proposal may require the establishment of a health care purchasing cooperative, but leave the questions as to the number of cooperatives, their competitive nature, and the governance of the cooperatives and under what scenarios, to state legislatures. This may be one of the most crucial ways that the administration allows for state flexibility in the development of their own health policy.

Another important issue deals with standardization of benefits. There will, in all likelihood, be a minimum benefit which will perhaps be more akin to an average or rich benefit plan in today's market.

The key to the success of this program is its ability to extract cost savings, not only on behalf of employers, but on behalf of the federal and state governments who, as John mentioned earlier, represent 40% of the consumption, or financing of health care. Cost savings are crucial in order to expand access to those who do not have prepaid coverage in today's market, those 37-40 million uninsured. How those cost savings are achieved is still an open question. One of the ideas under consideration is price controls of a limited duration, such as 18-24 months. Whether these price controls will require that all payors simply continue to pay the same prices they do for services today for the next 18 months, or whether the entire system goes to something like a Medicare fee schedule, is probably still an open question. Once price controls are in place, however, the government will need some way of extracting those savings from the private payors. Options under consideration include a premium tax on premiums paid by employers, a cap on premiums charged by carriers, and a variety of other taxes such as sin taxes, adjustments to income tax, and so on. I think it is fair to say that all of those alternatives are still under consideration.

It is only part of the picture to speculate on what the administration may propose. It is quite another to speculate on what the administration will be able to propose and successfully engineer through Congress. What are the political land mines that the administration can expect? First and foremost may be the reaction to this proposal by the small business community. Managed competition has the ability to completely redirect almost every existing relationship within the health care delivery and financing market. How small business responds to these changes will be key in terms of their continued ability to select coverage on behalf of their employees, the flexibility they are given within the new health care purchasing cooperative environment, and perhaps most importantly, the manner in which they are taxed or assessed for any expansion of coverage.

Finally, it is important to recognize the timing of the proposal and the speed with which it moves through Congress. If the Administration is able to achieve significant activity on the proposal by the end of this year towards an enactment date of early next year, that will be viewed as very positive for their prospects. If, on the other hand, deliberation on the proposal extends through next summer, and into the 1994 Congressional campaign elections, its prospects for enactment next year are very much reduced. The Democrats in the U.S. Senate believe they have more incumbents who are vulnerable to defeat than the Republicans, as do the Democrats

in the House of Representatives. It is, therefore, important not to discount the political factors that will come into play once the proposal is submitted to the Congress.

MS. CARSTENS: We want to open the floor to questions now.

MR. JOSEPH W. MORAN: I am a little uncomfortable about the absence of any presentation on what I perceive to be the big-picture perspective. First, I believe it may be appropriate for any or all of the panelists to comment on my observation that the structure of small group reform at the state level has failed to be consistent with small group reform objectives. I believe the primary objective is to enhance access to coverage, and to stimulate carriers to make coverage more accessible by requiring them to do so. Yet none of the statutory enactments to date create incentives for carriers to effectively expand the pervasiveness of coverage among high-cost risks who are now uninsured. As a matter of fact, all of the statutes impose penalties on the carriers that do the best job of increasing their penetration of high-cost risks in the marketplace, or increasing their share of high-cost risks in their portfolio. The penalties are in the form of assessments and nonreinsured claim costs for high-cost risks. This requires the carriers to add surcharges to their prices for their other customers. No regulators participated in the seminar, which I thought was quite conspicuous, since we are talking about reform by state regulators. I would like to know the potential impact of this absence and the likely aggravation of an already-existing adversarial relationship between regulators and carriers.

MR. SRITE: A lot of your comments are correct; there has not been a tremendous impact on access. The biggest impediment to access is cost, not the availability of coverage. We can focus on either the negatives of what has happened so far, or on the positives. From the positive standpoint, we have cleaned up our rating practices somewhat. We also have increased portability through the preexisting condition and takeover provisions that are in the new laws. We have, therefore, increased access in terms of providing coverage to new employees of a group. There are even a few groups that were not being accepted before but are now being accepted. This does not mean there has been complete success, or even mostly success, but I believe that is where we are headed next. We have increased awareness to the point where we are ready for whatever comes next. It is the next round of reform that maybe addresses the issues you are talking about.

MR. LYLE: I agree that very little has been done through existing small group reform legislation to enhance access. Many of the people who are uninsured drop coverage because of cost issues. There is not much in the reform packages that addresses the affordability of coverage. It is politically very easy to impose some requirements on the insurance community to guarantee access. However, if you want to expand access by using a tax subsidy, through a tax on providers or another form of taxation, you run into political problems since redistributing the monies around the system creates an overwhelming number of political issues. To some extent, it is not only the insurance community, but also the type of laws that have been enacted to date. I believe one of the reasons we are seeing reform on top of reform is because the early readings show that we have not done anything to effectively enhance coverage or expand the level of coverage.

MS. CARSTENS: Regarding your comment, Joe, on the omission of a regulator, we wanted to maintain a broad perspective to accommodate the people in the audience. We believed a regulator's perspective may have been too state-specific.

MR. GALLES: There are likely to be incentives in the new system for all to move to capitated rates, and away from the fee-for-service system. There also will be an opportunity for more state experimentation, so we have only just begun to see changes within states. The remark about the only way you can substantially improve access is to get costs back down to where people can afford them is appropriate. The small business community in particular is anxious to see an end to some of the cost shifting that has gone on. Unfortunately, small businesses also are reluctant to pay more taxes. Unless the federal and state governments do a better job of paying for the elderly and the poor, there will continue to be different levels of pricing and shifts from one community to another. Undoubtedly there will be an attempt at short-term cost containment that might include price controls. It is likely to include budgeting processes, which may engage providers and payors within local communities to address costs within hospitals, physician groups, and systems that exist and can be confronted. There is a real need to address duplication of services, over specialization, and the excess hospital beds that are present within the current system.

MR. J. MARTIN DICKLER: In New Jersey's neighboring state of New York, we already have community rating of small groups. Several companies have withdrawn. New York has a rather faulty reinsurance system to take care of the guaranteed issue risk. My projection is that, within a short period of time, we could be very close to a one-payor system in New York. I am just wondering whether or not Mr. Parker's prediction will come true, and that health care purchasing cooperatives will also lead us to a single-payor system.

MR. PARKER: I certainly do not think that is the intent of the health care purchasing cooperatives, but I think your assessment of New York is accurate. It would almost be fair to say that the intent of the New York legislation was to drive carriers out of the market in favor of movement towards a single-payor approach. This will be one of the implementation issues facing either Congress or the states, if they are given the authority to decide on whether the cooperatives will be available to accountable health plans; i.e. whether or not a cooperative can selectively choose the plans it seeks to do business with, or whether it must accept any carrier who is willing to offer coverage to those health care purchasing cooperatives. Community rating, in its most severe form, taken outside of the context of some other significant reforms, such as a move to capitation and increases in our ability to effectively manage utilization, has to be a concern for any carrier, other than the very largest.

MR. GALLES: We have had a number of our members in New York learn that, under these new community-rated systems and the guaranteed issue program, they do not need to provide coverage until coverage is really needed. They simply choose not to participate in the system until it becomes advantageous for them to do so. One of the problems I think New York is experiencing, and one that I hope we do not experience on a federal level, is that reforms have been implemented incrementally rather than applied to the overall system at the same time. No wonder many commercial insurers choose not to participate in that system at this time. Small

employers are angry about the premium increases and the fact that the cost of health care is higher than ever before.

MR. LYLE: The New York legislation not only serves to drive commercial carriers out, but it also serves to drag HMOs in. Regardless of how restrictive the requirements are for commercial carriers at this point, they are more restrictive for the HMOs that have not been major players in that market. There is some allowance for a preexisting condition provision in New York that is not applicable to HMOs. I mean, they truly have developed a system whereby you, in essence, do not have to purchase coverage until you are in the ambulance.

MR. SRITE: I think the question of whether we end up with a single-payor system or not has to do with how the different parties to the system react. If each party fights reform and does not try to make it work, then maybe we will end up with a single-payor system. The American people value choice. A single-payor system, by its nature, would limit choice to a great degree. The question is whether they will get fed up enough to be willing to give up that choice.

MR. S. MICHAEL MCLAUGHLIN: The first speaker, Jim Parker, commented that small group reform in 30-plus states was something of a laboratory experiment, and, if we observed what happened in the different states, we might learn a few lessons. I used to think that as well, but I believe that is perhaps an optimistic view, partly because of the pace of federal health care reform. Reform will be over before the results of the laboratory tests are in and I question whether anybody is even watching. Joe Moran raised the question regarding whether group reform was accomplishing some of what it was intended to accomplish, such as universality of access and lower cost. I wonder whether anyone on the federal health care reform task force has observed what is going on in small group reform, or any of the other phenomena happening with health care. Are you aware of anyone on the task force asking questions of regulators, employers or anyone?

MR. GALLES: One of the members of the task force is Gary Claxton, who has been with the NAIC. He may be one avenue through which regulators can provide input. We all need to remember that, before President Clinton became President, he was a Governor. He is very attentive to states and the need for state flexibility. In the San Diego paper, there was a story that quoted one of the architects of this managed care system who said that they expect a lot more experimentation within states. They believe they are just now beginning to learn from some of these programs, and there is a lot that we have to learn. They are suggesting that a state may still set up a Canadian-style system within its borders. This frustrates me, because of the businesses that are my members and do business in many states. They are having a hard time complying with the current reforms and it is going to be even tougher in the future. While the Task Force has been somewhat closed, this is just the beginning of the process. There is a long way to go and there will be lots of debate and lots of input.

MS. CARSTENS: One comment I will add is that regardless of whether or not the government is looking at what the states are doing, many states have done something. Even though there are now 30 states that have implemented some kind of small group reform legislation, there are very few results available to review. If

states do have results, they are very limited because everything is happening so quickly.

MR. THOMPSON: The federal government is definitely watching what the states are doing. The fact that so many states have implemented changes over the past few years is definitely going to influence the direction of the Clinton Task Force and there likely will be a more significant role for the states; a greater role than would have existed if all of this reform had not taken place. Even though there are a lot of bugs to be worked out, there are multiple state approaches out there. None of them really get down to the cost issue, but they are all looking at different things. The things I see coming out of the Clinton Task Force seem to be eroding some of the basic precepts. In the short run, there will be some general directives and influences that will put more of the burden back on the states. It will be a long process before anything really happens at the national level, which will put more emphasis on the state initiatives.

MS. CAROL J. MCCALL: I would like to add, in response to the question of whether or not President Clinton was paying attention to what was going on in the states, that I believe there has been some attention paid to what has been going on in California with the health care purchasing cooperatives. I know of several meetings that have taken place. I have a couple of questions for Mr. Parker regarding what may happen on a federal level. First, do you see large employers being swept in, or do you think there will still be an outside market for large employers? The second question is, do you think mandatory participation within a health care purchasing cooperative will be required for small employers, or will there still be voluntary choice and an outside market?

MR. PARKER: You have identified two of the crucial questions for the employer community. I have heard with varying degrees of reliability that employers of up to 100 lives may be required to purchase their coverage through a health care purchasing cooperative. I also have heard that this may be extended to employers of up to 10,000 lives. That is a key issue that may determine the employer community's ultimate support or opposition to the proposal. I have to think that the Administration will come in closer to 100 than 10,000. I have to think that the question of mandatory participation, or whether or not there can be multiple or competing health care purchasing cooperatives, may be a question that is more likely left to the states. The federal question may be whether or not there are health care purchasing cooperatives, either immediately or in the near term.

MS. MCCALL: Do you think that issue would be impacted by, say, the amount of rural area in a state? Addressing coverage for rural areas really is a problem, and different states will have a different solution.

MR. PARKER: That is another very important issue. Sixty to seventy percent of the country does not live near a metropolitan area that is a convenient vehicle for a health care purchasing cooperative.

MR. KEVIN M. DOLSKY: My comments relate to the disclosure portions of small group reform legislation, and I am setting aside for a minute the good point that Mr. McLaughlin made, that this may all be disposed of by the pace of federal reform.

Just looking at the NAIC-type reform that has been enacted, I see the disclosure part as being greatly underestimated. If there was adequate disclosure in the marketplace, some of the most onerous parts of small group rating would have been flushed out by the market, when people realized what happened when someone got sick in their group. Even though we have NAIC-type rating reforms which include disclosure, and basically codify some type of tier rating, we decided to expand on our disclosure and offer a couple of different types of rates in the marketplace. One is a nondurational rate that would begin higher, but, within the disclosure, we would say we are not going to raise rates as much at renewal. One of the things we found is that most employers are choosing to buy the higher start-up rate with the better guarantees and the disclosure about how the renewal rates will be calculated, as opposed to a durational rate which will be adjusted within the NAIC bands. When we talk about small group reform, we mainly talk about the rating and the access with very few comments about the disclosure. I do not know if others share that view.

MR. LYLE: I think these are all issues that we end up having to address in the financial statements that we prepare. I would be interested to know if anyone did a Section 8 opinion this last year, and whether they made any provision for these sorts of issues.

MR. THOMAS X. LONERGAN: I cannot answer your question directly, but I will give a little analogy. What is being talked about for health insurance was done for auto insurance years ago. It seems like the right for people to have auto insurance has taken priority over their right to have health insurance, which tells you a little bit about our society. One of the things a lot of property and casualty insurance companies have done is to reserve for future assessments from reinsurance pools. Whether you are ceding or not to reinsurance pools, if you expect to get an assessment based on your market share in previous years, you should be reserving for it. That is just an example of something that should be thought about when you put together your statutory reserves. The assessments could be significant, especially for companies like John Alden that write primarily in that market. I would like to ask a question of Mr. Srite regarding medium to small companies that are writing primarily in the small group market. How are they going to cope under a managed-competition-type arrangement? I work for a large company, and we currently have a number of HMOs and PPOs. How is a small- or a medium-sized company going to adapt to that kind of environment?

MR. SRITE: Actually, we have had five of our top executives spending the last three months trying to answer that exact question. We are a medium-sized company, but in the under-ten market, we may be the largest company in the country. The people in California seem to be interested in listening to carriers that have that unique perspective on the small business market. Obviously, the game is going to be much more local, and it will be much more difficult to have a national focus in the future. We have not gotten out of any markets yet, but it would be silly to think that any of us, even at CIGNA, are going to be able to stay in every market. So I think it is a question of recognizing the strengths that you have, and maybe a unique strength in the small group market, and then capitalizing on those strengths in selected areas.

MS. CARSTENS: An additional comment I will make is that I was involved in helping to determine the financial effects of continuing in the small group market in a state

which implemented some fairly radical reform. It is very difficult to model what the competition may do, with respect to staying in the market, and what your ending block of business will look like. It would be helpful if there were some guidelines, but obviously modeling assumptions can vary significantly, depending on what the state is doing.

MR. RICHARD W. HILL: My question has to do with the producers. Under the health care purchasing cooperative environment, the greatest savings will be reduced distribution costs. We are already seeing a lot of activity on the part of producer organizations, and they are going to be very anti-health care purchasing cooperative. What are your views on any possible role for producers in the future?

MS. CARSTENS: Let's take a response from the audience first.

MS. MCCALL: We did some focus groups of small employers and agents in California. There seemed to be, in both arenas, and particularly in the agent arena, a lot of misinformation about the health care purchasing cooperatives. We found that the small employers believe the agents add value to the whole process, and that agents are needed for communication and education. Once the agents in the focus groups understood that, they were much more in favor of the health care purchasing cooperatives, and were happy to hear that the employers were planning on using them in the majority of cases.

MR. SRITE: Small businesses, unlike larger businesses, do not have a benefits manager or a person really knowledgeable on the issues. These small businesses are usually mom-and-pop businesses with two to five employees. I agree that the agents help. In the future though, it will be up to the agents to prove they are adding value. In California, employers sign a form stating that the agent helped them select their plan and the agent is compensated for that. We believe the agent is a valuable part of the system, but it will be up to the agent to show and prove that value in the future.

MR. LYLE: I agree that it will be up to the agents to show their value. I was sitting through a presentation about a week ago, and the presenter had a slide, which was essentially a draft similar to the California purchasing group. It was subheaded, "Where's the agent in this picture?" That provides you with another opinion.

MR. HOBSON D. CARROLL: I would submit that we are not making a lot of inroads into the "uninsured population" or the people who lack insurance (I do not like to use the word access, because I think most people have access). Some of the people who do not have coverage believe that affordable health care means $20 a month. They do not want to pay for the true cost of coverage.

The second point addresses managed competition. It seems to me that many of the elements of managed competition are already in place in most of the metropolitan areas. I understand the problems with the rural areas. If you went to mandated coverage, in any of its various forms, where people had to be in the system, and you knew you were going to have the whole pool, the health care purchasing cooperatives represent glorified forms of Multiple Employer Welfare Associations (MEWAs). One of the problems with MEWAs is that people get in and out when they need

coverage, or when the rate goes up. If you had contractual limits with regard to minimum coverage requirements, you could basically extend a lot of state MEWA legislation to these health care purchasing cooperatives. I guarantee there would be agents selling them insurance, whether they would be accountable health plans (AHPs) or regular insurers or whatever.

My concern with some of the current legislation is whether anyone talks to these people in Washington, shakes them by the collar, and points out the reality of the situation to them. If you get to a point where you only have one or two in a state, and all employers below 100 lives have to be in there, you either have a monopoly or an oligopoly, at best. This will stifle innovation and service, prevent competition, and will not necessarily contain costs. We can have a lot of the positives from managed competition without necessarily going to a one-payor or three-payor system.

MR. GALLES: You are absolutely right. At the same time, there needs to be a system for blending public support for health care with private support for health care. There is no real avenue for that to happen in a way that serves our interests in the process. We are hoping that health care purchasing cooperatives will not only seek out carriers to deliver care to employers and employees, but that they will also engage the health care system and the providers within their communities to confront some of the costs. No matter how many health care purchasing cooperatives there are in a community, there will likely be more public support going through those systems to providers. Management of that system will be a very complex problem. Our concern as an employer organization, if this country or if states are going to require employer participation in these entities, is that we at least have some governing authority over them and the way they operate.

MR. MORAN: I would like to turn from politics back to professional actuarial activity for a moment. Has anyone addressed the impact of small group regulation on traditional actuarial functions such as the determination of a carrier's reserve liabilities with respect to its existing business, as influenced by the content and specifics of rating band restrictions and other constraints (including constraints a carrier may impose on itself by the wording of its disclosure statement for current renewals and current new business). In addition, actuaries need to give attention to the financial viability of a carrier's participation in the small group market in the context of small group reform legislation, the likely impact and erosion of the population of existing covered groups, the constraints on the capacity of a carrier to generate enough surplus to maintain growth and surplus at Moody's standard or some other recognized standard level, from its operating margins within a block of business. Does any panelist have any comments on either of those topics?

MR. LYLE: There are a number of issues that come up with regard to the financial implications. When you look at risk-based capital formulas that have been proposed for various entities, they do not include much in the way of provisions for rate guarantees or trend guarantees or performance or service guarantees. We do not necessarily have any capital requirements being established, say, in the NAIC risk-based capital formula for these sorts of guarantees. If you are doing a Section 8 opinion under the new standard valuation law, you have to be concerned with asset adequacy, and you probably should be addressing all of these issues. Hopefully, you would be if you are signing that opinion, but there really are no standards. It is an

evolving area, and something that certainly has to be addressed within the next few years in terms of what sort of considerations an actuary should have. Hopefully, the people that are signing these opinions are giving due consideration to these areas.