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STATE HEALTH REFORM INITIATIVES

Moderator: ALAN D. FORD
Panelists: JAMES GUTTERMAN
CAROL J. MCCALL
DANIEL EDWARD WINSLOW
Recorder: ALAN D. FORD

The panel will present a discussion by several experts on reform activity at the state level, including a review of some initial results.

MR. ALAN D. FORD: Jim Gutterman is an actuary with the New York State Insurance Department. As most of you know, New York has one of the most ambitious small group reform programs in the country. He's going to let you know about how well that's working.

Carol McCall is assistant vice president for actuarial services with Employer's Health Insurance (EHI), which is part of Humana. She's responsible for pricing, product development, and network development for the western region for Ephyesys and will be talking about some of her company's strategies and responses to health care reform in general as well as specific state initiatives.

The final speaker is Dan Winslow, who is a vice president and actuary with the Starmark, a subsidiary of Trustmark. Dan's had considerable personal experience with pricing and product development to help his company deal with small group markets and health care reform. He will speak about some various state activities and his company's responses.

MR. JAMES GUTTERMAN: I'm going to speak about health care reform in New York state over the past couple of years. First, I'll describe the most obvious aspect of that reform, the community rating law. Next I'm going to give some results and general observations of what's gone on in the marketplace. Last, I want to describe some fairly significant recent events that have been going on in the state that you might not be as aware of.

First, I'll give the highlights of the community rating law. It was signed into law July 1992, to be effective April 1, 1993. On that date, all small group and individual business in New York state under 51 lives had to comply with that law. There was no phase-in and it wasn't based on renewal date; all business shifted as of April 1.

One of the major aspects of the law is that it is true community rating. You can vary rates by area, but no variation by age, sex, industry, health status, or anything else you can think of is allowed. A June 12 preexisting condition clause is allowed, but the time that someone was insured under a prior carrier counts towards the preexisting condition clause, so essentially you have portability in the state. Continuous open enrollment is required, without underwriting. If you're in the market, you have to take anyone who comes to you. Associations are included so long as at least one of the groups in the association is under 50 lives. There are a couple of exceptions that grandfathered older associations.

One of the significant aspects of the community rating law (and something that you really can't have community ratings without, in my opinion) is its risk-sharing mechanisms. Part of the law specified that there would be a technical advisory group that would be formed to create the risk-sharing mechanisms. The technical advisory group was largely composed of actuarial people from various parts of the industry, as well as consumer groups and others. There is another session at this meeting with Alice Rosenblatt that will provide more detail on the plan. We have established three sets of risk-sharing pools. They translate to 21 pools because there are seven regions. We have a small group/individual demographic pool, a Medicare supplement pool, and a specified medical conditions pool, for each of the seven regions. The demographic pool is as its name implies. All carriers in the small group and individual marketplace submit demographic data by five-year age group. Those carriers that have a younger group on average will end up paying into the pools and those groups that have an older profile will end up drawing from the pools.

The specified medical conditions pool is designed to reimburse on certain large claims. It wasn't meant to be an exhaustive list. Basically four types of medical conditions—HIV, ventilator dependency, transplants, and neonates—are included. The stated goal of the pooling process is to share the cost variations attributable to significant differences in business coverage and to promote competition based solely on efficiency of claim handling, customer satisfaction, and the ability to manage health care services and administrative costs, and not on risk selection.

Another aspect of the law was that the state now has prior approval authority on rates in the small group arena. There is a file and use aspect of that law such that, if the actuary attests to having a price based on an expected loss ratio of over 75%, rates can be deemed approved. Then a year later you have to report experience, and if you don't meet the 75%, refunds must be made to customers.

Before I get into some of the results, I think I should describe the backdrop of the environment in New York. Probably one of the most notable is the Empire Blue Cross situation, which I imagine most, if not all, of you know about. Empire had both a management crisis and a financial crisis. At its peak, Empire insured roughly 8 million of the 18 million citizens in New York. It was, and to some degree still is, the insurer of last resort in the individual marketplace, with the exception of one or two commercial carriers. Basically the Blues were the only game in town in the individual marketplace in New York, and their financial results were showing the strain.

An important point to note is that before the law was enacted, roughly two-thirds of the business in the small group and individual marketplace was already community rated. The Blues and HMOs were already community rated. This law affected largely the commercial carriers, at least in terms of their rate making. It affected everybody in terms of the pooling process.

Also at this time, managed care was finally making its way to the East Coast and to New York. The HMOs had, at that time, just started and were getting an increasing market share in New York. Consumer acceptance of managed care was greatly increased and it still is.

The implementation was on April 1, 1993. There was immediately a lot of flux in the marketplace in terms of pricing. A great deal of disruption in the small group arena and in the individual arena occurred. People who had been age rated were suddenly community rated. Companies had to scramble to change their rating structure, and there were many winners and many losers. Naturally the people who made out less well were fairly vocal about it.

Company filings were mostly done in January and February. Companies that would have come in for rate increases at other times during the year were doing it all at once. Many carriers, uncertain with competition, took a conservative approach.

In the small group arena, we did a sampling from the rate filings and the statistics we asked for on enrollments. Enrollees in small group plans with more than a 20% rate cut were roughly 9%. Rate changes between -20% to +20% impacted roughly 55%, and rate increases of more than 20% impacted 36%. In the individual marketplace, decreases of more than 20% impacted 18% of all plans. Changes between -20% to +20% impacted 41% and increases of over 20% impacted 41%. There were many people who did have significant changes, and we read about that in the papers. There were many consumer complaints, but they died down quickly, and the pain was intense at the time of transition.

No major players withdrew from the marketplace. We had some fairly small carriers that withdrew. One large carrier did stop writing for a short period of time, then changed its mind. There was a large amount of price fluctuation in the small group arena between April 1 and July 1, 1993, as companies positioned themselves, seeing where everyone else was. Companies then came in for rate changes as they found they were too high or too low.

Let me get into some of the statistics that we compiled (Table 1). There are seven pooling regions. Regional demographic factors are basically the result of applying the age/sex index (specified in Regulation 146) to all submitted enrollee data for any particular quarter. (The average as you see it there, is not 1.0.) The message that I would take from this is that it hasn't been a dramatic change in the demographic makeup of the insured pool.

Just to give you a flavor for the rate level in the different areas, we basically surveyed carriers on the rate for their most commonly sold plan. These are median rates (Table 2). This is set up to show you magnitudes of differentials that are in the marketplace and rates of change—this is the increase in the median rate in the respective areas. We weight them based upon the enrollments of the different carriers based upon their contributions to the pools (Table 3). Essentially, they're enrollee weighted. We first started compiling this as of July 1993. It was too hard to pin down during the initial few months. It gives you a sense of what's going on as paralleling what is going on in the rest of the country. You should recognize that the nonprofit figure is in a political environment, and the timing of its rate increase isn't quite as structured, so a two-year period is a little better to show.

TABLE 1
NEW YORK INDIVIDUAL/SMALL GROUP DEMOGRAPHIC POOLS

	Regional Demographic Factor as of:								
Region	**4/1/93**	**7/1/93**	**10/1/93**	**1/1/94**	**4/1/94**	**7/1/94**	**10/1/94**	**1/1/95**	**4/1/95**
Albany	1.104	1.109	1.096	1.098	1.093	1.083	1.083	1.088	1.098
Buffalo	1.038	1.037	1.040	1.034	1.071	1.067	1.066	1.063	1.060
Mid-Hudson	1.038	1.050	1.064	1.073	1.074	1.071	1.070	1.083	1.089
New York	1.077	1.079	1.076	1.083	1.079	1.072	1.069	1.078	1.083
Rochester	0.994	0.993	0.988	1.011	1.033	1.033	1.033	1.041	1.040
Syracuse	1.028	1.027	1.023	1.024	1.026	1.033	1.037	1.039	1.040
Utica/Watertown	1.087	1.089	1.079	1.089	1.085	1.084	1.078	1.098	1.091

TABLE 2

PERCENTAGE CHANGE IN REPRESENTATIVE SMALL GROUP MONTHLY RATES SINCE 7/1/94
FOR INDIVIDUAL & FAMILY COVERAGE BY REGION, DATE, AND TYPE OF INSURER

As Of	Family Status	Albany	Buffalo	Long Island	Mid-Hudson	New York City	Rochester	Syracuse	Utica/Watertown	Westchester
		Commercials*								
07/01/95	Employee Only	$173.00	$163.00	$310.00†	$249.00†	$328.00	$163.00	$172.00	$183.00	$309.00
07/01/94		174.00	150.00	266.00†	220.00†	286.00	152.00	154.00	170.00	267.00
Change		−0.6%	8.7%	16.5%	13.2%	14.7%	7.2%	11.7%	7.6%	15.7%
07/01/95	Employee/	$383.00	$364.00	$655.00†	$529.00†	$731.00	$364.00	$369.00	$404.00	$711.00
07/1/94	Spouse	374.00	350.00	579.00†	483.00†	617.00	350.00	341.00	374.00	582.00
Change		2.4%	4.0%	13.1%	9.5%	18.5%	4.0%	8.2%	8.0%	22.2%
07/1/95	Employee/	$356.00	$310.00	$572.00†	$473.00†	$633.00	$310.00	$326.00	$353.00	$597.00
07/1/94	Child(ren)	331.00	286.00	507.00†	414.00†	562.00	288.00	296.00	331.00	530.00
Change		7.6%	8.4%	12.8%	14.3%	12.6%	7.6%	10.1%	6.6%	12.6%
07/1/95	Employee/	$564.00	$507.00	$917.00†	$747.00†	$1,019.00	$507.00	$523.00	$576.00	$967.00
07/1/94	Spouse/	531.00	464.00	811.00†	676.00†	900.00	471.00	480.00	531.00	837.00
Change	Child(ren)	6.2%	9.3%	13.1%	10.5%	13.2%	7.6%	9.0%	8.5%	15.5%
		HMOs*								
07/01/95	Employee Only	$152.66	$102.75	$180.83	$153.37**	$180.62**	$114.27	$147.30	$144.31	$172.44**
07/01/94		145.27	101.03	181.49	156.40**	181.49**	102.52	152.77	150.02	170.27**
Change		5.1%	1.7%	−0.4%	−1.9%	−0.5%	11.5%	−3.6%	−3.8%	1.3%
07/01/95	Family	$389.00	$270.37	$457.32	$397.57**	$457.32**	$290.56	$389.53	$357.76	$436.93**
07/1/94		362.33	256.80	437.68	381.89**	480.95**	256.80	392.52	381.08	419.27**
Change		7.4%	5.3%	4.5%	4.1%	−4.9%	13.1%	−0.8%	−6.1%	4.2%
		Blues‡								
07/01/95	Employee Only	$196.55	$172.45	$322.20	$229.30	$322.20	$201.53	$137.60	$146.02	$322.20
07/01/94		162.65	197.98	268.90	190.20	268.90	201.53	137.60	146.02	268.90
Change		20.8%	−12.9%	19.8%	20.6%	19.8%	0.0%	0.0%	0.0%	19.8%
07/01/95	Family	$479.60	$363.62	$786.15	$559.45	$786.15	$430.24	$308.25	$365.08	$786.15
07/01/94		381.80	389.85	627.95	428.90	627.95	430.24	308.25	365.08	627.95
Change		25.6%	−6.7%	25.2%	30.4%	25.2%	0.0%	0.0%	0.0%	25.2%

*Represents the median rate in each area for each Type of Coverage category. †Rates are generally lower in counties further away from New York City.
**Substantial variation in rates from county-to-county. ‡Represents the rates for the dominant carrier in each region.

TABLE 3
AVERAGE* STATEWIDE SMALL GROUP

Date	Commercials	HMOs	Nonprofits	All
Single Employee Rate†				
7/1/93	$232.00	$144.83	$226.05	$208.73
7/1/94	256.61	150.22	228.61	218.28
7/1/95	295.39	152.93	257.12	235.50
Annualized Increases				
7/93-7/94	10.6%	3.7%	1.1%	4.6%
7/94-7/95	15.1	1.8	12.5	7.9
7/93-7/95	12.9	2.8	6.6	6.2

*Premium weighted median rate in each pooling area for each type of carrier.
†Rates based on carriers' submissions to the New York State Insurance Department for their most commonly sold plan.

We survey quarterly enrollments on a carrier-by-carrier, form-by-form basis. Quite a bit of data verification and scrubbing goes into this, more than anything I've seen in all my years in industry. Numbers still will change as the administrator goes in and does a miniaudit of all the carriers. We catch what are relatively small errors, but a carrier will have a group in there that doesn't belong or is miscategorized. The older periods are pretty stable. Before April 1, 1995, I know we were questioning a couple of carriers, but we go through them on a form-by-form basis, and if in one quarter they don't have something for the form and another one they do, we question them, plug in an estimate or pull it out of there for all quarters. This is meant to be comparing apples with apples all the way through. I know we were questioning two carriers on their contributions, and I know there's at least one change in April 1995. Also, this is insured units.

The past couple of quarters we've asked for insured lives. I didn't want to busy up the table with that, but roughly if you use a factor of 1.98 on small group, 1.6 on individual, and 1.0 on the Medicare supplement, that would translate units to lives.

It is very important to comment on what's in here. Roughly 90% of Medicare supplement in New York state before the community rating law was already community rated. It was either the Blues, the American Association of Retired Persons (AARP) plan, or a few other small blocks. Another 5% of these numbers represent guaranteed renewable business that isn't community rated. Therefore, roughly 5% of the Medicare supplement business was impacted by the community rating law.

Likewise in the individual marketplace, the numbers on individual include both group conversions as well as old blocks of guaranteed renewable business that has basically been sealed off by carriers that aren't selling it any more. So roughly half of those numbers represent insured units that weren't impacted by the community rating law. The decline in the individual coverage, the rate of decline, and the magnitude of the decline have been about equal among those subject to the community rating and those not subject to the

community rating law. The drop-off was in the individual. Small group enrollments have remained fairly stable (Table 4).

TABLE 4
INDIVIDUAL, SMALL GROUP & MEDICARE SUPPLEMENT SUBSCRIBERS FOR NEW YORK LICENSED INSURERS, NEW YORK STATE*

	Insured Units† as of:			
	9/30/92	4/1/93	4/1/94	4/1/95
Small Group (Non-Med/Supplement)				
Commercials	325,199	277,948	283,422	192,701
HMOs	163,686	179,068	242,904	406,482
Nonprofits	502,848	480,921	410,829	351,588
Total	991,733	937,937	937,155	950,771
Individual (Non-Med/Supplement)				
Commercials	178,400	150,898	124,504	100,848
HMOs	29,116	32,223	47,262	74,940
Nonprofits	200,499	189,735	153,318	122,382
Total	408,015	372,856	325,084	298,170
Medicare Supplement				
Commercials	259,095	270,094	294,234	303,303
HMOs	384	438	1,467	1,548
Nonprofits	585,135	559,742	498,362	512,044
Total	844,614	830,274	794,063	816,895
Totals				
Commercials	762,694	698,940	702,160	596,852
HMOs	193,186	211,729	291,633	482,970
Nonprofits	1,288,482	1,230,398	1,062,509	986,014
Total	2,244,362	2,141,067	2,056,302	2,065,836

*Data reported as of September 29, 1995.
†An insured unit can represent one person or family.

The next table (Table 5) shows percentages of population without health insurance. This is census data, with all its pluses and minuses. There should be an update that has 1994 data coming out this fall. It basically shows New York was doing the same as or slightly better than its neighbor. This is everybody. You won't attribute it to the community rating law, plus or minus, but it gives you a sense of what was going on that we essentially mirrored what was going on in the country. The second is also from the census and shows New York state results (Table 6).

The positive impact of the New York law was basically consumer oriented, with elimination of barriers to coverage, restrictions on termination of coverage, portability, and affordability in the small group marketplace as your rates didn't go up egregiously because of claim experience.

One insurer sued the insurance department and the result was to uphold the pooling concept, but the court struck down the requirement that one- and two-life groups be

covered as small group. Basically, those groups weren't explicitly in the law, but in the regulation. Immediately, some commercials pulled out of New York state in the one and two life marketplace. We encouraged companies to stay in by allowing rate differentials on the one and two life groups for the excess morbidity and expense.

TABLE 5
PERCENTAGE OF PERSONS NOT COVERED
BY HEALTH INSURANCE 1992 AND 1993

	1992	1993
Connecticut	8.2%	10.0%
New Jersey	13.3	13.7
New York	13.9	13.9
Pennsylvania	8.7	10.8
Vermont	9.5	11.9
U.S.	15.0	15.3

Source: Bureau of the Census

TABLE 6
PERCENTAGE OF PERSONS IN NEW YORK STATE
NOT COVERED BY HEALTH INSURANCE, 1988-93

1988	10.7%
1989	11.8
1990	12.1
1991	12.7
1992	13.9
1993	13.9

Source: Bureau of the Census

We had lawsuits from the HMO conference board as well as the Health Insurance Association of America (HIAA) and some of the other commercials challenging the pools. That resulted in putting most of the pool money into escrow. We recently won the HMO lawsuit. Based upon the *Traveler's vs. Cuomo* decision, some money should be coming out of escrow very soon. We would expect a similar result with the HIAA lawsuit.

Administration was initially somewhat difficult for companies to comply with even though conceptually it was not that complex a pooling mechanism. It was meant to be fairly simple, but every company has its own system. There were added burdens on companies in difficult times when many were downsizing. Companies seem to be on track now. The pool administrators have gone into two thirds or three quarters of the companies on very quick audits and generally helped the companies to get themselves back on track. Certain things in the medical conditions pool need to be fixed. Many companies didn't submit

claims into the medical conditions pool; they just didn't know about it. The people who work on the premium end don't always talk to the people who work on the claim end. It was somewhat surprising.

The need for market conduct vigilance was apparent. We would find out after the fact, several companies have little blocks of business that they didn't know they had, and they had to comply with the law. It seems surprising. A couple of these had TPAs, and the company didn't realize it. We allow companies with minimal blocks to obtain an exception. But there were some companies that had measurable blocks that just didn't know they had them.

Some companies still turn down certain groups; we hope this is not intentionally but through bad communications to field staff. Some companies were paying no commissions on the very small groups and trying to avoid covering those groups. We had to amend the regulation for things like that. Those are things to consider.

Let's discuss current developments in the state. There were proposals for an "any willing provider" law last year. It didn't go that far, but it will likely come up again this year. Minimum maternity stays look like something that will happen, as there is bipartisan support on that. The whole hospital reimbursement system in the state with the 13% differential for the Blues needs to be addressed. The expiration of the law has been put off to July 1, 1996, because of the magnitude and the impact, and the time needed to review.

One last major piece of legislation is that, as of January 1, 1996, HMOs have to offer standard individual coverage in the state. There's a standard HMO plan and a standard point of service plan. The rate filings were coming in just recently. The standard HMO plan is a $15 office visit copayment and a $500 in-hospital deductible. The point of service is a $10 copayment and no deductible in-hospital, with 80/20 coinsurance. The $1,000 deductible is out of network. In conjunction with that, the demographic pool part of the risk-sharing process is going to be phased out over five years. That's a major development. The money that would have gone into the demographic pools will go to a restructured specified medical condition pool. Another technical advisory group has to be formed by law by September 1, 1995, and it's starting to form up about now.

I'll close in saying that the community rating law itself was not meant to be a cure-all for everything wrong in the health insurance field. It didn't directly address the problem with affordability or the individual insurance marketplace. But it was a significant step toward leveling the playing field and improving access.

MS. CAROL J. MCCALL: I'll be talking about a company's perspective on dealing with reform. I'd like to share with you how it has impacted my company and some of the things that we've done to deal with it. This is a piece that I may move rather quickly through because I want to talk about two other things. One is to review our experience in Maryland and the other is to review with you our experience in the California Health Insurance Purchasing Corporation (HIPC), as one of the few preferred provider organizations (PPOs) in the California HIPC, as well as some of the initial results of the risk adjustment process out there. Reform is obviously evolving. There's nothing new about small group reform. It's been with us for some time, but how you deal with it and how we deal with it at my company has changed significantly. Small group reform changed how

we think about our company both strategically and operationally, and the way we think about reform from a strategic and an operational perspective.

I'd like to focus on how we deal with reform today. I'll talk by corollary about how we used to deal with it. How we deal with it today is a much more dynamic process, at least at EHI. Initially, it was a very internal focus. What does it mean to us to deal with it at all? What's the impact on the company to profitability and can we survive? Today there's much more external focus, and we look not only at what it means to our company, but also how it changes the dynamics of the market. What's the impact on other carriers and other HMOs out there? That's probably the most significant shift in our thinking about reform.

One of the things that's helped us a great deal is that certain patterns have emerged in the types of reform that states adopt. They tend to fall into different types, and so through the initial process of reform, you can figure out what the impact is on your company and develop a response to reform type A and reform type B. I know what the impact is on us, now let's see how that impact stacks up relative to some of the other carriers and some of the other HMOs out there. What opportunities does it create? What barriers does it create? Senior management was very heavily involved when we were analyzing all the reforms in the early stages. Now, senior management gets involved mostly when the impact is different—either when the reform is new or when the dynamics of the market are unique, and it's something that we haven't seen before and we need to respond in a different way.

The other way in which our company has changed its response to reform, because we understand the impact on our company of various types of reform, is we understand we have that opportunity to influence the legislative process. If there's something that we think is a strategic advantage, we can go out and lobby for that in more places. If there's something that we think is a real disadvantage, then we can try to influence the process and get it either eliminated or at least the impact reduced before it happens.

Specifically, I have some examples of how small group reform changed our focus. The first example is acquisition. One of the things that I've found as I work in merger and acquisition activities is that small group reform has created both new opportunities and also new barriers to acquisition work. The new opportunities may seem relatively self-evident in that some carriers, the smaller ones in the market, may not be able to handle the impact of reform as well. They may decide to exit certain markets. Larger carriers, as we've done, have exited certain markets not because the impact of reform was onerous, but because certain elements of trying to prove that you're in compliance, such as certification requirements, were so onerous that we couldn't justify staying. For the most part, in addition to the opportunities that come because of carriers exiting the market, there are barriers that are created. First, obviously, you need to deal with reform, but when you're looking at a block of business, you have to look at the other carriers' practices. Are they in compliance? Because if they're not, there will be a significant impact on whether or not you can absorb this book of business.

Even if they are in compliance and they've done everything to the best of their ability, you also have to look at the laws in the state. Some states allow for different classes of business. Other states say everything is going to be in one class. If a state law isn't going to allow you to treat this acquired block separately and let it sit at its own claim cost level,

you have to look at the impact in your book, that is, your new business rate or the renewal rates of absorbing that into your manual.

Another thing that you have to look at, because it's covered by small group reform, are the things that you might have done in the past to manage a book of business—the renewal rate increases—you won't have these tools at your disposal any longer, so you really have to ask yourself, what kind of health is this block in? Can we manage it to a level of profitability? All of these things are going to be very important when you look at acquisition opportunities.

Another thing that small group reform does is it may have you looking at new market segment opportunities, either because you want to or because you must. One example would be the one life market, where you may decide that one life is not so bad. Small group reform has me in the market, maybe I'll go in a big way. There are reform laws out there that put you in the one life market whether you like it or not, and so that's going to create some opportunities and some barriers for you.

Another thing to consider is the self-funded market. Some carriers' response to small group reform has been to introduce self-funded products to small groups, thereby bypassing reform laws.

Because of small group reform, our company looked more at other laws that were on the books in different states. For example, do they have any willing provider laws? Do they have anything that creates an unlevel playing field between an indemnity carrier and an HMO with respect to their ability to pursue managed care products? For example, in Texas we wanted to introduce an exclusive provider organization (EPO) product and couldn't do so unless we had an HMO license. So, with a product that we had been able to introduce in many other states, we couldn't in Texas because we lacked the HMO license.

I could probably say now that I work for Humana. EHI has combined strategically with Humana. We've taken a very strong managed care company and put it together with a very strong small group carrier, and formed a new strategic alliance.

I'm only going to talk briefly about the impact operationally. Again, I'm going to focus on what we do now as opposed to what we did in the past. EHI is in 44 states, and so we have to deal with a great deal of variation in reform on a state-by-state basis. It was very important for us to have a standard process. We've been able to do that over time. It didn't start out that way, however. When reform first came up, it was going hot and heavy. We used to spend about 2,500 hours per month on reform—almost $2.5 million on the implementation costs, the people time, the effort. We've since changed that process, and we have something that works much better for us now. We actually have people who are not only dedicated to implementing reform, but also they're all in the same unit. They're able to do things much more effectively and efficiently. We can have more standard processes and standard responses to reform.

In some instances, we actually overcomply. One of the examples of that would be in deciding whether or not to give continuity of coverage. We have more liberal definitions than are required by most states so that what we've found is a common denominator

among all states, one that doesn't significantly increase our risk, but does significantly reduce the administrative burden with administering all the different laws.

Because we're in 44 states, we're significantly impacted by the sources of variation. It comes from the legislation, in the regulation language, or in the bill itself. There's also variation in how strict states are enforcing the laws that they have on their books. There's also a lot of variation in the company attitude toward reform. How you deal with these things in a company is going to depend on many of things.

In terms of dealing with the variation from state to state, it's going to depend on your fundamental response to reform. How does it affect you as a company? Can you find any sort of economies of scale in that process? Probably the most important thing affecting how you're going to respond to any given state situation is the dynamics of the market. We have had instances where identical legislation was passed in two different states, and our responses were very different based on the dynamics of that state.

There are different responses and our company has actually pursued many of them. One is to exit certain markets. An example here for us was Montana. We had very few lives in Montana. The reform from the philosophical side of it was very vanilla. It was the same as in many other states, but what got us was the monitoring mechanisms—all the things that you had to do to report and to certify, and for the number of lives that we had, which I think was 500, we sold it to the first passerby.

Sometimes our response has been to increase our managed care capacity, which we have done significantly with our Humana strategy.

I've talked about the enforcement from state to state. This varies widely from having people spend virtually no time on a given state with respect to these activities to significant effort. Sometimes all it takes is a letter once a year. Sometimes it requires monthly or quarterly activity reports, rate filings, and all kinds of things. Again, it was this type of thing that prompted us to leave Montana.

There's a great deal of variation out there among companies and what their attitudes are toward reform. They run the full range from companies complying with every aspect of reform, to companies that comply with most aspects, trying to meet the intent of the law, to companies that spend a lot of energy trying to find ways around it. I can say that, if you're a company trying to comply competing with companies that are trying to get around reform, it will be extremely frustrating if you're in a state that has very lax enforcement. I think Dan has some examples for you later.

I'd like to get into our experience in Maryland. This is just a brief overview of some of the things that were part of the law. We have guaranteed issue of all products and community rating by class, effective July 1, 1994. There was transition of the in-force book, but not quite as bad as New York. Maryland did allow you to do it on renewal date. Compression to full community rating is still taking place, as a 40% range that you can use. You can use it for age and/or area. There are standardized benefit packages, but they do allow buyups. Buyups are really the source of benefit competitiveness and differentiation in Maryland. There are minimum loss ratio requirements and a maximum allowable expense ratio.

I have some observations on experience in Maryland. The first one I don't think is unique to Maryland. The initial activity in the state was extremely high. Many people were out there kind of sniffing around, seeing what was happening as a result of reform. I've seen that in a lot of other states that had significant reform. Productivity is way up.

What was interesting, though, is the second observation, which is that the initial movement was mostly of substandard risks. I don't know if this is always the case and I think that there may be some operational issues that made that part of Maryland's initial rating. It had to do with the fact that the law was very difficult to get up and running for the in-force books of business. Many carriers' response, including Employers, was to push our renewals out. We said we're not ready to start to renew this business. We would just try to get up and running for new business. I know that there are other carriers that also pushed their renewals out. So what you have are people who are ready to sell new business, but not ready to renew. The preferred risks are staying put. Why do they want to go out and get a community rate that's higher than the rate that they have? The substandard risks on the other hand, know that they can go get a community rate, and guarantee issue right away. The activity that you have right away is in the substandard risk.

The market competitiveness has increased. Carriers are less able to compete based on the nuances of plan design. But, there's a great deal of competition based on buyups. If this is your cost range, most of your competitiveness is just right in here. To that extent, it has reduced the ability to compete based on how you differentiate your plan design. It changes the nature of what you use to compete with. There's a lot more emphasis on managed care.

Either you have it or you don't. That's one of the things I asked some people out in our field offices: What are people buying? They're either buying a 90/80 PPO or they're buying an HMO. What about our 90/70, what about our 80/50? No, it's either all or nothing. That's one market where you have to have some managed care capacity.

There has been consolidation of the market. Some players have left. Some players have left and come back. Maybe they weren't ready, but now they've reentered the small group market in Maryland.

There are a couple of different ways that carriers are interpreting rules. One is what you have to do to present rates. How you present rates and your ability to sell is very important to the agents out there. Some people say you have to present the basic plan and then present all these buyups in every possible combination. The employers are just overwhelmed, and this tends to not make as good a sale. Other people package as they see fit. A second interpretation difference is in the rate compression rules. There are two interpretations that I've found. One is that the rate compression applies to the whole rate and nothing but the rate. That is, whether you have a buyup or not, you have 40% you can play with and that's it. There are other carriers that feel that the rate variance that you're allowed applies separately to the base, and buyup carriers interpreting this way have a significant competitive advantage.

I want to talk about our experience in the California HIPC, one of the first state supported purchasing pools of its kind. In the first plan year, there were 18 participating plans in the HIPC—15 were HMOs and three were PPOs. There are now 24 plans. There are 22

HMOs and two PPOs. Only one of the PPOs operates statewide, and the other one operates only in the rural market. The first year it had 46,000 members—about 1% of the small group market share. It currently has almost 94,000, with almost everyone enrolled in an HMO. When interviewing the employer groups, they say the biggest selling point is the individual choice of plan. Twenty-two percent of the firms were previously uninsured.

In the risk adjustment process itself, there are some similarities and differences with what goes on in New York. It uses marker diagnoses and is based on an inpatient confinement. A risk assessment value is determined based on a carrier's mix of marker diagnoses relative to the plan. All the plans combined are 1.0, and if there are values for different participating carriers that fall outside the corridor of 0.95–1.05, then the risk adjustment process kicks in, otherwise it doesn't. It's really a two-step process and keeps transferring money until all the plans are within the corridor.

A problem with the risk adjustment process is that there are huge lags. Right now it's not live yet. We're still simulating results. It will first be used in the July 1996–97 plan year. The data for that will come from the 1994–95 plan year. The problem with that is that the money that is attached to the marker moves with the member, so the problems with such a huge lag is that the member could have moved to another participating carrier. The member could have left, or the carrier could have left. In all instances, the money doesn't go to the carrier with whom the claims are associated, so that's a problem.

Another problem is that the process is based only on inpatient data. One of the reasons for that is that the HMOs don't capture outpatient data at the same level of detail to make the risk adjustment process work. The problem with that is that it makes the calculation more retrospective than it otherwise would be. It is retrospective in the sense that the loss has already been incurred. Because of the reasons that I stated before, the money may not go to where the claim was actually incurred, and because of that, there is still incentive to avoid risk. If you want your risk adjustment process to work, then you have to try to minimize or eliminate the incentives to game the system.

I have a couple of observations about California. Again, we're still simulating the results, so nothing is final. An interesting observation is that there's no conclusive evidence that the pool is selected against. The HIPC was so glad when it could say that, because that was one of the primary concerns. What it did to even be allowed to say that was, when it was building the marker diagnoses and selecting them, the HIPC collected all kinds of data. The HIPC collected data from HMOs, from PPOs, from people inside the HIPC, outside the HIPC and before and after reform. The HIPC did this massive simulation and the risk assessment value for the people in the HIPC was 12 points less than for the outside market. That's pretty good, but the data used to do that weren't clean enough. In the outside market data, there were groups that were much older durationally. There was self-funded business. There were many larger groups included. Even so, it's a significant result, but this is as far as I can go. It's not conclusive that they are correct.

There is more compelling evidence, however, inside the pool in calculating who's going to receive money through this process. There's one receiver plan and it is EHI. John Alden would have been actually a more significant receiver plan than us had it not exited the HIPC. What's interesting is that John Alden had 2.8% of its members with marker diagnoses. EHI has 0.7%, whereas HMOs have 0.25% of their members with marker diagnoses.

It is interesting that, as we began these simulations, we had an open enrollment. John Alden and Aetna were the other two PPO carriers, and pulled out, so we had an opportunity to see where the marker diagnoses went, especially all of them that were sitting with John Alden. What happened was that EHI got a greater than market share percent of marker diagnoses at the open enrollment, so there is more compelling evidence inside the pool for selection between HMOs and PPOs.

If this simulation had been real, 13% of premium would have been transferred as a result. Even though the process only transfers 1% over all, EHI would have received an additional 13% of premium. I guess I'm not giving away information when I say it still wouldn't have been enough.

MR. DANIEL EDWARD WINSLOW: I'm an actuary for Starmark, a wholly owned subsidiary of Trustmark Mutual. My experience is more from the insurance company side. Starmark writes very small employers, typically from one to 15 employees, in over 30 states. Carol McCall and I share many similar problems.

First, I have a brief overview of individual health reform. Trustmark is one of the few companies left in the nation writing individual medical insurance. Overall, we are profitable in individual medical insurance. We're currently in business, or in the process of filing, in 48 states. That is a challenge with the states that have tried very aggressive reforms.

There are several states where writing new business with profit potential looks very difficult. Experiments are quite recent and have not had much time to play out. Guaranteed issue is being tried in several states—New York and Kentucky to name a couple. Our major concern is the individual medical market might become a dumping ground for large and small employer markets. Conversion policies from large employers and the various state CHIP plans are potential sources of severe strain. The individual market needs subsidies such as New Jersey has implemented.

One idea that regulators and legislators have considered is to model individual health reform after moderate small group reforms. The idea of a common rate manual for the insurer's whole book of business with the restricted, but wide rate band variations around an index rate, has been very successful in the small group market. Policies issued before a certain date would be exempt due to the wide variety of issue age and level premium rate structures on older policies. This might very well stamp out extremely high rates on older policies. Sometimes it seems insurers and regulators get too locked into old rating models for individual health insurance.

Moving on to small group health reform, my true expertise, my intention is to quickly move through some of our experiences with various state reforms. The major intention is to try to make some of our knowledge public, to help better understand some of the public policy consequences of these reforms. Unfortunately, much of the data is splintered among separate insurance companies and regulators. It's hard for any one person to get a broad viewpoint.

Overall, the market is currently profitable in small group medical insurance and has been profitable for many years. We have earned one of the highest returns on equity in the industry. We are committed to the market in participating in most, but not all states. Most

states with moderate reforms are working well from our viewpoint. One such state is Illinois, our home state. Illinois passed a plus or minus 25% rate band around an index rate, and 20% between class reform law January 1, 1994. This has effectively eliminated abusively high, 75% or 100%, annual rate increases.

Portability and guaranteed renewability provisions have also been valuable. A major political problem was solved without disrupting the market.

Moving on to states with more aggressive reform, let me emphasize that the experiences I'm about to relate are very normal. In informal conversations with many competitors and state regulators, all of us seem to be struggling with these issues.

Colorado is a state with guaranteed issue of a standard and basic plan with modified rates and unisex rating. This just started in January 1995. It is too early to have any concrete claims experience. However, we do know we are issuing standard and basic plans to employers who have employees with great health problems. We're tracking this in our underwriting department.

New Hampshire also implemented a moderate small group reform in January 1993 and aggressive reform in January 1995. It has guaranteed issue of all plans with modified community rating, a four to one age band during 1995, and unisex rating. New Hampshire does allow prices that vary slightly by size of group. Unfortunately, it also allows case splitting by the employer with multiple benefit plans. This alone caused several insurers to drop out of the state. Sick employees pick unmanaged care with low deductibles and low out-of-pockets. Healthy employees self-insure as much as possible with managed care plans and high deductibles. There appear to be many opportunities for antiselection by small and large employers.

Kentucky implemented the law January 15, 1995, with guaranteed issue of all plans and modified community rates and only a limited portfolio of standard plans allowed. Much of this is similar to New Hampshire. In addition, a health policy board is in charge of all health insurance in Kentucky. Kentucky is one of several states that have imposed requirements to approve policy forms and rate filing, with the perceived consumer perspective. One that is of particular concern is abolishing the monthly trend factors. Rates must stay constant for six months, with a 12-month rate guarantee for each small employer sold or renewed. In effect, an 18-month rate guarantee may exist.

Any rating in the state must stay on the market for six months. Let me tell you about an embarrassing (and I emphasize the word *embarrassing*) North Carolina experience to illustrate. North Carolina also put in a January 1995 reform, with guaranteed issue of standard and basic plans with modified community rates. At our company with multiple business units, we needed to put together a single rating system that was a compromise among the multiple rating systems currently being used. This is the embarrassing part. We miscalculated and had rates that were 10–12% lower than competitors. In three months, in-force premium in North Carolina went up by a factor of three. The sales people in North Carolina were ecstatic.

The actuaries, me being one of them, were deeply panicked. We raised our rates substantially to avoid betting the company on the success or failure of the then North Carolina

reform. Once again, our underwriters were informing us that many people with severe health conditions were being written.

The solution was an immediate rate increase to match the market premium levels. Sales stopped at the exponential growth curve and our losses in North Carolina were limited to levels that could be cross-subsidized from other profitable states. We expect to make a profit in North Carolina in 1996. Under Kentucky rules, we would have had to accept another several months' worth of sales at inadequate rates, but perhaps longer if our next six-month rate filing had already been locked in. With Kentucky-like rules, the cost is much higher.

Perhaps you feel we were exceedingly foolish. With all the environmental changes, virtually every small group carrier has at least one state that is a distressing story.

Florida is the first state that Starmark had experience with guaranteed issue of the whole medical portfolio at modified community rates starting in January 1994. Experience is starting to develop for us in Florida. We have examined our experience in some detail from January 1994 through June 1995 for incurred claims and premium. It is very poor claim experience and causing us significant losses. Quite noticeable antiselection occurred.

There is public information about all Florida small group insurers, and many of them seem to be experiencing deteriorating claim experience. Several have increased their rates significantly. Again, I find that these problems are shared by others in the industry. All in all, it is clear that Starmark does not currently have a formula for great success under the current laws in Florida. This is one of the biggest strategic issues facing us today. We'll find out in one to two years whether our next strategy will work. As a brief support of what Carol had to say, Starmark and Trustmark have made extensive investments to comply with these small group reform laws. We've added significantly to our legal department to guide the business units. Our actuarial department spent about a third of our time solely on small group reform compliance. We've also made extensive investments in computer systems to build in the flexibility needed for all the state variations. Of course, all this expense is passed on to the customer. We have required everyone to become knowledgeable about small group reform and invested heavily in educating marketers, actuaries, underwriters, claims processors, and customer service people. Our decentralized approach appears to work well for us.

One issue that has become clear across many states is that these reforms have been implemented with a spectrum of philosophies. There are many incentives and opportunities for the various players in the system. These laws are not all black and white. Insurance carriers have much opportunity to decide how aggressive to be in compliance with and avoiding the obligations in areas that range from light gray to dark gray, with room for personal interpretation. The carrier that most avoids the obligations gains a significant market and profit advantage. Agents now feel legal obligations in new situations. They must obtain the best deal for their client, yet directing sick clients to particular insurance carriers can force that insurer to withdraw from the market. Agents have new power and opportunity to make or break an insurance carrier or HMO. Underwriting used to protect insurance companies and HMOs from a poorer than average risk pool.

Small employers now have much more opportunity to manipulate the system. Large employers typically self-insure, as they're spending their own money on medical benefits and therefore cannot stick an insurer with large losses on antiselection. Small employers can change their size, number of employees, state of primary business residence and corporate form including subsidiaries and affiliates at the drop of a hat. For example, we've had an employer of 65 employees magically shrink to 49 employees in Florida, when one employee developed a problem with several hundreds of thousands of dollars in medical bills. The other employees went to an Illinois corporation.

Another example is a client who moved from Florida to Georgia once the client learned about the much lower medical insurance premiums in Georgia for a 25–50 employee company. Medical insurance is one of this company's largest costs of doing business. This helps to put sick people in the guaranteed issue market and remove healthy people. This manipulation can place stress on the overall small employer insurer risk pool.

Insurance departments are overwhelmed with the flood of new work taking place in a political spotlight. Many decisions and interpretations are made by politicians. Achieving fairness, consistency, and publication of all these decisions in a rapidly changing environment is difficult.

All this leads to my last point. A level playing field is very hard to achieve in this new environment. In Iowa, the community average experience rate pricing and fair marketing standards of the standard and basic plans are hot issues at Starmark. Fifty percent of our new business is highly substandard. We suspect we may be applying the law more vigorously than other insurance carriers. We're currently in a dialogue with the Iowa insurance department trying to obtain a clarification on what the minimum requirements are. In the meantime, we are continuing business in the state, but being forced to raise our rates. Luckily, Iowa premium is a fairly small part of our overall company's premium.

In Florida, we've heard of a competitor that is offering self-funded plans to small employers. Also, employee-leasing firms can accumulate a pool of healthy small businesses as clients and come close to acting as an insurance company. An employee-leasing firm can underwrite people who are legally its own employees, and the firm as a whole employs far more than 50 people. Both of these make an unlevel playing field with an insurance company that's doing guaranteed issue to sick people.

In New Mexico, the interpretation of the rating elements of small group reform laws knocked us out of the market for nearly a year. It was just recently that we received approval of our January 1995 form and rate filing and made our medical coverage (with maternity) product available for sale. There was a good faith effort by the New Mexico insurance department and by us to resolve the problem. Our sales representative in New Mexico is still not very happy.

In Colorado, the pricing of the standard and basic plans is of concern to us. Setting a plan factor that reflects the benefits is an art with judgment and skill and most important, a range of acceptable answers. It's not a scientific formula that has a single, unique, and verifiable correct answer. It's that judgment that can determine whether your company takes on the sickest people in Colorado. It is unlikely that all companies will apply equal judgment and create a level playing field.

Insurance pools aren't likely to create a level playing field. We know they are not cutting our losses in Florida. We'll approximately break even on Florida's reinsurance pool considering reinsurance premiums, claims and assessments, yet our direct claim experience is very poor with twice the expected level of large claims. Reinsurance pools don't create money, they only redistribute it.

In conclusion, let me reemphasize that Starmark experiences are normal. Many competitors and state regulators are struggling with these issues.

MICHAEL N. GEORGAS: My comment is directed to Dan Winslow. You said that the health care reform in Kentucky came into effect January 1995. That's not true. HB250 became law on April 15, 1994, and it went into effect July 15, 1995.

MR. WINSLOW: I'm sorry about that. I do know it's July 15, but with all the other January 1 dates, I just misspoke during the speech.

MR. DALE C. GRIFFIN: Both Carol and Dan mentioned varying company attitudes towards compliance and since the topic of this meeting is "Ethics and Professionalism," I wondered if either of you had any comments about how ethics and professionalism among actuaries relates to this whole question of varying interpretations.

MR. WINSLOW: The compliance effort is being set by top management, which may or may not include an actuary; many companies are not run by actuaries. I do feel it applies to ethics. Unfortunately, ethics are a very personal matter, and my viewpoint may very well not be the viewpoint of someone else. This is one of the reasons that can create an unlevel playing field with the other actuary feeling he or she did something that was ethical.

MS. MCCALL: I would add the comment that it can be a very frustrating process. EHI does a great deal to try to comply with reform. Even though we're not a company run by actuaries, I feel very fortunate that I work for a company for whom small group reform compliance is a high priority. The only thing that I can say is that in states where we have found a lot of activity that is definitely to be out of compliance, we do research and in some instances, we will call the state and talk about it, and by that process the state knows that this type of activity is going on.