

# **AN EVALUATION OF COLORADO'S SMALL-GROUP HEALTH INSURANCE REFORM LAWS**

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## Table of Contents

<b>I. EXECUTIVE SUMMARY .....</b>	<b>3</b>
<b>II. BACKGROUND AND METHODS .....</b>	<b>5</b>
A. METHODS .....	5
B. CONTENT AND PURPOSE OF REFORM.....	6
C. THE DANGERS OF REFORM .....	8
<b>III. THE EFFECTS OF HEALTH INSURANCE MARKET REFORMS .....</b>	<b>10</b>
A. AVAILABILITY .....	10
1. <i>Enrollment and Agents' Views</i> .....	10
2. MICRO GROUPS AND FIELD UNDERWRITING .....	15
3. <i>Standard and Basic Plans</i> .....	18
4. <i>Portability, Renewability, and Preexisting Conditions</i> .....	20
5. <i>Overall</i> .....	21
B. AFFORDABILITY .....	21
1. <i>Average Prices</i> .....	21
2. <i>Particular Rating Factors</i> .....	26
C. MARKET COMPETITION .....	28
1. <i>Market Structure and Benefit Packages</i> .....	28
2. <i>Managed Care</i> .....	31
3. <i>Price Competition</i> .....	32
4. <i>Quality Competition</i> .....	33
5. <i>Purchasing Cooperatives</i> .....	34
D. ADMINISTRABILITY .....	37
1. <i>General Compliance and DOI Enforcement</i> .....	37
2. <i>Border Problems and Fraud</i> .....	39
3. <i>Reinsurance</i> .....	42

## I. EXECUTIVE SUMMARY

This study evaluates how well Colorado's health insurance market reforms have met their objectives and whether they have avoided possible harms and failures. The primary focus is the state small-group market reform law, but this report also provides insight into the small-group portions of the federal Health Insurance Portability and Accountability Act (HIPAA). This is part of an intensive case study of seven states that have enacted varying reforms (Colorado, Florida, Iowa, New York, North Carolina, Ohio and Vermont), funded by the Robert Wood Johnson Foundation. This multiple-case study consists primarily of two rounds of structured, in-depth, open-ended interviews with sources in the insurance industry, as well as an analysis of documentary and secondary data. The principal reforms under study are: (1) guaranteed issue, (2) renewability and portability, (3) community rating, (4) restrictions on underwriting practices such as risk selection and preexisting condition exclusions, (5) reinsurance, and (6) public purchasing cooperatives. This report is intended to inform lawmakers, regulators, insurers, agents, purchasers, and the public policy community whether and how state and federal reforms have achieved their multiple purposes or caused any negative consequences, and how these reforms might be improved. The following is a summary of the major findings.

There are mixed indications that reform has produced both successes and problems, but on balance the overall impact has been favorable. These are the most successful features of Colorado's small-group market reforms:

- The law has not caused major market disruptions and has been effectively administered.
- The market remains highly competitive in price, product diversity, and number of carriers.
- Enrollment has held steady or increased and standardized benefit plans have sold well.
- Initially, prices held steady or dropped, except for indemnity plans.
- The CHIP purchasing cooperative has grown significantly.

The following are the less successful or negative features of the law:

- Prices are increasing, and initial enrollment gains are tailing off.
- Some insurers have left the market and competition is thinning out in rural areas.
- The CHIP and similar arrangements have only a very small percent of the market.
- There are indications of employer fraud among micro-size firms.
- Participation and use of the reinsurance pool has been much lower than expected.

Although these two lists are of equal length, the stronger impression is the positive one. The moderated and phased-in approach that Colorado took toward reform wins high praise from many of our interview subjects. It is noteworthy that, although Colorado's reform law has essentially the same features as those in some of the other states we have studied, Colorado has

fewer of the problems that occurred elsewhere. Nevertheless, Colorado's reform law remains highly controversial, especially the move to modified community rating. Many insurers continue to view Colorado as a state with a difficult regulatory environment.

## II. BACKGROUND AND METHODS

### A. Methods

The primary sources of information for this study are various components of the insurance industry. In Colorado, we conducted 26 interviews of 35 people in the summer and fall of 1997, and an additional round of 14 interviews with 17 of these people (or their designated replacements) in the summer and fall of 1998. Represented in this interview pool were three officials with the Division of Insurance (DOI) of the Department of Regulatory Agencies, five people with various other government or administrative functions connected with health policy, reinsurance, or the Cooperative for Health Insurance Purchasing (CHIP), six independent insurance agents, and 21 people at 10 insurers, representing 56% of the covered lives in 1996 in the small-group market. These were semi-structured in-depth interviews, most lasting approximately 1-2 hours each. However, 11 of these interviews with 18 people were with large, national insurers located out of state, in which Colorado was discussed only briefly. Interview subjects were told the purpose of the study, and promised anonymity to the extent feasible.

We also collected quantitative and documentary information in the form of market activity data, sales literature, and newspaper articles. Finally, we conducted a market testing study to determine the ability of an actual small employer and unhealthy individual to obtain insurance. An employer with three employees contacted 18 agents throughout the state in February 1998 to inquire about the availability of health insurance for the group of three, as well as for a group of two plus individual coverage for one unhealthy employee. These multiple sources of information and data were analyzed using both qualitative and quantitative techniques.

This report is organized in two main sections. The first section reviews the history, purpose, and content of these reforms. The second section presents our findings, to evaluate whether these reforms achieved their purposes and avoided potential harms or failures.

Before we begin, a word or two is required about terminology. Health insurance, like any other industry, has a specialized vocabulary with terms of art that sometimes differ from common understandings, and that often are used inconsistently even within the industry, due in part to regulatory differences among the states. For our present purposes, we value simplicity over precision, so we will use a lay vocabulary that glosses over many of the distinctions that are important within the industry. Thus, we use "insurer" to include, generically, both indemnity carriers and health maintenance organizations (HMOs). We use "managed care" to refer primarily to HMO plans, including point-of-service (POS), in contrast with "indemnity," by which we mean both traditional unconstrained fee-for-service as well as more managed forms of indemnity such as preferred provider organizations (PPOs). When we speak of agents, we generally intend to refer to independent agents, which are sometimes called brokers. We use the terms premium, price, and rate interchangeably to refer to how much insurance costs. And, by health insurance, we mean comprehensive major medical, in contrast with more limited or specialized coverages. Other, more technical terms will be defined later in the context in which they are important.

A final piece of background information is to note how Colorado compares with other states. Colorado is a relatively small state (about three million people) but one whose population is growing fairly rapidly. Its demographic and economic characteristics (1990-1992 data) were similar to national statistics, with the following notable exceptions. Median income is 14% higher than the national average and unemployment is lower. Health statistics (AIDS, deaths, prenatal care) are generally better than national averages. Health care costs are somewhat lower, and there is a higher degree of managed care penetration. The percent uninsured generally runs a couple of points below the national average.

## **B. Content and Purpose of Reform**

Colorado's major piece of insurance reform legislation is House Bill 1210, enacted in 1994 and fully effective January 1995. It applied to groups with 2-50 employees. Prior to this law, however, Colorado adopted some aspects of small-group reforms in 1991, relating to renewability, rating and portability, for groups size 2-25. The law was expanded effective January 1997 to reach down to groups of one, and again in mid-1997 to implement changes to comply with HIPAA.

The starting point of reform is to make sure that any willing purchaser has access to insurance and can retain that insurance through subsequent renewal periods. "Guaranteed issue" requires all insurers who participate in the small-group market to accept any applicant. An important distinction exists between states that, prior to HIPAA, required only *designated* policies to be issued and those that require guaranteed issue of *all* policy types marketed by a carrier. In Colorado, the guaranteed-issue requirement initially (in July 1994) applied only to standardized plans whose benefits are set by a government committee. These come in several different versions. One is a standard or common benefit package. The other is a more basic, leaner package. Versions of each exist for both indemnity/PPO and HMO/POS products. The guaranteed-issue requirement was expanded July 1997 to apply to all small-group products for groups size 2-50, to comply with HIPAA. The more limited guaranteed-issue requirement still applies to groups of one (i.e., the self-employed).

Enabling any group to obtain insurance is coupled with a "whole group" concept, which requires the employer to offer coverage to all individuals within a group. This prevents employers from angling for lower-cost policies by excluding sicker individuals in the group and minimizes the selection problems that result if healthier individuals are allowed to drop out of the risk pool and purchase individual insurance.

The reform law promotes continuity of coverage in three ways. First, insurers are prohibited from refusing to renew insurance except for fraud, nonpayment or similar malfeasance. The second aspect of continuity is to regulate the use of preexisting condition exclusion clauses. Insurers are prohibited from riding out specific health conditions altogether. They are allowed to place only an initial six-month preexisting exclusion on any condition manifested within six months before the date of coverage. Third, "portability" or continuity of coverage is promoted by requiring that subscribers, once enrolled, be able to transfer coverage to a new insurer either by changing jobs or changing insurers within the same workplace, without undergoing a new exclusion period so long as the gap in coverage does not exceed three months.

The second major component of the reforms is to restrict the degree of price variation among subscribers. These rating restrictions both: (1) limit the amount insurers may increase the price for a specific subscriber over time; and (2) compress the range of prices that the insurer can charge across its entire block of business at any given moment in time. Through 1997, Colorado limited year-to-year premium increases for any given group to 10% above the insurer's "trend." Trend is the increase in the insurer's rates for new business. The concept is to allow market wide cost increases that are driven by technology advances, inflation in the medical sector and the like, but to limit those increases that reflect group-specific health risk. Beginning in 1998, renewal rates must match new-business rates for all groups.

The second component of the rating reforms prevents any insurer from varying its prices among subscribers at any point in time more than a defined amount above or below its midpoint for policies with similar benefits and "case characteristics."<sup>1</sup> Colorado has progressively restricted this allowable range and the allowable rating factors. At first (beginning January 1995), certain (but not all) health risk factors could affect rates, but only 20% above or below each insurer's midpoint. In January 1997, the allowable range was tightened to +/-10%, and in 1998 it was cut to 0%. Now, rates may be adjusted only for age, location, family composition, and plan design and benefits. This constitutes modified rather than pure community rating because allowing full adjustment for age still permits rates to vary by about five-fold among individual subscribers, in addition to variations based on location and other allowable factor.

The third major component of the small-group market reforms is an administered reinsurance mechanism that allows individual insurers to reinsure any risks that are expected to generate costs exceeding the prices they may charge. The principal funding for the reinsurance entity is from the reinsurance premium paid by the ceding insurer. Insurers may prospectively reinsure either whole groups or high-risk individuals within groups. Colorado follows the National Association of Insurance Commissioners' (NAIC) model, which sets the premium to reinsure high-risk groups at 150% and for individuals at 500% of the marketwide average for a policy of similar coverage and case characteristics. Since insurers will reinsure only those groups and individuals they predict will have higher expenses than these prices, the reinsurance entity is expected to suffer losses, which are spread back to the insurance market through assessments against participating insurers based on the small-group market share. Insurers can choose whether or not to participate in this reinsurance system.

The final component of the small-group reforms in Colorado is a provision authorizing the formation of private purchasing cooperatives, to be supervised by the Department of Health Care Policy and Financing. This differs from the government-run or sponsored purchasing cooperatives that exist in several other states for the small-group market. In Colorado, rather than create a government purchasing cooperative, the reform law allows private cooperatives to obtain government permission to negotiate discounts from community rates. Discounts can be based only on administrative cost savings, however, and not on the health risk profile of those who enroll through the coops. In addition, these coops must be open to all purchasers. In 1995,

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<sup>1</sup> Observe that, during the first year of implementation, this limit can create a conflict with the restriction on annual increases for those insurers with existing wide spreads who would be forced to raise the rates at the low end of their rating bands more than the 10% annual increase limit.

an existing employer cooperative known as The Alliance formed an approved purchasing cooperative called the Cooperative for Health Insurance Purchasing (CHIP). More recently, a second cooperative was initiated in 1997 but was not operational at the time we conducted interviews.

### **C. The Dangers of Reform**

These reforms have attracted some critics who warn about possible adverse consequences, and a number of quieter voices that warn against setting hopes too high about their success. The strongest fear is that these reforms could be counterproductive, since they have the potential to increase prices and decrease coverage. These reforms may raise prices because they make insurance most attractive to the highest-risk subscribers by holding prices to less than the policy's actuarial value to them. The excess is built into the premiums paid by all purchasers, which will inevitably drive an undetermined number of lower-risk purchasers out of the market, thus raising the market average even more. This phenomenon is known as "adverse selection" against the market as a whole. This potential exists because the decision to purchase insurance remains voluntary, and existing purchasers are thought to be highly price sensitive.

These reforms also create the potential for administrative and regulatory complexity, circumvention, and strategic manipulation. High-risk individuals might pose as small groups to obtain more favorable rates, or low-risk employers might facilitate purchase of individual insurance by their workers or might try to artificially aggregate into groups that appear larger than the 50-worker threshold in order to avoid these laws. Insurers might attempt to avoid higher risks through various legitimate or illegitimate strategies, or they might pull entirely out of these regulated market segments. Also, these rules might cause distortions or unlevel parts of the competitive playing field that tend to favor some types of insurers over others.

This outline of the purposes of these reforms and their potential harms and failings points to four central criteria that can be used to evaluate the success of these reforms: the extent to which they promote (1) insurance *availability*, measured through increased enrollment; (2) *affordability*, measured through average prices; (3) market *competition*, measured in a variety of ways; and (4) regulatory *administrability*, also assessed in a variety of ways. This report organizes its analysis of the empirical evidence by focusing on these four criteria.

Various components of the reforms have importance across each of these categories. For instance, guaranteed issue, which points primarily to availability also might increase prices or lead to various circumvention techniques that affect administrability. Or rating restrictions, which affect primarily affordability, might result in less insurance being purchased. Many components of these reforms affect market competition, and some components, such as purchasing cooperatives, affect each of the criteria in equal measures. Therefore, this categorization scheme does not result in a neat pairing of each component and each effect. This is true to the complexity of this regulatory scheme, however, since each component interacts with all the others and with market and social conditions that are independent of these laws. Also, keep in mind as various statistical and descriptive data are presented that it is impossible to know for certain the actual and full impact of these reforms. A host of other economic and social conditions were changing simultaneously and so we will never know what the conditions would have been absent reform, even if we can tell what they are before and after reform. Nevertheless, by following the interwoven threads of information in this complex tapestry, it is possible to

draw some solid conclusions about whether these reforms have worked as intended, and, if so, why, and, if not, why not.

### III. THE EFFECTS OF HEALTH INSURANCE MARKET REFORMS

#### A. Availability

##### 1. Enrollment and Agents' Views

The first two years that Colorado's small-group insurance reforms were in effect, the percent of the overall non elderly population without insurance worsened significantly, from 14% in 1994 to 18% in 1996, at the same time that the national average remained about the same (Table 1). In 1997, however, Colorado's level of uninsurance improved one percentage point while the national average worsened half a point. These overall uninsured rates are not very revealing, however, since they respond to many other social and market segments than just the small-group employers to which the law is targeted. The small-group reform law was not intended by itself to solve the problem of the uninsured and achieve universal coverage.

**Table 1**  
**Private Health Insurance Coverage of the Nonelderly, 1992-1997\***

State	1992	1993	1994	1995	1996	1997
<b>Colorado</b>						
Nonelderly population	3,013,306	3,088,200	3,310,184	3,427,388	3,456,286	3,476,777
With employer coverage	65.3%	62.4%	69.5%	70.3%	65.2%	69.3%
With individual coverage	10.3%	13.7%	10.2%	8.6%	10.3%	8.0%
Uninsured	14.9%	15.2%	13.9%	16.3%	18.2%	16.8%
<b>United States</b>						
Nonelderly population	223,791,925	226,228,966	228,092,631	230,275,591	232,476,381	234,691,115
With employer coverage	61.9%	60.8%	64.8%	65.0%	65.1%	65.3%
With individual coverage	8.5%	9.2%	6.3%	6.0%	6.0%	5.8%
Uninsured	17.8%	18.1%	17.3%	17.5%	17.8%	18.4%

\* < 65 and not active military

Source: Alpha Center analysis of March Current Population Survey

When viewed with more moderated ambitions in mind, the small-group reforms appear to have had a positive but muted impact. First, the portion of small-firm workers with have

private insurance has held steady or increased slightly since 1994, according to data from the March Current Population Survey (CPS). These data are displayed in Table 2 and Figure 1. However, these changes, either up or down, are not statistically significant at a 95% confidence level.

**Table 2**

**Percentage of Colorado Workers with Private Health Insurance Coverage, 1991-1997**

<b>Group Size</b>	<b>1991</b>	<b>1992</b>	<b>1993</b>	<b>1994</b>	<b>1995</b>	<b>1996</b>	<b>1997</b>
Self-employed	79.70	76.26	74.14	81.09	85.05	80.90	85.98
< 25	69.60	70.53	69.76	73.53	75.41	71.77	71.83
25-99	80.30	83.93	79.21	80.06	76.87	77.74	80.71

Source: Analysis of March Current Population Survey by Reenie Wagner

Data that the DOI collects from insurers indicates that small-group enrollment grew substantially in the first three years following market reforms. Enrollment in the small-group market increased about 23% overall from 1994 to 1997, for an annual average of about 7% (Table 3). However, some of this increase comes from expanding the category of small firms in 1996 to include one-life groups. Following this expansion, small-group enrollment increased only 2% in 1997. Whether these increases are due to reporting anomalies is difficult to discern. In other states, we have found that insurers do not always accurately report enrollment and premium figures. Still, it appears that enrollment increases are keeping pace with the growth in the population and in small-firm employment.

**Table 3: Colorado Small-Group Enrollment, 1994-1997**

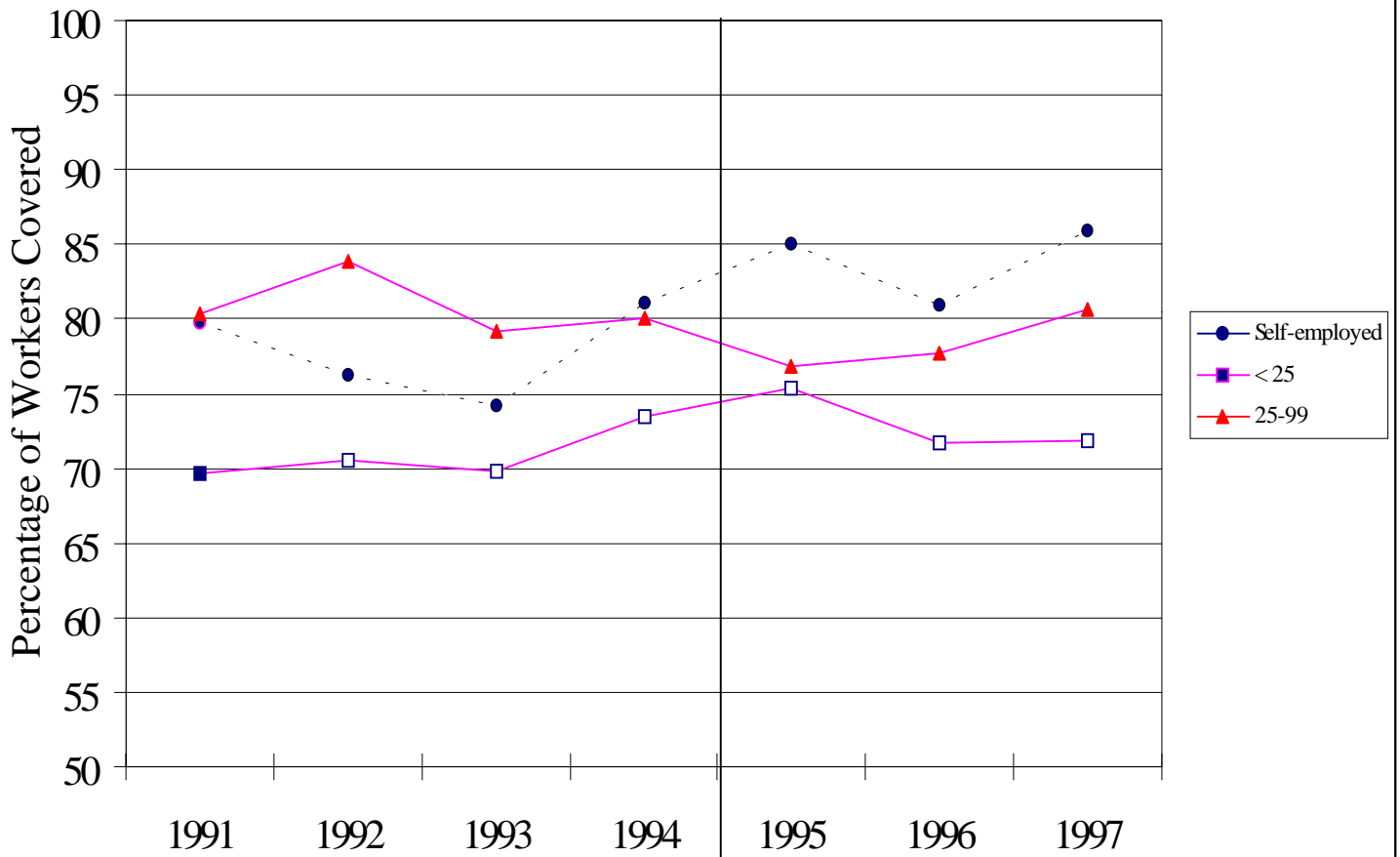
<b>1994</b>	<b>1995</b>	<b>1996</b>	<b>1997</b>
413,643	482,270	496,057	507,320

Notes: Enrollment = covered lives  
 Source: Colorado Division of Insurance

One indication that small-group reforms have caused a net improvement in the number of people with health insurance is to look at how many of those purchasing insurance previously did not have coverage. This suggests the potential impact of the guaranteed-issue requirement. We compiled the relevant information from the annual small-group activity reports for the top 23

small-group carriers in 1995, and calculated 26% of newly-issued coverage going to previously-uninsured groups. This is a remarkable figure, which, if accurate, would indicate a very

**Figure 1:  
Private Health Insurance Coverage of  
Colorado Workers by Group Size, 1991-1997**



Source: March Current  
Population Survey

significant success in bringing previously-uninsured people into coverage. It is difficult to interpret this figure, however, because it looks only to whether the employer had group coverage, and perhaps only whether it was small-group coverage, and only in the prior three months. This does not indicate how many employees previously had no coverage whatsoever, as opposed to coverage from such sources as another employer, individual insurance, or public programs. Moreover, we detected likely reporting inaccuracies, since the percentage for each insurer varied over a very large range, with six reporting 0%, and nine reporting over 40%. It may be that insurers' data collection and retrieval systems were not geared to collecting this information accurately, especially in the first year of reform.

Despite these uncertainties in the data, it is possible to conclude that the small-group laws have been an overall success in terms of enrollment. Enrollment counts have increased, and a significant portion of this appears to reflect previously-uninsured people. This is confirmed to some extent by the impressions gathered from our interviews. One large HMO told us that 30-40% of the small groups it has enrolled since reform would have been rejected previously. Agents are particularly enthusiastic about the impact of the law. One agent said:

*I feel like I'm a kid in a candy store representing my clients today. Because in the past in dealing in group health insurance, insurance companies could pick and choose as far as who they wanted to bring on based on what type of health conditions that were out there. With the advent of these new Colorado laws, they can't do that. . . . [Now], it's just so easy for us to be able to go out and spreadsheet the various companies and then make a determination with the client as far as what to go with. . . . It's wonderful because I can literally offer whatever the clients want and not have to worry about, "Well, I wonder if I'm going to have to go out and offer them a different program if they [are rejected by their first choice]." So it's been a very pleasant experience. . . . My business has tripled in size in less than a year . . . following the reform, . . . and it tripled again this year.*

The same agent explained that, prior to the law, some HMOs, notably Kaiser, voluntarily offered guaranteed-issue products, but only in the larger cities where their networks are strong, not in more sparsely-populated areas. Therefore, this agent sees the recent expansion of guaranteed-issue to all products as:

*. . . the best thing that ever happened . . . for the rural areas. Those poor people have been getting hammered. What's happened is the HMO markets, for the most part, have been dealing in the areas that are centers of influence that have a lot of people. And so, you get into these more rural areas - - as an example: the Vails of the world, the Aspens, Steamboat Springs, out in Eastern Colorado. The plans that, for the most part, are available to them have been these types of PPO plans or almost-indemnity plans. And so they're very expensive and since they had to be underwritten, a lot of these poor people were stuck with what they had. Well with this reform now, it's really opened up some big doors for them. So now that these PPO companies have to basically do the same thing that HMOs have been doing for a long time [offering all of their plans on a guaranteed-issue basis], it's really nice to see.*

Two agents viewed Colorado's reform law as a model for other states to follow:

*I think overall, on balance, the law was extremely beneficial. I think it accomplished what it was intended to do and I think it is a whale of a lot better than the laws in several other states where they had the ability to rate with a band. And I think that Colorado's approach is one that really ought to be modeled. I mean I dealt with major plans -- you know, Blue Cross/Blue Shield -- in some of these neighboring states who laughed at their*

*small-group reform. They consider it a joke. . . . That really bothers me. . . . It was supposed to help people and it didn't in some of those states. So Colorado I think was very positive.*

.....

*I really think this particular state is really in the forefront of the industry in many regards. I feel very lucky to have been part of watching how this has all happened. I deal with other states all over the country and I look at how so many of these other states have been run. I really have to say I commend what has happened in the reforms over the last several years. Thank God that this [HIPAA] bill has been passed throughout the rest of the country.*

Two agents noted that guaranteed issue makes their work easier, and thus justifies somewhat lower commissions. Another agent noted that the law was especially helpful to the self-employed:

**A:** *I just can't tell you how many business groups of one I wrote from the day they became official, legal.*

**Q:** These were people probably that were uninsurable before?

**A:** *Absolutely, I'm sure they were.*

This is confirmed by insurers' average group size, which for many insurers has dropped sharply following reform.

In some respects, however, the law may have made it more difficult for some groups to obtain insurance or switch companies, since several insurers intensified their underwriting process in response to the law. This is counterintuitive, since the law was supposed to largely eliminate medical underwriting, but insurers still retained discretion through mid-1997 to refuse coverage for their more popular products and offer only the statutory plans. Accordingly, one agent explained:

*What we saw initially as a result of the passage of this law is . . . insurance companies increase their underwriting statements, make it harder to gain the preferred product. It seems that we ended up with more and more people who were being offered only the basic and standard. . . . Let me give you an example and maybe this will help clarify it. We found that before if you were involved in some kind of [psychological] counseling, or had a child . . . whose grandmother just died and the child was kind of traumatized and so you took him to a counselor for a few sessions, . . . in the past the insurance companies would /ignore that and move on. Once this legislation was passed, anybody with any history of medical, psychological counseling in the last five years for anything . . . was declined. Anybody who had a lower back problem of any shape, size, form, any symptoms, was declined. . . . So you end up with a large number of people who previously . . . would have gotten the product that they wanted to or would have had a condition rider or would have had a little extra premium. Now they were just flat declined and they were told you have to go with a basic or standard.*

A somewhat different negative note was sounded by one agent who said that, in many respects, the reform law makes agents' jobs more difficult because of its complexity, and therefore fewer agents are inclined to sell health products:

*The unfortunate part about this whole business is that as all these rules, regulations, everything has become more and more complicated, it's harder and harder to write business. What we found is that more and more [agents are] leaving that marketplace. . . . We want to run a knowledgeable, professional business here . . . but there is a certain cost structure that goes with that, so you've got to decide how much time can you spend screwing around with this stuff. . . . [T]he work that we do to place a new piece of business, a two-, three-, four-, five-life group, will be this thick. . . . It's just that there is so much more crap you've got to go through. And the consumer isn't as knowledgeable. And they ask you questions about how does this work and that work, and you just spend so much time that you say to yourself after awhile, is it really worthwhile? We do it because . . . I just know from a political standpoint that if nobody served in that marketplace, then the government's going to step in because there's a void. And I think most of my peers feel the same way, but we really prefer not to.*

## **2. Micro Groups and Field Underwriting**

The success of Colorado's reform law in increasing availability of coverage is in notable contrast to other states we have studied, where we observed a number of difficulties in implementing guaranteed-issue requirements. This is especially so for the smallest groups, those with three or fewer employees which we refer to as micro-size groups. Previously, many insurers tended to avoid micro groups because they are more costly to sell and administer due to diseconomies of scale and because insurers view them as inherently higher risks due to greater selection effects. In other states, insurers have found various ways to continue avoiding to sell to this market segment, despite the guaranteed-issue requirement. They have also employed techniques to minimize their exposure under guaranteed issue for larger groups, in order to avoid receiving too many high-risk groups of any size.

We describe these techniques generally as "field underwriting." This term refers to a practice of encouraging agents to screen out applicants they know or suspect are higher risks. This is a legitimate practice in many parts of the insurance industry generally such as property, casualty, and life, because it efficiently avoids unnecessary work for the insurer and agent, and helps to steer subscribers to the plans and carriers that are most likely to offer affordable coverage. This practice also helps to detect when applicants are not being truthful about their risk factors. In part, this practice and these reasons explain why agents refer to themselves as underwriters in their professional certifications and trade association names, even though they do not perform the full underwriting function that insurers do in the home office. Nevertheless, for health insurance in a guaranteed-issue environment, field underwriting of this sort is not legitimate and violates the statutory requirement of fair marketing.

In Colorado, we observed much less indication of possible field underwriting than in other states. Insurers in some states attempt to avoid unwanted business by altering their commission structure to pay agents much less, or nothing at all, for micro groups or for guaranteed-issue business. In Colorado, the DOI ruled that this violates fair marketing requirements in the law, and so commission structures are uniform throughout the small-group market, although some insurers dropped their small-group commission across the board. We were told that other techniques insurers sometimes use to encourage agents to steer their bad business somewhere else were not in widespread use in Colorado. In large measure, we were told this is because the DOI took a tough enforcement stance with agents at the start of the law's implementation:

*With House Bill 1210, the Division of Insurance almost made the agents the enforcers. Because we're on the street, we see the product; we see the rate. You know, we're dealing with the carrier and . . . the Division of Insurance was very specific about [saying] you're as liable as the general agent or the carrier. That made big believers out of us. . . . We can't afford to mess with the Division because our license is everything to us. They have more time, more money, more resources. I mean, yea, we want to be in compliance.*

In Colorado, enforcement authorities recognized that agents play a critical role in the implementation of the law and that, because of their independence, they are well-positioned and well-motivated to ensure compliance. However, according to one agent, this sometimes places agents in the difficult position of constantly bearing bad news:

*In other words, if I know that there is an imminent pregnancy or a diabetic, would I direct it one way or the other? . . . You know where that might happen? I could see that happening with an agent that writes only with one carrier, . . . what we call "captive agents," and I suspect they could be afraid for their job. Whereas with us . . . you've got the regulators and the feds and the states and the legislators here, and they put pressure on the agent to do the right thing. . . . Nobody's happy really at any given time with the agent. Sometimes the carrier thinks that maybe it's the agent's fault perhaps for not field underwriting. The agent has a very tough middle of the road. We deliver the rate increases. We deliver the mandates from the state and then the employer looks at us and says, "What are you doing to me?"*

In order to gauge the extent of field underwriting, we conducted a market testing study to determine the ability of an actual small employer and unhealthy individual to obtain insurance. We retained a small employer with three employees to contact 18 agents throughout the state to inquire about the purchase of insurance. The group was composed of two people in good health and one with juvenile diabetes. The employer inquired about coverage for group sizes of both three and two. All of these agents indicated that coverage would be available for either of the group sizes, and none indicated any reluctance, either on their part or on the part of insurers, to cover either group size. Also, the market tester rated 78% of the agents as reasonably responsive. Several agents sent extensive and well-organized briefing materials of the sort usually provided only to larger groups because of the expense.

One aspect of Colorado law that makes it especially successful for micro groups is the DOI policy that insurers can require only certain types of information to confirm that one-life groups are legitimate businesses. In other states, insurers increase their scrutiny of the eligibility criteria for micro groups by demanding tax and payroll documentation, because they believe there is a much greater potential for fraud, discussed more below. In Colorado, however, the only documentation that law allows insurers to demand of self-employed applicants is an affidavit stating the business is real. As a result, there is a widespread belief among insurers, and to a lesser but significant extent by agents, that many people purchasing as a one-life group are not legitimate businesses. This concern is much greater in Colorado than in other states we have studied. Although the DOI has offered to investigate any alleged cases of fraud, and points to the fact that it has not had a single complaint, agents and insurers are not very inclined to antagonize potential customers by leveling such accusations. In any event, insurers and agents, such as the following, remain convinced that micro groups are taking unfair advantage of the law:

*This has been a way for an awful lot of people that have had preexisting conditions to basically start up their own business and go out and say, "I'm an Amway dealership." For*

*all we care, and all the insurance company cares, you sign an affidavit that you have a business and away you go. You have yourself a group plan. You could literally have some life-threatening disease and sign up. So, from that standpoint, that has really had a very large effect on the companies. . . . I know several carriers that are very, very worried about their block of business being so upside down in the groups of one. There have been some tremendous losses this past year as a result of that going to groups of one. The groups of two and above, not so much. But there has definitely been some pretty rampant misuse of that program. And I've got to say that there are a lot of brokers out there who are looking after their back pocket, not after the insurance company.*

Another agent complained:

*You know, it wouldn't have been so bad except Colorado tacked in one other piece of legislation. If you're a business owner with two employees or more, a carrier expects you to write a business check. They expect you to produce a quarterly state tax return to make sure they're getting the numbers. Okay. On the business group of one, Colorado says you couldn't ask a business owner anything except a piece of paper that notarizes that, yes, I'm a business group of one. Just because that person signed up and had an immediate claim, the only reason that a carrier can investigate is when he knows there's fraud. The fact that there's a claim immediately following issue is not sufficient reason, according to the Division of Insurance, to investigate fraud. As sure as I'm sitting here, I cringe to tell you how many business groups of one I've placed with HMOs and state-mandated plans that I believe in my heart are not legal businesses. I have the massage therapist. I have the book writer . . . and they're all working out of their home. When you call their number, that is supposedly their business number, the kid answers hello. I think that in our state, guarantee issuing and going down to the business group of one was not wrong, but you should apply the same standards to a business group of one as you do to any other business owner. If you are declaring your income on a Schedule C, what's the problem in proving that you're a business owner? . . . I can understand some business owners don't even get a checking account (which I think the IRS would find immensely interesting -- that you as a sole proprietor, business group of one, ran all your business through your personal checking account. You're asking for an audit.) But okay, okay. So it is. We could have at least required some kind of proof and the only thing we have is a sworn affidavit that they are filing on a Schedule C and other appropriate documentation. I think we did all of our carriers a real disservice by not carefully wording that business group of one.*

Another agent said he does not seek out business from micro groups simply because the effort involved is too great for the level of commissions involved:

*And so we write them because we're hoping it will grow from one to 250 employees, and occasionally that happens. We try not to. And the reason we try not to is we can't make any money at it. It's just as hard to write a two-life group as it is to write a 200-life group. In fact it's harder. But you don't make as much money, obviously, so we really try to avoid it. But when I say try to avoid it, what I mean is we don't run ads. We don't solicit them. We don't do direct mail. If somebody wants to buy it, obviously we'll help them. But we don't try to get that business because we found it to be just a ton of work . . . .*

Several indemnity insurers said that extending guaranteed issue down to groups of one and not allowing any rating flexibility makes Colorado an untenable market in which to compete. They believe that adverse selection concerns are much greater for micro-size groups and they observe that indemnity and PPO products suffer more from adverse selection than do HMOs. One large insurer with mainly HMO products documented that its loss ratio is 30 points higher for one-life groups, which caused it to lose \$1 million on these groups in 1997. Another insurer said that

absorbing these costs of fraud and adverse selection is hurting the rest of the market. Thus, although the reform law has greatly enhanced insurance availability for micro groups, almost no one was pleased by how the reform law requires insurers to handle these groups.

### 3. Standard and Basic Plans

A final aspect of the Colorado reform law that is uniquely successful in our study is the requirement of state-mandated standard and basic plans. In other states we have studied, sales of these plans have accounted for 5% or less of newly-issued coverage, and for only 1-2% of total outstanding coverage. This is especially true where only these plans are required to be guaranteed issue, because then avoiding selling these plans allows insurers to avoid higher-risk subscribers. Even though Colorado had this same structure to its guaranteed-issue law until mid-1997, its standard and basic plans have sold relatively well, especially the standard HMO plan. In 1996, the basic and standard plans accounted for about 12% of small-group enrollment (Table 4). This success is even more pronounced for HMO plans, over 20% of which were sold as basic or standard coverage in 1996, compared with only about 5% of indemnity and PPO coverage (Table 4). One prominent HMO sells almost 90% of its small-group coverage in the form of the standard plan, and another does so for over half of its small-group business. However, agents who sold primarily indemnity and PPO coverage said that the statutory plans account for less than 10% of their business.

**Table 4: Colorado Small-Group Enrollment by Plan Type, 1996**

	<b>Basic And Standard</b>	<b>All Others</b>	<b>Total</b>
Indemnity	2,002	36,958	38,960
PPO	13,406	227,521	240,927
HMO/POS	<u>43,820</u>	<u>159,558</u>	<u>203,378</u>
Total	59,228	424,037	483,265

Note: Enrollment = covered lives  
 Source: Colorado Division of Insurance

Basic and standard plans have played a significant part in the small-group market for several reasons. First, the DOI made an effort to keep the standard plan benefits as comprehensive as those available in insurers' more popular plans. The benefit structure of standard and nonstandard plans is especially comparable for HMOs, and so some of the leading HMOs have adopted the standard plan as their most comprehensive plan and promoted it accordingly. Some HMOs, notably FHP and Kaiser, went even further and decided voluntarily to guarantee-issue all of their plans. Kaiser has always done so, even prior to the reform law, and FHP adopted this policy in 1995 when the law took effect. This allows high-risk groups to enroll in plans other than those with state-mandated benefits, which keeps these plans from becoming de facto high-risk pools.

One important reason these HMOs were able to guarantee-issue their other plans is that the state-mandated benefits are fairly comprehensive. Higher-risk subscribers tend to be attracted to plans with the greatest benefits, so there is not a large increased exposure in adding guaranteed-issue plans whose benefits are leaner than the leading plan. Another factor encouraging this more liberal HMO policy is that many HMOs contract with providers on a capitated basis, so they do not retain most of the risk when they write high-risk groups. Instead, an HMO with capitated providers has an incentive to bring in as many covered lives as possible regardless of risk.

Because the standardized plans are so similar to other plans and are selling so well, the 1997 adoption of marketwide guaranteed issue for all plans had almost no impact. The standardized plans continue to sell at the same rate, and insurers and agents report little, if any, increase in the number of high-risk groups buying insurance. The only noticeable impact has been on insurers that were avoiding their share of high-risk subscribers by not actively marketing the standard and basic plans.

Another factor that helped the state-mandated plans to succeed is the legal requirement that insurers not only promote these plans in their literature, but also that they automatically quote them when they offer other coverage. Some other states require quoting these plans only after coverage is refused for an underwritten plan, and some states do not even require this. Also, other states do not specify how these plans are marketed, so that often no information is available on them, or only in the barest form. In Colorado, marketing requirements in the law specify that the standard and basic plans be offered prominently in very large type size on all forms and marketing literature used in the small-group market.

Finally, Colorado law takes an important stance in how standard and basic plans are rated compared with medically-underwritten or nonstandard coverage. In other states, carriers are allowed to establish separate rating structures for their more popular medically-underwritten plans and their state mandated guaranteed-issue plans. The rate structures are supposed to differ only based on the actuarial value of the relative benefits, but insurers are being allowed to compute benefit differences in a manner that reflects differences in the underlying risk pools for these products. Because guaranteed-issue products are certain to have higher-risk pools, benefit factors in these other states are being used as a proxy for health status in a manner that allows rates to vary much more than the allowable rate bands. As a result, the guaranteed-issue plans are rated at a level that makes them unattractive to anyone other than high-risk groups, despite the purpose of the rating bands to avoid this result.

In Colorado, this was avoided by insisting that the starting point for rating structures be the state-mandated plans. Deviations from this starting structure are allowed based on the actuarial value of benefit differences in other plans, but because rates for state-mandated plans determine rates for all other plans, there is an inherent check against setting rates for state-mandated plans so high that only high-risk groups are willing to purchase them. Keeping these plans within the range of ordinary market rates makes them more attractive to groups who could meet underwriting criteria for other plans. The importance of this rating structure is illustrated by the results for one company that did not comply. A market conduct examination found that, in 1995 and 1996, CIGNA was charging *less* for some underwritten plans with *richer* benefits than for the standard and basic plans, and justifying this because of the higher claims expected from guaranteed-issue plans. As a consequence, it sold only nine standard plans and no basic plans in

these two years, far fewer than its competitors. The DOI found this to be an obvious violation of the small-group laws.

Apart from how well standard and basic plans sell, they perform another important function in the market, namely, a reference price function that indicates to purchasers which insurers' prices are most attractive for comparable coverage. This provides a justification for retaining standardized plans, apart from their use as a source of coverage for high-risk subscribers. Even if purchasers do not select the standardized coverage, they can still use the price for this coverage as an indication of the value one is likely to find in the insurers' nonstandard plans. This reference pricing function is enhanced in Colorado by the stricter use of rating bands just described, which makes the prices for standardized plans a more relevant indicator of prices for other plans. This function is also enhanced in Colorado by the DOI's annual collection, tabulation, and publication of comparative pricing information for the statutory plans offered by all small-group insurers. One agent said that publication of rates has "been very, very positive in terms of consumer shopping." Another agent commented that this information has some, but only limited, use:

*Over time, the degree to which carriers have seen the published rates have any real effect on their market, I'm not privy to any of that so I don't really know. But I think it has. From our standpoint as a broker, it's really helped us with the public in terms of saying you ought to look at this report. I'm not sure a lot of lay people read that in the paper [and] get all excited about it like they would baseball scores or something. But I think it's given us a tool that we can use with the clients and look at the comparability. But having said that, having made those two points, the other problem is that this law, as you know, and its operation has now become so complicated that there really are some vagaries and there really are some people who just either had it mis-explained to them or don't understand it or don't have a solid understanding. Because the rates published in the paper are only for the basic and standard, not for the product that you want to buy. So just because you pick company A, who's got the lowest basic or standard, doesn't mean that they're necessarily going to be lower when you buy the product you want to buy. Because [for] the product you want to buy, there is no regulation as to what that looks like, and so you buy the first upgrade and you try to compare that to another company's first upgrade. The benefits aren't the same. So the cost comparison becomes very, very difficult. Also those [published] rates are only the first-year rates and insurers have the ability to modify those then based on their experience, their entire book of business. And so as a result, somebody could have very competitive first-year rates, but the second year you see the rates go up 22, 25%. And you say, how's that possible?*

#### **4. Portability, Renewability, and Preexisting Conditions**

The portability and preexisting condition provisions in the law are popular among our interview subjects and appear to have been implemented without much difficulty. Several agents said they prefer the state-law version that was in effect prior to HIPAA because they found it clearer and more "consumer friendly":

*It's almost too bad that the [HIPAA] bill didn't spend more time looking and reviewing what some of these states, like Colorado, have done in their reforms prior to [HIPAA's] being passed, because it really would have made things a lot more simple throughout the country. Because [when you consider] what the government has put into law versus what we've been doing the last couple of years, [what Colorado has done] has been so much easier.*

Another concern raised by some agents is that they find themselves spending too much time pricing alternative coverage for existing customers who are now able to shop around rather than accept price increases from their existing insurer. However, because large increases usually result from deteriorating health conditions, new insurers were willing, prior to HIPAA, to offer only statutory benefit plans with inferior coverage the employer did not want to purchase. According to one agent:

*The majority of people that we deal with . . . are companies that already have insurance, not companies who don't. And so what resulted was that we spent a lot of time presenting alternatives to people who never ended up changing carriers. "I bought this plan three years ago, got everybody covered under it, and got a prescription card. The rates went up. I'm really upset so I want to look at alternatives. Now you tell me all I can get is a basic or standard. Well, I'm not changing."*

Presumably, this reluctance-to-switch situation has changed under the new HIPAA law, which allows portability into any small-group benefit plan, not just statutory plans.

## **5. Overall**

On balance, the insurance reforms in Colorado have had a positive effect on insurance availability. Although there has been no detectable increase in the portion of small firms offering insurance, neither has there been a decrease, and enrollment counts reported by insurers have increased. Whether this is attributable to the law or instead to economic and demographic trends is difficult to disentangle. At least it can be said that coverage is now readily available for high-risk groups. Also, Colorado has had two notable successes compared with other states. First, standardized benefit plans have played a significant role in the market. Second, insurers have not engaged in risk avoidance tactics to the extent that exist in some other states.

### **B. Affordability**

#### **1. Average Prices**

Health insurance premiums in Colorado remained remarkably steady during the initial years of reform, and even declined for some products. Prices increased sharply in 1998, however. Each year, the DOI conducts a premium survey of all small-group insurers in the market, to determine their rates in Denver for the statutory standard benefit plan for designated age and family characteristics. The DOI found that average rates *declined* for HMOs from 3% to 7% in 1996 and declined again in 1997 from % to 5%, for different age and family characteristics. For PPO coverage, average rates increased only 1-6% in 1996, which is far lower than the double-digit increases that had prevailed prior to reform. In mid-1997, however, PPO rate increases moved up to the 5-10% range. In 1998, HMO rates increased an average of 12-13% from January 1997 to September 1998, and PPO and indemnity rates increased about 40% over the same time span.

These figures are based on market wide averages that give each insurer's rate equal weight regardless of market share. In order to determine whether this pattern of declining HMO rates and moderate indemnity and PPO rate increases prevails in the bulk of the market where most insurance is purchased, we conducted a similar comparison for the top five HMOs and the top 11 indemnity insurers by market share, based on rates for a single 36-year-old in Denver. We also looked at market medians rather than averages to avoid distortions from either high or low

outliers. As seen in Tables 5 and 6, our results largely confirm the DOI's for 1996, but show different results for 1997 and 1998. The median rate declined 16% for HMOs from 1995 to 1996, but increased 8% in 1997 and another 4% in 1998. For PPO coverage, the median rate among the market leaders rose only 3% from 1995 to 1996 but rose 26% in 1997 and another 19% in 1998.

We also see a mixed picture from the impressions conveyed by interview subjects. A few confirmed that intensified price competition and favorable pricing followed the reform law. One agent said:

*As a matter of fact, for the first time in . . . years, it's been very pleasant in that . . . there was a period four and five years ago where we just never knew what was going to happen with renewal [rates]. It was frightening because it seems like all we were doing was rewriting business over and over and over again, and that's the last thing we want to do. Since these reforms have come in, the carriers are basically saying, "We want to keep this business as long as we can. What can we do to keep it? Yes, we know that it's maybe not as profitable for us, but hopefully we can keep building up a block of business." We are in a situation where the competition is so stiff, especially in Colorado, that you want to be able to preserve that business. You don't want to keep writing it and losing it and writing it and losing it. And so, that's why it's been extremely stable out here, . . . with the exception of the PPO [rates], and it remains to be seen what happens with that in the future.*

But this was not the consistent or even the dominant theme that we heard based on subjective opinions. Other agents thought that the DOI's premium statistics were not based on the reality of the market that they experience. According to one such agent:

*I have never delivered a rate decrease. I can't even remember delivering a . . . [flat-rate renewal]. So I'm not sure how the Division of Insurance says overall rates have come down. . . . I know what I'm delivering has never been level or decreased. . . . [A DOI representative] just last week . . . again started to talk about rates are coming under control. That's not a safe thing to say in a room full of agents. The reality is if they're coming down, we're not seeing it. Maybe Robert Wood Johnson should have done a real actual rate study in the state of Colorado, the Division of Insurance's versus the reality of the world, what's being delivered on renewal. . . . Maybe [the DOI] study is all new-business rates and my experience and agents' experience is all renewals, which are old-business rates. You could in theory refile your rates and reduce the rate but that doesn't help on renewal for us because we still have a factor for claims experience.*

Another agent gave much the same account:

*The Insurance Commission quotes that have been done in the paper on state average PPO and HMO increases . . . were so ridiculously low, I just don't know how they came up with those numbers compared to what I've seen.*

Both agents and insurers confirmed the DOI report that rate increases were especially noticeable in 1998. Subjects consistently reported 1998 increases of 8-15% for HMOs in Denver, and 25-40% for PPOs in rural areas. One agent noted that current rate increases are especially steep for older clients.

**Table 5: Median Small-Group Premiums Among Top Colorado HMOs, 1995-1998**

HMO	Standard Plan Premium*	Market Share
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Colorado's Health Insurance Market Reforms

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<b><u>1995</u></b>	<b><u>\$</u></b>	<b><u>%</u></b>
Qual Med	95	10.5
HMO Colorado	117	17.9
Rocky Mountain	<b>120</b>	14.8
Kaiser	<b>121</b>	39.2
Comprecare/FHP	<u>141</u>	<u>17.7</u>
	1.48:1	100.0

High/low ratio

*82% of the market among leading insurers is at or below the median price.*

<b><u>1996</u></b>	<b><u>\$</u></b>	<b><u>%</u></b>
Qual Med	95	10.0
HMO Colorado	101	28.4
Rocky Mountain	<b>104</b>	13.3
Kaiser	112	28.4
Comprecare/FHP	<u>120</u>	<u>19.9</u>
High/low ratio	1.26:1	100.0

High/low ratio

*52% of the market among leading insurers is at or below the median price.*

<b><u>1997</u></b>	<b><u>\$</u></b>	<b><u>%</u></b>
Qual Med	95	10.3
HMO Colorado	100	29.7
Kaiser	<b>112</b>	24.4
Comprecare/FHP	120	23.3
Rocky Mountain	<u>135</u>	<u>12.2</u>
	1.42:1	99.9

High/low ratio

*64% of the market among leading insurers is at or below the median price*

<b><u>1998</u></b>	<b><u>\$</u></b>
HMO Colorado	113
Kaiser	116
Qual Med	<b>117</b>
Comprecare/FHP/Pacificare	131
Rocky Mountain	<u>181</u>
	1.61:1

High/low ratio

For single 36-year-old in Denver  
Source: Colorado Division of Insurance

**Table 6: Median Small-Group PPO Premiums Among Top Colorado Indemnity Insurers, 1995-1998**

<b>Indemnity Carrier</b>	<b>Standard Plan PPO Premium*</b>	<b>Market Share</b>
<b><u>1995</u></b>	<b><u>\$</u></b>	<b><u>%</u></b>
U.S. Life	74	10.1
Central Reserve	84	3.4
Travelers	86	30.2
Employers Health	87	18.3
United of Omaha	89	5.2
Time	<b>98</b>	5.0
Blue Cross/Blue Shield	104	5.7
Principal Mutual	105	6.9
John Alden	106	5.3
Prudential	117	4.0
United of Wisconsin	<u>139</u>	<u>6.0</u>
	1.88:1	100.0

*72% of the market among leading insurers is at or below the median price.*

<b><u>1996</u></b>	<b><u>\$</u></b>	<b><u>%</u></b>
U.S. Life	91	17.6
Woodmen Accident	93	3.4
GEM Insurance	97	3.9
United of Omaha	98	5.2
HSI Health Plans	98	4.9
Metra Health Insurance	<b>101</b>	7.1
Employers Health	105	27.1
Principal Mutual	106	10.0
John Alden	121	6.9
United of Wisconsin	137	5.9
National Group Life	<u>141</u>	<u>7.9</u>
	1.55:1	100.0

*42% of the market among leading insurers is at or below the median price.*

## Colorado's Health Insurance Market Reforms

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<b><u>1997</u></b>	<b><u>\$</u></b>	<b><u>%</u></b>
Blue Cross/Blue Shield	85	7.1
Principal Mutual	110	14.0
United of Omaha	113	3.5
Prudential	115	3.7
U.S. Life	124	17.7
Guardian	<b>127</b>	2.3
Employers Health	134	33.2
Time	140	2.9
United of Wisconsin	145	8.8
John Alden	146	4.3
National Group Life	<u>182</u>	<u>2.5</u>
	2.14:1	100.0

*48% of the market among leading insurers is at or below the median price.*

<b><u>1998</u></b>	<b><u>\$</u></b>
Blue Cross/Blue Shield	104
Prudential	121
Principal Mutual	144
United of Omaha	148
Employers Health	150
U.S. Life	<b>151</b>
Guardian	156
United of Wisconsin	178
Time/Fortis	227
John Alden	231
National Group Life	<u>256</u>
	2.46:1

\* For single 36-year-old in Denver

Note: These are the top 11 indemnity insurers for which complete premium data are available.

Source: Colorado Division of Insurance

There are several possible explanations for these divergent accounts. First, as several agents noted, new-business rates are not the most visible indication of rate trends. Most agents' business involves servicing existing accounts, for whom renewal rates are the most important consideration. Renewal rates can significantly exceed new-business rates because the group's average age increases, and because until 1998, insurers could increase individual groups as much as 10% more than the increase in new-business rates to reflect claims experience in the group.

A second explanation for why some agents experience rate increases much larger than the market averages is that they do not deal with the entire market but only with certain insurers and in certain parts of the state. Some of the agents who commented that rates were increasing were also agents who appeared to deal more with PPO and indemnity insurance, for which this impression is accurate. This type of insurance is more prevalent outside of the major cities,

where HMO networks are primarily based. Also, agents tend to deal with only a handful of insurers, and their individual pricing strategies vary widely. Agents described some insurers who imposed stiff increases the first year of reform, then lost business, and so dropped their rates sharply the following year. Other insurers held their rates steady, found they were attracting too much high-risk business, and so sharply increased their rates in subsequent years.

Despite these discrepancies, the overall impression is that small-group health insurance has remained affordable following reform, contrary to the expectations of some critics who warned that guaranteed issue and rating restrictions would drive up average prices faster than before due to adverse selection. Most subjects agreed that even the sharper increases in 1998 were due to market wide trends that included both large and small employers and did not result from stricter small-group laws producing adverse selection against the market. As one agent noted, although some insurers "screamed bloody murder" at first:

*. . . that flood [of bad claims] that we were expecting never materialized. And in Colorado we have guaranteed issue for groups of one. . . . A lot of industry people said, "Oh boy, you know you're going to get creamed." . . . There were all these doomsayers [who were proven to be wrong].*

## **2. Particular Rating Factors**

Market wide averages and trends paint one part of the picture, but affordability issues also must be examined from the perspective of particular demographic groups. Although rating restrictions do not affect the average price, they do have the potential to produce large increases or decreases for some groups that previously were at either extreme in the variation in rates. We inquired whether the imposition of rating bands and unisex rating and the move to adjusted community rating produced any price shock effect that drove lower-rated groups out of the market. Most subjects thought not, to any great extent, in part because the rating restrictions were phased in gradually. One DOI representative noted that they received many more consumer complaints about rate increases prior to the reforms than after.

However, we heard the following contrary views from some subjects. One actuary said that rate shock effects were masked by the unusually competitive conditions that happened to prevail in 1994-1996 as HMOs and PPOs were scrambling for market share in order to build up their networks. This subject speculated that the effects might be much worse if these reforms were implemented now.

A number of subjects were very strongly opposed to the move to adjusted community rating. This opposition comes almost entirely from indemnity insurers and agents, who led an effort in 1998, which nearly succeeded, to roll back the rating reforms and reinstate a broad rating band for health risk factors. They insist that modified community rating creates an unfair subsidy from the healthy to the sick, and makes it very difficult for indemnity insurers to compete with HMOs. This is because offering price discounts to healthy subscribers is the primary way in which indemnity insurers can compete with HMOs, since indemnity insurers and small PPOs lack managed care cost controls. Indemnity insurers also maintain that increasing rates for higher-risk subscribers is necessary to counter adverse selection, and they observe that sicker subscribers favor insurance with fewer managed care constraints. These concerns are especially acute for micro groups, for reasons noted above. As noted below, this has resulted in some smaller indemnity insurers withdrawing from the Colorado market; however, a number of

larger PPO insurers still remain active in the market.

Other rating factors have produced lesser degrees of controversy. Two agents noted that restricting family rates to only a few categories results in higher rates for families with fewer children. According to one agent:

*So if you have three children and somebody else has one, your rate needs to be the same. Now that doesn't take an intellectual giant to know that it's going to cost more if you have more children. So where do you think the carriers took the rates? Up. So all the carriers' rates significantly raise the family and the children's.*

Another agent noted that, because employers often do not contribute anything toward the family portion, a number of employees dropped back to single coverage, thereby reducing the number of people covered in a group, even though the group itself retained coverage:

*A: That family-rate thing just about put a lot of families out of insurance because the family rate went up with House Bill 1210, when they could no longer rate for each child. You would see the employee rate not go up so bad. I mean, carriers got pretty clever as to how they would go in and reset the rate if they wanted. Because what does an employer usually pay? Fifty to 100% of the employee rate, [but nothing for] the dependent rate. They tried to encourage keeping the employees on the plan, but, boy, you just raise those rates to the families. It was really difficult for the working person.*

**Q:** Now what happened when they raised [the family rates]?

*A: We saw a lot of families picking up the phone and calling insurance agents looking for individual coverage to cover their children with and perhaps their wives because they really could not afford the group rates, which is really scary because there is a major differential between types of coverages between individual and group.*

Similar anomalies were noted regarding the move to genderless rating. Although one might expect this to lower rates for some and raise them for others, one agent said that the only effect was to increase rates across the board:

*A: The other experience that we had is when we decided to become genderless in our state, . . . all we saw was the rates for the male groups go up.*

**Q:** And why is that? . . . One would anticipate that the rates would go down somewhat for women and up for men.

*A: In the old days if you had a group of five employees and they were all males, they did have a lower rate. The primary working force in the state of Colorado is males and so we saw many, many of our groups get rate increases because there [was no more gender rating]. . . . [Now], the carrier can only say that the rate is X dollars and it includes maternity. They have no way of knowing whether they are insuring a male or a female. So rates didn't go down to any of our groups, they went up. You'll find this consistent amongst the agencies. . . . The proof is in the pudding. I can give you two or three groups that were all males and that when that law passed, their rate went up considerably. If you've got, say three women here and they were all paying \$10 and the men over here are paying \$5, there wasn't an average of \$7.50 that everybody should pay. Oh no, the carriers . . . brought the men up. That's exactly what happened across the board. I didn't see any rate decrease and no agent did for women and for the genderless rating. You would have thought it would have saved some money somewhere, but it didn't.*

Although we did not hear this account from others, this observation arose late in our interviews and so we did not inquire elsewhere about it. Another agent said that unisex rating caused some primarily all-male groups such as construction firms to drop coverage.

Concerning the age factor, one subject noted that one HMO which previously had been willing to use pure community rating had since adopted age adjustments in its rates in order to deter adverse selection from guaranteed issue. As a result, its older subscribers received very large increases. Another subject observed that some insurers use steeper age slopes than others, in order to make their rates relatively more or less attractive to older or younger groups:

*You can go look at a rate sheet and look at 60-64 and go, "Well this company definitely wants that market," or "This company definitely wants to stay out of that market." So they have that leeway there. Which is good, they need to.*

One prominent HMO began using age brackets rather than pure community rating for small groups as a result of the reform law, fearing that it would lose too many younger groups to other insurers who adopted the age rating allowed by the law. As a result, the law caused this insurer to raise rates for older groups. One can speculate that this insurer would have adopted the same policy regardless of the reform law, however, in response to market competition.

Finally, as for the location factor, we were told that specifying the seven or eight regions that can be used for geographic rating worked well, since this keeps insurers from gerrymandering their rating areas to capture underlying industry and health risk factors in the resident population. However, some insurers (both HMOs and PPOs) are increasing the gap between rural and urban rates since it is more difficult to obtain provider discounts in rural areas where there is less provider competition.

## **C. Market Competition**

### **1. Market Structure and Benefit Packages**

From most indications, the small-group market in Colorado remains healthy and highly competitive. As noted above, enrollment has grown and prices have moderated or even dropped until 1998 when they increased sharply. Also, product innovation is seen in the rapid movement to HMOs, which is discussed more below. Many interview subjects commented on the intensely competitive environment among insurers. This can be further seen in terms of the structure of the market. As of 1998, 65 companies remained in the market, and about 40 of these had significant enrollment of 2,000 or more. In 1997, the top six firms accounted for only about 50% of the market, and market share among the top four ranged fairly evenly from 9 to 13%. This structure is essentially unchanged from 1993.

There are some troubling indications, however, that competition may be diminishing somewhat. First, the 65 insurers that remain is down from about 100 prior to reform, and down from 72 in 1996. Moreover, a number of these insurers are not active in the market or in all parts of the state in that they do not solicit new business through advertising or competitive pricing. Instead, they remain in the market only to service their existing subscribers who continue to renew with them. Several subjects, including some at the DOI, expressed concern that effective competition may be especially low in rural areas, where HMO networks are not well developed, and PPO and indemnity options are decreasing. Even in Denver, one subject described the

market as an oligopoly because it is dominated by four insurers and four provider networks. One Denver agent said there are only two PPOs actively marketing in late 1998. Also, several subjects complained that insurers have greatly reduced the number of plan variations they are willing to offer, in part because of the requirement that they make detailed disclosures for each plan variation, no matter how small the benefit differences are.

We solicited views on what prompted some insurers to officially or effectively withdraw from Colorado. DOI officials and one agent maintain that these are strategic business decisions made primarily by small or financially-troubled indemnity insurers that lack the market share and the managed care networks necessary to compete in the current market. According to this view, expressed by the following agent, it is not necessarily bad for competition to lose some of these insurers.

*I think those carriers that have not come into the world of managed care and are more fee-for-service with a very loose PPO or no PPO are not going to be able to survive. And those are the carriers [that have] been very good at cherry-picking the better risks, and they're smaller. They're what I call third- and fourth-tier carriers to begin with. They don't write a lot of business. They are probably going to leave the marketplace. The big carriers, especially in Colorado, have deep pockets and are still very competitive and they're going after market share. And I have no doubt they're pricing their product below cost to get market share. And your smaller carriers can't do that. If they are allowed to keep the plus-or-minus 10%, then they have an opportunity to cherry-pick the market.*

A couple of agents and several insurers, however, maintain these decisions to withdraw are driven primarily by the regulatory climate, in particular the move to modified community rating in 1998 and the elimination of renewal increases 10% above trend, coupled with HIPAA's requirement of guaranteed issue for all products. These subjects, such as the following agent, thus view the reform law as a threat to competition:

*By making all companies offer all of their plans on a guaranteed-issue basis, one of the things that concerns me more than anything is that we need competition. Competition is absolutely the driving force of our whole economy. If you get rid of competition because of some of these reforms like what we've done, . . . companies like these PPO companies, they may not be able to survive. And if that is a result of that, I think it's going to hurt all of us.*

We spoke with a number of insurers to determine which of these views appear well founded, and we discovered that there is some merit in both. Most insurers we spoke to did not think that the regulatory climate in Colorado is completely inhospitable. Several of those we spoke to who are pulling back in the market told us they are doing so for a combination of business and regulatory reasons, including the difficulty in competing with HMOs. However, two indemnity insurers said they cannot effectively shield themselves from adverse selection if they have no rating flexibility based on health risk characteristics. Several indemnity insurers nevertheless said Colorado is a potentially attractive market and so they are still active; others have not completely withdrawn but are instead "idling on the sidelines" by offering only the state-mandated plans until they assessed the full impact of the 1997-98 changes in the law. Also, at least one HMO, which is very prominent in the market, chose to enter the small-group market largely as a result of the reform law, and several other HMOs new to the state have entered the small-group market following reform. Subjects at two HMOs said there is more competition or more competitors now than prior to reform. Still, it is clear that some insurers have withdrawn

from Colorado mainly due to its 1997-1998 reforms.

A second potential negative consequence of the reform law for market competition is a reduction in the variety of benefit options. One way an insurer might guard against potential adverse selection in a guaranteed-issue environment is to pare back benefits so as not to be the most attractive plan for a high-risk subscriber. Subscribers with serious health problems are usually more interested in shopping for the most comprehensive benefits rather than the best price. Also, as explained above, the diminished ability under the reform law to medically underwrite might cause insurers to drop indemnity coverage in favor of tightly-managed plans, thereby diminishing consumer choice of plans, especially in rural areas where HMOs are less developed.

We heard from a number of sources that these developments are occurring in Colorado. One agent commented:

**A:** *I'm seeing less plans quoted by the carriers. So where American Community used to give me an indemnity, a PPO and a state-mandated plan, the only thing I can get from them is a state-mandated plan.*

**Q:** So they're offering fewer benefit options, is that right?

**A:** *Yea, plan designs. Fewer plan designs. Even the HMOs have reduced the number of plan designs.*

Two HMO insurers said they chose not to offer their PPO products in the small-group market. One of these attributed this decision to adverse selection concerns created by the reform law. The other of these insurers also chose to pare back the benefits of its HMO and POS products so as not to offer any plans that are more comprehensive than the state-mandated plans. Yet another HMO said it reduced the number of benefit plans for small groups so it now offers few benefit plans richer than the standard plan. An indemnity insurer said it decided to remain active in the Colorado market, but only after reducing its benefit package by raising deductibles and lowering lifetime maximums. And a large insurer with both indemnity and HMO products chose to stop selling traditional indemnity to small groups because it saw the law as an opportunity to move these groups into PPOs.

Several agents complained bitterly about the difficulty since reform in finding affordable PPO and indemnity products. We were warned to discount these attitudes somewhat due to the fact that agent commission rates are usually higher for these products than for HMOs and the fact that HMOs historically have been reluctant to sell through independent agents. Nevertheless, we heard this complaint made more strenuously in Colorado than in most of the other states we have studied. For example:

*We need to keep the freedom of choice of types of plans. . . . I feel that the direction of putting people into HMOs is one step away in this country, and especially in the state of Colorado, from socialized medicine. I believe that the Division of Insurance and the Robert Wood Johnson [Foundation] had every intent that Colorado Care is the way we should have gone. I feel that our legislative approach with House Bill 1210 and all the bills that were passed this session is a left-handed approach at moving us into less and less carriers, more and more HMOs and eventually a state-run or a federally-run health insurance plan. I've had people at the Division of Insurance say, "Would that be bad?" It's*

*pretty scary when you have your regulators making those type of comments.*

And another:

**A:** *My biggest concern and [that of] agents like myself is we see the limitation of competition as far as types of plans. . . . I'm just seeing the rates go up on the PPOs or the PPOs being eliminated. When I talk to carriers as to why they are eliminated, it's because of the rate restrictions in the state of Colorado, not so much the guaranteed issue on HIPAA. They can live with it. They are living with it in other states.*

**Q:** So you are saying that PPOs are being forced out . . . because they can't do medical underwriting?

**A:** *They can't do any medical underwriting. They can have no leniency at all in the rates.*

And, a third:

**A:** *I think there are only three indemnity carriers offering the old fashioned 80/20. . . .*

**Q:** But this has happened . . . because the HMOs have just been cheaper, that's all.

**A:** *They've been cheaper. But that isn't what's driven them [indemnity carriers] out of the marketplace. It's the fear of the risk. Because they'd be the only rabbit with their head out of ground at hunting time. If it's guaranteed issue and . . . you're a sick person, and . . . you have the money, you're going to [buy insurance] where you can [get] the best coverage for your family. An HMO is not always that.*

## **2. Managed Care**

The reduced availability of comprehensive indemnity coverage and the rapid shift to managed care reflects a shift in the nature of competition in the small-group market. Insurers are now competing much more based on their ability to manage the costs of care rather than their ability to select and accurately price health risks. Depending on one's views of managed care and the equity of health risk rating, this might be viewed as either a positive or negative development. It is undoubtedly one of the purposes of Colorado's market reforms, however. In this regard, the reform law has succeeded. In 1997, 47% of small-group covered lives were in HMO/POS plans, and another 44% were in PPOs, with only 9% in traditional indemnity plans. Indemnity carriers still remain prominent in the market, but they sell mostly PPO plans. Accordingly their market share among insurers with at least 3,000 lives has dropped only from 39% to 33% between 1994 and 1996. This decline in market share may be accelerating, however, since several agents commented that a vast majority of new small groups opt for HMO or POS coverage and that this coverage is more favorably priced than indemnity or PPO plans. This is confirmed by our market testing study, in which 56% of the agents contacted recommended HMO coverage, none recommended indemnity, and the remainder offered both types of plans.

There is a question whether this rapid shift in the small-group market can be attributed to the reform law. The same movement can be seen in most other parts of the country and so may be independent of the law. Both in Colorado and elsewhere, interview subjects commented that HMOs are hungry for "covered lives," and the small-group market simply offered the best potential for market expansion as the large-group market began to become saturated in the early-

to-mid 1990s. A number of subjects commented that HMOs were aggressively "buying market share" in this time period, meaning they were pricing below costs in order to build the base necessary to sustain and expand their provider networks.

A contrary view, however, is that these market developments coincided with the reform law in a fashion that the law may have precipitated or facilitated. This view had a number of adherents in our Colorado interviews. They observed that the reform law creates a set of market rules that are more compatible with how HMOs were already operating and so created more of a level playing field with indemnity insurers, which now find it much more difficult to compete since the mechanisms for risk selection are greatly reduced. One subject noted that HMOs are less concerned about adverse selection in an environment of guaranteed issue and community rating since they pass most of their insurance risk on to providers through capitation contracts.

Another possible explanation for how the reform law might have catalyzed the movement to HMOs is that, to the extent that healthier, lower-rated groups with indemnity coverage experienced a rate shock when rating bands were adopted, they may have been prompted to shop around at renewal time for more favorable rates, and when they looked they found that HMOs were more attractive. Also, it is important to note that the portability provisions of the law make<sup>2</sup> it easier for groups so inclined to switch to a different type of insurance.

### 3. Price Competition

It should be expected that these structural features of the small-group market would result in increased price competition, and in fact they have. As noted above, HMO prices in particular have held steady or even dropped following enactment of the reform law. Price competition can be seen not only in the average market prices, but also in the range in prices among insurers. The DOI reports that prices for standard plans in each of three years following reform (1995-1998) ranged from three- to four-fold for indemnity coverage and from one-and-a-half to two-fold for HMO coverage, across all insurers in the market. This suggests a lack of price competition. Such comparisons can be misleading, however, when done for all insurers registered to sell in the market, because this includes insurers who are not actively seeking new business.

To obtain a more revealing picture of price competition, we focused on the top five HMOs and top 11 indemnity insurers for each of three years. As reflected in Tables 5 and 6, premiums for standard coverage varied over a much narrower range of 2.5:1 or less for PPO coverage, and 1.6:1 or less for HMO coverage. Likewise, in our market testing study, the price quotes we received from agents across the state fell within a fairly tight range, with a spread of 1.3:1 for HMO coverage and 1.1:1 for PPO coverage.<sup>2</sup> The overall impression, then, is that this is a competitive and rational market with respect to price. This is confirmed by the market share figures in Table 5 and 6. In most years from 1995 to 1997, the leading insurers with prices at or below the median for HMO and PPO products had well over half of the market among these

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<sup>2</sup> These price quotes are for the coverage that most closely matched a specified benefit package, but there was some variation in covered benefits among insurers. Also, these quotes come from locations across the state and so reflect some price variability due to regional cost differences.

leading insurers. In years where this is not the case, the market leader is close to the median price.

As before, one can question whether these competitive conditions are due to the reform law or instead would have occurred regardless of reforms. At one level, this question does not matter since, in either event, it appears that the reform law has not diminished price competition. There are several reasons, however, to believe the law intensified these competitive conditions. First, most subjects attributed this intensified competition to HMOs' striving for market share, which as discussed above, is plausibly related to the reform law. Second, and even more directly related, a number of subjects quoted above commented that publication of the rates for the state-mandated benefit plans has intensified price competition by making direct "apple-to-apple" comparisons possible. One large insurer claimed, however, that actuaries already knew what other insurers were charging and they could make their own adjustments for benefit differences among nonstandard plans in order to gauge market prices. Regardless, publication of rates has clearly made it easier for consumers to engage in comparison pricing and therefore this plausibly has intensified price competition.

#### **4. Quality Competition**

Although price and product competition is undoubtedly strong in Colorado, what is noticeably subdued in the small-group market is competition based on outcome measures of quality. Naturally, this is relevant only to HMOs since indemnity insurers are not in a position to monitor or influence the quality of care, and one of the selling points of indemnity coverage is that subscribers are free to make their own decisions about which are the best providers. However, given the penetration of HMOs, one might expect at least some competitive focus on quality of care measures. To the contrary, in the vocabulary of most agents, "quality" refers to the quality of the benefits, that is, how comprehensive they are, and to the quality of the insurers' claims service, that is, how promptly and hassle-free claims are paid, not to the quality of care delivered.

We reviewed the sales literature from leading insurers, including HMOs, that is targeted to the small-group market and found no reference to outcome measures of quality such as the HEDIS measures developed by the National Committee for Quality Assurance. At most, there were passing generic references to the quality of providers in the network. The sales literature focuses instead on the particulars of benefit packages, and for HMOs, on the composition of the network. Much of insurers' strategic market positioning appears focused on differences in benefit packages.

The notable exception is the purchasing cooperative discussed below, called CHIP. The CHIP marketing literature offers a useful side-by-side comparison of not only benefits, but also network structure, how referral decisions are made, how physicians are compensated, member turnover, and medical loss ratios. In addition, CHIP has put considerable effort into a program that requires participating HMOs to issue uniform "report cards" that contain information about member satisfaction and selected clinical care indicators. Each HMO must adopt performance goals, which can result in the loss of up to 2% of premiums if not met. Moreover, CHIP has begun mailing these report cards directly to employees for use in their annual open-enrollment decisions. Studies are underway to determine whether employees consider this information relevant and useful.

Despite these efforts, the Colorado small-group market, similar to others we have studied, is far from the economic model envisioned by some reformers. Even though insurers do not use risk selection to the same extent as before, risk differentials still exist among insurers for a variety of possible reasons. First, insurers entered the reformed market with varying degrees of risk in their subscriber pools, and these historical patterns may have persisted. Second, risk differentials may exist by virtue of subscribers' natural preferences, such as the tendency of sicker people to prefer indemnity over HMO coverage, or the reluctance of sicker subscribers to switch insurers with a resulting advantage for newer market entrants. As a consequence, rate differences may still reflect risk segmentation to a considerable extent rather than underlying efficiency in the form of insurance or the delivery of medical care.

We have not been able to disentangle these possibilities, but it nevertheless is notable the extent to which risk pools do appear to vary across the market. Above, we report on a premium analysis that shows a significant, but narrowing, spread in rates among market leaders, especially among commercial indemnity carriers, despite a highly competitive market. We stress that these rate differences reflect a number of other factors besides risk segmentation. They are also determined by insurers' pricing strategies and by differences in benefit packages. However, they are suggestive of significant differences among risk pools.

## **5. Purchasing Cooperatives**

The purchasing cooperative component of the reform law is intended to promote all of the purposes of the small-group reforms, but rather than scatter the discussion of CHIP (the Cooperative for Health Insurance Purchase) throughout each part of this report, we consolidate our evaluation of CHIP here because most of the purposes relate directly to promoting market competition. We focus on CHIP because it was the first and only operational cooperative at the time of our interviews. Proponents of the law had expected several more to start when the law was passed, but as of this time, only one other was in the development phase.

We look first at enrollment. In its first year and a quarter (October 1995-December 1996), CHIP enrolled an impressive 736 employers covering 12,848 lives, about 9,000 of which were with small employers. (CHIP is open to employers of all size.) By July 1997, small-group enrollment had grown to about 15,000, but this growth has leveled off or dipped slightly since then. This amounts to only about 3% of total small-group enrollment statewide, but this is similar to the market penetration of purchasing cooperatives in Florida and California which have been in existence longer. About 40% of CHIP purchasers are groups of one, but the average group size is about 10, due in part to the fact that CHIP accepts groups over 50 and it was founded by an organization that is supported by larger employers. About 20% of enrollees were previously uninsured, which is approximately the same proportion as for the small-group market generally; also, as discussed above, we are not certain that this statistic reflects true lack of prior insurance. Nevertheless, the CHIP is among the most successful purchasing cooperatives in the country. We examine reasons for this success and potential barriers to even greater success.

Several factors contributed to CHIP's initial success. First, it arose from an existing private employer cooperative, so a knowledgeable and motivated organization already existed with credibility in the employer and insurance community. This differs from some other states where government-run cooperatives were created from scratch. In particular, we did not observe the same resistance to CHIP among agents and insurers that is present in other states where

hostility to government intervention affected attitudes about coops. Second, CHIP was able to attract immediate interest from all the strongest HMOs in the state, despite the fact that most health plans "bitterly opposed" the authorizing legislation. Four out of the top five HMOs participate, although one or two others were rumored to be thinking about dropping out. Participation by the top HMOs makes CHIP's product offerings attractive, since virtually all the providers in the major markets are represented in the included networks. Third, CHIP from the outset decided to sell through independent agents as well as directly, and it is quick to refer inquiries to agents. CHIP administrators worked hard to recruit and educate agents, so it did not alienate the agent community as happened in some other states we have studied. The premium is the same whether or not an employer uses an agent. In our market testing study, 61% of the agents contacted mentioned an opportunity to purchase through some type of pooled arrangement (not necessarily always CHIP), although only one agent did so with enthusiasm; the rest were rated as neutral in their stance.

The CHIP has been less successful in wielding its bargaining power to generate significant savings over market prices. Unlike more public cooperatives in other states, CHIP began with the right to engage in competitive bidding, rather than being forced to accept all willing insurers.

As a consequence, it was initially able to leverage price concessions from insurers in the form of a three-year limit on rate increases. However, one of the dilemmas of purchasing cooperatives is how they fit into the market's community rating rules. If they are allowed to offer significantly lower prices, they may undermine the structure of community rating and cause some degree of instability in the regular market. But to force them to charge the exact same community rate is to deny them one of their primary advantages, which the Colorado DOI initially did in its interpretation of the original law. Subsequently, the Colorado legislature adopted the compromise of allowing negotiated discounts from community rates based on administrative cost savings, that is, the portion of the premium that does not go toward paying medical costs. But price discounts based on differences in the health-risk profile of the subscriber pool were not allowed. This required some insurers to increase their CHIP rates much more than their market rates, even though they had originally agreed to do the opposite.

Accordingly, CHIP's prices are now higher than the rest of the market for most participating insurers. In 1998, insurers gave price discounts of 0%, 5%, 6%, and 11%, but CHIP adds 11% in agent and administrative fees, resulting in higher rates for all but one. The HMOs we spoke with said they do not give greater discounts than this because their administrative costs in selling through the CHIP are higher, not less. This is because the CHIP accounts for only a small portion of their total sales, so they still have to maintain essentially the same administrative overhead in marketing small-group insurance outside of CHIP. Therefore, the primary basis for the discount is the agent's commission, which CHIP adds back in itself.

Even though CHIP's prices are somewhat higher, it offers advantages in terms of superior information and employee choice. Above, we describe the exemplary approach CHIP has developed for presenting comparative quality and network information. Also, employers who purchase through CHIP must offer employees a chance to select from any of the insurers. One agent saw this as its major selling feature:

*We bought it here for our own company. I think it's wonderful. . . . I think that the single*

*greatest value that the CHIP provides is not its ability to negotiate as a group and get rates lower. I don't think that is a value at all. I don't think they do it. I think the value the CHIP provides is when you have a company like mine. We've never had HMOs before. Small business is a very personal business. And when the owner decides we're going to go to managed care, half the employees are going to be [upset] because their doctor's not in the network. The CHIP allows us to offer a multitude of products so there is a greater chance that your doc's in the network. That's the advantage. It gives choice to the employee, and I think that is so powerful. It tells volumes. We have historically been one of their biggest producers. And the reason we have been is because I believe fervently that there is a need for that in the marketplace, and I think it works really well.*

Not all subjects viewed this feature as an advantage, however. Insurers feel that increased employee choice produces greater adverse selection, particularly against point-of-service (POS) plans. Accordingly, in 1998, all of the participating insurers withdrew their dual choice option inside CHIP that had allowed the election of either HMO or POS coverage. Since this option is available outside of CHIP, some of the larger employers have since left CHIP. Also, two agents commented that the complexity of individual employee choice makes CHIP less attractive to agents and employers:

*I don't get involved with [CHIP]. Unfortunately for the consumer, from a billing standpoint, it's very, very confusing. . . . Say 90% of the people are with Pacificare and the other 10% are between two [other] companies. The employer really dislikes having that kind of situation because they don't know who's got what and how it works. And from a claims administration standpoint, it becomes somewhat of a nightmare.*

A CHIP administrator told us, however, that complaints of this nature are not widespread and that a number of agents like it well enough that they sell almost entirely through CHIP. Some of this opposition may be due to continuing resistance by agents, such as the following, who fear that if this prototype works well enough, they may eventually be out of business:

**A:** *Ultimately the CHIP is going to have to cross the bridge. That's the only way they're going to differentiate themselves and be able to reduce their price. . . . They're going to have to do it without commissions, without agents and brokers. And [the CHIP administrator] fervently denies that and says, "We'll never." Well that's just horse pucky because when you look at it, they can't negotiate [over price]. I mean the only other thing that's on the table is commission, very frankly. But at this point,*

**Q:** Agents and brokers would go bananas?

**A:** *They won't support it. You're right. And that's the conundrum . . . . There is no way out of that box canyon.*

Some insurers we spoke to also have continuing resistance, or absence of enthusiasm, toward CHIP. They do not see it as a source for very profitable business. And they and their captive sales force tend to see it as a competitor, even the insurers who sell through CHIP.

## **D. Administrability**

### **1. General Compliance and DOI Enforcement**

Finally, we address a series of concerns about the administrability of these laws. The Division of Insurance has been very proactive in administering the reform law. Shortly after it was first enacted, the DOI inspected a random sample of 36 insurers' forms, contracts, and marketing materials and found many instances of noncompliance, some that were serious. It used this information to notify the insurance community of the types of compliance problems it was finding, and gave insurers several months to correct mistakes. This was followed by a half dozen intensely focused market conduct exams of the leading insurers, which resulted in several large fines, discussed more below. The DOI also issues regular bulletins informing the industry of new laws, recent interpretations, and other compliance issues. The Division has a "consumer friendly" reputation for being "tough but fair" to insurers. Its brochure explaining the reform law is a model of clarity and usefulness. Especially useful is the DOI's annual collection and dissemination of premium rate information for all standard small-group plans. In the view of several interview subjects, the DOI staff is dedicated, knowledgeable, and responsive. One member in particular, Barbara Yondorf, is known for her active leadership on reform issues, both in Colorado and nationally, through the National Association of Insurance Commissioners. Following are representative favorable comments from agents:

*I think [the DOI has] been good. I think they have been aggressive. They now are actually going out and auditing companies and putting them through a compliance process to see if they're complying with the letter of the law and not just the concept of it. I think they've done a great job at trying to get information out so insurance companies have sales practices, literature, and information that's appropriate. I think they've done a great job of pushing this law into the public domain so that people are aware of it, even though it is complicated and easily misunderstood. I think that's been a noble and worthwhile thing for them to do. And I think they've been successful at it. I'm a real fan of the DOI. . . . I don't always agree with them on stuff. In fact there are more times than not that I don't agree. But I really have to [say] I think they've been very fair and have done a good job. And they've been helpful. When I call with a problem or I don't know how to handle something, they are very forthright in coming back and making some recommendations.*

.....

*Barbara, I think, is really responsible for a large part of this. She really did a tremendous job. Barbara, in my view, is a real genius in this regard, and she is very thoughtful.*

Naturally, these favorable views were not shared by all subjects. We heard a number of complaints, from both insurers and agents, that the DOI's enforcement activities have been too aggressive, nit-picky, or inconsistent. Whereas the DOI was once seen as "insurer friendly," following reform its relationship with the industry is much more adversarial. Several people mentioned that the DOI issued an early set of regulatory interpretations, many of which it later amended or reversed. One person said that DOI staff is known for giving inconsistent verbal interpretations, although the DOI said that insurers are skilled at "shopping" the DOI staff for the answer they want. Another person commented that the DOI has "taken a fair amount of poetic license" with some issues of statutory interpretation and "has really pushed the envelope and sort of dared people to challenge them."

Especially controversial has been the DOI's decision to issue several large fines (\$35,000-\$126,000) against prominent insurers such as Blue Cross, CIGNA, Kaiser and FHP/Pacificare, for violations of various rules, including the small-group laws, discovered during market conduct examinations. Critics feel that these are "good guy" "white-hat" insurers that try to comply and do not engage in purposeful violations, that most or all of the noncompliance does not go to the core of the law or occurred early in the implementation when insurers were still catching up, and that, in any event, imposing fines of this size only results in increasing costs to consumers. One person even suggested that fines of this size are motivated by the need for more money to support the division's operations. These critics also view it as unfair to issue highly public reprimands over fairly minor, technical issues, with which the media have had a "field day." Some insurers are "very angry" over how the DOI has treated them in public. The following are representative negative comments of this nature from agents:

*The Division of Insurance has used their market conduct survey rights and has really gone after carriers, gone back and looked at their marketing materials that were over a year old when people were still scrambling. I need to explain to you that House Bill 1210 had, I think, nine -- maybe more -- emergency regulations, all of which changed by the time the real regulations came out, which caused carriers to publish and republish and write and rewrite their brochures. I honestly believe that if a carrier is making a good faith effort, there is no reason to fine them. Let's face it, if you fine a carrier, who pays for it? Who ultimately pays for it? . . . One of the things that's driving the cost of health care is that every carrier has to have a staff full of attorneys and compliance people because every state has different regs. And now you get the federal regs [on top of the] the state regs. That drives cost. You're out of compliance. That drives costs. I just don't think that it was that necessary. . . . The market conduct surveys, I think, are just excessive. Carriers are afraid to complain because they don't need any more market conduct surveys. . . . I have yet to see a carrier deliberately go out to hurt an individual or an agent. I think that the carriers did an admirable job at trying to comply with 1210, a most difficult law. You have nine emergency regs, and they're still not what the regs come out to be. It was tough.*

Also, several subjects commented that the DOI has been more political and activist than is appropriate, in their view, for an administrative agency. They say that the DOI uses its reports as political tools and will not release data that contradicts its viewpoint. Barbara Yondorf, in particular, is said to be pursuing an "extreme radical" reform agenda that veers toward "socialized medicine":

*The unfortunate feeling, . . . especially amongst agents and carriers, is that the Division of Insurance . . . spend[s] too much of their time involved in writing legislation. Now, they'll deny this and yet . . . [the legislative staff] always gives [proposed bills] to the Division to read and the Division says well it's because we're checking to make sure it's legal. When they come back, . . . anything that the NAIC has done somehow wiggles its way in without question right into our legislation and into our state. It is perceived by carriers and agents that the Division really does have an agenda, a direction that they think a state ought to be run -- a type of, if you will, environment. And a lot of people, especially agents and carriers, think that's most unfortunate.*

Regardless of the view that one takes of the DOI's enforcement activities, our impression is that there is now a good level of compliance with the reform law among insurers and agents. Noticeably subdued in Colorado are the many indications of covert selection tactics or subtle field underwriting that we observed in other states. Especially noteworthy is the high degree of

sensitivity (one person said "paranoia") discussed above that we observed among agents as to their role in monitoring compliance. As noted above, the DOI took pains to let agents know their professional licensure might be affected if they were found to be cooperating with illegal tactics. As for insurers, we were told, and we observed nothing to contradict, that insurers are generally in compliance with the basic requirements of the law.

*There are carriers maybe that are more of the black hat than the white hat. There's a couple out there. But the carriers that the majority of the agents use and the majority of the business owners buy, do try to comply with Colorado law in good faith. I don't know of one [carrier] that hasn't come around to saying you're right and making it right with the client [when a compliance issue has been raised]. . . . I think the majority of carriers are really trying. And do they make mistakes? You bet they do. I have always found the carriers to be immensely willing to work with [me in] trying to figure whether they were out of compliance. . . . [There's not a] person -- on all the claims I've had and [with] all the law changes, that [when] I went to the carrier and said, "You know, you're out of compliance. You really can't do this," -- that hasn't come around to saying you're right and making it right with the client. . . .*

Noncompliance was apparently more widespread initially, before insurers learned the differences between Colorado's reform law and the versions they were familiar with in other states. Also, several subjects commented that the effective date of the law came so quickly after enactment that neither the industry nor the DOI was fully prepared, resulting in some confusion over precise issues of interpretation. Blue Cross of Colorado ceased marketing small-group insurance for a few months at the outset of the law because it did not have time to implement the necessary changes. In any event, for whatever reason, the DOI's random sample inspection of forms, contracts, and marketing materials for 36 insurers found a large number of violations. Some were very serious, such as failing to offer the statutory plans to all portions of the small-group market or having a preexisting exclusion period that was much too long.

Many of these initial problems were quickly resolved. Those that continued were usually with insurers with very small market shares and so the carriers may have failed to focus on the requirements in this market until forced to do so. To determine the level of continuing noncompliance with larger insurers, we examined some of the DOI market conduct reports to determine ourselves how serious violations were. Without entering into the debate over the propriety of the fines and their sizes, it does appear to us that most of the violations after the initial period are not blatant, in the sense that they do not constitute overt refusal to follow the core requirements of guaranteed issue and rating restrictions. They are more "errors of omission," as two subjects said, minor and inadvertent deviations from technical aspects of the law, or failure to properly document compliance, rather than evidence of purposeful strategies to evade or take advantage of the law. Nevertheless, some are serious. One large insurer was found to have failed to offer conversion plans to some employees in groups that discontinued group coverage, and another was found to have failed to actively market its standard and basic PPO plans and was found to be in serious noncompliance with the rating methodology by giving discounts to favored groups and by charging more for guaranteed-issue plans than for medically-underwritten ones.

## **2. Border Problems and Fraud**

We also inquired into particular enforcement issues that might be especially troubling or

unanticipated. These include list billing, self-insurance, fictitious associations, and employer fraud. These are all concerned with what we refer to as "border-crossing" problems. The potential for these problems arises when one segment of the market is regulated differently than another. This creates possible strategic advantages for low- or high-risk groups or individuals to cross into or out of the market, at either the high-size or low-size ends of the market, thereby unraveling or eroding the market divisions that are necessary to sustain this regulatory structure. We will discuss a variety of specific examples but our main focus will be list billing.

**List Billing.** This refers to an insurer or employer that excludes certain members from group coverage or sells individual coverage to members within an employer group, either with or without the employer contributing to the cost. This practice was common prior to the reform law for a variety of reasons. One use of list billing was for employers to purchase insurance for only selected employees by reimbursing them for the cost of individual coverage. This might be done in order to offer insurance only to "key employees" such as managers, or in order to avoid the costs of insuring an employee or family with health problems. Other forms of list billing were done as an accommodation to employees whose employers were not willing to buy insurance for anyone, but who wanted to facilitate their employees' purchase of insurance through payroll deduction.

The reform law prohibits list billing, following the philosophy that employers should treat their employees equally, and out of the pragmatic concern that if list billing were allowed to continue, employers with low-risk profiles would circumvent the rating rules by purchasing non-group insurance, thus bleeding good risks out of the small-group market. We found little evidence that this was happening. One agent, however, noted that the same effect occurs when employees find themselves priced out of family coverage and so opt on their own to decline group coverage for their family and instead purchase this coverage in the individual market:

*It's highly illegal to talk about putting your family on an individual plan in a place of business. Carriers tried to stop [employees' purchase of individual insurance] by participation requirements. The law tried to stop it by making sure agents weren't talking about individual [insurance] at the place of business. But the individuals weren't stupid. I mean if you can't afford a \$300 rate, you can't afford a \$300 rate. You don't want your family to go uncovered. So we would find a lot of calls from people just saying, "My husband has group insurance, but he can't afford the kids and I on the plan. What have you got?" Probably that could help account for why I have so darn many individuals. I shouldn't say darn many, but individuals are a lot of work, as much work as a group, and claims intensive and hand holding. What do you do? Your heart goes out to them. They've got to have coverage somewhere, and so you have the individual market. It's always a big job, too, of saying, "Do you realize what you are giving up when you go with an individual plan?"*

Not everyone is happy about the loss of list billing. According to one agent, "That caused a lot of grief with the individual carriers. That's very profitable business." Other agents complained that honoring the list-billing ban makes it confusing and complicated for very small family businesses and self-employed individuals for whom the distinction between individual and group insurance is obscure:

*It's now illegal for a business to buy individual health insurance and pay for it with a corporate check. That's the direction. One of the many, many complications that arose is that you have a one-life group. Now the one-life group is also an individual. So you as an*

*individual want to buy individual health insurance. I mean that's what individual health insurance is, right? But you want to pay for it with a corporate check. That's illegal. You have to pay for it with a personal check. So you got into all this sort of machinations where you say you want to buy insurance. I say, okay, that's what I do for a living, I'll sell it to you. Now I say tell me a little bit about your business. You say, oh, I'm in business for myself. I just want to buy an individual health insurance policy. I say, okay, great. We can do that. Next thing you know, you give me a corporate check [from] Elliot Wicks, Inc. And I say I can't take this check. What do you mean you can't take it? Then we get into that kind of thing. It has to be a personal check. Why? Well, because the state says so. What does the state care how I pay for this? It got really kind of goofy.*

To resolve some of this confusion, a subsequent amendment allows a self-employed individual to choose whether to purchase individual or group coverage. But if someone opts for individual coverage, they cannot switch back to the group market for three years, to prevent adverse selection. However, one insurer complained that it still takes a lot of time and effort to monitor compliance with the list-bill ban, since literally every check that comes in must be inspected before it is deposited to see if it is corporate or individual.

*Associations.* Good risks might also leave the small-group market at the high end, if small groups attempted to aggregate artificially into a group larger than 50. This might occur through what are known as "fictitious associations," the variety of which are too complex to describe thoroughly.

In the past, they have gone under the acronyms of MEWAs or METs. Associations might be used to cross the border at the small end by taking high-risk individuals and presenting them as an employer group. We found no indication that either was happening.

*Self-insurance.* Yet another border-crossing concern is the threat that this law would induce medium-size groups, those in the 25-50 range, to self-insure. This might occur if a group of good health risk felt it could save money by avoiding the rating bands. It is primarily for this reason that rating restrictions are not extended to groups any larger than 50. We found, however, no indication that groups below 50 are self-insuring at a significant rate.

*Employer Fraud.* Other potential circumvention techniques are not as structurally sophisticated, and they are perpetrated primarily by employers, not insurers. An employer with a sick family member or friend might falsely claim the person as an employee in order to take advantage of guaranteed issue or rating limitations. Or an employer who truly employs a person with sickness in the family might try to avoid the cost by "hiding" the person off of the payroll. Several subjects observed that, if circumvention and fraud is occurring in this market, it is probably of this nature, initiated by employers, rather than the forms initiated by insurers. The primary example is discussed above under "micro groups." Many agents and insurers suspect that a large number of sick individuals are committing fraud by falsely declaring themselves to be business owners. These subjects complained that the reform law allows for inadequate means to detect this behavior since it forbids them from requesting the same types of tax and payroll information that larger employers must supply. For these larger groups, agents and insurers are sensitive to the potential for fraud and take steps to prevent it, as insurers have every reason to do in order to avoid adverse selection. Several insurers commented that, following reform, underwriters' jobs shifted from focusing on medical issues to focusing on eligibility issues of this sort.

### 3. Reinsurance

A final feature of the law that cuts across several of our categories of discussion is reinsurance. The voluntary reinsurance pool created by the law is intended to provide a relief valve for insurers who are forced by guaranteed issue or rating restrictions to accept risks they believe are not adequately covered by the allowable premiums. Insurers can cede to the pool either high-risk groups or individuals within these groups, on payment of a reinsurance premium that for groups is 150% and for individuals is 500% of a statewide index rate that is based on the statutory standard and basic benefit plans, adjusted for the particular case characteristics in question. If these premiums are not sufficient to cover payments from the pool, losses are made up through an assessment against all participating insurers, proportionate to their small-group market share. This opportunity to cede bad risks is intended to protect insurers from adverse selection and to reduce their incentive to engage in covert risk selection, thus minimizing many of the gaming and policing problems that might otherwise arise under the law. Insurers can elect to either participate or to opt out of this reinsurance mechanism; the latter insurers are referred to as "risk assuming."

Most HMOs and larger indemnity insurers have opted out because they fear that smaller insurers will use this mechanism more aggressively, thereby forcing the larger ones or those who are inexperienced in medical underwriting to pay assessments out of proportion to their use of the reinsurance pool. As reinsuring carriers gained experience with the Colorado small-group reforms, the number of insurers participating has diminished. In the first half of 1997 alone, insurers representing 30% of the reinsured market withdrew from the reinsurance pool.

Participating insurers ceded 198 lives to the pool, and this jumped to 249 lives by mid-1996. Reinsurance premiums paid to the pool doubled over this same period, on an annualized basis.

Despite this increased use, the pool remained financially strong through mid-1996. Its medical loss ratio (the portion of premium paid out in medical claims) was only 22%, far lower than had been predicted, but even this was considerably higher than the 3% claims payout in the first year of operation. This may indicate that participating insurers are becoming more selective in choosing which cases to reinsure, although they may still be reinsuring too readily by ceding risks whose eventual claims payout is far less than the reinsurance premium. On the other hand, because these data come from early in the life of the reinsurance pool, they may not reflect the experience once claims mature from the pool's initial activity.

Interview subjects in Colorado and elsewhere explained the overall reinsurance pool dynamic as follows. In order to come out ahead in the reinsurance game, an insurer has to be better at predicting individual bad cases than its competitors, relative to market share. Doing so requires considerable investment of resources in medical underwriting. If a larger insurer's prediction ability is not as good as the smaller insurers', then not only might it end up paying more reinsurance premium than it receives in reinsured claims benefit, it might also end up paying through the marketwide assessments for the excess claims generated by the insurers that are more accurate. As a result, one person involved in Colorado's reinsurance administration regrets that this mechanism has institutionalized the very underwriting techniques and efforts that small-group reform was intended to reduce or eliminate:

*The mistake that I was referring to is that because of the way the system is set up, this process institutionalized that underwriting deal. So that underwriting now is just as important to an insurance company as it ever was. Because otherwise how do I know who I reinsure?*

Despite this drawback and the dwindling participation in the reinsurance pool, some interview subjects observed that it might be serving useful functions even if it is not much used. It might keep insurers in the market, or encourage new ones to enter, by reassuring those with tiny market shares that receiving one or two bad cases through guaranteed issue will not cause them to suffer an enormous loss. Also, a somewhat hidden function of reinsurance is that the reinsurance premium serves as a modulating device that regulators can use to tighten or loosen incentives for the industry. If reinsurance appears too expensive and regulators detect increasing signs of covert risk selection or are concerned that insurers are leaving the market, they can lower the premium to take pressure off insurers and encourage taking more risky groups. Or, if the reinsurance pool is being used excessively and assessments are mounting, the reinsurance premium can be raised. We have no indication, however, whether reinsurance has been used this way in Colorado.

For these reasons, the reinsurance pool may be beneficial even if it is not presently in great demand. On the other hand, it provides another continuing opportunity for insurers to compete and profit using underwriting and risk selection techniques, rather than with more efficiency-enhancing innovations.