RECORD OF SOCIETY OF ACTUARIES
1995 VOL. 21 NO. 3A

COMMUNITY RATING AND GUARANTEED ISSUES

Moderator: ROBERT F. WARREN
Panelists: JOHN M. FRIESEN
DONNA C. NOVAK
THOMAS J. STOIBER
Recorder: ROBERT F. WARREN

Experts will discuss and debate the merits and implications of community rating and guaranteed issue state requirements. State examples will be discussed.

MR. ROBERT F. WARREN: Possibly as a result of the debate on national health reform, many states passed legislation to increase the availability of affordable health insurance. A couple items that appear in just about all those reforms are community ratings, in one fashion or another, and guaranteed issue and renewability, with sometimes different kinds of criteria.

This panel will spend a couple minutes introducing the subject, and then we'd like to open it up as an interactive forum involving significant audience participation. We hope that occurs.

Tom Stoiber is with Coopers & Lybrand, and he is the chairperson of a group working on a guaranteed issue monograph. Donna Novak has had more than 20 years of insurance experience and is currently an actuary with the Blue Cross/Blue Shield association. She's a member of the AAA State Health Committee, and she played a lead role in that committee's risk-based capital (RBC) project. She's currently chairperson of the Academy Individual Market Reform Group. John Friesen is the vice president and chief actuary at the Blue Cross/Blue Shield of Maryland. John will talk about a specific law in the state of Maryland that became effective July 1, 1994. John has actuarial, underwriting, financial, and data recording responsibilities, and he'll talk about the design of that state and some early results that we've seen. I'm with Ernst & Young in Washington, DC.

MR. THOMAS J. STOIBER: Like Bob mentioned, I'm working on a monograph. We started about six months ago. The AAA began putting three monographs together this year. One is complete. One is on what we call universal access or guaranteed issue; that's the one that I'm chairperson of. We have a good group of people, including people from the major states that have tried this reform: New York, New Jersey, California, Florida (John Alden Life Insurance and Blue Cross/Blue Shield of Florida), Minnesota (Blue Cross/Blue Shield of Minnesota), and Nebraska (Mutual/United of Omaha Insurance). Our goal is to build what I consider an oxymoron here, a comprehensive primer for a policymaker. What I mean by that is comprehensive to the extent that we want to lay out all the issues that have to do with guaranteed issue and universal access, but be a primer because we're not writing for the audience of actuaries. Unfortunately, or maybe fortunately, we have to do all the actuarial homework to be comprehensive enough so that we can lay out the issue in general English. We are going to offer the Academy's availability for policymakers to ask us questions about the technicalities of the program. But in regard to readability, it will be a very comprehensive overview of the whole issue of guaranteed issue and universal access. Those terms are really the same. Don't get them mixed up with universal participation. Universal access is really from the consumer's perspective. "I need

to access the insurance system." The guaranteed issue is from the perspective of the insurance company. It has to guarantee an issue of a plan. Universal access guarantees the same concept but is just looking at it from a different perspective.

We're going to write this in two parts. We're running into a deadline. We wanted to have this done for the federal government representatives; they're meeting now, they're going to go on break soon for July 4 [1995], but we're trying to get something done for them. And also, to states, the NAIC is working on a very similar thing. So we've broken this up into two parts. The first part, the comprehensive primer, should be ready in about two weeks. We'll talk about all the issues, the cost implications of things. The second part will be a case study part. We selected five states. We're trying to gather all the statistics that are available in each one of those states. And we're going to examine them in light of the first part.

For example, is New York working? How much does guaranteed issue cost in New York? And here's our answer to that. The goal or the purpose of our monograph is really twofold. One is to offer insight into what this thing is going to cost. I've already had two or three calls from Senator Edward M. Kennedy's (D–MA) committee on human resources and a couple from North Dakota and, I believe, North Carolina. The first question we are always asked is, how much will the guaranteed issue cost? And the very first thing we say is, what do you mean by guaranteed issue? What most people mean by guaranteed issue deals with individual insurance. Well, we never answer with a straight face because that's what actuaries do.

The second question is, what are the implications for consumer behavior? Will they buy more? Will they buy less? Third is, what are the implications for the market? Will there be fewer carriers, more carriers, more activity, more competition, less competition? What's the whole ramification? That's the purpose of the Academy monograph.

The second goal we hope to accomplish is to describe, in fact, whether we have guaranteed issues at all. That's where I'm coming from in going through this study. This is an extremely important thing that we've observed, and we have to get the message across is that we don't have guaranteed issue anywhere in today's system; not to the extent that many policyholders are thinking. When I say from any perspective, I mean from market perspective. If you can, picture a big pie. Cut the pie up and take the nonelderly, the private sector market, insurance through employers, self-insured, or fully insured, HMOs, small employers, the uninsured, individual carriers, insurance through lawyers, associations, and so forth. Looking at the whole pie, are you really guaranteed insurance? That's the second goal of this.

I think it's important and we're going to make this point: ask the question, why do we want guaranteed issue universal access? And there's really only one reason. It's socially not acceptable in the U.S. (Canada doesn't have this problem) to lock people out of the system, particularly if they want to get in the system because of their health. "I have the money, I want insurance, I can't get it." That's not acceptable, which brings us to the security issue. Everyone here, I would have to guess, is at risk of being out of the insurance system someday. My father was an example of that. At age 57, he had a stroke on the job, he was out for three months, he got a notice from his employer stating that he wasn't needed anymore. "We found a younger guy who can do the same work for less

money." He was too young for Medicare, he didn't go through his two years of disability, and he was locked out of the system. He had been working in the large employers' system for 45 uninterrupted years and now was out on the street without insurance.

I mentioned before that the most important thing that people always ask is, what will this cost? Because we're an Academy group, most policymakers are looking to us for that answer. What are things going to cost? We've identified two areas of cost. One is, depending on what state you live in, about 75–92% are insured today. There's a presumption out there that the uninsured cost more money. If you dump into the system, it's going to add total aggregate cost in the system. That's going to be one cost item. How much does that cost? And the other is what I call an uneven distribution cost, the antiselection cost. What's the antiselection that will occur if you give the opportunity for people not to insure themselves? They're going to drop out of the system; the healthy ones will drop out. Just the individual market segment will add all these costs. That's the perspective we're taking this from.

We've identified four fundamental devices that the government has put together to address it. When I say government, I mean state or federal. We've identified allocation approaches, risk-adjustment approaches, what I call deterrents or lack of coverage, and undercoverage approaches to keep these costs down. For example, if we had a system in which all increased cost due to guaranteed issue was spread across everybody, guaranteed issue might cost 1% or 2%. Ideally, going back to the Clinton days, in his proposal everybody had to buy insurance. That was mandatory participation. We might have actually seen a reduction in cost, except for the Medicaid population. We're not going to talk about the Medicaid population.

If everybody was required by law to be insured, we might actually see a drop in cost. Why? Because everybody is sort of insured today, even through a high-risk pool, or charity care, or some other mechanism. The fact of the matter is we're dealing with a system that's totally voluntary. In a voluntary system people will opt out of the system. We have some statistics that sort of demonstrate the extent to which that might happen. At least we're going to provide insight into those statistics. That's where the allocation approach comes from.

Look at the large group market. Today COBRA gives you 18 months of coverage, but after that there is conversion. The other day someone identified an example in which the premium was $32,000 per year for a conversion policy. Is that guaranteed issue? One of my pet peeves in the small-group area is the participation minimum. An insurance carrier does not have to guarantee issue to a small-group employer if it does not get at least 75% participation. Is that guaranteed issue? I have a group of five, and two people don't want insurance because their husbands are covering them. The remaining three are sick; that's not a very good guarantee for those three people.

We talk about allocations approach. If you attended the session on risk adjustment, there was talk about the fact that if everybody was covered by insurance equally, randomly, there would be no issue to talk about. There would be no cost guarantee issue, because we'd have a random type of approach. If the large group and the small group markets, through conversion or whatever, didn't put these people on the street where their only alternative was individual, the individual costs wouldn't be that high. That's what we mean by

allocation. If we have a guaranteed issue system that says that the larger players have to accept individuals at the same rate that the individual carriers have to accept them, then we have less of a cost implication. The monograph is trying to explain that we might have a dumping effect here. Through participation, through large group conversions, through ERISA dumping, which is a really big issue these days, if a large employer wanted to cut its cost, all it would have to do is have an insurer guarantee issue individual policies to its sickest employees. The employees have to pay the high cost in the individual market, and the ERISA carrier, the employer, pays hardly anything. Anyway, those are some of the issues. I don't want to get too far, because this is an interactive forum. So let me leave it at that.

Let me go back to my thought on what I call this deterrent effect. Today many policymakers are asking, what if I have a preexisting condition of 12 months and I don't cover insureds for 12 months? What if it's six months? What about 24 months? What about open enrollments? Do they work for 30 days? So we're addressing those costs as well.

In part two of the state piece, the case study piece, we're slightly early on in our data. We're in data collection; we have information directly from the sources of the states that are collecting this data. Some of the big carriers are in this area, and we're assembling that information, and we are finding that there is very little information to actually identify the cost. Part of that is because we're building up, we're seeing a lot of noise in the system. New Yorkers, for example, have community rating. Well, how much of the cost is there through the community rating? Florida has a one-man group-type program. How much of it is due to the fact that it's a small employer versus really guaranteed issue? But we do have some observations, and I'd be happy to entertain questions in that regard as well.

MS. DONNA C. NOVAK: I want to explain the background of the AAA group that I'm involved with. At the end of last year, the NAIC completed its monograph on small-group reform. At one point in time that included individual reform. But toward the end of the development, individual reform was pulled out of that model law. At the time it was pulled out of the model law, the NAIC was still committed to writing a model act addressing individual reform. How many of you are concerned about a guaranteed issue, community-rated individual marketplace? The NAIC realizes that and is very concerned also.

So the regulatory framework group, which is the group that is crafting this model, turned to the life and health actuarial task force, which is a technical group of the NAIC, obviously composed of actuaries, and asked them for some input on what they could do to create a model that wouldn't cause problems in the marketplace. The life and health actuarial task force, in turn, asked for some support from the Academy. And we're working with that group. We produced a paper for the last NAIC meeting that went through each of the components of the model that they were concerned with and addressed them, providing as much data as we could. But as Tom said, data are very hard to come by, especially data that are relevant from the exact type of situation, the exact type of environment that the NAIC would be looking at in implementing this model.

We produced a report and I'll go through some of the points that we made. The NAIC has asked us to go one step further and try to provide data, or as much case history as possible, to support our opinions or our thoughts in the report. The guaranteed issue model that the

NAIC is looking at would right now be 365-day open enrollment. Of course, the antiselection issues in that type of environment could have a serious impact on the individual marketplace. So we recommended the preexisting condition limitations and possibly a 30-day open enrollment period. The NAIC has asked us to go back and look at the effectiveness of these measures as well as some others that are being proposed, such as increased premiums for individuals who were purchasing guaranteed issue insurance but who were not covered previously, and determine which of these mechanisms might be the most effective to prevent individuals from delaying coverage until they were sick.

Of course, the question comes up, how does preexisting condition work for a HMO, which really cannot administer preexisting condition limitations? You have a three-month, a four-month waiting period. What would be an effective waiting period? And we're really looking to the HMOs to provide us with any type of data or support for the effectiveness of different waiting periods.

Also, a part of our report addresses the importance of risk-spreading mechanisms, really for two purposes. One is to spread the cost of the individual, small-group, and large-group marketplaces somewhat more broadly. And then also, in addition to that, there is a risk-spreading mechanism to protect the solvency of the carriers in the marketplace because of random or nonrandom selection against a particular carrier in which a carrier would be taking on more risk than what it should. And again, we're hoping that another Academy group, which Bill Lane and Alice Rosenblatt are working on, is looking at risk-spreading mechanisms and can possibly provide some insight into what an effective risk-spreading mechanism would do. Effective being that it protects solvency but does not encourage inefficiency.

The NAIC has asked us to do some further work in the area of conversion rates and conversion rules and how that would work in a guaranteed issue environment. The original thought from the NAIC was that the conversion rates would equal possibly the group rate or the individual market rate, similar to COBRA. Is that realistic ? If anyone has expertise, that's another area where we would like some input.

A fourth area is Tom's area: who will stay and who will leave the marketplace in a guaranteed issue environment? The interest of the NAIC is, as Tom said, to ensure that if people need coverage that they have it available to them. So who will leave the marketplace and who will enter the marketplace? Is that goal being met? Tom's group is going into case studies of the handful of states, both in the small-group and individual marketplace, that currently have guaranteed issue. They hope to provide us with those answers. What is happening in New Jersey, New York, or Vermont? At this point, I will turn this over to John who will give us a real-life case study in Maryland.

MR. JOHN M. FRIESEN: How many of you are from companies that are actively participating in Maryland's small-group market? Quite a few. So obviously, many people are aware of what's going on in Maryland.

For some reason, Maryland is a hot bed of activity in health insurance and health care. I'm not sure exactly why. The theories range anywhere from being too close to Washington, D.C. to having some major health care institutions there, such as Johns Hopkins. Depending on what report you read, we're currently either third or fourth in the nation in terms of

HMO penetration in the marketplace, putting us in the elite company of California, Minnesota, and Massachusetts. We are also, I believe, the only state that has hospital prices controlled by a regulatory board. If you want to call it a cartel, I suppose you could do that. It sets the hospital prices each year and is basically designed to ensure the solvency of those hospitals. As a result, the occupancy rate is not quite like what you would hope, and you can't negotiate the price of the hospital costs the way you can in most of the rest of the country.

Maryland also has the dubious distinction of having one of the highest number of mandates in the country. So that gives you some background on what's going on in Maryland. While it may be a relatively small state both geographically and population-wise, it may, in fact, be an indicator of what will happen elsewhere.

Maryland Small Group Reform (HB 1359) was effective July 1, 1994 for new sales and renewals. Small-employer groups are defined as those having from 2 to 50 eligible employees. Eligible employees are defined as full-time, although in this year's session that was modified to include part-time employees, and it is to include self-employed next year. The preexisting conditions were phased out by January 1, 1995. Coverage has been renewable, unless the insurer is prepared to drop the entire line of business in the small-group marketplace. The coverages are community rated with age and geography only. Geography was defined for specific segments within the state. The differences among rates will be phased down starting with plus or minus 50%. In other words, the top rate is three times the low rate. That will phase down to plus or minus 16%. A minimum loss ratio of 75% was set, with a maximum expense ratio at 20% unless it happens to be a nonprofit. Nonprofits are 18%. A carrier may not require minimum employer contributions but it may impose minimum participation. There is also a reinsurance pool active in Maryland.

Listed below are the standard benefit plans that were put in place. This is very important in that this serves as the baseline coverage. If you're going to play in the marketplace you must provide this kind of coverage. You can upgrade from there. Some companies sell many upgrades; some companies do not. But you must provide the baseline. The baseline products were essentially supposed to be the actuarial equivalent of the minimum benefits of a federally qualified HMO. They also tie to a cost limit, which was supposed to be less than 12% of Maryland's average annual wage. You'll see that has some very dramatic effects on benefit design.

- Carrier must offer the comprehensive standard benefit plan, and product offerings can only deviate from the prescribed standard by enriching or upgrading benefits.
- The comprehensive standard benefit plan must provide at least the actuarial equivalent of the minimum benefits required of a federally qualified HMO.
- The community rate of the comprehensive standard benefit plan is intended to be less than 12% of Maryland's average annual wage.
- Four delivery systems are specifically identified as standards (but others are allowed): indemnity, PPO, point-of-service indemnity-based, and HMO.

Listed below are the details of coverage. The only comment I'll make is, the indemnity products end up being a very bare bones, stripped-down product to meet the cost limitation of 12% of the average wage.

COMPREHENSIVE STANDARD BENEFIT PLAN COVERAGE DETAILS

- Medically necessary services provided by a licensed health care practitioner under the law of the state in which he or she is practicing;
- Unlimited inpatient hospitalization (including detoxification in a hospital or related institution);
- Emergency room services;
- Ambulance services;
- Outpatient hospital services and surgery;
- Preventive services recommended by the U.S. Preventative Services Task Force and any other preventive services required to be offered by a federally qualified HMO;
- Home health care as an alternative to otherwise covered care in a hospital or related institution;
- Hospice (same coverage as Medicare);
- Durable medical equipment (including prosthetic devices; leg, arm, back, and neck braces; and training);
- Outpatient laboratory and diagnostic services;
- Outpatient short-term rehabilitative service (two months per condition for occupational therapy, speech therapy, physical therapy, and chiropractic services);
- 100 days in a skilled nursing facility as an alternative to otherwise covered care in a hospital or related institution;
- Infertility services;
- Nutritional services for the treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease limited to six visits per condition;
- Nonautologous bone marrow and cornea transplants, kidney transplants, and liver transplants for children with biliary atresia;
- Medical food when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorder;
- Family planning services (limited to counseling);
- Treatment of cleft lip and palate;
- Blood and blood products, including all cost-recovery expenses for blood, blood components, derivatives, biologics, and serums (including, but not limited to, red blood cells, platelets, plasma, immunoglobulins, and albumin);
- Pregnancy and maternity services, including abortions;
- Mental health and substance abuse. This includes 20 inpatient days (in a hospital or related institution) or partial hospitalization and unlimited outpatient visits subject to cost-sharing arrangements described below. Carriers must provide this service through a managed-care environment. Essentially, a "gatekeeper" would have to approve a treatment plan for a particular individual.
- Prescription drugs.

The cost goals could only be met by imposing high cost-sharing arrangements. For the services listed below, the following uniform cost-sharing arrangements were implemented:

- For outpatient visits for mental health and substance abuse, occupational therapy, physical therapy, speech therapy, and chiropractic services: 1–5 visits, carrier pays 80%; 6–30 visits, carrier pays 65%; 31 and more visits, carrier pays 50%

- Emergency room services: $35 copayment (waived if admitted) and applicable coinsurance amount;
- Outpatient services and surgery: $20 copayment or applicable coinsurance, whichever is greater;
- Outpatient laboratory and diagnostic service: $20 copayment or applicable coinsurance, whichever is greater (except for HMOs, see below);
- Infertility services: carrier pays 50%;
- Skilled nursing facility: $20 per day copayment or applicable coinsurance, whichever is greater;
- Prescription drugs: after a $150 deductible, there is a $15 per-fill co-payment;
- No coinsurance or deductibles (only $10 copay) for well-child visits for children 0–2 years of age (see general cost-sharing for children 2 and over).

The following cost-sharing arrangements are specific to each delivery system:

- Indemnity
  —Deductible: $500 per individual/$1,000 per family
  —Out-of-Pocket limit: $3,000 per individual/$6,000 per family
  —Lifetime maximum $1 million
  —Coinsurance 80/20
- PPO
  —Deductible: $250 per individual/$500 per family (combined in and out of network)
  —Out-of-pocket limit: $2,500 per individual/$5,000 per family
  —Lifetime maximum $1 million
  —Coinsurance: in network, 80/20; out of network, 60/40
- POS, "wrapped around" an indemnity delivery system and/or a PPO:
  —Deductible: $200 per individual/$400 per family
  —Out-of-pocket limit: $1,500 per individual/$3,000 per family for in network services; $3,000 per individual/$6,000 per family for out-of-network services
  —Maximum lifetime limit $1 million
  —Coinsurance: 80/20 in network; 60/40 out of network
- HMO
  —$10 copayment for primary care services
  —$20 copayment for specialty care
  —$20 copayment for physician inpatient hospital visits
  —$20 copayment for outpatient laboratory and diagnostic services or 50% of the cost of the services, whichever is less (applied per visit)
  —Out-of-pocket limit: 200% of the annual premium

Although the cost sharing arrangement for a POS "wrapped around" a HMO are not specified, HMOs are encouraged to develop and sell an optional POS rider (subject to guarantee issue) to all small employers. This rider would permit small employers and employees covered through a HMO to access specialty services outside the HMO network. Such a POS rider would not be subject to Maryland's mandated benefits. Rather, like all other delivery systems, this system would be required to cover the services specified in the comprehensive standard health benefit plan.

Here are some other features of House Bill 1359. Some organizations were created, specifically, the Health Care Access and Cost Commission, with many objectives. Specific

objectives were to build a claim database, establish a provider database, establish standards for electronic claims clearinghouses, reduce administrative costs, and establish a system to evaluate quality-of-care outcomes. The Commission is to implement a resource-based relative value schedule (RBRVS). That's a wide range of objectives. I would say that at this point, the only area that has had significant progress is building a claim database. A number of companies have asked to volunteer in a pilot program and provide claims that have been submitted. An advisory committee was also created with all practice parameters for specialties.

If you are presently doing business in a state that is considering something such as this, you are probably having concerns right now. We went through the same motions when this was imminent. We had concerns such as the impact on account-specific rates of legislated rating bandwidths. You know a great fear when you have that band imposed on you. What's going to happen to everybody? Our studies were much like everybody else's. The number of groups having significant increases is far more than the number of groups that have significant decreases. And therefore, you have a negative perceived impact. We all thought that was going to have a significant negative impact on the marketplace. The narrow rating bands make the coverage more affordable for the older people and less affordable for the younger people. It is also more affordable for people with a history of health problems and less affordable for healthy people. Regarding affordability of coverage, there was a great fear that employers and employees would change carriers more often. You no longer have the fear that your people, when you transfer coverage, may be left out in the cold.

Another concern was rate approval required by the Maryland administration, would become more difficult to get adequate rate increases. The jury is obviously out on this. We're still in the early days. But when a government agency is involved in rate approvals, you naturally think that will add another complication. The impact on associations was a significant issue in our marketplace. Associations before were rated as one large group. You could come out with one rate for a 5,000-life association. Well, now each separate segment of that association becomes a small group. So instead of having 5,000, you now have 1,000 groups of five people. It has rating implications, it has tremendous administrative implications, and so on.

Also was the fear that if and when the rates stabilize that the only distinguishing feature among carriers would become service. Now that's, of course, if you assume the same rate of risk, or that the same benefits get priced the same way by a whole different set of actuaries. We all know that's never going to happen. So that's probably not a valid concern.

There were some implementation trials and tribulations, but overall the process was actually relatively smooth. It didn't go nearly as badly as we had feared. A backlog of rate and benefit submissions caused some delays in carriers entering the market. Quite frankly, the insurance administration worked on a first-in, first-out basis. So if you're facing this kind of prospect in other states, the word of advice is to get it in early. That way you'll be in the marketplace early.

Legislation required some clarifications, especially regarding associations, which caused some initial confusion. There was also some confusion around minimum cost-sharing

arrangements. Some companies interpreted the basic benefits as requiring deductibles that were only out of network; others interpreted them as being in network; and, quite frankly, the wording was such that it could be interpreted either way. Eventually it was clarified that the deductibles were, in fact, permissible.

Having said all that, the insurance administration did a very good job of pushing through a large amount of paper, many applications, and so on. The process was relatively good. What happened during the first six months? We had heard that typically some carriers exit the market; I think that's what happens. But we saw an apparent increase in the number of carriers playing the marketplace. Again, I don't know why it happens in Maryland but it does. There's a wide range of rates on the standard packages. It is essentially comparing apples with apples, but if you look at the highest rates versus the lowest rates for indemnity products, it was in excess of a 200% difference. For HMO products it was in excess of 150%. Now these rates are all published so we know what they are.

Several re-rates were done by some carriers in reaction to initial rates. Some companies went into the marketplace, they weren't fully familiar with the Maryland marketplace, they guessed wrong and saw the rates of all their competitors, and they reacted. The dominant carriers offer a wide array of upgrades from the baseline benefits. Smaller carriers tend to stick to the standard benefits. A need to change every group's benefit design caused a massive sales backlog. This was another big lesson. For a small group, normally a renewal for a salesperson or a broker is simple. You're not going to spend time with a three-life group. You're going to call them and ask if their benefit is still good. "Why don't we just leave them the same as last year? Renewal is a 5% rate increase; take it or leave it." And we move on. It's quick. Not in this case; it has basically forced a face-to-face meeting with every small group to explain what the group's new benefits look like. Everybody had benefit changes. An incredible amount of work was created through the sales process. Therefore, there is backlog. So effective dates were often missed and so on.

The Maryland Insurance Administration does publish a price list every six months. The first one was published in September 1994. It lets you see exactly where you stand. It is public information that is handed it out at state fairs and events such as that. You get to see what's going on out there and you can react. Very few carriers initially offered the point-of-service product.

The shakedowns still continue in the second six months. We're almost through 12 months. I guess we have less than a week to go. There was a 40% increase in the number of carriers in the second six months over the first six months. I thought that was amazing. Obviously, some carriers sat back and waited to see what would happen and then decided they would play. So a significant number of new carriers are coming in. Even though right out of the gate there seems to be an increase in carriers, all the carriers were there to begin with. Forty percent increased their rates and 15% decreased their rates. A shakedown is going on. Companies are figuring out where they want to stand in the rankings.

The first annual claim expense reports were filed at year-end; it's an annual requirement. But quite frankly, the date is not credible because you're only looking at six months' worth of claims data. You can't draw too many conclusions from that.

What are the lessons and questions from all this? I mentioned the impact on the sales force. Quite frankly, that was one of the biggest ones. The sales force and the broker force were just swamped. As a result, they spent all their time on 2-employee to 50-employee sales, and we saw a dramatic drop in new business in the 50-plus groups. Nobody had time to go and sell business. They were too busy in the small-group area.

There was also an impact on the RBC requirements. What does this force? Does it change the business from a file and use to a prior-approval open-enrollment-type basis? In the formula that we use, that increases the surplus requirement 14% and 19%. I expect the NAIC formula to be similar. So you need to bear in mind that when this kind of thing happens, additional surplus is required. I mentioned that there was an increase in the number of groups for associations, which increases administration cost significantly.

There is the need for sales training to understand what appears to be a logical rate relationship. Indemnity products had to be stripped down so much to meet the price ceiling, and they looked different. In fact, the standard benefit packages, indemnity products, tend to cost less than the HMO product. This, of course, flies in the face of logic. Most people expect an HMO product to be the best bargain on the street. As a matter of fact, if you look strictly at rates, you would not come to that conclusion in the small-group marketplace in Maryland anymore. If you look at the benefits, then it becomes logical again, but that creates another issue. The sales problem is, are you going to take the time with a five-life group to explain the difference in benefits between this product and that product or explain that this one is a better value than that? The answer is probably not.

We now have to pay a great deal of attention to eligibility in underwriting. The eligibility rules were changed: 2 to 50, full-time, spousal waivers are not counted, and things such as that. We require (and I think most carriers require) you to have a statement from a broker salesperson that certifies that to the number of eligible lives within the group. This is another step in the underwriting process.

There are still some open questions. Did the overall number of insureds actually increase? Legislation was passed with the intent of trying to solve at least part of the uninsured problem. Did it solve the problem? At this point in time we don't know. The state is collecting the information. I expect it will publish it probably late in 1995. If I heard the earlier presentation correctly on New York small-group reform, there were saw some decreases in the number of insureds. All I have is some anecdotal information from our sales force. They have seen some people who were not previously insured buying coverage. Personally, I don't expect to see any huge increase in the number of insureds. I don't think this kind of legislation solves that problem.

Future expansion refinements of health care reform is another messy area. We went through all this change and so on a year ago. And then this year, more changes were made. Of course, as time goes on, they make some refinements. They change some of the eligibility clauses and so on and so forth. It means that in many cases, it's going to go through another cycle of changing the qualifications of certain groups and small-group reform. Quite frankly, I think we would have been better off just leaving it alone for a couple years, letting it settle down and then moving on. But there are further refinements going on. I'm sure there will be further in the future. They have started talking about individual health care reform, but it didn't happen yet. That also could happen.

The bottom line to all this is the many concerns when it first appears on the horizon. Some of those concerns are well founded; some are not. The process in Maryland was actually smoother than we had anticipated. I would also say that if you anticipate things correctly, if you position yourself correctly and so on, it does represent an opportunity just as much as a threat in terms of gaining or not gaining market share.

MR. WARREN: I find the contradictions among some of the state programs interesting. John brought up a couple points. The Maryland insurance department is expecting to look at rate filings a little more closely. I just read that the new Republican governor in New York is passing what's called a sweeping insurance reform bill in which he's going toward file-and-use rates. New York had always been fairly strict about community rates. So it seems to be going in different directions.

Associations, the insurance purchasing groups around the country, are becoming small communities of their own in certain areas. Yet in Maryland the associations are being broken down. That's an apparent contradiction to me. There's a place in New York State, one area in the country, where all their group and all their individual contracts were rolled into one large community, and everyone was rated the same. Their actuary a couple months ago said that seemed to work out well. There are many different ways to go and there are many contradictions. I open it up to any comments or questions about some of those subjects. Does anybody have a comment? Perhaps somebody from the panel has experience in some different states. What seems to be working and what doesn't work?

MS. NOVAK: It depends on whom you talk to. And that's one of the biggest problems. You'll hear New Jersey is working perfectly, and then some carriers in New Jersey will say they just went for their second rate increase in six months.

MR. WARREN: Is that due to the design of the law, or a design in their contract, or a marketing problem, or a population problem?

MS. NOVAK: Balancing out reactions; as we said, it takes them a while for things to balance out. And if you keep reacting to new changes, everybody has his or her opinion of how well that is working.

MR. STOIBER: Let me make an observation here. We're finding that when a program is first implemented, a great deal of market positioning goes on. For example, when California opened up its health care purchasing cooperatives, Blue Cross didn't want any part of it, for example, as the guaranteed issue vehicle. Many carriers went in there and rates actually decreased. I think it has been like that for two years in a row on the average. But then John Alden, the largest small-group carrier in the nation, pulls out. Why? It's very difficult to get at those whys, because they're company strategies.

The anecdotal information is: I'm not sure where reform is going, but this might be the only vehicle I can sell them in the future, so I had better get in there and I had better get some market share for a while. Maybe it will work and maybe it won't. A lot of experimentation is going on. I can't speak for John Alden, but it had seen its claim cost experience rise, and many actuaries have to be careful about examining results. If you measure results based on what the premiums are doing and the number of carriers, you get

one answer. If you measure results based on the companies' loss experience, you'll get another answer.

It's very possible that the companies' loss experiences are increasing in these areas, guaranteed issue states, and yet they're still ratcheting down their gross premiums to buy market share. Now that is evidence. Mutual of Omaha will tell you what happened in New York before and after reform in that state. Again, it's sort of muddied by community rating there. But it will be the first one to say that if it didn't have community rating, the guaranteed issue, by itself, for example, would have ended up with this sort of result.

So the shakeout period appears to be more than 6 months, even more than 18 months; it will probably be 2 years before you really see companies even explaining to themselves what this is doing to them.

MS. NOVAK: The first year you react to what you think will happen. And then it's a good 18 months plus before you know what really did happen. And then you start reacting to that.

MR. JERRY W. FICKES: We know that a couple of premature babies have already run up our claim costs. We knew we were going to make mistakes when we jumped into this. We got the pressure on taking individuals. We fought this very hard because that, again, would have brought in more people from the Children's Health Insurance Plan (CHIP) pool. We finally compromised to small-group employers; in other words, self-employed. But to get them under the 2–50 employees, we said that one other member of the family must come in and could be substituted as the second employee. So at least we brought two people in.

Donna, you were talking about my other half, over with the health actuarial working group. We do have self-employed in that law that went through in the small-group area. So we have individuals already sitting in one row. Then we have the pure individual in the other. We don't know where those that are not incorporated, sole proprietors, sit yet. But I think our big concern here is a fragmentation of that market as we go forward because some of the individuals might be covered and some might not. We look at what you were saying, Tom, as far as all these statistics involving these states. Of the states you named, basically most of them have a community rating or a Blue Cross of last resort.

To go to an individual there is not a big differential if you take a community rate and pull in individuals. But to go into states such as New Mexico, where we don't have that, you make a drastic change in the rate, especially when you ignore the gender factor. The gender factor is probably even a bigger one than the community rate; it makes it a completely different element.

The same thing is true with Maryland. Maryland is looking at HMOs and at all these. You could drive across your state to go from one HMO to another HMO. In New Mexico, we drive that far just to get our mail. We don't have HMOs. We don't even have doctors in some of these areas. So once again, I think many of these things that we're trying to do on a national scene will have to be fit to individual states and individual circumstances.

MR. FRIESEN: I would absolutely agree with the comment that the state differences are so important. I don't think we could have tried in Maryland what you've done in New Mexico. We have so many mandates. Assuming the government represents the people's wishes, there's no way it would go with the level of benefits that low. I think it points out that national standards probably aren't appropriate. They don't recognize regional differences.

MR. FICKES: If I may just add one more thing. The only reason we did what we did was because about two-and-a-half years ago we were faced with the possibility of accepting single payer; a Canadian style but not exactly the same. After the elderly found out that they were about to lose their Medicare and the government employees found out they were about to lose their paid-up government health insurance, the phone lines blew out of our legislature. And they decided that maybe they should postpone this for a year. They formed a task force to solve all the ills of the state. After one year, the only suggestions that were on the table were to go with this single payer, with a few modifications, or to go with the statewide HMO. All we used were basically the networks and not the insuring facilities.

Basically it meant we had no more insurance agents. We had no more insurance companies in our state. We prided ourselves to say, do you know what's out there today? Can we build on that? We developed this law, which is our voluntary health alliance, merely as a means of wedging something between these two mountains to keep the insurance industry as a player. Now this is going on in Washington. This part is the same from state to state. Political pressure is coming for us to do something. We had this pressure during the last two years in Washington, and things got better. The doctors slowed their rates of cost, the hospitals slowed their rates of cost. They're up higher than the doctors. The drug companies pulled in their horns somewhat. People lean back from the pressures.

We're starting to see those trends come back in again. This means that this pressure will come. And I wouldn't be surprised if something isn't done in the next year or two to see, again, Congress saying that we are going to have to do something again about health reform. So don't sit back and say, we won a battle or we won a war. I don't think we've gone that far yet. And we really have to address this while we have at least a momentary pause in the Washington situation, if we want to keep the insurance companies as a player in health insurance. I do like to use that as a distinction from health reform.

MR. WARREN: Whose influence seems to be on the rise or holding sway? Is it the insured these days? Or is it provider groups? Or is it the single-payer people? You mentioned it sort of falling out one way. Who's on the rise at the moment?

MR. FICKES: Actually, as far as the influence in our state, the insurance industry never had it. It's always basically been the doctors and the hospitals. They seem to have everybody's ear. Other groups, such as home nursing, are a very strong lobby. Of course, in New Mexico, there are acupuncturists, chiropractors, wave treatment therapists, and music therapists. You think you have mandates. You haven't even dreamed of half the things that come in front of our legislature. They all have strong lobbies. The insurance industry does not really have the strong lobby, at least in New Mexico. And I'm not sure it does in Washington.

MR. WARREN: How about in other states? Much of what's going on today is insurance reform. And that seems to be the big thing in Washington. There must be other states that are strong from the insurers' standpoint. Any experiences?

MR. CHRIS L. SIPES: I don't know how many of you know what's going on in Kentucky, but Maryland looks tame compared with what's going on in Kentucky. How many of you do business in Kentucky? OK, let me just kind of go down the shopping list here of what Maryland has and add some for Kentucky. Ours cuts in July 15 this year [1995]. It's both for direct pay and small groups up to 100 lines. Municipalities are mandated January 1, as are all the state universities and all are self-funded right now, into this community-rated pool.

There are two sets of rates: one for the individual market and one for the small-group and government entities together. There are the same restrictions on part-time down to 20 lives and 30 lives full-time. Preexisting has been limited to six months. You have full portability from the direct-pay market to the group market and the self-funded market to the group market. So you have full portability there. If you're insured in one of these, no preexisting clauses are applicable.

A state-run alliance is being set up to administer this business. The community rating and the portability applies whether you're in or out of the alliance. But the alliance piece is what the government entities are being forced into. And so a group of less than 100 employees would have a choice of either being in the alliance or being out of the alliance. The rating structures, though, are the same. The sex rating has been removed. It is age-rated and area rated. The areas have been defined in much the same way that they were in Maryland. I think there are six or seven areas in Kentucky.

But if you're in the alliance, all employees pick which benefits they want and which carrier they want, and the alliance bills and collects or remits to the carriers, so it becomes very much like direct-pay business for the carriers' risk. The benefit plans are dictated by the approved health plans that the state came up with. There were basically four of them. Then there are cost-sharing options so there is an indemnity-type program and an HMO program with two different clustering options on each. So you can choose from about 15 plans, but every carrier is selling the same plans. There's no variability there. Supplemental plans can be sold in addition to that, but you have to price the basic plan for price comparison for the marketplace.

The marketing is in turmoil because the commissions apparently will be added on by the alliance. So you can call the alliance and get your coverage direct as an employer with no agent. Or you can go through an agent and have an add-on to your rate to pay the commission for that agent.

In other words, it's a mess. There's the association turmoil that was in Maryland. We're hot and heavy in that. We administer, by ourselves, some 20,000 contracts in associations that are in Kentucky. The associations have gone to the legislatures and have gotten them to do battle right now with the health policy board, which is the entity that's implementing this, to allow the associations to be exempt from the community rating for the other small-group business.

MR. FRIESEN: They tried that in Maryland, but they didn't succeed, obviously.

MR. SIPES: Right. Although Maryland ranks up there, too, I think in Kentucky the political clout of the associations is very heavy. Associations can basically dictate among the heavy highway contractors and among some of those types of entities who the governor is in Kentucky. So it has really turned into an interesting battle here, as they come down to crunch time, on whether the associations will be allowed to have their own subset world. If so, they'd represent probably 50% of the small-group market already, and of course, it will grow dramatically if they're allowed to rate separately. There are many parallels with Maryland, but it does get worse.

MR. STOIBER: May I ask what you personally think is the big implication here? As a carrier writing there, what's the biggest risk?

MR. SIPES: The biggest risk right now is the rate controls and the rate filings as you go in. You go in blind, you have to file the rates, and you really don't know where the competition will be. You don't have the recourse of refiling. They're asking for a 12-month rate.

MR. STOIBER: If you're too high, can the alliance reject you?

MR. SIPES: Yes, it can reject you. Right now, it is in the midst of approving the rates.

MR. STOIBER: By statute? Are there any requirements needed to meet certain conditions?

MR. SIPES: No, there are not any loss ratio restrictions or anything. It's strictly an approval process right now. It took its HMO rating requirements that have been on the books for several years and basically applied those to all group insurance. Of course, direct pay was already filing.

MR. STOIBER: It sounds like a mirror image of the California plan, except we take direct-pay people.

MR. SIPES: It has pieces of California, Florida, New York, and Maryland.

MR. STOIBER: You said direct pay; does it take individuals?

MR. SIPES: Yes, the individual market is on a guaranteed-issue direct-pay basis.

MR. STOIBER: Can I ask where those high-risk individuals are today in Kentucky?

MR. SIPES: In Kentucky—most of them are probably uninsured right now.

MR. STOIBER: Do you have a high-risk pool or does your Blue Cross act as insurer of last resort?

MR. SIPES: No. They're just strictly uninsured because medical underwriting exemptions have been allowable.

MR. STOIBER: What if you're a new carrier and you don't write individual business? In other words, you do not have the administrative capability to administer to individuals. Do you still have to do that?

MR. SIPES: No, you don't have to participate in the individual market just because you only participate in the group market. No, those are separate rate filings and separate approvals. It's just that the alliance will do the billing and collection on that business and remit to the carrier, if the carrier goes through the alliance. Again, the carrier has the choice. It can be both in the alliance and out of the alliance, in the alliance only, or out of the alliance only. The only restriction is that the rate filing requirements and the rating structures are identical whether you're in or out of the alliance. The rates don't have to be identical, but the rate structures all do. Obviously, there's some antiselection. If you want a group of ten, the employees can choose ten different programs and five different carriers. The risk of each carrier involved there is different than if you go out of the alliance.

MR. STOIBER: Is this a passed bill?

MR. SIPES: The bill was passed. It was implemented. Kentucky has a biannual legislation, it doesn't meet again until January, which means some things may get fine-tuned or adjusted. There are some strong expectations. Again, this was passed a year-and-a-half ago in the heat of health care reform.

MR. STOIBER: When does the individual kick in?

MR. SIPES: Individual kicks in July 15.

MR. STOIBER: That's when I think you're going to get your reaction. California went down to three lives, and it is going down to two very soon. It really hasn't had a problem. The carriers compete on prices; insurability is available. But the individual market is new here. You're going to see companies such as State Farm, and I don't want to speak for anybody, seriously thinking about this.

FROM THE FLOOR: Golden Rule has a lawsuit going on right now. The jury is still out on that one. It is trying to get it settled before July 15[1995], though.

MR. HERBERT C. PETTERSEN: I contract with the Kentucky Department of Insurance. We've had a busy time. To add to what Chris said, the standard plans are for large group as well. They aren't just for the individual and the small group.

The legislature really has an ambitious schedule laid for everyone. And the health policy board actually has the authority for approval on all this, interestingly enough. We're in the process now of reviewing rates. As Chris mentioned, the original process was for those carriers that wanted to have coverage through the alliance. They responded to a request for proposal (RFP). Then the alliance board and administrative director reviewed all that. They then went into one-on-one sessions with each of these bidders and negotiated rates. Interestingly enough, those rates that had been agreed to with the alliance, of course, had not come to the department of insurance with whom the health policy board had delegated some of its preliminary authority. But all was subject to the health policy board's final

authority for approval of rates. So there's quite a bit of turmoil, especially because of this idea of having a 5% commission possibly available on the alliance business.

In addition, because of doing the administration that Chris was talking about, there is a fee for carriers doing business in the alliance. Initially, they had talked about a 1.5% fee for that administration requirement. The alliance presumably was going to increase that, probably monthly or every second or third month; it really hadn't been set. When we had discussion between the department of insurance and the alliance, they finally realized that they had to do some budgeting. So now they have set the fee at 1.75%, not to exceed 1.75%. They may decrease it, but it will not increase.

These rates that are filed with the alliance, as well as rates for business outside the alliance, are 12-month guaranteed for new business. But rates on new business, marketing rates, can be refiled every six months.

John, is there an alliance in Maryland at all?

MR. FRIESEN: No.

MR. PETTERSEN: Is there composite rating on the small group?

MR. FRIESEN: What do you mean by composite rating?

MR. PETTERSEN: Group rates as we're used to seeing them. Equal rates are available to each, say, individual, or each different two-, three-, or four-tier of family composition.

MR. FRIESEN: We have tier rating; yes, that's part of it.

MR. PETTERSEN: Because the rates that are being filed for the alliance are essentially a list-bill-type rate. As Chris pointed out, all employees in the small group can elect not only the carriers they want but also the plans they want as well. So there's obviously no way to do composite rating under that approach. Our bulletin 95-7, sent out from the department, talks about rate filings for business outside the alliance. We asked them to file-list bill rates also. But in addition to that, if a carrier wanted to do composite rating, it had to file the procedure that it would use and the circumstances under which it would use composite rating.

MR. FRIESEN: In fact, you can still compete in Maryland because it has tier rating, and you can use different slopes. Depending on what marketplace or segment of the market-place you're going after, you can influence it that way.

MR. PETTERSEN: One of the problems, of course, that we've talked about is that so much is involved in this in Kentucky. And the schedule laid out has had such a short timeframe. Unfortunately, there still is a great deal of confusion. That will probably cost for a while. I think I sense the number of carriers that want to wait and see what happens. One carrier, for instance, is going to market in just one area. I think that indicates to me that it wants to see how it works out. It wants to stay in Kentucky, but it's not a full-blown marketing effort.