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State Health-Care Reforms: The Good, the Bad, and the Preposterous

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Summary: The panel discusses state health-care reform over the past decade and offers insights as to what has worked, what hasn't, and what has been a total disaster. The panelists further discuss the states' responses to reforms that simply have not worked and the industry's response to this challenging environment. Finally, they share their ideas of the direction they expect to see state-level reforms to take.

Mr. James T. O'Connor: What are we going to be talking about today? Basically three things: 1) What propagated state health-care reform? 2) Have these reforms been successful? 3) Is today's health-care market a better one because of these health-care reforms? Helping us answer these issues is Lee Tooman, who is a vice president of Golden Rule. Lee started with Golden Rule in 1983 where he worked in the marketing and product management areas. He moved to government relations in 1992 and has lobbied scores of issues in dozens of states since that time. Lee earned a B.S. degree in business administration from Ohio State, an M.B.A. from the University of Toledo, and a J.D. from Indiana University.

Our second speaker is Julia Philips. Julia is currently a life and health actuary with the Minnesota Department of Commerce. Previous to her employment by the Minnesota Department she was a consulting actuary with Milliman & Robertson where she consulted with a number of individual and small group health carriers, so she has seen both sides of the issues.

I'm a principal and consultant with Milliman & Robertson in the Chicago office. My experience has been in the individual health and small group markets for most of

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my career. I've been with Milliman & Robertson for 12 years and previous to that was with Bankers Life & Casualty.

What started this reform activity in the states? There are a few things that I've identified. Probably first on the list was the dramatic increase in the number of uninsureds in the country and the mounting pressure to insure them. Many of these uninsureds were in the small group market, so a lot of attention was paid to this market. The individual market was, of course, another area where addressing access could help reduce the number of uninsureds.

The second item on the list was the increased cost in health insurance. We had double-digit trend inflation in the major medical markets for both small group and individual products for a number of consecutive years before these reforms came into play.

The third item on the list was the perceived abuse in the small group and individual markets. Carriers were seen as singling out employees and employer health status, and those were the people who were not getting covered and were the uninsureds. This was the perception. Very, very high rate increases were occurring in the market at times for certain individuals whose health status had changed and had deteriorated. These were the types of abuses that the states thought the small group laws could, at least in part, help to solve.

Finally, there was the threat of federal intervention on a territory that traditionally had been handled by state regulation. Together these things provided quite a bit of impetus to the states to start looking at what they could do to solve some of these problems and reform the industry as we knew it at that time.

The laws were focused on access, affordability, and quality. Never did anyone truly believe that the enactment of these laws would solve all these problems, but the hope was that they would minimize the problems.

In terms of access, the state laws that were passed looked at several things. First, nondiscrimination of employees related to health status. No longer could a small group carrier single out particular employees who had poor health status. You either took the entire group or you didn't take the group at all.

Second, guaranteed issue to small employers. In this case we started out somewhat slowly in that the states required guaranteed issue of generally two statutory plans (in some states it was more than two). In general they were referred to as the basic and standard plans. These were mandated plans that had to be offered on a guaranteed issue basis to anyone who did not meet other underwriting criteria for the carrier. Some states then decided that they wanted to extend this guaranteed-issue requirement and they applied it to all plans that the carrier was offering. Finally, in 1996, with the passage of the federal legislation Health Insurance Portability and Accountability Act of 1996 (HIPAA), all carriers were required to offer on a guaranteed issue basis their small-group plans. There were certain exceptions to the guaranteed issue, such as groups meeting participation contribution rules and certain managed care criteria.

Another aspect of these laws had to do with fair marketing. There were provisions in the law that required marketers to present all their plans to the people they were trying to sell to. They didn't want the marketers todecide which plans to offer based on their perception of what the health status was of those groups. Furthermore, there were a number of other requirements in terms of access.

In the individual market, states were also active with access issues. As of today, at least 13 states require at least some sort of guaranteed issue of individual plans. Another area of access that was addressed in these laws was mental health parity. Today, 18 states have passed some kind of law related to mental health parity. Some affect the small group market; some affect only the large group market; some affect the individual market and all three markets, actually.

Affordability was a real key that the NAIC model laws tried to address. In its first model law, and I think it was in 1991, the rating limitations were somewhat loosely defined; case characteristics that carriers could use in meeting those were somewhat loosely defined. In 1993, the NAIC passed a new version, which was adopted in most states and still applies today, in terms of the rating limitation laws. Typically, those laws were that carriers could adjust their rates in terms of some allowable case characteristic, and those allowable case characteristics were age, gender, family composition, and industry, and group size.

As time went on and as states began to adopt the NAIC model law, they made changes to these characteristics. Instead of all five of these case characteristics being allowed, many states limited them to age, gender, and family composition. Some decided that gender was not an allowable case characteristic. In addition, these laws restricted the carrier's range of rates, so the carrier was restricted generally to plus or minus 25 of what it defined as an index rate. Essentially this gave a range of 67% from the base rate 1/m the lowest rate that a carrier could offer to the highest rate that could be charged to any policyholder.

Class differences could be recognized to a certain extent and the laws defined what that extent was. The classes had to demonstrate clearly that there would be significant cost differences from one class to another and that they could only be due to such things as marketing distribution channels, acquisitions of blocks of business, selling to associations, and those types of things. And the allowable class difference was in the NAIC model—20% of the index rate. Many states made changes to these and over the years changed their laws; they became a little more restrictive in terms of what was allowed. A number of states adopted modified community rating, made limits much tighter, and allowed no particular allowance for health status differences.

There are eight states that adopted not only guaranteed issue, community rating of some sort, but also put extreme limits on preexisting condition clauses. Most of these, as many of you know, are in the New England area and the states Kentucky, New Jersey, New York, and Washington.

States also introduced the concept of mandated basic plans. These were plans that were adopted because of carriers complaining of all the mandated benefits that

they had to meet and that were causing an increase in the premium rates. So some states adopted what were to be low-cost plans that did not need to meet all the mandated benefits. From what I've been able to gather, they had not been too widespread or successful in terms of the number of groups that actually purchased these.

Finally, in terms of affordability and because of the guaranteed-issue nature of what was required, states introduced state reinsurance programs that would allow carriers to share the risks of the worst groups that had to be insured. We'll talk about this a little later.

The third area is quality. There are a number of quality issues that states have addressed through their regulations, one being provider open-access regulations. Many carriers wanted closed networks. In other words, they wanted to negotiate with the providers of their choice. Some providers objected to this. States reacted by saying that if a provider agreed to be subject to the payment and fee-schedule provisions of the carrier, that provider had to be recognized as a preferred provider. This is not terribly widespread, but certainly some states had adopted these.

Prohibition of gag clauses allowed the doctors who contracted with the carriers to give the type of medical care that they saw was best in the interest of their patients. The requirement of appeal processes ensured that the managed care plans did have some sort of appeal when managed care decisions were made that limited either access or the type of care that the patient's doctor or the patient thought that he or she should need. The National Center for Health Statistics and the Health Employer (Effectiveness) Data Information Set were introduced. These were not too directly related to state regulation, but certainly they were things that carriers were looking at, particularly HMO carriers in terms of putting out quality programs. And patient protection legislation has been an issue for a while. It gives the patient the ability to sue the HMO in those instances where the patient felt that care was not properly given.

Mr. Lee D. Tooman: Hopefully I'll say a few things that might aggravate you a little bit and cause you to take issue with me

I was actually quite grateful to get invited to this because it gave me a chance to think back. I've been lobbying health insurance issues for the better part of ten years. It gave me a chance to step back and review what I've seen and what has happened over the last few years. I'm going to talk about some of the issues that we've been dealing with and you've been dealing with, I'm sure. I'll talk about some of the things that in our view have misfired and have aggravated situations and not solved them, and I'll talk about how things can be improved.

To me, reform issues revolve around access and affordability. You really can't separate the two. They're tied together. If you don't have affordability, you don't have access; you've got to have both of them in order to make it work. One of the reform issues that we've been dealing with in our industry is the number of uninsured persons. It's kind of a mantra that's thrown out there and I'm sure you've heard it: 34 million, 39 million, 17%, this, that, and the other. One of the

things that hasn't been focused on quite as much are the uninsurable persons. About 99% of my job as a lobbyist has to do with education. There's a difference between being uninsured and uninsurable. You might be both, but not necessarily.

Underwriting has been a reform issue. Should insurance carriers be allowed to decline people? This has been a big issue over the years. How should rating practices be done fairly? Should there be limits on how much we raise rates and how quickly we raise them and how high they get vis-a-vis other rates? Portability—should people be able to jump from job to job from group to individual or individual to group without any new underwriting or preexisting condition limitations?

Regarding the defects of regulation, we've seen an enormous number of regulations. When I use the word regulation I'm thinking loosely legislation, regulation, things that have affected the way that we can conduct our business.As Jim said mandates have been around; there's an increasing number. For a while we had a bunch, then it slowed down, but in the last couple of years it's just been awful. In the 1998 session of the Illinois House of Representatives over 40 new mandates were passed. Almost all of them died in the Illinois Senate, which is much more conservative, but that's an enormous number of mandates. I've seen the same thing in Louisiana this year and in other places.

Patient protection has been a hot issue, and I'm sure that you all have been following the debate in Congress on that one. I think this is one that's not very well understood regarding its implication and its effects on access and affordability. I'll talk about it some more. Other reform issues include ERISA, the federal law that was designed for pension plans and that has become a shield for employers from state regulation of insurance.

Let me talk about the difference between uninsured and uninsurable. Of our nonelderly population 18.3% is uninsured, and that's an important distinction to keep in mind. If you look at the whole U.S. it's going to be a smaller percentage, because Medicare is generally covering everybody who's a senior citizen, but 18.3%is a big number.

But only about one percent of the nonelderly population is both uninsured and uninsurable. I'm not trivializing that number, but there is a vast difference. In our view that is a manageable number. In fact, only 2.5% of the uninsured have ever stated that they were refused coverage. If you take 2.5% of 18.3, you come up with about a 0.5%, so somewhere between 0.5% and 1% of the population can't get insurance, at least private insurance.

Being uninsured is a temporary condition. Most people are not chronically uninsured. They don't stay uninsured for long periods of time. In fact, about half of the periods of uninsurance last four months or less. What is happening is people are between jobs or they're in divorce situations or they are kids coming out of college.

Here are some of the perceived abuses and responses that I've been dealing with in the states. Carriers have denied some persons or groups coverage, so what is the response to that? What has it been? Required guaranteed issue. Either limited, or unlimited, if you will. Carriers have singled out sick persons or groups for large rate increases. I was involved in the debate several years ago when the NAIC undertook small group rating reform. I don't think the outcome was necessarily bad, but one of the things that troubled me was there were no good, reliable data on how much this was really happening. In fact, one of the working groups referred to the evidence as anecdotal. Nevertheless, that was a perception, and so we went to rate compression or even as far as pure community rating.

People shouldn't change jobs for fear of losing coverage. Job loss. That was the thing that was talked about over and over again in the states. So what was done? Well, let's mandate portability, and this is a bit tongue in cheek, but keep the current employer-based system. I'm going to come back to that a couple of times. There are an awful lot of people across all political spectrums who believe that this employer-based system, a third-party payer system, is the root of many of our problems. They believe that if we, as individuals, owned our insurance instead of employers owning it, a lot of problems would go away, but I will come back to that.

A few more perceived abuses and responses. Carriers do not pay for everything all the time, and believe me this is one of the toughest things. I don't know if any of you have ever lobbied, but I've gone to state legislatures and committee rooms. People are wheeled in with oxygen tanks, people who clearly have the most horrible stories to tell. They're going to generate a lot of sympathy. Even though major medical insurance really does do a good job of covering people, if we're not paying for everything, then let's mandate coverage for certain conditions.

I was in Florida earlier this year and the chairman of the Florida Senate Committee on Banking and Insurance was advocating an autism bill. He said, "I've worked personally very hard to kill a lot of mandates over the years, but this is a good one." Why is it a good one? Because somebody in his family has autism.

The federal government, I think in 1996, imposed mental health parity, limited larger groups, no more than 1% cost, and so forth. That was because of Pete Domenici, the Republican senator from New Mexico, whose relative had mental problems. This relative was having trouble getting coverage for them. So a lot of these things are very anecdotal.

A few years ago when President Clinton and a large number of people started talking about managed competition, HMOs were the solution. But people discovered that one of the keys to the HMOs' success was controlling cost by controlling utilization. People said let's pass patient protection measures. Let's make sure women can get to any OB-GYN, which they can, without having to go through a gatekeeper and provisions for specialists. And meanwhile this is all kind of done in a limited context.

For many employees their employers are their insurers, and I chose this language carefully. The employer is the insurer. I know all of you probably do health

insurance consulting, but I think most people don't realize that. ERISA preempts state insurance laws from reaching four in ten Americans. That's a gigantic number. Never mind Medicaid and Medicare, which are dictated to a lot by the federal government, but just ERISA alone is preempting state laws from reaching four out of ten people in this country. And federal tax laws harm the most in need.

I'm going to come back to this, but let me just demonstrate this to you a little bit. Federal tax laws favor employer-provided health insurance. The greater your income, the richer your benefits, the more the government subsidizes you. I have group insurance at work and it's a nice benefit plan. If it were richer the government would be subsidizing me more. It doesn't show up on my tax statement, the value of that insurance. It's fully deductible to the employer. But what about Suzie Waitress who has a job working for a small employer and the employer can't afford to provide health insurance? What help are we giving that person? Well, the fact is we're giving them no government help. Unless you're really poor and qualify for Medicaid or you live in a state that might have some support programs, you are out of luck. We've really got an inequitable system. All these issues have been talked about, debated. What do they all mean?

Too often in Golden Rule's view (Jim and Julia don't necessarily share this), inconsistent, poorly crafted legislation, and response to anecdotes result. Too often legislation is passed that does more harm than deliver good results.

Between 1990 and 1994, 16 states aggressively passed laws designed to increase access to health insurance. This was from a study; it was cited. Where do they come up with the 16 states? The Congressional Budget Office did its own studies and it did some upon small groups, some individuals. The people who produced this study looked at which states were common to both and there were 16 of them. In 1996, all 16 states experienced a growth in their uninsured populations, 8 times that of the other 34 states.

Let me talk about a couple of examples, and for those of you who are from these states you might have something to say to me after the meeting. In 1993 Washington State, had an active private health insurance market. But then the state-mandated guaranteed issue happened, and I'm really talking mostly about individual health insurance here. There were very liberal preexisting condition rules. You look back three months, and you can only exclude for three months going forward, and it's only treatment or advice and modified community rating. There were a bunch of other provisions that were put in place; some of them were repealed, but these stuck around.

Results and rates have soared and availability has dried up in the individual health insurance market. In 1996, the state's largest insurers suffered a collective disenrollment of 40,000 policyholders in the individual health insurance market, and today individual coverage is unavailable in 31 of 39 counties.

Now this is really a profound thing. The state has 39 counties. You cannot buy individual insurance from anybody, not Blue Shield, not Blue Cross, not anybody in the state. The other eight counties are basically fringe counties along the western

side of the state where the Idaho Blues and the Oregon Blues have some coverage, but otherwise you cannot buy it. The only option for you is they're opening up the risk pool so you can go there and you can pay a heck of a surcharge and buy insurance that way.

For example, in New Jersey 1993, was when the most radical things were enacted, such as guaranteed issue, pure community rating in the individual market, and plan standardization. You can't sell anything you design. It doesn't matter what the market may want. The state has decided what people may buy and what carriers may sell.

As for the results, rates are outrageously high and families are dropping coverage. These statistics are straight from the New Jersey Individual Health Reinsurance Program. These are not subject to any speculation. Between 1995 and March 1999 enrollment in the individual market declined—and this is an astounding thing to me—from 220,000 people to 122,000 people. Basically, it's not quite cut in half, but it's getting there.

For the HMO options annual family rates range from $8,832 to $11,688 for the carriers that are doing business in the state with a standard $20 co-pay plan and for Plan D. There are five plans: A, B, C, D, and E which include major medical, fee-for-service type of things. PPO: $20,000 to $127,000 a year for a boiler plate. You would think I'm making this up, but I am not. You can get on their Web site and check it out yourself. They come back to me and say, "But Lee nobody's buying that." Well, yes, we know nobody's buying it, that's obvious. Who in the world would afford it? They're buying Plan B or Plan C with much higher deductibles and much higher out-of-pocket potential cost.

And finally, one last example—New Hampshire in 1994. The state mandated guaranteed issue and modified community rating. This is starting to sound like a broken record. At the time, ten carriers were known to be active in the individual health insurance market including Golden Rule.

But in 1997, Blue Cross, which had been the prime proponent of this legislation, withdrew from the market and terminated all individual business. Blue Cross said, "We can't make a go of it any more, we're out of here." By 1999, only three carriers remained in the state. Of course, what does this really mean in terms of the effects and enrollment plunge between 1994-97? A number of nongroup policies dropped 44%. If more regulation is not the answer, what is?

..I brought this booklet titled *Building Blocks to Affordable Health Insurance*. This was prepared by the Council for Affordable Health Insurance. It's a trade association, and the carriers are mainly individual and small group writers of health insurance and Medicare as well. Several of your members participated in this study and put this material together. They outlined an eight-point plan: personal responsibility, guaranteed access and continuous coverage, appropriate pricing (and here I'm talking about rate bands and that sort of thing), sensible liability laws, increased disclosure, limits on mandates, tax equity, and consumer education.

By following those eight-point plans, this monograph says that a significant reduction in health insurance costs will follow, and with a significant reduction in health insurance costs, a corresponding increase in the number of people who are buying insurance will follow.

Well, I read this and I got to thinking, wait a minute, a lot of this sounds awfully familiar. I live in Indiana and in Indiana we have a lot of these things in place. I thought we don't have mandates, we have torte reform, we have a high-risk pool. I decided to look at what we have specifically in Indiana, how our costs compare to the nation, how our rate of insurance, uninsurance compares to those in the nation. Here's what I found from the Employee Benefits Research Institute. Probably many of you have seen this material and referred to it.

In the U.S. from March 1993 to March 1997 the percentage of nonelderly people without insurance averaged 15.5-18.1%. It fluctuated a little bit. But in Indiana it was much lower: from a low of 11.8% to a high of 14.6%. This was significantly less than in the nation as a whole. Indiana's Medicaid enrollment is one of the lowest in the country. Indiana's rate of uninsurance is quite low. However, listen to what they've done with their Medicaid program. They have expanded it significantly so the number of people without insurance has stayed constant, but they've traded private insurance for Medicaid insurance. In the case of Indiana we have one of the highest rates of private health insurance in the country. We have one of the lowest rates of Medicaid coverage in the country. And Indiana's medical costs are 13% less than the national average.

OK, so what have we got in Indiana that put this package together? I think that it's interesting because it tracks quite well with these building blocks. Again, Indiana ranked 42nd for Medicaid eligibility as a percentage of poverty. You have to be at 27% of poverty to qualify for Medicaid in Indiana. You have to be really poor. You're not going to get on Medicaid if you have the wherewithal to do otherwise.

HMO penetration is only 15.3% versus almost 30% for the country. I don't have a very satisfactory explanation for that. Hoosiers pride themselves on taking care of themselves and so forth. Maybe there's some of that. Maybe the HMOs haven't done a good job, but we don't have much HMO penetration.

Indiana enacted tax-free medical savings accounts (MSAs) in 1995 to encourage people to go to higher deductibles and save money. Indiana enacted the Indiana Long Term Care Program in 1994 to encourage persons to purchase long-term-care insurance. If you buy one of the state-approved long-term-care policies and you exhaust the benefits of the policy, you're not obligated to spend down all your assets in order to get on Medicaid. It's a way to say, you go do the right thing and then we will take care of you if what you bought isn't enough.

On the subject of guaranteed access, Indiana, like 26 or 27 other states, guarantees that every uninsurable person has access to high-quality affordable coverage through its Indiana Comprehensive Health Insurance Act, which is a fancy way of saying the high-risk pool in the state. Rates are capped at 150% and, in fact, are going down this year. They went out and did a polling of individual health

insurance and rates are coming down. It's not a great deal. I think it's 3-4%, but they're actually coming down. It's major medical coverage, choices of deductibles in managed care, preexisting conditions, with full portability if you're coming from something else. Current enrollment is about 4,000 persons.

Indiana also enacted small group portability in 1992 and individual portability in 1995, so if you get in the system and want to stay in the system, Indiana has put the laws in place to make sure that you can do so.

Indiana enacted reasonable rating reform in 1992, plus or minus 35%, not multiple classes, just one class of business. Indiana does not have rate authority over individual health insurance, and Indiana ranked as the second least expensive state in the country for worker's compensation insurance, in part because of its flexible rating regulation. I think this does tie together. When you think about this, if employers are not spending so much on worker's compensation, if those costs are held in check, it permits them to spend more on things like private health insurance.

We have sensible liability laws in the state of Indiana. In 1975, that's quite a while ago, we had medical malpractice reform. Doctors insure up to the first $100,000 per occurrence and $300,000 in the annual aggregate and a patient's compensation fund pays for claims up to the $750,000 statutory limit. You can't collect more than $750,000 in Indiana if you sue a doctor. Again, without saying if that's good or bad, that's the way that it is, but claims must first be presented to a medical review panel. Well, if you have got a claim and you go to the medical review panel and they say that you don't have claim, it's probably going to mean that you're not going to run and file a suit in court.

On the other hand, if the medical review panel says, "Yes, you have a valid claim. Your doctor really did a poor job," then you've got a good incentive to go to court. So that's one of the things that helped cut down on frivolous lawsuits as well.

In 1995 court reform was enacted. Punitive damages were limited to the greater of three times actual damages or $50,000. Disclosure— we haven't done a lot in the state. HMOs must provide enrollees information on structure, benefits, criteria for denying coverage, and cost-sharing provisions, and HMOs must also make available HMO comparison sheets. Not a lot. We have a very limited number of mandated benefits. Coverage for adopted kids. I mean that's so common it's not even a mandate any more.

There's nondiscrimination of chiropractors. We have to pay for mammograms. There's a schedule. Newborns get automatic coverage; diabetes coverage and there's self-management training. Again, one of those mandates has kind of swept the country isn't a big cost item. Forty-eight hour and 96-hour in-the-hospital maternity stays are required, but that's federal law now as well. There's nondiscrimination of victims of abuse. Finally, there are genetic testing limits on what we can do with genetic testing. We have a very limited number of state mandates. There's one more coverage, cleft lip that was paid for anyway without a mandate being necessary.

Let me close by saying we view all of these as helpful, but they were done in the context of state reform and state regulation. What happens when you've got other things like a tax system and an Internal Revenue Code that favors employer-provided insurance? If you think about what I said, what it's really doing is favoring high-cost insurance. It's favoring that because it's tax-deductible to the employer, tax-free to us, so the more the better.

We think that the unlimited tax benefit for employer-sponsored health insurance should come to an end. We think that it's unreasonable, especially with costs going up as much as they are, to not just have a top end on that. We have lots of limits in our tax code for lots of different things. It's time that we did something here. We should take the money. It's unbelievable the enormous amounts of money that are being subsidized by our federal government. We ought to spread it around more equitably, so that people who are low income, who don't qualify for Medicaid, who don't have employer-provided insurance, can still buy health insurance if they're not paying taxes, or get straight tax credit off their taxes if they are paying taxes.

The biggest beneficiaries are low-income persons, minorities, and early retirees. This is where the problem of uninsurance resides. These are the people who don't have insurance but who need it. For that reason we think that this would be the most beneficial thing.

Ms. Julia T. Philips: I'd like to keep my comments fairly brief. If you don't think of questions, then I will be asking questions of Lee and Jim, because I think this is a fantastic opportunity to talk to somebody who is at Golden Rule, which is a leading-edge company in the health insurance industry..
I am planning to talk mostly about Minnesota health-care reform. I have a lot of thoughts and opinions about federal changes. I have an academic study of the effects of health-care reform. I kind of feel the same way about this study that I feel about Minnesota law. Parts of it are excellent. I think there are some interesting conclusions. I would caution you that what I have here is an abstract. You can look this up yourself on the Web and you can even get the whole study on the Web for free, so I'd encourage you to do that.

I did notice that the author of this did come to the NAIC meeting, and from the abstract it appears that they studied individual market reform. As far as I can tell, they really did not study individual, so that's a little misleading in the abstract when they talk about the effects of individual. They didn't really do anything to enable them to draw any conclusions about the individual market, which, of course, as Lee pointed out, and I really agree with this, is probably the more critical or sensitive market in terms of trying to solve the problems without ruining the market.

Anyway, regarding Minnesota health-care reform. I do have mixed feelings about it. My opinions don't carry any weight. I'm simply a technical adviser to the real policymakers, but I tried to point out some of the things from one point of view that you could say are good and from another point of view that are bad. The phrase "parts of it are excellent" is how I feel about health-care reform. I don't want to

say anything bad, but there are some things that I think can be problematic and, of course, everything that's problematic for one person is good for somebody somewhere, so it's kind of hard to do too many value judgments.

I have been with the State of Minnesota for a little over four years. In that time I have really been in the position of enforcing laws that are in place, so I did have some participation in developing the laws in the first place. But really my viewpoint has been a very detailed, trying to figure out exactly how these things apply and how they work.

First of all, in Minnesota we have a provider tax. That tax applies to medical and dental services. There's an exemption for Medicare and also for Medicare supplement. I think this was more of a political thing than anything else. They were trying to get money to assist in paying for the subsidized program for poor people, but it was unacceptable to do it by raising costs for the elderly, so that exception was put into place.

One interesting thing about the provider tax is that because it is on medical services, it applies both to health care that is provided through an insured program and also to health care that is provided by itself; that is, paid for by a self-insured employer, so it really is a very broad-based tax. As we work on different kinds of health-care reforms, we find that narrowly based funding systems have a lot of problems and will sometimes sink the lifeboat. It seems to be the broader that you can get your base of funding the better.

That tax has recently been reduced to 1.5% instead of 2%, because the projections showed that the 2% was not entirely needed to fund our low-income subsidized programs. Our program is called Minnesota Care. Essentially it offers insurance to people who have too much money to be eligible for Medicaid—the working poor. It's a sliding-scale premium, but it starts off at an extremely low level and then rises. Actually, families with children are eligible up to the median income in Minnesota, so essentially half the population is eligible, but, of course, the population that is near the median income is paying almost all the costs. So most of the enrollment is the working poor in that Minnesota Care program.

Our health-care reform gave guaranteed issue to groups with 2–50 employees, and that seems to have been a success story. I think partly because we were lucky in 1993 when the reform went in, the trends were low. I am sure there are policymakers who are patting themselves on the back in Minnesota for having kept trends low, but in fact it was a nationwide phenomenon. I don't think our legislature can take credit for the slowdown in the rate of trends and health-care costs. But at a time when trends were low, whatever additional cost were introduced by guaranteed issue got lost in the shuffle and people were happy with it.

We have one of the oldest and biggest high-risk pools in the country. Our high-risk pool has been in place since 1976. The reason we have the biggest, and I don't know which is the chicken and which is the egg here, is because we have the lowest rates of any high-risk pool for similar benefits. That's partly because we cap the

rates at 125% of market, and it's partly because our market seems to be a rather healthy and low-priced market, but that is also a success story.

We hit a high of about 35,000 under-65 enrollees in the high-risk pool, and that actually happens to be about one percent of the under-65 population, which verifies what Lee was saying about the uninsurable population being maybe in the neighborhood of one percent of population. I have heard people in other states tell me that Minnesota has an unusually high number of uninsurable people, because we have all those people in our pool and they have a pool that has only 2,000 people in it. I guess my response is that if you're going to charge $400 or $500 a month, you're not going to get all of the uninsurable people in the pool.

I would even say that in Minnesota we don't have all of the uninsurable people. It costs about $100 a month for young single individuals and it costs about $300 a month for ages 60-64. I am sure there are uninsurable people who do not buy it because of the premium cost.

We have a requirement for an affordable conversion policy from group insurance. If a person's employer has a fully insured plan, which, again, as was previously mentioned, we're talking roughly about half of the group-insured population, then in Minnesota when your COBRA expires, the insurance company has to offer you a guaranteed renewable individual plan.
If you are in the other half and your employer is self-insured, there's no such requirement. The state legislature would have liked to, but the ERISA preemption prevents them from applying that requirement. All these things sound like a small amount, but that is a expensive additional cost on the insurance market, and it's a burden that the group insurance market has to bear. The group insurance market is paying between 1.5-2% to subsidize the high-risk pool, which is completely paid for by an assessment on insurance. The group insurance market also has got to provide this lifetime affordable coverage, which is another cost that is not borne by the self-insured employers that provide similar coverage.

We have rate bands. Rate bands have worked out quite well for us. Actuarially there's not a significant limitation on what the costs are by age-plus or minus 50% for age really means a 3:1 band. We have a 20% variation by area, which is probably somewhat smaller than the real variation, but hasn't been a big problem. What it means is that the lower-cost rural areas must to some extent subsidize the higher-cost metropolitan areas. We have a plus or minus 25% band for health status and claim experience.

Wellness factors are all in the band. Small group duration and industry are factors, and for individual coverage, occupation is a factor. That also has been seemingly a reasonable compromise in the sense that in the old days some companies would actually drive small groups out by reflecting their true anticipated cost and charging them rates that were 2-4 times what the best rate was. In this case it's limited to 1.67:1. The companies that are at the top still call me and complain that they shouldn't have to pay anything extra, and I tell them that the companies at the bottom are also complaining because they have to subsidize them, so I guess the pain is being shared.

We have genderless rates on all major medical type of insurance. We did look at some information early on about the impact of that on the individual market. I don't think it has much impact on the group market simply because most groups have a mix of men and women. In the individual market, our sense is that looking at the before- and after-age sex distributions, about 5% fewer men were covered because their rates went up and about 5% more women were covered, so it was kind of a trade-off there. I guess that's one of those things that maybe is good for some people and not so good for other people, but it was a public policy decision that gender is not an appropriate rating issue.

The reform also provided money for monitoring and data collection. Of course, as an actuary I'm just thrilled about monitoring and data collection. I think that's wonderful. It's also very difficult. We have a lot less information than I think we hoped for or that we would like to have. We did have low trends, so the cost increases were low. I don't think that had much to do with health-care reform. That was really a nationwide phenomenon.

We still have affordable individual coverage. I think that's probably because we did not go for guaranteed issue in the individual market. We still have underwriting. If you can't get an individual policy, you can go into the high-risk pool; that is our safety net.

There are some other parts that really were not so excellent. One of them was that we had growth limits. In fact, we had laws in place that said that any insurer that exceeded, let's say for example, a 10% increase in per-capita cost would have to pay a dollar-for-dollar penalty of everything they paid over that. So if that insurer saw a 15% trend adjusted for plan and age and everything, they would have to pay a penalty amount on the extra 5%.

That law didn't really make a lot of sense because the insurance companies don't really control the spending. They have a contractual obligation to pay those claims regardless of what they are, and that was actually kind of at the last minute repealed before anybody actually was told to pay that fine.

The growth limits didn't really restrain the growth and health-care spending, although it almost looked like they did, and trends have really started to go sharply upward recently. Gender restraints means there are fewer men covered. There is always a trade-off there. It's kind of a zero-sum game in terms of cost, unless you can find a way, such as managed care or something, to really reduce the cost without reducing the coverage. All these rating limitations merely move cost around.

The assessments on insurance companies to pay for the high-risk pool have a significant impact on the cost and affordability of coverage. This is unfortunate. It seems that perhaps from a public policy point of view the problem of uninsurable people is really a societal problem that should be paid by the broader society, not by those people who have chosen to purchase insurance. But it seems like the most convenient way to subsidize it is to have that assessment.

We have standardized plans for small group coverage. Almost no one buys them. No one wants the limited coverage. What they want is the full coverage at the lower price, so that has turned out to really not be successful. We had a small group buying cooperative that actually is defunct at this point. I think there's a version for public employers which is still going, but the idea that small groups can save a lot of money by banding together in a purchasing pool didn't really work out in Minnesota.

None of the state reforms can apply to self-insured employers—which makes it somewhat problematic—especially some of these funding issues. State reforms do not work when you only regulate half of the market and a shrinking half. Soon only a third of the market may be under state control.

It costs a lot of money to provide affordable lifetime conversion coverage. Maybe a small percentage depending on how far you've spread it, but it does come to a substantial amount overall. We also have minimum loss-ratio requirements. I guess they're somewhat different in philosophy than other minimum loss-ratio requirements. I think in most NAIC models the minimum loss ratio is really supposed to be a rock-bottom floor. If it's less than this, something's really wrong.

In Minnesota the loss-ratio requirements were really intended to be micro-managing the insurance company's business. The legislators knew that the loss ratios were on the average maybe 65-75%. The legislators said, "I know a good way to keep the rates down; let's force the loss ratio up to 82%," and that's what they did. Over time there was discussion about this, and there was the argument that this higher loss-ratio requirement was driving companies out of the market. So the legislatures did roll it back, but they were listening carefully to the argument and they said, "Well, let's see."

There are some carriers that can't leave the market in Minnesota because Minnesota is their only market; they're also the large ones that ought to be able to operate more efficiently. They are Blue Cross and Blue Shield of Minnesota, Medico, HMO, and Health Partners, so let's run it back for everybody else, but not for them. Now it's a formula, they don't name names in it, but the formula is that anybody who has more than 3% of the market in Minnesota for small employers has to meet an 82% loss ratio, and anyone who has less than 3% of the market has to meet a 75% loss ratio for small employer. There was some more discussion about the carriers that insure really tiny groups. For groups of under 10 employees, it's only 71%.

Mr. O'Connor: Have reforms been a success?

Regarding access, uninsured decreased initially when a lot of these laws came about, but since then uninsureds have increased and have continued to be on the rise. There's been an increase of 3.7 million uninsureds from 1995 to 1998. I've figured out some statistics here as to how those increases are divided among some ethnic lines, but the real key here is even though 47% may be of Hispanic origin, Hispanics constitute a 44% population increase . As a percentage of the uninsureds

that really hasn't changed. Even though there has been an only 4% increase in poor that's a little bit deceiving. Based on these government definitions, the amount of poor went down 26%, so there's really a true increase in the poor. It indicates that this is really a question more of affordability than anything else.

Without a doubt we can say that health plans are more accessible today to those in poor health status than they were back in 1991. I think that's a clear success story for the reforms, to the extent that they're affordable. At the same time, as Lee had said, it's intimately related to the affordability issue, and premium rates continue to rise. There were prior trend reductions due more to managed care than to anything else—than certainly to state reforms—but the trend again appears to be on the increase. Again, we're seeing double-digit trend increases in today's individual and small group markets. Certainly for the less managed plans.

It is more affordable for the unhealthy. We don't see 300-400% increases as we did 10 years ago for people with very unhealthy status. But it's more costly to the healthy, so, overall, for the market in total the costs have gone up.

The debate about quality continues. How can we deliver quality care at less cost? That's an issue all of us are probably involved in one way or the other, and it's a very difficult issue. Over the past eight years, the same issues are still at hand.

Is today's market a better one? From the consumer's perspective, there is more access and affordability for the unhealthy. The healthy, however, have less access, less affordability. It's more expensive for them. From the employer's perspective, health coverage is more costly. More and more of the very small groups—employers with two, three, four, or five employees—have dropped coverage and have gone an individual route. The owner is seeking individual coverage for himself, but his employees are kind of on the roam. The owner might recommend and bring in an insurance plan for an individual, but it's out of that individual's own pocket now because of the affordability issues. There are fewer carriers to choose from and more paperwork because of increased underwriting and affordability tracking.

From the insurer's perspective, there's been a consolidation of markets. As I said, fewer and fewer carriers are selling comprehensive medical insurance in the small group market. A lot of this is directly related to state reform and the compliance issues. Especially if you're a nationwide carrier, just tracking compliance from one state to another state is very costly. Many carriers have decided to bail out because it's too costly for them to remain, especially with the rising health costs that are out on the market. If you're a survivor, I guess that's great. If you're one of the companies that felt itself forced out, the self-care reforms, I guess, haven't worked too well for you.

From the insurer's perspective there has been decreased activity in the small group market. But there has been, it seems, an increased emphasis on the individual market, largely because of those mini-groups that dropped group coverage and are looking for some kind of individual coverage.

From a state's perspective, I imagine there's a lot more work for regulators with any of this health-care reform. Just checking on whether companies have been in compliance, things like that. Mergers and acquisitions are certainly on the rise which, forces the states to pay a lot of attention to in terms of the solvency of these plans. More insurables certainly have access and that's a plus, but at the same time there are more uninsureds that states need to be concerned with.

Has it worked? We have an increase in uninsureds. The cost of health insurance continues to rise. The many abuses in small group and individual markets do seem to have been reduced, so I think that's a success. And the threat of federal intrusion on state regulation, which encouraged a lot of this reform, that's become a reality with the passage of HIPPA, mental health parity, and patient protection.

If you have any questions, I'll be happy to answer any, and *Communicating for Agriculture*, if you're not familiar with it, is an excellent source of the individual state high-risk pools if you want to get some information.

Mr. Alexander D. Marek: This relates primarily to one of the points that Lee Tooman raised. The first building block that you mentioned is personal responsibility. I certainly agree that that's important, but as I look at medical care, one of my questions is, how would you arrange a system where personal responsibility works for people at both the lowest and the highest income levels?

Mr. Tooman: Well, I think you're exactly right. Poor people have Medicaid. Old people have Medicare. Most of us in this room, I imagine, have some form of employer-sponsored health insurance, and it's a wonderful value. I agree 100% and that's why I said at the beginning and at the end that in our view this tax code must be fixed. If we need to pay for it and if we're not going to spend any more tax dollars on it, then we need to cap what we're spending right now, what we're subsidizing, so yes, I believe it. I think you're right.

Mr. Marek: I guess I was getting at a slightly different issue which has to do with increased decision-making. If I have a 20% or a 30% copayment on a procedure, the percentage of my income that I spend on that copayment is going to be vastly different than the percent of somebody who's making the minimum wage, maybe has a health plan, but not a very rich one. How do you adjust the health plans so that we're all taking equal amounts of responsibility in some sense for medical positions?

Mr. Tooman: Well, I'm not sure I can answer your question. I think most of you know that Golden Rule has been the leading advocate for MSAs. I have one. About 800 of my fellow employees at Golden Rule have them, and we've sold them to many thousands of people. In the MSAs $32 million has been accumulated in less than two years since the federal program went into place. Forty two percent of the people who bought MSAs, and this is in the IRS report, previously had no insurance whatsoever. As far as we're concerned that's a terrific success story. It's just way too small. It needs to be a bigger. That's what we think has the most promise.

Ms. Philips: From the regulatory point of view, it is a very difficult issue in the sense that public policymakers do not want to see people going without needed medical care. To them that's kind of the overriding need, and they would not be in favor of anything that causes lower income people to pay out-of-pocket expenses; in fact, they really go to the extreme. I have had policymakers tell me they don't want even $1 co-payment because it might prevent some lower income person from getting needed medical care, but, of course, the missing piece. The balancing piece is whether society is ready to open the floodgates and just fund whatever anybody wants. The answer seems to be no. As an actuary I think, fine. If you're willing to pay, then give everybody all medical care with no co-payments, but nobody is stepping forward to pay for that and so we have to work out some other arrangements.

Mr. Anant Galande: I'd like to focus on another one of the building blocks that the Council for Affordable Health Insurance listed which was limiting state mandates. I live and work in a state that has very strong opinions about what is right and wrong about health care and generally doesn't seem to work well with other states in determining that. As Mr. Tooman has pointed out, there are certainly legislators across the country who are proposing mandates based on personal issues rather than on issues of constituents. My question is, is this really a reasonable goal?

Mr. Tooman: I think so. To give you one piece of evidence on that, my company and several others were in Florida lobbying and we had a meeting with the Senate Democrats. We were talking about a proposal and then we got on other issues like mandates. One of the fellows from the Council made a comment that mandates were driving up the costs and there could be a significant reduction in the cost if we were able to sell a mandate-free policy.

Now the Democrats are in the minority in the Senate and in the House in Florida. But Buddy Dyer, who is the minority leader in the Florida Senate, called us after the session and said, "I'd like to sponsor a bill that would permit carriers to do mandate-free insurance," and we helped him draft such a bill. We went down through the sections of the code and said, "You can offer a policy without these things. You have to put a big notice on the policy."

Buddy was taken to task with it in the papers. He said, "Look, I've been a big advocate of this stuff for a long time, but we have 25% of the Florida nonelderly population without insurance and we need to do everything we can to reign in costs for those folks." I think Minnesota has a program as well for the smaller market-share carriers to sell mandate-free insurance in the small-group market, so this is starting to take hold in the state and we'll see.

You know, the National Conference of State Legislators did a kind of a cheat sheet. They were in Indianapolis, about three months ago, and they said, "OK, is there a correlation between the number of mandates in the state and the number of people without insurance?" They concluded there wasn't. They looked at some states with high numbers of mandates and some with low, but discovered that not all mandates are created equal. That's assuming that a full mental-health parity

mandate is the same as a requirement that we pay for mammograms at ages 45, 50, 55, and 60. Anyway, everybody realizes costs are high. They're way too high and this is one of the areas that people are looking at to see if they can't dent the costs.

Ms. Dorothea D. Cardamone: I have a question, not necessarily for the panel. There might be some other people here with the background. I was wondering whether anybody had looked at Massachusetts. It's a very interesting state. I think they passed the law mandating all employers to provide insurance for their employees. Even employers of small firms have to make it available, but those employees don't necessarily have to take it. I think it would be interesting to see whether the numbers of uninsureds has gone down significantly in Massachusetts. Obviously they did other things. They kind of blended the small group and the individual markets. I'm just curious whether any of the panelists here or any of the members of the audience have any expertise? Are there any other states that are of interest to this discussion?

Mr. O'Connor: I haven't had the opportunity to follow-up on that at all. Lee?

Mr. Tooman: I don't know much about the small-group market in Massachusetts. They did impose a law, if you remember. Mike Dukakis, when he was governor, had an employer mandate to provide insurance that was never implemented. The effective date was postponed.

Ms. Cardamone: I think it was implemented.

Mr. Tooman: No, I'd bet money on that.

Ms. Cardamone: I think if you're employed in Massachusetts your employer has to provide it to you.

Mr. Tooman: The employer doesn't have to provide and pay for it. Now there may be some kind of mandate, but initially it was an employer mandate. You had to provide it, and you had to pay for it. Hawaii is the only state in the country that I know of that has such a thing and their rate of uninsureds is relatively low, but they certainly didn't eliminate it.

Ms. Cardamone: I don't know whether the Academy or one of the work groups could do this, but it would be very interesting to take all the different states and do a spreadsheet of how well things have worked out in the different categories. You could pick up on insurers, costs, what's happened, and what are the results. That would be very useful if somebody could accumulate that information for the states.

Mr. O'Connor: There are some organizations that have tracked year by year by state the number of uninsureds in a state. What they haven't done is, and it's very difficult, if not impossible to do, relate it to specific health-care reforms that have gone on. I might point out to you that the American Association of Retired Persons (AARP) has tracked state mandated laws relative to health-care reform and listed by state the number of uninsureds. If you get their publication back in, say, 1993

and compare it to their latest publication, you might get a sense of how states have moved over the years.

Lee had a slide that compared Indiana to the nation as a whole, and I think generally what you'd probably find is that the level of uninsureds has remained fairly stable in most states. Whether these state reforms have kept those from really going sky-high in terms of the number of uninsureds or not, we can never say. It appears to me from a glance that while you have some fluctuations in the percentage of uninsureds, state-by-state overall it's been maybe 17% several years ago, but we're back to 17%. We may have dipped in 1995, but it looks like we're back to where we were before that.

Ms. Cardamone: That observation is not consistent with the overall increase in the number of insureds, is it? If every state is seeing a stable level, then how do we come to the conclusion that the number of uninsureds is increasing?

Mr. O'Connor: Population is growing.

Ms. Cardamone: Population?

Mr. O'Connor: Yes.

Ms. Cardamone: What was the group that you referred to that had published something?

Mr. O'Connor: That's the AARP. They put out a publication each year that tracks state legislation like that.

Ms. Cardamone: For the under-65 population?

Mr. O'Connor: Yes.

Ms. Philips: I have an additional comment in terms of tracking things. It is extremely difficult to tie a reform to a result and see what happened. I guess there are two areas where I think we can draw conclusions. One is where there are actual programs with enrollments. We have a subsidized program that has 100,000 people in it. Even then it's a little squishy as to how many of them would have been in private insurance or whatever. I guess the other area where you can really tell is when a disaster happens and the individual market kind of blows up and goes away like Lee was talking about in a couple of states. Now that's when you can really see, but as far as positive impact, it's a lot more difficult to measure.

Mr. Alan R. Holcomb: Julia, in your presentation you talked about rate bands and you mentioned that there were subsidies involved in the limitation on area and on age. In my mind the low-cost areas subsidizing a high-cost area means that a low-income person is subsidizing a high-income person and a younger person with a lower salary will be subsidizing an older person with a higher salary.

Do you think this is appropriate, and how have you advised your state legislature that this subsidy is occurring?

Ms. Philips: First of all, I don't get to decide what the law is. My opinion doesn't really matter, at least not to the legislature. They ask my opinion on what the technical consequences would be or how to calculate something, but they don't come to me and say, "Julia, do you think it's appropriate to put in these limitations?" I have to say that nobody really cares about my public policy opinion, just my technical ones.

Remember that we're always dealing with averages. On the average, younger people have lower incomes. I think that if we start to try to fine tune fairness, we will never be able to achieve it. There's never going to be a perfectly fair method of calculating rates. I actually get that question fairly often. I get the question about family rates. Is it fair to charge the same contribution from a family with a lot of children compared to a family with only a spouse or with only one child? I generally answer that question by saying that fairness is only approximate and actuaries cannot really sit down and define perfect fairness and try to implement it.