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Providing Universal Access in a Voluntary Private-Sector Market

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This paper was prepared by the Academy's nine-member Guaranteed Issue/Universal Access Work Group, which is composed of actuaries who are experts in this area. The report's sole purpose is to assist the public policy process via the presentation of clear, objective analysis.

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Overview

Many are convinced that achieving "universal access" to health insurance by requiring insurers to "guarantee-issue" a qualified health insurance plan to all consumers (or their representative, such as employers) implies little more than an extension of an approach that is already working quite well in large portions of the health insurance market. This paper attempts to explain why the issues are more complex than this. It also attempts to provide a better understanding of the forces—economic or otherwise—with which reformers are confronted in trying to implement guaranteed issue successfully in a voluntary private insurance system—a system that does not mandate universal coverage.

In a voluntary health insurance market, universal access exacerbates a phenomenon known as "adverse selection," whereby individuals, given a choice among health plans, will analyze the financial ramifications, for themselves, of each plan, and then choose the one that they think—at that moment—will be the most financially beneficial. That same choice will, as a general rule, be financially harmful to the health plan. So, the fundamental questions for universal-access reform can be reduced to: How can we minimize the impact of adverse selection, in total, that results from universal access? Or, secondarily, how can we spread the impact of adverse selection equitably among all segments of the market to reduce market disruptions?

Adverse Selection: The Fundamental Problem

It is generally believed that universal access/guaranteed issue will convey many benefits: more people will be insured; there will be a greater spread of risk and expense; more care will be available to people when they are still in the early stage of an illness; and, ultimately, overall costs will be lower. However, insurance costs per person are expected to increase under guaranteed issue (for a relatively few, it could reduce or stabilize costs), and, depending on the specific structure of the reform, health care markets may be significantly disrupted. The force propelling these increased costs and market disruption is adverse selection.

Market Segmentation: A Major Complicating Factor

The private health insurance market in the United States is highly segmented, with the magnitude of the impact of adverse selection varying by market segment. In large-employer groups, adverse selection is minimal, because large employers usually pay most of the insurance cost and ask for only a minimal contribution from the employee—a deal that employees find impossible to beat on their own.

Adverse selection has a greater impact on smaller employers, because they are likely to have less money to contribute to health insurance for their workers. Also, with smaller numbers in the employee group, the expected health care costs become more sensitive to the health status and age of specific individuals within that group. Moreover, those small groups that opt to purchase health insurance may be basing their decisions on the perceived health care needs of their group. Therefore, until quite recently when states began "reforming" the small-employer market, insurers have tried to reduce the impact of adverse selection by basing premiums, to some extent, on the actual health status of the particular members of a given insured group. In the post-reform era, however, insurers rely more on adverse selection deterrents (discussed below), and on mechanisms to share the cost of the highest-risk cases among all insurers (discussed below), instead of using health-status-experience pricing.

The individual market constitutes a third market segment. A significant portion of the people who choose to purchase individual coverage generally do so because they anticipate needing health care services in the near future. Thus, insurers more carefully screen individual-coverage applicants for potential health problems, and are more likely to subject them to insurance provisions, such as preexisting-condition limitation periods.

Market Segment Reform

There are two basic options for reforming health insurance laws. One approach is to reform each segment of the market separately. Using this approach, controls can be built into reform legislation to prevent market disruption and cost inequity between markets. It is also possible to permit cost differentiation between markets that are not overly disruptive by creating barriers to prevent any overlap, by individual insureds, between market segments. A second approach is to control the adverse consequences of reform on any one market segment, to ensure that all markets share these consequences equally, thereby reducing market disruption.

Reforming market segments independently, without any restrictions over which market individuals are allowed to select when they purchase guaranteed-issue insurance, could lead to cost increases within a single market segment.

Creating Barriers between Individual and Small-Group Markets

If reforms are enacted independently, it is critical to ensure that every individual is subject to either small-employer or individual market segment regulations—but not both, making it necessary to establish "barriers" between these two segments.

Cross-Market Adverse Selection Issues: Without first carefully considering the potential impact on other market segments, reforming just one market segment (usually the individual market), in order to expand access to health insurance and control costs, could lead to disruptions within other market segments. Examples of this include the impact of continuation of coverage through COBRA and conversion policies and the selective transfer of risk among market segments.

Continuation of coverage through COBRA: Expanding guaranteed-issue provisions to the individual market could mean that every former employee previously covered as part of a large group, generally coming from the self-insured market segment, who is now eligible for COBRA, would have a choice of coverage source: COBRA or the individual market. Thus, expanding guaranteed-issue provisions to this market could make the individual market more attractive, thereby reducing the number of individuals opting for COBRA. Given that the average excess-risk cost for those with COBRA coverage is about 50% of premium for these individuals and that younger-aged people will generally find age-rated individual premiums to be less costly, transferring risks to the individual market segment may add another 1% to premiums.

Conversion policies: Once the COBRA extension period expires, many plans offer a conversion plan that is (usually) subject to individual-policy regulation. So, with individual guaranteed issue, it is quite likely that the entire market subsegment that is comprised of conversion policies would end up in the individual market segment, unless other regulatory controls were put in place to prevent it. Some "barrier"—for example, a provision that individuals eligible for group conversion are ineligible for guaranteed-issue individual market insurance—could be included in the reform legislation.

The cost involved would be greater than for COBRA, because all ages would be attracted to individual-market guaranteed issue, not just the younger age groups, and the costs for older age groups are already roughly three times that of the younger groups. This influx of various age groups into the individual market could increase premiums in that market segment by 2% to 3%.

Selective transfer of risk: One method that could be used to transfer risks selectively is high-risk dumping by self-insured group employers. In this approach, large employers would self-insure only their healthiest employees and transfer their higher-risk employees to the guaranteed-issue individual market. By doing so, self-insured employers could save money because the guaranteed-issue policy premiums would be less than the health care cost for which they would be otherwise responsible. Experience-rated insured employer groups could also transfer their high-risk employees into a guaranteed-issue market to take advantage of lower premiums in that market.

The use of state high-risk pools is a another method of selective risk transfer. Just as conversion policyholders would, most likely, be completely absorbed by the individual market, so would members of state high-risk pools. Individuals currently insured by such pools have no right of portability to other carriers or plans; also, by law, they usually pay more than the individual-market price. So, there would be no reason why all these people wouldn't immediately opt for coverage through the individual market segment, if it becomes fully guaranteed-issue. The individual market segment would then have to absorb these people, whose medical costs average 150% above "normal" costs.

Current Practices for Controlling Adverse Selection

Because group markets—particularly the small-employer segment—over the past few "reformed" years have already been "practicing" implementing universal access, we look to this segment to analyze the implications of procedures used. We analyze the outcomes of these procedures to determine their impact within the context of the small-employer segment, and also to determine how these procedures can be applied to the individual market segment, where such practices are extremely rare because guaranteed issue is nearly nonexistent.

Minimum Contribution Requirements

Minimum contribution requirements are designed to deter adverse selection. In the group market segment, it is common to allow denial and cancellation of coverage to all employees (or group members) if the employer (or group policyholder) does not contribute (or continue to contribute) a significant proportion of the premium, or capitation charge, for the employee.

Technically, contribution minimums create barriers that conflict with the goals of universal access, because employee accessibility is dependent on financial decisions made by employers.

Minimum Participation Requirements

Minimum participation requirements, which are also designed to deter the adverse selection that could ensue if an employer chooses to insure only his unhealthiest employees. Generally, they permit carriers—for group markets—to deny or cancel coverage, at their discretion, if some proportion (commonly around 25%) of the employees (or group members) decline to participate in the plan. Such stipulations are termed "participation minimums." They achieve the same effects as medical underwriting screens in the individual market. While participation minimums are recognized as contrary to the objective of universal access, most state reform legislation on the small-employer market segment has kept the use of this practice legal. Its value lies in its ability to control the extra cost burden that would otherwise fall on the small-employer market.

Minimum Contribution and Participation Requirement Implications

Improving access in group market segments by removing the barriers created by contribution minimums, participation minimums, or both, in the absence of any other controls, would likely increase the cost of insurance in those segments. However, if removal of these barriers were combined with new guaranteed-issue provisions in the individual market, such group insurance cost increases in the form of additional premiums would be offset by reductions in what otherwise would be substantial premium increases in a guaranteed-issue individual insurance market.

Participation and Contribution Minimums in the Individual Market

In theory, participation minimums and contribution minimums could also be applied to the individual market. Legislation could be designed with a requirement that guaranteed issue to an individual be permitted only if an individual carrier can demonstrate that it approached some number (say, five or more) of uninsureds with employment characteristics similar to those of the applicant, and 80% of them (in this illustration, four of the five) agreed to buy insurance. In practice, however, this is not feasible. This example is used here to illustrate the point that extending some recently passed small-group reform legislation provisions to individual insurance markets is not a simple matter—the unique characteristics of the individual market need to be considered.

Preexisting-Condition Limitations and Waiting Periods

Preexisting-condition limitations and waiting periods are two other provisions that are intended to control adverse selection. The use of preexisting-condition limitations let carriers exclude payment for medical expenses relating to conditions that began before the current insurance was issued, for a specified period of time, generally three to 12 months. Because of difficulties some HMOs have in billing for, and distinguishing preexisting-condition limitations, many HMOs cover all conditions immediately, but, if guaranteed-issue laws exacerbate adverse selection, it is more likely that waiting periods will become the preferred method for HMOs, while preexisting-limitation conditions will be the choice of traditional insurers.

Limited Periods of Open Enrollment

Open-enrollment periods can also function as a deterrent to adverse selection. During open- enrollment periods, individuals may apply for insurance without having to provide medical evidence of insurability. Usually set at 30 days occurring once a year, open-enrollment programs are not in wide use because, to be effective in deterring adverse selection costs, the open- enrollment period must be relatively short, leaving lengthy periods of time when access to insurance is not guaranteed. This, of course, significantly undermines the fundamental principle of guaranteed-issue reform.

Other issues for controlling adverse selection relate to the exclusion of part-time workers and late entrants, and the treatment of estranged dependents.

BROAD-BASED STRATEGIES FOR MAINTAINING MARKET EQUILIBRIUM

While remedies can be put in place to address nearly all issues that arise when market segments are reformed independently, it may nonetheless be preferable to reform all of the segments at the same time. If this is not possible, at minimum, simultaneous reform of the small-employer market and the individual market segments should be considered.

There are two more direct (but somewhat more complex) approaches to controlling adverse selection: allocation and risk adjustment.

One way to equalize the risks borne by the various carriers is to design a regulatory framework such that high-risk individuals are insured by carriers in proportion to the total number those carriers insure. This is the allocation method. A second method is risk adjustment. Risk adjustment methods transfer funds among carriers, so that costs are equitably distributed if the distribution of high-risk costs has somehow become biased as a result of a guaranteed-issue requirement. Risk adjustment methods can be divided into two categories: (1) those that transfer sums of monies between carriers based on past claim experience and (2) those that transfer monies based on expectations concerning biases among carriers. In practice, however, some combination of the two is more common. That combination approach is usually handled via mechanisms called reinsurance pools.

CONCLUSION

The key issues to address when providing for guaranteed issue in a voluntary private health insurance market are (1) how to minimize the impact of adverse selection, in total, that results from universal access, and (2) how to spread equitably the impact of adverse selection among all segments of the market to reduce market disruptions.

The conclusions expressed in this paper to address these issues may appear to condemn, a priori, any attempts to make universal access workable in a voluntary private market. However, our somewhat more optimistic conclusion is that a new system characterized by compromise can be designed within the framework of a voluntary system—a position that deviates from the long-held assumption that the only way to achieve the goal of universal access is to mandate insurance participation. Of course, from a purely technical standpoint, it should be clear that mandatory participation may most clearly achieve universal access at the most affordable price.

The clear benefit of such a compromise would be greater numbers of people with access to the private insurance market. The compromise might involve, say, a preexisting-condition exclusion limitation as a deterrent for adverse selection, a reinsurance pool (or other risk adjustment allocation method) to transfer any unintended cost shifts between markets, combined with premiums that are only slightly higher than today.

Ensuring universal access is a complex undertaking, comprised of a multitude of interrelated elements, all of which must be carefully understood. Any universal-access legislation must consider the interdependent nature of market segments, and must have clearly articulated goals. Finally, procedures must be put in place to monitor all of the emerging consequences of reform legislation—intended as well as unintended.

I. Introduction

This monograph is intended to serve as a primer on universal access to the private health insurance system for the non-elderly population in the United States. It is written from the perspective of experts who price and financially manage health care, American Academy of Actuaries' health actuaries.

Throughout the paper, "universal access" is used synonymously with "guaranteed issue." The two terms express the same concept from two different perspectives, that of the consumer and that of the private insurer,[1] respectively. Under universal access, insurers must "guarantee-issue" a qualified plan of insurance to consumers (or their representatives, such as employers) that, in the pre-reform environment,[2] they can legally deny to consumers, for reasons such as poor health. Thus, universal access (or guaranteed issue) is the legislated right, for health care consumers, to have reasonable access to fairly priced, comprehensive health insurance through the private sector.[3]

It is important to accurately define what is meant by guaranteed issue of "fairly priced, comprehensive" health insurance. We assume that under a reformed environment, carriers will not be allowed to: (1) charge different rates for the same plan, (2) charge different rates for plans that are "guaranteed" compared with those that are medically underwritten, or (3) co-offer different (i.e., more limited) benefit packages for less healthy insureds who are deemed to be higher-cost business. It is possible that health insurance reform could include regulations on access without regulations on rates or benefit packages, but without such regulated limits, it would be possible for carriers to set premiums so high or limit benefits so much that, in effect, access to insurance would be denied. This would be contrary to universal access goals and therefore is not a subject covered within this monograph. We do comment on which plan or set of plans within an insurer's portfolio the insurer must guarantee issue.

The concept of universal access should not be confused with universal coverage. Under universal coverage, all consumers must be covered; it is illegal for a consumer to forgo insurance. In contrast, under universal access, consumers are not required to purchase coverage or obtain it by some other means.

To many, universal access seems like a simple concept: All that is needed is a law preventing insurers from denying coverage to people who want insurance. This change, it is presumed, would stop insurers from selecting risks by denying coverage to the worst ones, and thereby allow people who cannot now obtain insurance to enter the marketplace, on a guaranteed basis. Indeed, this sort of practice already appears to be working on a voluntary basis in the large-employer insurance market, and seems to have substantially alleviated problems with access in the small-employer market in the several states that have enacted guaranteed-issue provisions as part of their health care reform.

However, the reality is that we don't have true universal access anywhere in the private health insurance market today, and extending guaranteed issue to all potential consumers is anything but simple. As guaranteed issue is extended to the buyers in various market segments—in particular individuals and very small groups—strong economic forces are likely to operate to make health insurance more unaffordable, and this may cause a decrease in the number of people with health insurance coverage.

This paper attempts to dispel the misconception that universal access implies little more than an extension of an approach that is already working in large portions of the health insurance market. It also attempts to give the reader a greater understanding of the forces with which reformers must contend if they wish to successfully implement guaranteed issue for individuals in a voluntary private insurance system—a system that does not mandate universal coverage.

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[1]Includes health maintenance organizations, Blue Cross/Blue Shield plans, self-insureds, and multi-employer welfare association plans, as well commercial carrier plans.

[2]A "pre-reform environment" refers to a period in time applicable to each market segment in which no law exists to require a carrier to guarantee issue a plan of coverage. It varies by state. For example, most states have "reformed" their small-employer market laws over the past few years. For the most part, other market segments remain "unreformed".

[3]Universal access may mean access to either public or private insurance programs. In this case, universal access is not synonymous with guaranteed issue. However, this monograph limits discussion to access to the private insurance system. With this restriction, universal access is synonymous with guaranteed issue. The work group recognizes the possibility of an integrated public/private system, but this monograph covers only the private insurance system.

II. The Problem Today

In today's voluntary private health insurance system, a person has the right to choose not to participate in the insurance system, thereby saving the money that would have been spent to pay premiums. Of course, in such cases, these individuals are expected to pay their own medical expenses, except when they must rely on the charity-care system in the U.S. However, in many situations today, individuals are locked out of coverage, no matter how much effort they expend, and, sometimes, regardless of how much they are willing to pay in premiums, because insurance carriers—except those in "reformed" states—are able to choose whom they will cover and whom they will deny. This inability to receive coverage is the problem that universal access legislation seeks to address.

Even when the situation isn't this drastic, we recognize that almost everyone under age 65 bears some risk that he won't be able to get health insurance, at some point. And some people are more vulnerable to this problem than others.

Among the most vulnerable are part-time workers, seasonal workers, those working for small employers, the self-employed, the unemployed (either by choice, such as early retirement, or by being laid off), and dependents. Some of these, such as part-time and seasonal workers, are seldom included within the group the employer is willing to cover. If they are covered by employer plans, the employer can decide to drop coverage, at any time, to control costs. Dependents, too, may not be included in the employer's covered group, although most employers do offer dependent coverage, frequently requiring employees to pay a substantial portion of the premium. In addition, if state law permits, employees with serious health problems may be excluded from a small-employer group's plan. Or, coverage for a small employer may be denied if one employee or employee dependent has a serious health problem.

Persons in these categories are compelled to seek coverage in the medically underwritten individual health insurance market, if they can't convince their employer or "association" to purchase coverage. In some states, even if the employer seeks coverage, he may find that he is uninsurable as a group anywhere in today's system. Usually about 90% of individuals will be able to purchase coverage,[4] but, since they will pay the entire premium or fee, their cost will be substantially higher than for comparable coverage at group insurance rates, where the employer pays a larger share of the premium. Some will not be able to afford the full cost of their individual insurance, and some who can may choose simply to forgo coverage, which is offered at standard rates with no restrictions, because they determine the economic costs to be too great. The lack of affordable coverage is an important problem that is not entirely overcome with guaranteed issue.

The health insurance coverage that is offered by large employers is frequently cited as a model that has worked well and should therefore be imitated in the small-group and individual markets. It is important to note, however, that the large-group market differs from the other two in terms of how much of the premiums individuals are required to contribute for individual and dependent care:

- Individuals in the large-group market generally pay a small portion of the cost;
- Individuals in the small-group market pay a greater portion of the cost; and
- Individuals in the individual market pay the full cost.

This is a critical difference: the lower the percentage of total premium individual employees must pay, the more likely it is that the individuals involved will choose to participate in a given plan. Therefore, individuals—both healthy and unhealthy— in the large-group market are most likely to participate in their employer's plan, and thus the risk mix (ratio of healthy to unhealthy persons) in this market is most like one would expect to find among the general population of workers. In contrast, the relative proportion of unhealthy people in the small-group and individual markets is likely to be greater: healthy individuals who are fairly certain that neither they nor their dependents are in imminent need for health care have less incentive to participate in the plan.

Other groups are more likely to have health insurance coverage: employees of large corporations and financially successful medium and smaller firms, for example. However, even these workers may become vulnerable if their situation, or that of their employer's, changes. Workers may lose their jobs or undergo a serious change in their health status, or an employer may decide to stop offering or contributing toward health insurance for workers. Any one of these circumstances can lead to a loss of coverage and a potential problem of lack of access to health insurance for these individuals.

Workers who lose their employer-sponsored coverage may be able to get temporary coverage via one of two safety nets. The first is continuation of coverage under COBRA, a federal law that applies to all employers with 20 or more employees. COBRA provides a guarantee that a continuation of the employer's plan of coverage will be extended for 18 months (and under some circumstances, 36 months) at a price that can be no more than 2% higher than the full premium charge the employer pays for active employees. The guarantee applies to dependents who lose their dependent status, workers who become unemployed for reasons other than just cause, and workers who become unable to work because of

[4]Of this 90% that are able to purchase health insurance coverage, approximately 20% will only be able to purchase coverage that has substandard rate levels and that often excludes some medical conditions.

disability. Under COBRA, the employee or former dependent pays the entire premium, without the ability to deduct these payments from their taxes, unless the employee or former dependent becomes self-insured, in which case they can deduct 25% of the premium. This, in effect, makes the cost substantially more than the "2% higher."

A second safety net for temporary continuation of coverage is available through what is known as a "conversion option." Currently, a number of states require that insurers offer this option, and some employers agree to offer it voluntarily. For those not covered under COBRA, there is an immediate option to convert to an individual policy. For those with COBRA coverage, after COBRA continuation of coverage expires, the worker or former dependent is guaranteed the option of a conversion plan to an individual policy. Although access to an individual policy is guaranteed, the benefits of these policies can be substantially limited; the premiums are frequently very high; and there is no choice of underwriting carrier. Thus, the combination of COBRA and conversion policies may not automatically result in true universal access.

Clearly, many Americans can expect to face the problem of not having access to health insurance at some time during their lives. When the problem of access is coupled with problems related to the affordability of the coverage that is available, the dilemma is even more serious.

A number of states have acted in recent years to extend guaranteed issue in the small-group market, among other goals such as pricing and renewability. Initially, these were relatively modest reforms, which limited the number of products that were guaranteed and allowed for a large degree of variation based on health status, risky occupations, etc. More recently, however, several states have enacted guarantees of all products and rating rules that place strict limits on rate variation due to risk-related variables. Although a great deal of data covering insurer experience under these guaranteed environments are not available, many of these states report that implementation of the reforms have not led to large increases in premiums (in fact, some states have indicated that there were no increases at all) or to major carriers withdrawing from the market. These states also note positive features of the market directly resulting from reforms on guarantees, rating, and renewability: Small employers now have rate stability. Specifically, they no longer have extreme differences in the price they pay for coverage depending on the health status of their employees at a given time.

While small-employer market reforms have resulted in such benefits for some small employers, including better access, many assume that small-group health insurance reform has largely solved the problem of access in states that have undertaken reform initiatives. However, despite all the reforms enacted over the past few years, not all access problems have been solved for the small-group market.

Here's what's been corrected: First, in reformed states, insurers can no longer simply deny coverage to an employer or any of its employees and dependents. Nor can they cancel coverage just because of claims experience or health status of an individual. Fair marketing rules require insurers to offer products without any attempt to direct high-cost employers to certain plans. Second, most states have combined other reforms with their guaranteed-issue provisions, most notably, restrictions on the differences in premium rates that insurers can charge one small employer over another. Thus, in some states, insurers can no longer induce an employer to cancel coverage by imposing big increases in premium rates.

Although these reforms have expanded access to coverage for those in the small-group market, they do not guarantee universal access. In general, the following restrictions still apply. Any worker whose health does not allow him or her to be actively at work when a plan is introduced by an employer for the first time can be denied coverage. Access for part-time employees is not required. If an employee initially waives his option for coverage, he may be denied coverage for a short time for health reasons at some later point. Access at the group level may be denied, or coverage canceled, by a carrier if more than a predetermined percentage of employees do not participate in the employer's plan (carriers can choose any percentage, as long as it is not discriminatory, and it is less than 25%). Access may be denied or coverage canceled by a carrier if the employer decides to contribute less than a predetermined percentage of the premium (the percentage to use is usually left to the carrier's discretion, as long as it is not discriminatory; it must be more than 50%).

Several such restrictions have been allowed to remain to avoid excessive increases in the average premium rate for the small-group market. But they do illustrate a basic point: To date, small-group reform has led to less than universal access, even within the small-group market.

In addition, small-group reform has done little to address the issue of continued access to coverage when a worker, or his dependent, loses coverage under the small-employer's plan. Generally, the only option that remains is the guarantee of conversion to an individual health insurance plan offered by the same insurer or, if the employer has 20 or more employees, continuation of coverage under COBRA. Several states have their own COBRA-like rules which apply to employers with as few as one-employee and that extend coverage beyond the standard 18-month period.

III. Major Obstacles to Legislative Reform

Adverse Selection: The Fundamental Problem

Many people who advocate the enactment of universal access/guaranteed issue assume that by merely improving access to health insurance will mean that more people will be insured; there will be a greater spread of risk and expense; more care will be available to people when they are still in the early stage of an illness (before the cost of treatment escalates); and, ultimately, overall costs will be lower. In fact, depending on the specific structure of the reform that is enacted, guaranteed issue could increase costs and significantly disrupt health care markets. The force propelling these increased costs per person and market disruption is adverse selection, which is a phenomenon whereby individuals, given a choice among health plans, will choose the plan that they think—at that moment—will be the most financially beneficial to them. That same choice is, as a general rule, financially harmful to the health plan.

Perhaps the easiest way to explain adverse selection is through illustrations derived from the current health insurance market.

> *Example 1*
> To illustrate how adverse selection works in the context of reform proposals that incorporate guaranteed issue, let us assume that only one market segment of insurers—say, those that insure small-employer groups—are prohibited from setting rates or limiting coverage based on health status. In this environment, an employer may find that his healthiest employees can be insured at a lower price by another market segment of insurers that are permitted to screen risks (e.g., individual carriers). Then, the remaining less healthy employees will have to be insured by the insurers that are required to guarantee-issue, which, in this example, are small-employer carriers.

> *Example 2*
> Some individuals may maintain constant coverage irrespective of their health status, while others may decide to save premium expenses by postponing the purchase of insurance, or dropping coverage, during periods when their health is at its best, and then start buying coverage again when they are likely to need medical care. Since the expected cost of care for the two groups will be the same, the loss of premium dollars from those adversely selecting against the insurance pool must be made up by those who maintained continuous coverage. In today's market, individuals would be discouraged from this type of adverse selection by (1) underwriting criteria that would, potentially, bar their reentry into the system when they are already ill and (2) preexisting-condition exclusions that would limit their coverage if they were able to reenter.

Thus, it is apparent that in an environment where health insurance coverage is voluntary, guaranteed issue can act as a catalyst to a proliferation of adverse selection. This is the fundamental reason why access to health care insurance is limited now. It is critical that proposals to guarantee every resident in a state the right to enter the insurance system must adequately address the issue of adverse selection, if they are to be successful.

If unaddressed, adverse selection will jeopardize the stability of insurance premium rates for everyone who maintains continuous coverage. Those who engage in adverse selection, by purchasing insurance coverage only when they perceive their risk for needing medical care is high, raise the price of insurance for all of the individuals who continuously pay their premiums. This is why adverse selection and the difficulty of finding effective means to curb it, is the single greatest impediment to guaranteed issue.

One might suggest that the problem could be solved by simply eliminating adverse selection. We know this is possible: In large-employer groups, adverse selection is minimal.[5] Large employers usually pay most of the cost of the insurance and ask only for a minimal contribution from the employee—a deal that employees find impossible to beat on their own. The chief motivator for selecting coverage, then, is price. It is likely that a reduction of employer incentives to contribute toward health premiums, for example a removal of the tax deductibility of premiums, would increase the importance of price in the large-employer market as well. Admittedly, if we could extend these circumstances to the small-employer and individual-health-insurance markets, we would simplify the complexities of offering universal access. However, while it's true that one could pass a law requiring that employers who offer coverage pay most of their employees' premiums, we would still have to find some way to encourage mass employer participation in such a venture, and we'd still need to find some surrogate employer contribution for the remaining individual insurance market.

One obvious solution comes to mind. As in Hawaii, where access to health insurance is not considered a problem (95% of the population is covered by health insurance), simply make participation a legal requirement for all employers. Then, require the government to serve as the surrogate for all the individuals not employed, paying most of the premium and selecting the plan(s) and insurers for the individuals' coverage.

Unfortunately, this approach requires a mandate that employers must offer coverage, as well as substantial new government subsidies. These conditions conflict with the intent of many reformers, and the assumption of voluntary participation in the health insurance market. Consequently, there is no

[5]The occurrence of adverse selection among large employers is usually connected to the large employer offering employees benefit choices. Employees generally select the option that they perceive will provide richer benefits or access to more providers.

easy way to entirely counteract the phenomenon of adverse selection within a private voluntary market.

In a voluntary market, the fundamental question for universal-access reform comes down to this: How can we minimize the impact of adverse selection in total, or, secondarily, spread its impact fairly among all segments of the market in a way that doesn't upset the economic balance so much as to cause more harm than good?

MARKET SEGMENTATION: A MAJOR COMPLICATING FACTOR

The private health insurance market in the United States is highly segmented—and has tended to become even more so over the last 15 years. Some segmentation is a natural consequence of the tradition wherein health insurance is voluntary and provided to most of the non-elderly employed population through employers. With rare exceptions, large employers provide health insurance or contribute to union-based health insurance coverage for some employees. Since they usually pay most of the premium for their workers and insure most of their full-time workers, their expected health care costs tend to reflect those of an able-bodied population with a stable age and sex mix of their work force. Smaller employers are often less able to contribute to health insurance for their workers and, with smaller numbers, the expected health are costs become more sensitive to the health status and age of specific individuals within the group. To avoid having their premium rates for all small groups become uncompetitive, insurers attempt to link the premium as closely as possible to the expected health care costs of the group.

Insurers also know that small groups may choose to purchase health insurance because of the perceived health care needs of the group, especially the needs of the managers and owners who make the decision to purchase. Hence, insurers must base premiums, to some extent, on the average health status of the entire pool in order to avoid adverse selection.

Individuals who do not have employer-sponsored health insurance may elect to purchase it on their own. Insurers treat individuals as a separate segment within the market because they are more likely to purchase insurance when they have a greater expectation that their health care costs will be greater. Thus, compared with small-group market applicants, applicants for individual coverage are (1) more likely to be carefully screened for potential health problems and (2) subject to longer-term restrictions such as riders and exclusions.

Over the past 10 years, rapidly rising health care costs have encouraged more widespread underwriting and greater refinement in risk classification. As health care costs have continued to rise, individuals and groups with low expected health care costs have found it increasingly advantageous to separate themselves, to the extent possible, from individuals and groups with high expected health care costs within any given insurance market segment. To compete effectively in a world of ever-less-affordable health care, insurers have readily accommodated the demands of healthy individuals for the lowest possible cost coverage and, through underwriting and risk classification, have become better at sorting prospective purchasers into higher- and lower-cost classes. As a result, premium rate differentials have widened and health insurance programs have become more specialized in their design, in order to attract certain targeted groups or individuals and simultaneously provide less healthy individuals access to health insurance that is less comprehensive and/or more costly.

Self-insurance and the operation of the Employee Retirement Income Security Act of 1974 (ERISA) are also related to increases in market segmentation. As health insurance has become a significant component of labor costs, especially for the rank and file, larger employers have found it advantageous to self-insure. Although larger-employer groups are generally not denied coverage like smaller groups, they are experience-rated over time. Thus, their premiums closely reflect the actual health care expenditures of their workers. If an employer self-insures, he can avoid some of the costs of purchasing insurance, such as the insurer's profit margin and expense loading and reserve requirements imposed by regulatory authorities. Even more important, because ERISA preempts state law for those that self-insure, the employer can avoid the premium taxes and assessments states impose to support state insurance agency programs and other state laws that mandate the provision of specified health benefits under insurance policies. ERISA self-insurance rules generally apply when each employer group is kept separate, eliminating any possibility of combining segments.

The high degree of market segmentation in the current health insurance environment increases the difficulty of establishing reforms, including guarantee-issue provisions. At the state level, employers that self-insure can evade reforms because of ERISA preemption. Even at the federal level, reforms can be difficult to impose uniformly because the preemption provisions in ERISA are so closely guarded by multiple special interests. Market segmentation can also frustrate the good intentions of reformers, because groups can structure themselves such that they shift all, or a part of, their high-cost risks to the reformed portion of the market, where these high costs must be shared by all who can only gain access to insurance within that segment. Others, with low costs, can move from the reformed portion of the market, leaving only those who cannot escape to share the burden of high-cost individuals and groups.

There are two basic options for reforming health insurance laws:

1) Reform insurance markets independently, using controls designed to (a) prevent market disruption and cost inequity between markets or (b) allow cost differentiation to exist between markets, but create barriers to prevent any overlap between market segments.

2) Reform insurance markets simultaneously, controlling the adverse consequences of reform on any one market segment to ensure that all markets share these consequences equally, thereby retaining the current market equilibrium.

These approaches are discussed in the next two chapters.

IV. Reforming Market Segments Independently: Issues and Options

The Problem: Adverse Selection

Adverse Selection Within a Market Segment

If market segments are reformed independently, without any restrictions over which market individuals are allowed to select when purchasing guaranteed-issue insurance, costs within a single market segment could quickly rise. For example, the extra costs that may have to be borne by the individual market segment alone could total 20% to 116% (Table 1).

Table 1
Potential Additional Costs to be Borne by the Individual Insurance Market, Based on Various Reform Options

Reference Page	Option	Range of Projected Additional Cost	
7	COBRA eligibles allowed to purchase individual coverage.	1%	1%
7	Conversion eligibles allowed to purchase individual coverage.	2% to	3%
8	Self-insured high-risk ERISA dumping	6% to	60%
8	Fully insured high-risk dumping	4% to	40%
8	High-Risk pool dissolution	7% to	12%
		20% to	116%

Source: American Academy of Actuaries

Note: We estimate this range based on our collective expertise. Many of these options have not been tried. Further, the results from those options that have been tried are at present too premature, and have not been operating within the constraints of all possible regulatory options.

Before it is possible to deal with the issue of adverse selection within a market segment, one must first develop an adequate definition for each market-segment size, and then determine the implications of using different sizes. For example, should 25 employees, 50, or 100 be used as the upper bound to categorize the small-employer market? Is 1, 2, or 3 the appropriate lower bound? The commonly cited number is 2 to 25 or 50.

The Boundary Around the Small-Employer Market Segment

Regarding a lower boundary, if reforms are enacted independently, it becomes increasingly important to distinguish a "one person" group, such as a "sole-proprietor" group from an individual. To ensure that an individual is subject to either small-employer market regulations or individual market segment regulations—but not both—it is necessary to establish "barriers" between these two segments. Typically, implementation of this type of reform measure has involved defining "sole-proprietor" as incorporating the assumption that the business must provide the substantial portion of the individual's total active earned income, for some specified minimum length of time. To further strengthen the definition, a requirement that the applicant must have claimed the 25% IRS deduction is often added.

While this "barrier" approach has seemed to work (e.g., in the state of Vermont), some individual-market insurers estimate that this provision will cause a loss of 15% to 35% of their market share to small-employer market insurers. For insurers operating in both small-group and individual markets, this may not be a serious problem, because they may be able to balance the costs between the two segments. However, it may present a dilemma for insurers that operate only in the individual market. For them, a loss of this magnitude could threaten their ability to keep prices competitive, encouraging them to leave the market. Companies with significant non-health insurance business, whose health insurance business is in only one market segment, are particularly likely to leave the market.

The significance of these issues fades considerably if all market segments are reformed at the same time, even if they are treated independently. However, if all market segments are not reformed simultaneously, then effective barriers must be drawn between market segments; there will be additional issues—beyond those that may affect single market segments—to deal with.

Regarding an upper boundary, it's been observed that setting the upper bounds of small employer regulations too high encourages employers to self-insure, in order to avoid regulation via ERISA preemption. That raises the issue of solvency control. The market has reacted by creating stop-loss coverage, which limits losses for any one or group of individuals.[6]

[6]Self-insurance with stop-loss coverage at a low level has been used by some employers to avoid small group regulations.

States could define stop-loss coverage as coverage in which an employer assumes at least half of the risk. Without such state intervention, stop-loss coverage has been designed by some employers with their reinsurers to work nearly the same as fully insured programs, thereby undermining the intent of ERISA and state insurance regulation.

Cross-Market Adverse Selection

States that have tried reforming just one market segment (usually the small-employer group market), to improve health insurance access and control costs, often find that disruptions within other market segments end up undermining the achievement of their goals. For example, when regulations in states without small-group reform do not prevent employers from selecting for their employees either small-employer group guaranteed-issue coverage or individual-market insured products, wherein medical underwriting practices entice the healthiest employees, it leaves the less healthy to insurers in the guaranteed-issue small-employer market. The employer may save money in total premium, but the cost to the small-employer insurer will likely increase, ultimately driving up premiums overall to that market segment. One solution to prevent this is to set up legislative barriers that permit consumers to enter only one market.

Below, we frame our discussion of independently reforming market segments by focusing our analysis on the market segment where access problems are most severe today—the individual market segment. While it is possible—and even desirable—to reform more than one segment independently, the added complexity an analysis of simultaneous market reforms would bring to this discussion would cloud the central issues. We assume that the reader has a basic understanding of insurance accessibility in the large employer markets and understand the fundamental issues of access that have been commonly reformed by most states on the small-employer market segment.

Continuation of Coverage Through COBRA: Expanding guaranteed-issue provisions to the individual market could mean that all former large-group employees (generally coming from the self-insured market segment), currently eligible for COBRA, would have a choice of coverage sources: COBRA or the individual market. Thus, expanding guaranteed-issue provisions to this market would determine the extent of the need for COBRA. In some reformed states, for example, small-group insurers must now accept all comers. As a result, it has been speculated that some former large-group employees with higher-than-average risk profiles, who would otherwise be eligible for COBRA, have been absorbed into the small-group insured market segment, to the benefit of the larger-group self-insured segment. Given that unhealthy people are less likely to be employable, and empirical evidence suggesting that small-group reform has not added much cost to the small-group insured market segment, one can fairly safely assume that requiring guarantee-issue provisions in the small-group market has had only minor consequences.

That will not be the case, however, with requiring guaranteed issue in the individual market, if the guarantee is accompanied by rating rules that allow for age rating. Since COBRA premium rates are group-rated, i.e., linked to the average-active-employee rate of the particular group (plus a 2% maximum increase), barring a group-rating requirement for individual reform, all younger-aged former employees that today are not medically eligible for individual insurance will find comparable coverage in the individual-market segment at cheaper initial prices—reductions of as much as 50%, for those still in their 20s. Consequently, we can expect that half of all current COBRA-covered persons will be transferred to the individual-market segment, reducing costs for the large-group market segment. Given that the average excess-risk cost for COBRA-covered persons today is about 50% of premium for these individuals, transfer of all risks to the individual-market segment may add another 1% to premiums.[7]

Conversion Policies: Once the COBRA extension period expires, many plans offer a conversion plan, which is (usually) subject to individual-policy regulation. Depending on the actual and allowable rates charged for such policies, the excess cost for persons covered by such plans varies between 200% and 400% of normal costs per person (depending upon the rate charged). Some states control premium rates; others do not. In any case, the premium rates are always significantly higher than premiums for normal individual policies, and coverage in many states tends to be for a fairly unattractive benefit package. Thus those who purchase the coverage have tended to be people who were virtually medically uninsurable in the underwritten market. So with individual guaranteed issue, the entire market subsegment comprised of conversion policies would be absorbed into the individual market segment, unless other regulatory controls were put in place to avoid it. A "barrier" like deeming individuals who are eligible for group conversion as ineligible for guaranteed-issue individual market insurance is such an example.

While no data have been gathered to estimate the number and dollars of claims paid for conversion plans, it is reasonable to expect that it would cost the individual-market segment about two to three times more than the expense related to the COBRA issue discussed above. The cost would be greater, unlike with the COBRA issue, because all ages would be attracted to individual-market guaranteed issue, not just the younger age groups, and the costs for older age groups are already roughly three times that of younger groups. This could increase individual-market premiums by 2% to 3%.

[7]Approximately 2% of all employees are on COBRA during a given year; 50% of costs are above standard costs; up to one-half (the younger half) opts out of COBRA to a guarantee-issue individual policy, a market segment one-fifth the size of medium and large groups will result in a one-time surge of 2% above standard costs to the individual market, which translates to a 1% increase in all premiums on individual business.

Selective Transfer of Risk

High-Risk Dumping by Self-Insured Groups: A particularly important issue is the ability of large employers to self-insure only their healthiest employees and pay the lower premiums for the higher-risk employees that could be obtained in the guaranteed-issue individual market. This scenario is generally referred to as "ERISA dumping."

In the situation where the higher-risk employee is to be covered by an individual policy, the self-insured market would no longer have to bear the extra cost. Depending on whether a state's reform subjected only the individual-market segment to this risk, it is not unreasonable to assume that an employer could select a very small portion of those employees with the highest risk profiles to be covered in the individual market, thereby saving at least 2% of health care expenses. That could result in as much as a 6% additional charge to the individual market, because it contains only one-third as many people. According to the National Center for Policy Analysis, 4% percent of the population accounts for half of all claims. It may therefore be possible for a large employer to find the two unhealthiest of every 100 employees and dump them into the individual market, thereby saving something close to 20%. Of course, that may not happen overnight, but it is possible. And, if it did, it could increase prices by ten times the 6% estimate—a potentially devastating outcome for the individual market.

High-Risk Dumping by Insured Groups: Another issue to be considered is the ability of insured groups to "dump" high-risk individuals into a guaranteed-issue market. For medium and large employers who do not self-insure, the problems for COBRA and conversion policies are the same. However, states can try to prevent the dumping of high-risk persons by these employers because they have the right to regulate against such dumping as a means of avoiding disequilibrium between market segments. How successful these regulations have been is not clear. The extra risk is similar to that of self-insureds noted above—ranging from 4% to 40%.

While access for employees' dependents and other group members isn't usually a problem, sometimes dependents do fall between the cracks. For example, when both spouses are in the paid labor force, a question arises as to which spouse's plan of coverage should cover the children. Typically, this is solved by letting the spouses themselves make the decision, thus permitting the costs to average out by employer. However, in a guaranteed-issue environment, particularly if it is known that a child has some serious condition, a self-insured employer may choose not to provide coverage, knowing that the child will have access through the other spouse's employer. That creates a problem–the market with guaranteed-issue reforms may end up with a disproportional share of high-cost dependents' costs. The additional cost for this risk is not considered to be major. Therefore, it is included in the 4% to 40% estimate above.

State High-Risk Pools: There are some potential areas of concern for the individual market for reforms in states with active high-risk pools. Just as conversion policyholders will most likely be completely absorbed by the individual market, so will members of state high-risk pools. Individuals currently insured by such pools have no right of portability to other carriers or plans; also, by law, they usually pay more than the individual market price. Given these conditions, there is no reason why all these people wouldn't immediately opt for coverage through the individual current market segment, if it becomes fully guarantee-issue. Consequently, the individual market segment would have to absorb these individuals, whose costs average 150% above "normal" costs or 250% of normal costs.

Early in 1994, specific estimates were made in Wisconsin and Florida for the cost burden this imposes on the individual market segment: 12% and up to 7%, respectively. (It should be noted that the Florida pool was not open to all eligible people due to funding problems; otherwise, the estimate would have been greater.) It could be higher in states such as Minnesota where enrollment in high risk pools is larger. In states without risk pools, these additional costs still exist, but the costs are borne by the uninsured market or are spread to all markets as uncompensated care, unless the state has a program like Massachusetts, where by state law the Blue Cross/Blue Shield plans must assume all such high risks. In these cases, the cost is included in various segments of that carrier's business and is frequently affected to a degree by other considerations (e.g., premium tax relief, provider discounts, etc.).

Tax Treatment of Premiums: The tax treatment of premiums is of importance when discussing methods of controlling the effects of adverse selection, because, as stated earlier, cost considerations greatly influence individuals' decisions concerning whether or not to purchase health insurance. Individuals who perceive the cost to be greater than anticipated returns will likely forgo coverage.

If guaranteed-issue reform is going to add cost to individual health insurance, then one way to mitigate this inequity is to eliminate the tax disadvantage now borne by those in the individual market. The cost of the tax deductibility of premiums, of course, will vary, depending on the tax bracket of the individual and whether costs are compared to a sole proprietor, partner, or incorporated employee. For a large employer paying about 35% of income for federal tax, the net after-tax cost is only 65 cents for every $1 paid in premium. The cost is even less when state income tax is taken into account. While the numbers are not as great for sole proprietors or partners, the issues are a bit more intricate, because there's no clear-cut difference between some sole proprietors and people who are simply out of work. Federal tax law allows one-fourth of premiums to be deducted, so a sole proprietor in the 28% tax bracket pays only 93 cents, after tax, for every $1 paid in premium. And in most states that piggyback their income tax formulas onto the federal formula, the difference in after-tax premiums is even larger between sole proprietors and corporations. While the loss of deductibility isn't really an added-cost issue to the individual, it is an added cost to all individuals who buy health insurance or for individuals who are migrating from COBRA or group coverage.

CURRENT PRACTICES FOR CONTROLLING ADVERSE SELECTION

The first half of this section examines issues that arise when one market segment is reformed independently of others—a situation that is not uncommon. Because group markets—particularly the small-employer segment—have already been "practicing" implementing universal access, we look to this segment to analyze the implications of procedures used. We analyze the outcomes of these procedures to determine their impact within the context of the small-employer segment, and also to determine how these procedures can be applied to the individual market segment, where such practices are extremely rare because guaranteed issue is nearly non-existent. We conclude this section by discussing a couple of individual market sub-segments that could be used as models for our analysis: conversion policies and high-risk pools.

Minimum Contribution Requirements

In the group market segment, it is common to allow denial of coverage to all employees (or group members) if the employer (or group policyholder) does not contribute a significant proportion of the premium, or capitation charge, for the employee. This practice, known as minimum contribution requirements, is quite effective in controlling adverse selection. Its effectiveness lies in its ability to remove the financial incentive of the employee to seek out his or her own coverage at a time most beneficial to them, which can become a significant issue, particularly if the employee is charged an average contribution within the group, is young enough to find an age-rated individual policy to his or her financial advantage, and he or she is healthy enough to pass the individual medical underwriting screen. Often, there are no required employer contributions for dependent coverage. Technically, contribution minimums create barriers that contradict with universal access goals, because employee accessibility is dependent upon financial decisions made by employers.

Minimum Participation Requirements

For group markets, it has also been common practice to permit carriers to deny coverage, at their discretion, if some proportion (commonly around 25%) of the employees (or group members) decline to participate in the plan in order to deter adverse selection. Such practices are termed "participation minimums." They are designed to deter the adverse selection that could ensue if an employer chose to insure only his unhealthiest employees. While such practices are recognized as contrary to the objective of universal access, most state reform legislation on the small-employer market segment has kept this practice legal; its value lies in its ability to retain the participation of many healthy lives while guaranteed issue is provided to the few (or one) high-risk individuals/individual in the group. Also, it discourages one sort of gaming, wherein an employer covers all his employees, but selects the healthiest to be insured by another insurer, in particular, an individual-market insurer if medical underwriting yields a lower cost.

One recent development in the small-employer market focuses on who gets to choose the threshold percentage. Usually, insurers are allowed to determine it, as long as they do not discriminate by group size. Some states, however, are considering the concept of stipulating some percentage in the statutes, to assure equity.

Minimum Contribution and Participation Requirement Implications

Improving access by removing the barriers of contribution minimums, participation minimums, or both, without any other controls would likely increase the cost of group insurance. However, if removal of these barriers were combined with instituting guarantee-issue provisions in the individual market, the cost, in the form of additional premiums, would be less than that described in the last section of this paper. In other words, cost increases would be offset. But, premium increases for persons in the group market would likely be about one-fifth of the increases for persons in the individual market, since the group market segments are substantially larger (by a factor of five).

It is difficult to determine the effectiveness of contribution minimums and participation minimums in deterring adverse selection independently, partly because they are nearly always operating jointly, and the threshold percentages vary by employer/group size. Removing participation minimums for a large group, where the employer contributes a substantial percentage of premiums, for example 80% or more, would probably have an insignificant impact on adverse selection. Employees in this case—including healthy ones who perceive that they are not likely to require health care services in the near future—will likely determine that paying only 20% of the premium is too good a deal to pass up.

Applying Participation and Contribution Minimums in the Individual Market

While the use of participation minimums and contribution minimums have only been applied in the group market, in theory, such practices could also be made applicable to the individual market.

To the extent guaranteed-issue requirements add cost to the individual market, consideration to equalizing the market by applying similar adverse selection control methods in each market segment should be made. As noted above, removal of participation minimums and contribution minimums in the group market segment would add costs, but, at the same time, help contain the extra costs on the individual market.

Legislation could be designed that requires guaranteed issue to an individual only if an individual carrier can demonstrate that it approached some number (say five or more, for illustrative purposes) of uninsureds with similar employment characteristics to the applicant, and 80% (in this illustration, four of the five) agreed to buy insurance. For example, if a young seasonal employee of an employer who does not offer group coverage applied to an individual insurance carrier, the individual carrier could first approach five of his co-workers with an offer to sell insurance guaranteed, and

accept the applicant contingent upon four of them accepting the offer. In practice, however, this is not feasible. This example is used here to illustrate the point that extending some recently passed small-group reform legislation provisions to individual insurance markets is not a simple matter—the unique characteristics of the individual market need to be considered.

Similarly, allowing individual carriers the right to cancel coverage if too high a proportion of healthier risks lapse could also be legislated. Designs for contribution minimums could also be developed, although it would raise the question of who purchases and pays for part of the policy. Would the federal government assume the role for the individual market?

In any case, while application of these practices may not be feasible in the individual market, this scenario demonstrates some of the reasons that the individual market segment is at a distinct disadvantage to group-market controls against adverse selection, with regard to feasibility at similar costs.

Exclusion of Part-Time Workers

Part-time employees may or may not have access to group coverage, depending on the description of the employer. In small-employer-group reform, guarantees are not always mandated. Should they in fact be guaranteed?

One problem with including them in the small-group guarantee is determining which employer should offer the coverage when a part-time employee has multiple employers. Another problem is economic. Providing full coverage may mean that the employer pays the same contribution as for full-time employees, thus making the cost proportionally higher than for full-time employees. This dampens some of the employer's incentive to hire part-timers—a situation that would have the greatest impact on younger people and smaller employers.

Exclusion of Late Entrants

"Late entrants" is a group-insurance term for employees and or dependents who initially opt to waive coverage, but who subsequently decide that they do want it. Access to insurance for these people is similar to those in the individual market segment, where full underwriting screens can keep people from getting any insurance coverage. However, access for people in small-employer reformed markets differs in that access is guaranteed at a later date during an "open-enrollment period" (described later). In addition, people in this market are often subject to longer preexisting-condition limitation periods than for other insureds—a practice that is also not unusual within large-group insurance.

These procedures are used because, like the individual market, the small-group market is susceptible to adverse selection risk. Guaranteeing access for these employees would add new costs to the system and invite individuals to game the system. If we assume once again that the adverse selection cost for individuals is 10%, the adverse selection cost for group premiums would diminish inversely with the size of the group.

Treatment of Estranged Dependents

Determining responsibility for providing health insurance for children of divorced parents can be problematic. Legally, a child may be a dependent of one parent working for an employer in a guaranteed market, but the other parent may—by court decree—be responsible for insurance coverage for the child. This parent may not have access to guaranteed insurance. If the child has a serious medical problem, the issue arises as to whom should bear the cost of coverage.

Preexisting-Condition Limitations and Waiting Periods

The use of preexisting-condition limitations is a practice that permits carriers to exclude payment for medical expenses relating to conditions that began before the current insurance was issued, for a specified period of time, generally three to 12 months. Waiting periods are similar in their application and purpose, except they exclude coverage for all conditions regardless of when they commenced, for a period of generally 30 days (sometimes as high as 90 days). Because of difficulties some HMOs have in billing for and distinguishing preexisting-condition limitations, many HMOs cover all conditions immediately, but, if guaranteed-issue laws heighten adverse selection, it is more likely that the use of waiting periods will become the preferred choice of HMOs, while preexisting-limitation conditions will be the choice of traditional insurers.

While this practice works technically so as to remove some of the adverse selection cost from the system, it also lessens access to it. Obviously, incurring a major medical expense during the pre-existing exclusion or waiting period is a risk. Despite this penalty, it has been widely accepted that denying some level of access for some stipulated period is an acceptable way to lessen the cost consequences of adverse selection.

Credits against the exclusion or waiting period are often provided for prior continuous coverage, so individuals or employers who are re-purchasing coverage for reasons other than adverse selection are not penalized. (Note: Later purchase of health insurance without invoking full preexisting condition exclusion periods enhances "portability," an element of many health insurance reform bills.)

Although small-group insurance reforms, including guaranteed issue, have been in place for several years in some states, no experience data are available for directly quantifying the effectiveness of the preexisting-condition limitation in isolation from the impact of other guarantee-issue elements of reform. However, there are several related models of insurance that have been around for some time that can provide some idea of their effectiveness. For the individual insurance risks, state high-risk pools, and, to a lesser extent, conventionally insured individual policies, can serve as such models. For small-group insurance, there was a time in the late 1980s when companies offered insurance on a guaranteed basis, although there were some additional elements that make this a less than perfect match. Looking back at experience during this time period can also provide insight into cost implications of such practices.

State high-risk pools have been operating for as long as a dozen years (Minnesota has been operating its high-risk pool

since 1976). Because pools operate in nearly the same way as pools of privately insured policies, the primary difference being that they serve medically uninsurable people exclusively, they cast some light on the experience one might expect if a guaranteed-issue environment were expanded to the entire marketplace within a voluntary system of insurance. Even these state-run pools have, typically, included preexisting-conditions exclusion periods as way of deterring anti-selection.

An unusual situation in Florida's high-risk pool in 1991 provides a unique opportunity to observe what happens to health insurance costs when a preexisting exclusion device is applied. In April 1991, all state residents otherwise uninsurable were given a one-time, six-month opportunity to enroll in the state's program, FCHA; the state's sole protection from adverse selection was a 12–month preexisting- condition exclusion period, which was strictly enforced. About 7,000 individuals enrolled during the six-month window.

Since there was no new enrollment beyond the six months, we can track what happened to costs immediately after the window closed, immediately after the 12-month exclusion period closed, and in the subsequent period beyond the 12 months. Reviewing these costs does not provide direct information on the potential impact on the individual market, which, even in the guaranteed environment, would be expected to have a better risk mix than a high-risk pool. However, the experience of these pools does shed some light on the effectiveness of preexisting-condition limitation periods. Even with a 12-month period, the cost during the time period immediately after the expiration of the period was found to be $140 per person more each month than the average cost of $300 during the period. That's nearly a one-year 50% surge in cost, which is equivalent to an additional cost of about 20% each year the policy is operating. To translate that additional cost to a premium impact we need to factor in the fact that high-risk pool members incur claims at a rate 3 to 5 times that of non-risk pool insureds. So, dividing these two, we can estimate the premium increases to range from 4% to 7%. (See Appendix 1 for a more thorough presentation of the implications of what happened in Florida.)

Experience of the preexisting conditions limitation for small-group insurance is documented by Stephen Brink, James Modaff, and Steven Sherman in their report, "Variation by Duration in Small Group Medical Insurance Claims" (pp 338, 341 and 376-380, Tables 4, 6 and A4, Transactions, Society of Actuaries, 1991-92 Reports). This article supports the conclusions with regard to Florida that significant adverse selection costs exist under such limitation provisions. With 389,000 months of guaranteed small-group insurance coverage experience in 1988 and 1989, with a 12-month preexisting condition exclusion period in place, costs surged immediately after the expiration of the twelfth month, decreased over the next 12 months, and slowly stabilized throughout the fourth and later years. Pertinent details are given in Appendix 2.

While these examples might indicate that 12 months is a common duration for a preexisting- condition exclusion, reforms of the last few years favor six months for the small-employer market and 12 months for individual. While we have no data to determine the relative cost difference between six and 12 months, it is safe to assert that the shorter the period, the less effective the preexisting condition exclusion will be as an adverse selection control. How much difference can be expected is a difficult question to answer. To attempt an answer, we can look to similar models to give us some clue about the maximum costs one might expect if the period was zero. The model we will use is the experience of group conversion.

Group conversion is a process whereby individual policies are made available, in some states, on a guaranteed basis to individuals who terminate from a group insurance plan. As discussed earlier, these policies are generally very costly. Most insurance companies have loss ratio experience for such plans, indicating that claim costs in the first year after conversion from group coverage vary between 180% and 500% of standard costs, depending to a great extent on the level of premium charged for the converted policy (Higher premium plans may attract only the very sickest, while lower premium plans attract a broader risk pool.).This figure becomes the baseline, i.e., the zero-day exclusion period cost, which can be used for interpolation for exclusion periods between zero and 12 months.

For example, suppose one is attempting to estimate the relative cost increase of requiring a six-month preexisting-limitation period on individual business, where rates would be limited to 150% of other non-guaranteed plans. To do this one might interpolate between 200% (the value close to a limited premium conversion plan with no preexisting exclusion period) and 140% (the claim costs after the relative surge noted for the Florida high-risk pool) to estimate the size of the increase in costs after the sixth month. The point here is not to demonstrate the actuarial techniques involved, but, rather, to indicate that many factors must be considered before any conclusion on additional cost can be reached.

Just as one would expect costs to increase as the preexisting-limitation periods decrease, it is safe to assert that the inverse is also true, as a preexisting-limitation periods increases, additional high-risk costs due to adverse selection will decrease. However, data show that even 24 months is not long enough to eradicate the cost increases completely. Thus, preexisting-limitation periods delay the additional costs, but do not fully eliminate them.

Limited Periods of Open Enrollment

Providing a window or limited period instead of continuous open enrollment also offers a deterrent to adverse selection. Open enrollment periods are periods set aside when individuals may apply for insurance without having to provide medical evidence of insurability. Usually set at 30 days occurring once a year, open enrollment programs are not in wide use because, to be effective in deterring adverse selection costs, the open enrollment period must be relatively short, leaving long periods of time when insurance is not guaranteed. This, of course, significantly undermines the fundamental principle of guaranteed-issue. Insignificant data are available to quantify the adverse selection cost of having open enrollment periods.

Guaranteeing an Entire Portfolio Or Only Selected Plans

Typically, in early small-employer reform efforts, insurers were required to guarantee issue only a specified "standard" or "basic" plan. Insurers retained the option of selectively issuing other plans in their portfolio based on applicant characteristics, such as health status. More recently, however, subtle changes have prompted reforms to include the requirement that all plans in an insurer's portfolio be guaranteed.

One factor leading to the increased use of requiring the guarantee of all plans is that the use of "standard" and "basic" plans requires defining "fair prices" or objectively determining the difference between the two "guaranteed" plans and other plans offered. Without doing this, access could be severely hampered, because rates for the other plans could be set significantly higher. Some states allow as much as a 100% differential to avoid the worst, assuming that this will provide access for everyone. However, access would not be "universal" if better products were made available to healthier risks of the insurer's choosing.

The combination of questions regarding objectively measuring rate differentials and questions regarding universality has led some states to adopt legislation requiring insurers to guarantee issue all plans in their portfolio. In this way, market forces act to prevent unfair rate differentials between plans, because individuals who are unhappy with a rate can switch plans or carriers. In such legislation, however, there still is a need to regulate premium rate differentials within a plan. It could be a simple matter of prohibiting any differential based on health status or experience, or more complex by limiting by a specified percentage. In any case, ensuring "objectivity" is no longer a problem, because benefits would be the same.

V. Maintaining Equilibrium in a Post-Reform Market

While the discussions above show that remedies can be developed to address almost all of the issues that arise when market segments are reformed independently, it may be better to reform all insurance markets simultaneously. If this is not possible, simultaneously reforming the small-employer market and the individual segments should be considered. For example, the undesirable burden placed on the individual-market when compelled to accept all comers can be lightened, with respect to persons from the small-employer market, if legislation exempts the individual market from having to guarantee conversion to all eligible people (regardless of the prior group carrier), and at the same time, requires adequate conversion coverage by the group insurer at fair market prices.

There are two more direct, but somewhat more complex, approaches than attempting to control adverse selection by building barriers either between market segments or setting up barriers to access as described in Chapter IV. These approaches can be used in conjunction with some, all, or none of the controls discussed in Chapter IV, allowing the extra cost of adverse selection to be borne by the system. Approach 1, "allocation," is intended to prevent the transfer of costs from their current location in today's more stable environment. Under this approach, regulations are in place to control which market must insure the high-risk individuals. Approach 2, "risk adjustment," involves the transfer of any unbalanced costs that arise out of desired guaranteed-issue reform elements. It is a mechanism for equitably sharing the expected (or known) costs of high-risk individuals by transferring charges or costs between insurers.

Allocation

At some point in life, nearly all individuals are deemed to be a desirable (i.e., insurable) individual—a situation which in some cases may only occur at birth. Thus, a system could be designed to retain individuals within the market segments in which they first obtained insurance, rather than permitting them to adversely select against the segment to which insurers direct them. This is the guiding principle behind the allocation approach.

The allocation approach attempts to equalize the risks borne by the various carriers by designing a regulatory framework that encourages high-risk individuals to be insured by carriers in proportion to the total number those carriers insure. While this approach has been considered, it has not yet been adopted by any state (although elements of it can be found). It is likely that the reason this approach hasn't been used is that few states have taken a total-market approach to reform. In addition, individuals involved may object to having a limited choice of carriers, even if this limited choice is only temporary.

One design of an allocation model would allow market forces to equitably distribute high-risk cases. For whatever reason when a person or employer changes carriers (by choice, employer choice, actions of a carrier, etc.), equitable allocation will be automatic if, in theory, a high-risk individual or group is guaranteed access to insurance only through the carrier that last insured that person or group, i.e., the source of that person's or employer's last coverage before they became an applicant for guaranteed-issue plans. The issues that follow from this concept depend on which market last provided coverage.

The following are design examples of how such an allocation could work for the more common sources of previous health insurance coverage. This is an incomplete list. Designs could also be developed for other previous sources of coverage, including Medicaid, self-funded, out-of-area HMOs, carriers leaving health insurance business, etc.

Group Carrier as Source

■ If a person loses insurance because of leaving a group, for whatever reason, regulations could be established to require the carrier who provided coverage to that group to be the only carrier required to provide individual coverage, even if the company did not have the administrative capability to do so. Group insurers could contract with individual market insurers for this service. Obviously, the extra cost would be borne by the group insurer, and, consequently, spread among active group insureds. While this would increase group costs, the relative size of the added cost would be small, and a much lower cost increase would accrue to the individual market. Minnesota used this approach in its 1992 Minnesota Care Reform legislation (including a cap on premiums).

Individual as a Source

■ Individuals who drop coverage, and then want to get back into the system, could be required to reenter via their prior carrier. A "pay-back" penalty approach described in detail in Appendix 3 would fit this model. A pay-back system does not exist today. It is method that would require individuals who voluntarily leave the insurance system to "pay back" previously unpaid premiums upon reentering the system at a "fair" surcharge level.

■ Individuals dissatisfied with their present carrier, for whatever reason, could be allowed the guaranteed right to purchase individual coverage from any other carrier. This could be dependent upon whether they have been covered by the individual carrier for a specified time period, such as 2 years. State insurance commissioners could make exceptions to this rule based on hardship. However, for some period of

time, any claim costs related to an illness that began during coverage under the prior carrier could be charged back to that previous carrier from the new one.

No Prior Insurance as a Source

■ There could be a stipulation that, after an individual has gone without coverage for some specified period of time (one year or more might be a good example), it would be unfair to attribute responsibility for new medical bills to the prior carrier. This approach may also be useful in drafting transition rules in states that adopt the allocation approach.

■ It has been proposed that a single clearinghouse, possibly the state insurance department, randomly assign one to three potential insurers who must guarantee-issue to the applicant, based on the insurer's proportion of all business transacted in the state. Alternatively, each carrier could be assigned some predetermined maximum number of applicants that it must guarantee-issue each year, based on its market share. This alternative, while offering the applicant more choices, subjects carriers to the risk that they will end up with a greater share of high risks than their competitors, if the predetermined maximum is set too high. Of course, if it set too low, some people will be locked out of the system.

RISK ADJUSTMENT

While allocation methods attempt to equalize risk distribution by preventing biased redistribution among insurers and—more importantly—between market segments, risk adjustment methods transfer funds among carriers, so that costs are redistributed in the event that the distribution of high-risk costs has somehow become biased as a result of a guaranteed-issue requirement. Risk adjustment methods also address biases resulting from other factors, most notably, community rating.[8] The following discussion highlights only the issues most germane to guaranteed-issue.

In theory, there are two types of risk adjustment mechanisms: those that transfer sums of monies between carriers based on past claim experience and those that transfer monies based on expectations concerning biases among carriers. For the latter, anticipated excess costs are generally calculated based on the demographic characteristics of the insureds or on data related to prior health care use. In practice, however, it is more common to see a combination: past claims transfers and anticipated high-risk costs. That combination approach is usually handled via mechanisms called "reinsurance pools," while those involving the transfer of anticipated costs are normally implemented before the costs are incurred, usually at the beginning of each year or at the time a risk is assumed. One example of a pure-past-claim-experience approach has been adopted for the individual market in New Jersey: participating insurers may ask for a transfer of monies to compensate them for losses, in excess of a certain threshold, at the end of the year. Requests must be made by mid-year, and must be based only on that year's reserves. The threshold is related to actual experienced loss ratios.

REINSURANCE POOLS: COMBINING TRANSFERS OF PAST CLAIMS AND ANTICIPATED FUTURE COSTS

Reinsurance pools are used extensively as one element in small-employer reforms. The insurer selects which groups, or individuals within the groups, are considered excess-cost insureds under a guaranteed-issued plan. For a premium, such as 150% of an established fair-premium schedule (developed by a state board that manages the pool) for an entire group, and 500% for an individual employee, the insurer may "sell" most of that risk to the reinsurance pool. The carrier does the administrative work on the case, but will be reimbursed for any claims it pays in excess of a threshold retention limit ($5,000 is common). The retention limit motivates the insurer to manage claim costs efficiently, while the high premium charge prompts the company to retain some of the burden for the high-risk case, thereby discouraging unnecessary use of the reinsurance pool. If the pool still incurs losses, the pool assesses all participating insurers to recover the loss. The carrier then spreads the extra costs (the high premium charge, claim retention, and assessment) among all its insureds.

While pools have been in place in many states for several years, their actual use has been minimal. Insurers who believe they are at less risk (compared with their competitors) of getting a higher-than-average proportion of high risks usually opt out of these pools. In contrast, smaller insurers and others who, because of their market position, believe they will get a higher proportion generally opt to participate. Unfortunately, when few participate, the benefits of reinsurance diminishes quickly, and, consequently, whether these pools have any real value is an open question at this time.

A requirement that all insurers participate would be one way to get around this problem, but large insurers and HMOs are generally resistant to this idea or believe they manage their claims costs more efficiently, which is typically the reason that HMOs do not participate with indemnity carriers.

At the other extreme, with guaranteed issue of individual insurance, this approach can become quite valuable. The key issues in this environment are (1) How high should premium levels be? and (2) Who should be sharing the costs: Only individual market segment carriers? All insurers under state regulation?, or the self-insured? Reinsuring only with carriers within the individual market segment will do little to the control costs which, previously in this paper, were identified as coming from other segments. This observation seems to imply that reinsurance with other market segments is an absolute requirement.

[8]For a more detailed discussion of risk adjustment, see Academy health care reform monographs numbers 1 and 14.

After a period of experimentation, during which time the right levels of premium and threshold are determined, there is no actuarially-based reason to believe such an approach could not work effectively to put a system reformed by adding guaranteed issue back into equilibrium.

The 500% premium charge, common for individuals reinsured in the small-group market, may be too high for the individual market segment, because of the higher proportion of risks likely to be in it. Quite possibility, 200% may be a better starting point. However, if other allocation-type controls, and effective preexisting controls were in place, a range of 250% to 300% may be more appropriate. Of course, even if equilibrium is achieved between markets by this method, as discussed earlier, some degree of adverse selection is unavoidable in a voluntary market. But the goal of keeping additional costs for all market segments at approximately 3% appears to be attainable, particularly if the ERISA dumping risk and ERISA cost claims are addressed.

TRANSFER OF ANTICIPATED CLAIMS

Many experts, actuaries included, believe that a system can be developed for determining the expected relative cost differences of including higher-than-normal cost individuals in an insured population for both group and individual market segments. In such a system that uses a risk adjustment mechanism, on a periodic basis (annually, for instance) all insured individuals are analyzed in terms of their predisposition to higher-than-average expected claims. By using a formula based on variables such as demographic characteristics, past claim history, or activity level, what is presumably an adequate estimate of extra costs can be made. Once identified, those costs are compared with those of other carriers in a market segment, or multiple segments; those that have a higher share of costs receive a balancing amount from those with lower-than-expected costs.

Most experts like this approach, in theory, because it's an equitable way to balance costs among market segments and insurers while at the same time preserving appropriate incentives for managing care of high quality and low costs. But there is one big problem: no one has yet developed a working system that could be considered a success. New York passed a law patterned very closely on this approach, but it is used in combination with other approaches (based on specific additional conditions), and is limited to a few demographic factors. Minnesota has created a public-private association to determine how risk adjustment between, and within, insured market segments will be handled in that state.

TRANSFER OF PAST CLAIMS

State high-risk pools and the New Jersey regulation can serve as models for demonstrating how past claims transfers can be handled as a method of risk adjustment. Based on claims experience relative to some fixed value, many state risk pools simply assess all insurers, in proportion to their state market share, an amount to keep the pool financially viable. Many states (including Wisconsin) simply set premium rates for the pool at roughly 150% of a standard market premium rate, with one state simply setting rates equal to 60% of plan costs. Any losses that the pool incurs because of higher-than-expected excess costs are simply assessed back to all insurers once they are recognized. The New Jersey model essentially assesses losses in excess of 80% of a participating carrier's premium.[9]

This simple concept entails some problems when put into practice. Calculating the fixed value relative to a loss ratio may mean that companies that underprice would be subsidized by others that price more fairly. Setting the fixed value at a level above a minimal break-even level for an insurer may discourage that insurer from competing in the market, and would make the system a lot like the reinsurance model described above, but without the same incentives for managing costs. Despite these drawbacks, one state, New Jersey, has implemented a variation of this concept in the individual market.

[9]Please refer to a forthcoming Academy of Actuaries' state health care reform case study report, which will include a discussion of New Jersey's system.

VI. Conclusion

The key issues to address when providing for guaranteed issue in a voluntary private health insurance market are (1) how to minimize the impact of adverse selection, in total, that results from universal access, and (2) how to spread equitably the impact of adverse selection among all segments of the market to reduce market disruptions.

The conclusions expressed in this paper to address these issues may appear to condemn, a priori, any attempts to make universal access workable in a voluntary private market. However, our somewhat more optimistic conclusion is that a new system characterized by compromise can be designed within framework of a voluntary system—a position that deviates from the long-held assumption that the only way to achieve the goal of universal access is to mandate insurance participation. Of course, from a purely technical standpoint, it should be clear that mandatory participation may most clearly achieve universal access at the most affordable price.

The clear benefit of such a compromise would be greater numbers of people with access to the private insurance market. The compromise might involve, say, a preexisting-condition exclusion limitation as a deterrent for adverse selection, a reinsurance pool (or other risk adjustment allocation method) to transfer any unintended cost shifts between markets, combined with premiums that are only slightly higher than today.

Ensuring universal access is a complex undertaking, comprised of a multitude of interrelated elements, all of which must be carefully understood. Any universal-access legislation must consider the interdependent nature of market segments, and must have clearly articulated goals. Finally, procedures must be put in place to monitor all of the emerging consequences of reform legislation—intended as well as unintended.

VII. Appendix 1

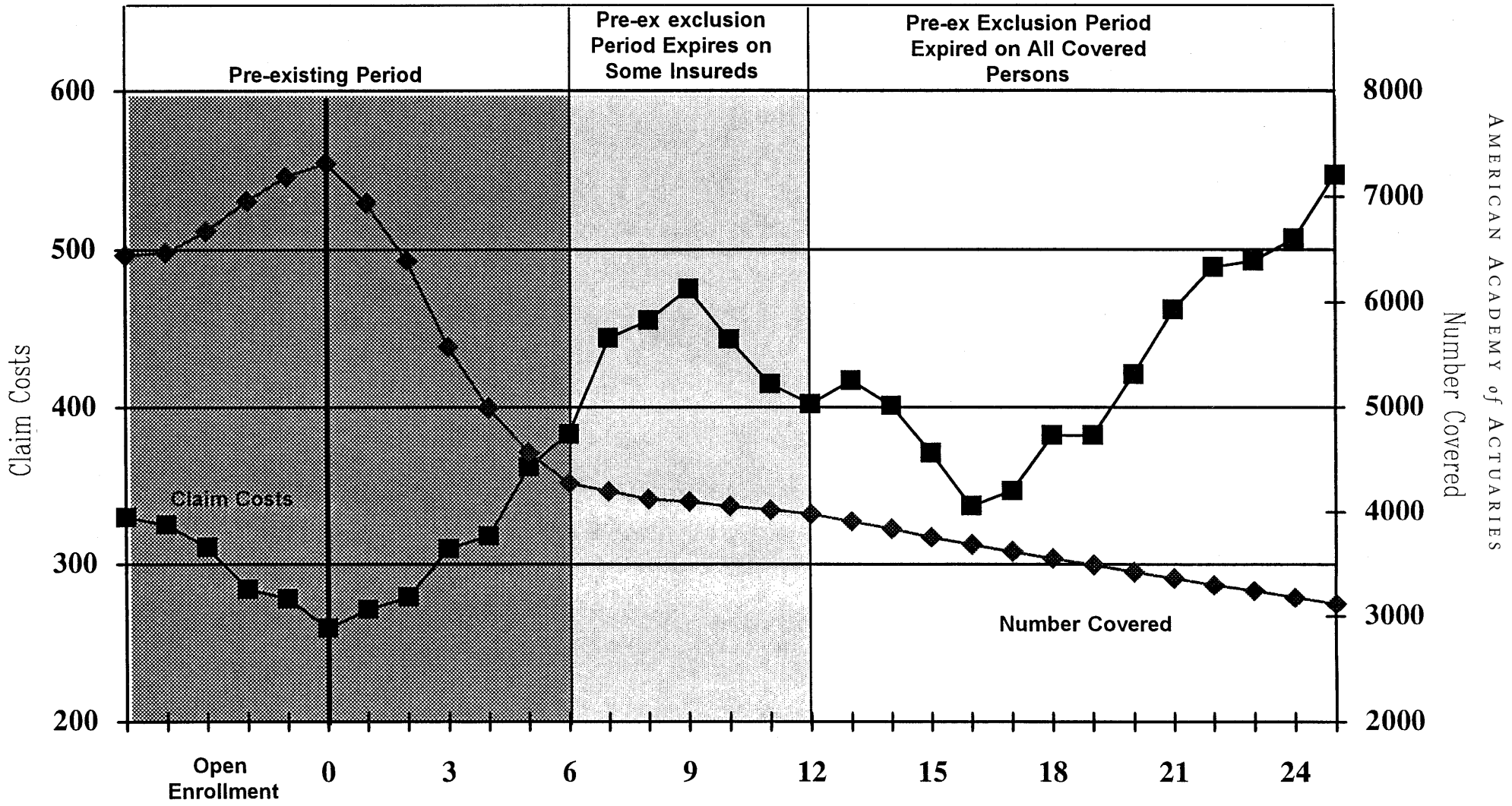
Florida Preexisting-Condition Limitations
Cost Data

The following graph shows a clear surge in costs after the preexisting exclusion period expires for most individuals, by more than a $140 per person per month, up from a relatively stable cost of around $300 during the exclusion period. Then, costs stabilize somewhat for the next six to nine months, only to begin to increase again, albeit not as abruptly as after the 12–month period. What this tells us, most likely, is that most individuals defer any noncritical treatment until after their preexisting exclusion period ends. The fact that costs seem to stabilize a few months after the preexisting period ends isn't so much an indication of an improvement in costs as of a readjustment to a cost level that is higher than what was experienced during the first 12 months when some conditions were excluded. The pattern wherein stabilization–period costs are higher than the initial 12–month–period costs is an expected result.

The fact that costs rise once again, at a relatively rapid pace, beyond the 21st month is a result of what is known as cumulative adverse selection, or, alternatively, adverse selection due to adverse lapse.

CHART 1
Average* Monthly Claim Costs VS Total Insureds on Patterns From Open Enrollment Periods Beyond Pre-existing Exclusion Periods

Florida Comprehension Health Association



* 3 month rolling average

The pool shrinks rapidly to less than half its original size in less than 28 months, thus substantiating the theory. (A more thorough discussion of this phenomenon is outside the scope of this monograph.) Charts 2 and 3 represent a restatement of Chart 1, expressing costs as annualized trend rates, which serves to illustrate our conclusions more clearly.

CHART 2
Annualized Trend on
Patterns From Open Enrollment Periods Beyond Pre-existing Exclusion Periods

Florida Comprehension Health Association

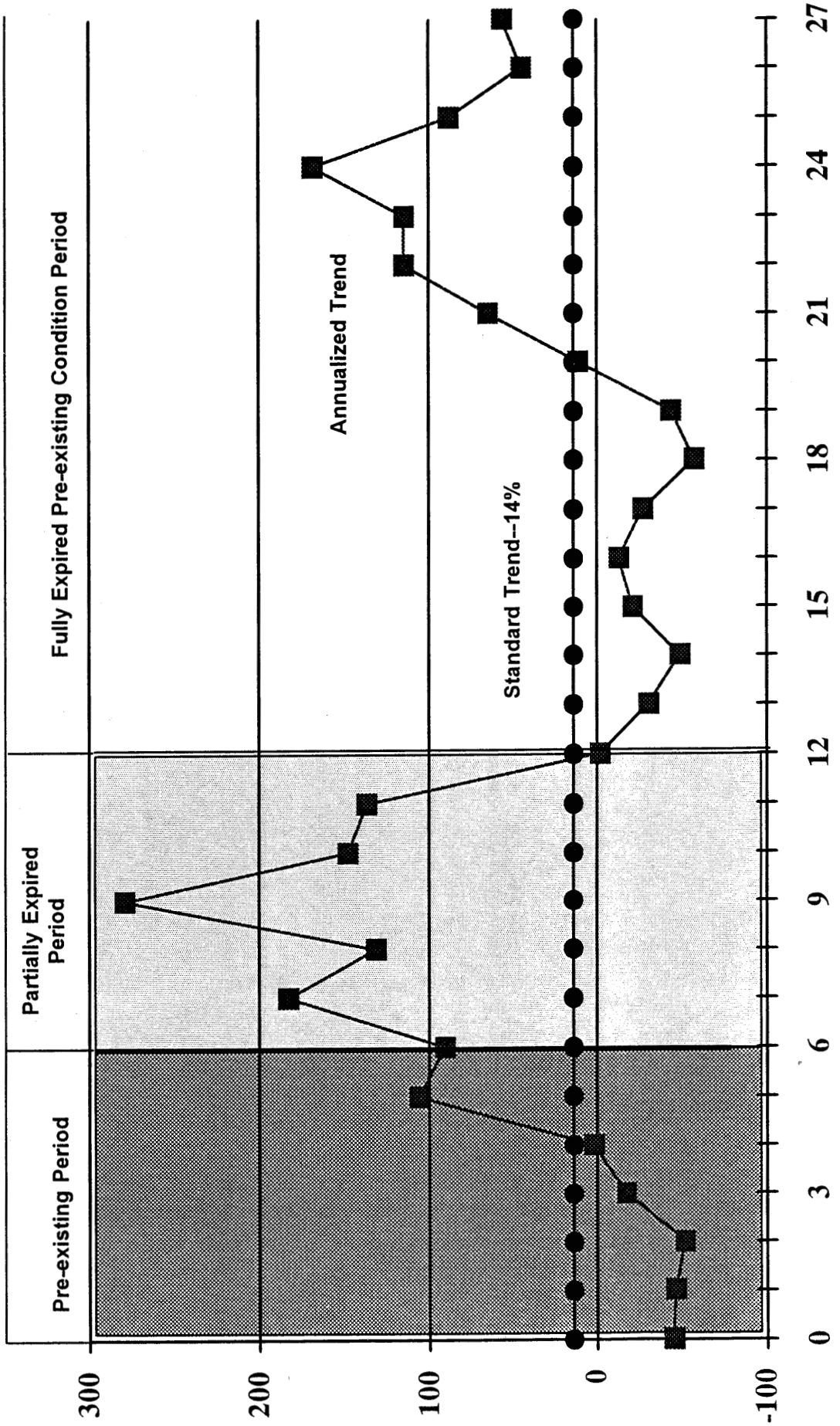
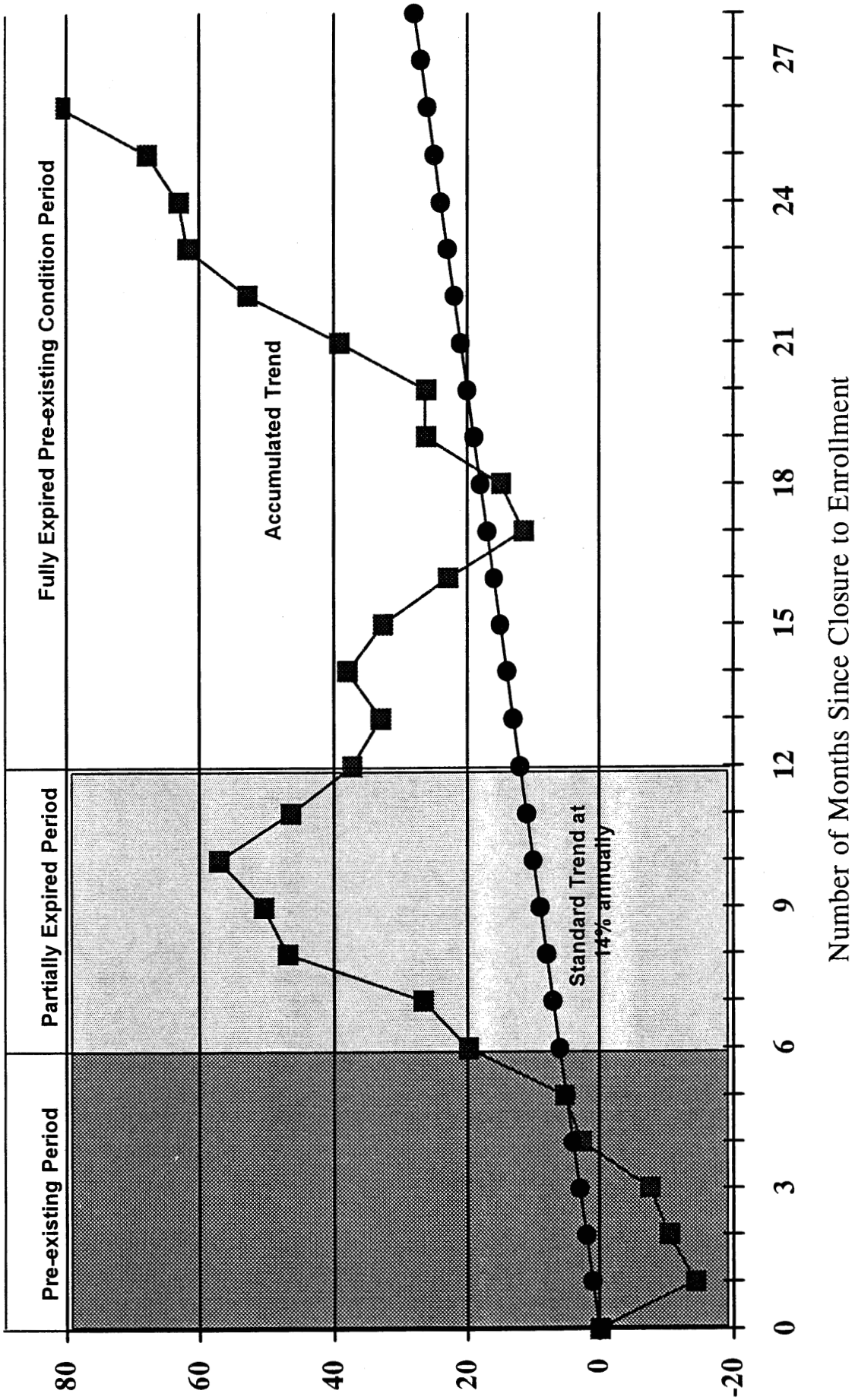


CHART 3
Accumulated Trend on
Patterns From Open Enrollment Periods Beyond Pre-existing Exclusion Periods

Florida Comprehension Health Association



Because claim costs are expected to increase each year, anyway–irrespective of any reforms–these trends must be compared with the normal trends for the health insurance business. This will allow us to isolate and analyze the impact of adverse selection by itself. Thus, each of the two graphs above has a standard–trend line. The extent that the trend line Florida deviates from this standard–trend line indicate's the relative cost of the adverse selection. The fact that the trend is sometimes better than normal in Chart 2 could easily be misinterpreted as a desirable result, so Chart 3 has been drawn to show the accumulated cost increases are always higher than with a standard accumulated trend.

VIII. Appendix 2

Small Group Preexisting-Condition Limitations Cost Data

Stephen Brink, James Modaff, and Steven Sherman in their report "Variation by Duration in Small Group Medical Insurance Claims", (pp 338, 341 and 376-380, Tables 4, 6 and A4, Transactions, Society of Actuaries, 1991-92 Reports)

Charts 4–6 illustrate a pattern of claim cost that support the conclusion that there are significant adverse selection costs in small groups with preexisting exclusion limitations.

These charts exhibit patterns, in the months immediately prior and after the preexisting period expires, that are very similar to what was noted in the Florida individual–model situation. Beyond 18 months, after the preexisting period expires, the two models differ for reasons unrelated to the preexisting provision claim costs, i.e., they do not accelerate in the ultimate years, probably because the cumulative adverse selection phenomenon is not a concern in the group example. (The group example, presumably, is based on groups paying premiums at rates comparable to market rates available through underwriting, while the Florida high risk pool is comprised of individuals paying much higher rates than are otherwise available through conventional private insurance. Guaranteed issue was commonly only available to those groups who could demonstrate prior continued coverage with good prior coverage loss experience. The significantly depressed costs noted in the earliest months of the small group experience is different from what was seen in the Florida individual model; the reason for the lower costs is also unrelated to preexisting condition provisions. It is the result of a deductible that was imposed in January despite the fact that another deductible had been applied a few months earlier when the policy was issued.

CHART 4
Average* "Monthly" Claim Costs by Pre-existing Exclusion Period Situation
1988-1989 Small Group Experience on Guaranteed Issued Business

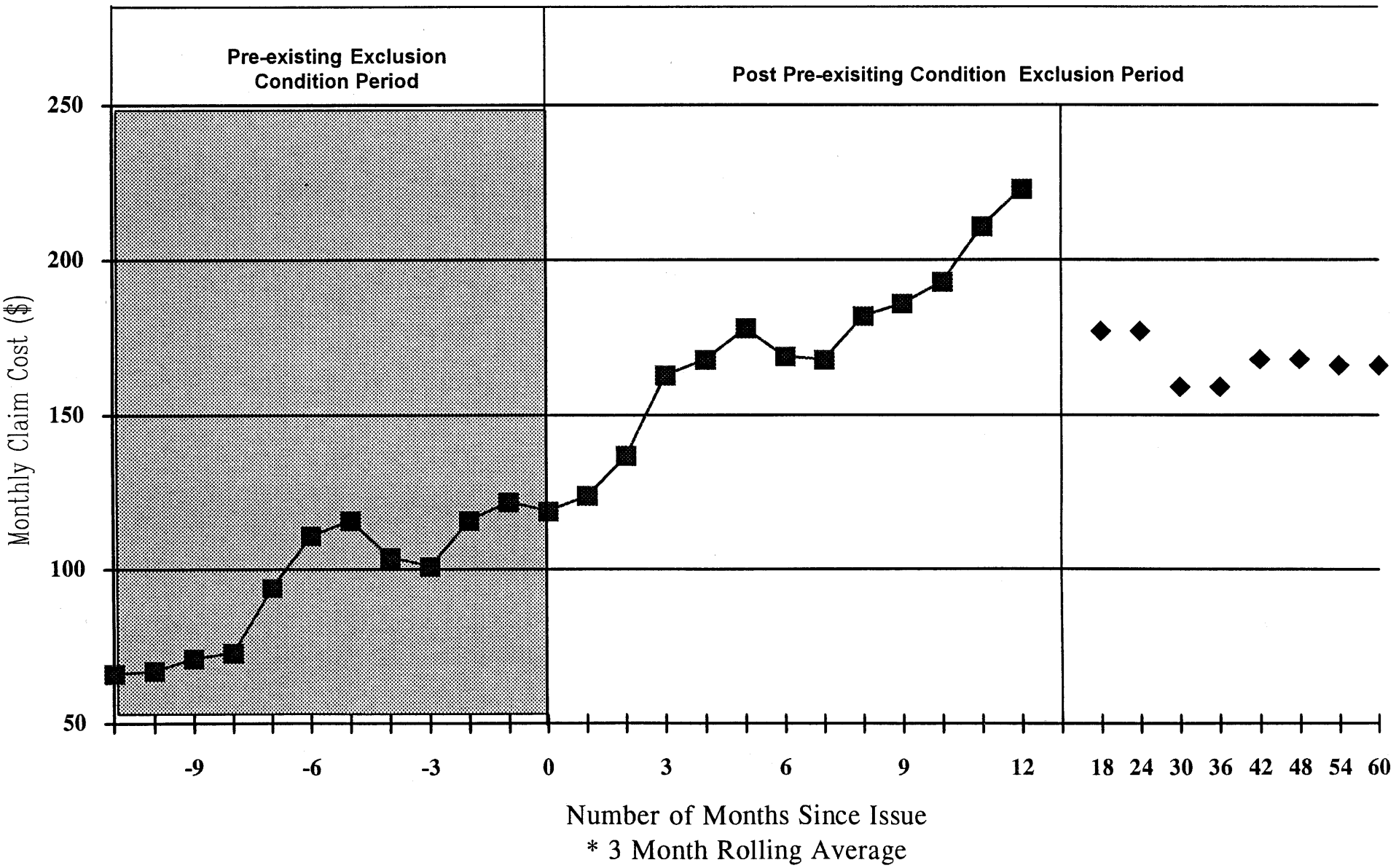


CHART 5
Annualized Trend by Pre-existing Exclusion Period Situation
1988-1989 Small Group Experience on Guaranteed Issued Business

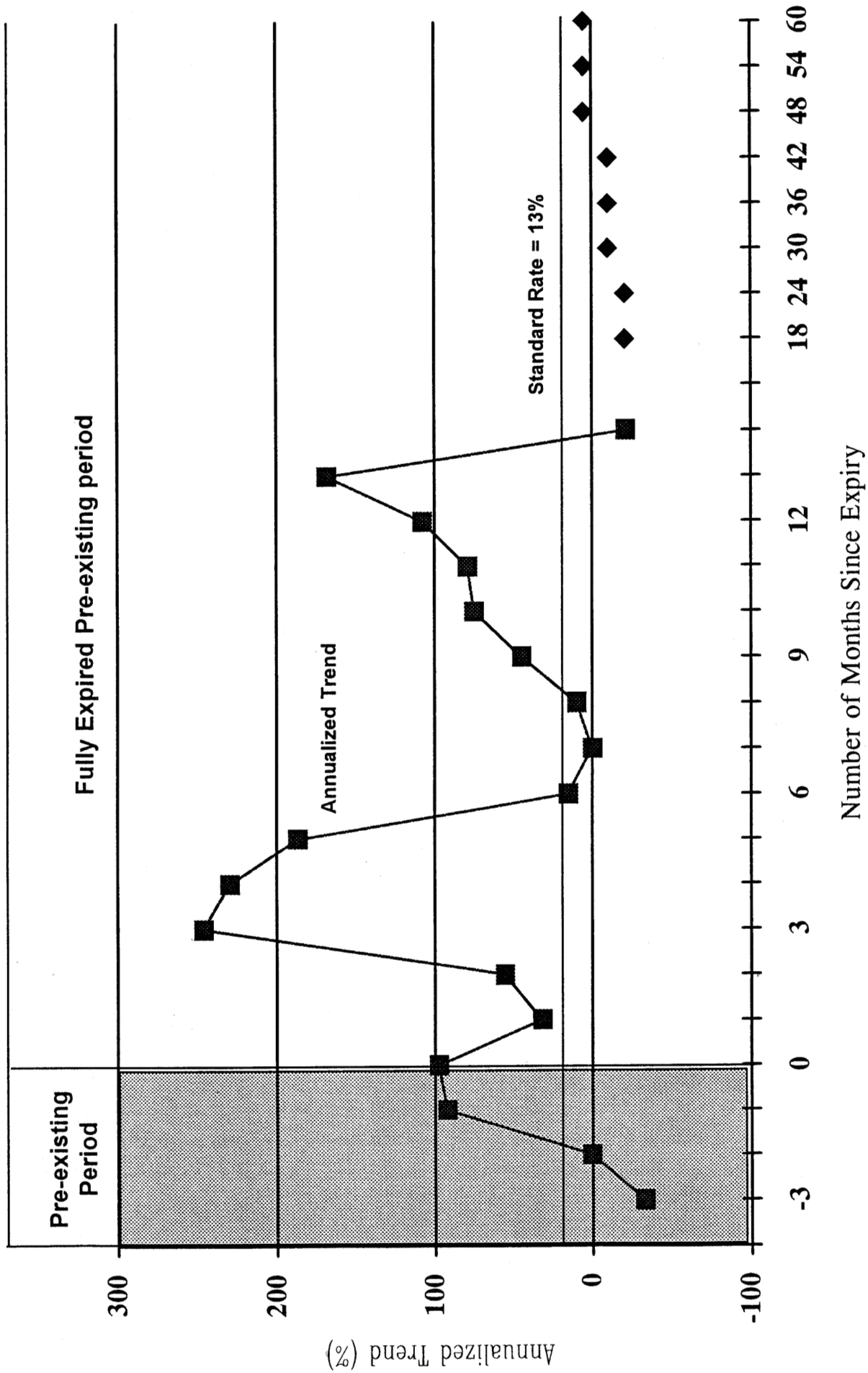
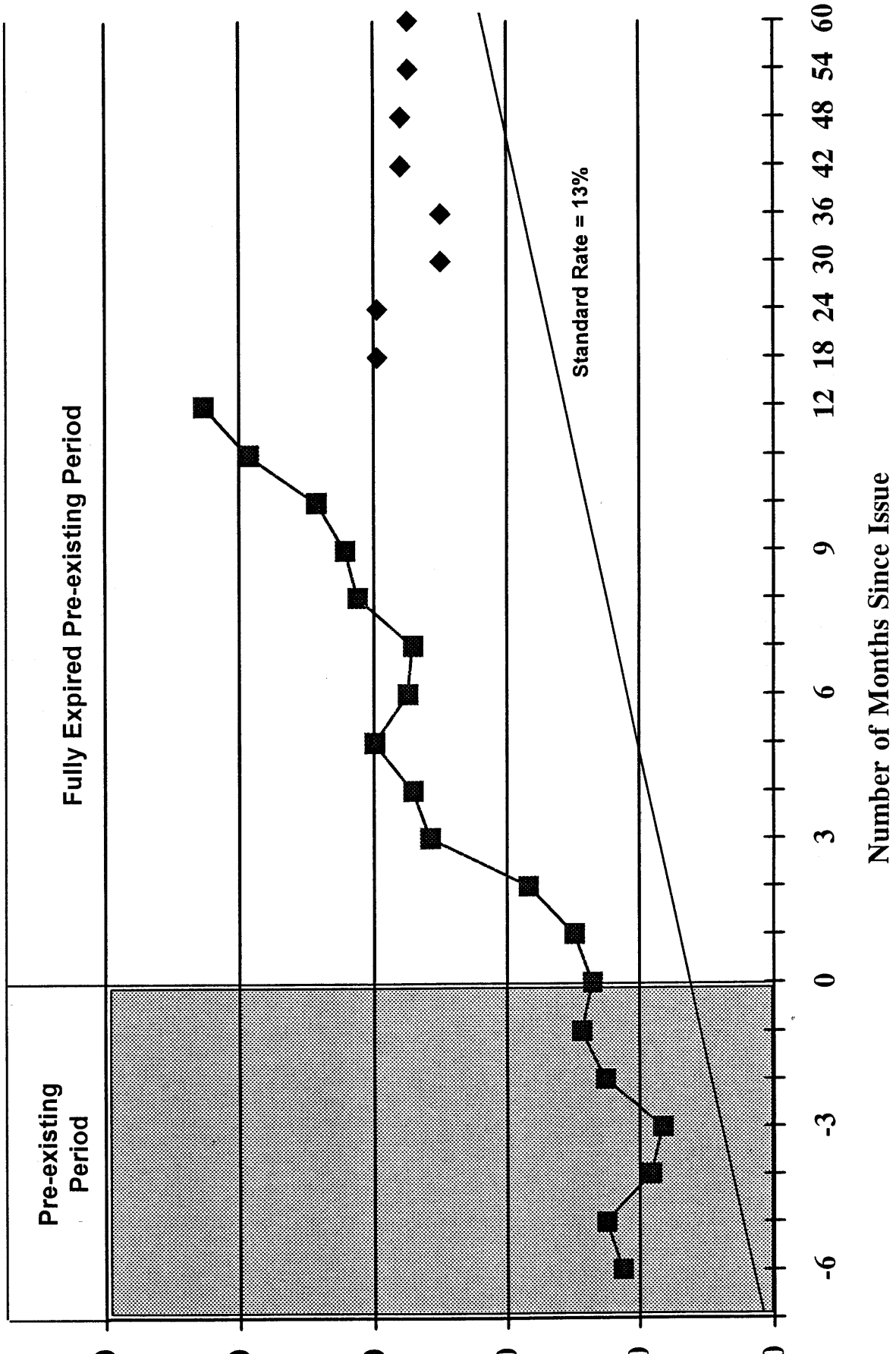


CHART 6
Accumulated Trend by Pre-existing Exclusion Period Situation
1988-1989 Small Group Experience on Guaranteed Issued Business



VIV. Appendix 3

Alternative Idea To Open Enrollment And Preexisting-Condition Exclusion—'Pay Back'

Both preexisting condition limitations and open enrollment practices can act as significant anti-selection deterrents to adverse selection because of their "penalty" orientation. Today's health insurance system compels individuals and/or employers to remain in the system and pay premiums, despite their health status, because the threat that they may not be covered when the need insurance coverage most.

Unfortunately, "not being covered" exposes a consumer to a penalty of unknown magnitude, irrespective of the motive and length of time the consumer or employer may have gambled without insurance. In some situations, the penalty could be so severe as to precipitate financial ruin for an individual. In response, we have developed an alternative concept that best fits the penalty with the crime, without undue financial pressure to increase the price of insurance.

Rather than expose an individual who gambles without insurance to risks of unlimited financial loss, an adequate deterrent might be one that links the magnitude of the "penalty" to the size of the crime. The "crime" in this situation not paying one's premium, and then opting to get back into the system. A reform feature could be designed so as to make an individual (or employer) pay an additional premium, equal to some factor of the monthly equivalent premium one must pay upon reentry into the system under a guarantee, multiplied by the number of months the individual was without insurance coverage. The factor could be two, subject to a minimum and maximum (such as five times the monthly premium as a minimum and the 48 times the monthly premium as a maximum.) In the worst–case scenario, an individual without insurance faces catastrophic medical cost. Presumably, that person would quickly take advantage of the guarantee and purchase a policy of coverage.

As noted above in the discussion on preexisting-condition exclusion limitations and open- enrollment practices, regardless of the length of time an individual has gone without insurance, he or she is at equal risk for the entire expense of treating a medical condition that may be excluded because of one of these practices. For example, if an individual suffered a stroke during a period without insurance coverage that resulted in a major medical expense of $25,000, the financial "penalty" for gambling and losing on coverage would be the same, regardless of whether that individual missed one premium payment or 36.

Let's assume that a man, named Joe incurs a stroke five days after he let his health insurance policy lapse. Let's also assume that Joe is required to pay $150 per month in premium under a new guaranteed–issued policy he purchases immediately after the stroke. Joe would be "penalized" $24,850 ($25,000 in medical expense, less the $150 premium he "saved" by letting his policy lapse for the gamble he took and lost.

Now, let's imagine that a second individual, Jane, let her prior health insurance policy lapse for a period of three years and also suffers a stroke, incurring a similar medical expense—$25,000. While Jane would have "saved" $5,400 in premium payments, her penalty for gambling on her need for insurance coverage would be $19,600.

This hypothetical example underscores the potential unfairness of penalties for foregoing insurance coverage. Joe, who simply missed his last premium payment by a mere five days, is penalized $5,250 more than Jane, who gambled for 36 months. Therefore, it seems logical that the penalty for going without insurance coverage should be tied more closely to the financial advantage (i.e., unspent premium dollars) that an individual gains when he or she decides to go without insurance coverage.

The "pay back" concept is based on the presumed goal of an entire population voluntarily choosing to be insured for health care costs. The ideal goal of an effective anti-selection deterrent is one that prevents costs per insured from rising above a baseline level, defined as the cost when 100% of a population is continuously covered. To attain such goals, the perfect "penalty" for the "crime" would be an amount equal to the amount of premium lost to the system.

Mechanically, the simplest way to impose the "penalty" would be to place a lien on everyone who voluntarily leaves the insurance system, equal to the amount of the premium they would have paid if they never left the system. While it would be ideal to call for payment of the lien on a regular basis, e.g., once per year, that would be tantamount to a mandatory participation system, and thus clearly in conflict with the goal of a voluntary system, so it is unworkable. The next best thing, is to penalize those antiselectors at the time they re-enter the system. The "penalty" under other preexisting condition provisions would be applied sometime after the antiselector reentered the system, i.e., at time a claim is filed, and then only if the claim occurs within the preexisting period. The size of the penalty in this new concept is equal to an unpaid back premium, times a percentage greater than 100%. The back premium rate could be based on the rate of the new plan of coverage purchased when one re-enters, payable to the new carrier. The percentage is set at some level greater than 100% for two reasons. First, the system needs some compensation for those who never reenter it (and there will be some people who never reenter, since the probability of incurring a reimbursable claim is only one out of two. Second, a penalty equal to any percentage of 100% or less of back premium would be the same as no penalty at all, thereby encouraging everyone to "gamble" by antiselecting.

Many configurations of this basic concept could be designed to work such that the penalty into one that not only would achieve the goal of maintaining the fair price (approaching baseline costs) and at the same time encourage full participation.

An example of this concept might best explain its merits. Recall that in the example above Jane and Joe were effectively penalized $19,600 and $24,850, respectively, for an identical $25,000 medical bill, under new (re-entered into the system) insurance coverage costing $150 per month. If the alternative "penalty" were set at 300% of back premium, Jane would have been penalized $16,200 (300% times the $150 per month for each of 36 months Jane was out of the system, if the maximum was 36 months or more.) Joe, under the same formula would be penalized $450 (300% times the $150 for the one month he was out of the system,) a much different result.

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