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

HEALTH CARE REFORM: STATE DEVELOPMENTS

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A discussion by several experts of reform activity at the state level will be included. What can be learned from reforms to date? What is likely to happen in the near term?

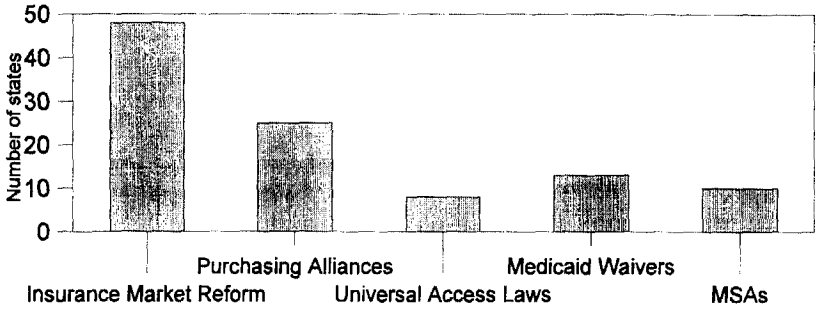
MR. JAMES T. O'CONNOR: I'm a consultant with Milliman & Robertson and, as you know, during the last several years we've seen almost all the states enact insurance reforms of some sort—from simple rate reform to guaranteed issue, community rated, mandated benefit plans and to more global reforms, such as managed Medicaid. Some are on their third or fourth iteration and the reform goes on today. In this session, we have three distinguished panelists who are experienced in dealing with the global issues as well as the nuts and bolts of state health care reform. John Vataha is a consultant with Peat Marwick, specializing in group insurance. He has been involved in helping his clients analyze and implement the reforms in various states. John will provide us with an overview of the various state reform initiatives, look at the challenges facing the states in succeeding in their goals, and tell of a few ideas of what may be coming.

Jim Hall has many years of small-group experience. He's an actuary with American Chambers Life Insurance Company, and he will discuss some of the practical issues and decisions a small-group carrier needs to make when faced with a new state health care reform law. He will use the new Kentucky law as a reference example in his comments.

Troy Pritchett is an actuary with the Utah Insurance Department. Troy will provide us with some thoughts from a regulator's perspective, and he will address the continuing work of the NAIC in developing its latest small-group health insurance reform model law. He will also update us on current activities in the State of Utah. So with that, I present John Vataha.

MR. JOHN C. VATAHA: I'd like to present an overview of the various types of reform initiatives within states, touch on the merits and drawbacks of the various initiatives, discuss some recent developments in the states, and wrap up by touching on some directions that states might be going in with health care reform. I'd like to emphasize that this is an overview. Any one of these topics probably could merit its own session. So having said that, these are the five main categories of state reform initiatives that I want to touch on today: insurance market reform, purchasing alliances, universal access laws, Medicaid waivers, and medical savings accounts (MSAs). I'll briefly describe each of these and discuss relative levels of implementation within the states. Chart 1 depicts the number of states that have enacted various reform initiatives. As you can see and, as Jim mentioned, almost every state has enacted some form of insurance market reform. Medicaid waivers and MSAs, although they're smaller in magnitude, represent one of the fastest growing components of state reform.

CHART 1
STATE REFORM INITIATIVES



INSURANCE MARKET REFORM

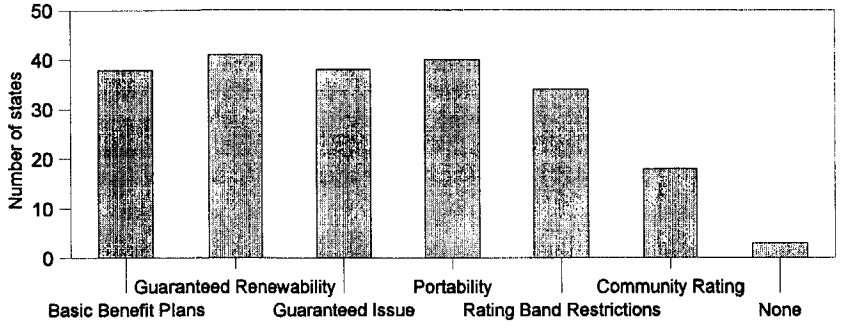
The first of the five categories I'd like to focus on is insurance market reform. A general definition of insurance market reform would be the establishment of rules governing rating, underwriting, availability, and affordability of insurance coverage for small groups. Again, the definition of a small group will vary from state to state, but typically it's defined as having from 3 to 25 employees, and some states take that all the way down to sole proprietorships or up to groups of 50. Most states have adopted the model legislation developed by the NAIC in the original small-group rating laws dating back to December 1991. Here are some common provisions of insurance market reform. I'd like to just go through them quickly to get some standard terminology:

- *Basic benefit plans* are designed to provide low-priced insurance products to small groups that may not be able to afford higher levels of coverage on their own. Generally, they're exempt from state-mandated benefits and include features such as high deductibles, low maximums, or limited covered services. More recently, states have been using basic benefit plans as a facilitator for price comparisons by requiring all carriers to provide identical levels of benefits.
- *Guaranteed renewability* requires a carrier to keep coverage in force for a group. The carrier is not able to cancel because of claims experience or changes in the health status of the group's employees.
- *Guaranteed issue* requires carriers to offer coverage to all groups, regardless of health status.
- *Portability* requires carriers to waive waiting periods for preexisting conditions if an insured previously had coverage under a similar plan of benefits.
- *Rating band restrictions* limit the difference among the lowest and highest rates a carrier can charge to different groups of employers. Here we need another definition: a different group of employers is usually defined as having a different risk characteristic, such as health status or different case characteristics such as age, gender, or industry.
- *Community rating* typically takes two different forms. Pure community rating would require a carrier to charge the same premium to everyone, and modified community rating would allow adjustments for age, gender, and industry, but not for claims experience or health status.

Chart 2 depicts the relative prevalence of insurance market reform measures among the states. As we can see here, an approximate equal number of states have enacted each of

those first five measures, and about half as many have put community rating laws on the books. Right now only three states have no laws regarding insurance market reform.

CHART 2
INSURANCE MARKET REFORM



PURCHASING ALLIANCES

Purchasing alliances are the assemblance of health insurance purchasers into large groups to take advantage of more favorable rates and expanded benefit options that normally wouldn't be available to them individually. A couple variations of purchasing alliances have arisen, based on who makes up the alliance. One type would be an alliance that is formed for state-funded coverages, such as Medicaid and state employees. A second type would be a voluntary alliance that would be formed for small employers and/or individuals. There could be some overlap between those two categories. A major advantage of a purchasing alliance is that large groups can more effectively negotiate with insurers regarding rates and benefit availability. That is hoped to stimulate some competition among participating insurers.

The early results have been relatively favorable. Here are a couple of state examples. California's purchasing alliance has enrolled between 4,500 and 5,000 employers and represents about 85,000 employees, which makes it a significant player in the market. California's plan is available to groups from 3 to 50 lives, and about 20 to 25 insurers are currently participating in the program. Premium rates in California are scheduled to decrease by about 5% this July, and that follows about a 6% reduction that was implemented after its first policy year. One criticism of the California alliance has been the demographics of the enrollees. About 60% are under age 40, and slightly more than 55% are males, which typically would represent lower-risk-type enrollees. The goal would be to have the alliance reach some of the higher-risk people. Somewhat offsetting that, though, is the fact that about 20% of the enrollees to date were previously uninsured.

Florida is another example of a purchasing alliance. Florida got off to somewhat of a rocky start in that its early enrollment did not reach initial projection levels, and a couple reasons have been cited. One was the lack of employer awareness; employers didn't even know the alliances were out there, and they didn't know how to get involved with them. A second reason was an underlying reluctance of an employer to join an alliance that it didn't know much about. However, of the groups that have enrolled, premium savings of between 5% and 20% have been reported. So the alliance seems to be working for those who know about it.

UNIVERSAL ACCESS LAWS

Universal access laws are defined as laws that contain provisions to systematically make coverage available to all citizens. I've defined some general categories of universal access laws. Employer mandates require an employer to provide insurance for all its full-time workers. One of the more well-known employer mandates is Washington State, which began with large employers in 1995 and extended to all employers by 1997. But because of the provisions of ERISA, which preempts state authority to regulate self-insured plans, Washington had to obtain a waiver from the federal government to implement its mandate. Its request was denied, which, in effect, rendered the mandate ineffective. Since that time, several revisions of Washington's law were proposed. Subsequently, in large part, it was repealed including the employer mandate. Oregon also has an employer mandate provision that has yet to be implemented. There has also been recent discussion regarding its repeal.

Play-or-pay legislation imposes an employer tax that can be avoided if a suitable plan of insurance is purchased for employees. Massachusetts was the pioneer in this type of legislation back in 1988, but has not yet implemented any play-or-pay regulations because of the changing political and economic climate within the state. It's also unlikely that this type of legislation would withstand a challenge based on ERISA.

Lastly, there are voluntary access laws relying on market forces to make universal access happen. Florida's reform law, which is an example of a pure voluntary approach, has as its centerpiece seven regional community health purchasing alliances that offer a menu of plans to all participating employers. Minnesota also makes use of the voluntary-type approach.

MEDICAID WAIVERS

Under a Section 1115 waiver, a state obtains permission from the Health Care Financing Administration (HCFA) to require its Medicaid recipients to enroll in a managed-care plan. The appeal is the large potential cost savings. Medicaid averages about 20% of a state's budget and it's often the fastest growing component of the budget. By capitating the cost of care through managed care organizations, the state can achieve significant cost savings. About 12 states have approved Section 1115 waivers from the HCFA. About a dozen more are pending, and many more than that are considering enacting this type of legislation. This is among the most active of the state reform initiatives today. One reason is because it's a good source of funding for expanding coverage. Because the state receives matching Medicaid funds even after it obtains a Section 1115 waiver, any cost savings that it achieves through managed care becomes available to support other reform initiatives. Typically the state seeks to expand its eligibility for Medicaid down to some percentage of the federal poverty level.

MEDICAL SAVINGS ACCOUNTS

Last, but not least, as I mentioned earlier, the area of MSAs is also an active area of reform. A very simple definition of an MSA is an account owned by an individual, funded by an employer and/or individual contributions on a tax-preferred basis, and used to pay for health care costs that aren't reimbursed by an insurance plan. Typically an MSA is offered in conjunction with a high-deductible major medical plan and is similar to a flexible spending account (FSA), except that funds that are left over in the MSA at the end of a plan year remain an asset of the individual. Under an FSA, any account surpluses are forfeited.

The principal advantage of an MSA is that, when combined with a high-deductible insurance product, the MSA can create an incentive for individuals to be more cost-conscious of how they spend their health care dollars. Conceptually how that works is that individuals are financing costs out of their own funds from the MSAs so they're more likely to consider both the necessity and the cost of care. That is hoped to stimulate competition among physicians on the basis of fees because they know their patients are shopping based on price.

The major disadvantage of an MSA today is that without a federal tax deduction, an MSA is not appealing when you look at it compared with an employer contribution toward an insurance plan, which is fully tax deductible. As we saw on Chart 1, about ten states have implemented MSAs, and many more have proposals that are now pending.

CHALLENGES OF REFORM

Some challenges face states enacting reform initiatives. First there is the limited impact of insurance market reform. As we saw earlier, almost every state has enacted some type of insurance market reform. However, the impact has been somewhat limited because insurance market reform doesn't reach self-employed groups because of ERISA preemption. Self-employed groups typically represent at least half the insured market. These types of reforms also do not address the problem of the uninsured population.

Second is the issue of financing the cost of increased access to insurance. Every state would like to ensure that coverage is available to all citizens. But how to pay for that becomes the real issue. Typically, there's no room in a state budget for additional health care expenditures. Employer mandates and employer pay-or-play legislation don't seem to be currently feasible because of the ERISA preemptions and, of course, additional income taxes are never well received.

Lastly, political factors also play a role. Reform laws typically have a long time frame over which they're implemented, especially far-reaching laws such as universal access. The political environment may change during the course of implementation as we saw last November [1994], with the increased Republican presence in state legislatures. Opposing parties might not share the same goals for reform, which often leads to repeal or revision of those provisions that are still to be implemented.

Here are some important recent developments. There is the Supreme Court ruling on the New York hospital surcharge. New York imposes a surcharge on hospital bills of patients covered by commercial insurance, HMOs and self-insured plans. It uses those funds to subsidize the higher cost experienced by Blue Cross and Blue Shield plans because of their acceptance of higher-risk insureds. The Supreme Court ruled on this surcharge and went against two lower court rulings by upholding the surcharge on the grounds that it was not in violation of the ERISA preemption.

A new NAIC small-group model was enacted this spring [1995], and it expands upon the provisions of preceding models in a couple of important ways. One way is that the definition of a small employer is extended down to sole proprietors. The second way is that it tightens some of the rating restrictions that were previously enacted.

There has been the introduction of MSA bills in Congress; quite a few bills out there right now have MSAs attached. One specifically is the Family Medical Savings and Investment

Act, which was recently introduced in the House by Bill Archer [R–TX] and Andy Jacobs, Jr. [D–IN]. That bill provides for tax-preferred status of MSA plans that meet certain requirements.

Finally, we have new reform laws. States continue to push forward with their own initiatives. Two examples of that are Indiana and South Dakota, which have recently passed reform laws that concentrate on insurance market reform but also touch on other reform measures, such as MSAs.

I'll look into my crystal ball for future initiatives. Incremental reform seems to be the way to go as has been evidenced by difficulties in those states trying to enact universal access laws as well as the failure of national health care reform proposals. The broad scope of reform makes it extremely difficult, if not impossible, to achieve total reform. Smaller step-by-step measures seem to have more success. So we're likely to see additional tightening of insurance reform laws, either via the new NAIC model or through states' own initiatives. The additional use of provider surcharges will probably stem from the Supreme Court ruling on New York, which could pave the way for other states that are searching for funding for their own reform initiatives.

Lastly, I will wrap up by talking about duplication of successful reform initiatives. Many states are pioneering some of these reform initiatives I've just mentioned. Other states will have their eyes on them, and any success that they see could lead to duplication as those states try to achieve the same level of success. This may or may not be possible due to differing political conditions and needs of the citizens of those states.

MR. JAMES F. HALL: Jim said that I have extensive experience in small group. Actually, I've worked for a small-group company for the last ten years, but what I'm doing today is nothing like what I did five years ago. So even though I have extensive experience, it has changed quite a bit. I work for American Chambers Life Insurance Company in Naperville, IL. We specialize in the small-group market. We have been selling a program called the United Chambers Insurance Plan for more than 25 years. We work in most of the states. I have spent the last three years dealing with many different varieties of health care reform.

I would like to discuss the new Kentucky legislation. It is effective next month, and we have been working on it a little bit. I will review Kentucky House Bill 250 and comment on our perspective of it and how it relates to risk rating and workload. I will also comment on what's new and what's not new with the legislation.

I personally have not worked with all the state reforms, but in the last three or four years we have seen more of the same things. Now and then we see something a little bit new, but they all seem to blend together. I don't know about the rest of you, but that's my perspective.

Actually, Kentucky House Bill 250 was passed quite a while ago. At our company, and from an actuarial perspective, we deal with new legislation relatively simply. I thoroughly review the state laws four or five times a year and pull out anything new. I found out about Kentucky House Bill 250 probably eight months ago.

KENTUCKY PURCHASING ALLIANCE

House Bill 250 establishes the Kentucky Health Purchasing Alliance, much like we have purchasing alliances in other states. This purchasing alliance is the exclusive alliance of the state. It has what I consider to be a new feature, mandatory alliance members who are state employees and elected officials. It also has voluntary alliance members. Voluntary alliance members are employers of 100 or less individuals and association members. The Insurance Department does not make carriers aware that the number of state employees and elected officials could be upward of 1.2 million people who will be rolled into the alliance quickly. So if the carrier is in the Alliance, it might get several of these people. We do a lot of business in Florida. I don't know that I would necessarily call the Alliance a huge success there, given the number of people put in every day.

Also, Kentucky House Bill 250 defines administrative responsibilities and duties of the alliance. Under administrative responsibilities it lists the requirement to create a board of directors. I find it interesting that no insurers or health care providers are allowed to be on the board of directors. The board of directors is to represent the interests of employers and health care consumers. It also defines alliance participation requirements, and they're pretty standard: you have to be a valid employer and have employees actively at work. It also states you cannot, as an alliance member, have an employer contribution requirement.

I'll talk a little bit about the Kentucky Health Policy Board. The Kentucky Health Policy Board was not created with respect to House Bill 250, but it is mentioned constantly throughout. The board has oversight and review responsibilities of the alliance. It also has data collection responsibilities for the annual review of the performance of the alliance. It is responsible for the definition of accountable health plans (AHPs). It is to establish a data system to be used by the AHPs, which includes the elements required to be filed with the alliance.

AHPs are the risk bearers in the alliance that sell the benefit plans. AHPs have to be created by health care providers, HMOs, or health insurers for providing health care services to alliance members. The alliance must approve the AHPs. At the earlier session on community rating and guaranteed issue, people were there from Kentucky and this topic came up. I have a packet of information on what you need to do to become an AHP. It's extremely extensive. It's not like in the other states where you just sign up.

The law goes even further in defining the approval criteria. It has 14 or 15 points that fall into various categories. An AHP has to be licensed and has to have the financial capacity to take on this new business. The law requires AHPs to have standardized electronic claims and billing procedures and formats. There are requirements concerning provider management and disclosure of provider arrangements. There are many other requirements to be an AHP.

One interesting thing in the provider disclosure requirements is that AHPs are required to disclose to the alliance the reimbursement arrangements with the providers. The required questions ask you to say how you are reimbursing providers. There have been questions proposed to the board concerning confidentiality; the board's response was that it will do whatever it can, as required by the law. Concerning the confidentiality issue, from my company's experience we have been able to get whatever competitors' information we want if they have filed it with the states. We obtain filings from a number of states for

other carriers, even though they have been stamped "confidential information, do not release." We can get them.

MODIFIED COMMUNITY RATING

Community rating methodology applies to all plans issued or renewed on or after July 15, 1995, individuals or groups of 100 or less, and alliance members. When I saw community rating, I used to panic. Every state has a different definition of community rating. You really have to read the law to figure out what was intended. I view community rating as one rate for everybody, irrelevant of age, sex, whatever. The only real difference is the benefit plan and whether you have dependents. So what Kentucky has from my point of view, is modified community rating. Rates are based upon age, area, family composition, benefit plan, cost containment, and whether you are in the alliance. The law also comments on limited discounts for healthy lifestyles. That's written in the law. I've seen no questions or answers on it. I am unclear as to its intent.

You must have separate rates for both your individual product and your group/public employee products. To sell to public employees you must be in the alliance. The modified community rating restrictions, however, apply to everybody, not just those in the alliance. The other thing that always jumps out at me is rating bands. The number shown in the rating part of the law is 300%. It is not written like it is in other states, and in reality it allows for a four-to-one rating band. The width of the rating band is a big deal for us because we do different things, depending on what the limits are.

OTHER PROVISIONS

Kentucky House Bill 250 has standard policy provisions, guaranteed renewability, and 6/6 preexisting conditions limitations. Both are the NAIC model law versions.

One of the things I found interesting is the wording which states that plans cannot discriminate against any provider willing to meet terms and conditions for participation. Does that mean that if I'm a doctor and I'm willing to accept the PPO level of reimbursement, that I can then be considered and treated as a PPO member? I haven't seen any questions, but these things jumped out at me. I wonder if people from Kentucky could respond to this.

Regarding the risk-adjustment process, in the laws it says that the board shall promulgate an administrator, and the regulations shall be applied on a marketwide basis. It has been clarified through question and answer bulletins put out by the department that the process really only applies to individuals, employers with 100 or less, and alliance members. It does not apply to everybody in the market. Regulations have been adopted, and I've downloaded them from Hi-Wire. They are very different from anything else I have seen in other states. I am not going to comment on them because I did not understand them after having read them twice.

In the standard unfair trade practices section, agents shall not discourage selection and insurers shall not compensate agents based on selection. Selection is directing individuals, employers, or groups to purchase from you or not from you, based on health status, claim experience, industry, occupation, or geographic location. You see that requirement a great deal. Basically, people should have the freedom to pick whatever they want.

STATE-MANDATED PLANS

One of the things I find interesting about the Kentucky bill is the order of things in the law. The last section in the law is the health benefit plans. You read this whole thing and finally get to the health benefit plans. That's the crux of the law, in my opinion.

The board shall define no more than five plans. There shall be two forms: indemnity and HMO, which shall be a high- and low-cost-sharing option. Then it makes a rather nebulous statement that one plan shall be a basic benefit plan. After July 15, 1995, no insurer shall issue or renew any individual or group to any benefit plan other than the state plan. It really doesn't affect us as a carrier, but if you have a 1,000-life group, you must sell it the state plan.

As a condition of transacting business in the state, insurers shall offer a basic benefit plan. The law defines the basic benefit plan. There is also a five-year lockout if you withdraw from the market. This is a really big kicker, at least for our company. We don't like to terminate people, and we don't like to pull out of any markets. We're really not in that business. Most states have something such as this. This is something I always look for. It is less accommodating, but not being wrong.

CARRIER IMPLEMENTATION STRATEGIES

The question is, when you're looking at this legislation, what are the real risks? Guaranteed issue? Today 80% of our business is in states where we're required to guarantee issue whatever plan to whomever wants it when they come to us. Eighty percent of our business is in states where we cannot differentiate rates between new business and in-force business. Guaranteed issue is a given in my opinion. For carriers that are not in states such as Florida, Massachusetts, Connecticut, and New Jersey, it might be slightly different, but those are four of the toughest states. Regarding the risk-adjustment process, with the reinsurance pools you know what you're going to get yourself into, and you are somewhat limited to what your assessments could be. The risk-adjustment process in Kentucky is very different. I don't yet fully understand it, so that is a risk.

The other thing that I consider to be a very big risk is the purchasing alliance. Why? Do I really want to get some of the mandatory members? As a company we specialize in writing small businesses, and we require people to be actively at work. Generally, our average case size is two to three persons. Now do I want to start being an insurer of the mandatory state employees? That's a completely different group of people from whom I have dealt with in the last ten years. They might be similar, but do I want to jump into the alliance? What if I guess wrong on my rates? I don't want to say guess, but if I'm the low guy in there with the rates, people are familiar with what went on in New Jersey, so do I get all the state employees? Or do I get a big chunk of them? That's a big risk.

Regarding rating issues, pricing of state-mandated plans, and supplemental benefit riders, you can sell 29 different plans if you're both an HMO and an indemnity carrier. Up to 30 different riders are offered with these various plans. What we are doing at American Chambers is not quite the bare minimum, but we're doing what is necessary to stay in the state and see what's going to happen. We're going to offer the standard plans that have the high and the low option, and we're going to offer the PPO version. So that's four plans: standard high and low and standard high and low with the PPO. We also have four mandated riders we must sell: mental illness, home health care basic and expanded, and

dental care. How do you differentiate between the home health care basic and the home health care expanded? I would be curious if somebody has some guidance on this.

Conversion to modified community rating will involve taking all our groups on the books today and converting them from their current rating structure to modified community rating. About a year-and-a-half ago, we embarked on a project to completely rewrite our rating system. The system we have today is totally parameterized and was written solely with the purpose of complying with the various forms of state regulation. So the conversion to community rates for us is really no big deal. The rating issues we're required to comply with are no different from what we are already doing today.

As for filing requirements, it's just another state, so it's just another diskette as far as we're concerned. Five years ago we only filed in one or two states. Now we're well into the double digits, probably closer to 20. Filing just takes more time.

The workload increases if you want to be an AHP. If anyone is interested, I have the forms to fill out to become an AHP. I guess that process is nearly completed, and the 13 or so carriers that will be in business have already been approved. A substantial amount of material is required. I know our organization could not answer a significant number of the questions. Many questions are related to lengths of stay and other claims type of data at a very detailed level.

The department was kind enough to send out a diskette with all the required plan wording on it. I was told by the person at our company who created the four plans that we are selling that it took four days to go through and modify the text even though it had been given to us on a diskette. So a significant amount of work is involved.

A comment about the wording: our plans are sold through a trust, we have certificate-holders, and the Kentucky plans are not written that way. We had to make many revisions to the language provided by the department.

Regarding administrative complications to those issues, I don't know how many people are aware, but all the plans available through Kentucky are on a policy-year benefit basis, not a calendar-year benefit basis. So even though our system is set up to do calendar-year deductibles and calendar-year benefits, this is not correct. I know we have not addressed that yet.

WHAT'S NEW? WHAT'S THE SAME?

What's new? Well, I think that health purchasing alliances and the exclusivity across the state and the mandatory members are pretty new. The whole idea of throwing all the public employees in there and just letting any carriers get them is new. It's not being done in California or Florida. The accountable health plans and the application process and the rigorous requirements associated with that are very new. It seems to me that they're going that extra step with the AHPs and the purchasing alliance to make a preliminary judgment as to the quality of managed care that the AHPs have before they let people in. I think that's a good step. We haven't seen it with any other purchasing alliances. Again, the risk-adjustment process is not a pool, it's not an experience refund like New Jersey.

Somebody in a prior session asked me to talk about Maryland. My comment about Maryland is that the mandated plans that Maryland provides are relatively rich benefits,

and you can only sell riders on top of those benefits. Basically, Maryland didn't offer you the opportunity to have catastrophic coverage. Kentucky does; it has a very wide range of plans if you want to sell them all and if you want to file for all the riders. It has a wide spread, and it does allow you to sell a $3,000 deductible, which there may be a market for. Having the mandated plans might be a good thing. There are enough of them. There's a wide-enough range, and it probably makes the comparison shopping good.

I did find it interesting that there are supplemental benefit riders that cover dental and vision care. They're limited benefits, but I think Kentucky is one of the first states to allow optional riders to mandate these types of benefits. I find it interesting that if you purchased in the alliance and you purchased a standard plan from carrier A, you can then purchase the supplemental benefit rider for home health care or dental or whatever from carrier B. Given that it's going to be difficult to price some of these riders, I don't know which carriers will be out there selling the home health care benefit rider and at what price, and that made it seem very complicated to me.

What's not new? The health policy board; everybody has a health policy board. Policy provisions; the guaranteed renewability and the preexisting conditions limitations are not new. Modified community rating, guaranteed issue, and the five-year lockout are not new. Most of the laws have all these things and they form a trend, at least in my mind. Guaranteed issue, modified community rating, five-year lock out, guaranteed renewability—every law we've seen today has those, and that is the direction we're moving in. We'll probably see more health purchasing alliances. Having dealt with much of the reforms, it all seems to me to be coming together.

A couple states are contemplating stepping back. I know the North Carolina legislature has proposed to back off from its current law. North Carolina's law goes to modified community rates in two years but maybe it does not like that. North Carolina initially required what I'll call composite rating. It did not allow list billings. It required you to charge each insured a rate based on an average age for the group. You could not individually apply any of the rate categories. They all had to be blended. Within weeks of implementation, the state actuary called and said, "Oh, by the way, ignore that part of the law for the time being."

You see many commonalities in the laws, but you do see discussions in various states concerning backing off. The commonality is the modified community rating, guaranteed renewability, and the guaranteed issue.

MR. TROY J. PRITCHETT: How many people think that 50 states doing 50 different things is a good thing? (Very few.) How many think it's a bad thing? (Most of the audience.) Let's change that question. Of everyone who said 50 states doing different things is not a good thing, how many would prefer the national health care package? (Very few.) Of those of you who voted yes, how many would prefer the national health care package that the Clinton Administration proposed or kind of proposed? Nobody. That's why we have this kind of stalemate.

I would like to talk about politics because, to me, these issues go to the core of politics of a given state. I'm new as a regulator. I started with Utah last October, as a direct result of health care reform in Utah, to both implement a small-group law that was passed and to help draft future changes of which I think there were will be many. One thing I learned by

attending NAIC meetings is that language is drafted who knows where, then it makes its way among various states, and then it's repealed here or changed there. I don't think anybody really understands where it's going. Does anybody want to make any predictions or comments? You said that you thought some states have moved back from some reforms. What's your prediction on how long Kentucky's legislation will last?

MR. HALL: I don't really have a prediction as to how long. It's being challenged today.

MR. PRITCHETT: Golden Rule, right.

MR. HALL: By Golden Rule, right. I haven't seen it back off, but there's been much discussion about backing off. What is interesting is what will actually happen in states such as Maine, which has become completely community rated. A number of states have these reforms, particularly the rating reforms implemented over a period of time. For a period of time, New Jersey said, you have to sell the state-mandated plans, and then it said you can sell your regular plans for a while. So, in my opinion, my frustration with it is, and you can look to Florida, no one ever lets one of the reforms run its course. So it becomes a political thing. The reforms are not given the opportunity to do anything before they're changed in many states.

MR. PRITCHETT: Does anybody want to comment on that? I have to get more controversial then, I guess. Does anybody think the ERISA preemption stinks? That's not controversial enough. Well, let me go back to some other issues about why I think these things will be changed a great deal. I think that insurance reform is a reactor rather than a driver in the health care area. At least in Utah this is true. One of the most significant things happening is the increasing managed care. Well, when you have increased managed care, one way to do it is to say that your managed care is to not issue to anybody who is ill. Okay, then all of a sudden your pool is cheaper than the other pool. Well, that's not the kind of managed care that's going to save costs overall. So insurance reform is a reaction. We say, "Okay, we'll allow managed care; we'll allow employers and insurance companies to try to control total costs and negotiate with doctors and providers and basically try to get cheaper care," but when you do it you cannot exclude the unhealthy people. That is why the real driver is managed care, and the insurance reform is a reaction to it.

The second significant driver is provider restructuring. I think we are going to see incredible changes in mergers with hospitals, drug companies, physician organizations, and so on. We are going from the cottage industry medical system into a corporatized medical system. Again, insurance reform is a reactor to that rather than a driver of that. It reacts with pricing for new capitation agreements that must take into account new kinds of entities.

The third large driver is what you do with all the billions and billions of dollars in benefits that Medicaid and Medicare are promising. If you look at the total amount of dollars involved, as compared with insurance reform it's a much larger driver. So how does that affect insurance reform? Well, the state says it has a Medicaid plan, if you have no money and no job, you have good care, but if you have a very lousy job or don't make a lot of money, you've got no care. That's politically irrational, but that's the kind of system we have. One reason it remains irrational is that the federal government is chipping in a lot of money for Medicaid, and you have to ask their approval on every waiver. So you don't

have the same options you would if each state were making its own decision with its own money. If major Medicaid reform would allow states to make their own decisions, I think all the insurance reform changes would have a different look.

In fact, Utah has a health insurance high-risk pool that was funded by a state subsidy. With insurance reform, including a modified form of guaranteed issue, the state will no longer be funding that high-risk pool. Again, it's more of a reactor to what's going on with limiting government-paid health care.

The fourth issue is the increased bargaining power by the ultimate payor of health care with large self-funded ERISA plans. I think that everyone else is trying to catch up.

Another area where states are different is in their history. Some states have always had a Blue Cross or another entity that was an insurer of last resort, and amazingly enough, it took a while for that to become unsustainable in many areas. If you are community rating and you are an insurer of last resort, other companies can pick off the better risks. Eventually, the theory says that by antiselection your rate should go up. If a given state has that situation and decides to basically save the carrier, then in some cases there will be one type of reform. In Utah we do not have that situation. Our Blue Cross has not been a guaranteed-issue-type insurer. So when we look at insurance reform we see different issues.

Let me tell you more about Utah. It might be interesting to get the Utah perspective because on the national level we are seeing more of a move to Republican government. How many of you in the 1980s thought we would have a Republican dominated legislature in the 1990s? (None responded.) When such a fundamental change is not predicted, it's hard to make predictions on what will happen with something such as the Kentucky alliance next year. If politics is a pendulum, when things get as Republican as they're going to get, then they'll look like Utah.

The Utah governor is the most popular governor in the United States. He has an 85% approval rate. That's higher than ice cream. I am very interested in what is going to happen when and if the Republicans say, OK, we are really going to cut back on Medicare and Medicaid. Now, if they vote, and they cut back, are they going to get thrown out of office the next time?

MS. ANNA M. RAPPAPORT: It strikes me that Medicare changes are going to be similar to what we've seen in employee benefits legislation. They are going to be obscure. They will be hard for the public generally to figure out. There will be cutbacks first on providers. It will be very hard to make significant increases in contributions. I think the Republicans can withstand some Medicare change, but I think it is going to be really complex and obscure. I think the really tough long-term issues will be in things we would consider as rationing and standards of care and what we cover. The short-term changes will be more in cost-sharing. I think there are also very significant issues in eligibility. I think there are also probably many threats coming to Medicaid programs in the states as well. But I think you're going to see very complicated material that's hard to figure out because that's going to be the way of trying to hide it. It's a question of how long it will hold up before the public will swing around the other way.

MR. PRITCHETT: Who's going to be the enemy that gets to develop the standards for rationing of care in Medicare? Do you think it will be HMOs or will it be a government entity?

MS. RAPPAPORT: The one argument I've heard recently is that it will be done through capitations and by basically shifting it down to the plans, rather than by making big standards that you're going to give the plans less money. By giving the plans less money, the plans will do the rationing as a way to respond to the money, and that's more likely than national standards. One of the things I also didn't hear, and I guess this is a long-term concern, is as the environment is changing and we're moving toward it, to what extent will standards apply to the care that is actually delivered and to the quality of care? I think that will be a real long-term issue. I think it will be diffused and hidden.

MR. PRITCHETT: Can you hide that much money, though? Talking about obscurity, I'd like to bring up one point that Newt Gingrich made in an editorial in *The Wall Street Journal*. He said to balance the budget without giving the American people their money back is to seek actuarial perfection instead of economic justice. Does anybody know what that means? I showed it to a lawyer in our office and he said, "Isn't actuarial perfection an oxymoron?" I said, "No, it's redundant."

MS. RAPPAPORT: Think about some of the benefit changes of the last decade in the retirement area. Take limits and chip out a little piece here and a little piece there. Look at the coverage definition and you'll see there's a list of things that Medicare does not cover now. It wouldn't surprise me to see that list grow by two, three, or four, every year or two. Those are the changes that are much more likely to be made than something that's really obvious on the surface.

MR. PRITCHETT: Theoretically, that should expand the Medicare supplement market.

MS. RAPPAPORT: That's true; more Medicare risk processes will also be needed.

MR. MARK E. LITOW: I am working on Medicare in Washington so I can report on this a little bit. Unfortunately, I agree with the previous speaker. I think that is the most likely direction, and I think that is a disaster for the country. The biggest problems in the country in health care, I believe, are the price controls that have created tremendous cost shifts to the under-age-65 market as well as all kinds of inefficiencies. Until those problems are addressed, and there are other serious problems, it will just create bigger problems. Unfortunately, price control is the easiest thing to sell in Washington. It's the easiest thing to hide under the carpet. It's the fastest thing to sell because we're cutting it by 10% or 20%. So if Medicare does take that direction, it will create more pressure. It will eventually be the Medicaid scenario we have today. Most providers will not take the rates, they provide two minutes of service because that's what the rate is worth and that's what we'll get. That's going to be the form of rationing that we're going to get if Medicare goes that road. I'm very afraid it will, but I think that's the answer to the question.

I am working on some other programs, such as voucher programs, that try to privatize Medicare. I think those things would eliminate the price controls over time. Those kinds of things would have very beneficial effects, I believe, on the under-65 markets in the long term.

MR. STUART D. RACHLIN: I've been actively involved in Kentucky. Kentucky's really getting the industry involved. It's a partnership in developing what will and won't be working. I'm curious about what your feeling is in the other states regarding the folks making the laws. Are they working with the industry in formalizing the policies and the laws, or are they really doing it one-sided?

MR. PRITCHETT: Well, let me tell you how the process has worked in Utah. My opinion as a regulator is that we have worked with the insurers. In our state, eight carriers write a high proportion of the insurance. In general, a health policy commission is the avenue through which, not just insurance reform, but all types of health reform, is discussed. That commission set up technical advisory groups in which the local and, to some extent, national players are involved. We have a limited individual guaranteed issue in Utah. We thought that if you don't have individual guaranteed issue, there's still the health status fear: I have insurance with my employer, I lost my job because I was ill, I ran out of COBRA, and now I can't get insurance again because I have poor health. That person was being prudent and had insurance, but now he or she is outside the system.

We have talked to carriers about their concerns. We found that the only people they trusted less than regulators were the other insurers. So they didn't want any risk-adjustment mechanisms that would move money among carriers. So we came up with was a cap on how many people a carrier had to take in, based on its total coverage count. That way one insurer wouldn't get all the high-risk people under open enrollment. The limit is a half a percentage of their total coverage. When you reach that, until the other insurers are up to that level, you do not have to take any more people under open enrollment. That was something that we negotiated with the carriers.

The carriers didn't want people to be able to switch among networks when they became ill because Utah is a very high HMO and managed care penetration state. So our version of guaranteed issue does not allow switching; it's a one-time guaranteed issue. Once you have coverage, you can't switch without going through underwriting. Another concern that we addressed with them was a preexisting condition on the guaranteed issue. We don't want people to buy the insurance on the way to the hospital. It's a two-pronged approach. If you have portability, then you have to go through underwriting, but you get a waiver of the preexisting condition exclusion for your past coverage. If you have not had insurance in the past, then you're eligible for guaranteed issue, but you have to wait 12 months on preexisting conditions.

Another concern that was addressed with the carriers was what happens if there is large ERISA flight because of this? In other words, what happens if groups that have 50 employees, because of the increased costs of having to pick up car loads of guaranteed issue costs, all go to self-insurance? So we said we would measure how fast premiums were going up, how many groups were leaving to self-insure, and if it was too high, the commissioner could shut it off. That's basically a safety valve. Those are the ways we worked with the carriers.

Another reason I think Governor Leavitt is so popular is because, in this process, a bill was developed during the year with industry input. When it got to the legislature, the industry came back with a report that said if you do this, individual insurance premiums will go up 40% after five years. The governor said to the industry presenting this report, "Well, what's your position on the bill?" The representative said, "I'm just presenting

information, we think the insurer is just in the middle." The governor said, "What's your position on our bill? Are you for it or against it? We've been working with you. Are you going to support it or aren't you?" Eventually it became something that the industry agreed to support when the vote was taken. In Utah, there was compliance with the industry because it's a probusiness state. Nobody wants to see the insurance industry have premiums that increase phenomenally. It's not a state where community rating will pass and young people will subsidize older people. Thank goodness I'm young right now.

MR. RODERICK E. TURNER: Are you asking the individual marketplace to take all comers on a guaranteed issue basis?

MR. PRITCHETT: We're asking the small group and the individuals.

MR. TURNER: Small group and individual?

MR. PRITCHETT: Right.

MR. TURNER: So if a group comes to apply for coverage, do they have to be issued?

MR. PRITCHETT: If you sell group, you'll take an individual.

MR. TURNER: So do you have to have an individual product on the marketplace?

MR. PRITCHETT: Yes, because the individual marketplace is what's left over. Working people are at least healthy enough to work. If you only pass the cost of high-risk people to the individual market and you keep it all with the individual market, you're going to have larger premium increases. It's our feeling that many of those people came from the insured marketplace and therefore the cost should be spread over the insured marketplace.

MR. TURNER: I think that's a good point. That's something we've seen in other states. They've discussed that, they've tried to push everything down to the individual marketplace, and not get the group marketplace or the group carriers or the ERISA carriers or anybody else to subsidize. It doesn't seem quite fair to ask the people who have to buy insurance in the individual marketplace, the farmers and the ranchers, to subsidize all these people who are coming from the group marketplace. So the only thing that you might have in your state, if the group carriers are avoiding issuing individual products, is you're asking carriers to offer the products.

MR. PRITCHETT: Also, you're not eligible for individual guaranteed issue if you have a conversion option that you did not exercise. That's another way of keeping the people in their original insurance options.

MR. TURNER: Are you controlling the rates on your conversion policies?

MR. PRITCHETT: Yes, instead of a 25% rate band, the high average rate band will be 35%. You can't have a separate conversion pool, which has very high rates, but it had to be within the same rate band as other individual products. Now I think Jerry will tell us how it really is.

MR. JERRY W. FICKES: I'm the chair of the health alliance in New Mexico, and I want to bring up a couple subjects that you were talking about. I think this was an excellent comment just made. We have been pushing everything toward the individual market, including the cost. Basically, we are driving the individual market away from any insurance carrier and from every state. Part of what we consider when we're looking at small-group reform is how to bring the individual back so it becomes really small-person reform, which would include individual or small groups all as one.

You talked earlier about managed care. Managed care consists of getting a discount for your HMO or getting a discount for your Blue Cross, which then causes the cost to go up for those who are insured. Because you're a large group you can compete on cost; when you're a small group or an individual, you end up paying. This has been pushed down, down, down. This is the cycle we have to reverse. You are dealing with the government continually. The government changes every two years, every four years, based upon what the people out there are screaming the most about. If we are going to wait for the government to put out what it is that we should do, then this industry should start getting their resumes ready because you're not really going to be a part of the solution. You're always looked at as at fault. So if you can, get in and be more proactive as to how we can get more people.

You talked about Medicaid. Medicaid, for the last three years, has been the state's answer to covering uninsureds. Whenever you get a high uninsured rate, believe me, we've had them in New Mexico, you increase participation in Medicaid. The federal government pays three-fourths, you pay one-fourth, and you then say, "Look what we did. We have more people covered and we lowered cost." You haven't really done a thing except transfer that cost to the federal government so that it can be paid for in a tax elsewhere. Now the government is going to start giving it back in blocks to stop this. So far, basically using the HMO has not really had a big dent in this. We're going to have to be more creative and get them into insurance companies, get them into alliances of some kind, where we can put some controls and some restrictions on the use of Medicaid.

Now in New Mexico, our health insurance alliance is not governmental. Its board consists of five members of the insurance industry: two HMOs, two indemnity carriers, and Blue Cross. It also has nine members from small groups: five small-group owners and four small-group employees. I happen to be the only one from government who sits there. I sit as chair because it helps avoid antitrust problems, but basically this is a nonprofit corporation. In other words, if they'd let us use a trademark, we could probably be a Blue Cross organization. We sit out there so that government can't really come charging at us. It becomes really the industry's job to come up with some solution.