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Actuarial Issues in the Evaluation of Healthcare Reform Proposals

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Summary: Why is it that two competent actuaries making reasonable assumptions can arrive at very different conclusions when evaluating the impact of proposed health care reforms? Are the answers really as different as they appear to be on the surface? This session will outline and highlight some of the key actuarial issues that arise in the course of these analyses. The leaders will use an interactive case study approach based on real-world examples from both the state and federal areas.

Mr. Thomas D. Snook: I'm in the Phoenix office of Milliman & Robertson (M&R), and I was in Houston for 17 years before I moved to Phoenix. I've done quite a bit of work relating to health care reform. I'm going to talk about some work I did in Texas relating to the small group reform that went on there. The purpose of my discussion is really to highlight the type of analysis that goes into this type of reform. I'll really highlight some of the assumptions that need to be made when you talk about what guaranteed issue is going to do to the small group marketplace, for example. I guess the main focus is that there is a certain vagueness in some of the assumptions that need to be made, but are difficult to make. After I speak I'll introduce Mark Litow, from the Milwaukee office of M&R. So we do have prepared presentations, but again, I want to encourage everybody to get up and interact, because this is an interactive forum.

As I said, this is a case study on the actuarial evaluation of a health care reform proposal. The case study is on Texas House Bill 2055, which was the small group reform bill. It is fairly similar to the NAIC model.

How many people in this room do health care work? OK, almost everybody. I wanted to be sure you know what I'm talking about when I say the NAIC model. So similar to the NAIC model, there's rating restrictions, there's guaranteed issue, and there's a reinsurance program put together to spread the risk associated with guaranteed issue. House Bill 2055 was adopted in 1993, but it delayed the implementation of guaranteed issue and the reinsurance program until 1995. The reason for the delay was because there were some people who were rather nervous about what guaranteed issue might do. House Bill 2055 called for an actuarial analysis of the reinsurance program and guaranteed issue before it was actually implemented.

I'm going to focus first on the reinsurance program because that was the first bit of work I did, but the major issue was what was the likelihood that this reinsurance pool would remain financially viable. A small group insurer who participates in the reinsurance program can cede either individuals or entire groups into a reinsurance program. This is supposed to help spread the risk associated with guaranteed issue. The premium rates are set by statute to be either 150% of market rates or 500% of market rates, depending on whether or not you cede the individual or the group. Those premium rates may not be adequate.

In fact, if the insurance companies do their underwriting correctly, they're only going to cede those people for whom they think the premiums are going to be cheaper than the claims. So we would reasonably expect this reinsurance program to run a deficit, and the deficits are to be funded by assessments to small group carriers. The Texas law had a 5% cap on assessments, and I think this was in the NAIC model as well. Those assessments could not exceed 5% or small group premium volume in aggregate. So the question was, is that 5% cap going to be hit, because when you hit the 5% cap, then the pool doesn't really have any other funding source. Assuming we'll find money elsewhere is kind of the politicians' way of not dealing with an issue.

They wanted to study what the likelihood is that we're going to hit this 5% cap. I went over some of these points already. The Texas health reinsurance system was the program set up by House Bill 2055. Again, the purpose is to help carriers pool risk and share risk associated with guaranteed issue; this is risk that they hadn't been taking previously in the small group market.

To determine whether or not it was likely that the program would hit its 5% cap, we did a financial projection, an actuarial assignment. Basically that means gathering data, creating a model, writing a report, and presenting it to the client or your management or whomever you're dealing with. That's what we did here. So we did a financial projection of the small group reinsurance program. To rephrase the

question, what are the likely levels of assessments to be over the next *n* years? We set it for three years because there was so much going on in the marketplace, we thought that anything beyond three would be of dubious value.

The key assumptions then that go into a projection of this sort are first of all the size of the assessment base. How much premium volume are you going to have to assess against to cover your shortfall? Second, what is the number of lives to be reinsured into the reinsurance program? What proportion of those lives are ceded as a group versus an individual? If a carrier cedes an individual and pays the higher premium for ceding that individual in a reinsurance program, it is obvious that they're going to be sicker or in poorer health status and have a higher claim cost than if you cede an entire group, where you may get a mix of healthy and unhealthy lives. The final key assumption is, what is the expected claim cost level for those reinsured lives?

Setting the first assumption means setting the size of the assessment base. The Texas Department of Insurance, our partner in crime on this project, did a poll of all the small group carriers in the state. The department asked them, first of all, what's the likelihood of participating in the reinsurance program or opting out? Big carriers can opt out if they apply to the commissioner and get approval and demonstrate that they can handle the guaranteed issue risk by themselves. So the intention of becoming a reinsuring carrier, and then what their current small group premium volume was, and what their anticipated future volume would be. So we're asking the carriers themselves how much small group volume they have in force and how much they would have in force in the future. We're assuming that the carriers know their business much better than anybody taking a big look at the marketplace in total. From this, it's fairly straightforward to calculate an assessment base. Actually, what we did was a little bit more complex than this in that we didn't ask whether their intention was to become a reinsurance carrier. We asked them, we did a range of probability, is it very likely to be a reinsuring carrier, because when we did this, the law wasn't in place yet, the carriers hadn't had to make—the law was in place, but the GI provision hadn't kicked in yet. The carriers probably hadn't decided yet what they wanted to do. So we were asking them what their current thought was on participating in the reinsurance program. We asked them whether it was very likely, somewhat likely, whether they were not sure, whether it was somewhat unlikely, or very unlikely. We then assigned a range of probabilities to those volumes, and calculated an expected value of our assessment base.

When I look back now on the work we did then, we overestimated the assessment base by a great deal, mainly because many more carriers opted out of participating in the reinsurance program than they told us they thought they would originally.

The impact of that is twofold. Number one, it means we have a smaller assessment base to work with, but it also means we're going to have fewer lives reinsured into the program. So your variance increases, but your expected volume really doesn't change one way or the other.

Let's discuss the number of reinsured lives. The Texas Department asked the carriers how many people they thought they were going to cede to the pool, considering the fact that it would be guaranteed issue. Many of these carriers are multistate carriers. They had experience in other states, so we asked them, of the business they write under guaranteed issue, how many do they think they are going to see? We also then reviewed the experience that existed in the other states that had programs in place at the time. The problem with this is that the experience in the other states was fairly thin. When we were doing this, it was mid-1994. Connecticut had a program up and running for a number of years, but their program was different in that they allowed existing business to be ceded into the pool, while all the other states, Texas included, only allowed new business written after the implementation of guaranteed issue to be ceded into this reinsurance program.

In addition to Connecticut, I think North Carolina was another state that had some experience, but at that time, it was all fairly new. We looked at and took into consideration the experience in the other states, but it was somewhat thin and had to be taken with a grain of salt. Because we didn't really know the answer, but we thought that we knew about where we'd be, we set scenarios. We used three ceding scenarios. The low was 1% of newly issued lives ceded; the high was 2% of newly issued lives being ceded; and the midpoint was 1.5% of newly issued lives ceded.

Where do we expect claim cost levels to be for people who are going to be participating who will be ceded into the reinsurance program? As you think about this, it really boils down to a question of how well a carrier is going to be able to determine the expected future claim cost of individuals. Carriers, as they go through the thought process, had no choice but to have guaranteed issue in business. The carrier is looking at a small group that it has written, and it has to make a decision about whether it wants to cede this whole group, whether it wants to cede anything individual in there, or whether it wants to retain the entire risk. The analysis then boils down to an expected value. You know what the premiums would be if you ceded the whole group. You know what the reinsurance premiums would be if you ceded certain individuals. That would be a cost to the insurance company. From these assumptions, you make an estimate of what you think the claim costs for that group would be. If the claim costs are higher than the premium, you cede; if they're less, you don't cede. That's a simplification, but it is essentially the analysis.

The question is, how sophisticated and how good a job would carriers do in guessing or estimating future claim cost levels for these individuals? This is kind of a new issue, because in the past all a carrier really had to do is say, well this risk is uninsurable, or might be uninsurable, and then they just decline the group or carve the individual out. That is illegal now. So to make our estimates of what the claim cost levels would be, we went to three data sources, two of which were internal. One is our own claim cost data base, or our claim probability distribution.

The M&R health care model calculates net claim cost by health status. You can ask Mark Litow about that because he developed it. Basically, it calculates assumptions of claim cost levels with individuals grouped into four health status categories: insurable, slightly impaired, very impaired, and uninsurable. The third data source was experience in other states. Again, that was kind of thin, which is why we had to go to outside sources. Table 1 will give you an idea of what the claim cost relativities look like. I didn't use the actual numbers because they're old and they're not really applicable anymore. Of those people who have a healthy status, a slightly impaired status, a significantly impaired status, and an uninsurable status, the report showed 88% of people in the small group market would fall into the healthy status. For the purpose of this illustration, I've set their claim costs to one, and then it grades up for the slightly impaired, the significantly impaired, and the uninsurable. There are definitions for each of those terms, and right now I don't remember what they are, other than they are uninsurable, which is fairly obvious. So you can see, it carries on the expected relationship with slightly impaired being the second largest group and having claim costs about 30% higher, and then significantly impaired and uninsurable would have very large claim costs. That's why they call them uninsurable.

TABLE 1
CLAIM COSTS BY HEALTH STATUS

Health Status	Distribution	Claim Costs
Healthy	88%	1.000
Slightly Impaired	7	1.289
Significantly Impaired	3	2.668
Uninsurable	2	6.367

What we wound up doing is defining a set of claim cost adverse selection factors based on those data and the other data for individually reinsured lives. Because we didn't know what the answer would be, but we thought we could reasonably estimate a range, we set some scenarios that varied with the degree of adverse selection that would be present—in other words, the degree of the carrier's ability to

capably underwrite the groups and cede sick lives. Also the scenarios varied with the reinsurance ceding scenario. If you have 1% of lives being ceded into the pool, you would expect a higher claim cost for those individuals. That's because you're carving off what are presumably the sickest 1%. If you're ceding 2%, you're going to have a slightly healthier group of individuals. Again, these were assumptions. We based these assumptions on individually reinsured lives, and then we made an assumption that I will admit right now was a blind leap of faith. The claim cost for lives, reinsured as part of an entire group, was set at 30% of that individual level. The 30% number comes from the relationship of the premium rates, 150–500%, so there was some logic to it. You look at average group sizes written in the small group markets, which is a very small group market, so there's some logic and consistency behind it, but other than that, it was a difficult assumption.

These claim cost selection scenarios are shown in Table 2. If 100% is defined as standard claim cost for a healthy individual, then there are the three participation levels—low, mid, and high. I didn't want to call the adverse selection scenarios low, mid and high because you're going to have adverse selection no matter what. That's the purpose of the reinsurance program. I called them moderate, high, and higher. I have adverse selection factors that range from 500%, in other words matching the reinsurance premium in the most optimistic scenario, up to 1,200% for the most pessimistic scenario.

TABLE 2
CLAIM COST SELECTION SCENARIOS
CLAIM COSTS AS A PERCENTAGE OF
STANDARD INDIVIDUALLY INSURED LIVES

Participation Level	Moderate	High	Higher
Low	800%	850%	1,200%
Mid	633	750	1,000
High	500	700	900

So what did we find? Projection under all scenarios resulted in assessments that ranged from almost nil, in a scenario where the claim cost equaled the premium (the only assessment that is needed to cover administration costs for the program), to the most pessimistic case, 1.6% of the assessment base. I'll admit that's a wide range of results. It seems very unlikely, even given what we thought was a very wide range of scenarios, that the 5% cap would be reached, at least in the first three years of the program. So what I got out of this, personally or professionally, is even when something looks like there's a lot of guesswork involved, if you make some reasonable assumptions instead of broad-range estimates to cover all likely

scenarios, you can still get valuable information out of that type of analysis. It's not something you'd want to bet the company surplus on, but for these purposes it was helpful.

That's what I'll call the easy part. The hard part was Texas then came back to me and asked how much is this guaranteed issue going to cost the marketplace anyway? It is a politically charged question and almost impossible to answer correctly because there are all sorts of things going on in the health care marketplace. Trends at this time had really collapsed from historical levels, and there was rapid growth, especially in Texas, of managed care penetration. That was changing things, so isolating the impact of guaranteed issue and what it would do was hard. That's the hard part. The good part is it's hard to tell whether you're wrong when you look back, but if you're in political-type situations, it is always helpful.

If all other factors are the same, guaranteed issue should mean that the average claim cost per life insured will go up. There are sick people out there who have a lot of medical expenses that you weren't covering before, but you're covering them now, so you add them to the pool, and claims go up. The problem is that all those other factors aren't the same, as I just described. There are many other changes going on in the health care marketplace that made it difficult to isolate the impact. One of the mitigating factors is managed care. Others are low trends and administrative savings that might arise out of guaranteed issue. If you're not underwriting individual groups anymore, that can, in theory, at least save you some money, although many carriers are underwriting for different purposes, such as reinsurance and rating. The impact on national health care reform was looming out there. So the approach to the analysis was again, we're actuaries, so we do financial projections, right? We can do a projection of claim cost levels before and after guaranteed issue. The question was, what is it going to do to premium rates in the marketplace. I didn't want to answer that question. I'll answer what it does to claim costs, and hope that they can infer that they should be related.

We did a three-year projection looking at the accumulated effects of guaranteed issue over three years. One would expect guaranteed issue to have its most significant impact when it was first implemented because you have a backlog pressure of uninsurables who will be seeking coverage, but you'll have a cumulative effect, because those people aren't going to give up their coverage unless they die, and you'll have other people who become uninsurable and need to seek insurance, so the effect is more cumulative.

The key assumptions then in this type of analysis is (1) the distribution with currently insured lives by health status, (2) claim costs by health status, which I

already talked about, and then (3) entry rates and exit rates. Entry rates are the rates at which people with high claim costs who previously would not have been insurable or gotten insurance can now seek coverage under. And that assumption is not 100%; in other words we don't want to assume that everybody who is sick is going to go get coverage because you still have that affordability barrier. People who are working for small groups generally don't make much money, and they may be getting charity care as it is, so paying a small group health insurance premium may not be a choice for them, or their employer may not even offer it. There is no reform of this type in the individual market in Texas, so there wasn't complete control by the insured individual as to whether he or she could enter the marketplace or not. The second assumption is what I'll call exit rates. I would call this a sensitive and highly politicized assumption. The claim costs and presumably the premium rates will go up because of guaranteed issue, and that will cause healthy people to drop their coverage for affordability reasons, and if they do, at what rate would they drop their coverage.

We'll talk about entry rates a little bit more. Entry rates are again, the rates at which the percentage of uninsured or impaired individuals will become insured as a result of guaranteed issue. These people were barred from coverage previously. Again, you assume a higher impact the first year. We do the scenario approach again, and in this one we set a very wide range of assumptions. They range from what I'd call an exceptionally optimistic assumption of 10% of uninsurable or impaired lives entering the small group market, up to 75%, which strikes me as very pessimistic. I didn't know what the answer would be. There wasn't really any good data from other states, so I just set a wide range of assumptions to see what would happen. The exit rate is the percentage of current insurers who leave the small group market because of a higher premium which resulted in guarantee issue. Again, a scenario approach with big ranges, assumed exit rates for healthy lives ranging from 0% to 5%. I use 0% because I wasn't convinced that this was definitely going to happen because of all the other changes in the marketplace. Trends were very low and managed care penetration was growing rapidly at the time, so I wasn't sure that premium rates were going to go up at all. I was not unsure because of guaranteed issue, but because of other mitigating factors in the market, and up to a pessimistic assumption, 5% of healthy lives that would exit the marketplace.

When you put all of this together, what do you get? In Table 3, the rows represent entry rates that I described, the rate at which guaranteed issue individuals would come in the marketplace. The columns represent exit rates. Our answers ranged from an optimistic scenario of 3% to a pessimistic scenario of 14%. What's interesting is even in my most pessimistic scenario, I came up with answers that did two things. Number one, they worked consistently with what some of the carriers in Texas were projecting. We saw projections ranging from 25 % to 30% increases.

Number two, what was really interesting is they weren't consistent with some that Mark had done in the state of New York. The carriers wanted to know why M&R did something different in New York, and why the answers were not consistent. I anticipated that, and fortunately, I asked Mark to peer review all my work, so we knew why there were some material differences. The main difference is that New York had community rating, which has all sorts of other different kind of impacts, and Texas didn't, so that resulted in some fairly diverse issues or answers.

TABLE 3
PERCENTAGE INCREASE IN COSTS AFTER GI

	Low Exits	Mid Exits	High Exits
Low Entries	2.9%	3.3%	4.0%
Mid Entries	7.5	8.1	8.9
High Entries	12.3	13.1	14.1

In conclusion, the points I wanted to make are first that this is kind of interesting work. The issues you're dealing with pose actuarial questions that are much different from our normal day-to-day work. The data are thin at best. You must make your assumptions carefully, and when you really don't know what an answer is going to be, like how many uninsurables are going to enter the market, make your assumptions carefully, set broad ranges, and see what happens.

The final point, which I haven't really talked about, is that the communication of these results is critical. This is especially true when you're dealing with policymakers or politicians. This work was all done for a Texas legislative committee, so there was public testimony, the press, and all the fun stuff that we like to get involved with. So when you're doing scenario testing, and when you're talking about projection of claim costs under guaranteed issue, you have to make it clear you're talking about projection of the impact of guaranteed issue. I made it very clear in both my report and my public testimony that this may not happen at all because of all these other mitigating factors that, to me, were having a very strong influence in the marketplace. So the communication, and how we, as actuaries, talk about the types of analyses we do and what they mean are very important when you're involved in these types of projects.

Mr. Michael N. Georgas: I just wanted to make a comment about something that happened recently that might surprise people. We received a letter from a county department of health in Kentucky that wanted to purchase our product, health insurance, for some of its AIDS patients. The state of Kentucky was buying health care from us for people that normally wouldn't be covered. So it seemed to try to

find a way around that affordability for some of its people. I thought you might find that curious.

Mr. Snook: Yes, that is definitely organized adverse selection at its finest.

From the floor: I sat on the Idaho committee, and it expanded its coverage to include individual guaranteed issue, and that has some very scary dicey things to it because it's possible for Medicaid to move its patients into the industry support.

Mr. Snook: And Mark is going to talk about the Kennedy-Kassebaum bill, which, of course, extends guaranteed issue to individual health insurance with some limitations. It has to be basically a continuation of some prior group coverage, but it will be interesting to see what Mark has to say about that.

Mr. Glen R. Volk: In the scenario testing you did, was the 1.6% kind of the upper bound for the worst case. What did that translate to as a loss ratio for the reinsurance pool? Second, any suggestions on what the right loss ratio should be? I don't know that 100% of this is necessarily the right target.

Mr. Snook: If the reinsurance program operates at a 100% loss ratio, it means the carriers really haven't done a good job of selecting against the pool and pooling their risks. I don't remember what the loss ratio was. That's a good question, I should have looked at that. I think it was more than 200%, and it may have been as high as 300%, but my memory is fairly vague on that. That's a good question. The whole point of this analysis is to determine what the appropriate loss ratio level is. We don't know, and the experience to date in both Texas and other states is that it looks like the carriers, so far, aren't doing a very good job of deciding what lives should go into the reinsurance program. I'm seeing loss ratios from state to state that are under 200%, generally speaking. In many cases, they are around 120%. The problem with that is that we're dealing with a very small number of reinsured lives, and we're talking about people who are going to have high claims. It's really hard to complete those claims to get an estimate of incurred claims from paid claims. There's a very long tail, and they have to run up the claims and submit the claims to the insurance company. The insurance company is going to turn around and cede it to the reinsurance company, the reinsurance company is going to pay them, and there could be as much as a 12-month lag from incurral of claim to reimbursement from the reinsurance program to the carrier.

I know that when MetraHealth, who is administering all but I think one of the state's reinsurance pools, prepares the financial, it assumes a 200% loss ratio in almost all the states, because the data have not been credible. So it just set incurred claims at

200% of premium. I don't know that anybody has been obsessing on that estimate to date.

Mr. Mark G. Litow: Yes, I've been involved with Wisconsin which has a high risk pool, so it's not a reinsurance pool; it's a little different. The setup there is that it charges people only after they have been rejected by two carriers. There's 50% total, and the idea of the premium is it is supposed to be 60% of the cost. The assessments are supposed to be 40% of the cost. So the loss ratio typically does run 150–200%, and it's made up by assessments that typically are running about $20 million a year. They can't get the ERISA plans, but that's across the rest of the industry.

From the Floor: I was recently on the board of a Connecticut small group pool, and that pool has in the last couple of years run below 100%. What we've seen is that many carriers have not been very diligent about pulling people out of the pool and have had miraculous recoveries and the like. Also, the premium rates in the pool had a very high trend factor, and they've sort of galloped ahead of actual trends. Often I think that some of these pools can maintain the premium rates and the loss ratios will come down over time. The Connecticut pool had some early assessments, and right now there's a surplus and quandaries as to what to do with it.

Mr. Snook: Let me ask you a couple of questions on that. Does Connecticut allow carriers to pull life or group out of the reinsurance program once they've ceded it?

From the Floor: Yes. It has to be done. You have to warn the pool ahead of time, I think it has to be done 30 days or 60 days before the anniversary, but you could pull the people out at almost any anniversary.

Mr. Snook: So there the carriers actually have two opportunities to select against the program. When they cede them, they can pull them out if they decide that they're healthier than they originally thought.

From the Floor: Yes.

From the Floor: I'd like to just let some states know what they might expect about enrollment. Several years ago, Florida put in guaranteed issue and reinsurance pools. We also created something called a Comprehensive Health Purchasing Alliance (CHPA). This was designed along with the purchasing alliances in the Hillary proposals. I looked at the statewide enrollment, all carriers, all products, etc., for those CHPAs after they had been in place about ten months. Small group reform in Florida is one life to fifty lives, and that can also be a key as far as what you should expect (one being the lowest number and 50 being the highest number).

At any rate, for the Florida CHPA experience, 80% of the groups had either one or two employees, and 80% of that 80% had one employee each. In other words, what Florida in my opinion had done was create individual guaranteed issue insurance without really knowing it.

Mr. Snook: Yes, I can echo that because of the work I've done in Arizona. Arizona has a program called a health care group, which is similar to a purchasing alliance, although it's a little different in that, one, it's run through the Medicaid program, believe it or not, rather than some separate entity. Second, a carrier, specifically an HMO, writes business through the health care group, and the carriers actually market that business. Other than that, it's very much like a purchasing alliance, and I think there are four HMOs in Arizona that participate. They found that they are writing one-to-three life groups almost exclusively, even though, technically and legally, they're supposed to write one-to-forty lives. They're not writing much business either, which surprised me. I think they're up to, if you pool the four plans together, 20,000 members after being in place for eight years. I think the affordability issue is as much a bar to coverage as the underwriting issue is.

Mr. John R. Buss: In your assessment base, you mentioned that the plan had been overstated because the companies weren't sure at the time whether they were going to enter the reinsurance pool or not. I guess the question that I have is, do you now know whether those companies that did not enter the pool did so because they chose to retain the entire risk, or did they opt out of the small group market? Also, what effect does that overestimation have on your the assessment itself, the 1.6%? How much would that change in retrospect knowing what the assessment base is likely to be now?

Mr. Snook: Two good questions. I'll answer your first question. It's more a matter of carriers not participating in the reinsurance program than it is carriers opting out of the small group market altogether, although I don't know the answer to that question. I don't know the answer to the second question either. I can guess, but that's no good, especially because I'm trying to talk the state into hiring me for another job, which is an analysis on the existing assessment base. I would do a projection and see what the likely assessment levels might be. So we want to study that, and we're trying to talk them into paying us for it. It's how we make our living, you know.

Our next presenter is Mark Litow, a principal in the Milwaukee office of M&R, and he has been very involved in health care reform issues, at both the state and federal level. He did some analysis work for the Council of Affordable Health Insurance related to small group reform, and also the Business Council for Affordable Health Care. He has done analysis for the congressional budget office, for the Joint

Committee on Taxation Relating to Medical Savings Accounts (MSAs), and also Medicare reform. The Joint Committee on Taxation is a group I wasn't familiar with. I guess it's a bipartisan group similar to the Congressional Budget Office (CBO), and it scores legislation for financial impact.

Most recently, when Kennedy-Kassebaum was being considered, Mark was called to the White House and was involved in the negotiations regarding MSA's that went into the health insurance persistency award Life Insurance Marketing and Research Association (now health insurance quality Award HIQA) or Kennedy-Kassebaum, or was it HR 3031?

Mr. Litow: It was HR 3103.

Mr. Snook: It has so many names, I can't keep track of it. Anyway, Mark is going to talk about that experience, and he's also going to talk about this experience with the various work he has done with the states on small group and individual health insurance market reforms.

Mr. Litow: One of the things that Tom told me was that we initially were supposed to be discussing state form, and now we're talking about general reform. I'm going to just put in a few comments about Medicare and Medicaid. When I talk about health care reform, I talk a lot about how, in Washington in particular, people always want to know about adverse selection. Adverse selection, in the terms of health care reform, really should have a much different definition than you might use. If your company gets hurt because you have a block of business that is a poor risk, and then you recall that adverse selection, from a health care reform perspective, we really shouldn't worry about that. We should worry about what's going to be the aggregate impact on the entire market. In this one, the politicians almost regularly flunk because of what they do. If somebody gets sick, and comes in with a health care problem, politicians decide they have to correct this problem. Often you may have a short-term gain and a tremendous long-term loss. We may punish 99% of the population to save 1% or help 1% or less of the population.

The vast majority of the reforms we put in this country are like this, which is why our health care reform system is such a mess. We're always using guaranteed issue, community rating, and mandated benefits. Just think about those. There are price controls under Medicare and Medicaid. Most of the problems we have in our system today are based on those types of reforms, and that's what we get. We have many different serious problems, and trying to explain this to the politicians is difficult because they don't really care. They can't get past the short-term problem.

Let's discuss the six markets in the whole health care reform system. Medicare, which included the disabled, is between 35 million and 40 million people. We have about $260 billion in cost including out-of-pocket costs under Medicare. So you have maybe about $175 billion of costs right now under the Medicare aged program, and another $20 billion or $25 billion under the disabled program. These are all rough numbers. There is about $60 billion of cost in the deductible and the coinsurance and so forth. This doesn't include drugs. Drugs are not covered by Medicare, and there is another item beyond that.

Next is the three private markets. Split the individual market, about 6% of the population, small group market, about 9% of the population, and the large group market, which includes all managed care, HMO, PPO, point-of-service (POS) plans, and indemnity carriers, about 45% of the entire population, which means about out of 260 million people, you have about 125 million in those groups. And those three employment markets make about $330 billion.

Then there are the uninsured, which is about 40 million people, from which there is probably about $40 billion in cost. Medicaid and some other private programs have about 30 million people in them, and probably have about $150 billion of cost at both the federal and state levels. So when you add all that up, you have almost $800 billion of cost when combined with the other costs coming in categories like drugs and administrative costs, research, and construction costs.

Now when you do health care reform, one of the things that you have to realize is that if you change something in the individual and the small group market, like New York State, it doesn't mean that's the only thing that's effective. In New York State, we had a tremendous drop because the individual market has just been destroyed. The small group market has been impacted. The numbers that come out of New York show about a 350,000 decrease in the number of insureds in those two markets in one year. However, at the same time, the Medicaid population and the large group population have gone up about the same amount. New York comes out and talks about what these reforms have done to the market. The reports all show that there's basically no change in the number of people without insurance in New York State, and that is absolutely true. Medicaid has gone up by about 175,000 insureds, and the large group has gone up about the same amount. So the question isn't exactly what has happened to those markets? That is part of the question because the costs have gone up dramatically. The question is, where have these people gone? If we hadn't put in these reforms, the result would have been much different. So everything in this system, as Tom talked about, is very interactive.

The other think I want to talk about within this is that in the small group and individual markets there are annual trends (Table 4). How high is the trend compared to the other markets? If you look at the second column in Table 4, the cost was just at the charge level. The Medicare and Medicaid numbers are lower than they have been. They've typically been –3%, –4%, –5%. Medicare and Medicaid have price controls. Medicare, through resource based relative value schedule and diagnostic related groups, and Medicaid through reimbursement systems to providers, keep lowering the cost relative to what we call the usual and customary level, although I will admit usual and customary in the country, like some areas of California, doesn't exist. And you can see that all those items tend to balance out, because people move their costs elsewhere.

TABLE 4
ILLUSTRATIVE COMPONENTS OF MEDICAL TRENDS BY MARKET
1995-1996 ESTIMATES

Type of Coverage	Base Charge Trend	Cost Shift	Base Utilization Trend	Excess Utilization Trend	Total Trend
Medicare	4.5%	-2.0%	0.5%	5.5%	8.6%
Small Group	4.5	8.0	0.5	0.1	13.5
Individual	4.5	8.0	0.5	0.1	13.5
Large Group	4.5	.5	0.5	0.1	5.7
Uninsured	4.5	-1.5	0.5	0.0	3.5
Medicaid	4.5	-2.0	0.5	4.0	7.1
Total	4.5	0.0	0.5	2.4	7.5

Now look at the column labeled excess utilization. What happens there? We now have a chart for the last 12 years of Part B and it shows how much excess utilization there has been every year. That number bounces between 3% and 7% each year. So physicians and providers keep finding ways to unbundle costs and create extra visits. If somebody comes in and says we're going to lower your billing rate by 20%, we're going to lower your premium by 20%, and gives no alternative mechanism to cover those costs, what would you do? Eventually you would stop seeing these patients if you could shift them to other markets, and that's what they've done. If there's no market to shift to, you may go into a different business. You may start working for a medical college instead of an insurance company. So these things are all happening. Price controls are really devastating because what happens with price controls is that we save money for a year or two, and the politicians love that, because they get reelected every two years except for the senators. The cost just reverses, and the economists know that. This is what is

happening to our health care system. We have a 3% extra trend that is close to what we should have had, and this is going on every year. We get more and more trend compounded upon itself, just like compound interest. People don't understand why health care inflation has been so high. If you look at our trend five years ago, that number on the left would be about 8%, and the number over on the right was probably closer to 13%. So we've had a year that is actually much more modest. There is a small increase in the large group number. That reflects many discounts going on in managed care that are bringing those charge levels down. So when you see these surveys talking about a 5% trend, that's true in the large group market, but it's not true across the board.

From the Floor: Do your cost shift numbers reflect a cost shift from managed care indemnity?

Mr. Litow: This is the whole system combined, so the large group includes the capitated plans under HMOs that would have big discounts, such as in California. They're getting bigger discounts, so many of those plans would have negative cost shifts, and the indemnity plans would be in there as well in the large group. So it's a hodge podge. In our model, we split those out. That model also had splits by HMO, PPO, and indemnity plans, and we didn't have one for POS plans. We probably have to put in one now. So that's what we're talking about here.

I've also done a report on Medicare that was very, very controversial. It was done for the National Center for Policy Analysis. I did this report in September 1995 and, of course, Medicare will be a huge debate. I didn't realize that 12 people at M&R peer reviewed this report, and everybody had a different opinion. There were all these assumptions, and nobody could agree, so we had many caveats in there about how the report was the author's opinion. These things are very controversial, and many people are scared to put out these assumptions. I'd rather put them out. I'm willing to get a little egg on my face because we need a starting point to evaluate these health care reforms. And any time you look at a health care reform, you have to know what your starting point is. I'll be in meetings and people will say guaranteed issue works fine and other people say guaranteed issue is a disaster. I say that in a large group market guaranteed issue is fine, and in an individual market, it's generally a disaster. You usually find out that they're talking about different markets. The politicians don't even know enough to ask this.

I walked in this Medicare meeting with this very controversial report. It was a press conference and every major network was there. I was shaking. I've never done a press conference where every major network attended. All the major Republicans walked into the room. You have to remember that they haven't read this report because I had just brought it in at 8:00 a.m., and the press conference was at 10:00.

A reporter says how wonderful this report is because it matches the Republican plan. I didn't know what the Republican plan was, so they described it to me while trying to lobby the Republicans to do this report.

After listening to the details, I realize that some aspects are the same and some are very different, and I had to explain this to the press. I didn't want to lie, so I explained what we did, and they started to realize that it wasn't so similar to the Republican plan. They asked, "If you change the subjects, wouldn't the results change?" I said, "Of course." They asked how would they change, and I said I didn't have the slightest idea. I sort of felt like an idiot up there, but we went on. The Republicans weren't real happy with me. As I was walking out of the room, Senator Thomas Daschle (D-South Dakota) walked in with all the major democrats. They did a press conference about how terrible the M&R report is, and how terrible the Republican plan is. These guys haven't read the report, and they of course didn't know what the Republican plan was until an hour before.

So this is what's going on in Washington and in many of your states. As actuaries, we need to stand up. It's not that we're going to know all the right numbers but we know many things these people don't know, and if we allow them to continue to put on these charades, we're going to get the kinds of reforms we're complaining about. So we have this debate in our firm all the time about whether we should get involved or not. I'll leave that to you, but based on my story, I'd rather be involved than not be involved.

Now I want to talk about the reforms in the small group market and the individual market. I'll discuss what has come out of the HR 3103, which is one of the nicer names that people call this bill. Right now we have guaranteed issue with some forms of rating bands, at last count, in about 18 states. Guaranteed issue varies dramatically from state to state. We have different rating restrictions, mandated benefits, and in every place we have these reforms. One thing is consistent: as we're getting the results in, we are having many problems with adverse selection. They were worried about adverse selection from metropolitan statistical areas (MSAs), and I told the Republicans, when we first met, "You guys are worried about adverse selection? I'd be worried about adverse selection in anything." MSAs are no different than putting in HMOs or anything else. You always have to worry about selection and adverse selection. They just talk like selection is adverse selection. If healthy people go one way and sick people go another way, that's adverse selection. I always say that's nonsense. The question is, how does the cost of those that you have match the value you receive? And when you get down to individual markets and baby group markets, which really is where all these problems occur, that is the issue. If small groups or individuals know that they're

paying a big subsidy, they will either get out of the market, or they'll reduce their coverage.

One of the mistakes I've made when I've rated guaranteed issue plans is we would generally assume that we have the exits and the entries, as Tom talked about. But what happens in many cases is people don't exit; they just start reducing their coverage through higher deductibles and so forth. The sicker groups and the sicker individuals don't reduce coverage. So you get a much heavier weighting on the higher cost groups which escalates this activity. That's one thing we found.

Mutual of Omaha did a study in New York on their business, and found half of the people didn't take the rate increase. A couple people actually took a rate increase in addition to trend that was maybe 10%. The rest of the people reduced coverage. They went to a very high deductible. In fact, the minimum deductible sold at Mutual in New York City was $5,000. That would have probably worked fine, except there was nobody else in the market. The sick people with guaranteed issue are still going to be in the market. If anybody is getting that big of a subsidy, they're not getting out of the market. They're going to be there. But the healthy people and the healthy groups will start leaving, and that's the problem. So in both these cases we got in the small group market. We have a shrinking market, particularly in those states with the reform, and depending on the degree of the reform. Often we get reduced benefit packages.

Just to summarize, we're going to have guaranteed issue under the federal legislation on all of the states in the small group market. What will guaranteed issue mean? Much of it is driven not so much by the preexisting condition clause. People can wait six or twelve months to get coverage. If there is a preexisting condition clause, no matter what type of coverage, what happens in the first few weeks after your preexisting condition runs out?

You get a flip up in the claims. What happens in the individual market with guaranteed issue? It goes up and then starts to drop back down. I think the gentlemen talked about that a little bit. The question really is what are the rating restrictions that go with guaranteed issue? If you have tight rating bands, you are going to have big problems in the states. If you have wide rating bands, you may not have much of a load at all. Keep in mind also that the load in small group is very dependent on your group size. If you have baby groups, it acts much more like individual. And don't think, by the way, that individuals and small groups don't go back and forth between the market. They do. If I can't get in the individual market and I get small group coverage, I'll take my spouse and form a two-employee group. People will do that all the time. I was in a hearing in New Jersey and they were trying to stop that type of thing. I said, "Good luck." You're

not going to stop people from going back and forth depending on which market is better. How are you going to find them? How are you going to trace them? So we have all those things, and the MSAs create something different. One of the critical things that we need in health care reform is to have the healthy people stay in the system. For the most part, it's easy to get the sick people into the system. Obviously we have to be concerned about people. They get sick and don't have coverage, and that's why you have high-risk pools and reinsurance pools. Those things seem to work fairly well.

But the MSAs are a way to reduce the subsidy that the healthy people pay. They're still going to pay a subsidy, but if you don't have that rating principle in baby groups and individual plans, people start dropping out. Where do we end up? A couple years down the road, all we will have left are the sick people, because the actual cost will just go right up. And that's a problem. So now we have all these states coming in, and it's going to be real interesting to see what happens in terms of the rating bands in the states, because HR 3103 has nothing about rating bands.

Table 5 came out of a study that the Council for Affordable Health Insurance released in April. We actually went through experience from a number of companies in various states, and Table 5 is sort of what we found. Now this is on an ultimate basis. In the first year, small group starts very slowly, although, again, it does depend on the size group, but on average, across the whole market, we have generally seen increases in premiums of 10–25% by the third and fourth year, but the first year or two, it's not as much as that. And generally, the rule of thumb we found is that the number of people insured in the market drops by about 40% of the premium increase. This has nothing to do with trend. This is just addition, but it's very hard to split that out, as Tom suggested, between community ratings. We tried to create a chart with wide bands. If you have full community rating, these would be the additional increases.

TABLE 5
SMALL GROUP MARKET

	Effects of GI and CR	
	Direct	**Indirect**
	Premium	**Insured**
Guaranteed Issue	+10 to 25%	-3 to 10%
Community Rating Full	+5 to 30	-3 to 25
Modified Community Rating	+1 to 20	-1 to 10

The other problem you have is that with any modified community rating, you get that spiral. Guaranteed issue is more of a direct hit, they're in or they're out, and community rating causes a spiral, because you get a rate increase. Some of the healthy reduce their coverage or drop coverage, so then you have to put in another rate increase, and you keep chasing your tail. The tighter that rating band is, the faster it coils. Of course, if it's real wide, you may not have that much of a problem

From the Floor: Could you define the terms?

Mr. Litow: The second row, community rating full, is what exists in New York. You charge the same rate for everybody, regardless of their health status. That would allow geographical splits.

From the Floor: There are no age or gender differences?

Mr. Litow: That's right.

From the Floor: What about modified community rating?

Mr. Litow: There's some rating restriction I should say, but it could be four to one, or three to one. It's just a very broad definition.

From The Floor: Is guaranteed issue a separate category?

Mr. Litow: We try to make it a separate category. In HR 3103, when we talked about the individual market, there is no rating restriction in that, so you as a carrier can charge a person $20,000 in premium or whatever. If they don't have an alternative mechanism, I don't know how long that's going to last, because those people are going to run to the state insurance department and complain. I think you'll have a law within a month to prevent the insurance companies from ripping off these people. I think if you had no rating band, and you underwrote those people, but still had to issue a product but could charge whatever you want. I don't know that you'd ever really get up to 10%. Of course, these numbers are all based on places where we have ratings bands. Is it totally independent? No, because I really don't think it is that high, especially in the larger size groups. When you have groups of two or three, you're always going to have a tendency to underage because in guaranteed issue it's hard to ever get a rate that's adequate for your entire group. But that number is probably high. On the other hand, from what we've seen lately, 25 combined with those could end up to be low. I mean I think the range is probably even wider than what we're finding. As more experience comes in, those are the kinds of things we're seeing. Did I answer your question?

From the Floor: What's the difference between direct and indirect?

Mr. Litow: It means there is a direct impact to the market, and in that case the premium. The insured effect is really sort of indirect. Maybe it's not a mistake. People don't realize that's really happening. You may see your block of coverage decline, and for some companies, it may grow. What we're trying to look at here is the aggregate effect on the entire market, not on any one carrier or any group of carriers. So when I use direct and indirect, indirect is an effect that you really don't see right up front.

From the Floor: Have you made any estimates of that number? How many individuals are opting to be uninsured or moving into an individual plan?

Mr. Litow: I have done estimates, and I'll get into some of that, particularly in the individual market on certain states. It becomes very tough because what you don't know, as I talked about in New York, is we know Medicaid is growing and we know the large group is growing. Now why are they growing? In Medicaid's case, some of it is probably due to the reform, some of it is probably due to things that they're doing within Medicaid in terms of increasing eligibility and changes in the benefit program. Why is the large group market growing in New York? The economy has improved somewhat during the period of time for which this is measured. I don't know how much is due to this reform, the employment situation, or the economy. I mean those are the kinds of things you will never know for sure. It's important to point those out, and it's important to get the numbers and make judgments as best you can about them, and caveat it appropriately. That's the way I look at it; you may look at it differently. That's what makes this so difficult. As I said, the other alternative is to stand on the sidelines and do nothing. You will get these kinds of reforms that can basically destroy the market, as has occurred in New York.

We have talked to various companies, and this is a result of some of that, but these are of course all averages. With respect to any one company, depending on what you're doing in terms of tier rating or durational rating or whatever you want to call it, and any other rating strategies, sometimes those companies are forced to change those strategies because of the reforms or because of how the market reacts to the reform. As a result, you can get all kinds of strange answers going on. We have obtained results from some of the states on a carrier-by-carrier basis. For instance, in New Jersey, we actually obtained the data from the state that was supplemented by carriers. The states don't have all those data, and we can't talk about any specific carrier, obviously, in the report. We could only say here's the average for company A, B, C, D. That's what we did in this.

In the small group market, we lumped results into various nonreform states. We took Connecticut, Massachusetts, and Florida, and we tracked a number of carriers over a period of several years. We actually ended up using the period of February 1993 to February 1996. We kept getting a different response from different time periods. Some companies didn't have the data or weren't able to get them to easily fit the exact time frames we gave them. Table 6 shows what we saw in Connecticut, Massachusetts, and Florida for small group only. In the nonreform states, the annual increase was about 10% or so, which is about five points higher in Connecticut and Massachusetts, which do have small group reforms, but are more modest in nature compared to a state like Florida. I probably should have changed this table because it was another four points higher on average. I remember that one of the companies, or maybe more, had negative increases in the nonreform states, but had some increases in Florida. There were other companies that had large increases in nonreform states, and even larger in Florida. But the interesting thing is it was almost consistently that—and the companies would jump around, but by the time we got to the end of the three years, almost all the companies had higher increases in Florida than they did in Connecticut and Massachusetts than they did in nonreform states.

TABLE 6
RESULTS IN CONNECTICUT, MASSACHUSETTS, AND FLORIDA
SMALL GROUP ONLY
SURVEY OF SMALL GROUP MARKET

	NonReform States	Connecticut and Massachusetts	Florida
Three-year increase	20-40%	41-61%	62-70%
One-year average	7-12%	12-17%	16-21%

What did the rates for insurance carriers do over that three-year period? Some of the reforms came in during that period or came in gradually, but this is just over that three-year period. For the companies that we measured, we got all the data filled in, but we had many more companies, and they were almost all fitting within this pattern. What was the average annual increase for these types of products for those companies?

From the Floor: But it excludes the full impact of guaranteed issue.

Mr. Litow: It's all combined in there. Everything is in there. It's just the rates for the companies.

Listed below are the characteristics of the individual market:

- Primarily underwritten market
- Some insurance of last resort
- Mandated benefits
- High average deductible
- Agent driven
- Shrinking market

You have to remember, when you do individual reforms, such as those that we did, we actually did get the experience from the carriers there. All the Blues in New York and the New Jersey Blues were insurers of last resort, and they were issuing people guaranteed issue. In both states, they had a sizeable part of the business, so you already had that, and that makes a big difference in measuring reforms. If you go into a state that has no insurer of last resort, and maybe has a high-risk pool, which may or may not be well funded, the results can be much different. So any time you do a reform again, you must look at measuring it before and after. One of the things in the current bill is the Department of Health and Human Services is expected to do a study on MSA's and measure the impact. I said, "You can't do the study. I don't know how to do that study. You'd have to know if you have 750,000 or 1.5 million people. You'd have to know where those 1.5 million people came from. How are you going to measure?" I said, "I can make an estimate, but I don't really know whether those people were very healthy. Perhaps they have been sick or somewhere in the middle. Unless you know that, I can put any spin I want on that." I can go to a group that says I love MSAs, or go to a group that says I hate MSAs, and get a totally different answer. Nobody knows what the answer is. They'll do the study anyway.

From the Floor: One of the things that is interesting in the individual market is you have the COBRA and group conversion. How do things like that enter into the analysis? As you bring in individual reform, it would seem like you could either have some very direct impacts or some real long-tail impacts.

Mr. Litow: That's a great question. Under HR 3103, you can only get guaranteed issue in the individual market if you have had 18 months of continuous coverage, and you have to exhaust COBRA coverage. You have to make sure that they have exhausted COBRA, which gets into many legal and fiduciary type issues, but I'm not going to talk about that because I don't feel very comfortable with it.

As far as conversion policies, they don't relate to that, so if you have conversion coverage, people will be able to choose whether they have the option of a conversion policy between this and going to guaranteed issue. And, of course, in Florida, the current law passed in October 1994 has a minimum loss-ratio

requirement of 120%. So it's amazing what the states can do in terms of those types of reform. So they definitely will have some effect. It's usually a small percentage of the people, but again, people now have the choice between guaranteed issue and the conversion policy. You have to make sure that they have exhausted their COBRA entitlement.

From the Floor: One interesting point we ought to realize is too much has been made of this 18-month requirement in HR 3103. The reason that happens is because COBRA can count towards that 18 months. If you can be employed for one month, fall off, elect COBRA, keep COBRA for 18 months, and then move into the individual market on a guaranteed issue basis, you won. There's really no effective requirement that you be employed and covered as an active employee for 18 months.

Mr. Litow: Yes, I agree with that. I think the issue that I'm concerned about is how the states are going to react in terms of the rating bands. That's the real wild card in this. Or are they going to turn to alternative mechanisms? A very good point.

Mr. Snook: I was not a big fan of the AAA report on that. It's not that I necessarily disagree with the report. I was very much against what the report didn't say, which was "this may be the analysis, but, here's the reality of the situation." I know there are many actuaries that see it my way, and some that don't, and again I think that's all worthy of debate.

From the Floor: I was one of the authors of that Academy report.

Mr. Litow: Good, we'll get a debate going.

From the Floor: Tom's earlier comment was that this stuff is very complex; on the other hand, it was very, very simple. All we were asked to do is develop a ratio—a numerator and a denominator. That is where we got into tremendous discussion. What exactly does Kennedy-Kassebaum or HR 3103 dictate as far as how to meet that 18-month test? To determine the numerator, we had to start thinking through how many people are going to be eligible for this conversion, how many people are out there with insurance, and how many people are covered by COBRA-size employers versus those that are going to go strictly from group insurance into eligibility. If they are in a nonCOBRA covered employer, then what's going to be the average morbidity, if you will, or range of morbidity of those people who go through COBRA and make the election for an individual insurance policy? All of those different ranges of scenarios or possible assumptions affect the numerator. Then you have to deal with the denominator to see what we are comparing this against. The numbers are insured with individual policies? Do we count the so-

called air breathers trust associations? What is the average premium that you use within that denominator base? Do you only consider what current actively marketed products are, which would get you one number for the denominator, or do you also consider the sum total of all insurance policies in force, which would include some very old coverage. With very high current premium rates or conversion products, which have current premium rates that are typically higher than standard underwritten policies, etc? As Tom Snook said earlier, there is a tremendous range of complexities on this. In an earlier presentation, someone said this isn't rocket science; it's more complex.

Mr. Litow: It's very true. This is a real tough issue for the Academy. This happens all the time, and I've had this fight up on Capitol Hill. I can't tell you how many times I have asked whether things have been considered and I've heard, "Well, the congressman or the senator who requests these things only asked specifically for this." They don't want to consider other things. The same thing applies to the Academy. It asks for one very specific thing. Even though one thing can cause a whole domino effect, and a number of other things can happen, it doesn't even want that information. This often happens in reform. And it's hard to even be at the same table with the politicians, because they are dictating the debate, and somehow we have to find out a way to take the question and answer it properly as opposed to answering it in a very one-sided way.

Mr. Snook: As a member of that committee, I saw several different kinds of studies. I think Heath Insurance Association of America did one, an individual carrier did one, the Rand Corporation did one, and the Academy did one. The possible range of increases in premiums was very close to the bottom line number of 2%–30% in individual premium rates. You'll discover this if you compare those different reports.

Mr. Litow: The thing to remember on the individual market is that when you put in guaranteed issue, you will get an immediate large effect. As soon as the preexisting condition period is over, it will come back down somewhat, but it's still going to be much higher than it otherwise would have been. So there is a much different type of impact. Very immediate and direct, and some of the states like New Jersey, where they did—in New York they required you to terminate all the policies as of, I think, it was April 1, 1993, so there it was just a blast furnace that went through, where as in New Jersey, you could keep the old plans, you just couldn't sell any new plans. So there are all these things that can happen that will modify how fast this effect occurs. We need to keep that in mind in terms of what happens. How people modify their coverages is very much an actuarial issue. I mean who can better estimate what the adverse selection issues are than actuaries? Actuaries have a reputation of being poor communicators. I didn't believe that for a while, but

maybe that's true. Politicians hate facts and hate information, and that's why they have actuaries. We bring what we're supposed to bring—the information, the facts, and the impressions. We have to change that impression.

Let's discuss the New York results. There were 350,000 fewer insureds in less than one year. There were massive cost increases in the market. You may have seen the Mutual of Omaha report that showed that the claim costs went up one year to 132%. It was selling high-deductible policies that might have worked fine, if there were other carriers to take the people who were in poorer health. You have to remember the people in poorer health would be there, and they'd much rather have richer coverage, but there wasn't anywhere else to obtain coverage without incurring the high deductibles.

That's the small group and the individual market combined. But in New York, the Medicaid and large group went up and offset that, so New York has always said that there was essentially no change in the number of people without insurance, and that is true. That is totally misleading, but it is true. We have to be willing to talk about all sides of the issues, not just about one specific thing. Of course the press doesn't understand these things either, and that makes it very difficult.

The New Jersey individual market is just in a disaster mode. Time Insurance went in there and ended up getting somewhere close to two-thirds of the entire market, and this was reported to the public. I believe it lost $27 million over a period of about a year, or maybe a little more than that, and it has now put in massive rate increases. You have to remember that in New Jersey it had guaranteed a 75% loss ratio. There were supposed to be assessments going back to whichever carriers were running higher than that from the small group and large group markets. So in theory, Time or another company could get a great deal of business. It would be great. As long as carriers can make a profit at a 75% loss ratio, which I'm sure they would, they would be fine. But when the money didn't come back through the assessments very quickly (even though I think it is starting to come back now), there was a deficit, and Time had to put in large rate increases. Other carriers who were trying to copy were also losing money. Our report in New Jersey showed that in the first year, the loss ratio of the market was 94%. So that's the situation in New Jersey. The number of carriers has been shrinking. There are lawsuits going on and the risk pool has been hampered by those as well.

The other state that we looked at that I was involved with in some degree is Kentucky, which is a much different situation. It is actually quite sad. They put in a bill, I believe it was July 1, 1995, and the carriers there sort of went crazy. I think they had been seeing the experience in some of the other states, and they immediately raised the rates in the individual market, on average, over 80%. The

small group market was on average around 20%. There was a massive uproar. They put in a moratorium on the bill. I went down to Kentucky representing at least one company. There were other actuaries from Blue Cross, Humana, and several HMOs. We all agreed, and we had a ratings chart, about how to do rating bands and all this stuff, and they passed the bill in the house based on it. Unfortunately, the senate came back with the governor and rejected the bill and threw it back out, and the new bill ended up being as bad as the first bill. I think most of the carriers in Kentucky, except for a few that have to stay there, are out of the market. It's a sad situation. Who does this punish? In my opinion, it's the consumer. The insurers will lose money, but eventually, if you lose enough money, you get out of the state. Somebody from an HMO in New York stood up at a seminar I was giving and said, "Do you want to know what's going on in New York now? New York has passed a bill that mandates HMOs offer individual coverage." She said her loss ratio is 190%. So I hope they don't have too much business. That's the type of responses we're getting. Instead of legislators admitting that these things aren't working and repealing them and trying something else that might have a chance of working, they don't ever want to admit they made a mistake, so they just keep passing more of this type of legislation. You have to remember that in health care we always have to worry about balancing items like cost, quality, and access (not just access to coverage, but access to treatment). You can have coverage like the type that exists in some of the European countries and Canada, where you can't get treatment. Then you come to the U.S., assuming you can afford treatment, and you have to deal with the HMO backlash that's going on in the West Coast. Why? Because the quality now has become an issue. You get the cost down. You can pay every provider $1 for service. We can get the lowest cost in the world, but if people won't have access to treatment, they won't get quality coverage.

I have always tried to work in South Africa and Japan, and I didn't realize what the situation in Japan is, because Japan has very low-cost health care. By the way, Japan's average hospital stay is down to 35 days. It used to be 50. What people don't realize is if you go into the hospital in Japan, they pay providers on average 25% of what's paid under Medicare in the U.S. And what has that done? If you go into the hospital in Japan, your family has to be with you because if your machine turns off at night, there isn't a nurse that will come rushing in. If you want meals, your family brings them. So it's a totally different atmosphere, and the quality is awful. They do have the technology, but they don't have the quality.