AN EVALUATION OF FLORIDA'S SMALL- GROUP HEALTH INSURANCE REFORM LAWS

Wake Forest University School of Medicine
Mark A. Hall, J.D., Principal Investigator
Elliot Wicks, Ph.D., Consultant
December 1998

Contact author at:
Department of Public Health Sciences
Wake Forest University School of Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1063
336-716-9807

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I. EXECUTIVE SUMMARY

This study evaluates how well Florida'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.

The views of our interview subjects are mixed about the impact of Florida's small-group reform laws. Most insurers viewed Florida's version of the law in negative terms, but most agents gave it strong praise. On balance, the law appears to have a favorable but subdued impact. These are its most successful features:

- The law has not caused major market disruptions and has not generated a large number of complaints or administrative problems
- The market remains highly competitive in price, product diversity, and number of carriers.
- Enrollment has increased, especially for micro-size groups.
- Prices have held steady, except for indemnity plans.
- The CHPA purchasing cooperative system is functional and self-sustaining. Prices have been kept in line with the market, and CHPAs offer a good source of coverage for the smallest firms.

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

- Insurers have developed techniques to discourage enrollment of micro groups in their most popular plans.
- Standardized benefit plans are not selling well outside the CHPAs.
- Tough prior-approval rate review, coupled with the modified community rating rules, makes Florida an unattractive market for a number of indemnity insurers.
- Carriers still compete to some extent on the basis of indirect risk selection.
- The CHPA system has not been as successful as expected, and insurers and agents participate with a distinct lack of enthusiasm.
- Reinsurance is experiencing rapidly diminishing participation and use, and it has not reduced risk pool differentials.

II. BACKGROUND AND METHODS

A. Methods

The primary sources of information for this study are various components of the insurance industry. In Florida, we conducted 28 interviews of 47 people in the spring, summer and fall of 1997, and an additional round of 20 interviews with 29 of these people (or their designated replacements) in the summer and fall of 1998. Represented in this interview pool were seven officials with the Florida Department of Insurance (DOI) and the Agency for Health Care Administration (AHCA), five independent agents active in small-group sales, 28 people at 15 insurance carriers (three in-state and seven out-of-state), two private consultants, five administrators of the reinsurance pool, a purchasing cooperative, and a third-party-administration firm. These were semi-structured interviews based on an interview guide, but the discussions were free-ranging and the coverage of topics varied somewhat among them. Most interviews were in person and lasted 1-2 hours, except for four that were by phone and 11 that were conducted out of state (covering a total of 19 of the interview subjects), in which Florida issues were addressed 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 17 agents throughout the state in January 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 and HMO carriers. 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 Florida compares with other states. Florida is a populous state with about 14 million people. Its demographic and economic characteristics (based on 1990-1992 data) are similar to national statistics, with the following notable exceptions. The population is somewhat older, and a good deal more urban than national averages. Income levels are lower (median family income is 14% below national average), and health statistics (AIDS, deaths, prenatal care) are worse. Jobs are concentrated in the service sector and in smaller firms, where employment-based insurance is less common. As a consequence, Florida's uninsurance rate is substantially higher than the national average.

B. Content and Purpose of Reform

Florida's small-group market reforms were enacted in a series of steps from 1992 to 1994. Rating reforms took effect in January 1992, followed by a guaranteed-issue requirement for basic and standard plans in January 1993. Initially, these laws applied only to groups of 3-25, but in 1994, the law was expanded to cover groups of 1-50, and the guaranteed-issue requirement was extended (through administrative clarification in April 1994) to all small-group products. In addition, the 1994 law tightened rating restrictions. These reforms do not, however, reach the individual market, that is, those people who purchase insurance on their own without any employer contribution.

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 Florida, the guaranteed-issue requirement initially (in 1993) applied only to standardized plans whose benefits are set by a government committee, which are referred to as "state-mandated" plans. They come in several different versions, including a basic, "bare bones" version, and one with a more standard or common benefit package, and versions of each for both indemnity and HMO products. The guaranteed-issue requirement was expanded in 1994 to apply to all small-group products, at the same time that the law was expanded from groups with 3-25 employees to groups of 1-50. (Also, the rating restrictions were tightened the same year, as described below.)

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 ridering out specific health conditions altogether. They are allowed to place only an initial 12-month preexisting exclusion on any condition manifested within six months before the date of coverage, and for 1-life groups (i.e., the self-

employed), a two-year exclusion period is allowed. 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 two months.

The second major component of the reforms is to restrict the degree of price variation among subscribers. In 1992, Florida initially adopted rating band restrictions that allowed individual health status to affect rates but only +/-20% above or below each insurer's midpoint rate. In 1994, Florida eliminated any rate variation based on individual health status and instead adopted "modified community rating." This rating method is called modified, rather than pure, community rating because full adjustment is still allowed for age and gender factors, as well a discount for nonsmokers. These allowable rating factors, along with location, can still result, at the extreme, in rate variations of almost 10-fold or more among different subscribers with the same family size who purchase the same product, although these distant outliers might be very rare.

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. Florida follows the National Association of Insurance Commissioners' 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 Florida is a statewide system of public purchasing cooperatives for the small-group market, known as Community Health Purchasing Alliances (CHPAs). These public purchasing cooperatives differ from private purchasing groups in several crucial respects. First, sponsorship and startup funding is public, not private. Second, membership is not restricted. Third, administration is more proactive, in that CHPAs carefully oversee marketing and enrollment. Finally, CHPAs provide the opportunity to choose from many insurers. Each CHPA contracts with a number of insurers who agree to abide by certain marketing and pricing rules. The core idea is to streamline the marketing function and to create a larger risk pool in a fashion that creates for small groups the same bargaining clout, administrative expertise, and employee choice that are typical for large employers. CHPAs do not, however, engage directly in price negotiation, as purchasing cooperatives do in a few other states.

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 their workers purchasing as individuals 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 Generally

Following the enactment of Florida's small-group insurance reforms, the percent of the overall population without insurance dropped significantly, from 24.5% in 1992, to 20.8% in 1994, but has risen since then, to 24% in 1997 (Table 1). There are several possible ways to interpret these numbers. Viewed negatively, they are all higher than the national average. Also, the trend downward from 1992 to 1994 and then back up again to 1997 might suggest that the initial milder versions of the law improved the level of insurance whereas the stronger versions enacted in 1994 worsened the situation. But these overall uninsured rates respond to many other social and market segments than just the small-group employers to which the law is targeted. The reform law was not intended to solve the problem of the uninsured and achieve universal coverage.

When viewed with more moderated ambitions in mind, these laws appear to have had a positive but muted impact. First, the portion of small-firm workers who have private insurance has held steady or increased slightly since 1991, according to data from the March Current Population Survey (CPS). These data are displayed in Table 2 and Figure 1. For most of these categories of firm size, however, the changes, either up or down and either year to year or over the span of time, are not statistically significant at a 95% confidence level. Only the nine percentage point increase in private insurance among the self-employed between 1992 and 1997 is statistically significant, and only for a comparison of those two years. This increase cannot be attributed to the reform law since the reform reached the self-employed only in 1994. Also, there is no obvious explanation for why insurance among the self-employed increased so sharply in 1997.

Data that the DOI collects from insurers indicates that small-group enrollment grew exponentially in the early years of reform, from 11,769 at the beginning of 1993 to 486,534 at the end of 1994, but these data are not reliable. The DOI only began collecting this data in 1993 and so there was a low level of compliance in the initial years of reporting. None of our interview subjects observed actual enrollment increases of this magnitude. A different analysis done by James Studnicki, Ph.D., indicates no net increase from 1993 to 1995 in small firms offering health insurance, comparing two different data sources: a 1993 survey of small employers by RAND, and 1995 data reported by insurers to the DOI.

DOI enrollment figures appear to be more reliable in 1995-1997. During that time, reported small-group enrollment increased 72% (Table 3). How much of this increase is still due to reporting anomalies is difficult to discern. There are sudden jumps without apparent explanation between the third and fourth quarters of 1995 and between year-end 1996 and year-end 1997, but the quarterly increases in 1996 are steady and sustained, ranging from 1.5% to 2.9% per quarter. Real enrollment increase is also indicated by quarterly DOI statistics for the number of new enrollees versus terminations. These show net increases in enrollment each

Table 1

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

State	1992	1993	1994	1995	1996	1997
Florida						
Nonelderly population	11,262,236	11,752,414	11,768,190	11,808,786	11,715,794	11,679,211
With employer coverage	53.0%	52.9%	58.1%	57.6%	58.1%	58.2%
With individual coverage	9.2%	10.3%	8.2%	8.0%	7.3%	7.6%
Uninsured	24.5%	24.1%	20.8%	22.0%	23.0%	23.9%
United States						
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

Table 2

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

Group Size	1991	1992	1993	1994	1995	1996	1997
Self-Employed	71.31	62.73	68.09	69.95	65.94	66.08	73.73
< 25	61.76	57.13	61.09	59.99	61.52	59.81	60.06
25-99	61.85	66.95	66.06	72.29	68.66	69.88	67.54

Source: Analysis of March Current Population Survey by Reenie Wagner

Table 3

Florida Small-Group Enrollment, 1995-1997*

	3/95	6/95	9/95	12/95	3/96	6/96	9/96	12/96	12/97
CHPA	36,316	45,982	57,813	65,760	73,068	75,418	77,254	76,370	87,090
Non-CHPA	1,012,920	1,095,796	1,008,630	1,238,619	1,286,174	1,311,807	1,349,826	1,371,594	1,716,928
Total	1,049,236	1,141,778	1,066,443	1,304,379	1,359,242	1,387,225	1,427,080	1,447,964	1,804,018

* Covered lives

Source: FL Division
of Insurer Services

Table 4

New Small-Group Enrollment by Policy Type, 1995-1996*

Plan Type	4thQ/95	1stQ/96	2ndQ/96	4thQ/96
Nonstandard				
Previously uninsured	74,913	104,126	77,244	130,387
Previously insured	65,486	85,187	124,386	54,521
Total new	140,399	189,313	201,630	184,908
% Previously uninsured	53%	55%	38%	71%
Cancelled	105,496	136,180	140,415	158,402
Net new	34,903	53,133	61,215	26,506
Standard w/ rider				
Previously uninsured	4,577	8,933	6,164	4,690
Previously insured	1,902	0	0	0
Total new	6,479	8,933	6,164	4,690
% Previously uninsured	71%	100%	100%	100%
Cancelled	2,261	4,896	5,256	6,904
Net new	4,218	4,037	908	(2,214)
Standard				
Previously uninsured	2,255	1,958	1,634	1,502
Previously insured	193	396	349	394
Total new	2,448	2,354	1,983	1,896
% Previously uninsured	92%	83%	82%	79%
Cancelled	2,476	2,754	2,524	3,094
Net new	(28)	(400)	(541)	(1,198)
Basic				
Previously uninsured	286	186	246	253
Previously insured	0	14	16	3
Total new	286	200	262	256
% Previously uninsured	100%	93%	94%	99%
Cancelled	165	230	164	337
Net new	121	(30)	98	(81)
Plus				
Previously uninsured	191	1,158	1,389	2,198
Previously insured	1	52	75	128
Total new	192	1,210	1,464	2,326
% Previously uninsured	99%	96%	95%	95%
Cancelled	0	153	305	381
Net new	192	1,057	1,159	1,945

* Covered lives; not including CHPA sales

Source: FL Division of Insurer Services Quarterly Enrollment Reports

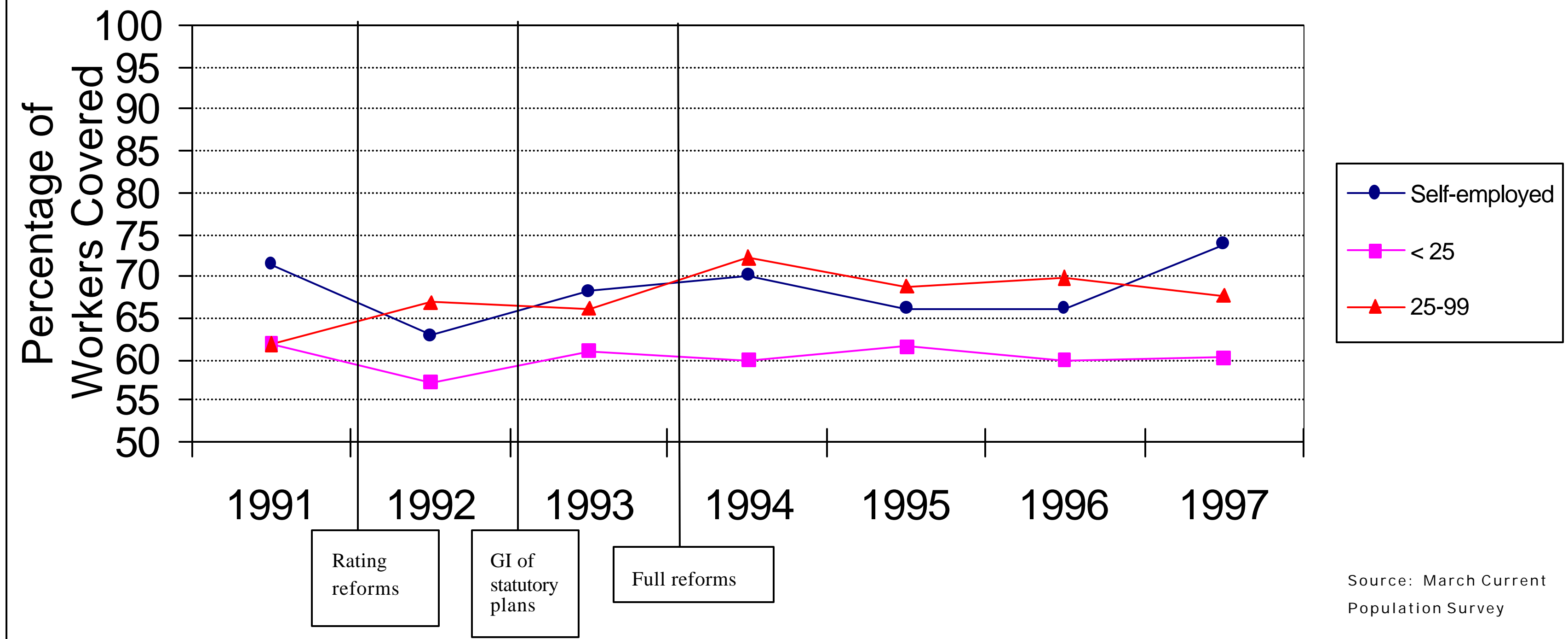
Figure 1:
Private Health Insurance Coverage of
Florida Workers by Group Size, 1991-1997
Percentage of Workers Covered
100
95
90
85
80
75
70
65
60
55
50
1991
1992
1993
1994
1995
1996
1997
Self-employed
< 25
25-99
Rating reforms
GI of statutory plans
Full reforms
Source: March Current Population Survey

quarter for reporting insurers. However, it is troubling that 10% of subscribers cancel coverage each quarter (Tables 3, 4)

We cannot determine for sure whether and to what extent increased small-group enrollment is due to the reform law or instead to underlying economic and labor market conditions. Some insight is possible by observing how many new policies are being issued to previously-uninsured groups. Previously uninsured is defined for these purposes as lacking insurance during the month prior to enrollment. For insurers' largest block of small-group business, consisting of nonstandard plans sold outside the CHPAs and representing over 80% of small-group sales, well over half of newly-issued policies go to previously-uninsured groups (Table 4). Even more dramatic, 95% of statutory plans are reported as being sold to previously-uninsured groups.

These are remarkable figures that deserve further analysis. One interpretation is that the guaranteed-issue law has brought huge numbers of previously-uninsured subscribers into the market. But numbers this large would surely be reflected in rapidly increasing claims figures, which is not the case as discussed below. Another explanation is that, rather than these being groups that are chronically uninsurable, many of these are new businesses or businesses that, for economic reasons, are only now deciding to purchase. In addition, because the "look-back" period for determination of previous coverage is only 1-2 months, many of these are probably groups whose previous insurance lapsed for only a short time. Finally, the strong possibility exists that there are reporting anomalies. Insurers are told to distinguish between groups that are newly insured and those who are merely switching insurance and therefore are merely new to the carrier. As discussed below, there has been a high level of turnover among insured groups that switch insurers to obtain better prices or benefits, so if insurers are not precise in their recordkeeping, the newly-insured figure may be exaggerated. Reporting anomalies are suggested by the fact that, for the statutory plans, 100% of the standard plans with riders (which is the largest category) were reported in 1996 as sold to previously uninsured, which is unrealistic as a statewide statistic and inconsistent with the 70% figure reported for the same category in the fourth quarter of 1995 (Table 4). Similarly, the portion of nonstandard plans reported as sold to previously uninsured jumps wildly from one quarter to the next, for no apparent reason. Also, we were told by the agents we interviewed that they rarely have clients who previously were uninsured. Instead, most of their activity is finding new insurance for someone who already has coverage.

2. Industry Views and Field Underwriting

Lacking better data, the best measure of the impact of guaranteed issue is the informed opinions of industry informants. Most of our subjects viewed guaranteed issue in Florida as being successful. Several people, including agents and DOI representatives, commented that it has resulted in an "appreciable" or "substantial" growth in small-group business. Some agents said they had not seen a significant increase in enrollment, and they praised the law only in so far

as it made it easier to shop for new coverage (portability). But most agents were enthusiastic about the ease of selling health insurance now. A 1996 survey of 100 Tampa-area health insurance agents conducted by James Studnicki, Ph.D., found that 69% of the agents for whom small-group business is the major focus think that the reform law "has made selling small groups easier," and the same is true for 52% of the agents who sell small-group insurance only occasionally. Here are two sample views:

> *I think [the reform] has done three wonderful things. One is guaranteed issue; two, they have [set] a cap on what [insurers] can charge you for renewals; . . . and three, is they give you credit for any preexisting [exclusion period] you have met on the old plan in the new plan. Those are three great things.*

> [*This] has been the best thing that has happened to us in a long time. I just think that Florida has done an exceptionally good job on the reform system. It's been great for the consumer because everybody has access. You can keep it after you leave -- portability. Prices are good. And for the agent, it's been terrific because most of us didn't want to be in the health insurance business previously. You were in it because it was an accommodation [to the client] or you used it to get some [other kind of business] that you wanted. But now a lot of us are in it because it's a good place to be. It was a great opportunity when it came in. . . . Before health care reform, . . . if you had any major catastrophic or ongoing claim situations, then really what would happen [is] the carrier could decline to quote or price it so that it was priced out of the market. Which really made it impossible for employers to change if they had somebody who had ongoing [medical] situations. . . .When an employer calls me now and wants group insurance, maybe he's never had it before. I know whatever carrier is the best rate-wise and benefits for them. I don't have to worry that I can't write the group. . . . It's nice to know when I walk into a group I don't have to worry about, okay, who do you have that is sick, you know, what's lurking out there. Because previously, [I would] go in and start enrolling and the employer didn't know somebody had a problem until we started filling out the medical applications and then, oh no, [the insurer would tell us] we can't do this. And that makes you look bad, and makes the employer look bad. That's the very best positive side of small-group reform. That you don't have to do that anymore.*

One large insurer shared this view, commenting that reform has simplified business since the carrier spends much less time than before justifying underwriting decisions to agents and employers. Two insurers, one an HMO and another with both indemnity and HMO products,

liked the fact that the reform law leveled the playing field and made them more competitive by eliminating risk selection as a basis of competition.

Insurers, however, were much more likely than agents to criticize the reform law. One insurer acknowledged an increase in enrollment, but said this was not a result of the reform law; instead, increased enrollment came from the intense competition among HMOs serving the Medicare and Medicaid populations which are required to meet quotas for private enrollment in order to expand their public enrollment. HMOs went aggressively after small employers because this was seen as a source of new private enrollment that had not yet been fully tapped.

Another insurer told us that guaranteed issue had a somewhat negative impact by forcing the company to drop some plans it was unwilling to sell on a guaranteed-issue basis, due to adverse selection problems discussed below. This forced the carrier to require some renewing subscribers to switch coverage they liked. The insurer would have preferred to be able to do what some other states allow, which is to keep existing groups in their medically-underwritten policies and require guaranteed issue of only policies that are being sold to new subscribers.

A number of indemnity insurers viewed Florida in especially negative terms -- as a tough state in which to do business. They attributed this in part to the general market conditions favoring HMOs, but also in part to the reform law and Florida's tough prior-rate-approval practices. Some of these insurers have pulled out of the state or stopped marketing actively. Others are still in the state, in part because they have too much business at stake to give up on the Florida market, but they remain active in the state with the attitude that the "jury is still out." Almost no insurer subject we spoke to was highly favorable about the reform law. Nevertheless, most appear willing to work with the law. One agent summed up nicely by noting, "We heard a lot of noise from the carriers that they didn't like the [new] system, but everybody seems to be doing well."

The most troubling aspect of implementing guaranteed issue that we encountered is the acknowledgment by almost everyone we asked that some degree of field underwriting is occurring. 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.

A DOI representative confirmed that field underwriting occurs, but explained that it is difficult to detect with the department's available resources. One industry source said that regulators "can't

hold a candle" to the creative abilities of the insurers to encourage risk selection. The following extensive discussion with an agent explains how this works:

> **Q:** I've not heard this argued in this state but I have heard it argued in other states that there is a kind of subtle pressure put on by carriers to do, in effect, field underwriting. To not sell to certain groups. To find ways to avoid selling to them.
>
> **A:** *To pre-underwrite, . . . be selective of what you bring to them.*
>
> **Q:** Does it happen?
>
> **A:** *Yes. . . .It depends how loyal [agents] are to their number-one carrier -- the carrier they place most business with. If a group comes along that's a really sick group that has lots of problems, I'm sure they [agents] think twice about it. I don't know any human being who wouldn't think twice about it. If your livelihood is coming from one carrier who has taken good care or you, you don't want to lose that relationship you have with that carrier. It's ultimately that's how we make a living. . . .*
>
> **Q:** How do [insurers encourage this?] I mean you'd like to make this sale I assume?
>
> **A:** *It's their sales reps. They become your friends. They become who you depend on and they pull strings for you. They get things accomplished for you and in return they unsubtly or subtly ask you to be careful what you send them. . . . It's not anything official. It's nothing written. It's nothing official. It's more or less, I scratch your back, you scratch my back.*
>
> **Q:** And how do they scratch your back?
>
> **A:** *Going the extra [mile] when I have a problem. If I've got a problem with a case, they'll overextend themselves to see that it gets corrected. And that really boils down to the more business you place with a particular carrier, the more they're going to go that extra mile for you. But in return, they want you to be careful what you send them.*
>
> **Q:** How can agents be careful?
>
> **A:** *Well, when you are talking to an employer, . . . you find out, have you got any health problems that you are aware of, any large claims, any ongoing maternities? You field-underwrite it. You ask*

the questions that previously the employees each had to answer, at least generic questions. Which also not only helps you determine [whether] that's a really bad account [that] I don't want to take to my best carrier because my name will be mud there, it also helps you to determine who's going to give you the best price for it.

Q: Do agents then ultimately place these groups with somebody else?

A: *Some of them do. . . . Some agents will probably walk away from [the group]. Won't even do anything for it. Ignore it.*

Q: I see. So they just don't call back.

A: *Yea. They figure some other agent will come along and they'll take care of it. I [personally] can't do that. I have a problem with [doing] that. The [other] guys in [my] office say it's the mothering in me.*

Q: What do the employers do under these circumstances?

A: *They're not aware of it.*

Q: How extensive is this field underwriting? I mean does it happen a good deal or is it a very rare thing?

A: *I think it was more intense when [guaranteed issue] first began because we didn't know what it was going to do. . . . [W]e all got a little gun shy and wanted to make sure that whatever we were writing was good business so that our market would be there and we weren't going to have to go out the next year and recreate the wheel.*

In order to gauge the extent and impact of field underwriting, we conducted a market testing study to determine the ability of an actual small employer with a high-risk profile to obtain insurance. A small employer composed of two workers in good health and one with juvenile diabetes contacted 17 agents throughout the state to inquire about coverage. No agent indicated that coverage would be unavailable, and only one indicated that some insurers might be reluctant to cover this group. Florida agents were highly responsive; only two of the 17 were rated by the market tester as having a sluggish response and none was unreasonable.

3. Micro Groups

The one area where interview subjects most consistently pointed to increased enrollment is with respect to groups of 1-3 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. This forced micro groups in the past to purchase insurance in the individual market. Extending the small-group law down to employer groups of one (i.e., to the self-employed) requires insurers to market their small-group products to this segment, which offers the prospect of better coverage at lower prices than is available through the individual market. This might result in enrollment gains simply due to migration from the individual to the small-group market. Although we were unable to establish this directly, it is noteworthy that sales in the individual market have dropped significantly following the expansion of the small-group law to one-life groups.

Several agents noted that the small-group law has been especially successful in stimulating sales for micro groups. According to one agent, "That's been the best thing that could have happened." Several insurers previously never sold to micro groups, or offered only individual coverage, but now attribute much of their recent enrollment growth to groups under 10 or under five. Evidence of this can be seen in the fact that average group size has dropped sharply for several agents and insurers we spoke with. One indemnity insurer said its average group size plummeted following the law, from 4-5 employees down to 1-2.

In other respects, the expansion of the law to cover one-life groups has hampered availability. As explained above, these groups are seen by insurers as inherently less desirable due to greater marketing and administrative expense and greater adverse selection. Two interview subjects described this dislike as rising to "paranoia," but several insurers documented their significantly higher claims costs. At one HMO, the claims experience is 22% worse for one-life groups than for the overall small-group block, and this differential is increasing. At another insurer, the loss ratio for its PPO products for groups of 1-2 employees is 25 points higher than for groups size 3-9, and 30 points higher than groups size 10-50. These ranges were confirmed by a third insurer, one specializing in indemnity products. Although the statute allows the preexisting exclusion period to be doubled to 24 months for one-life groups, this apparently has not offset the greater adverse selection. Moreover, these medical loss ratio figures do not reflect the increased per-unit marketing and administrative costs.

Because the rating rules discussed below do not allow adjustments to reflect these added costs or selection effects based on group size, insurers have adopted a number of strategies to minimize their exposure to micro groups. One indemnity insurer told us this was one among several factors in their decision to withdraw from the market. Another insurer said that some of their competitors use the allowable rating factors such as age or geographic location as proxies for group size, to make their price less attractive to the smallest groups. Several agents told us that insurers are much more demanding about the documentation they require for micro groups or take longer to give quotes and process applications. For instance:

> *You can tell [insurers] don't really want that [one-person] business . . . just because [of their] attitude [toward] them. . . . [Insurers] want every document; not that you don't rightfully have to get it, but sometimes they*

want a few more documents from a one- person group than they would from a three-person group. . . .I called the other day on one of the carriers who had given me a lead. The lady's kidneys need an organ transplant . . . in a few years possibly. So we were calling underwriting to try to get them to give a little assurance of what their guidelines are with claims and all that. And the sales people basically said, hey, we don't even know if this group is a legitimate group. I said, well if they are not, then the story is closed. But in the meantime just keep talking to us.

It is noteworthy, however, that sometimes this strategy backfires on insurers. One agent told us about an insurer that makes it difficult to qualify micro groups:

I give them all my heart transplants and all the good stuff [sarcasm implied]. I have a client recently [in a group under 10] that had a probability of having a transplant. They liked [this insurer], so I just had them call in directly.

Insurers respond that problems of group legitimacy and subscriber cheating are indeed much greater with one-life groups. They observe that it is much easier for one high-risk person or a family to create a fictitious business simply to obtain insurance than it is for larger groups of unrelated individuals. One insurer maintains that fraud of this sort is rampant in parts of Florida, and that agents are facilitating this fraud. Others, however, say this is not the case.

The most prominent way insurers attempted to avoid micro groups was by slashing their agent commissions to 1-3%. This was confirmed by almost all interview subjects, including those at the DOI. Small-group commissions are usually in the 5-8% range, and insurers in other states usually pay higher, not lower, percentages for smaller groups to offset the diseconomies of scale. For instance, commissions in the individual market are usually 10-15%. Although the statute requires insurers to engage in "fair marketing," the DOI declined for many years to interpret this as requiring consistent commissions, believing that its statutory authority to do so was not sufficiently clear, especially considering the tradition of never previously having regulated agent commissions. However, the DOI finally relented to increasing pressure from agents and other advocates, and in July 1998 issued a directive prohibiting insurers from lowering commissions based on small group sizes. The DOI also warned against slow processing of applications.

Prior to this directive, almost every major insurer except Blue Cross had cut its commissions to as low as 1% for groups of 1-3. This had obvious effects on agents' interest in selling this business. According to one:

Bringing the guaranteed issue down to one or two lives I think initially . . . wound up in the beginning increasing our business and so we were happy about it because we were making money at it. But what has happened over the last year and a half or so is that all these companies who write

> *that business have drastically cut commissions from those groups, so really you are looking at a loss financially when you consider how much time you have to put into it. . . .But this is a business, and you know, most of the agents that I know still will service the client because they feel it is the right thing to do, and some of them will pass on the business and tell them to call somebody else.*

According to another:

> *I'm in the phone book for "Group Health Insurance" and "Individual" and I wish I wasn't. I get probably two, three calls a day [from one-life groups] and it's not a nice call to have to call back and know that I am going to waste 15 minutes of my time. And those people want to shop and see more mail than anybody. I am stereotyping but. . . I lose money when they call me because I have to pay a secretary, I have to pay postage, I have to pay for the phone call, and I have to take 15-20 minutes to explain it. And . . . if it's for her little kid, six-years-old, $80 a month is the premium. I think I get 3% commission on this one, so that's $2.40 a month times a year is 26 bucks. Take out the taxes and I haven't paid the secretary. You see what I mean? And [they want me to] drive over [to meet them in person]. It's ridiculous.*

Similar comments were quoted in a February 19, 1997, *Wall Street Journal* article on this subject. One agent said he will not write micro groups as a result of low commissions: "In my opinion, the insurers just fired the entire sales force." A CHPA director quoted in the same article said, "My board and I feel very strongly that this insults the intent of guaranteed-issue health insurance. . . . It severely inhibits our ability to serve the small-group market -- the very people who need insurance the most." A July 1998 article quotes an agent as reporting that one insurer "flat out told me to my face over the phone that we don't want that business and we want to get rid of it." This same insurer acknowledged that agents can decide to whom to market and it does not make sense for them to build up a business based on micro groups.

What many agents tend to do with these unwanted groups is send them to or place them in the CHPAs. They take this route, even though they otherwise might avoid CHPAs, because it allows them to meet their public service obligation and it is much easier to obtain quotes. Also, CHPAs require new businesses to be in existence only three months, whereas insurers are allowed to demand 1-2 years of prior existence in order to prove legitimacy. CHPAs are also somewhat less demanding in paperwork requirements than are some insurers. In contrast, some agents view selling through CHPAs as being more work for larger groups because this requires them to counsel individual employees about the full range of plans rather than selling a single plan to the entire group. As a consequence, the average group size in CHPA is drastically lower than the rest of the small-group market, at only about 2.2 employees. CHPAs have been able to service primarily the micro market and still retain competitive prices (as discussed below) because rating rules don't allow insurers to price their CHPA business differently than their non-

CHPA business unless they have 2,000 lives in CHPA.

We do not intend to paint an entirely bleak picture of insurance availability for micro groups. On the positive side, recall what was said above that the reform law has greatly increased small-group enrollment for these groups. Also, our market testing study found in January 1998 that a group of three with one unhealthy worker had no problem finding coverage, that agents were responsive, and that only one agent out of 17 encouraged coverage through CHPA.

Most of the same agents and insurers that complained in our interviews about the problems with micro groups acknowledged that the present system is tolerable. Few people thought that taking these groups increased average rates sufficiently to drive off business from larger small groups. The primary attitude was one of concern, described by some as paranoia, about attracting a disproportionate share of these groups. One feature that buffers against this threat is the reinsurance mechanism discussed below, which offers generous treatment of high-risk micro groups by allowing them to be ceded to the reinsurance pool at the group rate rather than the much higher individual rate that some states require. However, a number of people we spoke with clearly would prefer that one-life groups not be included in the small-group reform. This view was expressed primarily by insurers, but also by two agents and one person with the DOI.

4. Portability, Renewability, and Preexisting Conditions

The portability and preexisting condition provisions in the law are widely popular among our interview subjects and appear to have been implemented without much difficulty. Several agents said something to the effect that these are the "most important" features of the law. No one complained explicitly that the preexisting limits were too short, or too long, although note the discussion above about the 24-month exclusion period for one-life groups. Also, two subjects observed that some HMOs that originally had shorter or no preexisting exclusion periods were forced by the imposition of guaranteed issue to impose or lengthen the exclusion period. In addition, a few subjects said there were some difficulties interpreting or administering portability provisions, for instance, in deciding what types of prior coverage are similar enough to qualify, but this concern should be reduced as HIPAA is implemented.

Similarly, the guaranteed-renewability provisions were seen favorably by most interview subjects. The one concern raised is that these have been interpreted to require insurers to allow subscribers to keep the exact same coverage as long as they want, rather than allowing insurers to switch subscribers to similar but updated policies. This forces insurers to keep obsolete policies in effect that they are no longer marketing and creates administrative difficulties when insurers attempt to streamline their claims processing and other functions.

5. Overall

On balance, the insurance reforms in Florida have produced mixed and muted results with respect to the availability criterion. These laws have not produced a huge influx of new

subscribers. However, there has been some increase in small-group enrollment. Whether this is attributable to the law or instead to economic and demographic factors is difficult to disentangle. Only increased enrollment for micro groups, which has been especially notable, can be clearly attributed to the law, although even there the small-group enrollment gains may come partly or mostly at the expense of enrollment losses in the individual market. At least it can be said that the deterioration in the small-group market that preceded these laws has been halted, and possibly reversed. In addition, coverage is now readily available for high-risk groups.

Availability appears to be hampered, however, by practices such as covert field underwriting and explicit reduction in agent commissions to discourage enrollment of micro groups. These and some other more isolated practices appear to constitute manipulation, circumvention, or perhaps outright violation of the law. Their aggregate impact is undetermined, however, and may be significantly blunted by the ready ability to obtain coverage through CHPA.

B. Affordability

1. Prices

We were not provided with longitudinal data adequate to determine the law’s effects on marketwide price levels, but there are several indications that premiums for small employers have held remarkably steady over the past few years, especially compared with the double-digit increases that were common in the late 1980s. One agent commented that "it seemed like when health care reform came in . . . the prices dropped about 30%. . . . The pricing was very, very favorable and still is." One insurer with both indemnity and HMO products showed no increase in average premiums per enrollee from 1995 to 1996. These average premium figures are not adjusted for any changes in benefits or for the composition of the risk pools. Average premiums might hold steady only because benefits are being pared back, such as by increasing deductibles or lowering coverage for prescription drugs, or because subscribers’ risk profile is improving.

There are several other indications, however, that prices are increasing. One significant insurer with both indemnity and HMO products showed no increase in overall premiums per member from 1994 to 1995, but a 12% increase from 1995 to 1996. A second insurer with only indemnity coverage showed a similar pattern. A DOI survey of the top nine indemnity carriers based on a standard five-member group shows rate increases from January 1993 to January 1996 averaging 45%, but ranging from a 9% rate decrease to a 135% increase over this three-year span. Also, several agents we interviewed perceived that rate increases have been steep:

> *Rate increases over the last two years [1996 and 1997] were astronomical. They're finally calming down, getting back into a normal-type range. I talked to my counterparts all over the state at state meetings with life underwriters and it was the same consensus all over the state.*

> *Just to give you an idea: In the [first] six months [of 1997], [for] renewals*

on business that I've had on the books, I've had rate increases that ranged anywhere from 11% to 102%.

In 1998, interview subjects more consistently reported rate increases in the 7-15% range, for both indemnity and HMO carriers.

These contradictory indications and views might be the result of different patterns for different products and insurers. As has been mentioned, the small-group laws took effect at the same time that competition from HMOs was greatly intensifying. This may have caused a selection effect in which good risks left indemnity products for HMOs, at the same time that HMOs were aggressively pricing their product to obtain market share. Several interview subjects spoke of insurers "buying market share," meaning they sacrificed profit, or perhaps took losses, in order to gain volume. Thus, one actuary observed that, at the same time that rates for indemnity insurance were increasing rapidly, as much as 30% a year, rates for HMO products were substantially lower, perhaps as much as 40% less. Thus, the average market trend might be very modest, but different insurers and agents would form radically different impressions based on their experience.

Another explanation for wide differences in perceived pricing is that aggressive pricing strategies may have led to wide swings in prices from one year to the next for particular insurers. We heard from several different sources that in 1994, the first year of marketwide guaranteed issue and modified community rating, a number of indemnity insurers kept their rate increases very low, expecting that others were doing the same, and later found out that they had underpriced. As a result, they attracted too many bad risks. In order to make up significant losses, they then increased rates steeply, which severely hurt their new enrollment in the subsequent year, leaving them trapped in a position from which they might not ever be able to recover. Under different rating and regulatory rules, they might have been able to close off a block of bad business by not selling existing policies to new subscribers, and then creating new policies that are slightly different and priced attractively in order to gain new enrollment. But guaranteed renewal and portability, coupled with the modified community rating rules in Florida, effectively keep insurers from segregating their bad risks from their newer, good risk pools in this fashion, which is quite common in other states. The law was intended to have this result because some insurers were using the more flexible rating rules to aggressively "churn" their accounts. But, eliminating this flexibility also has the effect of hampering insurers with bad risk pools from competing effectively for new business. One agent explained the result in the market:

I remember [just before] January 1, 1994 [when guaranteed issue took effect], one carrier that I obtained a quote from in November. This is an eight- or 10-life case. And actually the rate that I got for a December 1 effective date was about 15% higher than the one in January on a guaranteed-issue basis. So different companies use different philosophies as far as getting into the market. I think the quality carriers, and this particular carrier is a first-class company, they took the attitude, well we're going to use Group Insurance 101 from the CLU [certified life underwriters]

course and we're going to try and get as many lives on the books as we can. We know we're going to get some of the bad, but we want as many of the good that we can. Unfortunately what happened to them is that it blew them out of the water and they're still really not in the marketplace from a price standpoint as a result of the losses experienced in the 18 months that they were really aggressively seeking market share.

Q: Okay. So they underpriced and then they ended up getting some bad business.
A: *They got nailed.*

We heard the same story from three other indemnity insurers. One of these explained that "we tried like crazy" to stay in the market with guaranteed issue and modified community rating, but the carrier "severely underpriced" in 1994, with rate increases of only 4%, because it thought others were doing the same and it wanted to remain. But, when claims started to come in, it found that it had "really screwed up." The company had targeted a 72% loss ratio and ended up with 92%. (These figures represent only the portion of premium paid out as medical claims, not the expenses of selling and administration, which run 10-20%.) "Once you make this kind of mistake, you can't ever recover," this actuary said. These carriers attributed the inability to recover not only to the rating rules designed to eliminate churning, but also to the fact that Florida, apart from the small-group laws, requires prior approval by the DOI for increases in average rates ("trend"). These insurers complained that this rate review authority, which does not exist in many other states, has been used to ratchet down their requests for rate increases, which keeps them from recouping their full losses even when their requests are actuarially justified. Of these four insurers, three have either officially or effectively withdrawn from the market, and one is still struggling to stay in and compete, although it indicates that the "jury is still out" on whether it will remain active in the Florida market.

It is a separate question whether and which of these mixed results are attributable to the reform law or to underlying market conditions. The intensely competitive environment that kept marketwide averages down but that also led to difficult or disastrous pricing decisions, generally exists across the country, in large part due to the shift to managed care. Of course, these reform laws also were enacted across the country, and it is possible that they facilitated or precipitated the move to managed care. We discuss that possibility more below. For the moment, though, we turn our attention to more direct impacts of the reform law on average prices.

2. Adverse Selection Against the Market

We evaluated the extent to which the reform law may have increased average prices and destabilized the market by causing adverse selection against the market as a whole. Rating restrictions have this potential by increasing costs for healthier subscribers, thereby at the margin driving some from the market, and by lowering costs for higher risks, thereby attracting more into the market. This rate compression, coupled with guaranteed issue, was expected to increase average prices noticeably. Again, we lack sufficient data over time to make a conclusive

determination of whether this actually occurred in Florida, so we turn to more subjective and anecdotal indications, which again prove to be somewhat inconsistent.

Data from insurers suggest that some degree of adverse selection has occurred. At one large insurer with both HMO and indemnity products, loss ratios for various small-group products have increased from 60-70% in 1994 to 80-100% in 1996. Loss ratios are affected by both claims and prices, however, and so this worsening situation may be due to intensified price competition rather than increasing claims. More revealing are the average claims per small-group enrollee. Two insurers, one indemnity and one mixed HMO/indemnity, show a sharp increase in average claims from 1994 to 1996. For the indemnity insurer, average claims went from $1,976 to $2,354 to $3,380. For the mixed insurer, claims increased from $2,337 to $2,653 to $2,844. An HMO told us that, before 1994, it offered the same rate to small groups and larger groups, but now the smaller groups pay 9% more due mostly to higher claims costs, and the differential is growing. However, average claims at another insurer, one with both indemnity and HMO products, dropped from $1,311 in 1995 to $1,194 in 1996.

Another insurer we spoke with conducted a detailed study of the extent of adverse selection in its small, but substantial, block of indemnity subscribers (accounting for 3-4% of the market). It tracked the number of enrollees that it classified as substandard risks. As a portion of new subscribers, substandard risks in Florida increased from 2.6% in 1993 to 13.5% in 1995. In 1994, these substandard risks generated claims that were about three times higher than for standard risks. As a consequence, average claims per covered life for Florida policies that this indemnity insurer has issued since 1993 *doubled* from 1993 to 1995.

These isolated figures are not fully revealing for several reasons. As before, they are not adjusted for changes in benefits. Also, they reflect only a small portion of the market, and may come from companies who, due to bad luck or to market conditions, have suffered more severe adverse selection than others. For instance, the rapid movement to HMOs has left insurers with only indemnity plans holding worse risks, since HMOs are thought to attract healthier subscribers, and in general subscribers are less inclined to switch insurance if they are in the midst of treatment.

Subjective opinions on the question of marketwide adverse selection are somewhat mixed. A similar study to ours that was done by Lazarus and Associates in 1995 found that adverse selection was not significant. According to one of their interview subjects, "What happened is that we [the carriers] all traded bad business in 1994. The net effect was minimal." Other subjects in the Lazarus study said that claims went up just a few points, as expected, which was "no big deal." We heard the same view from a several of our subjects. They observed that small-group rates have behaved pretty much in sync with large group rates. However, others thought differently, saying that prices are heating up more for small groups than large groups. Here are the thoughts of two agents:

> *Now that the guaranteed-issue claims are matured -- the cancers and hearts and the AIDS [cases] that they didn't have to take previously that*

now they're taking at face value [i.e., community rates] -- [these cases] have started to mature and the premiums are creeping up and it's getting very expensive in Florida to get health insurance.

It took about 18 months for it to really heat up. The marketplace really heated up from a pricing standpoint. I mean, you read in the trade publications that the cost of medical care is flat. Well, it wasn't in Florida because of the loss ratios justifying more significant increases.

Another agent said the pattern was just the opposite: initially high increases, but now leveling off.

Rates have gone up. There's no question, especially the first couple of years after we had guaranteed issuance we had huge increases. . . . It was not unusual to see increases of 30-40% a year. I would say this year [Spring 1997] the renewals that I have for my businesses are leveling out and most of them are probably between 7 and 10%, which is good.

So far, we have discussed mainly the effects of reform on average prices, either marketwide or for particular carriers. Also important, however, are the effects on prices for individual subscribers at either the high end or the low end of the range in prices. Modified community rating requires price reductions for some groups but price increases for others. We inquired whether the move to modified community rating resulted in any "rate shock" in which some subscribers received large increases and decided to drop coverage. Some subjects responded that they heard of a number of vocal complaints at the time modified community rating took effect when some groups received steep rate increases. One insurer said that some of its lowest-risk groups received increases of 30-40%. On the other hand, some of its poor risks had no increase or even a 15% reduction. Here is one agent's account:

A: *I had, probably, six groups where the premiums went down, out of say 130 [groups]. So, it helped those six people. Those were the only six people that the rates brought it down. Everybody else got a regular adjustment.*

Q: And did any of the groups that you had out of that 130 get a huge increase?

A: *Some of them did. . . . I believe I remember one being up to 50%.*

Q: Would you hazard a guess as to how many that might have happened?

A: *About two that I can think of, two to three.*

Some of the outcry was precipitated by insurers and agents who, when they sent out notices of rate increases to subscribers, explained that the increase was mainly due to the recent small-

group reform, and encouraged subscribers to write their legislators and call the insurance department to complain.

However, few of our subjects thought that this resulted in groups dropping coverage. Usually, after these groups came to understand the reason for the increase and learned that they could not obtain better prices elsewhere, they ended up keeping their coverage, or perhaps they opted for lower benefits or for a managed care plan. The agent last quoted explained:

> **Q:** Did you lose any of those groups . . . that got [large increases]? What did they say to you when they got that kind of an increase?
>
> **A:** *They say the same thing that everybody else would, whether they get a dollar increase or a hundred-dollar increase: "It's not right and it's not fair." And then I say, "I agree, but let me show you what the market bears." Then we do a spreadsheet and they decide if it's the best deal to stay or move.*

Another agent confirmed:

> I *haven't had anybody totally cut their insurance out yet. I've had some threaten -- you know, they can't afford to keep doing this. But currently I haven't had any employer do away with their health insurance because of small-group reforms and the rate increases. They've just made changes in their plans. They've gone to a lot higher deductibles. Or the employee is having to pay more of the premium.*

It may be possible, though, that rate increases caused some individuals within covered groups to decline coverage offered by their employer.

Rating rules also have the potential to increase costs and deter coverage for particular demographic groups, depending on which rating factors are allowed for gender and family composition. The agent last quoted explained that it is now more costly for single parents since allowable family composition factors do not distinguish various family sizes:

> *I had one particular carrier that would give you [separate rates for] an employee, an employee plus spouse, an employee plus one child, an employee plus two children, . . . and for up to three children, which helped the single parent. The parent who was by themselves, who only had one child, got a much-reduced rate versus an employee who maybe had two or three children. . . . The state said that you couldn't do that anymore. . . . So it really hurt the single moms out there that had one child. It really impacted . . . quite a few of my groups where the employees maybe couldn't even afford to [keep] their child [on their insurance] anymore.*

3. Particular Rating Practices

We heard of some additional, more subtle, effects of the rating rules and ways in which some insurers use them to their advantage. One insurer subject said that some other insurers were manipulating composite rating techniques to create rates that were lower for lower-risk groups than would be the case if normal rate tables were used. We do not fully understand how this would be accomplished, and we did not hear this from other sources. Perhaps this refers to a technique mentioned by two other sources, who said that some insurers have found various ways to load the allowable rating factors to produce higher rates for less attractive groups. One example is using steeper age and gender slopes than actuarial data justify to attract more younger subscribers or to avoid micro groups, based on demographic calculations about the composition of these groups.

Geographic rating factors were also cited by two sources as problematic. Florida rating rules allow separate rates for each county, rather than grouping by metropolitan areas or larger population blocks. This allows insurers to set rates that are relatively more or less attractive for different economic and industry characteristics of the populations. One agent explained this as follows.

> *[Insurers] look at a county and they go, okay, that county is mostly blue collar or fishing industry. . . . For example, [Outlying] is the county next to us. Their rates are 15% higher than [Center City] rates. And I've argued with carriers that it doesn't make sense because the groups in [Outlying] County are going to come to [Center City] for their care. There isn't anything in [Outlying] County. They don't even have a hospital. So the rationale is not there. In fact, . . . I am meeting with two underwriters on Tuesday to argue some of my points with them. I don't see their logic in how they're doing their community rating, . . . looking at the county as the type of industries that are mainly in there and using those factors. . . .[Center City] is considered a white-collar county. Mostly white-collar business here, . . . very little industry. Then you go look at [Outlying County], which is mainly a fishing industry, a lot of blue-collar workers there, and they're getting impacted.*

Despite the mixed and often contradictory aspects of these opinions and data, the overall impression is that small-group reform has not had a strong negative impact on affordability in Florida. The small-group market is intensely price competitive. Despite some dramatic price increases for a number of insurers and subscribers, and despite fluctuations in price in different years, the overall trend of prices in Florida appears to be moderate. Several interview subjects commented that the rating limits are working reasonably well and were implemented without undue disruption, in large part because they were phased in over several years. This is not to say there have been no disruptions and no complaints. Clearly there have been. But prices overall remain affordable.

C. Market Competition

1. Market Concentration and Choice

As noted above, the health insurance market for small employers in Florida has been a highly competitive one over the past several years. This can be seen in several ways. Looking first at structural features, although the total number of carriers registered to sell small-group insurance declined sharply following enactment of the small-group law, from over 200 to about 100, there are still a large number of insurers in the market. Most of those who left had very small market shares and weren't "committed" to the market, so that the competition among those who remain is, in the words of one insurer subject, "much fiercer." Smaller insurers were not the only ones to leave the market, however. According to several subjects, the insurers who officially or effectively left the market included some with large blocks of business and some of the largest and most recognizable insurers in the country. Some insurers who remain in the market do so only marginally, in order to keep the business of renewing subscribers, but they do not offer rates that are attractive for new subscribers since rating rules do not permit insurers to set lower rates for new versus renewing business. If an insurer cannot offer a competitive community rate, then it faces the choice of either canceling all its small-group business and leaving the state entirely, in which case it cannot return for a number of years, or keeping its renewing subscribers and setting rates high enough to anticipate the adverse selection that inevitably affects a block of business that is not attracting new subscribers (for reasons described more below). The consequence is that many of the approximately 100 insurers that are technically in the market do not effectively contribute to its price competitiveness or diversity in product offerings.

It is also of some concern that the Florida small-group market is becoming increasingly concentrated. According to the Lazarus and Associates' 1995 report, in 1993 about 50% of the market was held by the four largest insurers. However, in 1998, the top half the market was composed of only two five firms, United and Blue Cross, with Humana a very close third. Only five insurers have more than 5% of the market.

Nevertheless, market vibrancy is indicated by the noticeable increase in the number of smaller, new HMOs serving more local markets. There has also been a dramatic increase in HMO enrollment, both with established carriers and new market entrants. By the end of 1997, HMOs accounted for over half of small-group enrollment, and the vast majority of indemnity enrollment was in PPOs. One independent firm that manages a large block of small-group business for several insurers conducted focus groups with small business owners and found that, prior to reform, fewer than 10% were inclined to purchase HMO coverage whereas two-thirds were inclined to purchase indemnity coverage, but after reform these ratios were reversed. In our market testing study, 60% of the agents recommended HMO coverage and none recommended indemnity, although indemnity was offered along with HMO coverage by 70% of the agents. Whether or not these are positive developments depends on one's view of managed care.

These mixed indicators of market concentration are reflected in the mixed views we

heard from agents. In the view of some, like the following, the market still has a good array of options to choose from:

> *I know that a few carriers left [when the small-group laws were enacted], but not any of the major players, . . . because I was dealing with most companies that I am dealing with today. So most of them just adapted and moved forward.*

In the view of others, however, there are significantly fewer competitors, with mixed consequences:

> *It [small-group reform] really took a lot of the players out of Florida. A lot of the insurance companies that were writing small groups from one to 50 lives in Florida decided that they didn't want to abide by all these regulations and be controlled by the state. Therefore they pulled their product out or they pulled out of the state of Florida completely. So over the last three years we're really getting down to the cream of the crop. The ones that are really going to stay in it for the long haul. . . . [I]n Tallahassee it's had a very adverse effect. We had numerous carriers who would write business here and [now] we're down to just a handful of carriers that will even do business in Tallahassee or that are even competitive. . . . Principal is the only one [left] that is a large name carrier. The rest of them are smaller carriers not as highly rated on Best ratings.*

These differing perceptions may be due to the fact that each insurer is not equally active in every part of the state, so that the amount of effective competition in one area may be much less than in another. Differing perceptions may be due also to agents' preferences for indemnity versus managed care. The agent last quoted, for instance, appears to us to be speaking primarily of indemnity offerings and does not reflect the fact that there are several new HMOs competing in the Tallahassee market.

Indeed, the reduced presence of indemnity offerings is noticeable throughout the small-group market, both in Florida and many other states. Traditional indemnity products are virtually nonexistent in the CHPAs, which are dominated by HMO and PPO products. Several subjects said the same was happening in the rest of the Florida market, namely, that traditional indemnity is "drying up" and has "shrunk to nothing." According to one agent, "We've seen [some] carriers pull indemnity and PPO plans off the markets so the only things they're doing now are HMOs and point-of-service plans." Those insurers that keep their indemnity products are raising deductibles rapidly:

> *You don't see a $100 deductible anymore. You don't see, or hardly ever see, a $200 or $250 deductible. . . . The deductibles are up to $300, $500. I've got them as high as $1,000.*

These trends are driven by concerns over adverse selection. Indemnity products are thought to be favored by patients who are chronically ill or anticipate the need for expensive treatment because they allow greater choice of specialists and sicker patients prefer lower deductibles and more generous coverage of prescriptions. In a guaranteed-issue environment, insurers fear that having the most generous benefits will attract all of the worst kinds of cases like AIDS and severe diabetes. These concerns increase as the degree of selection that subscribers have increases. This is primary explanation given for why indemnity products are almost entirely unavailable in the CHPAs.

A final concern about coverage options expressed by one agent is that some insurers are setting severe limits on what they will pay for out-of-network services in PPO and POS plans. This exposes subscribers to much greater out-of-pocket expense than their stated deductible, copayment, and out-of-pocket maximums, since out-of-network providers are not subject to negotiated discounts and so can bill patients for the full amount of unreimbursed charges. This can result in subscribers incurring huge uninsured liability without realizing it.

2. Price Competition

As previously noted, the small-group market in Florida is widely regarded as being highly price competitive. It could be expected that this price competitiveness would be reflected in data about insurers' relative prices. We looked at insurers' average premiums for all small-group enrollees among the top 10 insurers in 1995, which represent 69% of the total market. These figures are displayed in Table 5. One important caveat: these premium averages are only approximations of relative price, since they do not account for differences in benefit packages among insurers, or for differences in the respective risk pools (e.g., having relatively younger or older policyholders). Therefore, these figures do not, strictly speaking, compare apples to apples. Nevertheless, they are the best insight we have, and we think they are reasonable approximations.

Examination of Table 5 reveals several interesting facts. First, there is surprising spread in premiums even among the top 10, with the highest average premium almost six times greater than the lowest. This is far greater than we have seen in other states. However, if the high-cost outlier is dropped (Humana Health), this multiple drops considerably, to 3.5, still high, but in line

Table 5

Premium Variation for Top Small-Group Carriers, 1995*

Carrier	Market Share	Monthly Prem/ Enrollee	Difference From Median
Health Options	11.4%	$82.57	$(61.10)

Travelers	8.7%	105.21	(38.45)
Av-Med	4.1%	108.79	(34.87)
United Wisconsin Life	6.6%	123.89	(19.78)
Pan American Life	7.9%	139.39	(4.27)
John Alden	14.2%	147.94	4.27
Blue Cross/Blue Shield	15.5%	158.02	14.35
Humana Medical Plan	10.7%	288.60	144.94
Principal Mutual Life	14.6%	289.27	145.60
Humana Health Ins.**	6.3%	478.73	335.06
Total	100.0%		
Median Prem/Enrollee		**$143.67**	
Mkt Share at/below Median		**38.6%**	
Prem/Enrollee Spread		**$396.16**	
High Prem/Low Prem		**5.80**	

* Top carriers by premium volume; includes CHPA sales

** Does not include small groups prior to 1994

Source: FL Division of Insurer Services Quarterly Enrollment and Gross Annual Premium reports, 12/95

with other states we have analyzed. Moreover, the insurers with premiums at or below the median have 51% of the market share among these top firms. Finally, in our market testing study, the price quotes we received from agents across the state fell within a much tighter range, with spreads of 1.17-1.57 to 1, depending on group size and type of product. [1] The overall

[1] 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.

impression, then, is that this is a competitive and rational market, with respect to price. This is confirmed by the analysis of CHPA premiums, which is discussed below.

Another indication of price competitiveness is the high loss ratio that many market leaders experience, which could mean that competition is forcing insurers to cut their profit margins, or for some to take significant losses. In 1996, half of the top dozen small-group insurers had loss ratios for their small-group nonstatutory policies (their most popular products) in the 88-98% range, which is quite high given the additional costs of marketing and administration. Only three of the top dozen insurers have loss ratios below 80% (ranging from 64 to 79%).

Not everyone views this degree of price competitiveness in positive terms. Some interview subjects characterize aggressive pricing as "low-balling" or "buying market share." Others observe that lower premiums by new market entrants reflect a degree of biased selection since, all other things being equal, newer risk pools are healthier than older ones. This is due to two factors: new subscribers are still subject to preexisting condition exclusions, and people with health problems are reluctant to switch insurance in the midst of treatment (so even without underwriting, new subscribers tend to be healthier than renewing subscribers). Insurers may try to seize on this advantage by creating new subsidiaries or product offerings to separate their new subscribers from their existing pools. This results in a situation that some subjects viewed as an unhealthy degree of market volatility. Others, naturally, might view this as favorable price competition and product innovation.

Regardless, it is not clear whether these competitive market characteristics are a consequence of these reform laws. The market was already competitive to some degree before these laws, but the laws appear to have amplified the extent of price competition. First, portability makes it easier for subscribers to switch insurers in order to save a few dollars. Insurers in other states report that their retention (or persistence) rates (the percentage of subscribers that renew, or the length of time they stay with the carrier) have dropped significantly following enactment of these laws. This can be seen to some extent in Table 4 (although we don't have the comparative information for pre-reform years), which reveals that for every 10 new subscribers that an insurer attracted in 1995-1996 outside of CHPA, it lost approximately 7-8 existing subscribers. This table, in combination with Table 3, also shows that 10-14% of existing non-CHPA subscribers switched insurers each quarter, amounting to about a quarter of subscribers that year.

Small-group reforms also contribute to the selection effects that favor new entrants. Guaranteed renewability ensures that unhealthy subscribers can keep their coverage, thereby magnifying the difference between newly-enrolled and renewed subscriber pools. Modified community rating keeps insurers from establishing different rates for different risk pools if the benefits are the same, which keeps them from competing directly with new market entrants by offering lower rates for newer business.

It is debatable how serious a problem this is. Undoubtedly, some insurers are hit harder

by these selection effects than are others, which is unfair and undermines the goal of using competitive forces to promote true economic efficiency. On the other hand, the effects of favorable selection wear off rather rapidly, and so new insurers often find that they have to raise their rates steeply after just a year or two, especially if they underpriced initially relative to the risks they received. If so, their enrollment will deteriorate rapidly since existing healthy subscribers will leave and they will not attract new enrollees. This is illustrated by the experience of several established insurers described above that badly underpriced in the first year of the full reforms (1994). Also, subjects in 1998 said that low-balling tactics are no longer as prevalent as they once were.

It is also debatable whether the reform law is responsible for the increased enrollment in HMOs. Most interview subjects opined that it is not, since the movement to managed care appears to be happening nationwide and independent of these laws. They viewed the small-group market as simply the next logical place for HMOs to look for sales growth after the large group market began to become saturated. One interview subject at an HMO made a forceful argument that HMOs are desperate for market share because they must increase their private enrollment in order to take on more Medicare and Medicaid enrollees, under a rule no longer in effect, that required at least 50% private enrollment. This subject attributed the intensified HMO competition in the small-group market directly to this motivation, since the larger group market was much more saturated with managed care than the small-group segment.

On the other hand, the movement to managed care in the small-group market largely coincides with the small-group reform law, and this coincidence has happened in most other states. There are several possible theories about why the law might have helped to precipitate the move to managed care. First, since HMOs customarily offer open enrollment and modified community rating, these laws helped to level the playing field by requiring other insurers to do business on the same terms. Second, to the extent these laws caused any rate-shock effect, they may have provoked indemnity subscribers to look around for alternatives more aggressively than if prices had continued to climb at a more gradual pace. These speculations were confirmed by several interview subjects. One agent observed that indemnity prices indeed rose steeply in 1994, at least for some insurers. One insurer with both indemnity and HMO products said that the reform law was directly responsible for making the small-group market a "major target" for their HMO products. Another HMO, however, characterized its marketing attitude and that of some other HMOs toward the small-group segment as "benign neglect" or only a "tepid embracing," but this subject also thought this attitude was a mistake.

3. Standardized Benefit Plans

Another way the reform law might promote price competition is by creating standardized benefit packages. Historically, one problem with price shopping is that intricacies in benefit packages have made it extremely difficult to evaluate comparable products. Eliminating this confusion is one reason the law requires insurers to offer statutory benefit plans and requires all plans to contain a minimum set of benefits. We evaluated the extent to which the law is meeting these objectives.

On the positive side, several agents commented that benefit plans are indeed becoming more similar, even in the non-standard plans. "You're no [longer] seeing the major differences between one carrier and another, between the Cadillac and the Volkswagen." But most subjects thought the statutory plans have had little effect. First, very few are being sold outside the CHPAs. Several agents had not sold a single one. One agent, who actually served on the committee that formulated the statutory benefit packages, commented that "standard and basic plans need to be offered by all carriers; I have not written one." Statewide, the statutory plans accounted for less than 5% of new small-group sales outside the CHPAs in 1996 (Table 4). The basic plan is especially unattractive, accounting for .1% of new non-CHPA sales in that same period -- that is, only one out of 1,000 new subscribers. However, marketwide, statutory plans accounted for 8% of total small-group enrollment at the end of 1997.

The most common explanation for these low sales is that the benefits are too unattractive, especially in the basic plan. According to one agent:

> *If you look at the plan, the basic is more or less not worth the paper it's written on. I mean it is just so limited [in] benefits and the cost is not, not a huge difference between the basic and standard for most carriers. . . . It's like why bother almost, when they can buy up to the next higher level for not normally a great deal of difference.*

The standard plan is seen in somewhat more favorable terms, but it too has benefit limits that agents do not view favorably, such as lifetime maximums and limits on mental health coverage and organ transplants. "Why write a plan that has a million-dollar maximum when you can write a plan that is unlimited for two or three or five percent more money? It just doesn't make any sense."

In response to these complaints, regulators have allowed variations in the statutory benefits that result in standardized plans whose coverage is much closer to what is available "on the street." Sales of these "plus plans" and "standard plans with riders" now account for most of the statutory plans sold -- 77% in the fourth quarter of 1996 (Table 4). On learning about the availability of these new, more flexible versions of the standardized plans, one agent said, "Gee whiz! I wish they had that attitude to begin with."

Another explanation for the low sales of statutory plans is the negative perception that some people attach to a plan whose benefits are set by government regulation:

> **A:** *Usually when you mention to a client, "Listen we have this available through the state of Florida," I don't know how or why but when it comes to being provided by a government agency, people seem to be turned off by that and [would] rather purchase health insurance through the private sector.*

Q: OK, now, help me with [understanding] that a little bit because my understanding was that ... the state actually has nothing to do with that plan?

A: *Yeah, but as long as people think that, perception is reality.*

Q: But do you tell them that it's a state plan?

A: *No, no, absolutely. I just say it is the basic and standard plans that are provided through, I'm not saying that it's the state, but it's really provided because the state has made them available.*

A further explanation is that most insurers choose not to actively market these plans. In contrast with the slick, color brochures that insurers usually use for their own plans, for the statutory plans insurers at best provide a plain, single-page summary of benefits. More often, they provide nothing at all, leaving to the agent the task of explaining the plan contents. This, coupled with the government taint, creates a distinct marketing void. Here is how one agent put this point:

> *I would not say that [the standard plan] is marketed by companies. . . . A lot of times when we get called by people, a lot of people already have an idea of what they want. And so, you know, you are going to give them what they want and not try to sell them what they don't want. . . . You know some of that has to do with marketing. I mean you're talking the "basic and the standard" plan with the state of Florida. If they called it the Flamingo Plan like they do for Lotto, maybe people would flock to it, I don't know. But because it is very mundane -- "basic and standard" -- I just don't think it has a whole lot of appeal.*

Non-standard benefit plans ("street plans") are marketed much more effectively because both insurers and purchasers like to individualize their benefit packages. For insurers, this is one way to express their product and corporate identity and so attempt to distinguish themselves from their competitors. Another explanation we were given in other states, but not so much in Florida, is that administering the statutory plans is difficult and expensive. When insurers create and modify their own benefit packages, they make certain system changes that help to automate rating and claims processing decisions. This automation comes at an expense, but if it is not done, rating and claims processing by hand is much more time consuming. Standardized benefits can also be structured in a way that is incompatible with the insurer's system. For instance, hospital benefits might be structured by days, dollar amounts, or diagnosis. A system designed for one structure does not adapt well to a different structure in benefits.

Nevertheless, sales of the standardized plans are significant. They accounted for almost 10,000 new sales in the fourth quarter of 1996 (Table 4) and for about 150,000 covered lives at the end of 1997. Even if statutory plans are not selling as well as anticipated, the availability of standardized plans can facilitate comparison pricing by serving as a barometer of an insurer's

overall price competitiveness. This reference pricing function is enhanced by the presence of CHPAs, as described in more detail below.

4. Non-price Competition

These laws were also intended by some proponents to alter the nature of non-price competition. Traditionally, insurers competed primarily based on their ability to select and accurately price risks, and by tailoring their benefits package to consumer preferences. These laws were expected to greatly reduce the amount of risk selection and to move the market toward more standardized benefits. We evaluated their performance in this regard also.

including the small-group segment, primarily as a result of rapidly increasing penetration of managed care. This has focused competitive pressures on price and on the structure of the insurance plan. Whether these developments are attributable to these reform laws is debated above. Most interview subjects believed they are independent of the law, although we theorize that the law may have stimulated or catalyzed these developments.

In any event, the result is that insurers are competing much more on the basis of their ability to control the underlying costs of treatment rather than on the basis of their ability to select risk. According to one of the interview subjects quoted in the 1995 Lazarus report, "The whole game has changed. It used to be underwriting, risk selection and claims investigation; now it's networks and managed care." This view was confirmed by one insurer we spoke with, who explained that the small-group reform law encouraged that carrier to pursue HMO products more aggressively, realizing that the ability to profit through risk selection is now greatly diminished and so the company is now able to compete more effectively using its expertise in managing care. An agent further explained that, except for the reinsurance decision discussed below, medical underwriting has virtually disappeared:

> **Q:** Well what about field underwriting, does that go on?
>
> **A:** *Not in the small-group market cause it's not even an issue. Carriers in Florida can ask health questions if they are . . . reinsuring carriers, for the purposes of reinsuring only. They cannot use any of the information they obtain on the health statements to underwrite the case because there is no medical underwriting. . . . Most of the carriers down here now aren't even . . . bothering to ask health questions.*

Whether or not this is a positive development depends on one's view of managed care. Indemnity insurers complain that the reform law unfairly keeps them from competing with HMOs by denying them the only ability they have to reduce prices, namely, to adjust rates to reflect health status. This, they believe, results in adverse selection against indemnity products, which makes them uncompetitive and threatens to reduce product choice. Despite these concerns and a large reduction in the number of indemnity insurers and in their market share, there is still

ample product choice in the small-group market.

What is noticeably absent in the small-group market is any form of 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 richness of the benefits, the size of the provider network, and to 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, targeted to the small-group market and found almost no reference to outcome measures of quality such as the HEDIS measures developed by National Committee on Quality Assurance. At most, there were passing generic references to the quality of providers in the network. The focus of almost all of the sales literature is on the particulars of the benefit packages, and for HMOs on the composition of the network. Much of insurers' strategic market positioning appears focused on differences in benefit packages. Most sales brochures offer a dizzying array of ways to mix and match various components of coverage such as deductibles, copayment levels, maximum payouts, and various riders for prescription drug benefits or mental health coverage.

The same is true for the most part even within the CHPAs. They were supposed to embody the pure form of managed competition that focuses competition entirely on price and outcome-based quality, with most benefit differences neutralized. But the CHPAs are only now beginning to look at the possibility of using simple patient satisfaction measures. The use of HEDIS type outcome measures is still a topic under study, but for implementation at an undefined future point. One CHPA administrator expressed his disappointment by stating that he came to the job thinking he would be a reformer and innovator, working with techniques such as outcome measures of quality, but he quickly discovered that his main job is to sell as much insurance as possible and to leave the high-minded ideals for a future time when there are a sufficient number of enrollees to justify the effort.

As a consequence, the Florida small-group market, similar to others we have studied, is far from the model envisioned by some reformers. Even though insurers do not use risk selection to the same extent as before, risk selection was acknowledged by virtually all of our interview subjects to still remain as an important, and perhaps the most important, factor determining insurers' profitability. 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, insurers have available a number of covert risk selection techniques described above which may result in their systematically attracting better risks. Some of these techniques are perfectly legitimate, such as crafting benefit packages to appeal to healthier subscribers; others are not legitimate or are of questionable legality, such as encouraging field underwriting. Third, 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 surprisingly wide spread in rates, despite a highly competitive market. We also examined loss ratios, which reflect the difference between premiums and medical claim costs. Here too, there is wide variation across the market. In 1996, the loss ratios for the small-group nonstatutory plans among the top dozen insurers ranged from 64% to 98%. We stress that these differences in rates and claim costs 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. This suggestion is confirmed by an analysis performed by the Lewin Group, which surveyed 20 small-group firms to determine the extent of risk differentials. Using the California risk adjustment methodology, these researchers determined based on 1995 information that, among the top dozen insurers they surveyed (which are not the same as the top dozen in the market), differences in risk factors were almost three times greater than what is accounted for in the modified community rating factors.

5. Purchasing Cooperatives

The Community Health Purchasing Alliances (CHPAs) are intended to promote all of the purposes of the small-group reforms, but rather than scatter the discussion of CHPAs throughout each part of this report, we consolidate our evaluation of them here because most of the purposes relate directly to promoting market competition. We look first at enrollment. In its first two years, September 1994 - September 1996, the CHPAs showed impressive enrollment growth (Table 3), but enrollment leveled off sharply in 1997 at approximately 75,000, before increasing again in 1998 to approximately 91,000 in mid-1998. This amounts to about 5% of small-group enrollment, which is only a fourth of the 20% that was first projected. It remains to be seen whether CHPA enrollment will continue to grow. Much of the 1998 increase came from a one-time gain that occurred when a private association of accountants transferred its membership to CHPA. Cutting in the other direction, we heard indications that other private associations may be gearing up to compete with CHPAs, and the agents we interviewed in 1998 reported less CHPA activity than in prior years. However, none of our agent subjects are among the 50-70 in the state who actively sell CHPA products. A final indication of CHPA success is that about half of its enrollees were previously uninsured, which is approximately the same proportion as for the small-group market outside of CHPAs. As discussed above, though, we do not think this statistic is very revealing. Nevertheless, the Florida CHPAs are among the most successful public purchasing cooperatives in the country. We examine reasons for this success, and reasons why they have not been more successful.

Initially, there was a high level of insurer participation in the CHPAs, and prices were lower than in the rest of the small-group market. A careful analysis by Lazarus and Associates in

1995 found that insurers' rates inside the CHPAs averaged about 6% less than for identical coverage outside CHPAs. Insurers are allowed to offer lower rates in CHPAs, despite community rating, since rating rules allow them to reflect the administrative cost savings that were anticipated from CHPAs. Only the medical claims portion of an insurer's rate structure may not vary inside and outside of CHPAs, unless an insurer has a large enough block inside CHPAs (approximately 2,000 subscribers) to constitute a "credible" actuarial base. At present, only Blue Cross has permission to maintain entirely different rating blocks for CHPA and non-CHPA small groups.

Following the initial years, CHPA rates have crept up. Tables 6 and 7, analyzed more below, report on the range of median premiums per covered life for the top HMO and PPO plans in CHPA 1994-1996. The median for HMOs has increased 13% over this time span, from $97 a month to $109, and the median for PPOs has increased 30%, from $113 to $147. Most interview subjects told us that insurers' prices now are essentially the same inside and outside the CHPAs, but the modest administrative fees added by the CHPAs make the final cost somewhat higher. This is confirmed by a 1996 study directed by James Studnicki at the University of South Florida. Most (61%) small employers surveyed who were quoted but rejected CHPA coverage said that CHPA prices were higher, 29% saw no price advantage, and only 9% thought CHPA prices were lower. A direct comparison of rates for identical plans with insurers both inside and outside CHPA found as follows: CHPA was more expensive only about a third of the time in 1995, but two-thirds of the time in 1996. In 1995, the average price advantage for CHPA was only 3.6%, which is only slightly more than the additional administrative charges of 2-3% that purchasers must pay through CHPA, whereas in 1996 identical CHPA plans were, on average, 10.4% higher not counting the administrative fees.

Table 6
Premium Variation for Top CHPA HMOs, 1994-1996*

Carrier	Market Share	Monthly Prem/ Enrollee	Difference From Median
3rd Quarter, 1994			
Aetna Health Plan of FL	7.6%	$84.21	$(12.81)
Av-Med	11.9%	87.95	(9.07)
Cigna Health Care of FL	55.4%	92.27	(4.74)
Health Options Inc.	14.0%	97.02	-
Humana Medical Plan	6.7%	105.59	8.57
Principal Health Care of FL	2.4%	116.24	19.22
Prudential Health Care Plan	2.0%	124.67	27.65
Total	100.0%		
Median Prem/Enrollee		**$97.02**	
Mkt Share at/below Median		**88.9%**	
Prem/Enrollee Spread		**$40.46**	
High Prem/Low Prem		**1.48**	
3rd Quarter, 1995			
Carrier	**Market Share**	**Monthly Prem/ Enrollee**	**Difference From Median**
Aetna Health Plan of FL	13.3%	$92.13	$(8.11)
Humana Medical Plan	55.4%	92.96	(7.28)
Prudential Health Care Plan	9.0%	95.37	(4.88)
Health Options	10.8%	100.25	-
Principal Health Care of FL	4.0%	114.20	13.96
Cigna Health Care of FL	4.6%	114.35	14.10
Av-Med	2.9%	120.36	20.12
Total	100.0%		
Median Prem/Enrollee		**$100.25**	
Mkt Share at/below Median		**88.5%**	

Prem/Enrollee Spread		**$28.23**	
High Prem/Low Prem		**1.31**	
3rd Quarter, 1996			
Carrier	**Market Share**	**Monthly Prem/ Enrollee**	**Difference From Median**
PCA Family Health Plan	7.3%	$80.24	$(29.18)
Health Options	14.7%	103.13	(6.29)
Aetna Health Plan of FL	16.4%	105.62	(3.80)
WellCare HMO	7.7%	109.42	-
Humana Medical Plan	40.1%	114.90	5.48
Prudential Health Care Plan	9.1%	120.21	10.79
Av-Med	4.8%	123.02	13.60
Total	100.0%		
Median Prem/Enrollee		**$109.42**	
Mkt Share at/below Median		**46.0%**	
Prem/Enrollee Spread		**$42.78**	
High Prem/Low Prem		**1.53**	
	3rdQ/94	**3rdQ/95**	**3rdQ/96**
Median Prem/Enrollee	$97.02	$100.25	$109.42
Mkt Share at/below Median	88.9%	88.5%	46.0%
Prem/Enrollee Spread	$40.46	$28.23	$42.78
High Prem/Low Prem	1.48	1.31	1.53

* Top HMOs by premium volume

Source: FL Agency for Health Care Administration Monthly CHPA Activity Reports

Table 7

Premium Variation for Top CHPA PPO/Indemnity Carriers, 1994-1996*

3rd Quarter, 1994			
Carrier	**Market Share**	**Monthly Prem/ Enrollee**	**Difference From Median**
Fortis Benefits	23.1%	$93.60	$(19.39)
John Alden	39.9%	104.99	(8.00)
Time	4.5%	105.19	(7.81)
Humana Health Ins.	10.1%	112.99	-
Principal Mutual	7.5%	132.41	19.41
Blue Cross/Blue Shield	10.4%	133.90	20.91
Aetna Life Ins.	4.5%	138.58	25.59
Total	100.0%		
Median Prem/Enrollee		**$112.99**	
Mkt Share at/below Median		**77.6%**	
Prem/Enrollee Spread		**$44.98**	
High Prem/Low Prem		**1.48**	

3rd Quarter, 1995			
Carrier	**Market Share**	**Monthly Prem/ Enrollee**	**Difference From Median**
Fortis Benefits	26.9%	$111.43	$(20.58)
Time	3.9%	116.05	(15.97)
Humana Health Ins.	26.6%	126.24	(5.78)
John Alden	21.9%	132.02	-
Aetna Life Ins.	6.0%	140.17	8.15
Blue Cross/Blue Shield	13.3%	152.56	20.55
United Wisconsin Life	1.4%	174.25	42.23
Total	100.0%		
Median Prem/Enrollee		**$132.02**	
Mkt Share at/below Median		**79.2%**	
Prem/Enrollee Spread		**$62.81**	

High Prem/Low Prem		**1.56**	
3rd Quarter, 1996			
	Market	**Monthly Prem/**	**Difference**
Carrier	**Share**	**Enrollee**	**From Median**
Aetna Life Ins.	2.9%	$94.98	$(52.03)
Av-Med Ins.	1.1%	124.17	(22.84)
John Alden	10.2%	128.23	(18.78)
Humana Health Ins.	57.5%	147.01	-
Prudential	3.2%	154.41	7.40
Blue Cross/Blue Shield	24.7%	162.96	15.94
Connecticut General	0.4%	207.73	60.72
Total	100.0%		
Median Prem/Enrollee		**$147.01**	
Mkt Share at/below Median		**71.7%**	
Prem/Enrollee Spread		**$112.75**	
High Prem/Low Prem		**2.19**	

	3rdQ/94	**3rdQ/95**	**3rdQ/96**
Median Prem/Enrollee	$112.99	$132.02	$147.01
Mkt Share at/below Median	77.6%	79.2%	71.7%
Prem/Enrollee Spread	$44.98	$62.81	$112.75
High Prem/Low Prem	1.48	1.56	2.19

* Top PPO/indemnity carriers by premium volume

Source: FL Agency for Health Care Administration Monthly CHPA Activity Reports

Keeping the rates roughly in line with the rest of the market is an accomplishment, however, since CHPA enrollment encompasses a larger proportion of micro groups than the regular market. Its average group size is 2.1 employees, which is about half the average size for the overall small-group market. About 80% of the groups purchasing in CHPAs have only 1-2 employees. Since micro groups typically have higher medical loss ratios, it is some accomplishment that CHPA rates have remained competitive, but there are concerns that adverse selection problems will start to push the rates higher than the market averages for insurers like Blue Cross that are allowed to deviate from community rates. An analysis of 1995 data by the Lewin Group found that, using the California HIPC risk adjustment formula, CHPA plans would

have to receive transfer payments amounting to 13% of the average CHPA premium in order to equalize the risk differential with the rest of the market. Indemnity insurers feel particularly hard hit by adverse selection within the CHPAs. One national insurer explained that at first it entered the CHPAs with enthusiasm, viewing them as a good chance to gain valuable early experience in a sales structure expected to soon sweep the country. But, after the first year, the carrier withdrew from the CHPAs after finding that its loss ratios were 15-20 points higher than in the rest of the market. Other indemnity carriers have done likewise. As a consequence, there are no traditional indemnity products sold through the CHPAs, only PPOs and HMOs.

The absence of more expensive indemnity offerings may restrict choice to some degree, but this also has helped to keep CHPA prices competitive. Another reason CHPA prices have remained competitive is the large number of insurers that continue to participate. Initially, insurers had a keen interest in participating because it was anticipated that the CHPAs would be used to offer enrollment to state employees and to Medicaid recipients. At the outset, about 45 insurers statewide participated in one or more of the CHPA districts. Insurer participation has dropped off since then, mainly because the anticipated expansion of CHPAs has not occurred. Nevertheless, there are still ample numbers of insurers: in 1998 there were about 31 plans statewide, ranging from 10 to 20 in each district. Also, the CHPA market is not excessively concentrated. As of January 1996, four firms constituted 54% of the CHPA market, with market share being fairly evenly distributed among them in a range of 10-19% each. CHPA market shares for the next five firms ranged from 4% to 7%, accounting for another 23% of the market, so that nine firms accounted for 77% of the CHPA business.

As a consequence of this market structure, price competition within CHPA has been keen. We performed an analysis of premiums and market share within CHPA for the years 1994-1996 to determine what portion of the CHPA market was purchasing at or below the median price. To eliminate outliers and enable comparability, we restricted the analysis to the top seven HMO and PPO firms each year, which represented approximately 90% of the HMO sales and 98% of the PPO sales in CHPA each year. Price was estimated as a simple average of total premiums divided by total covered lives. These premium averages are only approximations of relative price, since they do not account for differences in the mix of benefit packages among insurers, nor for differences in their respective age mixes. Therefore, these figures do not, strictly speaking, compare apples to apples. Nevertheless, we think they are reasonable approximations. The results are displayed in Tables 6 and 7.

There are several noteworthy points. First, the range in HMO premiums is tight, and diminishes from 1994 to 1995. The same is true for 1996 if we drop the lowest-cost HMO plan (PCA), which that year is an obvious outlier (in contrast with the first two years where there is a cluster of plans at the bottom of the premium range). Dropping the outlier for 1996 results in a premium range that diminishes from a multiple of 1.48 in 1994 to a multiple of 1.19 in 1996, among the top seven HMOs. A similar, although not identical picture, emerges for PPOs in Table 7. There too the high-to-low multiple is tight, but it increases each year. In part, this is due to the fact that the PPO market is less than a third of the HMO market in the CHPAs and so presenting the top seven firms results in more extreme outliers than for the HMOs. If the high-cost outlier is

dropped in 1995, the PPO price multiple drops to 1.37. If either the high-cost or the low-cost outlier is dropped in 1996, the PPO price multiple reduces to 1.7 that year. If both outliers are dropped, the multiple among the remaining five firms is 1.31 in 1996.

The second indication of a price-competitive market is the very high portion of the purchasers among these top firms that buy from firms at or below the median price. For HMOs, the portion of the market in the bottom half of the price range is 89% in 1994 and 1995 and 83% in 1996 if the outlier is dropped. Among PPOs, these low-price market shares are 78% in 1994, 79% in 1995 and 72% in 1996. The figures in these two paragraphs might be compared with those discussed above and reported in Table 5 for the non-CHPA small-group market. Note, however, that the analysis there is not comparable because it combines all plan types rather than isolating PPO from HMO products, and it includes mostly non-standard benefit plans that vary widely among insurers. Therefore, the premium averages are less reflective of relative prices than is the case for the CHPA figures.

Even though the CHPA market is highly price competitive, we found that few if any insurers sell through CHPA with any enthusiasm. Most sell only a few percent of their small-group business through CHPA, and many no longer offer a price discount for CHPA business. The impression we gathered from our interviews is that many, perhaps most, insurers who participate do so only because they have seen it as a politically advantageous way to stay in good favor with government officials who strongly endorsed the CHPAs, including the late Governor Chiles. Some insurers spoke of regulators who browbeat them into remaining in the CHPAs by threatening to support or to not oppose regulation hostile to managed care. One subject spoke of insurers being dragged into CHPA participation "kicking and screaming." One regulator said that initial participation may have been in response to political pressure, but claimed this is no longer the case. Another subject noted that a good test for this will be whether insurers pull out of the CHPAs following the 1999 change in the governorship.

Insurers are unenthusiastic for several reasons. First, they perceive the hostility that agents have toward CHPAs, and they are extremely sensitive about antagonizing agents in a guaranteed-issue market. Second, insurers find that certain structural features make CHPA business less attractive. Insurers that use captive or select agents do not like the fact that CHPAs require them to sell their products through any licensed agent. This dilutes the volume of business their own agents can expect, which weakens their agents' loyalty, and insurers believe that altering their relationship with agents exposes them to adverse selection. Insurers fear that agents who don't usually do business with them will steer high-risk CHPA clients to them so as not to alienate the insurers with which the agents usually do business. Two subjects spoke of the "paranoia" that insurers have about adverse selection, and this is consistent with our sense in general that insurers are extremely sensitive to the potential that agents have to steer high risks to them. Some insurers also do not like the fact that CHPA forces them to rely on others to determine whether employer groups are cheating or who their actual employees are and who is actually paying for the employer's share of the premium.

The most significant reason insurers are lukewarm to CHPA is their view that it increases

their administrative work and costs. All the insurers we spoke with felt that the administrative savings that CHPAs were supposed to generate have not been realized. CHPAs were to save on marketing and administrative costs for insurers by taking over many of these functions, including sales, enrollment, and premium collection. Insurers, however, say that their administrative systems set up to perform these functions are sunk costs that they must incur in order to sell small-group insurance outside of CHPA, and since the CHPA business is such a small portion of their overall sales, there is only a minute savings at best. Moreover, some insurers view CHPAs as *adding* to their administrative costs because, when billing or enrollment problems arise, they now have to resolve them through the third-party administration (TPA) firm that handles the CHPA business rather than directly with the employer. Also, qualifying as an "accountable health plan" requires submitting to an additional layer of regulatory approval and oversight, especially for PPO plans that are not already subject to AHCA jurisdiction. And, some insurers are very reluctant to work closely with Health Plan Services (HPS), the TPA firm that contracts for CHPA enrollment and billing administration, since this firm also sells small-group insurance and so is viewed by insurers as a competitor. These are not simply the inevitable complaints of those in a regulated industry. We heard these views confirmed by several interview subjects involved in CHPA administration and by the insurers that otherwise are the most supportive of CHPA.

Many of these problems are related to the absence of economies of scale. If CHPA enrollment were a greater proportion of small-group business, then insurers would be better able to adapt their administrative structures in order to take advantage of economizing opportunities. Also, if more business were at stake, insurers would be more eager to participate and to offer greater price discounts to obtain a larger share of that business. From one point of view, this appears to be an intractable dilemma: costs are not lower because the potential market is so small, but the market is small because cost savings have not been achieved. From another point of view, however, the problem may reside in the fact that CHPA market share is divided among so many insurers due to the requirement that it be open to any willing insurer. An alternative would be for CHPA to restrict participation to just a few, hand-picked insurers who were the most committed, and to allow insurers to sell small-group products solely through CHPA. This would require, however, that CHPA have the authority to negotiate over rates, which the current legislation expressly forbids. The absence of negotiation has not resulted in uncompetitive prices, due in part to the large number of participating insurers. But the large number of insurers has diluted the market share of each to the point that no insurer has any great incentive to capitalize on administrative savings and aggressively market CHPA products.

Most agents we interviewed also do not view CHPAs favorably. Indeed, many agents were openly hostile, even though they receive the same level of commissions from CHPA business as from sales outside of CHPAs. The extent of hostility is reflected in the 1996 survey by Studnicki of 100 health insurance agents in the Tampa area, which found that about 30% of agents "had no use for CHPA."

The greatest hostility arises from the fact that CHPA threatens the role of agents in the small-group market. The CHPA proposal arose in the midst of the national debate over the

Clinton health care plan, and some versions of these purchasing cooperatives do not allow any role for agents. Florida law requires that CHPA sell only through agents, and most insurers pay the same commissions for sales inside and outside of CHPA, but agents still bristle at the idea of a government-sponsored institution that alters the structure of their industry. Here are representative comments:

A: *I don't work with the CHPAs and I have made a conscious effort not to. I don't think that they should be funded by the state using our tax dollars. I think if the CHPAs can stand on their own with private money, then so be it, but I don't think that they should be in direct competition with us as agents and be supplemented by the government . . . . I feel like the CHPA is in competition with me.*

Q: In what sense?

A: *Well, it's another entity out there that I compete with for business and I don't think that I should have to compete with an organization that is funded by the government. Why don't they give agents money?*

CHPAs represent about a little less than 5% of the business written in Florida in the small group [market]. They failed. They failed miserably . . . .We've pumped in about $7 million over the last three years into these things. Taxpayers' dollars, my dollars, and these guys are competing with me. I've got a serious problem with that. If they had succeeded, it would be something different. But they have failed miserably. . . .The CHPAs are an experiment that I think should be terminated. Like all government programs they just seem to hang on forever and ever and ever. They serve no purpose.

I think that some [agents] don't like [CHPAs] simply because of the way [the government] came out of the chute saying that they are going to be the savior for everything and everyone. It is kind of ridiculous to have that kind of attitude, but that's just the way it came across. It didn't unfold that way, not in my eyes, so I think they are just a competitor like anybody else.

Several interview subjects explained that the anti-government opposition is strongest among general agents, who stand to lose the most from CHPA. General agents act as field representatives for insurers by recruiting, training, and motivating independent agents to sell the insurer's products. For this role, general agents receive a 2-5% "override" commission in

addition to the selling agent's commission. CHPA makes no allowance for this role. General agents are usually with larger and more successful agencies and so they wield considerable leadership in the profession. Therefore, their attitude of strong opposition is likely to influence the views of field agents. It should be noted, however, that we did not speak to any of the 50-70 agents in the state who do a substantial amount of CHPA business, and we were told of one general agent who is wildly enthusiastic about CHPA.

The anti-government attitude might be expected to abate somewhat now that administrative subsidy for CHPA has come to an end. CHPAs themselves are private, nonprofit entities staffed mostly by people from the industry, and the centralized administration is contracted to a TPA firm. Nevertheless, government sponsorship will remain in the lineage of CHPA, and in the form of ongoing oversight and operational rules from AHCA. Some of the people we spoke to in CHPA administration observed that this is an additional barrier to effective operations since requiring agency or legislative approval and insisting on uniform rules makes it slow and difficult to explore creative innovations and adapt to local market environments. Too many people want to have their "thumb print" on each decision, which makes it difficult to reach consensus and act quickly. Also, CHPAs feel handicapped in their ability to focus marketing in the urban areas that have the most potential.

Apart from government involvement, agents told us several, more specific reasons they oppose or do not embrace CHPAs. In favor of CHPAs, they acknowledged that it is easy to obtain quick quotations by calling a 1-800 number. They also see the advantage of CHPAs when an employer wants to offer a range of enrollment options to employees rather than pick a single plan. However, the agents we spoke with sold very little business through the CHPAs because they usually found the offerings outside of CHPAs to be just as attractive or more so, and selling through CHPA is somewhat less convenient. CHPA benefits are seen by some agents as less attractive because CHPAs offer primarily only the statutory benefit plans discussed above. Although the statutory plans have been expanded recently to include versions that are closer to so-called "street" plans, there still are no CHPA plans that are not also available in the regular market. Indeed, the guaranteed-issue law requires this result. Agents view selling the same plans through CHPA as entailing more work in some ways because giving employees individual choice means having to explain the options to each employee rather than to one employer. This helps to explain why CHPAs receive mostly one- and two-life groups, because for them this work differential does not exist. Employee-level choice also causes agent commissions to be divided up among more insurers, which can affect productivity bonuses. As a consequence, the agents we spoke to, who specialize in small-group health insurance, are not eager to sell through CHPA. Here are their explanations:

A: *I guess the main advantage that they offer is that they can do a quote almost instantaneously. So from an agent's perspective, it's very helpful because you can see all the carriers are competitive. If we can go directly to the carrier we do. We normally will quote CHPA and then not necessarily use them unless we need more*

than one carrier in the same group. It's extremely useful when you've got a small group where you need more than one carrier. . . . That's very, very nice if you need it. . . .

Q: And what would be a situation where you would need more than one carrier?

A: *Well maybe the owners of the company like the top-of-the-line Blue Cross plan and for the rank-and-file they want to do . . . any HMO that's available. They may pay the single rate for employees, but it lets the owners have access to top of the line if they want to pay for it.*

Q: . . . How much do you sell, roughly, through the CHPAs?

A: *Not very much. I have two cases in force with them. . . . If we had our preferences, we'd go direct. But, you know, where it fits, it fits; you want to do what's best for the client. If it fits, that's what we do.*

Q: You can call the 1-800 number and get the CHPA quote for your client within 24 hours, right?

A: *Oh, absolutely, same day, no problem.*

Q: So do you show that to your client?

A: *I used to show it to every client, but I stopped showing it about six months ago unless they want to see it . . . because for the year that I did quote it, less than one out of every 10, maybe two or three out of every 10, might be a little bit lower but not enough to warrant going to it. So, once I shopped it hard for a year and knew about where they stood in the marketplace, then I stopped burning up that paper and having them quote, and I just talk to clients about it and if they were interested, I would get a quote. . . . I do have a CHPA client.*

Q: One out of your 130?

A: *I got one. It's a one-person group.*

These attitudes are confirmed by the analysis of CHPA performed by Studnicki and associates. They found that only 13% of CHPA quotes to agents result in sales, compared with 38% of CHPA quotes given directly to small employers, or compared with the 50% closure rate reported by agents themselves for their general small-group business. Of the Tampa-area agents

surveyed for whom small-group business is the major focus and who use CHPA, 43% use CHPA strictly to gain price information but not to purchase.

These attitudes are not shared by all agents. In our market testing study, 65% of the agents at least mentioned CHPA, although only one strongly recommended it. We heard, however, that some agents sell health insurance almost exclusively through CHPA. CHPA district managers have developed relationships with these favored agents, and phone calls to the central CHPA numbers are referred to these agents. These tend to be property and casualty agents or agents who do not specialize in health insurance. Although we did not speak to any of them directly, we were told they find the CHPAs to be a convenient way to sell health insurance as part of a general insurance practice without having to go through the time and cost necessary to establish relationships with different insurers and general agents, and without having to master all of the complicated rules governing health insurance. Selling health insurance gives them a source of potential new customers for other, more profitable, lines of insurance. Thus, CHPA has allowed some agents to sell health insurance that otherwise would have avoided this line of business.

We do not mean in this report to paint a predominantly negative view of CHPA. We go on at some length about the deficits, in part because that reflects the views of most of our agent and insurer interview subjects, and in part because critical appraisal tends to invite more discussion than does favorable appraisal. There are a number of important points on the favorable side of the ledger, however. First, AHCA, HPS, and the CHPA administrators have taken a number of steps to address these perceived problems. They have aggressively recruited agents, and largely won over their reluctant participation. One interview subject described an initial informational meeting for agents in which the atmosphere was one of "extreme hostility" because agents were "rabidly" opposed to CHPAs. A year later, there was another meeting at which many more agents showed up than were invited, and they eagerly took notes about how the program worked. CHPA administrators have also worked to increase the flexibility of benefit offerings. CHPAs now sell a "Plus" version of the standard plan, with enhanced benefits, and insurers are encouraged to offer their best-selling small-group product without regard to standardized benefits. These Plus and "street" plans now account for about half of CHPA sales.

In addition, it is important to stress the positive impact that CHPA may have even if sales are not as substantial as was hoped. The comments above confirm that offering employees a choice of more than one plan is important to some small employers, and probably more important to the employees themselves, to whom we did not speak. It should be noted, however, that most groups purchasing through CHPAs have only 1-2 employees, and most offer a choice of only 2-3 plans rather than the full range available in the district.

Quite a few interview subjects mentioned that CHPA serves as a vehicle for small, start-up HMOs to enter the market or expand. CHPA provides these new market entrants a ready platform for marketing and it supplies much of the administrative capacity that otherwise would have to be absorbed through overhead and startup capital. However, it was observed that these benefits are not as great as they could be if insurers were to be allowed to sell small-group

policies *exclusively* through CHPA. The fact that they must sell outside CHPA requires them to staff all the necessary marketing and administrative functions in a fashion that is somewhat redundant of CHPA and therefore takes away from the possible administrative economies CHPA might offer.

Another, less tangible market benefit that CHPA serves, and perhaps the most significant, is that it provides rapid and comparable pricing information both to purchasers and to competitors. Several insurers told us that their actuaries consult the CHPA rate information in setting their own rates for the outside market. Several agents, some of which are quoted above, commented on the usefulness of this information, not only for their CHPA sales, but for evaluating prices outside CHPA. In the words of one agent, "Everybody knows what everybody else is charging now. It definitely makes sense [for CHPA to disseminate rate information]." This is confirmed by the agents interviewed for the Lazarus report in 1995. One said, "The CHPAs . . . [are] marketing heaven. I don't buy products there, but I always shop there. It's the best spreadsheeting service ever." Another observed:

> *That's the beauty of it from an agent's point of view. You can say to your client, "Here, I've shopped the market for you," and I'm no longer a salesman pushing one product, I'm a counselor. I say, "Here's the health insurance marketplace; let's make an informed decision together."*

Before closing, there are a few minor drawbacks worth noting that relate primarily to the individual choice model of the Florida CHPA. First, employee-level choice requires agents' commissions to be calculated on a per-employee basis, depending on which plan each one chooses. This tends to fracture the group's commission over a number of insurers, which agents and insurers dislike. This also allowed insurers to pay commissions based on a much lower rate than if the same group had purchased outside the CHPA because, before differential commissions were banned, insurers based the commission rate on the number of employees who signed up with them rather than on the size of the employer group. Second, calculating the employer's premium based on each employee undermines composite rating, in which employers are quoted a single, per-worker rate for the their workforce based on the group's overall demographics. CHPA requires that each employee be rated according to demographic characteristics, which means that employers are made more aware of the risk differentials across age and gender brackets. This might make employers less inclined to hire or keep female or older workers.

On balance, CHPA appears to be an important component of the Florida small-group market reforms. Although the sales numbers have fallen far short of initial expectations, they are higher than most other public purchasing cooperatives elsewhere in the country, and CHPA has not become a de facto high-risk pool as has happened in some other states. Perhaps most importantly, CHPA has served to catalyze price competition and the movement to managed care in the small-group market. There are some unique attributes to both the successes and limitations in Florida. CHPA is as successful as it has been in large part due to the false expectation that it would form the basis for selling to state employees. Many of the limitations are due to the fact

that CHPA was created in the midst of a very heated national debate over health care reform, in which most agents and many insurers initially were very hostile to the concept of government-sponsored purchasing cooperatives. Several interview subjects spoke of the legislation being compromised as a result in a way that undermined the potential success of CHPA, for instance, by requiring CHPAs to accept all insurers, by refusing the power to negotiate over rates, and by imposing the complications that come with maintaining 11 (now eight) different district administrations.

Looking to the future, we heard a number of suggestions about how CHPA might improve. Several subjects spoke of the need for CHPA to reduce administrative overhead. In order for this to happen, these subjects think it will be necessary for some consolidation to occur among the districts. Initially there were 11 districts, and through mergers there are now eight. Some subjects thought a single, central administration makes the most sense. Some consideration should also be given to the factors discussed above that result in most micro groups being steered toward CHPA, since this might undermine the stability of the risk pool and lead to prices higher than the market. We heard mixed views about whether CHPA should have the power to negotiate over price, with most subjects believing that this is not essential. However, several said that authority to limit the number of participating insurers is essential in order to generate the market share required to obtain real commitment from any insurer.

D. Administrability

1. General Compliance and DOI Enforcement

Finally, we address a series of concerns about the administrability of these laws. The Department of Insurance has been moderately proactive in administering these laws. In 1995, the DOI investigated and fined three insurers for failing to actively market the statutory plans in earlier years when only those plans were guaranteed issue. The DOI also issues regular bulletins informing the industry of new laws, recent interpretations, and other compliance issues. The department has a reputation for being tough but fair in the review of rate increases. In addition, it collects and tabulates quarterly statistics about market activity, which helps to monitor enrollment and premium trends. In the view of several interview subjects, the DOI staff is dedicated and knowledgeable, although somewhat underfunded and understaffed. Here are representative views:

> *When agents run into problems with carriers being out of compliance, . . . we can get the Department to jump on them. . . . I could just pick up the phone and say [to the head of the bureau] we've got a problem here. She'd get on the horn to the legal-eagles for the . . . company in question and it was pretty much resolved overnight.*

> *They [the DOI] are a bunch of wonderful people. And I mean that honestly.*

I know they work hard. I know they are understaffed sometimes, and I know they don't have the financial backing that they need. But the times that I have dealt with them, they have been polite. They have been cooperative. And I think that sometimes they get a bad rap.

One agent, however, thought that the DOI's enforcement is too aggressive, to the detriment of the market:

One of the biggest concerns with Florida is if you look at some of the other states that have small-group reform, they've not had the problems we've had because there are not so many bureaucrats dictating and dragging their feet and dictating as much. And the carriers have just gotten tired of it. They're tired of fighting with the state of Florida over every little issue to get it approved. So instead of fighting with Florida they just pull out.

Other interview subjects, like the following, considered the DOI to be lax in its enforcement of the small-group laws, or spotty in their responsiveness to complaints:

DOI does not have the best reputation in the state of Florida. They're not usually user- friendly unless you know somebody. I have friends that work for DOI so I call them and hope that they can help me solve a problem. They're not agent friendly . . . unless you've made a friendship. If you just call a lot of times, you may luck out and get somebody who's going to be very helpful. But in general, they're not user-friendly, not to the agents nor to the carriers.

I've never heard of any enforcement. I've never met an agent or group that's ever had the state come in to see if it was being handled properly. . . .There is no policing going on that I have seen yet by the state or by the carriers. . . . I've not gotten anything from the state saying, "What's going on with John Doe's account?" And we do have forms that we have to have the employer sign stating that he is a small employer, that are state certifications that are supposed to go back to the state. Nobody's ever called. I've never had any contact in that arena by carriers or by the state.

One persistent complaint we heard from many sources is the reluctance of the DOI to prevent the tactics described above that result in most micro groups being steered to the CHPAs. As noted above, in July 1998 the DOI finally prohibited lower commissions for smaller groups.

There are other respects in which the DOI has not been fully effective. The department has not initiated much enforcement or monitoring activity with respect to these laws since the initial batch of investigations. Its enforcement is almost entirely reactive, by responding to

complaints, rather than through DOI-initiated inspections or investigations. Consumers generally are not aware of the nuances of the law and therefore may not know on their own to complain if the guaranteed-issue or portability provisions are misapplied. This knowledge usually comes from the agent. The other possible source of complaints that might result in enforcement activity is from insurers themselves as they observe unfair or illegal tactics by their competitors. Although a number of insurer subjects we spoke with alluded to such behavior by their competitors, they were also not inclined to lodge complaints with the DOI.

Our impression, however, is that noncompliance is not widespread or large scale. Agents are well motivated to enforce the law's basic requirements since doing so assists their clients. If they complain to insurers about apparent noncompliance, insurers are usually responsive since they want to stay in the good favor of their agents. Similarly, most insurers are motivated to make sure they are in compliance in order to stay in the good graces of the department, which affects their business lives in so many different ways. Most of the insurers we spoke with have well-staffed regulatory compliance positions to track legal developments and carry out corporate compliance. Some interview subjects spoke of persistent noncompliance through covert or subtle risk selection techniques, but most subjects felt this occurred only at the fringes of the market, or only within gray zones where the law was subject to different interpretations. Early in the law, there were more prominent instances of overt noncompliance. Some of that was due to initial confusion or misunderstanding over the law's requirements, but some was due to insurers that brazenly refused to comply until enforcement actions were brought. The DOI's early enforcement actions appear to have had a sentinel effect that has deterred subsequent abuses.

We also found little indication that the law's implementation is being hampered or undermined by lack of knowledge. Almost all interview subjects were very knowledgeable about the law's requirements. Agents for the most part gain this knowledge directly from the insurers, who send frequent operational instructions and updates with respect to their products and procedures. The CHPAs are also active in training and informing agents. Thus, although the DOI and the agents' professional associations take only limited steps to publicize the law and determine knowledge and compliance, basic knowledge and compliance appear to us to be fairly accurate within the industry. This is true despite the fact that knowledge and enforcement of the small-group law has been made somewhat more difficult by the frequent legislative amendments.

2. Border Problems and Fraud

We also inquired into particular enforcement issues that might be especially troubling. One of those relates to field underwriting, which we discussed above. Other areas include list billing, self-insurance, and fictitious associations. 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.

List billing. This refers to an insurer who 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.[2]

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 nongroup insurance, thus bleeding good risks out of the small-group market. We found little evidence that this was happening. One insurer, however, said they hear from agents that some employers are buying individual coverage for just one or two key employees, in violation of the law. And in our market testing study, one agent (out of 17) recommended individual coverage for two employees in a group of three in order to avoid insuring an employee with diabetes.

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 private 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 little indication that either was happening. However, one subject said that business association groups are being permitted to sell small-group insurance at rates significantly less than the community rate. DOI rules allow this only to the extent that the associations create administrative cost savings, such as by not paying agent commissions, but one subject alleged that the DOI was allowing association rates as much as 15% lower than the community rate, a difference that could only be due to selecting more favorable risks. We have not confirmed this account, and other subjects said there is less use of private associations than before reform.

Another indication of possible circumvention of this nature is the fact that several Florida insurers sell small-group insurance through group trust arrangements established out of state. In other states, a group trust arrangement can be used to circumvent regulation by, for instance,

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[2] List billing is easily confused with a concept known as "composite rating", but it is fundamentally different. Composite rating refers to how rates for group insurance are calculated when true group insurance is purchased: as an average rate for each employee times the number of employees, rather than as the sum of different than list billing because it involves true group insurance, in contrast with techniques that allow the sale of individual insurance or partial group coverage within employer groups

disguising individual insurance as group insurance, or disguising small-group insurance as large group insurance. It is not clear to us why group trust arrangements are being used by some insurers in Florida. We were told that this does not result in avoiding the small-group law.

Self-insurance. Yet another border crossing concern is the threat that this law would induce medium-sized 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 rules 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. One agent, however, said that there was a recent flurry of some insurers offering stop-loss coverage with very low attachment points to small groups. The agent did not believe, however, that this was happening very much at present, in part due to the implementation of HIPAA, which in some respects erodes the advantages that ERISA preemption creates for self-funded groups.

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" them 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. One insurer that is active in many states told us that it thinks this type of fraud is widespread in Florida and is facilitated by some agents, who help set up dummy corporations at fictitious addresses in order to allow sick individuals to take advantage of guaranteed issue by pretending to be a micro group or part of a small group. This insurer claimed the problem is much worse in Florida than elsewhere and is one of the primary reasons it is reducing its marketing effort in the state.

We observed other indications, however, that agents and insurers are sensitive to this potential fraud and take steps to prevent it by requesting payroll and tax documentation. One agent told us:

> *I'll remind my employers, "Okay guys, you've got this many employees, why don't I have these on the group. What's the deal here?" . . . [I look at the payroll and tax forms and] I go back to the employer and say, "Okay, John's not on here, why isn't he on? I need a form to show me that he's taking the coverage or he's not taking the coverage." The policing, I think, is still coming from the agents.*

Another agent thought that carriers were also careful about checking this documentation:

> *Carriers are being extremely careful, are checking wage and tax reports so they don't have people added to plans that maybe are not employed or don't belong on the plan. They're really, really careful and picky about that. I guess they should be.*

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 the market average for the statutory benefit plan with the particular coverage and case characteristics in question. Florida differs from other states in allowing micro groups, including groups of one, to be reinsured at the group rate, even if this is less than the individual rate for one reinsured. 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."

Initially, most indemnity insurers except for the very largest opted to participate, but virtually no HMOs have participated, and the number of indemnity insurers that participate has dropped off dramatically. HMOs and the largest indemnity insurers opt 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 Florida small-group reforms, the larger participating insurers withdrew one by one until, at the end of 1996, participating insurers composed only 7.4% of the small-group market. Most participating insurers have microscopic market shares. At the end of 1996, the largest participating insurer had 2.2% of the small-group market, the next largest had 1.7%, the third largest .8%, and everyone else had less than .7%. Twenty-five of the 36 participating insurers had less than .1% market share.

Interview subjects explained the 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 their 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. In fact, underwriting gains and losses and total gains and losses vary considerably among participating insurers. According to an analysis by the Lewin Group, one-third of the 21 insurers with ceded lives in the pool in 1995 made money that year, based on premiums paid versus claims paid. Gains ranged from $22,018 to $2,713,173. The other two-thirds lost amounts ranging from $1,304 to $959,166. After including assessments paid, four insurers came out ahead, with gains ranging from $36,281 to $1,927,262. Reinsurance losses were as high as $1,133,169, but most were under $100,000.

Although the two largest insurers in 1995 came out ahead, the next four largest were among the top money losers, confirming that the larger participating insurers feel greater exposure. This has resulted in a dynamic in which, as larger insurers withdraw from the pool, successively smaller ones find themselves in the top positions, and so themselves withdraw in later years. As a consequence, the reinsurance pool continues to shrink. By December 1997, the next two largest participants had pulled out (although in this instance they pulled out of the entire market, not just the reinsurance pool). This left the pool with only 5% of the small-group market as participants.

Another dynamic that has occurred is that the participating insurers have become more selective in choosing which cases to reinsure. Initially, many reinsuring insurers found they were reinsuring too readily and therefore ceding risks whose eventual claims payout was less than the reinsurance premium. In 1994, reinsured cases generated only a moderately high loss ratio (claims paid versus reinsurance premium paid) of 90%. In 1995, the loss ratio climbed to 158%, and by mid-year 1996 to 196%. (Later reported data indicates that the loss ratio for year-end 1996 may have fallen to 71%, but there appears to be a discrepancy in the data that we have not resolved.) More selective ceding can be seen even more clearly in that the average claims per ceded life rose from $2,054 in 1994 to $5,143 in 1995. As a consequence, there have been significant marketwide assessments, amounting to approximately $10 million by the end of 1996, which accounts for about 40% of the pool’s total revenues (the rest coming from premiums).

As a consequence of participating insurers’ dropping out and those remaining becoming more selective in which risks to cede, the number of ceded lives diminished from a peak of 2,286 in mid-1995 to 982 in mid-1997 and less than 700 in mid-1998. At the end of 1996, only 15 insurers had ceded lives in the pool. Despite this dwindling use of reinsurance, some interview subjects observed that reinsurance 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. A 1996 survey by the Lewin Group of 13 insurers with ceded lives found, however, that most (61%) would stay in the Florida market even if reinsurance were not available, and only one of the 13 would definitely leave the market. Moreover, almost all of the participating insurers also participated in reinsurance in other states where they did business, indicating that Florida’s market is not viewed by them as any more risky than markets in other states.

The second important function the reinsurance pool serves is to encourage insurers to take micro-size groups, which as explained above are strongly disfavored due to anti-selection concerns. The Florida law treats micro groups more generously than do the reinsurance pools in many other states by allowing these groups to be ceded for the lesser of the group or individual rates. Accordingly, a substantial portion of the ceded lives in the pool consist of micro groups. At the end of 1996, 66% of the total 1,119 ceded lives came from whole-group reinsurance, and these groups had an average of 1.8 people each. Considering that one-employee groups are likely to include some family members as well, this average indicates a very strong predominance of one-person groups.

Another useful but 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, 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 do not know if this potential has been used in Florida.

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.