

ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

8359 SENATE LABOR & COMMERCE

FLORIDA SMALL GROUP HMO PLAN DESIGNS

	<u>STANDARD PLAN</u>	<u>BASIC PLAN</u>
Physician Services		
(All must be provided by or authorized by Primary Care Physician)		
-Primary Care Physician Office Visits	\$ 10 Copay Per Visit	\$ 10 Copay Per Visit
-Specialist Consultation, Diagnosis, and Treatment	\$ 10 Copay Per Visit	\$ 20 Copay Per Visit
-Other Outpatient Nonsurgical Physician Care	\$ 10 Copay Per Visit	\$ 20 Copay Per Visit
-Periodic Physical Exams (Maximum 1/CY)	No Charge	No Charge
-Surgical Care in Physician's Office (Carriers may limit non-surgical back treatments to ten visits)	\$ 25 Copay Per Procedure	\$ 50 Copay Per Procedure
Hospital Services		
-Inpatient Care at Participating Hospitals (including all general services and semi-private room)	\$100 Per Day, days 1-6 Balance Paid at 100%	\$250 Per Day, days 1-5 Balance Paid at 100%
-Outpatient Surgical Care	\$ 60 Copay Per Procedure Covered in Full	\$100 Copay Per Procedure Covered in Full
-Outpatient Non-Surgical Care (including x-ray and lab)	Covered in Full	Covered in Full
-Preadmission Testing		
Emergency Services		
-Emergency Care through Primary Care Physician's Office	\$ 10 Copay Per Visit	\$ 10 Copay Per Visit
-Emergency Care Services through Emergency Room In Service Area Hospital ER Visit (waived if admitted)	\$ 25 Copay Per Visit	\$ 50 Copay Per Visit
Out of Service Area Hospital ER Visit	\$ 50 Copay Per Visit	\$100 Copay Per Visit
Ancillary Services		
-Home Health Care	\$ 10 Copay Per Visit	Not Covered
-Ambulance	\$ 25 Copay	\$ 25 Copay
-Skilled Nursing Facility (Maximum 100 days lifetime)	\$ 20 Copay Per Day	Not Covered
-Durable Medical Equipment	No Charge	No Charge
Mental and Nervous Disorders		
-Inpatient (Maximum 10 days/CY) Maximum Inpatient Days Covered	\$100 Per Day 10 Days/CY	\$250 Per Day 3 Days/CY
-Outpatient Visit Maximum Number of Outpatient Visits	\$ 10 Copay Per Visit 20 Visits/CY	\$ 20 Copay Per Visit 5 Visits/CY
Alcoholism and Chemical Dependency		
-Inpatient Detoxification (as medically appropriate)	Not Covered	Not Covered
-Outpatient Visits	Not Covered	Not Covered



Alaska State Legislature

Senate

Office of the Secretary

OFFICIAL BUSINESS

PO BOX V
CAPITOL BUILDING
JUNEAU, ALASKA 99811

FOR YOUR IMMEDIATE ATTENTION

DATE: 3-24-93

TO SENATE COMMITTEE: LABOR AND COMMERCE (Senator Kelly)

FROM: Office of the Senate Secretary

The Chairman of the above-referenced Committee has waived the Committee referral on the following bill(s):

SENATE BILL NO. 40

RELATING TO HEALTH INSURANCE FOR SMALL EMPLOYERS; EFD

Please give the bill file(s) to the page delivering this message for forwarding to the next Committee of referral.

Thank you for your prompt attention to this request.

JR/s

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

SMALL GROUP MARKET REFORM

SENATE BILL 40

PRESENTED BY

JAN ANDREA MEISELS

LEGISLATIVE DIRECTOR

BEFORE THE

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

March 23, 1993

2111 Clarendon Street, Suite 220
Woodland Hills, CA 91367-0321
818-704-9271

I am Jan Andrea Meisels, Legislative Director, Health Insurance Association of America. HIAA is a trade association of the nation's leading commercial insurance carriers that provide health insurance for approximately 95 million Americans. HIAA actively supports SB 40.

The small employer market provides one of the most vivid examples of how health care cost inflation continues to afflict our financing system. Faced with unrelenting demands to hold health care costs down, insurers and employers have intensified the search for ways to moderate premium increases. Leaving high-risk individuals out of group coverage has been one such response. The "excessive employer churning" that newspaper accounts often bring to our attention is largely a function of employers seeking the lowest available rate. We, too, constantly hear the charge by small employers that the presence of a high-risk individual in their group has made it impossible to obtain coverage at any price.

This dynamic is complicated further by the tumultuous labor market of a small employer. Small employers are far more likely than larger organizations to go in and out of business. Our own annual employer survey suggests that employees of small firms also are more likely to change jobs. Employee turnover among small, insured firms is about 23 percent annually and is twice that level for small employers without coverage. These factors contribute to the reluctance of such employers to offer coverage as well as the difficulties of serving the market.

As the complexities of the small employer market have grown, and the likelihood of individuals' being separated from the

financing system has increased, there is a growing perception that even if they have coverage, they stand a reasonable chance of losing it if they change employers, or if they have poor claims experience.

Mr. Chairman and members of the committee, we have now reached the point where substantial small employer market changes are needed if we are to serve the longer-term interests of small employers and meet the concerns of policymakers. Thus far 24 other states have enacted small group market reform which includes similar reforms as reflected in SB-40. SB-40 incorporates a comprehensive set of small group market reforms that HIAA believes can be achieved in the context of a viable private marketplace. The essence of SB-40 is to make certain changes in the market so that it provides substantially more predictability and protection to the purchasers of coverage. Let me emphasize that to work, these changes will have to apply to all players in the small employer market -- insurance companies, medical service plans, multiple employer welfare associations, etc. All competing entities in the small employer market, including non-insured benefit plans, would have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage. The reforms included in SB 40 ensures fair access to and continuity of coverage for small employers and their employees. The issues embraced in SB 40 are:

guaranteed availability -- all small employer groups would be able to obtain private health insurance regardless of the health risk they present.

coverage of whole groups -- coverage would be made available to entire employer groups; neither an employer nor an insurer would be able to exclude from the group's coverage individuals who present high medical risks.

renewability of coverage -- at renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be canceled because of deteriorating health.

continuity of coverage -- once a person is covered in the small employer market and satisfied a plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.

premium pricing limits -- insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

To give effect to these proposals, SB-40 authorizes a private not-for-profit Small Employer Health Reinsurance Association. Without the Reinsurance Association these reforms are not achievable. The Reinsurance Association allows insurers to pay a premium in exchange for having the reinsurer bear the risk for reinsured individuals. This allows insurers to treat all individuals in a group the same way -- as SB-40 does not break up groups for the purpose of reinsurance -- all members would have the same benefits. The reinsurer stands behind the insurer and simply reimburses for claims associated with reinsured

individuals. This allows insurers to spread high risks, broadly through the private market rather than concentrated in one small employer group.

Besides the small group market reforms discussed above, one of the most effective means to obtain cost control is to improve our health delivery and financing system through effective managed care programs. Managed care has proved it can control costs. A growing number of studies from the seminal Rand Study of HMOs in the mid 1970's to the recent Lavenhol and Horwath study which assessed the cost savings of managed care in the CHAMPUS Reform Initiative (savings to both the Defense Department and CHAMPUS beneficiaries of \$148.9 million in 1988 and 1989). For these and other reasons cost containment provisions including aspects of managed care maybe incorporated into the small employer health plans developed by the Small Employer Health Reinsurance Board. Small employers are also the affected party when various legislators mandate their plans include specific providers or services. The cumulative effect of the various mandated benefits is to increase the overall cost of the insurance plan to the small employers who is in the most need of relief for the high cost of health care and are too small to self-insure and thus escape these mandates. A study in 1989 by a University of Illinois economist concluded that 16 percent of small employers not providing health insurance would offer benefits in the absence of state mandates.

Therefore, SB-40 exempts small employer health plans from any laws that would impose restrictions on insurers negotiating with

providers for services or prices of services or requires the small employer plans to include specific benefits or services rendered by certain providers.

The following is a brief discussion of each section of SB-40:

Section 1. Purpose -- describes the purpose of the bill by summarizing the issues addressed in SB-40.

Section 2. Prohibits unfair marketing practices delineated in 21.56.180.

Section 3. Exempts small employer health plans from any laws that would impose restrictions on insurers negotiating with providers for services or prices of services.

Section 4. Exempts small employer health plans from any laws that would impose restrictions on insurers negotiating with providers to include specific benefits or services rendered by certain providers.

Section 5. Small Employer Health Reinsurance Association. 21.56.10 -- creates a not-for-profit private legal entity whose membership consists of all insurers in the small employer insurance market -- insurance companies, hospital and medical service corporations, HMOs, and multiple employer welfare arrangements (which is not Medicaid, but a "term of art" describing unrelated multiple employers joining together for purposes of providing benefits plans).

21.56.020 -- describes the reinsurance association board composition which assures representation for all types of insurers doing business in the small group market including

welfare arrangements and guarantees a majority of seats to insurers in the small group market.

21.56.030 -- discusses the various powers of the Association board defining an array of health coverage products by which reinsurance will be provided and issued, as well as developing the methodology for determining the reinsured product premium rates.

21.56.040 -- requires the reinsurance association to submit a plan of operation to the Insurance Director for approval. This plan assures fair, reasonable and equitable administration of the Association. It permits the Director of Insurance, after notice and hearing, to adopt reasonable regulations.

21.56.050 -- establishes specific provisions for reinsurance of eligible employees of a small employer or dependents of eligible employees. By requiring carriers to accept groups/individuals within groups with greater than normal risks, insurers need assistance in spreading the greater risk, therefore, the establishment of the Reinsurance Association. Carriers are required to pay the first \$5,000 of claims before reinsurance assumes the risk because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price (paid by the insurer to the reinsurance mechanism) is capped (1.5 times the adjusted average market premium for groups and 5.0 times for individuals) to encourage carriers to participate in the small employer market, in the aggregate the cost of reinsured persons may well exceed the reinsurance premiums. The administrating insurer will determine any losses

annually. Any losses are covered through assessments from all members in the Reinsurance Association based on the member's share of total premiums net of reinsurance premiums paid for coverage under the chapter in the small employer market, including, to the extent permitted under ERISA, other benefit arrangements covering small employers. Assessments are capped at five percent of premiums charged for health benefit plans covering small employers.

To assure that insurers only cede (place) risk to the reinsurance mechanism when necessary, the premiums charged by the reinsurer are set at 1.5 times the average adjusted market premium price for similar type groups and benefits or 5 times the average adjusted premium market price for individuals with similar type benefits. Insurers are constrained from recouping the increased reinsurance costs as they may only attempt to recoup the 1.5 times average adjusted market premium price within the constraints of the overall rating bands described below. Only the level of coverage provided up to but not exceeding the coverage provided in a small employer health benefit plan is eligible for reinsurance.

This section also recognizes that federally qualified HMOs reinsurance premium may be modified to reflect the portion of the risk ceded to the Association, i.e., federally qualified benefits may be different from the benefits determined to be included in the reinsured health plans by the reinsurance board. 21.56.060 -- establishes the member health benefit plan committee (including insurers, small employers, health care providers and

agents or brokers. The committee recommends benefit levels, cost sharing provisions for the basic and standard plan. These plans are required to incorporate cost containment techniques developed by the board, including but not limited to high cost case management, hospital precertification techniques and other cost containment techniques established by the Association.

21.56.070 -- requires that every two years the board will report to the insurance director and legislature on effectiveness of the act.

21.56.080-21.56.100 -- exempts the Association from the Administrative Procedures Act, imposition of taxes and limits the liability of the Association board.

21.56.110 -- Small Employer Health Insurance Plans. The program applies to all health insurance plans for individuals and group health benefit plans if they provide coverage to 2-25 eligible employees and the employer pays all or part of the premium and the health plan is applicable to the IRS code section 26 U.S.C. 106 or 26 U.S.C. 162.

This section also exempts all small employer health plans (25 employees or less) from any restrictions on an insurer's ability to negotiate with providers regarding reimbursement for services and eliminates the requirement that the benefit plan cover specific mandated benefits or classes of providers. These provisions will increase the affordability of small employer health plans while providing quality health care to Alaska residents.

21.56.120 -- Premium Rating Requirements. This provision provides stability and predictability of rates.

The premium pricing limitations included in this chapter limits an insurer's ability to vary rates for groups in similar geography, demographic composition and plan design. Specifically, an insurers premiums for similar groups could not vary by more than 35 percent from the carrier's index rate (arithmetic average of applicable base rate and highest rate). There is also a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increases to no more than 15 percent above the carrier's trend (the year-to-year increase in the lowest new business rate). These provisions assure the small employer availability of and accessibility to predictable and renewable insurance rates.

Carriers are also required to disclose in its solicitation and sales material how the premium rates from specified small employers are establishing provisions of the plan and file an annual actuarial certification with the director.

21.56.130 -- Renewability of Coverage. Lists specified reasons why a health plan may not be renewed, i.e., nonpayment of premiums, fraud or misrepresentation by a small employer; noncompliance with minimum participation or employer contributions, etc. Specifies steps a carrier must take if the insurer decides to nonrenew all of its health benefit plans.

21.56.140 -- Required offer of Coverage. As a condition of doing business in the state with small employers, a small employer

insurer is required to offer a basic and a standard health benefit plan. The basic and standard plans are filed with the director who may disapprove them after a hearing.

21.56.150 -- Required Health Benefit Provisions. Benefit plans may not deny, exclude or limit benefits for more than 12 months due to a preexisting condition. This guarantees the availability of insurance to all small employers and removes the concerns of people with preexisting conditions that they would have to satisfy additional preexisting condition exclusions if they change jobs or if their employer changed insurance carriers. Once someone had satisfied a plan's 12-month preexisting condition restriction he or she would no longer be required to satisfy those requirements again when changing jobs or when the employer changes insurers. Carriers must offer coverage to all eligible employees and dependents and may not select only certain individuals.

21.56.160 -- Exemption From Required Offer of Coverage.

Delineates when an insurer does not have to offer coverage, i.e. the small employer not located in carrier's geographic area; the carrier does not have capacity to deliver service adequately to members; the carrier is only maintaining in force business and ceased enrolling new employer groups before January 1, 1993.

21.56.170 -- Conditions For Ceasing To Do Business. Insurers ceasing to do business in the small employer market are required to give notice of this decision to the insurance department, the reinsurance board, the policyholder and the employer. Coverage is required to be continued for one year after the date of

notification. An insurer is also prevented from reentering the small group market for at least five years from the date the notice was given that they decided to cease to do business in this Alaska market.

21.56.180 -- Fair Marketing Standards. Specifies standards for insurers to follow including the requirement to affirmatively market basic and standard health plans, an insurer may not deny compensation to an agent/broker due to adverse health status, claims experience, etc. of small employers.

21.56.190 -- Mandatory Reissue of Coverage. In order that carriers not selectively "dump" their business before the effective date of the bill, the director may adopt regulations to require a carrier to reissue a health benefit plan to a small employer if it was nonrenewed after January 1, 1993.

21.56.250 -- Definitions. This section describes all the terms used in this chapter.

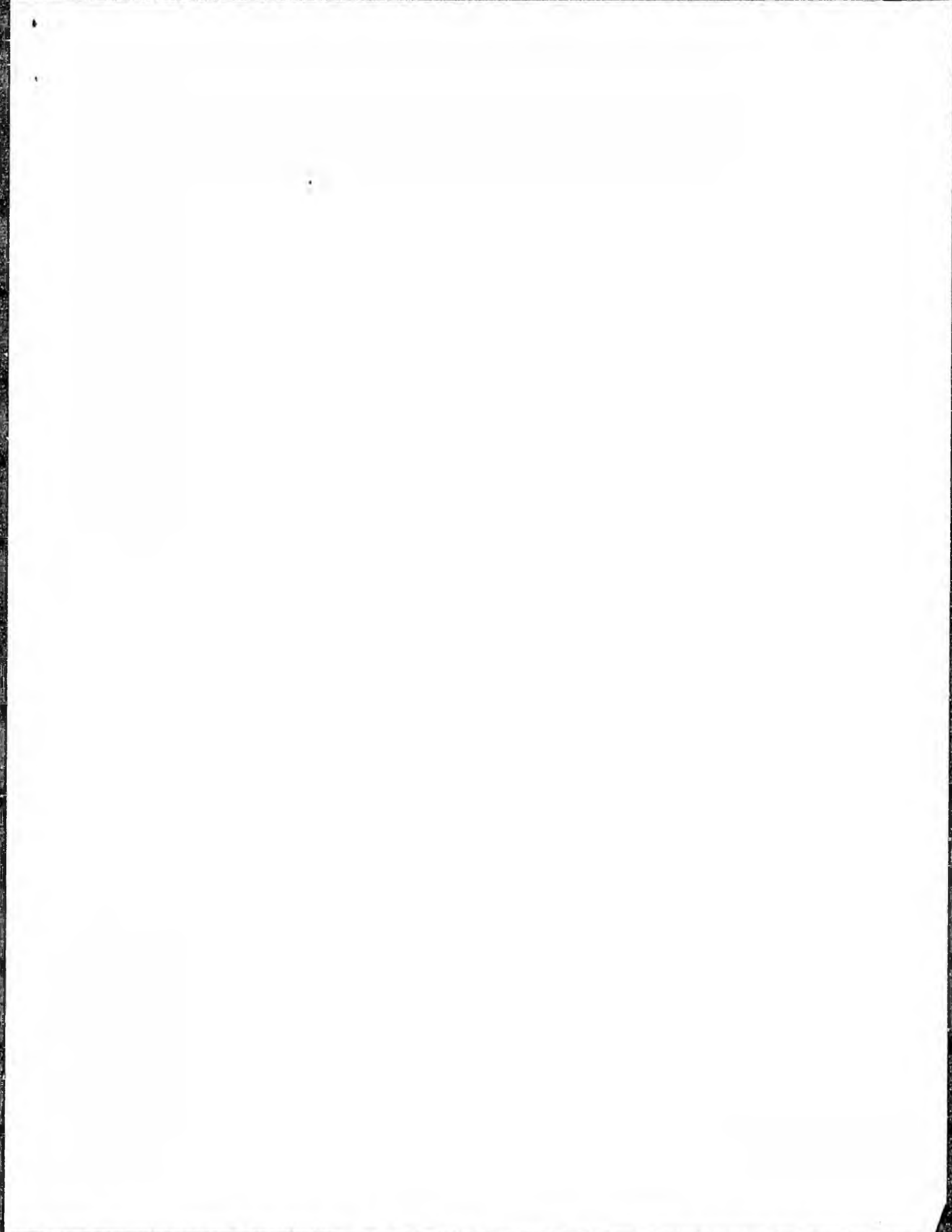
Sections 6,7. The term "insurer" was redefined for this chapter to include HMOs. Therefore, it is necessary to cross reference the definition of HMO for these purposes to the provisions of this chapter. Sections 6 and 7 achieve this purpose.

Sections 8,9. The term "insurer" was redefined for this chapter to include hospital or medical service corporations. Therefore, it is necessary to cross reference the other sections of the insurance code related to these organizations for the purpose of applicability to this chapter.

Section 10. Premium Rate Restriction. This addresses premiums for policies that are delivered prior to the effective date of the bill, by allowing the premium rating restrictions to be phased in over three years, thereby limiting any potential "sticker shock" small employers may experience to the premium rate restrictions.

Section 11. Transition. Not all sections of the chapter become effective upon enactment. This section lists those portions of the chapter which begin at dates later than the July 1, 1993 effective date.

Section 14. Lists the effective date of the chapter as July 1, 1993.



WAAA

WASH. POST 3/14/93

JANE BRYANT QUINN

A 'Community' Approach To Cutting Health Costs

Health insurers like to think they're part of the answer to the high cost of health care. But they're actually part of the problem.

They've figured out ways to "cherry-pick" the insurance market—keeping the healthy, who don't file many medical claims, while throwing sick people overboard.

Big-company health plans usually aren't affected. But small companies and individuals have been taking it in the teeth. If one person in a small group gets sick, rates may rise by 50 percent or 100 percent for everyone.

President Clinton's health care reforms are certain to address this issue. In the meantime, a majority of the states are trying out ideas of their own.

The egalitarian solution is a pricing system known as "community rating." This is how health insurance used to be priced, and how some Blue Cross/Blue Shield plans are still priced. In setting rates, the healthy are averaged with the sick. Everyone gets the same or a similar rate (although people are sometimes grouped by geographical area, family size or other specific characteristics).

Community rating is often coupled with "guaranteed issue"—meaning that the insurers have to accept all applicants, regardless of health.

Five states are in the process of introducing community rates. Two—New York and New Jersey—aim to make premiums uniform within specified groupings, for example for everyone living in the same geographical area. In the others—Oregon, Maine and Vermont—limited rate variation is allowed, although rates can't be increased for those in poor health. The laws in New York and New Jersey cover individual policies as well as small-group plans. The others cover only small groups.

For buyers of individual insurance, community rating could lead to problems. Everyone is averaged together, so younger or healthier people may have to pay more to help cover the claims of the sick. As a result, larger numbers of healthy people may decide not to buy. "I think you should rate separately for children, for young adults and for old adults," said Deborah Chollet, director of the Center for Insurance Research at Georgia State University.

Instead of going all the way to community rating, 25 states have recently passed "rate banding" laws for small-group insurance (small groups are often defined as groups of up to 25, but sometimes up to 50). These laws stop insurers from hitting small companies with excessive price increases when one employee or dependent comes down with a costly illness.

Under rate banding, a small company's health insurance premiums have to be set within a fixed range. Rates can rise in line with the trend in each insurer's medical claims costs, now increasing at around 15 percent annually (that covers increased use of medical services, as well as rising prices for health care). But a company with an employee who's grievously ill typically cannot be charged any more than 15 percent above average.

For a company paying below the average, there might still be a sizable premium increase in the first year that a worker falls ill. But small companies wouldn't take a 50 percent or 100 percent hit. Furthermore, their premium increases would soon fall back to the medical trend rate.

Rate-banding states allow several bands that separate people by circumstances such as age and health. So rates among different types of employer groups can vary by more than 15 percent. Still, the law stops aggressive insurers from picking off the best risks and dumping the rest.

States with rate banding usually tie it to guaranteed-issue—forcing the insurers to take all comers. So small companies with, say, one sick employee can still get a policy for all.

Rate-banded group insurance should not be as expensive for younger or healthy people as community-rated policies might become, said Chris Petersen, assistant general counsel for the Health Insurance Association of America. That's because there are many more healthy people than sick ones. If more small companies buy insurance, they'll increase the number of healthy people in the pool, relative to the number of sick ones. So overall, rates shouldn't have to climb a lot, he said.

Although these programs make insurance pricing more predictable, they don't solve the affordability problem. But consider them fingers in the dike until the country figures out how to pay for basic care for everyone.

Also appeared in
NY Daily News 3/14

A M E N D M E N T

OFFERED IN THE SENATE

BY SENATOR PEARCE

TO: SB 40

Page 5, line 8:

Delete "and"

Page 5, after line 8:

Insert a new paragraph to read:

"(5) effectuating a methodology for applying the dollar thresholds contained in this section for insurers that pay or reimburse health care providers by capitation or salary; and"

Renumber the following paragraph accordingly.

~~Page 5, line 17:~~

~~Delete "health care"~~

A M E N D M E N T

OFFERED IN THE SENATE

TO: SB 40

BY SENATOR PEARCE

Page 7, lines 16 - 18.

Delete all material.

Renumber the following paragraphs accordingly.

A M E N D M E N T

OFFERED IN THE SENATE

BY SENATOR PEARCE

TO: SB 40

Page 11, after line 17:

Insert a new subsection to read:

"(d) This chapter does not apply to a policy or certificate of insurance that covers a specified disease or to a hospital indemnity or limited benefit health insurance policy if the insurer offering the policy or certificate files with the director on or before March 1 of each year a statement that (1) certifies that the policy or certificate described in this subsection is being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance, or major medical expense insurance and (2) includes a summary description of each policy or certificate, including the average annual premium rate or range of rates, charged for the policy or certificate in this state. An insurer who offers a policy or certificate described in this subsection in this state for the first time shall provide the information described in this subsection not less than 30 days before the policy or certificate is issued or delivered in this state."

A M E N D M E N T

OFFERED IN THE SENATE
TO: SB 40

BY SENATOR PEARCE

Page 13, lines 11 - 13:

Delete all material and insert:

"(8) for the purposes of this subsection, a health benefit plan that contains a restricted network provision may not be considered similar coverage to a health benefit plan that does not contain a restricted network provision if the restriction of benefits to network providers results in substantial differences in claim costs;"

A M E N D M E N T

OFFERED IN THE SENATE

BY SENATOR PEARCE

TO: SB 40

Page 16, line 24:

Delete "health benefit plan"

Insert "small employer insurer"

Page 16, line 25, after "services":

Insert "in a health benefit plan"

Page 16, line 28:

Delete "30"

Insert "90"

Page 16, line 29, after "coverage;":

Insert "the period of continuous coverage may not include a waiting period for the effective date of coverage applied by the employer or insurer;"

Page 17, lines 20 - 23:

Delete all material and insert:

"(7) except as provided in (1) and (3) of this section, a small employer insurer may not, by a rider or amendment applicable to a specific individual, restrict or exclude coverage or benefits by specific type of illness, treatment, medical condition, or service otherwise covered by the plan."

A M E N D M E N T

OFFERED IN THE SENATE
TO: SB 40

BY SENATOR PEARCE

Page 18, line 4:

Delete all material and insert:

"(4) if the small employer insurer is only maintaining in-force business and has ceased enrolling new employer groups on or before January 1, 1993; this paragraph does not exempt a small employer insurer from the other provisions of this chapter; or"

Renumber the following paragraph accordingly.

~~Page 18, line 11.~~

~~Delete "health insurance"~~

~~Page 18, line 16:~~

~~Delete "health insurance"~~

A M E N D M E N T

OFFERED IN THE SENATE

BY SENATOR PEARCE

TO: SB 40

Page 20, after line 13:

Insert a new section to read:

"Sec. 21.56.190. MANDATORY REISSUE OF COVERAGE. The director may adopt regulations to require small employer insurers, as a condition of transacting business with small employers in this state after July 1, 1993, to reissue a health benefit plan to a small employer who has had its health benefit plan terminated or not renewed by the insurer after January 1, 1993. The director may prescribe the terms for the reissue of coverage that the director determines are reasonable and necessary to provide continuity of coverage to small employers."

A M E N D M E N T

OFFERED IN THE SENATE

BY SENATOR PEARCE

TO: SB 40

Page 21, line 24:

Delete "expense policy"

Insert "policy or certificate, major medical expense insurance,"

Page 21, line 27:

Delete ", but"

Insert "; "health benefit plan""

Page 21, line 30, after "payment insurance":

Insert "if the insurer complies with the provisions of AS 21.56.110(d), or a Taft-Harley trust"

Page 24, after line 6:

Insert a new paragraph to read:

"(26) "Taft-Hartley trust" means a jointly managed trust, as allowed by 29 U.S.C. 141 - 187, containing a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours and working conditions of employees as allowed by 29 U.S.C. 157;"

Renumber the following paragraph accordingly.

HIAA
ON
HEALTH CARE
FINANCING
FOR ALL
AMERICANS

HOW REINSURANCE WORKS

For more than two years, the Health Insurance Association of America (HIAA) has been developing the components of a reform package designed to address the unique requirements of the small employer market. These reforms, when taken as a whole, will ensure fair access to and continuation of coverage for small employers and their employees. These reforms constitute a meaningful basis for enhancing and expanding health care coverage.

Small employers, unlike their larger counterparts, are likely to go into and out of business frequently. Similarly, their employees tend to move from job to job frequently. Finally, small employers change insurance carriers more often in an attempt to obtain more favorable rates. All of these factors, combined with growing health care cost pressures, make it exceedingly difficult for insurance carriers to provide coverage to the small employer and they also make it more likely that individuals within this market will lose health care coverage at some point. HIAA's small employer market reforms tackle these problems in a reasonable and workable manner.

The HIAA proposal would ensure that any small employer may obtain coverage (regardless of the health condition of its employees or the inherent administrative burdens they pose). The following examples illustrate how this would work.

SITUATION: Tom's Tree Trimmers opens for business with a full-time work force of five employees. With workers engaged in dangerous work, where statistics suggest that personal injury is far more likely to occur than in, say, a computer sales and repair outlet, obtaining affordable health insurance may be difficult. Let us suppose that two employees, Harry and Sam, have serious health problems, which insurance companies term **pre-existing conditions**. To obtain coverage, the president of Tom's Tree Trimmers could face the following options: terminate Harry's and Sam's employment, insure everyone except Harry and Sam, or provide no insurance for any of the employees.

SOLUTION: Under the HIAA reform proposal, Tom's Tree Trimmers would not be excluded from coverage because it is engaged in dangerous work or because two of its employees, Harry and Sam, have pre-existing conditions. Also, the carrier selling insurance to the company would be permitted to reinsure Harry and Sam, the high risk employees (unknown to Harry, Sam, and their employer), by paying a reinsurance premium. In exchange for the reinsurance premium, the reinsurer would agree to reimburse the insurer for Harry's and Sam's costs.

SITUATION: During the course of the year a third employee at Tom's Tree Trimmers, George, becomes seriously ill. Will his condition threaten coverage for himself or his coworkers?

Health Insurance Association of America

1025 Connecticut Avenue N.W., Washington, DC 20036 ☐ 202-223-7780 ☐ FAX 202-223-7897

SOLUTION: Under HIAA's reform proposal, insurance coverage would be maintained for all employees, regardless of any of the employees' conditions. Tom's Tree Trimmers' insurance carrier would be obligated to renew the contract (unless the company failed to pay its premiums in a timely fashion or was dishonest with the carrier).

SITUATION: George, who has had several months of poor health, is on the road to recovery. He decides to leave Tom's Tree Trimmers to gain experience at a small computer sales and repair outlet, the Corner Computer Company. He is concerned that he will not be able to obtain coverage with his new employer because of his health record with Tom's Tree Trimmers. He is aware that, prior to the reforms in the small employer market, employees who changed jobs or employers that changed carriers could face recurring pre-existing condition limitations. George realizes that this could leave him without health care coverage.

SOLUTION: Under the HIAA proposal, George would be guaranteed continuity of coverage and would not be subject to any new pre-existing condition limitations if he changes jobs or his employer switches carriers, since he satisfied those while employed by Tom's Tree Trimmers (this assumes that George did not allow his coverage to lapse for a sustained period of time).

SITUATION: Both Tom's Tree Trimmers and the Corner Computer Company are concerned that their health premiums will rise inordinately if one or more employees is found to be seriously ill.

SOLUTION: Under the HIAA proposal, an insurance carrier would have to limit how much its rates, based upon the group's health history, varied. Carriers could vary their rates for similar small employer groups (those with similar demographics, plan type, and geographic area) by no more than 35 percent above or below their midpoint rate (the midpoint rate is halfway between the carriers lowest and highest rate). Carriers would also have to limit their industry rating adjustment to 15 percent. Finally, the year-to-year premium increase for a group could be no more than 15 percent above the carriers "trend" (defined as the increase in the lowest new business rate). To reflect cost differentials between managed care and non-managed care products, carriers could establish separate trends.

SITUATION: A new firm, Tree Doctors, Inc., opens for business in the same community as Tom's Tree Trimmers. Like its competitor, Tree Doctors employs five employees. At the time it opens for business, all of its employees are healthy. The president of Tree Doctors, Inc. knows that he is in stiff competition with Tom's Tree Trimmers. He is concerned that he may be at a competitive disadvantage if any of his costs are higher than those of Tom's Tree Trimmers. Since Tom's Tree Trimmers has been in business for some time, the owner of Tree Doctors, Inc. is concerned that he may not be able to purchase health insurance coverage at a rate that will be similar to the rates charged to his competitor.

SOLUTION: Under the HIAA proposal, the availability of reinsurance combined with the premium rate limits would moderate the premium difference between groups. The HIAA plan would ensure that Tree Doctors, Inc. did not incur inordinately high premiums relative to demographically similar firms.

RATING LIMIT ILLUSTRATION

NAIC	HIAA																								
<p>BAND RULES</p> <ul style="list-style-type: none"> - Within a block, the rates for similar groups may be no more than 25% above or below the block's midpoint rate. - The midpoint rate for a carrier's highest rated block may be no more than 20% above the midpoint for the carrier's lowest rated block. 	<ul style="list-style-type: none"> - A carrier's rates for similar groups may be no more than 35% above or below the carrier's midpoint rate. 																								
<p>HYPOTHETICAL EXAMPLE</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">RATES</th> <th style="width: 15%;">Block A</th> <th style="width: 15%;">Block B</th> <th style="width: 15%;">All Blocks</th> </tr> </thead> <tbody> <tr> <td>Highest</td> <td style="text-align: center;">125</td> <td style="text-align: center;">150</td> <td style="text-align: center;">150</td> </tr> <tr> <td>Midpoint</td> <td style="text-align: center;">100</td> <td style="text-align: center;">120 (20% above 100)</td> <td></td> </tr> <tr> <td>Lowest</td> <td style="text-align: center;">75</td> <td style="text-align: center;">90</td> <td style="text-align: center;">75 (overall low to high ratio of 1:2)</td> </tr> </tbody> </table>	RATES	Block A	Block B	All Blocks	Highest	125	150	150	Midpoint	100	120 (20% above 100)		Lowest	75	90	75 (overall low to high ratio of 1:2)	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">RATES</th> <th style="width: 15%;">All Blocks</th> </tr> </thead> <tbody> <tr> <td>Highest</td> <td style="text-align: center;">156</td> </tr> <tr> <td>Midpoint</td> <td style="text-align: center;">116</td> </tr> <tr> <td>Lowest</td> <td style="text-align: center;">75 (overall low to high ratio of 1:2.08)</td> </tr> </tbody> </table>	RATES	All Blocks	Highest	156	Midpoint	116	Lowest	75 (overall low to high ratio of 1:2.08)
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<p>YEAR-TO-YEAR INCREASE RULE</p> <ul style="list-style-type: none"> - Carriers would have to limit a group's year-to-year premium increase to no more than 15% above the carrier's "trend" (trend is defined as the year-to-year increase in the lowest new business rate). 	<ul style="list-style-type: none"> - Carriers would have to limit a group's year-to-year premium increase to no more than 15% above the carrier's "trend" (trend is defined as the year-to-year increase in the lowest new business rate). 																								
<p>INDUSTRY RATING RULE</p> <p>None</p>	<ul style="list-style-type: none"> - ±15% limit on how much a carrier could vary rates by industry. 																								

COMPREHENSIVE SMALL EMPLOYER PACKAGES

	CALIFORNIA	CONNECTICUT
Availability	Guaranteed issue of small employer products (group size 5-50 by 7/1/93; 4-50 by 7/1/94; 3-50 by 7/1/95) (1992 HB 1672) §10700(x), 10705(b)h	Guaranteed issue §38a-552, 5682(b)
Group Size	3-50 §10700(x)	1-25 §38a-564(4)
Individual Policies	Individual policies sold to small employers meeting certain requirements are subject to this Act §10702	Insurers may issue individual special health care plans subject to the laws applicable to individual health insurance, provided such policies shall be identical to individual special health care plans made available by the Health Reinsurance Association. §38a-552, 566
Case Characteristics	Includes age (7 categories), geography (9 regions), family composition (4 categories), and plan design which are used to determine the standard employee risk rate §10700(w)	Appears to include everything except claims experience §38a-564(27)
Rating Restrictions	Premium rates may not vary from the standard employee risk rate by more than 120% nor less than 80% until July 1, 1996; effective July 1, 1996, premium rates may not vary from the standard employee risk rate by more than 110% nor less than 90% §10700(v), 10714	Premium rates may not exceed 200% of the lowest new business rate for the same or similar case characteristics §38a-567(5)
Transitional Period	See above	5 years; after July 1, 1995, rating restrictions will be applied to plans issued prior to July 1, 1990 §38a-567(5)
Renewal Rating	10% permitted for risk adjustment factors; renewal rates are effective for at least six months §10714(b)1(2)	Trend plus 20% plus changes in case characteristics §38a-567(6)
Renewability	Guaranteed renewable except "for cause" §10705(b), 10713	Guaranteed renewable except "for cause" §38a-567(3)
Whole Groups	Carriers are required to take the whole group §10707	Cannot exclude eligible employees or dependents on the basis of an actual or expected health condition §38a-567(4)
Continuity of Coverage	Preexisting condition limitation of 6 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods; if employment is terminated or employer's contribution toward the coverage has terminated, there is a 90-day period allowed for continuity of coverage §10706, 10708(a,b), 10709(a)	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §38a-567(1.2)
Reinsurance type	Prospective/with opt out §10719, 10720(d)	Prospective/mandatory (effec. 5/1/91) §38a-569
Reinsurance Price	No provision	Whole Group: 150% Individual: 500% §38a-569(c)
Cost Sharing	No provision	\$5000 for all plans except those which supplement the basic hospital or hospital surgical plans, in which case the deductible is \$2000 §38a-569(b1)
Assessments	No cap §10721	(1) Apportioned among all members in proportion to their respective shares of the total premiums earned from small group plans, (2) apportioned among all members in proportion to their respective shares of total premiums earned from other plans; members' assessments cannot exceed 40% of the total assessment for the first year, 50% for the second §38a-569 e(2)
Other	Establishes a purchasing pool for small employers §10730	
Effective Date	July 1, 1993, but see phase-in effective dates above	July 1, 1990

	DELAWARE	FLORIDA
Availability	Guaranteed issue (groups of 2-25) §7207(a)3	Guaranteed issue with cap (group size 3-25) (1992 SB 2390) §627.6699(3)r, (5)a
Group Size	1-25 §7202(cc)	1-25 §627.4106(2)a
Individual Policies	Does not apply to individual health policies §7203	With regard to rating and renewability provisions, does not apply to individual policies if the insurer certifies to the department that the policy was issued in good faith with no knowledge or intent that the policy is paid by or the premiums are reimbursed by a small employer §627.4106(4)
Case Characteristics	Demographic or other objective characteristics of small employer are considered by carrier in determination of premiums; Claims experience, health status, and duration of coverage are not case characteristics; small employer carrier shall not use characteristics other than age, gender, industry, geographic area, family composition, unhealthy lifestyle choices, and group size without prior approval of Commissioner §7202(p), 7204, 7205(4)	Demographic or other objective characteristics of small employer are considered by carrier in determination of premiums; Claims experience, health status, and duration of coverage are not case characteristics §627.4106(2)a
Rating Restrictions	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar benefit plans shall not vary from the index rate by more than 35%, with an additional combined variation of no more than 10% for gender and geography, and the actuarially justified adjustment for age and family composition, provided that the carrier file age and family composition tables with the Commissioner §7205(1,2)	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §627.4106(5)1,3
Transitional Period	For plans delivered or issued for delivery prior to the effective date of this chapter, a premium rate may have a one-year transition period §7205(7)	5 years §627.4106(9)
Renewal Rating	Trend plus 15% plus changes in case characteristics §7205(3)6	Trend plus 15% plus changes in case characteristics §627.4106(5)b
Renewability	Guaranteed renewable except "for cause" §7206	Guaranteed renewable except "for cause" §627.4106(6)
Whole Groups	Carriers must offer coverage to all eligible employees and dependents §7207(u)	Carriers must offer coverage to all eligible employees and dependents §627.6699(5)e(7)
Continuity of Coverage	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 60 days prior to the new coverage, exclusive of applicable waiting periods §7207(c)	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §627.6699(5)e(1)(2)
Reinsurance type	Prospective/with an opt-out §7210	Prospective/with an opt-out §627.6699(8)
Reinsurance Price	Whole Group: 150% Individual: 500% §7210(n)4	Whole Group: 150% Individual: 500% §627.6699(8)h(1)a,b
Cost Sharing	\$5,000 plus 10% of the next \$50,000 §7210(L)2b, (L)3a	\$5000 per year plus 10% of incurred claims during a calendar year §627.6699(8)9(4)
Assessments	Formula to be set by Board but must be 50% - 150% of carrier's proportional share of all reinsuring carriers' small employer premiums; maximum amount shall be 5% of total premiums earned in previous year from small employer plans §7210(L)2(b), L(3)c	1st tier: an amount not to exceed 5% of small employer premiums; 2nd tier, if necessary: an amount not to exceed .5% of premiums collected on all health benefit plans issued by small and large group carriers §627.6699(8)1(2)
Other	Allows reinsurance of existing business §7210(n)3	Carriers paying 2nd tier assessments will receive a credit for assessments paid to the Florida Risk Pool §627.6699(8)1(2)b
Effective Date	January 4, 1993	October 1, 1992 (rating & renewability provisions 10/1/91)

	HAWAII	IOWA
Availability	State run, employment based program; all residents are eligible	Guaranteed issue §513B
Group Size	No provision	1-25; however, must have at least 2 participating employees at the date of issue of health benefit plan §513B.2(12)
Individual Policies	No provision	Does not apply to individual policies which are subject to policy form and premium rate approval §513B.3
Case Characteristics	No provision	Case characteristics include age, industry classification, geographic area, family composition, and group size; gender may be used provided the insurance division has conducted an independent, actuarial study that determined use of gender to be actuarially justified; other case characteristics shall not be used without prior approval of commissioner §513B.2(4)
Rating Restrictions	No provision	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §513B.4
Transitional Period	No provision	3 years §513B.4
Renewal Rating	No provision	Trend plus 15% plus changes in case characteristics §513B.4
Renewability	No provision	Guaranteed renewable except "for cause" §513B.5
Whole Groups	No provision	Must offer to whole group, except as permitted with regard to late enrollees §513B.7A(3)c
Continuity of Coverage	No provision	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §513B.7A(3)3
Reinsurance Type	No provision	Prospective/with an opt-out §513b.7(D)
Reinsurance Price	No provision	Whole Group: 150% Individual: 500% §513B.7(D)9(b)
Cost Sharing	No provision	\$5,000 and 10% of the next \$50,000 of incurred claims during a calendar year; liability maximum of \$10,00 in any one calendar year with respect to any reinsured individual §513B.7(D)8(D)
Assessments	No provision	Formula to be set by Board but must be 50% - 150% of carrier's proportional share of all reinsuring carriers' small employer premiums; amount shall be 5% of total premiums earned in previous year from small employer plans §513B.7(D)11(2)
Other	Employees required to pay 1.5% of wages, or half the premium whichever is less; employers provide the balance for each employee working more than 20 hours per week; dependent coverage is optional; unemployed residents above poverty level pay a small fee for doctor visits and a portion of the premium with the remainder being funded by the State; poor are covered by Medicaid	
Effective Date		July 1, 1992

	KANSAS	MAINE
Availability	Guaranteed issue (group size: 3-25) (1992 SB 561) §4(b), 12(a)	Guaranteed issue (1992 HP 507) §2808-B 4(A)
Group Size	1-25 §3(z)	1-24 §2808-B 1(D)
Individual Policies	Individual policies issued to individuals and dependents totally independent of any group, association, or trust arrangement shall not be subject to this Act §4(a), 4(a)3(c)	No provision §2808-B(7)
Case Characteristics	Case characteristics include the geographic area, age and sex, industry classification, number of employees and dependents, family composition, and other objective criteria as may be approved by the commissioner; claims experience, health status, and duration of coverage are not case characteristics §3(g)	A carrier may not vary the premium rate due to the health status, claims experience or policy duration of the eligible group; age, gender, industry, and geography within the bands; family status, smoking status, participation in wellness programs, and group size may be used outside rate bands §2808-B 2(B)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §7(1)(2)	Premium rates for age, gender, industry, and geographic area may not vary by +/- 50% of the community rate until 7/14/94, +/- 33% of the community rate until 7/14/95, +/- 20% of the community rate until 7/14/96, +/- 10% of the community rate until 7/14/97, and 0% of the community rate by 7/14/97; restrictions are repealed 7/14/94 unless continued or modified §2808-B 2(D)
Transitional Period	3 years §7(6)	None
Renewal Rating	Trend plus 15% plus changes in case characteristics §7(3)(b)	No provision
Renewability	Guaranteed renewable except "for cause" §5(c)	Guaranteed renewable except "for cause" §2808-B (4)B
Whole Groups	Prohibits carrier from excluding any employee or dependent on the basis of an actual or expected health condition §5(c)6(e)	(1990 - applies to all groups) Prohibits carriers from excluding any person from group; all new eligible employees must be added; may reject group until guaranteed issue is effective §2829-B
Continuity of Coverage	Preexisting condition limitations of 12 months and waiting periods not to exceed one year; waiting periods may be waived if individual was covered by a group policy prior to the effective date of coverage with no gap in coverage §5(a)(b)	(1990 - applies to all groups) Requires continuity for any person eligible for coverage in prior 3 months in a group replacement situation or for person moving from individual to group or group-to-group coverage; limit on 10% on premium rate increases for preexisting conditions during first 12 months of employment; preexisting condition limitations of 6 months for individual policies, except up to 24 months for any condition that as of the effective date of coverage requires ongoing medical treatment (H 1641) §2849-2(B)B,6 §2850(2)
Reinsurance Type	Prospective/with an opt-out §11(a)	Requires the Bureau of Insurance to report to the Banking and Insurance Committee on or before January 1, 1993, on reinsurance models with opt-out §5
Reinsurance Price	To be established by the reinsurance board §13(g)6	No provision
Cost Sharing	\$10,000 plus 10% of the next \$50,000; maximum in one calendar year shall not exceed 20% of total premiums §11(h)6(f)	No provision
Assessments	Not to exceed 5% of small employer plan premiums; second tier not to exceed 1% of total premium upon which assessment is based §11(k)2(c)	No provision
Other	Must reinsure the entire group; all carriers, whether reinsuring or not, subject to second tier assessment §11(k)2(b)	Marketing standards; superintendent will develop standardized plans §2808-B (6)
Effective Date	July 1, 1992	July 15, 1993 (for rating and guaranteed issue)

	MASSACHUSETTS	MINNESOTA
Availability	Guaranteed issue; however, until December 31, 1994, a carrier can limit the guaranteed issue requirement to 90 consecutive days a year; certain association groups are exempted from all but the reinsurance portion of the bill (1991 HB 6307) §2(b), 4(a)1	Guaranteed issue of all products sold in small employer market (1992 HB 2800, SB 2605) §3 subd. 1, 4 subd. 1
Group Size	1-25 §1	2-29 §subd. 26
Individual Policies	Does not apply to individual policies §2(a)	All provisions except guaranteed issue apply to individual policies §12 subd. 1, 2, 6 subd. 27(f)(ii)
Case Characteristics	Age, sex, rate basis type, industry, number of eligible persons, and participation rate of a group §1	Relevant characteristics of small employer as determined by carrier in determination of premiums; claims experience, health status, industry, duration of coverage, and gender are not case characteristics §2 subd. 6, 3 subd. 4
Rating Restrictions	Premium rates are limited to a 2-1 rate band; however, the following adjustments are permitted outside that band: benefit level, geography +/- 20%, group size +/- 5%, wellness discount -5%, phase out adjustment for experience and duration rating on existing business to reach +/- 15% by 12/31/94, age +/- 33% until 12/31/93 §3(a)1, 3(a)3(4), 3(a)7	Rates must not vary by more than +/- 25% of the index rate for same or similar coverage; inside the rating band, variations can be based only on health status (includes refraining from tobacco use or other actuarially valid lifestyle factors), claims experience, industry, and length of time employer has been covered; adjustments outside the band: age +/- 50%, geography +/- 20%, rate cells are permitted based on number of adults and children covered under the policy §8 subd. 2, 3, 4, 5, 6
Transitional Period	Phase out of rating restrictions §3(a)8	None
Renewal Rating	Trend plus 10% plus changes in case characteristics §3(b)	No provision
Renewability	Guaranteed renewable except "for cause" §4(b)(1)(2)	Guaranteed renewable except "for cause" §3 subd. 5
Whole Groups	Prohibits policies from excluding eligible employees or eligible dependents on the basis of an actual or expected health condition of such person §5(a)	Application must include all eligible employees §4 subd. 1
Continuity of Coverage	Preexisting condition exclusion of 6 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage and if previous coverage was reasonably actuarially equivalent to new coverage §5(b)	Preexisting condition exclusion of 12 months; requires credit for time covered under qualifying prior coverage; permits 18 month preexisting condition limitation for late entrants §3 subd. 4
Reinsurance Type	Prospective/mandatory for commercials §8	prospective/with an opt-out §13, 18(1)
Reinsurance Price	Whole Groups: 150% Individuals: 500% §8(1)(2)	Whole Groups: 150% Individuals: 500% §21(1)
Cost Sharing	\$5,000 §8	\$5,000, plus 10% of the next \$50,000 §20(1)
Assessments	5% of small employer premiums; if inadequate, other funding sources will be recommended §8(7)	Initially, \$100; in addition, not to exceed 4% of the member's small group market premium (if it is determined that premium charges are insufficient to cover the losses) §22(2)(3)
Other		Loss ratios: Initially 65% for individual policies, 75% for group policies; increases by 1% per year to 70% and 80%, respectively §8(1)
Effective Date	April 1, 1992	Most provisions July 1, 1993

	MISSOURI	NEW HAMPSHIRE
Availability	Guaranteed issue (1992 SB 796) §6	No provision (1992 HB 321)
Group Size	3-25 §1(28)	2-50 §420-F:1(XI)
Individual Policies	No provision §2(1)(2)(3), 3	Does not apply to individual health policies which are subject to policy form and premium rate approval §420-F:2(I)(II)
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §1(9), 4(10)	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §420-F:1(IV)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §4(1)(2)	Rates charged during a rating period to small employers with similar case characteristics for same or similar coverage shall not vary from the index rate by more than 30% §420-F:3(D)a
Transitional Period	3 years §4(3)b	5 years §420-F:3(I)(3)c
Renewal Rating	Trend plus 15% plus changes in case characteristics §4(3)b	Trend plus 15% plus changes in case characteristics §420-F:3(I)2
Renewability	Guaranteed renewable except "for cause" §5	Guaranteed renewable except "for cause" §420-F:4
Whole Groups	Insurer must cover the whole group §6(5)a	Insurer must cover the whole group §420-F:4
Continuity of Coverage	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §6(2)1(2)	Preexisting condition limitations consistent with insurance department rules
Reinsurance Type	Prospective/mandatory with an opt-out after three years §7(1)	No provision
Reinsurance Price	Whole Group: 150% §7(9)2	No provision
Cost Sharing	\$5,000 plus 10% of the remaining incurred claims; maximum limit of \$25,000 §7(8)3	No provision
Assessments	Formula to be set by Board but must be 50% - 150% of carrier's proportional share of all reinsuring carriers' small employer premiums; maximum amount shall be 5% of total premiums earned in previous year from small employer plans §11(2)b, 11(3)c	No provision
Other		
Effective Date	Guaranteed issue and continuity of coverage provision effective July 1, 1994; all other sections effective July 1, 1993	January 1, 1993

	NEW JERSEY
Availability	Continuous open enrollment (guaranteed issue) §3b
Group Size	2-49 §1
Individual Policies	Applies to all health benefit plans covering eligible employees of one or more small employers §2
Case Characteristics	Prohibits the use of age, sex, health status, residence or occupation with community rating. §1
Rating Restrictions	Rates may not exceed 4 times the base premium rate charged to the lowest-rated group. Plans must be community rated by 1/1/97. 1/1/94 to 12/31/95, premium rates charged to highest rated group shall not be greater than 300% of rate charged to lowest rated group. 1/1/96 to 12/31/96 greater than 200%. §9
Transitional Period	Policies whose term extends beyond 12/31/93. Policies contracted on or after 1/1/94. §9(h)(i)
Renewal Rating	Beginning 1/1/95 may make informational filing with commissioner of increase or decrease provided the loss ratio not be less than 75% of the premium. §9g
Renewability	Guaranteed renewable except "for cause" §7
Whole Groups	Must offer coverage to all employees and their dependents. Cannot exclude based on actual or expected health condition. §2
Continuity of Coverage	Generally no preexisting condition limitation. Preex may apply to a group of 2-5 if the period is 180 days forward and 6 months back, however, if 10 or more late enrollees request coverage pre-ex does not apply. Credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods. §6
Reinsurance Type	Prospective §12
Reinsurance Price	Whole Group: 150% Individual: 500% §20
Cost Sharing	Receive reimbursement in accordance with standards developed by board. §19a
Assessments	Apportioned among all reinsuring members in proportion to their respective shares of the premiums earned from small group plans. Additional assessments of all members not to exceed 1% of premiums. §21c
Other	No pre-ex permitted - see continuity of coverage. Some earners paying 2nd tier assessments will receive a credit. §21c
Effective Date	

	NEW YORK	NORTH CAROLINA
Availability	Continuous open enrollment (guaranteed issue) (1992 A 12350-A) §3231	Guaranteed issue §58-50-125(d)
Group Size	3-50 for open enrollment §3231	3-25 §58-50-110(22)
Individual Policies	Must be community rated and must be offered through open enrollment §3231	Does not apply to individual health policies §58-50-115
Case Characteristics	Prohibits the use of age, sex, health status, or occupations; geography is permitted on a county-wide (or larger) basis; Since not prohibited, presumably group size, participation, wellness, and other case characteristics are permitted §3231(a,b)	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §58-50-110(6)
Rating Restrictions	No statutory restrictions on permitted case characteristics, but Department has rate approval authority for initial rates §3231(c)(e)	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 25%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 35% §58-50-130(b)1,2
Transitional Period	The one-year delay in effective date is viewed as the transition period	3 years §58-50-130(b)7
Renewal Rating	Prior rating approval; beginning April 1, 1994, rates shall be deemed approved if policy has an anticipated loss ratio of not less than 75% §3231(a), 3231(2)a	Trend plus 15% plus changes in case characteristics §58-50-130(b)3(b)
Renewability	Coverage may not be terminated due to claims experience §3231	Guaranteed renewable except "for cause" §58-50-130a(3)
Whole Groups	Carriers must offer coverage to all employees and their dependents §3231	No provision
Continuity of Coverage	Plans must credit the time a person was covered under previous health insurance plan or benefit arrangement if the previous coverage was continuous to a date not more than 60 days prior to the effective date of new coverage §3232(a), 4518(a)	Preexisting condition limitation of 12 months; credit shall be given if a person was covered under qualifying previous coverage if previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §58-50-130
Reinsurance Type	Regulations shall include reinsurance or pooling process designed to share the risk of high claims costs; cost variations based on demographic factors and possible adverse selection §3233(c)	Prospective/with an opt-out §58-50-150
Reinsurance Price	No provision	Whole Group: 150% Individual: 500% §58-50-150(e)2(e)
Cost Sharing	No provision	\$5,000 plus 10% of the next \$50,000 §58-50-150(e)2(e)
Assessments	No provision	First 3 years: 50% - 150% of amount it would have been had assessments been based on proportional relationship of small carrier's total premiums; not to exceed 4% §58-50-150(i)
Other	1 and 2 live employers must be classified in either the individuals or small groups rating category by the insurer §3231(b)	
Effective Date	Community rating and open enrollment take effect April 1, 1993; continuity of coverage takes effect January 1, 1993 §21	January 1, 1992

OHIO	
Availability	Modified open enrollment. Carriers must open enroll 1/2 of 1% of total block of business.
Group Size	2-50 §3923.58
Individual Policies	Subject to law if any portion of the premium or benefits is paid by the employer, or any individual is reimbursed for any portion of the premium. §3924.02(A)
Case Characteristics	Geography, age, sex and industry classification. Does not include claims experience, health status or duration of coverage. §3924.01(E)
Rating Restrictions	Premium rates for small employer plans with similar case characteristics may not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate. §3024.04
Transitional Period	Rates that exceed rate band may not use experience.
Renewal Rating	Trend plus 15% changes in case characteristics. §3924.04(C)
Renewability	Guaranteed renewable except "for cause." 3924.03(C)
Whole Groups	Cannot exclude eligible employees or dependents on the basis of an actual or expected health condition. §3924.03(F)
Continuity of Coverage	Preexisting condition limitation of 12 months relating to conditions 6 months before coverage. Waiting periods shall not be more than 90 days. Plans shall credit the time a person was covered under a previous health plan for 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period. Late enrollees may be excluded up to 24 months. §3924.03 (A)(B)
Reinsurance Type	§3924.07
Reinsurance Price	Whole Group: 150% Individual: 500% §3924.12(A)
Cost Sharing	
Assessments	Apportioned among all members in proportion to their respective shares of the total premiums earned from small group plans. Assessment will not exceed 1%. §3924.13(B)
Other	
Effective Date	

	OREGON	RHODE ISLAND
Availability	Guaranteed issue (1991 SB 1076) §6(4)	Guaranteed issue (groups of 3-25) (1992 H 9011 Sub. A) §27-49-8(A)
Group Size	3-25 §3(25)	1-50 §27-49-4(AA)
Individual Policies	Applies to individual policies providing health benefits covering one or more employees of a small employer; provisions of OR 742.005 do not apply to individual policies subject to this law §5(1)(2)	Does not apply to individual health policies. §27-49-4
Case Characteristics	Geography and differences in family size and composition §7(6)b	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §27-49-3(F)
Rating Restrictions	Premium rates may not vary from the geographic average rate by more than 33% except that the premium rate may be adjusted to reflect the provision of additional benefits not covered by the basic health care plan and differences in family size and composition §7(6)b	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §27-49-6(1,2)
Transitional Period	Effective on the date the reinsurance pool becomes operational §7(10)a	3 years §27-49-6(7)
Renewal Rating	Trend plus 15% plus adjustments to reflect provision of benefits not required to be covered by basic health care plan §7(6)c(B)	Trend plus 15% plus changes in case characteristics §27-49-6(3)b
Renewability	Guaranteed renewable except "for cause" §7(4)	Guaranteed renewable except "for cause" §27-49-7
Whole Groups	Prohibits carriers from excluding individuals on the basis of actual or expected health condition §7(3)	Carriers are required to take the whole group §27-49-8c(5a)
Continuity of Coverage	Preexisting condition limitation of 6 months; credit shall be given if the person was covered under a previous group or individual plan if the previous coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §7(1)(2)	Plans must credit the time a person was covered by qualified previous coverage provided the coverage was continuous; qualified previous coverage is defined as Medicare, Medicaid, employer-based health insurance, or individual insurance providing similar or exceeding benefits. §27-49-8(c)
Reinsurance Type	Prospective/with an opt-out §10,11	Prospective/with an opt-out §27-49-11
Reinsurance Price	Existing business: none Whole Group: 150% Individual: 300% §11(8)a,b	Whole Group: 150% Individual: 500% §27-49-11(9)5(2)
Cost Sharing	\$5,000 plus 15% of the next \$100,000 §11(7)d	First \$5,000 of reimbursed claims §27-49-11(9)(4A)
Assessments	Maximum assessment is 4% of small employer premium plus 1% of members' total health insurance premiums §11(12)a	5% of total premiums earned in small employer market §27-49-11(L)(3e)
Other		Standard and economy health benefit plans are included within the law and are based on Rhode Island's low-cost limited mandated benefit law. Copayment, deductibles, and coinsurance are outlined. §27-49-12
Effective Date	On or after the date the Oregon Small Employer Reinsurance Pool becomes operational	July 21, 1992

	SOUTH CAROLINA
Availability	No provision
Group Size	1-25 §38-71-920(1)
Individual Policies	Does not apply to individual health policies subject to policy form and premium rate approval §38-71-930(A,B)
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §38-71-920(5)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §38-71-940
Transitional Period	5 years §38-71-940(A)4
Renewal Rating	Trend plus 15% plus changes in case characteristics §38-71-940(A)3(B)
Renewability	Guaranteed renewable except "for cause" §38-71-950
Whole Groups	Prohibits carriers from excluding any individual from the group; however, in groups of 10 or less, evidence of individual insurability may be required §38-71-730(3)
Continuity of Coverage	Preexisting condition limitations of 12 months; credit shall be given for time served under a prior plan if the coverage is selected when the person first becomes eligible and the coverage is continuous; service waiting periods are not considered to interrupt continuous service §38-71-730(4)
Reinsurance Type	No provision
Reinsurance Price	No provision
Cost Sharing	No provision
Assessments	No provision
Other	
Effective Date	January 1, 1992

	TENNESSEE	VERMONT
Availability	Guaranteed issue (1992 SB 2578) §8(E)	Guaranteed issue §4080a(4)d(1)
Group Size	3-25 §3(24)	1-49 §4080a(1)
Individual Policies	Does not apply to individual policies §6(a,b)	May not offer a health benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the act §4080a(4)h(3)m
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §3(6)	The following risk classification factors are prohibited: demographic rating, including age and gender, geographic area rating, industry rating, medical underwriting and screening, experience rating, tier rating, or durational rating; Commissioner may by rule permit carriers to use one or more risk classifications §4080a(h)1
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 25%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 35% §9(b)	Premiums may not deviate by more than +/- 20% of the community rate filed by the small employer carrier §4080a(h)2
Transitional Period	3 years §9(b)7	In force business will not be subject to the provisions of the Act until the later of the date of renewal, anniversary, or July 1, 1992 §5112(6)b
Renewal Rating	Trend plus 15% plus change in case characteristics 9(b)3(B)	No provision
Renewability	Guaranteed renewable except "for cause" §9(3)	Must guarantee rates for six months; must guarantee acceptance §4080a(k)
Whole Groups	No provision	Carrier must take entire group §4080a(s)4(d)
Continuity of Coverage	Preexisting condition limitation of 12 months; plans shall credit the time person was covered under a previous group health benefit plan if previous coverage was continuous 30 days prior to the new coverage §9(1,2)	Preexisting condition limitation of 12 months; limitation shall be waived if there is evidence of substantially equivalent continuous coverage during previous 9 months §4080a(c)
Reinsurance Type	Prospective/with an opt-out §13(e)	Prospective/mandatory for commercials; participants must guarantee solvency w/out limitation on a pro-rata basis §4080a(o)
Reinsurance Price	Whole Group: 150% Individual: 500% §13(g)2(e)	No provision
Cost Sharing	\$5,000 plus 10% of the next \$50,000 §13(g)2(c)	No provision
Assessments	Capped at 5% of small employer premiums; formula to be set by board but must be 50% to 150% of carrier's proportional share of all reinsuring carriers' small employer premiums §13(h)(2,4)	No provision
Other	Guaranteed issue requirement suspended if assessment cap is reached §13(h)4	Participation requirement = 75% of employees; most provisions do not apply to registered carriers who on 1/1/91 and thereafter have written or collected less than \$100,000 in annual gross premiums for group health benefit plans §4080a(1)h(3)l
Effective Date	July 1, 1992; January 1, 1993 for preexisting condition and guaranteed renewable provisions	July 1, 1992

	VIRGINIA	WISCONSIN
Availability	Guaranteed issue.* §38.2-3431(D) (*1993 HB 2353 amendments awaiting Governor's signature)	Guaranteed issue (1992 A 655) §635.26
Group Size	2-23 for primary small group, 2-50 for small group §38.2-3431(B)	2-25 §635.20(12)a
Individual Policies	Subject if any portion of the premiums or benefits is paid by the employer, if the employee is reimbursed or if the plan is treated as part of a program for the purpose of the US Internal Revenue Code. §38.2-3431(A)	Applies to individual policies §635.02(8)
Case Characteristics	Based on a community rate subject to demographic rating including age, gender and geography. May not use claim experience, health status or duration.*	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §6305.05(2)(3), 635.18(4)
Rating Restrictions	Premium rates charged by a small employer may deviate above or below the community rate by no more than 20% for claim experience, health status and duration only during a rating period for such groups within similar demographics for the same or similar coverage. Rating factors, including case characteristics will be applied consistently with respect to all primary small employers in similar demographics. Adjustments in rates for claims experience, health status and duration from issue may not be applied individually.*	Premium rates for small employer plans with similar case characteristics may not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate §635.05(1)
Transitional Period	No provision	3 years
Renewal Rating	No provision	Trend plus 15% plus changes in case characteristics §635.05(2)2
Renewability	Guaranteed renewable except "for cause" §38.2-3432(7)	Guaranteed renewable except "for cause" §635.07
Whole Groups	Prohibits carriers from excluding individuals because of health status §38.2-3432(1)(3)	Insurer must offer coverage to the entire group §635.25(2)
Continuity of Coverage	Preexisting condition limitation of 12 months; time shall be credited to a person covered under previous individual or group coverage in the small employer market of equal or greater value if coverage was continuous 30 days prior to new coverage, exclusive of applicable waiting periods. Late enrollees may be excluded for 18 months. §38.2-3432(1)(3)	Preexisting condition limitation of 12 months; credit shall be given to individuals who were previously covered by qualifying coverage if the coverage was continuous 30 days prior to the new coverage, exclusive of applicable waiting periods §635.17
Reinsurance Type	No provision	Reinsurance type and assessments shall be studied by the Health Insurance Board §635.23
Reinsurance Price	No provision	No provision
Cost Sharing	No provision	No provision
Assessments	No provision	No provision
Other		
Effective Date	April 1, 1994	Day after publication

WYOMING	
Availability	Guaranteed issue §26-19-306
Group Size	2-25 §26-19-302(xxi)
Individual Policies	Does not apply to individual policies which are subject to approval for policy form §26-19-303
Case Characteristics	Relevant demographics of small employer as considered by carrier in determination of premiums; claims experience, health status, and duration of coverage are not case characteristics §26-19-302(v)
Rating Restrictions	Index rate for one class of business shall not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25% §26-19-304
Transitional Period	3 years §26-19-304(a)viii
Renewal Rating	Trend plus 15% plus changes in case characteristics §26-19-304(a)iii(B)
Renewability	Guaranteed renewable except "for cause" §26-19-305
Whole Groups	Insurers are required to offer coverage to the entire group §26-19-306(c)vi
Continuity of Coverage	Preexisting condition limitation of 12 months; credit shall be given for time person was previously covered if previous coverage was continuous 30 days prior to new coverage, exclusive of applicable waiting periods, or for a person who become unemployed and are provided coverage if the person obtains employment and coverage within 60 days §26-19-306(c)i
Reinsurance Type	Prospective/mandatory §26-19-307
Reinsurance Price	Whole Group: 150% Individual: 500% §26-19-307(k)i,ii
Cost Sharing	\$5,000 §26-19-307(l)x,v
Assessments	Not to exceed 5% of the total small group premiums §26-19-307(n)A
Other	
Effective Date	No earlier than March 31, 1993

COMPREHENSIVE SMALL EMPLOYER PACKAGES

	HIAA	NAIC
Availability	Guaranteed issue	Guaranteed issue (groups of 3-25)
Group Size	3-25	1-25
Individual Policies	Individual policies sold to small employer subject to Act; however, if state has effective rate regulation, the rating requirements do not apply	Does apply to individual policies; although drafting note says that states may wish to consider exempting individual health policies from the rating provisions
Case Characteristics	Geography, age, sex, size of employer, and other objective criteria; but does not include claims experience, health status, or duration of coverage	Small employer carriers may not use case characteristics other than age, gender, industry, geographic area, family composition, and group size without prior approval of Commissioner
Rating Restrictions	Premium rates for small employer plans with similar case characteristics may not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate	Index rate for one class of business may not exceed the index rate for any other class of business by more than 20%; for a class of business, the premium rates charged small employers with similar case characteristics shall not vary from the index rate by more than 25%
Transitional Period	3 years	3 years
Renewal Rating	Trend plus 15% plus changes in case characteristics	Trend plus 15% plus changes in case characteristics
Renewability	Guaranteed renewable except "for cause"	Guaranteed renewable except "for cause"
Whole Groups	Carriers must take the entire group	Carriers must take the entire group
Continuity of Coverage	Plans must credit the time a person was covered under a previous employer-based plan if coverage was continuous.	Plans must credit the time a person was covered by qualified previous coverage provided the coverage was continuous; qualified previous coverage is defined as Medicare, Medicaid, employer-based health insurance, or individual insurance providing similar or exceeding benefits
Reinsurance Type	Prospective/mandatory	Individual states will determine whether to make participation in reinsurance mandatory or voluntary
Reinsurance Price	Whole Group: 150% Individual: 500%	Whole Group: 150% Individual: 500%
Cost Sharing	None	First \$5000 of reinsured claims plus 10% of next \$50,000
Assessments	4% of the premium of small employer market net of reinsurance premiums paid	5% of the premium of the small employer market
Other	Carriers may reinsure existing business and new adds	
Effective Date		



MarketPlace Report

A MONTHLY ACTIVITY SUMMARY

The Connecticut Small Employer Health Reinsurance Pool (CSEHRP) is a reinsurance pool created by the Connecticut legislative Public Act 90-114 in which employers may place high cost individuals and groups. This makes possible and encourages the insuring of groups (of one to twenty-five full-time eligible employees) which otherwise would be underwritten.

September 1992

Activity in the MarketPlace and in the Pool

Sales Activity

4,687 PLANS SOLD TO UNINSURED SMALL BUSINESSES

- Includes 4,323 other plans sold by carriers during the same period.
- In addition, 85 Special Plans and 279 Small Employer Plans have been sold to the previously uninsured.

1,324 SMALL EMPLOYER AND SPECIAL PLANS SOLD

The activity for the Small Employer and the Special Plans sold include sales to previously insured businesses as well as sales to businesses who have had insurance. Renewed plans will be included in later reports as in-force business.

Based on responses by all of the 47 Connecticut Small Employer Carriers and the Health Reinsurance Association of Connecticut (HRA), continued growth in sales is reported for the first sixteen months:

- 1,236 Small Employer Plans: The basic plan for businesses of 1 to 25 employees.
- 88 Special Plans (non-HRA): The plan for businesses that have not been insured for at least two years.
- 300 Special Plans (HRA): The plan with a special version for individuals or groups who meet the eligibility and income requirements of the new law

Reinsurance Activity

3,328 PLANS REINSURED WITH THE POOL

As of the September ceding by 22 Small Employer Carriers, the type of plan that is coded the most is the Small Employer Plan.

Whole Group reinsurance still exceeds Individual reinsurance.

- 1,606 plans reinsured as Whole Groups.
- 1,722 plans with Individual Reinsurance.

923 NEWLY SOLD PLANS REINSURED WITH THE POOL

New business that was reinsured with the Pool was 20% of the total plans sold to previously uninsured (923/4,687).

2,405 PREVIOUSLY INSURED PLANS REINSURED WITH THE POOL

Ceding from the existing book of business commenced January 1, 1992.

9,368 PERSONS REINSURED

The average size of Whole Groups ceded to the Pool is 4.6 persons, including dependents. The average group size has been in the 2-5 person range since the inception of the Pool.

- 7,365 persons reinsured as Whole Groups from 1,606 plans with Whole Group reinsurance = 4.6 average group size.
- Reinsured lives from newly sold plans total 2,514.
- Reinsured lives from previously insured plans total 6,854.

- Reinsurance pool provisions create a nonprofit prospective reinsurance pool to protect carriers from insuring a disproportionate share of high risk individuals or groups.

In addition to amendments to the rating limits mentioned above, additional amendments since enactment include:

- Requirements for replacement of another carrier's coverage when that carrier leaves the small group market.
- Reenrollment criteria for coverage that was not renewed for cause--such as fraud or misrepresentation.
- Variations in premium rates among employees of a particular employer may not be based upon health status, claims experience or duration of coverage. That is, an employer could not make it's high risk employees pay more for coverage.
- Preexisting condition limit credits have been liberalized to allow credit for individuals covered under plans other than as Connecticut residents.
- Changes to general and administrative requirements such as actuarial certification, fair marketing practices, documentation of rating and underwriting practices, and provisions for suspending rating restrictions.

THE EFFECT OF REFORMS

Private insurance reforms have been implemented, on schedule, without any real surprises and with some lessons for the future.

Since May of 1991, CSEHRP has been reinsuring high risk employers and participating carriers have been selling health plans to small employers.

Forty-seven carriers in CT are participating members in the reinsurance pool--although only 22 have actually reinsured any groups or individuals.

Another lesson learned was that groups that were outside of the rating bands before reforms need special regulations or procedures for bringing their rates into the rating bands.

Some of the lessons we have learned are reflected in the amendments above. In addition we have learned that different provisions of the law are sometimes in conflict, especially during initial implementation. For example, a group with a current rate that is half of the lowest rate after reforms would receive a 100 percent rate increase to conform to the new rating limits. Obviously, this

affordability was only addressed by increasing the stability of rates from year to year and imposing rate limits for higher risk groups. It was recognized that additional changes to the law might be needed. Additional health care initiatives, beyond the insurance reforms in PA-134, were expected to be necessary to make health care, and thus health insurance, more affordable.

To implement the private insurance reform section of 90-134, the insurance industry completed all of the product development and market changes required by the Act on schedule and has amended the law as needed in subsequent years. The state government, however, has never fully fund its part of the program and, since enactment of PA 90-134, has passed up clear opportunities to do so. Thus, today, more than two years after passage into law, the effect of this experiment is difficult to judge because the Act has never been fully funded or fully implemented.

KEY PROVISIONS OF INSURANCE REFORM SECTION OF PA 90-134

- **Guaranteed issue** of small employer and special health care plans to small employers (1-25 eligible employees) without regard to health status. (However, there is no mandate that employers provide coverage.)
- **Guaranteed eligibility** ensures that eligible employees and their families cannot be refused coverage under an employer's plan.
- **Rating limits** restrict the maximum rates for small employers and limit periodic rate increases.

The maximum rate for small employers is restricted to 150 percent of the lowest rate for any other employer group in the same actuarial class. Originally the maximum was 200 percent, but it was revised after enactment.

Periodic rate increases are limited to the sum of the increase in the base premium rate, plus any adjustment as a result of changes in case characteristics, plus 15 percent of the base premium rate (originally 20 percent).

- **Guaranteed renewability** requires carriers to renew coverage at the policyholder's option.
- **Restrictions on preexisting condition limits** prohibit carriers from applying more than a 12-month preexisting condition limit and requires plans to credit the time a person was continuously covered under a previous group plan toward any preexisting condition limitation. Coverage is considered continuous if there has been less than a 30-day lapse in coverage.

- Reinsurance pool provisions create a nonprofit prospective reinsurance pool to protect carriers from insuring a disproportionate share of high risk individuals or groups.

In addition to amendments to the rating limits mentioned above, additional amendments since enactment include:

- Requirements for replacement of another carrier's coverage when that carrier leaves the small group market.
- Reenrollment criteria for coverage that was not renewed for cause--such as fraud or misrepresentation.
- Variations in premium rates among employees of a particular employer may not be based upon health status, claims experience or duration of coverage. That is, an employer could not make it's high risk employees pay more for coverage.
- Preexisting condition limit credits have been liberalized to allow credit for individuals covered under plans other than as Connecticut residents.
- Changes to general and administrative requirements such as actuarial certification, fair marketing practices, documentation of rating and underwriting practices, and provisions for suspending rating restrictions.

THE EFFECT OF REFORMS

Private insurance reforms have been implemented, on schedule, without any real surprises and with some lessons for the future.

Since May of 1991, CSEHRP has been reinsuring high risk employers and participating carriers have been selling health plans to small employers.

Forty-seven carriers in CT are participating members in the reinsurance pool--although only 22 have actually reinsured any groups or individuals.

Another lesson learned was that groups that were outside of the rating bands before reforms need special regulations or procedures for bringing their rates into the rating bands.

Some of the lessons we have learned are reflected in the amendments above. In addition we have learned that different provisions of the law are sometimes in conflict, especially during initial implementation. For example, a group with a current rate that is half of the lowest rate after reforms would receive a 100 percent rate increase to conform to the new rating limits. Obviously, this

creates a conflict between the maximum annual rate increase allowed and the rating bands. A decision has to be made as to which provision takes precedence.

Lastly, we have learned that most of the 30,000 uninsured small employers in CT have 10 or fewer employees. Traditional marketing approaches by carriers and agents had to be reconsidered in order to target these smaller groups. Mass marketing techniques such as direct response mailings are being utilized instead.

Since its inception, PA 90-134 has provided coverage to between 19,000 to 25,000 previously uninsured Connecticut employees and their families.

As of the end of September 1992, carriers had sold 4,687 plans to previously uninsured employers. On average, this would imply that about 19-25 thousand uninsured have been provided coverage. However, this figure has not yet been adjusted for withdrawals, so the actual number of newly insureds is probably a little less.

As of the same date, CSEIRP had reinsured 3328 plans (9368 insureds): 1606 plans (7365 insureds) with whole group coverage, 1722 plans (2003 insureds) with individual coverage.

Public program reforms (including Medicaid expansion and subsidies) have been only marginally funded, seriously jeopardizing the ability of this legislation to provide health care to more than a handful of the 60,000 uninsureds it was intended to help.

Private insurance reforms alone have already helped many uninsureds to get health insurance and will continue to do more to expand coverage to the uninsured. However, without fully funding the public program reforms, Connecticut can only hope to make a dent in its uninsured problem.

Rating reforms and guaranteed issue have not generated large increases in the average rates that many opponents feared.

Critics who cite theoretical studies with doomsday estimates of premiums rising up to 40 percent on average should study some real results in CT. Rating reforms have caused the rates for some employers to go up and others to go down. In total, the costs for these reforms range from HIAA's estimate of less than 4 percent, on average, to some other estimates of as much as 10 percent, on average. However, it must be remembered that these estimates are averages and specific employers and insurers will see their rates increase or decrease based upon their specific mix of employees and business.

05/25/92 10:40 211 HEALTH INS ASSN 2/0017/007

For fiscal year 1992, the CT Reinsurance Pool has an accrued assessment of just over 1 percent of small employer carrier premiums.

For fiscal year 1992, the first full year of operation, the accrued reinsurance assessment amounts to \$6.6 million. This assessment will be spread over a small employer premium base of \$513-530 million. Thus, the 1992 assessment would be about 1.3 percent of premium.

SUMMARY

The state must find a way to fund the public programs in PA 90-134 to help the poor and near-poor who are uninsured.

Affordability of health care and health insurance is still an issue for the majority of patients and insureds in Connecticut. This problem still needs addressed.

Connecticut's market reforms and reinsurance pool are working as expected, fixing those areas in the private insurance market that needed to be fixed.

While PA 90-134 will never live up to its full potential as long as the public program reforms are not funded, the results so far have proved it to be an innovative, workable solution to the access problem, to the extent that it has been implemented.

**ULLICO Inc.**

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Vice President and Chief Legal Officer
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August 4, 1992

VIA FACSIMILE AND OVERNIGHT DELIVERY BY UNITED PARCEL SERVICE

The Honorable James E. Long
Commissioner
Chairman of the NAIC Health Care
Insurance Access Working Group
North Carolina Department of Insurance
430 North Salisbury Street
Dobbs Building
Raleigh, North Carolina 27611

RE: The Union Labor Life Insurance Company

The National Association of Insurance Commissioners (NAIC) Small Employer
Health Insurance Availability Model Act (Prospective Reinsurance and Allocation
With or Without an Opt-Out)(the "Model Acts")

Dear Commissioner Long:

At the NAIC Summer National meeting in Washington, D.C., the Health Care Insurance Access Working Group (the "Working Group") requested that The Union Labor Life Insurance Company ("Union Labor Life") provide additional information regarding Taft-Hartley Trusts.

The language suggested in our February 7th and March 5th letters is intended to clarify that Taft-Hartley Trusts are not within the purview of the Model Acts, and not to carve-out a contrived exception; the nature of Taft-Hartley Trusts do not present the problems which reforms like the Model Acts seek to redress. This language prevents Taft-Hartley Trusts from engaging in 50 State-by-State battles with State insurance regulators on the issue of whether Taft-Hartley Trusts are governed by small group access reform legislation.

To explain the unique nature of Taft-Hartley Trusts and the reason why a clarification is warranted in the Model Acts, we believe that addressing the areas of history, collective bargaining, and how an insurance policy is written for a Taft-Hartley Trust may assist your Working Group in its deliberations.

I. History

It is useful to examine the reason for the 1947 Labor Management Relations Act (popular name, Taft-Hartley Act), 29 U.S.C. § 141 *et seq.*

BACKGROUND ON THE TAFT-HARTLEY
TRUSTS

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Prior to World War II, a federal law called the Wagner Act, which is frequently characterized as "pro-union" legislation, provided unions with sweeping rights and powers. The Taft-Hartley Act of 1947 was an amendment to the Wagner Act; the Taft-Hartley Act is considered one of the major pieces of federal legislation in U.S. history. The Taft-Hartley Act restored to management in unionized industries some of the bargaining power management had lost in the Wagner Act. The Taft-Hartley Act attempted to balance the rights of unions and management in issues such as free speech, unfair labor practices, secondary boycotts, and sympathy strikes, to name just a few issues.

The Taft-Hartley Act grants to employees the right not only to organize and to bargain collectively but also the right to refrain from such activities. Collective bargaining, as a fundamental right of union employees, empowers the worker - via the worker's bargaining representative - to bargain for wages, hours, benefits, and working conditions. Among the benefits for which union workers bargain are health and welfare plans.

II. Bargaining under the Taft-Hartley Act for a Health and Welfare Plan

When a union sits down with management at the bargaining table, access to health care is a standard element to be bargained along with wages and hours in a workday.

Once union and management reach consensus on a health and welfare plan, one of two events occur: the employer either agrees to provide a health and welfare plan, or, the employer agrees to a contribution to a trust account which then establishes a health and welfare plan. In this second event, the employer and the union have taken the initial step to form a Taft-Hartley Trust. Thus, the early stages of the Taft-Hartley Trust are the agreement for funding of the trust, and, the formation of the trust to administer and manage the plan.

A trust for a health and welfare plan may be funded in one of two ways: (1) the employer contributes a certain amount of money per hour worked by each employee to the plan trust, or, (2) the employer makes a form of lump-sum contribution on a periodic basis to the plan trust.

The trust which is formed is the vehicle into which the monies for the health and welfare plan are deposited and through which the management and administration of the plan occurs. The Taft-Hartley Act mandates that the trust be governed by Trustees; the plan must have equal numbers of Trustees appointed by management and labor. The Trustees act as fiduciaries to the plan beneficiaries; the beneficiaries are the collectively bargained workers receiving the health and welfare benefits provided by the plan.

A trust may provide benefits to collectively bargained workers of one employer, or, the trust may provide benefits to the collectively bargained workers of more than one employer. Taft-Hartley Trusts operate with economic efficiency because the collective bargaining and purchasing power of more than one employer may be used to obtain benefits for workers without sacrificing the level of benefits.

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III. Writing an Insurance Policy for a Taft-Hartley Trust formed to provide a Health and Welfare Plan

The following elements are present when a health insurance policy is written to a Taft-Hartley Trust:

- a. The policy is written to the Trust; the Trust is the policyholder not the employers who fund the trust. Therefore, the Trust is the purchaser or provider of any coverage.
- b. The Trustees are the fiduciaries to the health and welfare plan and to the beneficiaries of the health and welfare plan.
- c. Once in a Trust, the member employer(s) of the Trust "lose" their identity, not only pursuant to the Taft-Hartley Act but also pursuant to the federal Internal Revenue Code. Under the federal Internal Revenue Code, 26 U.S.C. § 419, *et seq.*, contributions of the Trust are tax-qualified as deductible to the employer.
- d. An insurance policy is written based upon the number of lives in the Trust. An insurer will not consider the number of lives of each individual member employer of the Trust; the only significant number is the number of lives in the Trust.
- e. Insureds who are beneficiaries of the Trust (i.e., the collectively bargained employees) have their own agent (i.e., the Trustees representing the collectively bargained employees) representing their interest in the Trust which provides their health insurance; indeed, what better representation can a consumer of health insurance receive than through a representative who sits in on the day-to-day operation of the Trust and who has a fiduciary duty to such consumer?

As illustrated above, a health and welfare benefit plan established pursuant to a collective bargaining agreement and funded through a Taft-Hartley Trust is a unique method of providing a plan of benefits to any size group of bargaining group members.

The Taft-Hartley Trust is unique because it is a creation of the labor laws of the United States. The Taft-Hartley Trust is not a creation of insurance law.

IV. A Taft-Hartley Trust is not a MEWA

Throughout this discussion, it is important to note that a Taft-Hartley Trust is not a MEWA.

a. The Basic Distinction Between a MEWA and a Taft-Hartley Trust

A MEWA, or Multiple Employer Welfare Arrangement, is defined in section 3 of the federal Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, a MEWA is defined as an "employee welfare benefit plan, . . . which is established or maintained for the purpose of offering or providing any benefit . . . except that such term does not include any such plan or other arrangement which is established or maintained - (i) under or pursuant to one or more agreements which the Secretary (of Labor) finds to be collective bargaining agreements . . ." 29 U.S.C. § 1002(40)(A)(Supp. 1992)(emphasis added).

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Because Taft-Hartley Trusts, by definition, can only be formed pursuant to a collective bargaining agreement. Taft-Hartley Trusts are not vulnerable to the maladies which your Working Group has been addressing in your deliberations.

To the extent that ERISA applies to any benefit plan, ERISA also applies to Taft-Hartley Trusts. Taft-Hartley Trusts also are federally regulated by the Labor Management Relations Act, federal Unfair Labor Practice regulations, the U.S. Department of Labor, and - for tax treatment of the Taft-Hartley Trust monies - the federal Internal Revenue Service.

b. An Employer in a Taft-Hartley Trust Cannot Abandon its Obligation to the Insureds

Contributions to a Taft-Hartley Trust for a health and welfare plan exceed the amount of medical premiums; the excess monies are used to fund reserves. These reserves act as a financial safety-net for the Trust in the event of unexpected rate increases and downturns in the amount of monies paid into the Trust corpus. There is an approach known as a "maintenance of benefits" provision which can be negotiated and which commits the employer to supporting a specified level of benefits.

In the event an employer decides to withdraw from the Trust, the employer is faced with liabilities: it is assessed an amount to cover its pro-rata responsibility for its liability to the Trust (sometimes called a "back liability"), and, it forfeits its pro-rata share of monies it had contributed to the Trust reserves which had not been expended (of course, these monies can be withdrawn only if there are extra monies available in the reserve to withdraw, and only if the Trustees agree to withdrawal of these monies).¹

Because an employer is contractually bound to the Trust, the employer cannot simply walk away from its duties and responsibilities to the Trust and to the insureds covered by the Trust. It is because of the employer's contractual obligations that it must provide the monies necessary to purchase health insurance for the employees covered by the Trust - whether or not the employer remains in the Trust.

This establishment of a reserve is unique to a Taft-Hartley Trust. MEWAs do not establish reserves. The employer's tax-qualified contributions to the Trust provide an incentive for employers to stay in the Trust. However, even when an employer leaves the Trust, the insureds in the Trust do not lose their health insurance coverage.

¹The federal Internal Revenue Code governs the tax treatment of these monies; the monies cannot revert back to the employer, they must be used to purchase employee benefits. For example, they are sometimes used to purchase paid-up life insurance for the employees who are the beneficiaries of the Trust.

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V. A Taft-Hartley Trust is a True Group

To the best of our knowledge, all States have traditionally treated Taft-Hartley groups as "true groups" - and not as small groups - under their existing group insurance laws.

As a sample, the insurance laws of every member of the NAIC Health Care Insurance Access Working Group treat Taft-Hartley Trusts as "true groups". See Arizona Insurance Laws § 20-1401(2); California Insurance Laws § 10270.5(a)(3); Colorado Insurance Laws § 10-8-116(b); Delaware Insurance Laws § 3504; Florida Insurance Laws § 627.654; Indiana Insurance Laws § 27-8-5-16(3); Iowa Insurance Laws § 509.1(4)(a); Nebraska Insurance Laws § 44-760(2); North Carolina Insurance Laws § 58-51-80(b)(1); North Dakota Insurance Laws § 26.1-36-05; Virginia Insurance Laws § 38.2-3524; Washington Insurance Laws § 48.21.010; and Wisconsin Insurance Laws § 632.897(c).

VI. Taft-Hartley Trusts vary in size

Though usually most Taft-Hartley Trusts consist of, at a minimum, 100 or more lives, the Trust size can be as small as 20 lives.

It is not necessary under access reform legislation to impose any numerical quantification of employees in a Taft-Hartley Trust. Indeed, to state that, in order to be a Taft-Hartley Trust, the Trust must have at least "x" number of lives, emasculates the purpose for the Taft-Hartley Trust clarification language and ignores the history of the Taft-Hartley Act. The focus of small group reform legislation is access. Access is not an issue with Taft-Hartley Trusts; collectively bargained employees are in a unique situation in that their bargaining unit representative sits at a bargaining table with management representatives and collectively bargain the wages, hours, working conditions, and the provision of benefits. Additionally, collectively bargained employees continue to have their interests represented in their health and welfare plan because their Trustees join with the management Trustees in the management and administration of the plan.

To help understand why a numerical quantification of the number of employees in a Taft-Hartley Trust is not necessary, it is a useful illustration to understand the sizes of Taft-Hartley Trusts presently written by Union Labor Life which are under 100 lives: 59 lives, 85 lives, 21 lives, 67 lives, 66 lives, 93 lives, and 19 lives. All of these Trusts are bona-fide Taft-Hartley Trusts (formed pursuant to collective bargaining agreements; governed jointly by labor trustees and management trustees; eligible for favorable tax treatment under the federal Internal Revenue Code). For example, the Taft-Hartley Trust listed above with 19 lives is a small construction company in California. Particularly with the stagnant state of our national economy, Union Labor Life is witnessing the shrinking size of some Taft-Hartley Trusts. However, just because a Taft-Hartley Trust decreases in size does not mean that the Trust loses its status as a Taft-Hartley Trust.

Regardless of the number of lives in a Taft-Hartley Trust, the Trust is still managed by an equal number of labor and management Trustees, and it is still regulated by the laws and regulations mentioned previously in this letter.

The focus of a Taft-Hartley Trust is substance over number, i.e., what is important is the number of lives in the Trust, not the number of employers nor the number of employees of each employer member of the Trust.

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VII. Applicability to Model Acts

The Model Acts, therefore, require additional language clarifying that Taft-Hartley Trusts are not within their scope.

Union Labor Life would like the NAIC to consider additional language for the definition of "small employer" clarifying that Taft-Hartley Trusts are not within the purview of the Model Acts. Specifically, we would like to expand the exclusion for employers who file consolidated returns to include Taft-Hartley groups (the gray-lined language is our suggested language):

"Small employer" means any . . . corporation . . . that . . . employed no more than twenty-five (25) eligible employees, the majority of whom were employed in this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, ~~including collectively bargained Taft-Hartley groups~~ shall be considered one employer.

Also, it is preferable to define the clarification in terms of coverage, rather than carriers. Therefore, a straight-forward way to insert the clarification language in the Model Acts is in the definition of "health benefit plan" (the gray-lined language is our suggested language):

"Health benefit plan" . . . does not include . . . automobile medical payment insurance ~~or benefits provided under a Taft-Hartley Trust~~.

This change in the definition of "health benefit plan" will also require the addition of a definition of a Taft-Hartley Trust in Section 3 of the Model Acts:

"Taft-Hartley Trust" means a jointly-managed trust, as allowed by 29 U.S.C. § 141 *et seq.*, containing a plan of benefits for employees which is negotiated in a collective bargaining agreement governing the wages, hours, and working conditions of the employees, as allowed by 29 U.S.C. § 157.

These two changes above will provide the language required to effectuate the clarification. The language will also provide an assurance that the clarification does not address MEWAs or other arrangements (such as unions which are not registered with the U.S. Department of Labor and/or "shell" unions which are not operated pursuant to the federal Labor Management Relations Act and the federal Taft-Hartley Act).

Finally, the Working Group may also want to exclude from the definition in of "eligible employee" in the Model Acts an employee who is covered under the terms of a Taft-Hartley Trust. With definitions of a Taft-Hartley Trust and Health Benefit Plan clarified, simple exclusionary language in "eligible employee" will provide that employees covered under a Taft-Hartley Trust are not an "eligible employee" for purposes of the Model Acts (the gray-lined language is our suggested language):

"Eligible employee" . . . does not include an employee who works on a part-time, temporary or substitute basis ~~or does not include~~

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August 4, 1992
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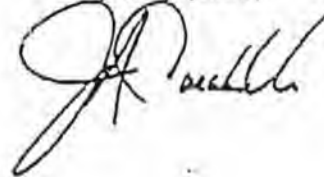
~~employees whose plans of benefits are provided in connection with a Taft-Hartley Trust.~~

VIII. Conclusion

The Taft-Hartley Trust issue is very important to us; the Taft-Hartley market is the market niche in which we operate. Union Labor Life appreciates the opportunity to explain our position on the Taft-Hartley Trust clarification issue to the Working Group and appreciates the continued dialogue with the Working Group.

Union Labor Life is looking forward to discussing the Taft-Hartley Trust clarification issue with the Working Group at the NAIC interim meeting in San Francisco on August 13th. In the interim should you have any questions please feel free to contact Victoria Fimea at (202) 682-6687.

Very truly yours,



JACVEF:dlc

LOS40AP, CAP
PRC-82-046



Health Insurance Association of America

March 27, 1992

TO: Gordon Evans

FROM: Jan Andrea Meisels

SUBJECT: RATING EXAMPLES USING NAIC AND HIAA RATING BANDS

The following examples may assist you in explaining the differences between the NAIC and HIAA rating bands in the small group market legislation.

NAIC restricts rating differences between classes of business to 20%; and differences between groups within the same class to 25% (difference for health status, claims history, etc.).

For ease of arithmetic lets say the lowest premium in a class is \$100/employee/month. Therefore the maximum premium difference between classes is 20% or \$120.

Within a class of business the rates may vary by 25% -- therefore, for the class with the \$100/ee/mo premium it may vary between \$75 - \$125; for the \$120 class it may vary between \$92.75 - \$156.25.

Example: 5 life group \$100/ee/mo premium (For the \$120 class substitute in equation for that calculation i.e. 5 x \$156.25 = \$781.25, etc.).

5 persons x \$125 (maximum can charge in the \$100 class) =
\$625.00

due to high risk in group, carrier wants to reinsure the group; carrier must pay 1.5 x average premium, for sake of example, use \$100/ee/mo as average premium

5 persons x \$100/ee x 1.5 = \$750.00

cost of reinsurance to carrier	\$750.00/mo
premium collected from employer	625.00

- \$125.00/mo deficit

Group has one high risk so decision is to reinsure one person in group:

NAIC requires 5 x average premium to reinsure individual

1 x 100 x 5.0 = \$500.00 cost of reinsurance to carrier

premium collected from employer \$625.00

cost of reinsurance - 500.00

+ 125.00

The +\$125 is to pay any claims for the other 4 persons in the group. If in this case they reinsured the entire group, and if there is more than one person in group which is high risk, it would be better for them to do so, as they are in a deficit mode. Therefore, they have a decision to make as to whether or not it is economically better for them to reinsure. The decision will rest on the expectation of what the payout is of the members of the group: For example:

Persons in group	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
claims exper.	\$700	\$100	\$100	\$0	\$0
		total payout is \$900			

remember the premium collected is \$125 x 5 or \$625. Under the current situation a carrier could exclude "A", and the premium would be \$400.00 while the payout would only be \$200. Under the proposed market reforms (SB242) the carrier may not exclude "A", and is required to take the whole group.

The carrier would probably reinsure person "A" not the whole group in this scenario.

In order for the carrier to make up losses for the reinsurance payout, they would charge "healthier" groups some what more but the increased rate would have to fall with the rate bands permitted in statute (+/- 25%).

HIAA model

In the HIAA model the rating band is +/- 35%, with no class of business differential. For the sake of the example I am using the premium/ee/month as \$110 which half way between the premium price of the two classes I used in the NAIC example (\$100 and \$120). Therefore the rates may vary from \$71.50 - \$ 148.50 based on an average premium of \$110.

Example:

5 life group \$110/ee/mo premium

5 persons x \$148.50 (maximum can charge -- 35 percent over the \$110) = \$742.50

due to a high risk person in the group the carrier wants to reinsure the group; the carrier must pay the reinsurance pool 1.5 x the average premium.

5 persons x \$110/ee x 1.5 = \$825.00

cost of reinsurance to carrier \$825.00/mo
premium collected from employer 742.50/mo

\$ 82.50/mo deficit

Group has one high risk person so the decision is to reinsure one person in group:

HIAA also requires 5 x average premium to reinsure individual

1 x \$110 x 5.0 = \$550.00 cost to reinsure to carrier

premium collected from employer (5x \$148.50 = \$742.50)

Premium collected \$742.50
cost of reinsurance - 550.00

\$187.50

The +\$ 187.50 is to pay any claims for the other 4 persons in the group. If in this case they reinsured the entire group, and if there is more than one person in the group which is high risk, it would be better for them to do so, as they are in a deficit mode. Therefore, the carrier has a decision to make as to whether it is economically better for them to reinsure or not. The decision will rest on the expectation of what the payout is of the members of the group:

Persons in group	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>
claims exp.	\$700	\$100	\$100	\$0	\$0

Total payout is \$900

The amount of premium collected was \$742.50 (5 x \$148.50). Under the current situation a carrier could exclude "A" and the premium would be \$440 and the payout would only be \$200. Under the proposed market reforms (SB242) the carrier may not exclude "A" due to the requirement to take the whole group.

The carrier would probably reinsure person "A" and not the whole group in this scenario. In order for the carrier to make up the losses for reinsurance payout, they would charge "healthier" groups some more but the carrier is limited in what the increase would be by the legislation's premium pricing limitations (+/- 35%) and the renewal limitations of best price to new business (proxy for health care cost increases) plus a maximum of 15%

Please feel free to share this memo as appropriate.

NFIB Alaska

National Federation of
Independent Business

POSITION PAPER

OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS
NFIB/ALASKA

TO

SENATE LABOR AND COMMERCE COMMITTEE

IN
SUPPORT
OF

SB 40 - HEALTH INSURANCE FOR SMALL EMPLOYERS

9159 Skywood Lane
Juneau, AK 99801



The Guardian of
Small Business

NFIB POSITION PAPER

Chairman, members of the Committee, my name is Resa Jerrel, and I am the State Director for the National Federation of Independent Business - NFIB/Alaska. I am happy to be here today in support of SB 40.

BACKGROUND

NFIB/Alaska is comprised of 5,000 small and independent business owners. The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our members on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues.

For the record the following are the results of the 1991 NFIB/Alaska ballot questions regarding health insurance:

Should legislation be passed in order to create a voluntary health insurance plan which would be administered by private insurance companies and which would pool small businesses together so they could purchase employee health insurance at group rates?

Yes 72% No 17% Undecided 11%

If this pooling of employers in order to purchase health insurance was available, would you participate?

Yes 50% No 19% Undecided 31%

Should employers be allowed the option of having their employees pay part of the premium cost of health insurance purchased through the above pooling plan?

Yes 90% No 5% Undecided 5%

The NFIB Foundation Survey nationwide first found health insurance listed as a key concern for small business in 1986 when it was cited as the number one problem for small business owners out of 75 potential problems. Again in 1990, 92% of small business owners characterized health insurance as a "serious problem". The NFIB Foundation recently released Survey, Problems and Priorities, it listed the cost of health insurance as still the number one problem. No other difficulty was close. Sixty-one (61) percent ranked the problem "critical," the most extreme assessment it could be given.

On 1992 ballot we asked our members in Alaska to choose from eleven (11) problem areas - the most costly or burdensome problem

they faced - the top two were: #1 workers compensation cost and, #2 health insurance for employees.

Further surveys have found that small business owners want to offer health insurance as a fringe benefit out of both a sense of family obligation and competitive necessity.

The ability of the small business owner to provide insurance is greatly influenced by the high costs of premiums and profitability of the business. For many small business the skyrocketing annual premium increases, small profit margins, struggling regional economies, and restricted cash flow all contribute to the increasing difficulty small business owners have in purchasing health insurance. If the cost of purchasing or continuing to provide health insurance continues increasing, small business owners will be forced to increase employee contributions, cut benefits, raise deductibles or in some cases drop coverage altogether.

Small business are most severely impacted by adverse selection, the demographics of the work force of small business (such as, age and gender of employees and the hours they work), higher employee turnover resulting in unpredictable participation rates, and a lack of expertise and clout in purchasing plans. By virtue of their size, small businesses have very little access to cost containment mechanisms available to large firms such as self-insurance. Being unable to obtain the benefits of self-insurance they must comply with expensive state mandates, pay state premium taxes and shoulder a larger portion of the carrier's administrative expenses.

SMALL BUSINESS MARKET REFORM

Small business owners desire to build on the existing health care system. SB 40 is a voluntary health insurance program to provide more accessibility, renewability, predictability and stability for small businesses. It is a viable means of providing health insurance to the uninsured population in Alaska.

State mandates cumulatively can raise the cost of health insurance for small businesses. SB 40 has a provision that state mandates do not apply to health benefit plans provided to small employers. This will allow the insurance industry to design and market affordable health insurance policies. A lower cost plan would have great appeal to firms that currently do not offer health insurance coverage. Small businesses are willing to provide health insurance to employees, as long as the cost is not prohibitive.

It also, requires the small employer insurers to disclose information relating to premium rates and health benefit plans. It requires insurers to describe in detail their rating practices and renewal underwriting practices. Providing this information will help small business owners to be better informed. The Congressional Budget Office believes that "giving consumers the information they need to make more informed decisions might enhance both the quality and cost-effectiveness of care."

Thank you for the opportunity to comment on this legislation. NFIB/Alaska has and will continue to support this and other legislation that will help make privately administered health insurance more available and affordable for small businesses.

Alaska State Legislature

3111 C Street, Suite 150
Anchorage, Alaska 99503
(907) 561-2038



During Session:
P.O. Box V
Juneau, Alaska 99811
(907) 465-4993

Senator Drue Pearce
District G

Senate Bill 40

Small Employer Health Insurance Reform

SB-40 promotes the availability of health insurance coverage for small employers and reforms the small employer health insurance market. Without requiring additional state expenditures, it provides:

- * Guaranteed Availability - All small employer groups would be able to obtain private health insurance regardless of the health risk they represent (see Sec. 21.56.140(a)).
- * Coverage of Whole Groups - Coverage must be available to entire groups. Neither an employer nor an insurer could exclude individuals having high medical risks from the group's coverage (see Sec. 21.56.150(6)).
- * Renewability of Coverage - Once a person is covered and has satisfied a plan's preexisting condition requirements, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers (see Sec. 21.56.150(2)).
- * Premium Pricing Limits - The bill limits how much insurance companies could vary their rates for groups similar in geography, demography, and plan design. It also limits increases in rates (see Sec. 21.56.120).

Based on model legislation drafted by the National Association of Insurance Commissioners, SB-40 would improve the overall fairness and efficiency of the small employers health insurance market. It enjoys support from the National Federation of Independent Business, the Alaska State Chamber of Commerce, the Alaska State Hospital and Nursing Home Association, and other organizations.

SPONSOR STATEMENT

FISCAL NOTE

102

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SB 40

Revision Date: _____

Department Affected: Commerce and Economic Development

Title: Health Insurance for Small Employers

BRU: Insurance

Sponsor: Senators Pearce and Salo

Component: Operations

Requestor: _____

COMPONENT SERIAL NO. 354

EXPENDITURES/REVENUES:

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
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REVENUE FUND SOURCE:	0	0	0	0	0	0
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FUNDING:

1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY 93) impact: 0

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact.

Prepared by: Joan Brown, Administrative Officer

Phone: 465-2597

Division: Insurance

Date: March 1, 1993

Approved by Commissioner: Paul Fuhs

Agency: Commerce and Economic Development

Date: 3-1-93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE

For further distribution information call the Governor's Legislative Office

SB 40: "An Act relating to health insurance for small employers and providing for an effective date."

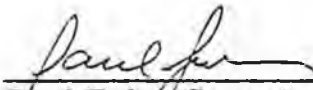
The department is neutral on this legislation.

One of the more challenging issues facing this country and Alaska is the ever-increasing number of small employers unable to afford health care insurance. This bill would address small employers who have been unable to purchase health care.

The bill sets up a reinsurance pool for insurers writing small employers health insurance in the state. In order for the bill to be effective, certain provisions have to be met. First, health is not a term defined in Title 21; the appropriate term is disability. Second, the division of insurance cannot be a member of the reinsurance board and be a regulatory agency for the pool. This creates a conflict for the division. The authority of the director should be for approval only and not for appointment. The pool and coverages they provide should be exempt from the mandatory coverages in Title 21. The pool shall be subject to the marketing and financial sections of Title 21. The pool should not be subject to a subsidy from the legislature or exempt from taxation.

Additionally, 21.56.010 should clarify if hospital and medical service corporations and health maintenance organizations, as defined in 21.87 and 21.86, respectively, are included in membership. They are included on the board.

Section 21.56.060 should state that the committee be made up of the members approved in Section 21.56.020. The director should only have the authority to approve so not to cause a conflict. The cross-section of members in Section 21.56.020 is adequate enough to establish the appropriate benefit plan committee and would help expedite selection and implementation of the pool.


Paul Fuhs, Commissioner

3-1-93
Date

BILL ANALYSIS - SB 40

"An Act relating to health insurance for small employers and providing for an effective date."

Sec. 1. PURPOSE.

The bill provides health insurance to small employers without cost shifting, adverse selection and limits the use of preexisting condition exclusions.

AS 21.36.025 UNFAIR MARKETING PRACTICES PROHIBITED.

It is a violation to violate AS 21.56.180.

AS 21.36.090(d).

This section adds 21.56 to the list of titles that may not permit unfair discrimination against a person who provides a service covered under a group disability policy.

AS 21.36.090(d).

This is a repeat of Sec. 3.

Sec. 21.56.010. CREATION MEMBERSHIP.

This section creates a nonprofit legal entity known as Small Employer Health Reinsurance Association (SEHRA) and consists of all insurers licensed to transact health insurance in the state. Participation is mandatory as a condition for transacting health insurance in the state.

Sec. 21.56.020. BOARD OF DIRECTORS: ORGANIZATION.

(a) The board of directors of the association consists of nine individuals subject to approval by the director. The director shall endeavor to appoint at least six board members who are also small employer insurers.

(b) One board member shall represent a health maintenance organization, one board member shall represent a hospital or medical service corporation, one board member's principal health insurance business shall be in the small employer market, and one board member's principal health insurance business shall be in the large employer market.

(c) A member of the board serves for a term of three years and may be reappointed to an unlimited number of terms.

Sec. 21.56.030. GENERAL POWERS.

(1) exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative functions;

(4) establish administrative and accounting procedures for the operation of the association;

(5) take legal action as necessary to avoid the payment of improper claims against the association;

(6) define the array of health coverage products for which reinsurance will be provided and issue reinsurance policies;

(7) establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the association;

(8) establish actuarial functions appropriate to the operation of the association;

(9) assess members under the provisions of this chapter and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses; interim assessments shall be credited as offsets against regular assessments due following the close of the calendar year;

(10) appoint appropriate legal, actuarial, and other committees as are necessary to provide technical assistance in the operation of the association, design of a policy or contract, or to assist in other functions of the association;

(11) borrow money to accomplish the purposes of the association; notes or other evidence of indebtedness of the association that are not in default are investments for insurers and may be carried as admitted assets.

Sec. 21.56.040. PLAN OF OPERATION.

The director may, after notice and hearing, approve the plan of operation that should include but not be limited to:

- (1) handling and accounting of program assets and money of the association and for an annual fiscal report to the director;
- (2) reinsuring risks under the provision of this section;
- (3) collecting assessments from all members to provide for claims reinsured by the association and for administrative expenses incurred or estimated to be incurred by the association;
- (4) selection of an administering insurer and establish the administering insurer's powers and duties; and
- (5) provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 21.56.050. HEALTH CARE REINSURANCE.

This section establishes the procedures, premiums and assessment mechanisms for the reinsurance association to follow. All plans of implementation are subject to director approval and contain time guideline before the director may act.

Sec. 21.56.060. HEALTH BENEFIT PLAN COMMITTEE.

This section establishes the members who will recommend benefit levels, cost sharing levels, exclusion and limitations for the basic and standard health benefit plan. The plan may contain cost containment features. The members are as follows:

- (1) three members who are representatives of participating insurers;
 - (2) one member who represents small employers;
 - (3) one member who represents employees of small employers;
- and
- (4) one member who represents health care providers; and

- (5) one member who represents agents or brokers.

Sec. 21.56.070. REQUIRED REPORT.

The board shall study and report at least once every two years to the director and to the legislature on the effectiveness of this chapter. The report must analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability.

Sec. 21.56.080. ADMINISTRATIVE PROCEDURE ACT.

The association is exempt from AS 44.62 (Administrative Procedure Act).

Sec. 21.56.090. TAX EXEMPTION.

The association is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property.

Sec. 21.56.100. LIMITATION OF LIABILITY.

A member of the association is not liable for civil damages resulting from an act or omission of the member on behalf of the association unless the member acts with gross negligence or intentional misconduct.

Sec. 21.56.110. APPLICABILITY.

Sets the conditions that must be met for the individual or group health benefit plan to apply. Other provisions of law requiring coverage or benefits do not apply to these plans unless stated in this chapter.

Sec. 21.56.120. PREMIUM RATE RESTRICTIONS DISCLOSURES; REPORTS; CONFIDENTIALITY.

This section establishes the premium basis that small employer insurers may charge. They include maximums by percentage. Underwriting characteristics are established and disclosure is required by the insurer giving coverage. Information and specific groups or employers, employees filed with the director will be held in confidence.

Sec. 21.56.130. RENEWABILITY OF COVERAGE.

- (a) A health benefit plan subject to this chapter shall be renewable

at the option of the small employer, except for nonpayment of the required premiums; fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives; noncompliance with the minimum participation or employer contribution requirements; repeated misuse of a provider network provision.

The director may find that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders; or impair the insurer's ability to meet its contractual obligations than it may not be renewed.

(b) A small employer insurer that elects not to renew a health benefit plan for any reason and pulls out of the market may not write new business in the small employer market in this state for a period of five years from the date of notice to the director.

(c) If a small employer insurer is doing business in only one established geographic service area of the state, the provisions in this section apply only to the insurer's operation in that established service area.

Sec. 21.56.140. REQUIRED OFFER OF COVERAGE.

(a) A small employer insurer shall, as a condition of transacting business in this state with small employers, offer to small employers at least two health benefit plans.

(b) A small employer insurer shall file basic health benefit plans and the standard health benefit plans to be used by the insurer.

(c) The director at any time may disapprove the continued use by the small employer insurer of a basic or standard health benefit plan if the plan does not meet the requirements of this chapter.

Sec. 21.56.150. REQUIRED HEALTH BENEFIT PROVISION.

This section establishes mandatory benefits if a plan is to be considered under this chapter. It also establishes guidelines for preexisting condition clauses to be used in plan coverage.

Sec. 21.56.160. EXEMPTION FROM REQUIRED OFFER OF COVERAGE.

This section establishes exemptions for small employer insurers which include but are not limited to geographical area, authorization of certificate of authority, and financial conditions.

Sec. 21.56.170. CONDITIONS FOR CEASING TO DO BUSINESS.

A small employer insurer, welfare arrangement may cease doing business in the state but must notify policy/contract holder and cannot participate in the small employer market for five years.

Sec. 21.56.180. FAIR MARKETING STANDARDS.

Establishing standards of how the standard and basic health plan is to be marketed. Puts limitations on compensation to agents, brokers, MGA, TPA involved in marketing the plan.

Sec. 21.56.250. DEFINITIONS.

Defines various terms used in the legislation.

Sec. 6. 21.86.260(a).

This title does not apply to health maintenance organization unless stipulated in this chapter.

Sec. 7. 21.86.260(a).

Same as above but add medical service corporation or hospital corporation licensed under 21.87 or 21.09.

Sec. 8. 21.87.340.

List other provisions applicable to this chapter.

Sec. 9. 21.87.340.

Same as above.

Sec. 10. PREMIUM RATE RESTRICTION.

This establishes guidelines for premium calculation/administration if a plan is written by an insurer prior to July 1, 1993.

Sec. 11. TRANSITION.

Establishes guidelines for implementation and effective dates for the plan and

the association.

Sec. 12. REPEAL AS 21.36.025 AND 21.56.

Sec. 13.

Sections 4, 7, 9, 12 take effect July 1, 1997.

Sec. 14.

Except as provided in section 13 of this Act, this Act takes effect July 1, 1993.

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MEMORANDUM

February 6, 1993

SUBJECT: Small employer health insurance (SB 40)
TO: Senator Drue Pearce
FROM: Michael F. Ford *M.F.*
Legislative Counsel

The following is a section by section analysis of SB 40:

Section 1 - Findings.

Section 2 - Makes a violation of insurance marketing practices under AS 21.56.180 an unfair trade practice.

Section 3 - Establishes the provisions of AS 21.56 as an exception to the requirement that an insurer may not discriminate between health care providers.

Section 4 - Sunset section that repeals changes in sec. 3.

Section 5 -

Sec. 21.56.010 - Establishes the Small Employer Health Reinsurance Association and requires certain insurers to be members.

Sec. 21.56.020 - Establishes the board of directors of the association and provides for specific board representation and organization.

Sec. 21.56.030 - Establishes the general powers of the association.

Sec. 21.56.040 - Requires the association to submit a plan of operation to the director of the division of insurance. Requires members to comply with the plan and establishes specific components of the plan.

Sec. 21.56.050 - Establishes specific provisions that apply to reinsurance provided by a member to employees or dependents of employees of a small employer. Imposes

SECTIONAL ANALYSIS

certain restrictions on reinsurance of group plans other than small employer health benefit plans and establishes limits for premiums charged for reinsured coverage and for coverage provided by a health maintenance organization. Provides for member assessments, by the administering insurer.

Sec. 21.56.060 - Establishes the health benefit plan committee. Requires the committee to design a basic and a standard health benefit plan.

Sec. 21.56.070 - Requires the board to report on the effectiveness of the chapter.

Sec. 21.56.080 - Exempts the association from the Administrative Procedure Act.

Sec. 21.56.090 - Exempts the association from payment of taxes, except for real or personal property taxes.

Sec. 21.56.100 - Provides immunity from civil actions filed against a member of the association for a negligent act on behalf of the association.

Sec. 21.56.110 - Establishes when an individual or group health benefit plan is subject to AS 21.56 and provides that other laws requiring coverage, reimbursement, utilization, or consideration of a specific health care provider do not apply to a health benefit plan provided to a small employer. Exempts a health benefit plan offered to a small employer from certain restrictions contained in other laws.

Sec. 21.56.120 - Establishes underwriting and rating requirements applicable to health benefits plans covering small employers.

Sec. 21.56.130 - Establishes when a health benefit plan is required to be renewed.

Sec. 21.56.140 - Requires a guaranteed issue insurer to offer at least two small employer health benefit plans and that the plans provide certain coverage. Allows a guaranteed issue insurer to reinsure, make special premium arrangements, or appeal unfair administrative or credit risk.

Sec. 21.56.150 - Establishes certain provisions that must be included in a health benefit plan.

Sec. 21.56.160 - Exempts certain small employer insurers from being required to offer health insurance coverage.

Sec. 21.56.170 - Establishes certain conditions that must be met before an insurer or welfare arrangement may cease doing business in the small employer market.

Sec. 21.56.180 - Establishes fair marketing requirements for health benefit plans.

Sec. 21.56.250 - Definitions.

Section 6 - Provides that a health maintenance organization is subject to the small employer health insurance provisions contained in AS 21.56.

Section 7 - Sunset provision that repeals changes in sec. 6.

Section 8 - Provides that a hospital or medical service corporation is subject to the small employer health insurance provisions contained in AS 21.56.

Section 9 - Sunset provision that repeals changes in sec. 8.

Section 10 - Provision that allows premium rates to exceed the limits under 21.56.120(a) for a period of three years. Establishes limits on the percentage increase in premium rates.

Section 11 - Transition section. Requires the small employer Health Reinsurance Association to submit a health insurance plan to the Director of the Division of Insurance.

Section 12 - Sunset repeal provisions.

Sections 13 & 14 - Effective dates.

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