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INDIVIDUAL HEALTH "HOT" TOPICS

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The interactive forum will be a discussion of "hot topics" regarding individual health. Some topics will include: rate filing and/or health care reform implications of recent and proposed legislation.

MS. MARTHA M. SPENNY: I want to tell you what the format will be for this interactive forum and then introduce our speakers. We will to break this session into two parts. Our first section will be a discussion of individual health and the NAIC, from four different points of view. Then in the second part, after we've had a chance to be interactive with a question and answer period, each panelist will take a state and discuss individual reform in that state. So now let me introduce our distinguished speakers. Jerry Fickes will bring us the regulators' point of view. He's been chief actuary for the life and health division of the State of New Mexico for seven years. He serves on several current committees of the NAIC, including the special committee on health care reform and is the chairperson of the health actuarial working group. Prior to the New Mexico Department of Insurance, he worked in the insurance industry, including ten years as president and CEO for National Fidelity Life.

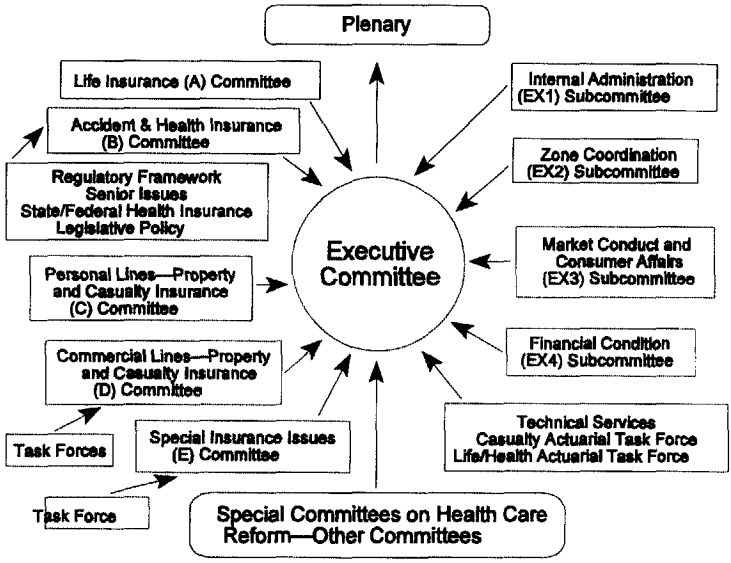
Donna Novak has over 20 years of experience in the insurance industry and is currently an actuary with Blue Cross/Blue Shield Association. She is chairperson of the AAA's Individual Market Reform Work Group which is supporting the NAIC in its work on the individual market reform model law. Donna will bring us both the Academy and the Blue Cross/Blue Shield Association Perspective.

Bill Weller will bring us the perspective of the Health Insurance Association of America (HIAA), which is a trade association representing over 250 health insurers. Bill has been with HIAA for about five years, where he is senior actuary. Prior to HIAA, Bill also worked for the insurance industry as an actuarial officer in several companies, including Penn Mutual Life Insurance Company, Safeco Insurance Company, North American Company for Life and Health, and Blue Cross/Blue Shield of Maryland. We will begin with Jerry Fickes.

MR. JERRY W. FICKES: First thing I'd like to do, if I can make one point, is talk about the NAIC. In fact, my wife said to concentrate very hard when you talk because every good speech should have one point, at least. Well my one point is how the NAIC works. You think many of these laws are handed down just out of mystery or out of somebody's thought. They are created from many, different sources. I'll give you a little idea of how big the NAIC has gotten to be. At the St. Louis Meeting, just three weeks ago, we had 166 separate sessions for the NAIC. These are separate meetings. The opening meeting was 83 sessions. All the rest had been added in the beginning, just because we didn't have time in the regular slot for them. Now in the NAIC, we have committees, task forces, and working groups. These are all under the plenary, which is made up of all the commissioners. Committees report up to the

executive committee in plenary. Task forces basically report in to the committees, and working groups may be under the task force or under the committee.

CHART 1
COMMITTEE STRUCTURE CHART



Each of these groups is working with different subjects and bringing them forward to the next level after resolution. As a result, very often in the NAIC, just like in your company, things of an actuarial significance shoot up the line and become a law without actuaries going through them. It's a little bit like when you design a product and the marketing director changes it, or your compliance officer, who's an attorney, makes a change in it and never says anything to you, but he just changed the benefits. It's a little upsetting, but nevertheless, it does happen. Chart 1 shows some of the committees that are actually dealing in various areas of actuarial significance. They are the (EX) Special Committee on Health Reform, which is one of the top committees, the Accident & Health (B) Committee, which is a top committee with several subcommittees, and the Life and Health Actuarial Task Force. I'll get into each of these a little bit further.

We'll start with the (EX) Special Committee on Health Reform. Thirty-four states and Washington, D.C. are represented because this is a top-level committee. Its representation normally consists of the commissioners, themselves, and they look at the various federal laws as they are proposed. There's actually a Washington staff of the NAIC that works with the staff of the various representatives or senators on the Congressional committees that develop these laws. We continually receive these laws when they're in a draft stage. We have the opportunity to make comments through our committee and our staff returns those almost instantly to the lawmakers. So consequently, we have been very proactive in what's been going on in Washington. If we hadn't been, I think you might be very surprised at some of the things that would have gone through Congress.

The (Ex) Special Committee on Health Reform reviews federal laws such as HR996—Rate Compression (Farwell); HR1610—Portability (Thomas); and HR483—Medicare Select. This committee involves the District of Columbia and the following 34 states:

•Alabama	•Arizona	•Arkansas	•Colorado
•Delaware	•Florida	•Hawaii	•Illinois
•Indiana	•Iowa	•Maine	•Maryland
•Massachusetts	•Missouri	•Montana	•Nebraska
•New Hampshire	•New Jersey	•New Mexico	•New York
•North Dakota	•Ohio	•Oklahoma	•Oregon
•Pennsylvania	•South Dakota	•Texas	•Utah
•Vermont	•Virginia	•Washington	•Wisconsin
•West Virginia	•Wyoming		

Not all of the bills would have included you in the best light; for example, HR996, which is Representative Harris W. Fawell's (R–IL) bill. Almost 20 of us had to respond to him, as to the individual state reforms that are going on, to try to get some information as to what the states have done, because we believe many of the things in the Fawell bill are steps backwards in the health reform issue. In other areas, they are mimicking some of the things the NAIC did in coming up with its small group reform, such as using the 4:1 community rating compression and slide to the 2:1. Legislators' question to us is, will this work? And how well will it work? HR 1610 is a bill proposed by Representative Craig Thomas (R–WY). This is maybe one of the first bipartisan types of bills that we've seen in Washington. It deals with portability. Actually we have encouraged Representative Thomas to go ahead. We have tried to point out some of the areas that we feel require some refinement, but on the whole what we're saying is, this bill deals with one of these subjects that may be better handled with a federal guideline than with a state guideline. There are some of these points, where as long as each state does something different, we aren't going to get very far in the reform issue. This one deals with portability. We've had many conversations in this committee.

Probably the most favorable committee on the hill is the Senate Labor and Human Resources Committee chaired by Senator Nancy Randon Kassebaum (R–KS). The committee is very receptive to listening to ideas from the NAIC as to what should be done going forward for a possible incremental type of change. The last one mentioned is HR483 for the Medicare select. There's also a Senate bill, but the NAIC backed more of the HR 483 than it did the Senate version. There are many other bills we are reviewing. These are the ones that we feel have a chance of possibly going someplace.

We have another committee that meets at the same level called the Accident & Health (B) Committee. Almost all laws regulating the health insurance industry come through this committee. Only nine states are on that committee: Colorado, Delaware, Florida, Maine, North Dakota, Ohio, Oregon, Washington, and Wisconsin. Once they pass something, then it goes to plenary, where all the commissioners vote whether to make it into a model act. This is the one that addresses accident and health issues from all these task forces and working groups listed below.

Task Forces
- Senior Issues
- Regulatory Framework
- State and Federal Health Insurance Legislative Policy

Working Groups
- Limited Benefit Plans
- Coordination of Benefits
- Experimental Treatments
- Discriminatory Practices
- Purchasing Alliances
- Health Plan Accountability
- Small Group Reform
- Individual Reform

The Senior Issues Task Force is under the Accident & Health (B) Committee called to be known as varying committees that included the Medicare Supplement Committee and the Long-Term Care Committee. There were many working groups. Its name was changed a year ago to the Senior Issues Task Force. It now embodies all these subjects. I happen to also sit on this task force and its plate is very full. There are 11 states that are represented. Some of these states, by the way, are the same states that are up on the B Committee. So they're carrying up their own ideas to the B Committee. We address all items that relate to seniors. We do this sometimes through working groups, and one of the current issues has been Medicare select. This is something that came up where the time clock almost ran out on us. But, finally, it looks like it is going to turn around and be allowed in almost all states.

The Medicare refund manual, this is something that the health actuarial working group put out and because of what has happened with the pre-COBRA business, we are looking at whether or not there needs to be any changes in this manual. Medicare rating, using attained age/issue age is being debated. We entered into that as the health actuarial working group at the last meeting. We said in this particular case we feel that this is more of a social issue than an actuarial issue. That if you are going to throw out one methodology and make the other one mandatory, that is a social decision, not an actuarial decision. Once you've made it however, there are some actuarial decisions that should be made. For example, if you go to the issue age, which is what basically the consumer advocates are pushing, then you may have to consider prefunding and nonforfeitures—things that we would hate to see come up again. Long-term care issues are still under the Senior Issues Task Force. Many of these working groups are starting to finish up. The benefit triggers working group seems to be almost finished. The nonforfeiture isn't completely done. It has been transferred over for completion to the health actuarial working group. Items that are still outstanding are joint coverage, limited pay policies, many things that just weren't wrapped up.

The Regulatory Framework Task Force has probably created more attention than any other task force. Again answering directly up to the Accident & Health (B) Committee, this task force has 11 states on it. It actually was started at the time that the Clinton people were trying to do national health care. The NAIC was racing to see if it could come up with a format that would fit better to keep the insurance industry as a player. What Washington was doing, would basically have eliminated a great deal of the insurance industry as well as the agents in this country. We started working on this almost three years ago, with a

great deal of haste. Since then the task force has broken into some various working groups, such as purchasing alliances, health plan accountability, small group reform and individual reform (which you are hearing the most of, especially after what's happened just in our last two or three meetings).

Small group reform and individual reform was completed at the NAIC meeting in Minnesota. The model act was ready to be moved forward. We found out that the community rating was included in the model act. By the way, at this time this had not been referred to the health actuarial working group. The model act was ready to be referred up. We found out that the act included community rating on a compression of 2:1, and it had a few other things which we thought might need further consideration. One of the things we attacked right away was the 2:1 compression, the lack of gender, and tried to convince the regulatory working group that they should take a look at the cost implications in doing this. The implications of suddenly going into this, in various states, especially the states that do not have 80% in a Blue Cross plan because they are not insurers of last resort, could affect the number of younger uninsureds. Going to a state out in the West, where you don't have this, you can make a big differential, especially in the younger males. This then moved to some discussions with the health actuarial working group and the debate continued through December.

In December, individual was added into the model act. They were going to have an individual reform to match the small group reform. Once again it came almost to a debate between the two committees as to whether or not individual should be added. We felt we had removed the individual from the act. What ended up was the individual was pulled out, but self-employed groups of one are still in. So now we have the problem with the fragmentation of the individual market. To do that and to address it, we got them to agree to work with the health actuarial working group to try to come up with some solution. When it was time to pass the small group reform, which included the self-employed, there was big debate and I'm sure you have heard about this. To get it through, there had to be a footnote or a drafting note that stated the rating method should be carefully considered by each state before moving to each additional compression. At the time it was 4:1 on a compression for two years, going to 3:1 and then at the end of five years to 2:1. I always said that's a little bit like the saying on the side of the cigarette package: be careful; using this rating method may be harmful to the individuals in your state. They didn't like that when I told them that.

Eight states are represented on the Health Actuarial Working Group. We restructured the task force this year into four working groups. Each of these working groups now reports to the task force. The task force doesn't have any real reporting line, other than to the plenary, although all the things that it does for health insurance will come through the Health Actuarial Working Group and will go to the Accident and Health (B) Committee. Anything for life or annuities will go from those particular working groups to the task force and then up to the Life Insurance (A) Committee. It looked this year as if we would have absolutely nothing on our plate. We now have this coordination and by the way, we're starting to use the Health Actuarial Working Group more as you would use a staff actuary in a company. It is here, it's available for the committees to be a resource to use as you put your model acts together. We are to work with the small group regulatory reform to include individual. The Academy volunteered. We accepted its help immediately, and Donna will get more into the study that has come out of this. The issue of new standards for long-term care has now been put on our plate, as to what we're going to do

about valuation issues. We expected good tables that we could work with like the commissioners disability table (CDT). Instead we get a whole new concept. We may not turn it around in 30 days. We have to update manuals again possibly for Medicare supplement. The Medicare working group has asked if it can look at it. We said yes, because we sit on that also, but the Medicare Working Group will bring it back to the Health Actuarial Working Group for the final disposition before it is moved upstairs. We will also support the Senior Issues Task Force, and I think if the Accident and Health (B) Committee puts together a working group on limited benefit policies, that we will also support that effort. There is a big push underway to eliminate this type of policy or to modify it. The actuarial group will be involved and working in support from the stand-point of loss ratios and disclosure. We keep talking disclosure. This always sounds like a job for the disclosure actuary, which is an illustration actuary, or a new job that we've created for job security for all the actuaries.

The Senior Issues Task Force involves the District of Columbia and the following 15 states:

- Alaska
- California
- Colorado
- Connecticut
- Florida
- Illinois
- Louisiana
- Maine
- Nebraska
- New Jersey
- New Mexico
- New York
- Oklahoma
- Texas
- Utah

Working Groups

- Life Actuarial
- Annuity Actuarial
- Health Actuarial
- Reinsurance Actuarial

These Working Groups involve the District of Columbia and the following seven states:

- Colorado
- Florida
- Illinois
- Maine
- Minnesota
- Nebraska
- New Mexico

MS. DONNA C. NOVAK: I plan to do an abbreviated version of the presentation that the Academy did for the NAIC. Jerry's task force at the NAIC, the Life and Health Actuarial Task Force, had asked us to look into nine specific components it was considering as part of an individual reform bill. These nine components are (1) guaranteed issue or 365-day open enrollment; (2) preexisting condition limitations; (3) anti-dumping regulations; (4) guaranteed renewability; (5) mandatory basic and standard or some similar type of predefined health benefit plan; (6) risk-spreading mechanisms; (7) prohibition of experience rating on renewal; (8) the market coordination between individual market and a small group market, especially in light of the small group model act that had just passed through plenary; (9) conversion rates and continuation rates. Conversion rates, as communicated to us, was a plan for continuation of coverage where conversion rates would equal continuation rates, or the rates of the individual if they had stayed in the group plan, similar to a COBRA-type situation.

One of the first points that we on the Academy's Individual Group Reform Work Group made is that the individual marketplace is not the same as the small group marketplace. We had some serious concerns about taking the small group model act and just putting it on the individual marketplace. As actuaries, we feel that there will be many more self-selection issues in the individual marketplace than in the small group marketplace. There are a number of reasons for that. We felt that there was much more price sensitivity in the individual marketplace than there had been in the small group marketplace. So with the same price effect of guaranteed issue in the small group, we would expect to see more of a migration in the individual marketplace. And the individual marketplace has a tendency to be the market of last resort and that has some serious implications in a guaranteed issue, individual marketplace.

When we looked at these components, we had identified three major goals that the NAIC had for individual reform. We felt that if we were going to go through the reform components, determine if they were going to be effective or not, and then react to, if they weren't going to be effective, what possible modifications could be made to mitigate any unwanted effects, we needed to know what the NAIC's goals were. We worked with the NAIC extensively to determine exactly what its goals were. One goal was to maintain or increase the total of number of people who have good comprehensive health insurance coverage with a sustainable premium. So, it is looking for comprehension of health insurance as well as the number of people who are actually covered. A second goal was to improve the fairness and efficiency of the marketplace and assure consumer protection.

There were some subgoals within each major goal that we looked at. For instance, under improving the fairness and efficiency of the marketplace, were the subgoals of spreading the risk more broadly; preventing abusive rating practices; and so on. So we actually worked through some of the definitions of these goals and fine-tuned them a little bit.

We took each one of the components and looked at them individually and said, for instance, with a guaranteed issue environment, what would you need in addition to guaranteed issue in order for this to be effective in the individual marketplace, and in order to reach the goals and not cause a disruption in the individual marketplace? In that way we developed a structure of components that would work together and would stabilize the marketplace. Guaranteed issue, or 365-day open enrollment, would enhance availability of comprehensive coverage and increase affordability but it would also increase the average cost of coverage. In order to stabilize the marketplace, we felt that preexisting condition limitations or something comparable would be needed.

We are actually in the second phase of this project. We delivered our report, but the NAIC has asked us to go back and do some further research and advise them in some particular areas. We are looking for people to be involved in that process. This is a great opportunity for actuaries to actually give the benefit of their expertise to policymakers.

One of the areas that we have been asked to look at is alternatives to preexisting condition limitations. What's working in different states? What might be even a better alternative to these limitations? Perhaps 30-day open enrollment plus preexisting condition limitations. How do you mitigate the antiselection issue which preexisting condition limitations are designed to do, so individuals don't wait until they're ill in order to become insured? In a health maintenance organization (HMO) environment, is a 30-day, 60-day, 90-day waiting period sufficient or will any antiselection move to the HMO submarketplace?

Also we will be looking at the effect of the individual market being the market of last resort. We are all aware of the fact that there is some need for antidumping legislation. Otherwise, depending upon how the rating structures of the group marketplace and the individual guaranteed issue are, the group marketplace could transfer their high-risk individuals into the individual marketplace. Also, Medicaid can transfer their high-risk individuals into a guaranteed issue individual marketplace. We will also research the need for risk spreading, which I will talk more about shortly.

Preexisting condition limitations would increase the number of people without coverage to the extent of the preexisting condition that is not covered. But if it was effective, preexisting limits would decrease the average cost. One consideration would be the prior coverage that would be allowed to be credited against the preexisting condition. In some cases, a high deductible plan is used as credit against a preexisting limitation, which would allow an individual to game the system. So, you'd want to define the credit, in terms of the type of coverage used for credit, so it was at least as comprehensive as the coverage being applied for.

Guaranteed renewability is being included in many of the federal reform proposals. This will increase the number of individuals with comprehensive coverage because they will not be canceled. But in a guaranteed issue environment, there's a question as to what the need for guaranteed renewability would be and it does lock carriers into obsolete products. So our recommendation was that a carrier could cancel a whole policy form and replace it with a comparable policy form with the approval of the department of insurance. That would allow some methodology for replacement of obsolete products. Of course, there is the pooling and closed block problem with guaranteed renewability, which I think many of us are familiar with.

What we've seen in some markets where individual reform has taken place, is that carriers, in order to protect themselves from the high-risk individuals, have offered only high deductible plans and less comprehensive plans. Typically your high-risk individual wants the most comprehensive coverage. Therefore, there would be a need for some type of mandatory, basic and standard benefit if the goal was to have these comprehensive coverages available in the marketplace. Therefore, the need for basic and standard comes from a goal that these comprehensive products are made available. Unfortunately, the comprehensive products that are described in a model may become overpriced because of the self-selection, unless there's some type of pooling or actuarial equivalent filled in. Also, it may be difficult to force carriers to actually write these products at a rate that would be affordable and market them. Also, once you have a definition of a basic and standard plan, you experience lobbying from special interest groups that want their type of specialty covered by the basic and standard plan. Regulators have to be very careful not to build these products into something that's unaffordable for the marketplace.

Risk-spreading mechanisms will be needed in a guaranteed issue individual marketplace to serve two purposes. One purpose is to spread the cost of individual coverage as broadly as possible. These mechanisms actually create some subsidization from the group marketplace, that is, small group, large group and, if possible, ERISA groups.

The goals are to protect the carrier solvency and to mitigate the market segmentation between individual and group. Considerations of different mechanisms are the administrative costs and the effectiveness of the mechanism. Also, the potential of subsidizing an

inefficient carrier is a big concern of the marketplace and regulators. Some of these mechanisms would actually subsidize inefficiency. Of course, if the mechanism isn't designed correctly, it could encourage groups to become self-insured and leave the marketplace all together.

The prohibition of experience rating on renewal in the individual marketplace becomes a pooling issue. Typically an individual is not experience rated on their own experience, but is pooled more broadly. In states where they are allowed, special experience-rated pools do exist. There might be a problem with rate shock as those individual experience pool rate increases up to the average for the market, due to total market pooling. This is a state-bystate issue.

The original intention of the NAIC was to implement rating restrictions in the individual market that match those in the small group market. Initially, this appeared logical, but the more we looked at the reality of the situation, there were reasons to leave the individual market as age rated and not restricted rates. The small group model, as currently written, restricts rates to narrow bands which indent higher-risk individuals into the small group market. If you accept the assumptions that the individual market already has the higher-risk individuals and that the group market has a broader base to accept risks, you would want high-risk individuals to move from the individual to the group market. Also, the NAIC plans to relook at group sizes of one, two and three, when they expand to individual market reform and, therefore, move to a coordinated market reform. Currently, individuals in groups of one, two or three, antiselect against the individual market if rates are lower for high-risk individuals.

Conversion rates, is another area that the NAIC has asked us to look at further. Conversion rate regulation does two things. It provides a subsidy from the group marketplace because the group has to subsidize the poor experience of the individuals that opt for conversion coverage. And it also provides availability of coverage for individuals who are leaving the group marketplace. Guaranteed issue provides the availability. So in a guaranteed issue environment, the goal that conversion policies would satisfy, would be the subsidization from the group marketplace. The NAIC has asked us to do a little bit more research into this area, and why conversion rates in some areas are high and in others are quite low.

In phase two we will look at five areas.

1. The effectiveness of risk-spreading mechanisms. What currently is being done and what's effective. The AAA already has a group working in this area and we're hoping to use some of its research.
2. The effectiveness of a 30-day per year open enrollment with 12/12 preexisting condition limitations or, for HMOs' waiting periods.
3. Continuous coverage or continuation of coverage for those with qualifying previous coverage.
4. Alternatives to 365-day open enrollment, such as a 30-day open enrollment period with 12/12 preexisting condition limitations.
5. The question of who will leave the marketplace in an individual guaranteed issue and who will enter the marketplace. The goal of the NAIC, is to make sure that insurance is available for those who need it. There's another Academy group, headed by Tom Stoiber, that is also looking at some of these issues and we're

hoping to take advantage of their work, such as case studies of states where reform has been enacted and documenting the results that have been realized.

The next issue I've been asked to address, is Blue Cross/Blue Shield's position on reform issues. Blue Cross/Blue Shield Association is very concerned that the individual marketplace not be disrupted and very concerned about guaranteed issue in the individual marketplace. It feels that, for a guaranteed issue marketplace to work, some risk adjustment mechanisms will be needed to protect the solvency of carriers and the viability of the marketplace. For the same antiselection reasons that concern us with guaranteed issue, it is concerned about some of the preexisting and limited preexisting requirements. We're very much for bills, such as HR 1610 proposed by Representative Thomas (R–WY) that guaranteed portability within the group marketplace, the group-to-group portability. His bill supports the idea that this portability is needed, but is concerned about the group to individual portability without some type of mechanism to protect against antiselection.

Blue Cross/Blue Shield Association is aware, because its plans are state specific, of how different marketplaces are from state to state. It is concerned about a "one-size-fits-all-type" solution to individual reform. Every state has different circumstances which would mean that some reforms could work very well in one state, yet cause significant problems in the individual marketplace of another state.

In a guaranteed renewal environment, Blue Cross/Blue Shield Association is concerned with closed pools and obsolete coverages having to be offered. It supports the ability to replace a product with a similar more up-to-date product. In general, the association has some concern about the risk segmentation with metropolitan statistical areas (MSAs).

MR. WILLIAM C. WELLER: For those of you keeping count, I think this is a good actuarial meeting. We have three actuaries speaking, but they are presenting four opinions. But we make up for that because there were nine points the NAIC asked for input on, and if you counted, we only have eight that we actually included in the Academy's report. So we're right on target.

From HIAA's perspective, we are very concerned about the individual market and the idea that it is possible to easily transfer concepts that we think work reasonably well in the group marketplace, into the individual marketplace. A couple of points that haven't been noted so far: (1) We are particularly concerned that the loss ratio standards that are typically used by regulators in the individual market, do not allow reasonable credit for managed care expenses. If we are trying to move the marketplace towards more of a managed care environment, and we want to encourage that, HIAA thinks there needs to be some adjustment for the additional costs and maybe a little bit more of a level playing field because we believe that some HMOs are able to include some of their managed care expenses in the benefit portion. (2) HIAA is very concerned that portability can easily produce a dumping situation into the individual market. (3) Employees, offered open enrollment within a group, are subsidized because the employer generally pays some portion in order to meet any minimum participation. There is no similar subsidy in the individual market. Finally, preexisting exclusions are probably not going to be enough of a deterrent in the individual marketplace to offset antiselection impact of continuous open enrollment.

The marketplace and the problems that I have heard reform is attempting to solve can basically be summarized into three issues. The first is clearly affordability, and I don't think that as regulators or insurers that we can solve the problem that the underlying cost of the care is beyond the ability of many people to pay for it without any employer contribution. The second one is the natural tendency of waiting until necessary to find coverage. You do not hear people complaining to regulators about the fact that they cannot get coverage when they are healthy; it is that they cannot get coverage when they are not healthy. The third area that clearly is being looked at is, the proportion of people who have never had accessibility.

We are concerned that the second issue, waiting until they need health care, is looked at as a problem of the insurers, that somehow the insurers are at fault for allowing people to wait until they need insurance before they come and seek it. In terms of the overall reform, HIAA thinks that in the individual marketplace, the high-risk pools that provide comprehensive coverage with a surcharge on the premium as well as a broad base subsidy, makes sense for a number of reasons. The higher cost of that insurance is probably more understandable to most people than the preexisting exclusion (and the rules for when it applies). So when added to preexisting, there is truly a control there that they believe. The subsidy, as the Academy report noted, is needed if we are going to have some type of guaranteed access in the individual market. HIAA feels that subsidy should be targeted as closely as possible to those people who need it, which are the high-risk people.

There are a number of parts of individual reform that HIAA does support. Going down the NAIC's list of nine points, I will cover all eight of them. On guarantee issue: we do not support a guaranteed issue with 365-days open enrollment. We believe that guaranteed access should be provided and we think the high-risk pool is the best approach for that. With regard to preexisting exclusion and portability, we support that. We think that the preexisting exclusion should be consistent with the requirement for late enrollees of group, because if you think about it, the individual is always a late enrollee in the individual marketplace. Guaranteed renewable: we support that in terms of the general approach defined for the small group marketplace. Basic and standard plans: the high-risk pool would need to offer a basic and a standard plan. We support tThe issue of rates reflecting experience on renewal or the need to do some pooling. Risk spreading: obviously the high-risk pool requires a subsidy. So do all of those we generally support.

Market coordination: in terms of having the same rating rules for group and individual, we do not support this. The individual market is a different marketplace from the small group market. You do not have any averaging among the employees and dependents of a group. We think the individual market needs much broader rating categories than those adopted by the NAIC for the small group market. Finally, conversion versus COBRA is obviously not stating the issue correctly. The issue is what are the responsibilities of the two marketplaces, the group and the individual when a person is no longer an employee of an employer (or a dependent) with an employer contribution. We think that the issue that needs to be looked at is who is going to be able to pay when there is no employer contribution.

On the topics related to limited benefits products or supplemental insurance as HIAA likes to call it, there are three issues that have come up as Jerry noted. On loss ratios, we think that there have been a number of expenses that have been added over a period of years: additional disclosures that are required, significantly more reporting in some states,

risk-based capital requirements, and so on. The premium size for supplemental coverage has not increased to the extent that the premium has increased for major medical, and yet frequently we fear that there exists the belief that there is a great deal of margin because premiums have increased. We need to maintain, in the supplemental marketplace, a national approach to reduce the administrative costs of differences from state to state. That does not mean that we think that federal regulation is the solution, but we would encourage the NAIC and the states to adopt a national approach and to discourage variations. There are some people who want to eliminate a number of these products. We think that very few of them are willing to step forward and say they want to eliminate them, but they are very willing to regulate them out of existence.

With regard to individual health reform and federal issues, certainly portability seems to be the hot item in Washington these days. Group-to-group portability is certainly going to pass this year. There may be something that includes individual-to-individual under very specific circumstances. For example, if you move out of the area for the plan, or if you cease to become a dependent, or that you have access to essentially individual coverage within the locale that you are living, rather than having only one carrier responsible for you. The big issue is obviously the issue of group-to-individual portability, which includes not just insured groups from insurers, but the potential for portability from self-insured programs. This is a very political issue and we are very fearful that group-to-individual portability, including guaranteed issue, will have a significant detrimental effect on the individual marketplace.

MS. SPENNY: We talk about specific state reforms, and Jerry Fickes will bring us up-to-date on New Mexico reforms.

MR. FICKES: Over the past two years, we have been putting together the New Mexico Health Insurance Alliance. It is not actually a governmental program. It was designed in the government, but released to the industry and the small groups. This is small group, it's not individual at this time. But as you see these developed, you run into the same experience that we've run into. When we designed this for small group, the representatives and the senators in our state immediately said, we need individual coverage. You have to include individual. We went into subcommittee and long debate, trying to keep individuals out. One, we didn't want to bring our chip pool people into the small group pool immediately. We knew that would defeat it financially. In 1993, the chip pool in about 25 states was actually subsidized $160 million for 100,000 people. That's approximately $1,600 per year, per person. Now that subsidy is either in premium tax offsets, in government grants, or in excess premium over the standard. We didn't want to lose what we have and throw the people with that loss into our small group reform. We received a great deal of pressure. We finally compromised. We would allow a self-employed into our small group, provided a dependent came with them, so that we had at least two people entering the group. This was about the best that we could do.

We then started looking at some of the other items that tied in with the individual. We had and have looked at portability, a different portability that involves individuals more than any other state. Our small group alliance is convertible to an individual policy of the same benefits, that is just like COBRA and you may stay in that group experience, until you are 65. In other words, it's full portability. Even if you move, the HMOs have arrangements with indemnity carriers to take that particular policy when you move out of territory, so that we have coverage up until that person can go on to Medicare.

We returned the experience to the small group place, not putting it into the individual markets. We felt this was a very important step, until we could solve the individual market. We had to go in and change some of the laws for the individual markets, so that we would not have cherry picking because we did go to a modified community rating. Ours is basically compression of 3.5:1. You read the law and it will say 250%, but that is a difference; it's 3.5:1. This did not cause as many problems, and would not have caused as many young males that were in a small group to go over to the individual coverage, as did the compression due to gender. We went to a 1.23:1 gender ratio. Many states are going to unisex. As a result in the individual market we have just created a new policy that has male maternity coverage. The loss ratio is very good. But this is one of the big problems, because suddenly you can not rate maternity outside of this overall limit of the 1:3.5 and the 1:1.23.

We found many other problems. We had to carry our preexisting condition limitations through to the individual market. We had to do many changes to the individual market so that there would not be the cherry picking, in the small group marketplace. I happen to be the chair of the New Mexico Health Alliance, also. I have been threatened with law suits for discrimination because we did not bring in individuals. It's a very hot topic, there are many individuals, by the way, some of them that have chip coverage, who do not appreciate that something else has been made available for small groups. They want in on it. We have to find a solution and find it very soon or I'm afraid we'll go back to our state legislature, which was looking at single pay or five HMO which were only for networks, not for coverage and with no agents involved, basically telling the insurance industry, as we would say in Spanish, "Adios."

MS. NOVAK: I have seen some press that said that insurance reform is working in New Jersey. So we wanted to look at what is happening in New Jersey. Effective August 1993, there is full community rating guaranteed issue for the individual market. Individuals were eligible for guaranteed issue if they were not eligible for group coverage and were not eligible for Medicaid. Medicaid, there's some question, I understand, if that is actually going to hold up in court if it should go to court. But at least there's some recognition of antidumping in New Jersey. There are six standard benefit plans that have been defined in New Jersey, five indemnity and one HMO plan. There's already quite a bit of lobbying to include music therapy or other coverages within those plans. New Jersey has a pay or play, so that if a carrier is not selling individual coverage, they are assessed. If a carrier wants to be exempt from that assessment, they have to write a sufficient amount of individual coverage in order to be exempt from the assessment; or if they apply to be exempt and do not write that level of coverage, then they can get a partial exemption from the assessment. What the assessment is based upon is loss ratios at a 75% target. So if a carrier writing individual insurance would have loss ratios in excess of 75%, then they can apply for a transfer of funds. There's some concern that carriers that will be eligible for this subsidy, would not be as efficient as they should be, therefore would not be managing their care the way they should be. And the assessments will not reach to the self-insured marketplace right now. The self-insured are not included and so the base right now is for insurance only.

MR. WELLER: I will cover Iowa. It's legislation provided primarily for continuity of coverage. It required individual carriers to guarantee issue a basic or standard plan of benefits to people with qualifying previous coverage, or within 30 days of a qualifying event. Carriers are allowed to issue any other plan on an underwritten basis. Rules are

included to deal with rating variations, that is, between the basic and standard plans and those subject to underwriting. There are fair marketing disclosure, portability, preexisting, and renewability rules. The basic or standard plans are issued to eligible individuals, defined as those with qualifying existing coverage, group insurance, individual insurance or in what is called in Iowa, an organized delivery system. A person is ineligible if they have access to coverage through the employer. They are trying to deal with the antidumping. Eligible individuals have to apply within 30 days of the qualifying event, which would be a loss of Medicaid, a loss of dependent status, or age majority. Also, if you go through and reach the end of COBRA coverage, then you have 30 days to apply at that point in time. Finally, you have 30 days to apply if you have a rate increase on other individual coverage. That is to avoid the closed block of business situations. The basic and standard plans will be defined by the commissioner—and will have 12/12 preexisting condition limitations and they may not be ridered. This just went into law and has not been done yet. In recognition that there will be losses on the basic and standard plans, two adjustments were included in the law. All those people who apply within the time allowed after a qualifying event, come in at the standard rate. Since this is also looked at as the high-risk pool, other people without prior coverage defining a qualifying event come in at a substandard rate.

The whole thing is then subsidized and the losses may be recovered from the individual health benefits reinsurance association. One of the things that I thought was particularly interesting is that the subsidy is spread across all health insurers, but essentially it benefits people who had prior health insurance more. If the person previously had self-insurance, you would not have any guarantee issue until COBRA ran out and then the premium would be the substandard rate. However, Iowa has the option where a self-funded plan can agree to be subject to the assessment for the losses. When a self-insured plan is willing to do that, then a change of employment, and so on, for their employees and dependents becomes eligible as a qualifying event. It is a way to make a positive out of the distinction between the insurance marketplace that is regulated (and can be required to provide the subsidy) and the self-funded marketplace that the regulator can not reach. Instead of saying well, we have to provide for those people, they provide the option for that, which I thought was very interesting.

The Iowa rating rules apply to new issues of underwritten plans by defining blocks of the same individual health plan. Then they allow rate variations so that any block would be consistent with another block. Theoretically, you are able to get a rate for one policy form, which was two times the rate of another policy form for comparable coverage. However, since the high-risk pool provides a basic and standard plan with a maximum of 150% of standard, it seems unlikely that you would be able to actually utilize the full range the law allows.

MS. MICHELLE G. DYKE: I wondered if anyone could comment on the success or lack thereof of Minnesota's individual market reform?

MS. SPENNY: Which part of the individual reform are you talking about? The high-risk pool in Minnesota is doing quite well right now.

MS. DYKE: More with respect to its restrictions on the individual coverages with the increasing loss ratio requirements and the community rating.

MR. THOMAS J. STOIBER: I'm heading up an Academy working group on guaranteed issue and we're doing a case study. One of the cases we're studying is Minnesota. The legislature requires an annual report on guaranteed issue. Guaranteed issue was repealed. The compression of premiums to pure community rated won't go into force. That report strongly recommended against the community rating compression. The increasing loss ratio remains there.

MS. NOVAK: I know they're still looking at risk adjustment in the state, although guaranteed issue has been dropped for now. There is a group that is looking at risk adjustment for the future.

MR. SCOTT A. GESKE: Also the regulated all-payer option was repealed. However, the growth limits that restrict the amount you may trend up was maintained. There is still the ability of the state to regulate what a provider can increase his fees by from year to year, but I'm not sure how they can do that without the regulated all-payer option.

MR. SIDNEY A. RICHARD: Bill, earlier you made a comment about using expenses for managed care to be counted as claims. Are you aware of any states that are currently allowing individual companies to use managed care expenses as claims?

MR. WELLER: It's my understanding that as part of Minnesota's minimum loss ratio rules, that some expenses relating to controlling or managing health care are allowed as claims. They do not go through strictly as expenses. I don't know that there are any other states that are allowing that at this point in time.

MR. RICHARD: At one point I heard that Florida did.

MR. WELLER: I do not recall that Florida provided any such adjustment when it finally passed its regulations. We had talked about it with Florida regulators in numerous workshops, and they recognized that there was some value to the argument, but I don't think it ended up in the final regulations.