

# AN EVALUATION OF IOWA'S HEALTH INSURANCE REFORM LAWS

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## I. EXECUTIVE SUMMARY

This study evaluates how well Iowa'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 examines state law reforms of the individual health insurance market, and it takes a preliminary look at 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, as well as an analysis of documentary and secondary data. The principal reforms under study are the series of enactments from 1991 through 1997 that provide the following for the small-group and individual markets: (1) guaranteed issue of some or all plans, (2) renewability and portability, (3) rating band restrictions, (4) restrictions on underwriting practices such as risk selection and preexisting condition exclusions, (5) voluntary 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.

On balance, Iowa's insurance market reforms have had a positive, but muted, effect in advancing their goals. These are the most successful features:

- The law has not caused major market disruptions and has been effectively administered.
- The market remains competitive in price, product diversity, and number of insurers.
- Enrollment has not declined in the small-group market.
- Price increases have been moderate, and there is less churning.
- The portability-to-individual-insurance provision has been popular.

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

- Very few standardized guaranteed-issue plans have sold in the small-group market, and there are indications of field underwriting.
- The small-group market remains highly concentrated in a few large competitors.
- Wide rate variation is still allowed, and carriers can still compete to a considerable extent on the basis of risk selection.
- The health insurance purchasing cooperative could not sustain its operations.
- Use of the reinsurance pool has been much lower than expected.

Although these reforms have achieved less than their ambitions, it is unrealistic to expect

them to produce universal coverage and lasting cost containment. As a set of incremental reforms, they received widespread support. Every interview subject saw them as a positive step in the right direction. This agent best captured the prevailing sentiment:

*When we talk about the impact of these reforms, . . . everybody wants to find one single thing that's like turning on a light and solves all the problems. And it's not that way, and I think it's going to continue to take a wide range of little things that collectively add up to a big thing.*

## II. BACKGROUND AND METHODS

### A. Methods

The primary sources of information for this study are various components of the insurance industry. In Iowa, we conducted two rounds of interviews, in the fall of 1997 and of 1998. Included in this interview pool are five independent agents, eight people with three insurers representing over 85% of the small-group market, five people with the Division of Insurance (DOI), and two reinsurance or purchasing cooperative administrators. These were semi-structured in-depth interviews lasting approximately 1-2 hours each. They were 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 one-on-one, but a number were over the phone and in groups of 2-5 subjects.

Also, we collected extensive documentary data and information from insurers, insurance regulators, and agents, and from newspapers and other academic and public policy studies. Finally, we conducted a market testing study to determine the ability of an actual small employer and unhealthy individual to obtain insurance. An employer with three employees contacted 18 agents throughout the state in May 1998 to inquire about the availability of health insurance for the group of three, as well as for a group of two plus individual coverage for one unhealthy employee. These multiple sources of information and data were analyzed using both qualitative and quantitative techniques.

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

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

A final piece of background information is to note how Iowa compares with other states. Iowa is a small rural state that is much more racially homogeneous than national averages. A greater portion of its economy is concentrated in small firms and self-employed individuals than

elsewhere. Health statistics and health care spending are better than national averages, and Iowa entered the reform era with fewer people uninsured (12% versus 18% nationally in 1992).

## **B. The Content and Purpose of Insurance Market Reforms**

Iowa's insurance market reforms were enacted in stages from 1991 through 1997. Initial reforms were targeted to the small-group market, defined at first as employers with 2-25 workers but expanded in 1992 to groups of 50. Small-group portability provisions were adopted in 1991, rating restrictions in 1992, guaranteed issue of basic and standard plans in July 1994, and guaranteed issue of all small-group products in 1997. Individual market reforms began in April 1996, with rating restrictions and portability provisions, which were augmented slightly in 1997 to comply with HIPAA.

The core of these reforms is to make sure that any willing small-group 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 like Iowa that, prior to HIPAA, required guaranteed issue only for designated policies and states that require this for all policies. Prior to HIPAA, Iowa's small-group guaranteed-issue law applied only to two "state-mandated" plans, a bare-bones version called "basic" and a more common version called "standard." In 1997, however, Iowa conformed its law to HIPAA by requiring guaranteed issue of all small-group products.

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 latter technique is sometimes called "list billing," meaning that the insurer bills for the cost of individual coverage for a list of certain employees. To the extent this attempts to avoid reform laws by having employers pay for less-regulated individual insurance, this practice is usually prohibited. But in a unique move, Iowa law encourages list billing through what is known as the "conduit" provision in the law. This provision requires employers who do not offer group coverage to at least give their employees the opportunity to purchase individual coverage through list-billing arrangements that allow the convenience of payroll deduction.

Insurance reform laws promote continuity of coverage in three ways. First, insurers are prohibited from refusing to renew insurance except for fraud, nonpayment or similar malfeasance. Second, insurers are prohibited from riding out specific health conditions altogether, and they are allowed to place only an initial 12-month preexisting exclusion on any condition manifested within six months before the date of coverage.

Third, these reforms promote "portability" or continuity of coverage 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. Iowa was one of the first states to extend the portability concept to the individual market, in a fashion that mirrors but predates HIPAA. Beginning April 1996, Iowa required that all insurers offer a basic and standard

plan to anyone with prior group coverage within two months of application. This is not the same as a more encompassing guaranteed-issue requirement since it does not cover everyone applying for individual coverage. However, a similar effect is achieved in combination with Iowa's individual high-risk pool, called the Iowa Comprehensive Health Association. This industry-funded pool offers coverage for anyone declined or rated up for conventional individual insurance. After a year in this pool, a person may invoke the portability provisions just described to transfer to conventional individual coverage.

The next major component of the reforms is to construct a variety of rating restrictions that compress the degree of price variation among subscribers. Iowa follows the National Association of Insurance Commissioners' (NAIC) model by limiting year-to-year premium increases for any given small group to 15% above the insurer's "trend." Trend is defined as the increase in the insurers' rates for new business. The concept is to allow marketwide cost increases that are driven by technology advances, inflation in the medical sector and the like, but to limit those increases that reflect group-specific health risk.

The second component of the rating reforms prevents any insurer from varying its prices among subscribers at any point in time more than a defined range. For small-group products, rates can vary only +/- 25% from the midpoint for policies with similar benefits and "case characteristics." No rate variation for health status is allowed, however, for state-mandated basic and standard policies. Iowa adds another layer of complexity by allowing separate blocks or classes of business for different small-group policy forms. Following the original NAIC model, Iowa applies the small-group rating limits separately to each block or class of business, but to prevent circumvention of the rating limits by block gerrymandering (e.g., defining a block of business to consist of mostly sicker subscribers), the rating law also requires block midpoint rates to be within 20% of each other. Finally, rating differences are allowed to reflect the actuarial value of differences among benefits in different policies. As a consequence, considerable rating flexibility remains. Because each allowable factor can be added to each of the others, health risk adjustments can be as great as two-fold, and additional demographic adjustments can produce rates that vary several fold more at the extreme, although these distant outliers will be rare among groups.

Rating restrictions for the individual market are structured somewhat differently. No restrictions apply *within* a block, only *among* blocks. Thus, for a given policy form, there is no limit at the time the policy is issued on the extent to which rates can vary among individuals based on demographic or health risk factors, except for basic and standard individual policies which can have no health risk adjustment within the block. The rating limits apply only to block midpoint rates. For medically-underwritten coverage, block midpoints can vary only 30% for demographics, 30% for health status, and 20% for other factors. Rates for basic and standard plans can vary only half of these amounts. Also, annual rate increases for any block cannot be any more than 15% greater than for any other block.

The next major component of the insurance market reforms consists of two administered reinsurance and risk adjustment mechanisms that protect insurers from receiving a disproportionate share of very high risks. In the small-group market, there is a voluntary reinsurance pool that allows 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. Iowa follows the NAIC model, which

allows insurers to 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 standard benefit plan with the particular case characteristics in question. 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 in proportion to their small-group market shares.

In the individual market, Iowa has a mandatory risk adjustment system for the guaranteed-issue basic and standard plans. This works differently than small-group reinsurance. Individual insurers with loss ratios less than 90% for these plans are assessed in order to subsidize those whose loss ratios are higher than 90%. Also, if individual insurers in the aggregate have a loss ratio above 90% for standard and basic plans, then group insurers are assessed in proportion to their market share, to bring the aggregate loss ratio down to this level. For this purpose, self-insured public and private employers also participate in the risk adjustment system. Doing so allows them to place their high-risk employees or family members directly in these basic and standard plans rather than their having to go first to the state high-risk pool.

The final component of the insurance market reforms in Iowa is a provision authorizing the formation of private purchasing cooperatives to be supervised by the DOI. This differs from the government-run or sponsored purchasing cooperatives that exist in several other states for the small-group market. In Iowa, rather than create a government purchasing cooperative, the reform law allows private cooperatives to operate under regulatory rules.

### **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. Low-risk employers might facilitate purchase of individual insurance by their workers or might try to artificially aggregate into groups that appear larger than the 50-worker threshold in order to avoid these laws. Insurers might attempt to avoid higher risks through various legitimate or illegitimate strategies, or they might pull entirely out of these regulated market segments. Also, these rules might cause distortions or unlevel parts of the competitive playing field that tend to favor some types of insurers over others.

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

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

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

#### A. Availability

##### 1. Enrollment Gains

There is no clear evidence that Iowa's insurance market reforms have increased enrollment or decreased the overall level of uninsured, either statewide or in the individual or small employer markets. *Statewide*, the percent uninsured measured by the March Current Population Survey has fluctuated from year to year but has worsened somewhat since 1994, in contrast with the national figures which remain essentially unchanged (Table 1). Year-to-year fluctuations may be statistical artifacts of the small sample sizes in a state with a population the size of Iowa's. In the *small-group* market, private coverage appears to have declined somewhat following the 1994 reforms, as shown in Table 2 and Figure 1, but these trends are not statistically significant (at the  $p < .05$  level) except for groups under 25, for which the 1997 level is significantly lower only with respect to 1991, three years prior to the full reforms<sup>1</sup>

The picture in the small-group market is somewhat more encouraging based on numbers reported by the Iowa Division of Insurance, collected through annual reporting from insurers. These reports show that the total number of small groups covered increased 15.5% from 1994 to 1997 (Table 3). Although this data source reports only the number of employer groups, not the number of employees, we saw no indication that the average number of enrollees per group has declined in recent years. However, national studies indicate that the proportion of employees per group who elect coverage has dropped in recent years, especially as the result of increased employee cost-sharing for dependent coverage. Therefore, total enrollment among small groups may not have increased, as suggested by the CPS figures above. On the other hand, the DOI data source reflects policies sold only by indemnity carriers, not by HMOs, and so the increase in the number of small groups covered may be greater than shown in Table 3. Still, the increase in absolute enrollment is not as revealing as the *proportion* of small groups enrolling. Economic changes may have resulted in a growth in the number of small employers, so the best measure of the level of insurance remains the CPS data, which shows no increase (Table 1). Also, we have found in other states that enrollment counts reported by insurers frequently contain errors.

A further possible indicator of whether small-group reforms have increased availability of insurance is the portion of new coverage that is sold to previously-uninsured groups. DOI data indicate that a remarkable 28-58% of new small-group purchasers lacked prior coverage (Table 3). However, we do not have confidence that this statistic is accurate and meaningful. Previously uninsured is defined by the DOI as lacking small group insurance during the three months prior to enrollment. This can include groups that were chronically uninsured, new businesses, groups

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<sup>1</sup> Also, the 1996 level for the self-employed is significantly lower than in 1991 and 1993, but there is no obvious reason why this would result from the small-group reforms, and this may be an artifact of changes in the survey questions in 1994. Also, coverage for the self-employed improved sharply in 1997m although not with statistical significance.

whose previous insurance lapsed for three months, and previously-insured individuals or large groups switching to small-group coverage. Given the loose nature of this definition and questions about the accuracy of insurers' data (observe the disparities among insurers in Table 3), there is serious doubt about how much weight can be placed on this statistic.

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

State	1992	1993	1994	1995	1996	1997
<b>Iowa</b>						
Nonelderly population	2,510,161	2,433,507	2,391,695	2,536,913	2,549,851	2,467,842
With employer coverage	66.9%	66.5%	70.6%	68.9%	69.2%	70.9%
With individual coverage	13.1%	17.3%	12.0%	11.9%	12.0%	10.4%
Uninsured	11.9%	10.9%	11.3%	12.8%	13.1%	13.6%
<b>United States</b>						
Nonelderly population	223,791,925	226,228,966	228,092,631	230,275,591	232,476,381	234,691,115
With employer coverage	61.9%	60.8%	64.8%	65.0%	65.1%	65.3%
With individual coverage	8.5%	9.2%	6.3%	6.0%	6.0%	5.8%
Uninsured	17.8%	18.1%	17.3%	17.5%	17.8%	18.4%

\* < 65 and not active military

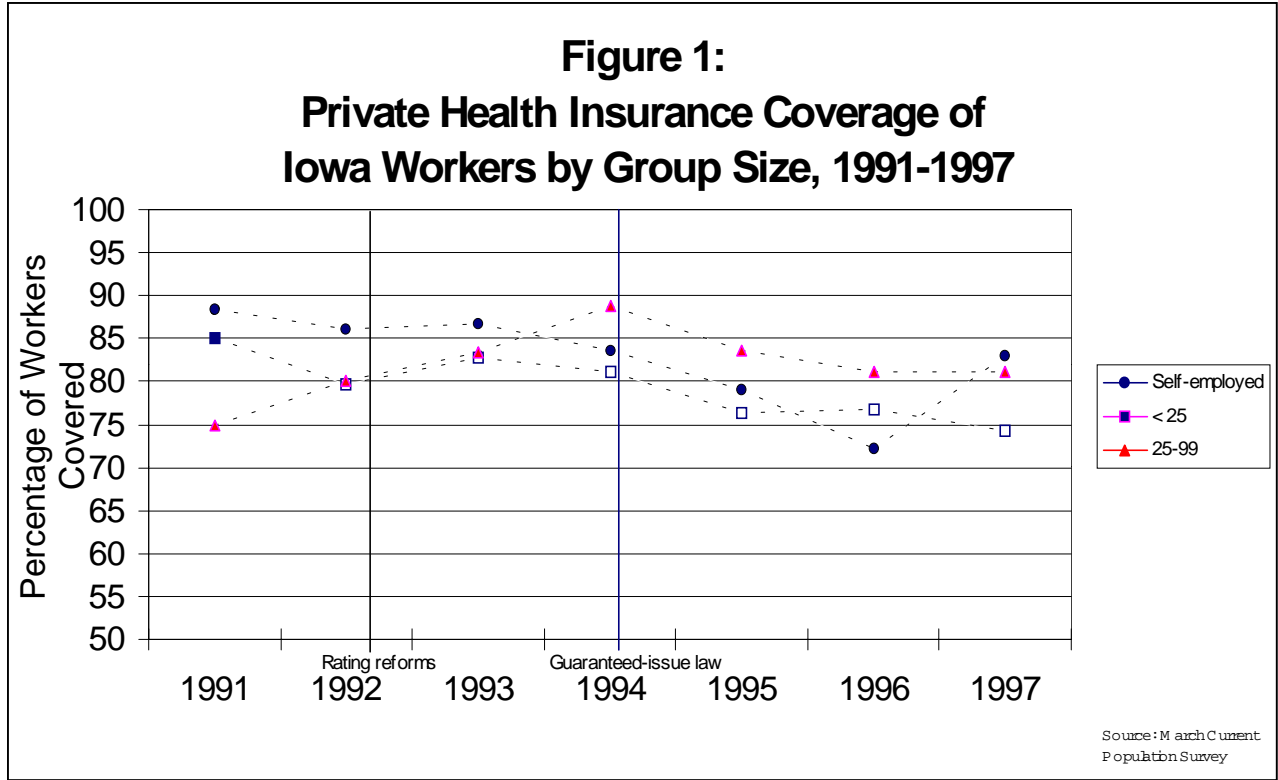
Source: Alpha Center analysis of March Current Population Survey

**Table 2**

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

Group Size	1991	1992	1993	1994	1995	1996	1997
Self-employed	88.35	86.13	86.81	83.57	79.13	72.20	83.05
< 25	85.04	79.70	82.79	81.07	76.28	76.66	74.20
25-99	74.87	80.16	83.34	88.90	83.56	81.14	81.17

Source: Analysis of March Current Population Survey by Reenie Wagner



**Table 3****Iowa Small-Group Enrollment by Indemnity Carrier, 1994-1997**

<b>Carrier</b>	<b>Groups</b>	<b>Market Share</b>	<b>New Basic &amp; Standard</b>	<b>Previously Uninsured</b>
Blue Cross/Blue Shield				
<b>1994</b>	5,844	63.0%	17	21.5%
<b>1995</b>	6,233	61.6%	9	38.1%
<b>1996</b>	6,291	52.0%	17	31.9%
<b>1997</b>	6,294	58.7%	0	45.0%
Principal Mutual				
<b>1994</b>	2,223	23.9%	36	72.6%
<b>1995</b>	2,702	26.7%	133	80.1%
<b>1996</b>	2,786	23.0%	92	37.8%
<b>1997</b>	2,810	26.2%	27	55.3%
All Others				
<b>1994</b>	1,216	13.1%	6	11.5%
<b>1995</b>	1,186	11.7%	3	51.8%
<b>1996</b>	3,017	24.9%	134	31.4%
<b>1997</b>	1,621	15.1%	4	9.2%
Total				
<b>1994</b>	9,283	100.0%	59	40.6%
<b>1995</b>	10,121	100.0%	145	57.5%
<b>1996</b>	12,094	100.0%	243	32.8%
<b>1997</b>	10,725	100.0%	31	36.8%

Source: Iowa Division of Insurance Small Employer Annual Reports

Data sources are more limited with respect to the *individual* market. The Current Population Survey shows the portion of the population with individual coverage dropped almost two percentage points in 1997, the first full year of individual reforms. However, this drop may be a statistical artifact of the small sample sizes in a state of Iowa's size. By another measure,

individual enrollment related to Iowa's reforms increased in 1997. Premium volume for basic and standard individual plans increased from \$1.8 million in 1996, the first partial year of reform, to \$9.9 million in 1997, the first full year under the reforms. However, either figure is only a tiny fraction (less than 2%) of total premium volume for individual coverage, so this provides only a limited view of the very early impact of the individual reforms.

On balance, we lack any clear indication that the level of coverage among small-firm workers or individuals has increased following insurance market reforms. Moreover, we have no way to tell whether any trends in enrollment detected from these sources are due to the law or instead result from underlying economic conditions or demographic trends. In order to gain more insight, we turn to the views of informed observers or participants in the market, and to statistics about the number of guaranteed-issue plans sold.

## 2. Agent's Views

Several agents commented favorably about the impact of small-group reforms on insurance availability. One said:

*[The law] does make the agent's life easier. I mean, there's no doubt about it because it allows us to provide a movement for those groups who have been locked in previously because of health conditions. It allows us to make sure their rates aren't going to be 100% increased based on their own claims. I mean, there are good things there to it.*

The following agent was the most glowing:

*Well, from an agent's standpoint, it's very positive. It certainly allows an agent or a broker to have discussions with an employer, and be confident that you, in fact, are going to get something for the client. As opposed to historically, if a small employer was mindful that they had one, two or three members of their group that had significant health problems, they just felt a sense of futility and hopelessness in the sense of being able to get a product. At least now, they know that it's there, and, in fact, they can get something. So it changes the mental attitude from one of hopelessness, I think, to one of, gee, there's a way we can do this. Now you always have the problem of being able to afford it. . . . I think it has made a dramatic difference in the morale of employees, which in turn has repercussions to the employer in turnover and productivity and those kinds of issues. I think it has been very successful. It's not perfect, but it's a great improvement over where it used to be. I've been around long enough to remember the times when you had to go back out and say, "I'm sorry, employees x, y, z over here can't have coverage. We can't get it for him. We can't move your group." So . . . there is a big difference. . . . I don't have that quantified in terms of a number. We have not tracked that number, and quite frankly, we haven't even attempted to. But I can say unequivocally that there is a significant number of people who are in the system that previously were not.*

Other agents described the law's impact in more muted or negative terms. One explained that the law may have expanded the scope of coverage, even if it did not increase the number of people covered:

*I would answer that probably no, [there are] not a number of people [who were previously] uninsured now having coverage, but a number of people who maybe were covered but not fully covered [who] are now covered in full. So yes, there is more insurance coverage. But, for example, a lot of people when they have a contribution, a lot of the younger workers who are not making as much money simply don't perceive the value of the insurance if*

*they have to pay a fair amount, a ratio of their paycheck that they think is too high. So they would just decline it. Even though it is available, they will decline it, and they still are [uninsured]. And so [the law] didn't necessarily stop that by any means. . . . For the most part it was that situation of extending coverage to conditions for people who were already covered, not increasing the number of people covered.*

Another agent felt strongly that the law had not brought in many previously-uninsured groups:

*The vast majority of people uninsured choose to be uninsured. . . . Now [that] there is a guarantee-issue product, . . . the marketplace for that, for all practical purposes, is not people who have been uninsured in the past. The marketplace is for people who already have a plan . . . [but] their rates have gone through the ceiling. They are looking for a way to save some money. . . . People aren't coming and saying, "Oh my gosh, now I can get insurance. Sign me up." People are uninsured, the vast majority, because they choose to be uninsured. It is a financial decision they make. They are going to try and go without insurance. . . . I have not seen any rush of employers coming to us wanting coverage because of this new law because they couldn't get it before. We just have not had any.*

One agent painted an even dimmer picture, saying that the whole-group requirement encourages employers to avoid hiring employees with health problems, since they can no longer be excluded from coverage:

*In today's world, when I talk to employers behind closed doors like we are doing, you'll sit there and tell me, "Look, if I get a woman in here and she even looks slightly pregnant, I'm not hiring her. If the guy has a limp, I'm not hiring him." I've had employers even do that in public. Employers are saying, "Hey, these people are affecting my rate. So, if I think there's a health condition, since I can't ask about it, I'm not hiring them". That is not legal, but to prove that is going to be very difficult. [For instance] . . . you and your wife are sitting at home and you are the only two that know about it, and you say, "I had a gal that came in and she's about 25 pounds overweight. I can't tell if she's pregnant or not. I'm not hiring her." Because now I have got to pay for that pregnancy whether she has got insurance or she doesn't have insurance. It's not worth it.*

### **3. Guaranteed-Issue Plans**

One good indication of whether small-group reforms have increased insurance availability is to observe the number of statutory or "state-mandated" basic and standard benefit plans issued each year. Until 1997, these were the only plans stipulated as guaranteed issue, and so they sold primarily to groups that could not qualify for coverage under traditional, medically-underwritten policies. It is a good approximation that groups purchasing this coverage do so only as the result of the reform law. As reflected in Table 3, fewer than 500 employers have purchased this coverage statewide in the four years since the reform law. On an annualized basis, this is only about 1% of the total number of small groups covered and probably an even lower percentage of total enrollment since guaranteed-issue groups are usually much smaller on average than medically-underwritten groups (owing to the averaging effect that one or two sick individuals have on the insurability of groups of different size).

Almost all the agents we spoke to confirmed that sales of these state-mandated plans are low, and they gave a variety of explanations why. The most common explanation is the perceived inferiority of the benefit plans. The basic plan is a bare-bones type coverage with a low cap on maximum benefits. Although the standard plan is more comprehensive, it has a high deductible that resembles catastrophic coverage:

**Q:** Let's talk about the standard and the basic plans, the legislative plans. What percentage of your clients are in those plans?

**A:** *Well, zero on the basic. The basic plan is so skinny, so lacking in coverage, that I've never sold a single one. And I would be interested in knowing how many have been sold in the entire state, but I bet you could count them on your hands. They've just not sold. . . . It only has a quarter-million-dollar lifetime benefit, for example. And I don't have a schematic of coverage in front of me to recite all the coverages, but it has a very significant co-insurance requirement. One-quarter-million-dollar lifetime benefit, restricted coverage, and it's just not, you know, a high quality plan. . . .*

*The standard plan, however, has a one-million-dollar benefit. It has pretty broad comprehensive coverage. . . . We have several clients in the standard plan. The standard plan in Iowa is by no means a stripped-down plan. . . . I suspect that 10% of my new business has been in the standard plan since we have had guarantee issue available. . . . It's a pretty darn good quality product, although I think it has a couple of deficiencies that some people would not be happy with. . . . It has a \$1,000 deductible, and depending on a person's personal viewpoint regarding deductible, a \$1,000 deductible is either good or bad. I personally like large deductibles and don't view that as an impediment. The problem is if you're dealing with a client that can't afford hardly a \$100 deductible, then suddenly the \$1,000 overwhelms them, and they reject it as not being a good plan. I think if we can get people to step back a second, and reflect on the fact that this insurance product is to take care of catastrophic instances, then the more routine things, perhaps, can be taken care of by the individual. Then suddenly the standard plan becomes much more attractive. If you have somebody who has a mind set of, "Gee, every time I have a hospital or a medical bill, the insurance company ought to pay it," -- if that's the psychology -- then they wouldn't like the standard plan at all.*

This agent echoed the same sentiments:

**A:** *I think it is good, high quality coverage. It is very reasonable in price.*

**Q:** But, you have only sold two or three. That seems surprising.

**A:** *The reason for that is we as a society have done a terrible job at educating people on what insurance is for. It starts with the physicians and the hospitals and with insurance companies. People think that everything should be covered. I always say, conception to resurrection. Where in reality, the basic or standard has more than adequate insurance coverage because it covers catastrophic. That is what people should be buying insurance for. If you try to take a first-dollar plan away or a low-deductible plan away, they scream bloody murder. We are trying to re-educate people, and it rolls in this MSA thing too. I am dumbfounded that people are not at the front door knocking at the door trying to buy MSAs. I am dumbfounded. It is because the public has not been educated, like I said, and the media. The public doesn't know why they buy insurance. They think nothing of having a \$500 or \$1,000 deductible on their home, but if they don't have first-dollar [doctor visits], they think that their plan stinks. We don't even have a lot of \$500 deductible plans. Most of ours are \$100-\$200-\$300.*

Because the statutory benefit plans are perceived as inferior, two agents commented that employers with conventional coverage are reluctant to switch to a statutory plan in order to obtain coverage for one or two sick members of the group. These agents explained at length that more of these plans would sell if employers could opt to enroll only their sicker employees in the statutory plans rather than being forced to enroll all or none of them. Another agent, however,

said that this disincentive does not exist since it is possible under Iowa law for an employer to offer a standard or basic policy only to high-risk employees and cover the rest under a medically-underwritten plan.

The final complaint we heard about the statutory plans is that selling them took more, rather than less, work, even though they are guaranteed issue, because prior to the 1997 law, applicants were forced to go through the medical-underwriting process to be eligible even when it was obvious they would be denied conventional coverage.

**A:** *Believe it or not, the way it's structured in most companies in Iowa, it takes a lot more work to sell the standard plan, the state-mandated standard plan, than it does to sell a non-mandated plan.*

**Q:** Really. That is surprising because that is the opposite of what I have heard in other states that had guaranteed-issue plans. . . . Generally, they say it takes less paperwork. Is that not the case?

**A:** *The fact is, it's just the opposite. The way the markets in Iowa are operating is that in order to put somebody in . . . the state-mandated plan, you first must make application through the traditional channel, have the individual rejected and then subsequently make application for the state-mandated plan.*

**Q:** Oh, so you still have to go through the underwriting portion.

**A:** *You have to go through all the hoops, yeah. . . . They do allow you to submit both applications at once and obtain a statement from the applicant that if my underwritten application is declined or ridered, then proceed with the issuance of the standard plan. That's somewhat helpful, but it's more work. You have to explain both options to the client. It's pretty laborious, quite frankly.*

**Q:** There must be cases where you know right up front that it's not going to pass, but you still have to go through all the hoops.

**A:** *Absolutely. So, you work harder for less money. But having said that, it's still a good deal.*

Now that guaranteed issue applies to all small-group plans, this issue is moot with respect to small group coverage, but it still may be relevant to basic and standard plans in the individual market. In the small-group market, however, the transition to all-products guaranteed issue has gone smoothly, causing "barely a ripple." Several insurers noted that they had become accustomed to these market rules in other states, so they were well prepared for the change in Iowa. Also, Blue Cross, by far the largest insurer, was already offering guaranteed issue for most or all of its small-group products. One indication that insurers have not resisted this move is that, unlike some other states we have studied, there are no reports of their using rating flexibility more aggressively than before to ward off adverse selection. There are other, contrary indications, however, noted in the following section.

#### **4. Field Underwriting and Agents Commissions**

Insurance market reforms that seek to improve insurance availability can be hampered by various techniques of "field underwriting." This term refers to a practice of encouraging agents to

screen out applicants they know or suspect are higher risk. In other lines of insurance, this practice 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. Property and casualty insurers, for instance, give their lead agents field manuals or software programs that contain the general underwriting parameters so agents will know whether it is worth their effort to submit applications. Insurers or general agents also give field agents informal, "pre-screening" opinions over the phone for the same purpose. As a result, for products that are not guaranteed issue, many applications from uninsurable clients never come in to the home office for a formal decision.

Although this practice may be legitimate and efficient for most lines of insurance, field underwriting for health insurance undermines the purpose of guaranteed-issue laws by making it more difficult for higher-risk applicants to find affordable coverage. This also creates an uneven playing field by encouraging agents to send higher-risk clients to one insurer rather than another. Many interview subjects acknowledged that field underwriting in various forms occurs for health insurance, although some subjects, such as this agent, said that it did not: "I think the carriers have been very honorable, and I think they're doing a good job." Other agents, however, explained in some detail how insurers encourage field underwriting:

**A:** *Insurance companies . . . can cut their field force down. "You are one of our top agents. Here are some things we are doing for you. Remember, here is your loss ratio. Here are some of the things we are going to do for you . . . if [the loss ratio] is here." Or they can suddenly say, "Don't bring us that business."*

**Q:** Does that, in fact, happen?

**A:** *Oh yes. That happens everyday. When I talk to any of the carriers, the first things they are telling me about is we want to do business with you. But, we don't want your bad business. If you have these kind of cases, just don't bring them here. Send those to Blue Cross or American Medical or whoever the other carriers may be. If you bring in enough bad business, . . . all of the sudden you just don't have a contract anymore. They can terminate a contract for cause or no cause. They don't have to have a cause to terminate your contract. They can do it for almost any reason they want to.*

**Q:** Is this a widespread practice?

**A:** *Yes. . . . I don't know how illegal it is. After July 1 [1997], they have got to take the business and offer a quote based on their underwriting standard. I don't [know if field underwriting is a] the violation of the law. I suppose if we read the intent of it and look at it, it probably is. Most carriers are still going to encourage you not to bring your bad business to the door. . . . That is why I say you see carriers cutting their contracts down from 40,000 agents down to 2,000. It is because they don't want that agent writing 10 groups a year to be doing the business with them anymore. Out of that 10 groups, if that agent brings two to the table that are really sick, there just isn't enough premium in the other eight groups to make that a profitable block of business. . . . [Carriers] want to get a better quality agent, a better relationship with the agent. Have the agent do a more thorough job of field underwriting and just not take that business to them. [From] July 1*

*forward that's getting even more apparent. Companies that had 42,000 licensed agents prior to July 1 have carved back to maybe 2,000 licensed agents. Because they want relationships with agents that they can trust that will walk by some of that business and just not write it.*

The following agent was especially candid about agents' ability to avoid undesirable business.

**Q:** You've sold no [guaranteed-issue plans] in the small-group market then.

**A:** *In the small-group market, no.*

**Q:** Okay. And why do you think that is, that you haven't sold them in the small-group market?

**A:** *If a small group is otherwise uninsurable, it probably would be something I wouldn't pursue anyway. If the insurability of the participants would be that adverse across the board, it would be something I would steer away from as an individual salesperson. . . . We're talking about a three- to five-person group, very, very small group. Yes, you can tell immediately based upon the age group, the general ages of the participants. You have an idea as well, as an insurance person, of their insurability. And if it appears that it is a small enough group that there is going to be a problem acceptance-wise, I would probably walk away from the group. . . . If I approach a small group and in the process of soliciting that group, if I determine that I don't think we can issue the plan for whatever reason, then I would not re-establish contact with that group. . . . In 20 years experience . . . I can't recall any group that's come back to me and said, "Hey, why didn't you pursue selling us insurance?"*

Agents also explained that insurers have increased their participation requirements (the percentage of eligible employees that must purchase insurance) in response to the expanded guaranteed-issue law, in order to have more flexibility to turn down groups.

The potential for field underwriting to undermine guaranteed issue is limited, however, by the independent status of most insurance agents and the fact they work on commission. Accordingly, their primary loyalty is to their clients, not the insurers, and they have every incentive to sell to both high- and low-risk groups. Indeed, to the extent commission revenue is higher for higher risks, perhaps the incentive is greater for these groups. One agent confirmed this very point:

*Most carriers are still going to encourage you not to bring your bad business to the door. . . . I don't want to seem harsh on carriers because I don't want to be. The agent field force is probably part of the problem too. As I traveled around . . . speaking to agent groups on health care reform, I would have agents . . . telling me, "I've got 45 groups that have been turned down by every company in the nation. By God, I'm gonna write those. I'm gonna make \$250,000 like that." They're pulling all of this shit out of their files that over the last five years nobody's touched. A five-man group [that has] two cancers. These agents are now frothing at the mouth because somebody's gonna have to take them. They are going to have to move that business somewhere. Those are the kind of agents that carriers didn't want to have their hands on when the law came into effect.*

To counteract this potential adverse selection, a number of insurers have lowered their commissions for guaranteed-issue products, according to one agent, by four to seven percentage points. Initially, some insurers attempted to eliminate commissions altogether, but the DOI required that some reasonable commission be maintained, which it defines for small-group sales

as at least three-quarters of the normal commission. Some insurers have used this leeway to reduce their commission rates for the very smallest groups. Also, differential commission rates is an issue of concern for the individual market:

**Q:** Now are the commissions that are paid to agents for selling these [individual] standard and basic plans much different from the regular commissions?

**A:** *Significantly lower than the traditional market. . . . As a matter of fact, there was a movement by some companies to pay zero commission on these state-mandated plans. And after some discussion and so forth, it is now mandated by Iowa law that the companies must pay a commission, but the commissions are significantly less. . . . I would have to look this up to be precise, but I believe, for example, that the commission on the [individual] standard plan, state-mandated plan, is somewhere around 3 or 4 %, and you contrast that in the small-group market to probably 10 or 12%.*

**Q:** It sounds like then the carriers are trying to discourage selling these standard plans. Would you agree that might be a reason for the lower commissions?

**A:** *I'm not sure that I want to be quite that judgmental on the carriers' part. I think it partly has to do with the fact that the carriers have a perception that this is an automatic sell for the agent, so why do you have to get compensated at the same level as other situations? Secondly, part of the concept of this health care reform and increasing availability and affordability and so forth had to do with the notion that everybody in the system is giving a little bit. The carriers are, hopefully, not making their normal . . . underwriting profit. In fact, they would argue vehemently that they've only got 10 [percentage] points in the [price of the] state-mandated plan in which to do everything: pay agents' commissions, underwrite, you know, do it all. So there's simply not enough money in the sock to pay more commission, and I think they're right about that. They can prove that in black and white. So I don't think they're attempting to discourage it per se by artificially depressing the commissions. I think there's the recognition that there's a limited amount of money available here for underwriting and commissions and marketing and so the commissions are depressed accordingly.*

In order to gauge the extent of field underwriting, we conducted a market testing study to determine the ability of an actual small employer and unhealthy individual to obtain insurance. We retained a small employer with three employees to contact 18 agents throughout the state to inquire about the purchase of insurance. The group was composed of two people in good health and one with juvenile diabetes. The employer inquired about coverage for group sizes of both three and two. Five agents (28%) indicated the unhealthy individual would face some difficulty finding coverage on her own. However, only one of the 18 agents indicated that coverage would not be available for the group of three that included an unhealthy individual. The market tester rated 83% of the agents as reasonably responsive. Several agents sent extensive and well-organized briefing materials of the sort usually provided only to larger groups.

## **5. Portability, Preexisting Conditions, and Individual Market Reforms**

An aspect of Iowa's reform law that was viewed positively by almost all subjects is the cluster of provisions relating to portability and limits on preexisting condition exclusions. On limiting preexisting condition exclusions, one agent commented:

*I think it's been helpful from the consumer perspective. It has certainly been publicized*

*and as an agent something I am fully supportive of. The preex policies of insurance companies prior to the legislation was oftentimes a much misunderstood policy, and oftentimes caused more of a bad feeling or a negative attitude toward the insurance company for denial of claims on that basis. So I think the new legislation, which at least brings some uniformity in that, I think in the long run will be very, very helpful. I think it's still too soon yet to have an impact though.*

Another felt that the 12-month exclusion period that the law allows strikes the correct balance between improved availability versus guarding against adverse selection:

*Well, I would be reluctant to tinker with it right now. Consumers would like to have no preexisting restrictions at all. And, you know, that absolutely is not practical unless you've got some type of mandated coverage for everybody so that everybody is in the pool. And so as long as individuals have the ability to game the system, I don't think that's an improvement that can be made. So, I would not tinker with the current system until we have significantly more experience than we have now. You know, we made some pretty big changes in Iowa, and we need to kind of let these babies percolate a little bit and see where we are.*

The portability provisions were also seen as a success, especially those that allow movement from the small-group to the individual market. Enrollment in the individual market basic and standard plans increased dramatically in 1997 and 1998, to about 5,000. Total premiums for these plans increased over five-fold from 1996 to 1997. As a consequence, most of the people previously in the high-risk pool have been able to purchase coverage in the regular market. Enrollment in the high-risk pool has plummeted from about 1,500 to about 350. This mechanism has also helped spouses of retirees who are not yet eligible for Medicare and workers who are in between jobs or who are quitting a job to go into business for themselves. Most subjects felt these are very positive protections, but they do not affect a large number of people. One agent, though, thought the impact was more significant:

**A:** *I think the individual reforms have been a huge benefit, huge benefit. Because people now have the basic and standard plan, which they didn't have before. That is where the reform has been very good for everybody involved on the individual [side]. Before, they got turned down. They didn't have anything [besides the high-risk pool]. Now they have an option.*

**Q:** I assume you sell more of those?

**A:** *Lots more. . . .*

**Q:** What proportion [of your individual business] would you [guess] you sell as basic or standard [guaranteed-issue plans]?

**A:** *At this point probably about 25%.*

**Q:** So, these are the people who would otherwise not be getting coverage?

**A:** *Right. I think that will increase, though. I think people are still being educated that they can have some kind of insurance. We have not reached all the public that does not know that there is something available. I really believe that.*

## 6. The Conduit Law

Iowa's insurance reforms have a unique provision known as the "conduit law," which rather than requiring employers to purchase insurance, requires only that they offer workers the option of buying individual insurance through payroll deduction. This is also known as "list billing," since insurers, rather than selling employers a group policy, send them a list each month of the amounts to deduct from workers' pay checks for insurance the workers purchase individually. Most other states prohibit list billing because they view this as circumvention of their small-group reform laws. Agents frequently dislike this prohibition. Iowa legislators saw the conduit law as a good way to expand coverage without imposing an employer mandate.

Most subjects commented that this law, while a good, innovative idea, has not had any noticeable effect in the market. Employers' only obligation is to give notice that this option exists, but employees seldom read or follow up on this information. It usually requires an agent to press the idea. However, one agent who specializes in selling insurance through list billing said that he could do this prior to the law just as well, so the conduit law has had no impact on his business. Another agent said the conduit law "is a sham as far as legislation is concerned. . . . I don't think it has impacted the desire to acquire insurance through the work site." A labor union representative has been quoted as saying this law is a "do-nothing type of thing," and one employer has called it "totally a waste of time." One informed subject said the conduit law had not been mentioned in over two years. One agent, however, thought the conduit law was working well and was prompting at least one insurer to promote more list billing arrangements:

*It's kind of an interesting thing. . . . I was part of the group that developed the idea, the employer conduit. [I was a] very big believer in it, big promoter of it, and to this day continue with that philosophy. I do think it's a thing that was bigger in talk than in action. I don't think it has produced huge numbers of new insured people. Or to say it differently, I don't think it's brought huge numbers of people into the insurance mechanism that previously were uninsured. But it definitely has brought some. It definitely has up-ticked the employer awareness of the whole issue about health insurance as a benefit to their employees. And I think it's been a definite improvement in the Iowa system. . . . It's a little thing that's very positive. . . .*

*[Employers] are not required to provide any counsel to their employees, and many merely post a sign on the bulletin board, so to speak, or give a bulletin in the paycheck, pay envelope, that sort of thing. . . . Some small groups that I work with -- and only a handful -- have had me come and put on employee meetings and set up so-called "list bill" which is a spin-off of this employer conduit. We are finding more companies in Iowa, Blue Cross/Blue Shield as the greatest case in point, willing to market individual products through an employer setting, and present to the employer a list bill of those participating employees. . . . [This] was not happening prior to these reforms, but it is happening now and much to the credit of Blue Cross/Blue Shield. They are at the forefront of making it available.*

In our market testing study, we found that five of the 18 agents (27%) contacted by a small employer suggested that the employer arrange for separate individual coverage for the one unhealthy member of the group. This is a higher proportion than in other states that prohibit list billing.

*On balance, Iowa's insurance market reforms have produced largely positive but muted results with respect to the availability criterion. These laws have not produced a huge influx of new subscribers, nor have they reduced the overall level of uninsurance*

*statewide. Instead, the percent uninsured has increased somewhat, few guaranteed-issue standard and basic plans have sold in the small-group market, and field underwriting may be hampering access or skewing risk pools. However, small-group enrollment has not dropped and may have increased, and the portability provisions and restrictions on preexisting condition exclusions are widely viewed as successful, although they have only a limited impact. In addition, high-risk groups and individuals can now obtain coverage from many more insurers than before reform.*

## **B. Affordability**

### **1. Average Prices and Adverse Selection**

In contrast with other states we have studied, we found no data sources in Iowa that allow us to track trends in small-group or individual insurance premiums or rates following the reform law. Therefore, we must rely entirely on the impressions of our interview subjects. Almost no one said that the reform law had driven up prices, as we heard in several other states we have studied. On the other hand, prices do not appear to have dropped or leveled off, as we observed in some other states. Instead, in the small-group market, we heard from most subjects that price increases in the first few years following reform were moderate, in the 6-8% range, but in 1998 prices have increased 8-15%. In both cases, these increases were approximately the same for large groups, indicating that the small-group reform law did not impose a large price burden. The somewhat lower price trends in other states may be due to the fierce competition for market share that resulted in those states from the rapid growth of managed care in their small-group markets, which has not occurred in Iowa. As noted below, this is not due to any defect in Iowa's reform laws but instead to the traditional preference in Iowa for indemnity coverage, and its more highly concentrated market both prior to and after reform.

The reform law might lead to increased prices if it caused adverse selection against the market in significant numbers, that is, if lower risks dropped out of the market and higher risks came in. One subject (quoted above) suggested that this might be the case in Iowa, to the extent that agents seek out high-risk business that was previously declined, but most subjects believed that significant adverse selection has not occurred in Iowa, even following the 1997 move to guaranteed issue for all products. Hence, any increases in price appear to be unrelated to the reform law.

Undoubtedly, employers and individuals continue to face affordability problems, but agents commented that employers who want to purchase insurance have found ways to reduce benefits or share the costs:

**Q:** Are there employers that you find that still say, "I'm interested in getting coverage but, boy, because . . . of high-risk situations, this is too expensive. I'm not going to provide coverage"?

**A:** *I don't really think so because they can pass on at least 50% of the cost to the employees. So if they are wanting to provide it as a service to the employees, most of our employers will either choose a lower level of benefits, a higher deductible, or a more restricted plan, or they will pass on more of the cost, or a combination of them. It's not something that is out of reach for most employers.*

## 2. Rating Bands and Price Variation

One reason that adverse selection has not been a problem is that Iowa's rating restrictions are looser than the community rating rules in some other states. Many subjects commented that the rating bands and allowable rating categories still permit a great deal of rate variation among groups and individuals based on health risk and demographic factors. Although the small-group bands appear to allow only a +/- 25% variation for individual health risk, this, in combination with allowable variation among blocks of business, still permits a 2:1 difference based on health status. One agent partially explained how this is so:

*Well, I tell you when you start looking at rates and you actually start looking at stuff, it's real complicated to explain how health insurance companies calculate stuff. It's just like when you figure out you've got a [+/-] 25% window, the average human would think that's gonna be a 50% swing in rates. But actually when you calculate it out, it calculates out to about 67% [from bottom to top]. When you do actuarial calculations, it just doesn't come out the same as when a human typically looks at something. . . . So even though it's guaranteed issue, . . . in Iowa, with the rating band window of opportunity that you have on new business, you can still have the same group, same demographics . . . and based on the underwriting of the company, have a 67% soaring in the rates based on how they underwrite the group.*

In addition, rates can vary by other allowable factors such as age and gender, and these factors can combine to produce even greater variations at the furthest extreme. As a consequence, one agent commented:

*I, personally, did not observe any difference [in rating practices following the reform law]. These rate bands and restrictions bands, whatever you want to call them, are in there to be sure. But I can tell you they're pretty wide. I just delivered a renewal late last week. One of the rate increases was about 31%. I don't care what the band says, [a] 31% rate increase is a pretty good lick. I'm not saying that's typical. But the point is, you know, the rate restriction band, if that's the right word to use, is sufficiently broad that it allows a pretty big rate increase to take place.*

Other subjects, however, felt the rating reforms have significantly compressed rate variation. One subject noted that rating reforms have lessened the churning or turnover that results from wide differences in prices among different blocks of business:

*See, what used to happen is . . . we had different pools. I would start up a new pool or new association. I would sell it to everybody. As this association matured, the rates went up. . . . I would come out with another new association. The rate would be half of this. Well, then that would go [up as the risk pool worsened]. Then another new association. You had a huge discrepancy in rates before, and this has really compressed it significantly. We see a lot fewer people changing insurance carriers now than [they] did five to 10 years ago . . . . Because everybody has got to play by the same rating structure too.*

Two other subjects, both actuaries, felt that further compression in rates by moving toward community rating is not advisable in a state like Iowa with an older population. Several other subjects felt strongly that tighter rate bands would make it difficult for indemnity coverage to remain affordable, which is important in a state like Iowa where indemnity is strongly favored and where it is difficult to develop managed care networks because of smaller and more dispersed population.

### 3. Benefit Adjustments and Pricing of Basic and Standard Plans

In addition to asking about the reform law's effects on average prices and the range in prices, we inquired about particular rating practices that relate to how the rating reforms are interpreted and implemented. Our main focus was on how well monitored or standardized are the actuarial judgments that lie behind various rating factors. The rating rules require insurers to provide actuarial justification and certification for their use of a variety of different rating factors and differentials. If this is not done consistently or evenhandedly among insurers, a wider or different degree of price variation might exist than even these fairly loose rules are intended to permit. For instance, the rules are designed to minimize premium variation among blocks of business due to risk selection effects, that is, due to healthier or sicker subscribers belonging to one risk pool rather than another. But, other rating factors, such as age, gender, location, and benefits, are allowed without constraint, as long as they are actuarially justified. The difficulty that arises is that an unconstrained rating factor might be used as a proxy or substitute for one that is meant to be limited. Thus, if both older and sicker patients choose one type of insurance over another, the age rating factor might be exaggerated to capture some of the health risk difference as well.

These examples are stated as theoretical possibilities, but several actuaries acknowledged the potential does exist to manipulate rating factors to some degree. The Division of Insurance requires actuarial certification, but only in the most general of terms. It does not routinely engage in detailed audits or require or inspect actual backup data to support actuarial conclusions. Nevertheless, no one complained that actuarial judgment and leeway were being abused.

In particular, we saw no indication that differences in benefit packages were being used to rate the state-mandated plans higher than is actuarially justified. This does happen in some other states we have studied, where the actuarial value of benefit differences are exaggerated in order to capture some of the health-risk characteristics of the different risk pools that purchased guaranteed-issue versus medically-underwritten coverage prior to HIPAA. In other states, there were extreme anomalies such as leaner "basic and standard" benefit packages costing more than medically-underwritten comprehensive coverage, or two guaranteed-issue plans that differ only by the size of the deductible having rate differences that exceed the deductible differential, due to the fact that higher risks prefer richer benefits. In Iowa, the reform law specifically addresses this concern, first by not allowing any rate variation based on health status for basic and standard plans, and second by requiring that "premiums for identical groups differ only by amounts attributable to plan design and not reflect differences due to the nature of the groups assumed to select particular health benefit plans."

These provisions appear to be somewhat but not entirely effective. Several agents, such as the following, commented that the standardized plans are favorably or reasonably priced, but they still cost more than traditional plans, even though their benefits are not as generous:

**Q:** Are the standard plans priced much higher than the traditional plans?

**A:** *Oh, yeah, they're higher because you've got adverse selection here and you know that is obviously going to drive the rate. I'm not sure I could quantify the difference, but I think it's easy to say that the standard plan is probably 25-30% higher than a comparable non-guarantee-issue plan or a comparable non-standard plan I should say. . . . The rates for the state-mandated plans are obviously higher than for the underwritten plans, but given*

*the loss experience and the adverse selection that's going on, I think the rates are quite reasonable. Just comparatively speaking, when I look at the standard rates and the underwritten rates, they are significantly higher, but they are not outrageous. I guess that's the way I would put it.*

Also, one actuary noted that the rating rules are sufficiently complex that some insurers from out of state with small market shares are undoubtedly not in compliance, but may not realize it.

## **C. Market Competition**

### **1. Market Structure and Price Competition**

To assess the reform law's impact on market competition, we first examine the structure of the market. Our focus is mostly on the small-group market, since that is the only market segment for which we were provided data.

The health insurance market in Iowa has been and continues to be highly concentrated. Blue Cross continues to dominate with about 60% of small groups, and we are told it has a similar presence in the individual and large-group markets. Principal Mutual, the next largest, has maintained a small-group market share of about 25%. Only two or three other insurers have as much as 2-3% of the small-group market or sell to more than 50 new small groups a year.

This highly concentrated market has remained essentially unchanged in the three years following small-group reforms. We were told by some subjects that, following the reform law, a number of insurers pulled out of Iowa, but most of these apparently had microscopic market shares or were not actively seeking new business prior to the reforms. Some pulled out as part of a national plan of consolidation and strategic focus rather than in reaction to Iowa's version of the reform law. So, the effective number of competitors remains essentially the same as before the reform law.

We did not attempt to measure the degree of competition among agents, but we heard from some that the complexities of both the state and the federal reform laws have made it more difficult for agents to sell health insurance unless they specialize in this product.

We also inquired how price competitive the small-group market has been following reform. Although several interview subjects said the market is price competitive, we did not hear that there is the same degree of cut-throat price competition that we observed in other states, where price competition appears to have intensified following reform. Instead, we heard several comments that it remains difficult to compare prices among insurers. One subject noted that the basic and standard plans, which have the potential to allow "apples-to-apples" price comparison, do not have this result because the requirement of filling out a full application and undergoing medical underwriting before obtaining a quote makes it cumbersome to obtain multiple quotes. For medically-underwritten plans, the ability to engage in meaningful price shopping is undercut by the extent to which insurers can quote highly discounted rates at the low end of the rating band that do not reflect the actual price at which they are willing to sell. One agent explained:

*I would say 85% of the agents I deal with . . . have no clue what the manual rate versus the rating bands are. Most agents don't realize that when a company quotes you their*

*quote, they're discounting their manual. In essence, in Iowa what you've got is a 25% window below manual and a 25% window above manual, manual rate being what the insurance company publishes with the state of Iowa. Typically, what a carrier will do is they'll discount to the maximum on their manual when they issue an agent a quote. An agent doesn't have a clue that they're doing that. So, when you go out to talk to a group, they're giving you a quote based on the most preferred health status that group could have, so they look the most competitive.*

## 2. Risk Selection and the Nature of Competition

One anticipated consequence of small-group market reforms was to alter the nature of competition by diminishing insurers' ability to compete based on their accuracy in evaluating health risk. From several indications, the reform law has not had this impact to any great extent. The degree of rate variation that is allowed among blocks of business and for various rating factors means that insurers can still compete through risk selection and rating prowess to a considerable extent. Also, several subjects, such as the following agent, noted that insurers attempt to engage in favorable risk selection by altering their benefit packages to avoid attracting the sickest subscribers:

*Everybody carved back their benefits greatly because nobody wanted to look the most attractive out there on the street to attract that sick business. I think that started with the beginning of small-group reform. Carriers are not necessarily as dressed up as they maybe were prior to reform laws . . . .*

Finally, the field-underwriting techniques mentioned above allow insurers to compete based on risk avoidance. As a consequence, rate differences among insurers still reflect risk segmentation to a considerable extent rather than the underlying efficiency in the form of insurance or the delivery of medical care. As one agent explained:

*I really cannot say that the carriers have done anything to increase their efficiency. True, the idea would be . . . that you wouldn't just be able to cherry-pick the good risks. But I really don't think that I could say [there is more efficiency]. . . . Some [carriers] are a little more lenient in their underwriting than others, but they are all going to bump up the costs based on the risks as they see it, and they don't want those risks. They aren't out there beating down the doors to get the standard plans, obviously.*

According to another:

**Q:** Do you see the carriers competing any differently after reform than they did before, such as more on price or less on price, less on risk selection or in any qualitatively different way?

**A:** *I really don't see a big change, no.*

Other subjects disagreed, however. One in particular spoke at length on the beneficial effect the rating reforms have had on stopping insurers from aggressively "churning" their business by segregating old from new groups into different risk pools with widely different rates:

*[The reform law] equalizes the playing field for competition. The carriers are now having to focus . . . on their administrative costs and actually finding ways to reduce claims costs. . . . Before the regulation, there were so many non-standardized plans, . . . you were not really comparing apples to apples on the same playing field. You were starting this new*

*pool every year that has no losses in it. You were constantly, whether it is an outside company or whether it is a company against itself, you were constantly offering something to somebody below the actual market rate to get them to come in to the plan. I think that has standardized a lot. . . .*

**Q:** To recap what you said, it has encouraged competition on the basis of improving efficiency as opposed to trying to figure out a way to get the low-risk people . . . ?

**A:** *Exactly. The motive has gone from trying to make an underwriting profit -- in other words trying to not cover the high risk -- to saying we are going to try to cover everybody, but we can be more efficient and deliver the care at a lower cost, we can still make money doing it that way. That is an ideal world.*

Despite these heartening comments, this agent did not attribute these beneficial changes to the reform law, but rather to the natural progression of competitive forces in the market:

*I think [this] is a consequence of long-term survival. I think . . . the vast majority of laws that have been passed really trail the trends. They are not causing the trends. They are reacting. . . . I really believe the system is reforming itself as we speak, without legislation.*

### **3. Managed Care**

One indication that competitive forces have not changed fundamentally in the small-group market is that, in sharp contrast to other states, there has been little movement toward HMOs. In other states, a rapid rise in HMO enrollment by small employers has coincided with small-group market reform laws, and there is some justification for concluding these laws have facilitated or precipitated this movement. This has not happened in Iowa. Both the individual and the small-group markets remain overwhelmingly indemnity-based. In 1996 and 1997, HMOs accounted for less than 5% of market enrollment, an amount one agent described as a "thimbleful." On the other hand, there has been some significant movement to other types of managed care, namely PPOs, which now account for the great bulk of small-group enrollment. Also, in our market testing study, 16 of 18 agents (89%) offered HMO or PPO coverage as an option to traditional indemnity, and five agents (27%) recommended this coverage. None appeared more favorable to indemnity. Thus, although HMOs still have a low market share, they are an available market option to most purchasers.

Low HMO penetration should not necessarily be seen as a consequence of the reform law. We were given several explanations for this phenomenon. First, we were told Iowans have a strong preference for indemnity-based insurance. Second, the sparse population in most parts of the state make it difficult to form exclusive or restrictive provider networks. In other states, large employers' movement to HMOs in the late 1980s and early 1990s paved the way for small-group enrollment in HMOs, since the necessary provider networks were already in place. These conditions conducive to managed care do not yet exist in Iowa.

In other states where HMO networks did exist for small employers, there was intense price competition, since HMOs were desperate for enrollment gains necessary to justify their investments in network development. The strong presence of HMOs also tended to alter the nature of competition, since they traditionally have not competed based on their medical underwriting skills. That these trends occurred at the same time as the reform laws in other states

may be largely a coincidence rather than the result of the laws' design. But the fact that they did not happen in Iowa means that changes in competition have been much less pronounced than elsewhere.

#### 4. Purchasing Cooperatives

The purchasing cooperative component of the reform law is intended to promote all of the purposes of the small-group reforms. But rather than scatter this discussion throughout each part of this report, we consolidate our evaluation here because most of the purposes relate directly to promoting market competition.

In 1994, the Independent Insurance Agents of Iowa, a trade association, created the Independent Health Alliance of Iowa (IHAI), which was also known by the generic name HIPC (pronounced "hippick") for health insurance purchasing cooperative. Its enrollment grew rapidly to over 600 groups and 4,000 lives within less than a year and to over 1,200 groups in its second year. At its peak, eight insurers participated. But the HIPC never came close to reaching the original expectation of hundreds of thousands of enrollees. It ceased operations in 1995 when John Alden, the largest insurer, pulled out and the company that contracted to do the administrative work was purchased. The new owner declined to renew the contract.

Opinions varied widely on whether the HIPC was a good idea, from "a terrific concept, a terrific idea for the consumer, a great idea for the agent" to "a nightmare for the customer." Rather than resolve this disagreement, we analyze what did and did not work well for the HIPC, and what lessons can be learned about its failure.

On the positive side, we heard that when the HIPC was operating, it achieved the two main objectives of enhanced employee choice and intensified price competition. The HIPC allowed individual employees to select from a large slate of insurers and benefit packages and to change their choices each year at open enrollment. One agent who commented on this positive feature said:

*It was an excellent tool because it did allow those employees that said, "I'm healthy. I never use my insurance. I don't want to pay out beaucoup bucks for it. I want to pay a \$1,000 deductible." And they could do that. Then I had employees within that same group that had small children. They wanted shots and office visits for ear infections and antibiotics paid. They could choose a very rich plan that had a drug card and a \$10 office visit co-pay and maybe paid-in-full in the hospital. . . . Each individual employee made their own choice.*

We also heard that the HIPC had a strong price-competitive impact. Initial prices were set through pure competitive bidding, in response to a request for proposals. Prices after the first year declined:

*The concept of the carriers having to submit their rates blind every year was excellent, because they didn't dare make them too high or they would have no market share. . . . So they were forced to try to keep those rates competitive. . . . We saw the rates come down. One year one carrier was completely out of the ballpark and the next year, they brought their rates down because they got no enrollment the year before. . . . Rates were overall a decrease the first year, I believe, and like 7% overall the second year.*

Several people commented that the competitive impact spilled over to the regular market.

Even though the two leading insurers, Blue Cross and Principal Mutual, did not participate, they had to restrain their price increases in order to remain competitive:

*I don't think there is any question that the HIPC had an indirect [impact]. I don't want to overstate this and make it bigger than it was because it was a pretty small deal really. But I think the HIPC had a very competitive effect on the market in the sense that companies . . . that did not participate in the HIPC had to be aware of the HIPC and what it was doing and what its pricing structure was. And so I think the HIPC had a modest impact in terms of mitigating price increases. And again, I don't want to overstate that.*

Others felt the competitive impact was stronger, but attributed this to price cutting out of a desire to make the HIPC fail.

Other positive features included allowing employers more flexibility in how little they had to contribute to the premium (only 20% compared with the normal 50%), and requiring participation by as few as 50% of eligible employees. The HIPC also offered group insurance to self-employed individuals, who otherwise could purchase only individual coverage, and it allowed an easier route to obtain quotes on standard and basic guaranteed-issue plans.

As for the HIPC's negative features, several agents commented at length on the complexity and greater work involved both for them and for employers when individual employee choice is allowed. According to one:

*When it initially was announced and we saw the plans and the booklet of rates and everything, my first response was, no way am I ever going to try to sell this. This is awful. Because what you had was six or seven different plans that were offered, and each employee could choose between those high-level to basic and standard plans. And then each of those plans were offered by several different carriers . . . and then each of those were age rated. And so you had like eight pages of rates that each group had to look at, and it was such a foreign concept to an employee to get to choose a plan. They were just befuddled because they had never been asked to make choices before. They weren't educated. And so it was, whenever one of my employers would choose to go with that plan, it was a dramatic education process.*

According to another:

*I found it to be very, very confusing. I did acquire some quotes and do some presentations from that co-op. But I found it to be very, very cumbersome and something that was not understood by the public, and consequently had a tendency to shy away from it. . . . Insurance plans as a whole are confusing. When you compound it through another element like a purchasing cooperative, that further complicates something which is not easily understood. . . . I found it to be a lot of detail, a lot of paperwork, a lot of busyness that didn't bring results.*

And, according to a third:

*The way it was designed is if you . . . go into a 15-life group, each four or five insurance companies had three or four [benefit] options. Let's say there are 30 options. You go into a 15-life group and each employee would have 30 options. Then, at renewal, you have to get them all enrolled. From an employer standpoint it is simply a nightmare because you have 30 different prices, . . . you could have 30 different plan designs. . . . They were somewhat standardized, maybe 80 or 90% of the plans were the same, [but] each one had a few different wrinkles in it, depending on the carrier and what they had filed in the state for the plan.*

*Very few people bought it. The people that did buy it, it was a nightmare. . . . For us, we thought it would actually drive the customer's cost up because there is a huge administrative cost going along with enrolling, implementing, communicating the benefits and then another layer on covering your fanny. Now you have got 15 plans that you have to make sure that everybody understands, as opposed to one or two plans. There is a tremendous amount more work for the employer, more work for the employee, more work for everybody involved. If it was half the cost, it might have been worth it. But the savings was not substantial. It was not justified.*

**Q:** I can understand why it is more work for you, but why for the employer?

**A:** *The employer, . . . they have got a bill they have got to track. If they are going to pay 50% of the premium, let's say, right now they are going to pay 50% of one rate. If their people in this company happen to choose four different plans, there are four different rates that they have to count that premium on. Then, they also have to have the information on hand when a new person comes on. . . . Their personnel person at their local office is going to have to know about all four plans, . . . "Well, here's the plans we offer. . . ."*

*You could sell it to a one-person group. I think they sold some of those. If you had a family [business], it was fine. A group of more than three or four people was not going to buy it because it was just a nightmare.*

*The greater work involved might have been less of a drawback to agents if commissions were generous, but most agents thought otherwise. The HIPC set commissions at 5% a year, which is substantially less than what most insurers usually pay in Iowa for new business. The HIPC justified this by observing that the first-year shortfall is made up by the expectation that there would be less work at renewal. Nevertheless, agents saw HIPC sales as hurting their commissions, and this could not help but influence their recommendations to some extent:*

**A:** *It grieves me, and I'm serious about that, it grieves me to face the reality that agents are commissioned, when in fact it needs to be the consumer [who is] paramount in the decision. But I just know in my heart that the commission differential made the HIPC less attractive to agents in the placement of business.*

**Q:** And how much was the differential?

**A:** *Half in a lot of cases, . . . sometimes as little as a third.*

Even if agents did not overtly steer business away from the HIPC, their loyalty to the leading carriers prompted them to see if these carriers would match favorable HIPC prices, that is, to use the HIPC only as a price-quoting service, not as a vehicle to actually place business. While this may have accentuated the HIPC's impact on marketwide price competition, it diverted potential enrollment.

Another drawback was that, even though a good number of insurers participated in the HIPC, neither of the two dominant insurers (Blue Cross and Principal) did. They account for over 85% of the small-group market. We heard various reasons why they may have declined, including sour grapes over being denied authority to operate a single-carrier purchasing cooperative. But for whatever reason, the HIPC opportunity attracted only insurers with very small market shares. Some agents said this made it more difficult to sell the HIPC to their clients, in part because the reputation of these smaller insurers was not as good:

*The two biggest players, Principal and Blue Cross, didn't participate. . . . The carriers that they had were not top-notch carriers. They were carriers that we wouldn't do business with to begin with, or we would only do business with after advising our customer that it was not what we would call a lead company or a quality company.*

In other states where HIPCs have government sponsorship, we observed that reluctant insurers still participated because of political pressure from regulators or because the HIPC structure was tied to other, more attractive, markets such as state employees. Leading insurers in other states might also be more willing to participate because they have less dominant market shares. In any event, whatever political appeal the Iowa HIPC initially had quickly dissipated after the November 1994 elections, when it became clear that more threatening health care reform would not be enacted. The impetus for the HIPC came largely from a desire to develop a market-based and industry-run mechanism that would preempt government reform ideas like those in the Clinton plan, and so much of the HIPC's support died along with the movement for comprehensive health care reform.

A final set of features resulted in the HIPC's attracting worse risks than the outside market, which made it difficult to remain price competitive and made it less attractive to participating insurers. First, it was easier to obtain price quotes for basic and standard guaranteed-issue policies without having to undergo full medical underwriting. As a result:

*Too many agents viewed the HIPC as a source of last resort and, I hate to use this phrase, but I know they dumped some business in there. . . . Something like 80% of the small groups we wrote in the HIPC . . . previously had been uninsured.*

Another source said about one quarter of the HIPC's groups purchased the guaranteed-issue plans, in contrast with less than 1.5% in the outside market.

Second, the HIPC adopted modified community rating rather than using the full flexibility of the rate bands, and it declined to use gender and industry rating factors that were in widespread use outside the HIPC, so its rates were disproportionately attractive to less-healthy populations. It also offered the same rates to groups of one, even though these are generally seen as being higher risk due to greater adverse selection and higher in per-person administrative costs. This reinforced the impression that the HIPC was primarily for people who could not afford insurance elsewhere, and it made the HIPC less attractive to insurers. It would have been difficult to avoid this result, however, without aggravating other problems, since the more rating factors and underwriting discretion that is allowed, the more complex the administrative operation becomes. One subject said that the individual-choice form of purchasing cooperative is feasible only with age-adjusted community rating, but this rating method is not feasible as long as risk rating is allowed in the rest of the market.

It is impossible to know whether the HIPC's failings could have been avoided or could still be corrected and the idea made to work. One informed source said that the two greatest obstacles were the lack of participation by Blue Cross and Principal Mutual, and the more liberal rating rules. Neither of these appear correctable without fairly fundamental changes in the reform law and the HIPC's structure, changes which would be legitimately opposed for other reasons. Nevertheless, two agents expressed regret that the HIPC idea did not succeed and hoped that it could be made viable.

## D. Administrability

### 1. General Compliance and DOI Enforcement

Finally, we address a series of concerns about the administrability of these laws. The Division of Insurance has a knowledgeable and dedicated staff. When complaints are filed, the DOI has a reputation for responding quickly. One insurer commented that the DOI is vested in making these reforms work, and it is "all over" a problem once it is brought to their attention. One agent said:

*I think they've done a very good job. They say that the best officiated basketball game is one in which you don't notice the official, but rather let the game flow, and I think that's kind of the way the Iowa Insurance Department has been. They have sent out timely bulletins reminding their constituents of requirements. . . . They have sent out information reminding companies of the need to do certain things in the reform market. And I think the companies' marketing forces have complied. So . . . I don't think they've had a lot to do. But whatever it is, I think they've done it.*

Many interview subjects commented on the good, non-adversarial relationship the DOI has with insurers. Both camps think highly of each other, and interpretation and enforcement issues are almost always resolved informally through conversation and compromise. This may be due to the fact that Des Moines is second only to Hartford, Connecticut, as a national headquarters for insurers, who are a major source of employment. A cordial regulatory atmosphere helps attract insurers to locate in the state. This does not equate to a fast and loose attitude about legal enforcement, however. Domestic insurers have a strong civic presence, and they want to preserve the cooperative atmosphere. So they have good reasons to play by the rules.

In other respects, though, the DOI has not been fully effective. Due to limited resources and competing priorities, it has not initiated much enforcement or monitoring activity with respect to these laws. Its enforcement is almost entirely reactive, by responding to complaints, as this agent explained:

**A:** *[The law] is policed by protest. So if someone complains, certainly they investigate it and will make sure that the appropriate things are done to correct anything that is being done wrong. But it's not actively gone out and audited.*

**Q:** Are there people getting away with things they shouldn't?

**A:** *Oh, of course there are. We see it all the time. Partly it's because they're dealing with agents who don't know the laws, and they haven't told them, "This is wrong. You can't do this." I'm sure there are some. I would like to think there aren't, but I know there are some agents who will say what they don't know won't hurt them.*

**Q:** Why do you suppose the department hasn't been a bit more proactive?

**A:** *Probably manpower and time. You're talking some serious commitments here of money, time, and manpower. You're not talking about sending out a survey. You would have to go out and audit records and ask questions and talk to people, and that's a lot of money. And if it's not broken don't fix it. You know, that's going to be the way you look at it . . . Their job is to protect the consumer as well as enforce the laws. And if they're not*

*getting protest from the consumer, they probably have enough else to do that they're not going out and auditing. They're not putting out a fire if they don't see any smoke.*

This same agent explained that consumers generally are not aware of the nuances of the law and therefore may not know on their own to complain if they are not offered open enrollment or if the portability provisions are misapplied. This knowledge usually comes from the agent, but agents are more likely to complain directly to the responsible insurer, and agents who do not specialize in health insurance may not be up to speed on the law's intricacies.

**Q:** Of course, you said the consumer as the employer often doesn't know the law either.

**A:** *They don't. And the employees don't know. They don't know their rights. So, it just trucks along because no one knows it should be different, so they're not complaining. . . .*

*Group insurance is not the marketplace it was 20 years ago. It's a lot more complex, and a lot of agents, this is not their primary focus. And so they probably aren't . . . keeping up on top of all the laws and changes in the last few years. . . .*

**Q:** I assume the carriers try to help you in that.

**A:** *They do. They put out seminars a lot. Training you on their product or how you go about the correct marketing or submission of a new case or whatever. But in the end, it is up to an agent to want to know the rules and abide by them.*

Another agent echoed the difficulties agents have keeping up with changes in the law:

*It is just so complicated. . . . I guess I feel lucky because I work in a big agency like this where we can all pick each other's brains. I don't know what Joe Blow out here in some county, I don't know how he knows all this stuff.*

Despite these shortcomings, we found no indication that the law's implementation was being hampered or undermined by lack of knowledge. 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 insurers we spoke with have well-staffed regulatory compliance positions to track legal developments and carry out corporate compliance. 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 accurate and widespread within the industry. 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 DOI, which affects their business lives in so many different ways.

## **2. Border Problems**

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 associations and self-insurance. These are 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.

*Associations.* Good risks might 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 associations, the variety of which are too complex to describe thoroughly. In the past, they have gone under the acronyms of MEWAs or METs. They also exist in the form of business and trade groups, such as chambers of commerce, that offer their members the chance to purchase a group policy.

Several subjects commented that association purchasing arrangements are much less prominent than prior to reform. This is due to the fact that the law looks behind the surface of the association and regulates insurance according to the size of the employer group that purchases it. Also, the rating rules no longer allow insurers to maintain large differences in rates for different blocks of small-group business. This limits the extent to which healthy groups can get lower rates by forming associations. These restrictions appear largely successful, although a couple of subjects commented that there have been some continuing problems with associations set up out-of-state not complying with the law.

*Self-insurance.* Another border-crossing concern is the threat that the reform law would induce medium-sized groups, those in the 25-50 range, to self-insure. This might occur if a group 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. Partial self-insurance can be marketed to smaller groups by selling stop-loss policies with very low attachment points, in the range of \$10,000 per employee, which is equivalent to a high deductible catastrophic plan, but is structured to avoid characterizing the plan as ordinary insurance. However, we observed little indication this was happening. One agent noted that there was some of this activity prior to reform, but that it has since died out. Another agent, however, thought that more small employers have been self-insuring in recent years. However, this agent did not attribute this trend to the reform law, but rather to marketing efforts by TPA firms and the desire to avoid the premium tax and mandated benefit laws that apply to regulated insurance.

### **3. Reinsurance and Risk Adjustment**

A final feature of the law that cuts across several of our categories of discussion is reinsurance and risk adjustment. These are 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. The small-group reinsurance pool has played almost no role, however. The two largest insurers, representing over 85% of the small-group market, have opted not to participate because they are large enough to absorb their own losses or purchase commercial reinsurance, and they fear that smaller insurers will use this mechanism more aggressively, thereby forcing them to pay assessments out of proportion to their use of the reinsurance pool. Among smaller insurers, although participation in the pool has remained widespread, at over 40 insurers, these insurers seldom use the pool. At its peak, in 1994, there were only 14 lives ceded to the pool, but this quickly shrunk to the present level of only a single person. Apparently, insurers concluded that they were ceding too many cases in the first year,

cases that ultimately did not produce high claims. This is seen in the fact that the pool maintained a very enviable medical loss ratio (the portion of premium paid out in medical claims) of less than 2% through 1996.

The risk adjustment system established for individual-market basic and standard plans works differently than small-group reinsurance, and has had greater impact. Insurers whose loss ratios exceed 90% for these plans receive subsidies from other insurers and large self-insured groups. In 1996, six insurers were eligible for subsidies totaling about \$95,000, which is about 5% of total premiums collected. In 1997, losses were much greater, such that five insurers were eligible for \$3.5 million in subsidy, or about 36% of total premiums.