AN EVALUATION OF HEALTH INSURANCE REFORM LAWS: THE VIEWS OF NATIONAL INSURERS

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I. EXECUTIVE SUMMARY

This study evaluates how well health insurance market reforms have met their objectives and whether they have avoided possible harms and failures. The primary focus is state small-group market reform laws, but this report also looks at state reforms to the individual market, and it provides insight into the small-group portions of the federal Health Insurance Portability and Accountability Act (HIPAA). This is part of an intensive case study of seven states that have enacted varying reforms (Colorado, Florida, Iowa, New York, North Carolina, Ohio and Vermont), funded by the Robert Wood Johnson Foundation. This multiple-case study consists primarily of two rounds of structured, in-depth, open-ended interviews with sources in the insurance industry, as well as an analysis of documentary and secondary data. The principal reforms under study are: (1) guaranteed issue, (2) renewability and portability, (3) rating restrictions, (4) restrictions on underwriting practices such as risk selection and preexisting condition exclusions, (5) reinsurance, and (6) purchasing cooperatives. These reports are 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.

Insurance market reform laws have been a mixture of modest successes and outright failures, in the view of the insurance industry subjects we interviewed. The most successful features are found in the small-group laws. Their basic features are viewed by insurers as acceptable and workable, including guaranteed issue of all products, and some degree of rating restriction. Although most insurers resist adjusted or pure community rating and prefer to retain some rate variation for individual health status, for most insurers this feature is only a secondary factor in deciding whether to remain in or enter a state. More important than the variation in rates is the state's willingness to grant reasonable and prompt requests to increase average or overall rates, which is not a feature of the small-group reform laws. A feature of these laws that has not worked well is the requirement that insurers offer one or more standard benefit packages. And, considerable controversy remains over the proper treatment of "micro-size" groups of five and fewer employees.

In the individual market, industry views of the reform laws are almost entirely negative. Here, insurers provided evidence that most of their fears have come true, at least to some extent, in several states. Adverse selection caused by guaranteed issue and rating restrictions has increased prices and decreased enrollment. Insurers unable to compete under these conditions have left markets that were already very thin.

In the small-group market, the competitive dynamic following the reform law has been more positive, but still subject to differing views. In the initial years under reform, prices remained fairly level for managed care products but increased sharply for indemnity products. Price increases have been steeper across the board in more recent years. Enrollment has increased in many states and shifted dramatically to managed care. Whether these trends are due to the law or instead to underlying economic and social conditions is subject to debate. Some

view this shift to managed care as a positive development, partly attributable to the reform laws, since competition is now more focused on managing the costs of care rather than on the ability to select risks. Indemnity insurers, however, think with some justification that health maintenance organizations (HMOs) have benefited from favorable selection and that indemnity products have suffered from adverse selection, and they observe that the reform laws hamper their ability to effectively counteract this biased selection. Others believe these trends are largely independent of the reform laws. In any event, it is clear that small-group markets remain competitive following these reforms, and that competition still focuses to a considerable extent on risk selection strategies, including field underwriting.

Purchasing cooperatives have not had a significant impact on the small-group market because both agents and insurers resist participation, for both political and business reasons. Reinsurance pools have also had a much smaller role than initially envisioned because reforms have brought in fewer high-risk groups than insurers had feared and it is more difficult than they first realized to accurately identify the worst risks. Nevertheless, both purchasing cooperatives and reinsurance may have played a role in preserving a healthy competitive dynamic.

The reform laws have not created large regulatory burdens for government, but they are seen by insurers as imposing heavy administrative burdens on them, especially since each state differs in the many details of the law, and the laws have been enacted and amended in a series rapid legislative waves. Because insurers are attentive to regulatory compliance, there are no signs of widespread or overt violation. However, a number of worrisome techniques exist for circumventing these laws, most of which are plausibly legitimate but others of which are not and are difficult to police.

Overall, despite the relative success of the small-group laws, it is clear in the minds of these interview subjects that these reforms have not solved the major issues of coverage and cost containment that plague health care public policy. These reforms by themselves are not capable of such a solution because these two goals are internally conflicting. Increased enrollment comes mostly from higher-risk groups, which necessarily increases the price of insurance and thereby discourages further enrollment gains. What the small-group laws have achieved, however, is important. So far, they have stabilized the market and halted the erosion that was occurring prior to reform, and they have done so at the same time that they have made insurance available to any group at average market rates, regardless of health.

II. BACKGROUND AND METHODS

The primary sources of information for this study are various components of the insurance industry: insurance regulators, insurers (commercial, nonprofit, and HMOs), agents/brokers, public and private purchasing cooperatives, reinsurance pool administrators, and trade associations. This report, however, is based solely on interviews with insurers. Its purpose is to reflect the views of insurers that are active in several or all of our study states and so who, in their interviews, did not focus on the particular features of any one state. Twenty-three interviews were conducted in 1997 with 40 individuals at 11 insurers, and a second round of 15 interviews was conducted in 1998 with 19 individuals at 10 of these insurers. These included two large insurers, with mostly managed care products, active in both large-group and small-group markets; four insurers, with mostly indemnity products, that specialize in small-group coverage; three insurers, with mostly indemnity products, that specialize in individual coverage; and two other indemnity insurers that specialize in both individual and small-group coverage. This sampling covers many of the most nationally prominent insurers in the small-group and individual markets. Accordingly, it is weighted towards smaller, indemnity insurers that focus on these markets. However, several of the subjects at the largest insurers worked at other large insurers in recent years and so gave us perspectives from three other companies that sell mostly in the large-group market.

These were semi-structured in-depth interviews, most lasting approximately 1-2 hours each. All interview subjects were told the purpose of the study, and promised anonymity to the extent feasible. We also collected quantitative and documentary information in the form of market activity data and sales literature. These multiple sources of information and data were analyzed using both qualitative and quantitative techniques.

In a separate document, we describe the content and purpose of insurance market reforms, and we outline their objectives and potential harms and failings. That overview 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.

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

III. THE EFFECTS OF HEALTH INSURANCE MARKET REFORMS

A. Availability

1. Market Entry and Exit

In other reports, we discuss whether small-group and individual market reforms have had any positive or negative impact on overall enrollment in each of our study states. There, we conclude that these reforms have not increased small-group enrollment substantially, and they may have caused a drop of enrollment in the individual market, although it is difficult to tell for sure since other economic and social changes accompanied these reforms. Nevertheless, we see no indication that small-group reforms have caused any serious declines in enrollment, and so those reforms appear to have stopped the erosion that was occurring in that market segment. These conclusions are broadly consistent with the views we heard in our interviews with these national insurers.

The direct impact on enrollment was not the focus of these interviews, however. Instead, we focused on whether these reforms increase or hamper availability according to whether they cause insurers to view these market segments more or less favorably, and therefore whether insurers have increased marketing efforts or instead have withdrawn from markets as the consequence of the reform laws. We heard fairly consistent accounts, which differed between the small-group and the individual markets.

Small-group market. In the small-group market, the structure of the reform law is usually not the primary factor that determines strategic decisions about market entry and exit. The reform law makes a difference at the margin, if other factors are pushing an insurer to consider withdrawing or entering, and certain versions of the reform law are sometimes the impetus for making this decision, but the reform law is seldom the primary reason to leave the small-group market. Several insurers, both large and small, commented that they take a national view of their small-group block, in which they make marketing and pricing decisions uniformly across states, or vary these decisions only according to market conditions, not in order to exploit regulatory differences. Other insurers are more selective about which states to do business in, but most of them make decisions about market entry and exit primarily based on market conditions such as the degree of managed care penetration and how strong their agent network is. Almost all the insurers we spoke to viewed the small-group laws as a whole in at least somewhat positive terms. As noted below, insurers have especially favorable views of the portability and whole-group provisions of the law.

This does not mean that the small-group laws had no negative impact. Insurers report a number of instances in which they pulled out of states in reaction to some aspect of the small-group laws. One insurer withdrew from all of its small-group markets when HIPAA was enacted.

Almost every insurer pulled out of Kentucky to avoid both its individual and small-group reforms, and almost every insurer had a list of other states whose small-group reform laws were thought to be too tough. However, there is no pattern to these decisions indicating that any particular version of small-group reforms is unacceptable to the industry at large. The one insurer that pulled out of all small-group markets suggested that it likely would have reached this decision in any event based on internal allocation of resources and that HIPAA was merely the impetus for coming to a decision. Other insurers similarly decided to withdraw from states with tougher small-group laws because they had very small market shares and so did not want to gear up to comply with a new set of regulations. However, one indemnity insurer that specializes in groups under five stressed that it pulled out of four out of its top five markets -- Florida, New Jersey, Connecticut, and Massachusetts -- due mainly to the impact of small-group reforms.

The particular features of the small-group laws that insurers find more objectionable usually do not include the guaranteed-issue requirements in isolation. For instance, HIPAA's enactment of guaranteed issue for all group products did not, by itself, cause any of these insurers to withdraw from selected states. One large insurer said that HIPAA was a "non-event" in the small-group market, and another said they had become very accustomed to all-products guaranteed issue in states that had required this prior to HIPAA. As discussed below, insurers' main focus is on the rating restrictions. Most are willing, and some are happy, to accept guaranteed issue of all small-group products as long as sufficient rating flexibility is allowed. The main exception to this generalization is for micro groups, as discussed more below.

There were a few negative notes, however, sounded about guaranteed issue generally. First, guaranteed issue has caused some insurers to become more, not less, aggressive about medical underwriting than before. This anomaly results from the fact that medical underwriting can be used not only to decline coverage but also to set the premium. In states that allow some flexibility in rates to reflect health status, insurers are putting much more effort into evaluating health status in order to make fine-grained rate adjustments, whereas before they may have issued more of their coverage at standard rates because they had the ability to decline coverage when there was any doubt about health status. One underwriter at a prominent indemnity insurer said that HIPAA has caused a "dramatic change" in how her company does medical underwriting, requiring all guidelines and processes to be revamped. The carrier now conducts group underwriting much more like individual-market underwriting, by carefully assessing particular health conditions of each member of the group.

Another negative consequence flows from the whole-group requirement. This has prompted many insurers to become more demanding in their participation requirements, for instance, declining to cover a group (when allowed by state law) unless 75-100% of eligible employees without other coverage enroll in the group plan. This is done in order to prevent employees from adding or dropping coverage as they anticipate the need--for instance, when they are expecting a pregnancy. But the effect may be to deny coverage to groups that previously would have been accepted when more individual medical underwriting was allowed.

The general acceptance of the guaranteed-issue aspects of the small-group laws is in distinct contrast to industry views only a few years ago. Prior to and early in the reform era, many insurers strongly resisted all but the mildest and most limited versions of these reforms, thinking that anything else was "to the left of Karl Marx," in the words of one industry source critical of this view. However, several of these insurers we spoke to conceded that their worst fears never materialized and that they learned they could live with even the strongest versions of small-group reforms if market opportunities were attractive enough. Most insurers we spoke to remained in New York's and New Jersey's small-group markets, for instance, despite all-products guaranteed issue and nearly-pure community rating. Insurers were able to test the waters and gain experience with different versions of small-group reforms, implemented in stages over time, and so could build their confidence under a regulatory regime that initially was viewed as foreign and hostile to their way of doing business. This is not to say that insurers are content with this outcome; very few are. But very few stated categorically that it is impossible to remain in business under even the most aggressive version of the small-group laws.

The basis for these attitudes can be seen in the operating statistics from several of these insurers, displayed in Tables 1-4. We looked at several indicators of market success to see if they correlated with variations in the strength of the reform laws in our study states. We classified states with pure (or nearly-pure) community rating and all-products guaranteed issue as "strong," states with limited guaranteed issue and wide rating bands as "weaker," and states with modified community rating or tighter bands and either version of guaranteed issue as "medium." We looked at average premiums, average claims, loss ratios, or proportion of the carrier's small-group block of business and changes to these over time to see if there are any patterns correlating with the strength of the reform laws. We found some, but not a great many. The insurers in Tables 2-4 were equally successful or unsuccessful in states with weaker and medium-strength laws. Some of the measures were worse for the insurers in Tables 2 and 4 for states with strong reform laws, but not all of the measures and not dramatically so. The insurer in Table 1 was the only one showing a consistent pattern from weak to medium to strong, for the one measure of average claims, but this insurer specializes in very small groups for which adverse selection problems are somewhat greater, as discussed more below.

Individual Market. The story is considerably different with respect to individual market reforms, however. In this market segment, we heard frequently that insurers are unwilling to remain in the market if guaranteed issue is required for all products under tight rating rules. Insurers reported leaving Kentucky, New York, and Vermont (three of our study states) as well as Massachusetts, New Jersey and Washington for this reason. This position is not uniform and absolute. Some of our interview subjects remained in each of these states, but each one withdrew from at least some of these states, and some subject companies withdrew from all of these states, primarily because of the individual reform law. One insurer withdrew entirely from all of its individual markets, in part due to the wave of reform laws.

This reaction has a greater impact on availability not only because the reaction is stronger and more widespread, but also because the individual market is generally much thinner than the small-group market to begin with. In other reports, we undertake a more detailed analysis of particular states to examine the full impact of insurers' decisions to withdraw. Here, it suffices to summarize the primary features they found objectionable or acceptable, and the strength of the objections.

Only one insurer we spoke to who is active in the individual market avoids any state that requires guaranteed issue of individual products. Other insurers are reluctant to remain in states with this requirement, but are sometimes willing to do so if they have a good market position and are able to guard sufficiently against adverse selection. Such guards include a lengthy preexisting exclusion period of 12 months or more, and the ability to raise rates quickly if claims experience is worse than projected. Insurers also like the ability to vary new-business rates according to medical-underwriting criteria and to eliminate coverage benefits that attract higher risks.

To illustrate, one individual insurer hostile to these reforms initially remained in New York, despite pure community rating and guaranteed issue of all individual products. It had a significant block of business and a good network of agents. The state regulators had a track record of giving reasonable rate increases. The law allows a preexisting condition exclusion of 12 months, and initially the state allowed very high deductibles and did not impose a uniform benefits requirement. Other insurers gave similar accounts about Vermont, New Hampshire, and New Jersey, although there was no general agreement about the acceptability of reforms in any of these states, and widespread concern about each of them. Another factor that prompted some insurers to remain in states with tough individual-market reforms is an "all markets" provision in the law, which prevents insurers from selectively leaving only the individual market and remaining in the group market. This encouraged some insurers who otherwise never sell individual coverage to do so in states such as New Jersey and Massachusetts. However, some other insurers said they will leave the group market if they are required to enter the individual market under these reform rules. Also, some insurers that initially remained in these markets subsequently withdrew based on unfavorable experience under these reforms, or based on changes in their strategic planning largely unrelated to these reforms.

Insurers' opposition to aggressive reform laws in the individual market is not crassly political or strategic. They genuinely believe that it is not possible to sustain a viable market or to remain profitable under guaranteed issue and community rating of individual products. They see the threat of adverse selection as insurmountable, and without adequate rating flexibility, they fear the consequences of an adverse selection spiral in premiums. One subject captured the sentiment shared by many others with the explanation that guaranteed issue plus community rating is an "oxymoron," totally contrary to insurance logic: "The intersection of insurance with guaranteed issue and community rating in the individual market is a null set." This is because these market rules lead to a situation where people who buy insurance are primarily those who are certain they will need it. In the industry view, this is not insurance; rather, it is a bizarre form of subsidy for the payment of predictable medical expenses. Insurers contend that the natural result is to convert the individual market to a virtual high-risk pool. If that effect is desired, they argue that it is better to create an actual high-risk pool, as many states have done, and design a sensible subsidy system that spreads the burden more broadly than only over the individual market. Several subjects noted that the individual market comprises much less than 10% of all private health insurance and therefore is much too small a base on which to build an implicit subsidy system for those who are uninsurable. The predictable result, they claim, is to virtually eliminate true, affordable insurance for those individuals who are insurable. In other reports, we evaluate the extent to which these claims are accurate. Here, we merely report them as being the genuine and widespread concerns that motivate most national insurers to avoid markets with this combination of reforms.

A few interview subjects had idiosyncratic views, however. One insurer who specializes in individual insurance is striving to live under guaranteed-issue laws because it wants to maintain a national presence. Another insurer, with mostly small- and large-group business, thinks that the individual market should be folded entirely into the group market so that the same regulatory and market structures apply to each and there is no longer a distinction in the pricing and design of the different policies. It claims this is feasible as long as there are sufficient safeguards against adverse selection, as outlined above. Alternatively, this insurer and one other were open to the "all markets" approach used in New Jersey and Massachusetts, for instance, in which the two markets are kept separate but group insurers are required to either sell or help subsidize the individual market in order to provide a larger base over which to absorb losses.

2. Basic and Standard Plans

One indication of whether small-group market reforms have increased availability is to observe the number of "basic and standard" benefit plans sold in those states where these are the only small-group plans required to be issued on a guaranteed basis (prior to HIPAA). Because these plans are typically sold to groups that cannot 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.

State-mandated standard and basic plans are widely viewed as being a failure. In the words of one insurer subject, they have been a "big flop," so much so that, surprisingly, most insurers we spoke to would prefer guaranteed issue of all of their regular plans than of a standardized plan whose benefits are mandated. This mandate requires insurers to make expensive changes in their administrative systems in order to reflect the different coverage and contractual terms. This is considerably more difficult than simply adding specified mandated benefits to existing plans since these can be done through riders and so do not require the construction of entirely separate administrative platforms. One large insurer said that the administrative changes required to comply with the standardized plans required by small-group laws cost it hundreds of thousands of dollars.

This investment has brought very little return. Every insurer reported selling only microscopic numbers of these plans, except in states like Maryland and New Jersey where only standardized plans are allowed. One large national insurer had only 32 of these plans in effect in 23 states at the end of 1996. Another insurer specializing in small-group coverage and active nationally, had only about two dozen groups enrolled in these plans in 18 states.

Insurers gave a number of reasons for poor sales of these plans. First, they are widely perceived as inferior coverage. The basic plans have very limited, "bare bones," coverage. The standard plans are more comprehensive, but usually have coverage gaps that make them less attractive, or, when this is not the case, their coverage is close enough to traditional plans to not be worth the special effort to market and administer them. Even when standard plans are comprehensive, agents and employers think that these plans are inferior because they are called the "state plan" and they think that groups who purchase them are placed in a "state pool" like Medicaid or the high-risk pools in the individual market.

The primary reason these plans are unpopular with insurers, of course, is that they are usually designed to sell mainly to high-risk subscribers who do not meet underwriting criteria for traditional coverage. Therefore, insurers have good reason to avoid selling these plans. They do so in a variety of ways. First, they use the flexibility in the rating laws to price these plans higher than their traditional coverage, a topic we explore further below. Second, insurers do not market these plans with the same glossy brochures that describe their favored products. At best, they have a plain description of the statutory benefits available on request, but more often they leave this entirely to the agent to describe. Also, many states do not require insurers to mention or offer this coverage until applicants have been turned down for coverage, but applicants who know they will not qualify may not bother to apply. Finally, insurers often pay agents lower commissions on these plans where this is allowed by state regulators. In the words of one insurer, they do so for the obvious reason that "we don't want that business."

These issues might be considered to be moot now that HIPAA requires all small-group plans to be guaranteed issue, but the laws requiring these plans still exist in most states that adopted them. Moreover, some of the techniques used to avoid selling these plans might be extended to other guaranteed-issue plans, as discussed in the next section. An argument could be made for keeping these plans, even if they are not selling well, in order to serve a price referencing function that allows easier "apples-to-apples" comparison of the relative value offered by competing insurers in their nonstandard plans. Most of our insurer subjects did not believe even this function was being served because of the leeway in the rating rules discussed below, which makes pricing for these products a poor proxy for the actuarial value of other products offered by the same insurer.

3. Field Underwriting

he discussion above reveals that insurers have at their disposal a range of techniques to minimize the number of plans they sell to high-risk subscribers. Several of these techniques are examples of what we refer to as "field underwriting." This term refers to a practice of encouraging agents to screen out applicants they know or suspect will not meet underwriting criteria. 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. There is a greater need to detect subscriber fraud and misrepresentation at the outset because courts and regulators have restricted insurers' rights to rescind policies when misinformation in the application is discovered at the time claims are submitted. 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 of insurers in the home office. Insurers 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 by phone for the same purpose. As a result, 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, it undermines the functioning of an open-enrollment or guaranteed-issue environment by discouraging agents from taking higher-risk clients. It also creates an uneven playing field by encouraging agents to send higher-risk clients to one insurer rather than another and by putting at a distinct disadvantage those insurers that choose not to use these tactics.

Every person we spoke to acknowledged that field underwriting occurs in some fashion and that many insurers encourage or monitor this practice. According to one, "It goes on all the time but no one will admit it." Most describe this in defensive terms, explaining that they do not have a corporate policy or practice of discouraging agents from sending them their reasonable share of bad risks, but they are acutely aware of the risk that some agents will "dump" only their bad cases on them. Agents are motivated to favor some insurers or disfavor others not only by personal biases or friendships, but also because of the natural desire to want to "work with a winner." Agents tend to do most of their business with a handful of insurers, sometimes as few as one or two, and they realize that the insurers' success translates into their success through lower prices, more sales, and hopefully a better profit margin from which to pay increased commissions. Insurers foster this loyalty in a number of overt and subtle ways. They pay "production bonuses" to agents with a higher volume of business. Also, their field representatives who recruit and train agents use their personal skills in a "proactive" fashion to create an "atmosphere" of cooperation in which agents are more likely to send their bad cases elsewhere. One insurer observed that "our clients are our agents," not the general public, and gave us examples of its advertisements in professional magazines directed to agents. A number of insurers advertise exclusively in this manner, rather than directly to the public.

To guard against anti-selection through field underwriting, insurers have adopted a number of defensive strategies. Many pay lower commissions on the sale of guaranteed-issue plans where this is allowed by state regulators. Some regulators have prohibited this practice, but others allow it, at least within a reasonable range since it is traditional to vary commissions by type of plan and market segment according to average profitability. In a few states, insurers are allowed to pay bonuses based on the loss ratios accrued from the subscribers sent by each agent, but most states prohibit this much more direct and explicit reward for steering good and bad business.

Even where bonuses based on loss ratios are not allowed, insurers can monitor loss ratios from each agent and investigate suspicious situations. For instance, one source said that some insurers find that 80% of their highest-risk cases come from agents who only sell one policy a year to that insurer. Where insurers believe agents are dumping bad business on them, they can challenge the agent or refuse to do business with him. Although this confrontational move could lead the agent to complain to insurance regulators, they rarely do since usually they have little business at stake anyway, and insurers have a variety of legitimate grounds they can invoke for dropping agents.

Rather than act selectively against agents who are abusing them, some insurers have taken more systematic steps to avoid this potential by being much more selective in choosing their agents at the outset. Since "dumping" usually comes only from agents who do very little business with that insurer, insurers can set higher production quotas that agents are required to meet in order to remain certified with them. Alternatively, they can increase the mandatory training requirements or erect other "barriers" that make it very inconvenient to remain certified unless the agent is committed to doing a substantial volume of business with the insurer. We heard from several sources that these practices are becoming more widespread and intensified in response to guaranteed-issue laws. One source said some insurers are refusing to do business with agents whose policies generate unacceptable loss ratios.

Despite these opportunities and techniques for insurers to use their relationship with independent agents to avoid attracting higher risks, we found that, for the most part, insurers employ these as defensive rather than offensive strategies, meaning they try to avoid agents they think are abusing them but do not try to systematically avoid higher risks. If they did, this strategy would likely backfire since agents, because of their independence, have primary allegiance to their clients and are well positioned and motivated to enforce the guaranteed-issue requirements. Moreover, we did not hear or observe that major insurers are overtly or aggressively avoiding their guaranteed-issue requirement by means such as refusing to process applications or selectively denying claims to subscribers they want to avoid. Both agent and insurer subjects explained that tactics like these would quickly give insurers a "black eye" in the minds of regulators, agents, and the public, and so these "desperation strategies" are not viable in the long run.

One legitimate strategy that insurers have available for avoiding groups with higher risks is to impose participation and contribution requirements that specify what percentage of eligible employees must opt for coverage or what percent of the premium the employer must pay. These guard against employers who purchase insurance simply because one or two workers expect to have substantial medical expenses. Typical are requirements that employers pay at least 50% of the premium and that at least 75% of eligible employees participate. Insurers have increased these requirements in response to the reform laws, which may have the effect of deterring some employers who are on the fence from purchasing insurance for their workers.

4. Micro Groups

Prior to HIPAA, states varied in the extent to which they included groups with fewer than five employees in their guaranteed-issue requirement, and states still vary in whether they include one-life groups (i.e., the self-employed). We solicited insurers' views on how these "micro" groups should be treated under the guaranteed-issue laws. Several insurers are strongly opposed to extending guaranteed issue to the self-employed, and regard this as a negative feature of a reform law that discourages them from entering or remaining in a state. Insurers view groups with fewer than 4-5 members as behaving much more like individual than group purchasers. These "mom and pop" groups have much greater price sensitivity, and are much more likely to enter and leave the insurance market based on the expected medical needs of individuals. Accordingly, there is greater adverse selection than in the group market. One insurer said that in its experience, when one-life groups are covered by guaranteed issue, the claims are 50-60% higher than the rest of the small-group block, which is consistent with the degree of adverse selection under COBRA continuation coverage. The insurer in Table 1, which specializes in micro groups, shows progressively higher average claims as the guaranteed-issue requirement strengthens across different states. Another insurer reports that, where allowed by law, it rates groups of two 12-20% higher than average, groups of three 10% higher, and groups of four 7.5% higher. Thus, insurers view each of these small sizes as being distinctly and progressively more prone to adverse selection.

Table 1: Average Claims Per Employee by Type of Small-Group Guaranteed-Issue Reform, 1996

Policy Status	No GI (10 States)	GI Std Plans Only (20 States)	GI All Plans (10 States)
All Policies	$134.82	$165.57	$175.04
Active Policies	149.99	189.23	204.49
Cancelled Policies	92.92	141.69	144.96
Difference (cancelled vs. active)	61%	34%	41%

Source: Indemnity insurer specializing in groups under 10

Accordingly, most small-group insurers strongly favor treating one-life groups as part of the individual market, or at least allowing a separate rating factor to reflect the greater adverse selection effects. Confirming this view, one individual insurer said it is glad to see states adopt guaranteed issue for one-life groups because that tends to draw off the higher risks from the individual market, leaving them with better risks. Larger group insurers are willing to include these groups as part of small-group reforms, viewing this as part of the cost of doing business which they are able to spread over their block of larger groups. However, these insurers do not seek out that business and so usually do not adjust their commission structure to pay agents for the extra work, proportionate to premium volume, necessary to sell to smaller groups. The smaller insurers, however, do tend to focus on this market segment and so are willing to pay higher commissions for smaller groups, but only if they feel they can adequately price for the degree of risk they receive. Because this aspect of the reform law is more critical to their operations, they are more likely to withdraw from a state if it extends guaranteed issue to one-life groups. Several insurers said they withdrew from states such as Florida, Colorado, and Connecticut because guaranteed issue was extended to one-life groups without any leeway to adjust rates. This leaves only the insurers who prefer not to sell to this group size. Even limiting guaranteed issue to two-life groups, as HIPAA does, might have the same impact, however, on larger insurers. One such insurer explained that in states that regard one-life groups as part of the individual market, it has to avoid selling to them in order to not be considered an individual-market carrier and thus subject to those additional regulations. In short, finding the best regulatory strategy for this market segment remains problematic.

5. Portability and Preexisting Condition Limits

The most popular aspect of the reform laws is the cluster of provisions that allow subscribers to keep insurance once they purchase. Even the insurers who are most strongly opposed to these laws in general think that the portability provisions and limits on preexisting condition exclusion periods are useful. Generally speaking, insurers seem willing to live with preexisting condition limits as short as six months in the group market and 12 months in the individual market, although some insurers prefer limits twice these lengths. All insurers, however, oppose limits as short as three months, because then the potential for adverse selection gets too "scary."

The other concern raised is the administrative difficulty created by portability provisions that require insurers to assess whether applicants' prior coverage is "equivalent," for purposes of determining whether they are eligible for a waiver of the preexisting condition exclusion. These and other aspects of the portability laws caused one insurer, prior to HIPAA, to allocate 20% more administrative effort in states with these provisions. Now that HIPAA has standardized this aspect of the small-group law, these administrative burdens may lessen once initial HIPAA compliance is complete, but we do not know this since our interviews were conducted prior to HIPAA.

B. Affordability

1. Trends in Average Prices

Small-group Market. Most of the insurers we interviewed said that rates have increased substantially following small-group reforms, as can been seen in Tables 2-3, but there is little indication that increases were any greater in states with tighter restrictions than in others. Most subjects said that price increases were very restrained for HMOs and managed care plans during the initial years of reform, but were more substantial for indemnity-based products, and prices have increased substantially for both types of plans in the past two years. This can be seen by comparing the two indemnity insurers in Tables 2 and 3 with the insurer in Table 4 that has more managed care plans. This indicates that factors affecting prices have been more systemic than the reform laws. Actuaries we spoke to confirmed this view. Most said their small-group pricing decisions are made on a national basis in response to varying market conditions and are not affected by variations in the small-group reform laws. There was also general agreement that the small-group market has been highly price competitive following reform.

Affordability would be compromised, however, if small-group laws caused serious adverse selection that drew in higher risks and drove off better risks. By most indications, this has not occurred in the small-group market. When asked specifically whether they added any amounts to their rates to anticipate adverse selection in states that adopted reform laws, some actuaries did initially, but they learned from experience that the 5-10% they added was unnecessary, so in recent years these actuaries have not included any anticipated adverse selection in their pricing decisions, choosing instead to reflect any increased claims in future rates if increased claims in fact materialize. Several subjects said that only 5-10% of applicants under guaranteed issue would have previously been declined, and many of these do not end up purchasing because they still find the rates too high. One subject said that insurers at first thought market reforms would "end life as we know it" and cause the market to "crash and burn," but they soon found that their worst fears were wrong and that anticipated adverse selection did not occur. This can be seen in the average claims figures in Tables 3-4, which show no relationship to the strength of the reform laws.

Some insurers felt the reform laws caused an initial bump in average prices. One insurer documented that, in its three largest states, guaranteed-issue policies generated 2.6 times more claims than the policies that passed or would have passed medical-underwriting screens, and that the number of guaranteed-issue policies sold in the first two years under reform caused a 10% increase in overall claims costs for this block of business. The same insurer shows consistently higher average claims in states with stronger guaranteed-issue laws (Table 1). However, this is an insurer that specializes in very small groups for whom adverse selection problems are more significant, as explained above. Also, neither this insurer nor any other subject thought that even the most aggressive reforms have caused any continuing adverse selection spiral in the small-group market. The absence of serious adverse selection is also indicated by the very low use of the reinsurance pools in the small-group market, as discussed below.

Table 2: Increase in Average Premium Per Employee by Strength of Small-Group Reform Law, 1992-1996

Reform Strength	Average Premium/Employee 1992	1996	Average Premium Increase
Strong			
Kentucky	$2,789	$4,310	55%
New York	3,080	7,818	154%
Vermont	2,103	4,770	127%
Medium			
California	3,150	5,314	69%
Colorado	2,860	3,898	36%
Connecticut	3,477	6,820	96%
Iowa	1,477	2,886	95%
Florida	3,348	4,336	30%
Minnesota	3,004	4,090	36%
Weaker			
New Mexico	1,671	3,434	106%
North Carolina	2,502	3,356	34%
Ohio	3,017	4,301	43%

Source: Small-group indemnity insurer

Table 3: Operating Statistics by Strength of Small-Group Reforms, 1994-1996

Reform Strength	Change in Share of 10-State Block**	Avg Prem/EE Change	Avg Claims/EE Change	Loss Ratio Change (in points)
Strong				
Kentucky*	-100%	+4%	+20%	+28.2
Vermont	+50%	+24%	-10%	-
Medium				
Colorado	+9%	+10%	+21%	+7.7
Connecticut	-60%	+60%	+80%	+8.9
Florida	-29%	+32%	+71%	+20.1
Iowa	-33%	+27%	+48%	+11.5
Minnesota	+188%	+5%	+22%	+10.9
Weaker				
New Mexico	0%	+22%	+41%	+6.7
North Carolina	-17%	+34%	+40%	+3.5
Ohio	+39%	+15%	+41%	+13.5

* Note: Most recent premium and claims data for KY are for 1995 as carrier left the state in 1996.

** This column shows the change in each state's portion of this insurer's block of small-group business across all 10 of these states.

Source: Indemnity insurer specializing in groups under 10

Table 4: Operating Statistics by Strength of Small-Group Reforms, 1994-1996

Reform Strength	Change in Share of 12-State Block**	Avg Prem/EE Change	Avg Claims/EE Change	Loss Ratio Change (in points)
Strong				
Kentucky	-71%	+11%	+38%	+23.3
New York	-50%	+2%	+14%	+7.6
Vermont	0%	-33%	-31%	+3.2
Medium				
California	-15%	-1%	-1%	0
Colorado	0%	+6%	+22%	+11
Connecticut	-43%	+5%	+4%	-.2
Florida	+50%	+10%	+22%	+8.6
Iowa	0%	+1%	+72%	+48
Minnesota*	-100%	-19%	+12%	+27.6
Weaker				
New Mexico	0%	+10%	-6%	-14.1
North Carolina	+109%	0%	+3%	+2.2
Ohio	-33%	+1%	-8%	-8.7

* Note: Most recent premium and claims data for MN are for 1995 as carrier left the state in 1996.

** This column shows the change in each state's portion of this insurer's block of small-group business across all 12 of these states.

Source: Multi-line insurer with both large and small groups

Individual Market. We heard a considerably different story about the individual market. In states that implemented community rating and guaranteed issue in the individual market, insurers we spoke to experienced serious adverse selection. One insurer told of selling the exact same coverage on both sides of the Delaware River; the cost in New Jersey was twice as much as in Pennsylvania. Another insurer said that, in New Jersey, it had to sell policies to a woman in a coma and to a man whose brain tumor was so large it could be seen through his nose. This insurer discovered that an agent had left a stack of its application forms in the waiting room of a hospital emergency room. Other insurers gave examples of precipitous price increases in New Jersey and Washington of 50 or 100% in the space of just a few months; these were required to respond to a very rapid influx of new high-risk subscribers.

Most of the worst examples came from states with very short or no preexisting condition exclusion periods and with other restrictions on insurers' ability to counter adverse selection, such as paring back benefits. States like New York and Vermont, where this is not the case, have maintained a more stable market. Although New York in particular has experienced substantial price increases as the result of the individual reform laws, few subjects thought that an adverse selection spiral has resulted that would cripple the market, as they view as having happened in Kentucky and Washington. Instead, they see the reform law as having produced a virtual high-risk pool, but one that is probably sustainable. This obviously has serious affordability consequences for younger and healthier subscribers, but it contrasts with claims that the market cannot survive in any form.

2. Particular Rating Restrictions

In addition to the effect of guaranteed issue on *average* prices, small-group reforms affect prices through the impact of rating restrictions on the *range* of prices. Compressing price variation has favorable results for higher risks and unfavorable results for lower risks. We found in our interviews that this is the aspect of insurance market reforms that insurers are most sensitive to. They are willing to accept a wide variety of guaranteed-issue requirements in both the small-group and individual markets. But we heard repeatedly in our interviews that certain rating restrictions are unacceptable when coupled with guaranteed issue, in either market segment. Almost every insurer opposed pure community rating, although a number of them continue to operate in states such as New York and Vermont with pure or nearly-pure community rating -- even in the individual market -- if the market potential is substantial enough and the regulatory environment is otherwise acceptable. One insurer said it had learned through its experience in Vermont that it can survive in the small-group market under-nearly pure community rating, although it subsequently has stopped seeking new business there. We observed a number of instances, however, of insurers with more tenuous market positions withdrawing from a state that adopted pure community rating in either market segment, and one or two insurers we spoke to said they will not do business in any state with nearly-pure community rating in the individual market.

More critical than community rating, however, is the state's attitude toward regulating rate increases. Small-group and individual market reform laws do not address increases in average rates, only the spread in rates among particular purchasers, relative to the insurer's average. Increase in average rates is addressed by states' rate regulation laws. A number of states require prior approval before using new rating factors or new rate tables. Some of these states have fairly lenient and low-visibility informal review processes, conducted by staff or contract actuaries in the insurance department. Other states, however, have a more formalized, intensive and public review process to scrutinize insurers' justifications for rate increases. Insurers dislike these tougher review processes because they tend to politicize rate increases and slow down the process. This gives insurers much less confidence that they will be able to increase rates as needed to stem losses if they find their prices are too low relative to the risks they are attracting.

These concerns are heightened by rating restrictions that change rating practices and compress the variation in prices among subscribers, because these changes carry the risk of causing adverse selection, or they require adopting different actuarial assumptions that may prove to be wrong. It is critical to the profitability of insurers to be able to make quick mid-stream corrections in their rates if they discover their loss ratios are too high. To illustrate, two insurers explained that, when small-group reforms were implemented in Florida, they made incorrect actuarial assumptions that caused them to set prices too low initially and that it took them several years to get their loss ratios to an acceptable level because of the rate review process. Another insurer illustrated the volatility of pricing and profitability with an example in New Jersey. It entered the reform market with one of the lowest priced individual-market plans, which resulted in huge enrollment gains but also serious adverse selection. New Jersey, however, allows immediate rate increases, and so when this insurer quickly raised its rates, its enrollment plummeted but its loss ratios greatly improved. Another insurer claimed that a number of carriers entered the New Jersey individual market because the state decided to "depoliticize" its rate review process. Another insurer said it has convinced a number of states to eliminate public rate review mechanisms in favor of minimum loss ratio standards which allow insurers to set and change their rates as they wish but require them to make refunds if their loss ratios fall too low.

The ability to quickly correct price errors and not be locked into a losing block of business was mentioned by every insurer as critical to the decision of whether a regulatory environment is acceptable. Every insurer mentioned Kentucky as a state that is unacceptable for this reason, because it required a one-year rate guarantee and the review process for increases was seen as highly political and adding another six months onto the rate increase cycle. Moreover, Kentucky required special justification for rate increases of more than 3% above medical inflation. Massachusetts, South Carolina, and Washington were also mentioned as states where it is difficult to receive justifiable rate increases. Florida and New York were mentioned as states where rate review is tough, but the results are usually acceptable. Both states are seen as getting tougher, and there was some disagreement about recent rulings from each. One insurer said it withdrew entirely from the individual markets in all states because of the increasingly political climate surrounding rate review. Another said that New York is an example of a state that will give insurers almost any increase they want in group rates but that is overly restrictive on individual rate increases.

The fact that flexibility in rate renewals, and not the degree of rating restriction, is the key regulatory issue is demonstrated by data from several insurers indicating that loss ratios bear no predictable relationship to the strength of reform laws. Even if rating and guaranteed-issue rules cause serious adverse selection, as long as prices are allowed to reflect increased claims costs, insurers will remain profitable. This can be seen for the small-group market in Tables 3 and 4. For the individual market, one prominent insurer had essentially the same loss ratios in New York for both its guaranteed-issue plans issued after reform and its medically underwritten plans issued prior to reform. In all nine of its guaranteed-issue states combined, its loss ratio for individual business was a very acceptable 70% in 1996.

With adequate flexibility in overall or average rates assured, insurers are much more amenable to a variety of different restrictions in the range of rates and allowable rating factors. Several subjects noted that insurers had adapted to rating restrictions of greater severity as they evolved through several stages of legislation. One insurer said that the degree of rate restriction that is feasible varies from state to state because the purchasing habits and market structures in different states lead to different degrees of price sensitivity and potential for adverse selection.

Generally speaking, these insurers clearly prefer rating bands of +/- 25%, which allow them to offer significant discounts to healthier subscribers and to rate up higher risks. Twenty-five percent appears at first to be a fairly narrow band, but this adjustment for individual health status comes *on top of* adjustments for age and gender, which themselves allow for a 10-fold variation at the furthest extremes. Also, a +/-25% range translates into the ability to increase rates as much as 67% for higher risks. Insurers are not required to set their standard rates at the middle of the band. Most issue standard rates at or near the bottom of the band, leaving very little or no room for discounted rates for especially healthy applicants, but expanding the range over which they can increase rates for sicker groups and individuals.

Insurers we interviewed are not eager to do business under adjusted community rating, but most are willing to live with no individual health status adjustment in the small-group market if they are permitted substantial age/gender adjustments. However, two indemnity insurers said they pulled out markets such as Florida and Colorado where they had substantial market positions, in large part because of adjusted community rating, while they were willing to stay in other markets such as California and North Carolina that allow same rate adjustment. One of these insurers explained that it is critical to retain the ability to issue lower rates to new business than to renewing subscribers, in order to avoid being locked out of the market with a bad book of existing business.

Also, several indemnity insurers argued forcefully that adjusted community rating does not allow them to guard adequately against adverse selection from HMOs. They contend, with some justification, that sicker people, on average, prefer indemnity and PPO products because they impose fewer restrictions on choice of physician and covered prescriptions. If these insurers are allowed to reflect this increased morbidity only in their average rates, then they cannot offer a price-competitive product to healthier subscribers. This has the potential, they claim, to price indemnity-based products out of the market except for higher risks, even though there are lower risks willing to pay some extra for increased choice and coverage. The extent to which these serious claims are true will have to be resolved through more quantitative and direct empirical measures. Based on our observations, however, PPO products are still widely available even in tightly regulated small-group markets. Their prices are increasing significantly faster, however, than HMO products, and pure indemnity products have all but disappeared from several of the more tightly regulated small-group markets. We are not in a position to determine whether this is due to adverse selection or instead to the absence of managed care cost controls employed by HMOs.

Another impact that restrictive rating rules might have on the market is to deter insurers from adopting innovations in benefits, such as medical savings accounts and disease management programs. One insurer noted that it is difficult to know for certain what impact these changes will have on costs and on purchasers' selection decisions, so they are reluctant to try out new benefit structures in states where rating rules are perceived as less forgiving of possible pricing mistakes.

Others, however, said that rating rules usually allow considerable leeway for rating adjustments based on differences in benefits. Indeed, several interview subjects indicated that authorities are too lax in monitoring adjustments for benefit differentials, which creates greater health-risk differentials than the rating rules are intended to allow. Valuing benefit differences among plans requires an exercise of actuarial judgment for which there are different techniques. One technique is to declare simply that benefits are worth the claims cost they generate, so that different benefit packages are rated according to the claims experience for the pool of subscribers to each package. The problem with this approach is that it confounds benefit differences and selection effects. If some plans are more attractive to healthier or sicker populations, then the claims experience will reflect underlying health risk as well as benefit differences. Using simple claims experience can result in anomalies such as placing a higher actuarial value on a benefit package that objectively is less rich. For instance, if two plans are identical except that Plan B offers free membership in a health club, Plan B should be more expensive but, measured by claims experience, this difference will likely be muted, or reversed, since health-conscious subscribers will likely gravitate toward the free membership. Used in a different manner, claims-based measures of benefit differences can be used to exaggerate the actuarial value of different deductible levels, for instance. A plan with a $100 deductible is worth more than an identical one with a $500 deductible, but certainly not more than $400. But measured purely by claims experience, the low-deductible plan might in fact produce an actuarial measure greater than the difference in the deductible, since higher risks gravitate toward richer benefits.

Some subjects said that they do not attempt to use this leeway in the rating rules but instead set benefit factors according to national actuarial standards and data, which they apply equally to guaranteed-issue and medically underwritten products. Actuaries at other insurers, however, candidly admitted that, where allowed to do so by regulators, they use the benefit factor to pass through the full impact of selection effects, even if the result is a greater difference in premium than there is between deductibles of two plans. We observed several actual instances of anomalous pricing patterns such as premium differences greater than the difference between deductibles in two plans that otherwise have identical coverage. The effect is to convert guaranteed-issue standard and basic plans into high-risk pools since these plans are priced almost directly according to the risks they attract rather than according to an objective measure of the value of the benefits. Other states require actuaries to separate selection effects from the actuarial value of benefit differentials, but these judgments are still made more by intuition than by hard data, and insurance regulators vary widely in their ability to scrutinize these judgments.

C. Market Competition

1. Market Structure

Small-group reforms have not undermined competition, in the view of the insurers we interviewed. Our subjects clearly perceive themselves as facing stiff competition for small-group business, especially from HMOs, as discussed more below. However, the number of competitors has diminished somewhat following these reforms, especially among indemnity insurers. While competition remains intense, the number of competitors is noticeably fewer, especially in rural areas where managed care networks are not as developed. We solicited views on why the number of carriers has diminished somewhat.

Several subjects explained that two forces are at work. First, there has been a wave of consolidations and mergers among insurers, mostly HMOs. Second, national insurers have become more selective in picking which markets to concentrate on. This is especially true for indemnity insurers. The first of these forces appears unrelated to the reform laws. Our subjects believe the second one, however, is partially related to these laws. Several indemnity insurers explained that, prior to reform, they considered themselves to be national companies and so would market in virtually every state, even if they had very small market shares. Following reform, these insurers gave up this "mile wide and inch deep" philosophy in favor of selecting those states and regions within states where they believed they could compete the most effectively. This occurred partly in reaction to increasing competition from HMOs and the capital resources necessary to develop managed care networks of their own. But this strategic focusing also resulted from experience under the reform laws. Indemnity insurers found that they could compete more effectively under some versions of these laws than others. As noted above, few insurers said that there any versions of these laws they are completely unwilling to accept, but most insurers said that the regulatory environment is one factor they now consider in deciding whether or not to remain or become active in a state. Thus, they view states as having both legal and business risks and opportunities.

This is true both for insurers that supported these reforms and those that did not. One insurer in particular, an indemnity insurer that is active in both the individual and small-group markets, explained that it initially embraced these laws in a proactive manner, even in the toughest states, with the philosophy that it had to learn to compete under them in order to survive. But it found after two years or so that its losses in some states were unacceptably high, and so it began a concerted effort to strategize which regulatory environments are more accommodating. Other insurers entered the reform era with this approach. The three largest insurers we spoke to, however, continue to compete in most states regardless of how the small-group laws are constructed.

In the individual market, this tendency to be selective and to leave markets with tough reform laws is much more pronounced. This is of some concern since the individual market typically has many fewer competitors than the small-group market. Also, it is not only the so-called "cherry pickers," i.e., insurers that historically engaged in more aggressive underwriting, that have left the more highly-regulated markets. One national insurer withdrew from the individual market entirely, and it attributed this decision in part to the increasing reform momentum. It explained that it previously had competed by offering more stable rates and more generous coverage than other individual insurers and so, ironically, it found that individual-market reforms made it less competitive because the reforms lessened the distinction between its way of doing business and that of its competitors.

2. Managed Care, Risk Selection, and the Focus of Competition

The most notable respect in which market competition has changed following these reform laws is the rapid shift to managed care in the small-group market. In most states we studied, HMOs doubled their small-group market share within 2-3 years of reform enactment, and they now constitute a substantial majority of this market. We solicited views on whether this trend is attributable to the reform laws or is independent of it. Views were about equally split. About half of our subjects believed that small groups increasingly turned to HMOs as the result of HMOs' increased marketing to this segment, and as a consequence of increasing indemnity premiums. The fact that the reform laws were enacted at the same time is a coincidence, in this view. In the view of the other half, however, the reform laws precipitated this movement to managed care. This is so for several possible reasons.

First, by enacting open enrollment and community rating, the reform laws created a more equal playing field, one more consistent with the manner in which HMOs were already accustomed to competing. This gave them a leg up in operating under these rules, and it deprived indemnity insurers of their primary means of cost control, namely, more careful selection of risks. Second, to the extent the reform laws caused a price shock for some subscribers by moving toward community rating, these laws may have prompted some subscribers to look elsewhere for cheaper coverage, and HMOs offered comprehensive coverage at a lower price. Third, the portability provisions of the law facilitated this ability to easily change insurers to avoid a price increase.

To the extent that insurance market reforms have facilitated the move to managed care, they have shifted the focus of competition from risk selection to risk management. Whether this is a good or bad effect depends on one's perspective. In the view of indemnity insurers and subscribers, insurers should not be in the business of influencing medical care decisions. Nevertheless, even indemnity insurers have made this shift to some degree, in that most have developed quasi-managed-care products such as PPOs, or they have partnered with HMOs to offer the out-of-network component of point-of-service coverage. Nevertheless, significant competitive energies are still directed toward risk selection. First, a number of states still allow some degree of premium variation based on individual health status. Second, even states with modified or pure community rating allow insurers to engage in medical underwriting for purposes of deciding whether to cede particular groups or individuals to the voluntary reinsurance pool. Third, prior to HIPAA, a number of states required guaranteed issue only of designated plans. Several interview subjects noted that these activities continue to keep medical underwriters on the job, although there are fewer than before reform. One insurer reports that it employs more underwriters now than prior to reform, relative to the size of its small-group block of business. However, as discussed below, a sizeable portion of underwriters' time is now spent on regulatory compliance instead of traditional medical underwriting.

Another way in which insurers can control the risk profile of their subscribers is in how they design their benefit packages. Because sicker subscribers are naturally drawn to more comprehensive benefits, one possible strategy is to reduce benefits by increasing deductibles and limiting prescription drug coverage. Several insurers conceded that this is an explicit strategy in their marketing, especially in the individual market. Some forms of this strategy result in adding benefits. One insurer, for instance, said that it was adding health club membership, wellness visits, and immunizations in order to "attract healthy subscribers." It is noteworthy that these are benefits that are also typical of HMOs.

Most insurers, however, said that reductions and changes in benefits are in response to market forces, especially employers' desire to reduce costs. In either event, changes in benefits can be seen as valuable marketplace innovations rather than attempted manipulation of market dynamics. Several subjects noted that a good array of benefit options is available, and insurers continually try to innovate different and hybrid insurance structures in their efforts to determine the optimal mix between choice and cost controls. On the other hand, states with individual-market reforms no longer have low-deductible indemnity plans, and the move to guaranteed issue of all small-group products prompted insurers to weed out many benefit plans that they were not willing to sell on this basis or were no longer marketing actively. Even insurers who continue to pride themselves on offering "gourmet" rich benefit plans are setting limits on particular high-cost items such as in vitro fertilization and "designer" drugs that they believe are sought out by subscribers with special high-cost needs.

Another factor that affects risk distribution among insurers is how new an insurer's book of business is. Most subjects commented on the reluctance of sicker subscribers to change insurance, since there is a strong desire for stability during the course of treatment or illness. As a consequence, there is a natural selection effect that occurs in that subscribers that change insurers are, all other things being equal, healthier than those who do not. Several subjects stressed the strength of this natural selection effect, which is described as the "durational effect" because it shows up according to the length of time subscribers have been with an insurer. One experienced actuary said the most surprising result of small-group reform was the extent to which the durational effect persists even without initial medical underwriting. In this insurer's large block of small-group business, new subscribers have 15-20% fewer claims than existing ones, an effect that largely disappears in a year. Another actuary, at a smaller indemnity insurer, agreed that the durational effect continues in the small-group market, but said that it is less pronounced than before reform because it was partly due to preexisting condition limitations, which are now shorter. A third actuary found that its loss ratio for small groups that renew is substantially higher than for those whose policies lapse, an indication that the durational effect continues despite guaranteed issue. This can also be seen for the insurer reported in Table 1.

Actuaries and underwriters, prior to reform, thought that the durational effect (i.e., the worsening risk profile over time) was due mostly to the medical-underwriting process, which produces a more select risk group at the outset that then tends to deteriorate over time according to the statistical phenomenon known as "regression to the mean." Accordingly, if medical underwriting is eliminated, new subscribers should present approximately the same risk profile as existing ones and the durational effect should be greatly reduced. To the contrary, the insurers we spoke to all continue to experience a substantial durational effect in the small-group market, indicating that most of the "select" risk quality of new small-group subscribers was due more to natural risk selection behavior than to insurers' underwriting prowess in accurately identifying and excluding bad risks.

The resilience of the durational effect is significant for the competitive impact of small-group reforms because it means insurers improve their risk pools by attracting newer subscribers. This can intensify price competition, but it can also lead to market volatility through strategic "low balling" or "buying market share." Several subjects observed that the durational effect allows new market entrants to offer lower premiums initially but this advantage wears off rather rapidly and so new insurers often find that they have to raise their rates steeply after just a year or two, especially if they underpriced initially relative to the risks they received. If so, their enrollment will deteriorate rapidly since existing healthy subscribers will leave and the insurers will not attract new enrollees. Under tight rate restrictions, a new insurer has difficulty in continuing to attract new subscribers because allowable renewal rate increases are keyed to the trend in the new-business rate. Insurers face the dilemma of either taking a loss on renewing subscribers, or offering an uncompetitive rate to new subscribers. As a result, one actuary explained that "one year's genius can be next year's bozo," since a great new-business rate that attracts lots of business will end up locking the insurer into a rate structure that cannot sustain increased claims as the durational effect takes its toll.

There are differing views on whether the reform law encourages or discourages low-balling and market volatility, and to what extent this is desirable. The portability provisions that allow subscribers to easily switch insurers when rate increases are steep tends to increase volatility, as does the disruption caused when new rating rules lead to mistaken actuarial assumptions. One large insurer lost over 40% of its current small-group indemnity subscribers in 1996, although this was due in part to its corporate strategy of moving these groups into its HMO products. A smaller indemnity insurer recounted a time in 1995 when its block of individual business in New Jersey increased six-fold in just a few months because it had the lowest-priced product. Because people are free to switch insurers "monthly, daily, hourly," they are always on the lookout for a better deal. Another indemnity insurer with mostly individual and small groups typically loses 40% of its new subscribers after the first year and another 30% after the second year.

In other respects, however, the small-group laws promote market and pricing stability. Most insurers realize that they have only a limited leeway to impose rate increases greater than the trend in new-business rates and so they are reluctant to engage in "low-balling" strategies to gain an artificial advantage from new business. In states with adjusted community rating, renewal rates cannot deviate at all from new-business rates. While this has a stabilizing effect, it creates a degree of price stability that may not be optimal for vigorous price competition. As one pricing actuary explained, occasional price wars can be good for consumers, as gasoline and air fare markets demonstrate.

A final indication of the nature of competition is the extent to which insurers' marketing efforts focus on aspects other than price. While price and product competition appear to be thriving in the small-group market, what is noticeably absent is any form of competition based on outcome measures of quality. Naturally, this is relevant only to HMOs since indemnity insurers are not in a position to monitor or influence the quality of care, and one of the selling points of indemnity coverage is that subscribers are free to make their own decisions about which are the best providers. However, given the penetration of HMOs, one might expect at least some competitive focus on quality of care measures. We reviewed insurers' sales literature targeted to the small-group market and found almost no reference to outcome measures of quality such as the HEDIS measures developed by the National Committee on Quality Assurance (NCQA), even from HMOs. At most, there were passing generic references to the quality of providers in the network. The focus of the sales literature is on the particulars of the benefit packages, and for HMOs on the composition of the network. Most sales brochures offer a dizzying array of ways to mix and match various components of coverage such as deductibles, co-payment levels, maximum payouts, and various riders for prescription drug benefits or mental health coverage.

In summary, although the small-group market remains highly competitive in structure and in its focus on price and product diversity, it is far from the economic model envisioned by some reformers. Even though insurers do not use risk selection to the same extent as before, risk selection still remains as an important, and perhaps the most important, factor determining insurers' profitability. This clouds to a considerable extent the ability of consumers to determine from a plan's price the underlying efficiency in the form of insurance or the delivery of medical care.

3. Purchasing Cooperatives

Purchasing cooperatives are intended to promote all of the purposes of the small-group reforms, but rather than scatter their discussion throughout each part of this report, we consolidate our evaluation of them here because most of the purposes relate directly to promoting market competition.

None of the insurers we spoke to were enthusiastic about public purchasing cooperatives and only a few actually chose to participate in them. Two or three subjects thought that, in principle, they are a good idea, but based on their company's corporate policy or their initial experience with them, they no longer participate. The others who do participate do so with some reluctance or caution, usually more out of a sense of political necessity than from any eagerness to gain more business. The perceived political necessity arises from the fact that regulators or legislators in several states strongly support the public purchasing coops, so participation is seen as advisable to maintain status as a "good citizen."

We heard three basic reasons for not embracing coops. First, several insurers thought they created additional administrative burdens in some states where enrollment, billing, and agent commissions must be handled on an individual-employee basis rather than a group basis. Second, many insurers opposed purchasing coops for largely political reasons, arising from the opposition of their agents. Coops are seen by agents as a direct threat to their role in the market, a fear that is heightened by coops' connection with the failed Clinton health care reform plan. Insurers are highly sensitive to maintaining favorable relations with their agents because of the concerns about adverse selection described above under the discussion of field underwriting. Thus, several insurers said that supporting or participating in coops is contrary to their corporate culture of being "agent friendly" or agent driven. One insurer would have supported coops except for the fact that this would have "sent a bad message" to its agents. Another said it did not want to alienate agents, who are its "lifeline."

Finally, almost every one of the indemnity insurers we spoke to believed that adverse selection problems make it too difficult to compete successfully in coops that offer individual-employee choice. They believe that HMOs tend to receive the better risks, and that this is accentuated when choice occurs at an individual rather than a group level. With group-level choice, indemnity insurers feel they can control selection problems to some extent by imposing participation requirements which allow them to decline coverage to a group if only a few of the eligible employees opt for coverage. This is not allowed in most coops. Accordingly, group insurers believe coops behave much more like the individual market, which many insurers are unwilling to participate in. One insurer pointed to the fact that its PPO product is very successful in the regular California small-group market but is unprofitable in the Health Insurance Plan of California (HIPC). Although the HIPC has a risk adjustment mechanism, this insurer believes it does not correct for adverse selection against PPOs sufficiently to allow it to be profitable in the coop.

D. Administrability

1. General Compliance and Enforcement

We heard mixed views on the effectiveness of state departments of insurance (DOIs) in administering and enforcing these laws. Some subjects said that insurance regulators take a mostly passive enforcement stance, responding to complaints but not monitoring in a proactive fashion. Therefore, some subjects believed that a few carriers managed to remain in blatant violation of guaranteed-issue requirements. One insurer complained that regulators are often inconsistent or arbitrary in their interpretations of the law's gray zones and that insurers have learned to "shop" for favorable rulings from among DOI staff members or that staff sometimes reverse positions after the insurer has come to rely on an initial ruling. Others, however, thought that basic compliance is widespread and that insurance regulators are active and fair in policing the laws through reviewing policy forms and rates and conducting market conduct exams. One insurer noted that the reform era has produced a fundamentally different relationship between regulators and the industry in that, now, the two frequently meet to address common public policy concerns in a productive manner, which has created more of a social consciousness among the "rank and file" of the industry.

For the most part, however, these national insurers complained about the highly regulatory environment created by these reform laws. They explained in some detail that, although the laws are similar across the states, the differences are numerous and intricate enough that ensuring compliance is a large, complex, and never-ending task. Although industry lobbyists initially pushed for state-level reforms and resisted federal reform, most of the sources we spoke to seemed to prefer the uniformity brought about by HIPAA.

One said it is "absurd" to have 50 different versions of market reform. Another said it had undertaken 800 different project initiatives to comply with various reform laws in recent years. A third said the task of compliance "overwhelmed" them to the extent they had to withdraw from some states in an effort to triage their internal resources. A fourth estimated its compliance department would have to work 18 months nearly full time to incorporate all the changes in state laws brought about by HIPAA. A fifth estimated the company had 40 people spread throughout every department devoted to legal compliance with reform laws, and this figure is only those who make sure that others are doing their jobs correctly, so it does not count the added effort imposed on those actually doing the work. A sixth insurer estimated it had made hundreds or thousands of rate and form filings in recent years because of reform laws, and often it has to do so repeatedly in the same state as different stages of reform are implemented or as regulators change or clarify their interpretation of the fine points.

These increased efforts offset the reduced efforts required in medical underwriting. Although at first there was "massive panic" among health insurance underwriters who thought these laws would "put them out of business," they found there was even more work than before, although now their focus is regulatory compliance and employer eligibility rather than health status. One insurer has coined a new job description of "legislative underwriting," which includes a greater focus on meeting eligibility requirements and finding the types of employer fraud described below. One insurer estimated that its actuarial staff had doubled as the result of reform laws, and another insurer gave the same estimate for its compliance staff. However, it should be noted that these subjects are probably lumping together all legislative and regulatory initiatives in recent years dealing with health insurance and not reporting only the separate impact of small-group and individual market reforms.

2. Particular Compliance Issues

We also inquired into particular enforcement issues that might be especially troubling. One of these is field underwriting, which is discussed above. Other areas include list billing, self-insurance, and private associations. These are all concerned with what we refer to as "border crossing" problems. The potential for these problems arises when one segment of the market is regulated differently than another. This creates possible strategic advantages for low- or high-risk groups or individuals to cross into or out of the market, at either the high-size or low-size ends of the market, thereby unraveling or eroding the market divisions that are necessary to sustain this regulatory structure. We will discuss a variety of specific examples.

List Billing. This refers to an insurer who excludes certain members from group coverage or sells individual coverage to members within an employer group, either with or without the employer contributing to the cost. This use of the term is not meant to be in contrast with "composite billing," which captures a different distinction, namely, whether groups are billed based on average group characteristics or instead are billed in a way that identifies each employee's unique costs. That use of the term "list billing" occurs within the purchase of group insurance. We mean here to identify the use of list billing that allows the sale of individual insurance through payroll deduction.

This practice was common prior to the reform law for a variety of reasons. One use of list billing was for employers to purchase insurance for only selected employees by reimbursing them for the cost of individual coverage. This might be done in order to offer insurance only to "key employees" such as managers, or in order to avoid the costs of insuring an employee or family with health problems. Other forms of list billing were done as an accommodation to employees whose employers were not willing to buy insurance for anyone, but who wanted to facilitate their employees' purchase of insurance through payroll deduction. Small-group reform laws often prohibit list billing, following the philosophy that employers should treat their employees equally, and out of the pragmatic concern that if list billing were allowed to continue, employers with low-risk profiles would circumvent the rating rules by purchasing non-group insurance, thus bleeding good risks out of the small-group market.

Many subjects thought the law had effectively eliminated this practice. One or two subjects, however, said that list billing arrangements like these continue to some degree, although they are not actively promoted by their company. One knowledgeable subject, however, said that list billing is still common, and in fact has grown more common among micro-size groups. This subject insisted that reform laws frequently do not prohibit list billing arrangements, or that whether this is prohibited is a matter of interpretation. Regulators in some states declare that small-group laws apply only if an employer contributes to the cost of the insurance and takes a business deduction expense, and that it is perfectly legal to sell individual insurance through payroll deduction as long as the employee genuinely is paying the premium after taxes. This subject explained that insurers are not in a position to find out and "don't care" if the employer compensates these employees with higher wages to offset their insurance costs. All insurers look at is whether the check they receive is from the employer's account or from the employee and whether the proper acknowledgments have been signed saying that the employee is receiving no contribution from the employer. Given this leniency, "a lot of carriers have become more aggressive" about marketing individual insurance in a list-billing arrangement. Another subject with knowledge of practices in many states confirmed that regulators are increasingly allowing the sale of individual coverage to employees if insurers properly document that employers are not paying for the insurance.

Private Associations. Good risks might also leave the small-group market at the high end if small groups attempted to aggregate artificially into a group larger than 50. This might occur through what are known as "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. Similarly, association sales vehicles might be used to avoid individual market reforms by aggregating low-risk individuals into a group.

According to several subjects, the small-group laws have been effective in eliminating the use of associations of employers to escape regulation. The laws in many states look behind the surface of the association and regulate 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 into associations. These restrictions have eliminated the major advantage of associations, in the eyes of most of the small-group insurers we spoke to, and so they make much less use of this sales vehicle for groups than in the past.

However, association-type arrangements are still used by several insurers we spoke to, especially in the individual market. Apparently, several or many states allow insurers to establish group trust" arrangements, which mimic large-group plans but which actually are vehicles to sell to individuals. This technique involves issuing a single master plan to an out-of-state trust created by the insurer, and then having the trust issue certificates of coverage as individuals are enrolled in the trust group. Sometimes the trust is described as an association, which individuals join in order to obtain insurance. One subject described these as "air-breather associations," meaning that the membership qualifications are broad enough that anyone can join. However, they receive insurance only if they meet underwriting criteria.

Some subjects describe this as a legitimate technique to avoid having to meet regulatory requirements in every single state, since it allows an insurer to file its products and rates in only one state but market in other states. This allows much easier movement into and out of different markets without having to refile for approval each time. This practice took hold prior to insurance market reforms, but avoiding these reforms is another inducement to retain the practice. Ohio and Kentucky are two states where these associations of individuals appear to be in widespread use and result in large portions of the individual market falling outside of the reach of the reform law. Also, this group trust arrangement avoids more traditional regulatory burdens such as more intensive rate regulation and mandated benefits that apply to individual insurance.

Insurers that use this sales vehicle say that it is widespread and perfectly legitimate. According to one, "Lots of insurers do this; everyone knows about it." This technique also extends beyond the individual market. One insurer explained that it combines the group trust arrangement with a list billing approach, so that it can sell insurance to employees without falling under the jurisdiction of either set of market rules. Another subject said that the sale of group certificates to individuals through list billing falls within a "regulatory vacuum" that is neither individual nor group insurance. These subjects explained, however, that this works only in about half the states, and the degree of regulatory protection varies widely depending on the precise wording of regulations, for instance, whether they apply to "policies" or "certificates" that are either "issued" or "sold" in the state. Several subjects insisted that these arrangements do not avoid guaranteed issue and rating restriction laws, only rate regulation and sometimes mandated benefits. Others, however, thought these arrangements can sometimes avoid all of these regulations.

Self-insurance. Yet another border-crossing concern is the threat that this law would induce medium-sized groups, those in the 25-50 range, to self-insure. This might occur if a group of good health risk felt it could save money by avoiding rating restrictions. It is primarily for this reason that the small-group laws are not extended to groups any larger than 50. We found mixed indications about whether groups below 50 are self-insuring at a significant rate. Some subjects thought that self insurance is not significant in the small-group market and is not being done on a widespread basis to avoid market reforms. Others, however, thought that, in recent years, there has been an noticeable increase in active marketing of self-insurance with stop-loss coverage to this market segment. Most viewed this as being driven by general concerns over costs rather than a strategy specifically to avoid the reform laws.

Applicant Fraud. Other potential circumvention techniques are not as structurally sophisticated, and they are perpetrated primarily by applicants, not insurers. An employer with a sick family member or friend might falsely claim the person as an employee in order to take advantage of guaranteed issue or rating limitations. Or an employer who truly employs a person with sickness in the family might try to avoid the cost by "hiding" the person off of the payroll. Several subjects observed that, if circumvention and fraud is occurring in this market, it is probably of this nature. Two insurers complained in particular about the "astounding" level of fraud in the New Jersey individual market. They said that people there buy several duplicative policies and then submit the same medical claims to all at once. At worst, if the insurer catches them, all they can do is cancel the policy, and then they must refund their premium. Another complaint was the absence of any durational residency requirement, which allows people to "cross the bridge," claim an intent to remain, and purchase insurance immediately. There is an infamous story circulating of a woman who brings pregnant women over from Israel just to deliver their babies in New Jersey; they buy insurance, deliver, cancel, and then return home, so it is said. One insurer that is active in many states told us that it thinks this type of fraud is widespread in Florida and is facilitated by some agents, who help set up dummy corporations at fictitious addresses in order to allow sick individuals to take advantage of guaranteed issue by pretending to be a micro group or part of a small group.

We observed other indications, however, that agents and insurers are sensitive to this potential fraud and take steps to prevent it by requesting payroll and tax documentation. On the other hand, one subject speculated that employers "underwrite in the personnel office," meaning they decline to hire people who will increase their health insurance costs. Although this is prohibited by the Americans with Disabilities Act (ADA), it is too subtle to police effectively, and, ironically, the ADA does not apply to smaller employers. Although rating restrictions may somewhat mitigate this incentive for employers, age-adjusted rating still creates a strong incentive to avoid older workers, and rating bands still allow some rate variation based on individual health status.

3. Reinsurance

A final feature of the law that cuts across several of our categories of discussion is reinsurance. The voluntary reinsurance pools that exist in most states 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. Insurers can elect to either participate or to opt out of this reinsurance mechanism; the latter insurers are referred to as "risk assuming." Participating insurers can cede to the pool either high-risk groups or individuals within these groups, on payment of a reinsurance premium that for groups is 150% and for individuals is 500% of a market average premium for the particular case characteristics in question. (The reinsurance premium is usually calculated based on the statutory standard benefit plan, and insurers are usually allowed to reinsure only up to the extent of its coverage.) If these premiums are not sufficient to cover payments from the pool, losses are made up through an assessment against all participating insurers, proportionate to their small-group market share. This opportunity to cede bad risks is intended to protect insurers from adverse selection and to reduce their incentive to engage in covert risk selection, thus minimizing many of the gaming and policing problems that might otherwise arise under the law. Reinsurance also offers a protection against extreme risks that can help encourage insurers with smaller market shares to remain in the market.

Although a reinsurance mechanism was stressed by the industry at the time of reform laws as essential to the success of reforms, very few of the insurers we spoke to thought highly of reinsurance. Larger insurers who initially supported the idea in concept quickly found from initial experience that it was not necessary for them since they could purchase their own reinsurance, so they soon withdrew from the voluntary reinsurance pools or never joined in the first place. This has resulted in a dynamic in which the reinsurance pools have progressively shrunk in most states. As larger insurers withdraw, medium-sized insurers find that they are now required to pay the largest portion of assessments, and so they reconsider their decision to participate, leaving even smaller insurers at the top of the list. One subject said that, when an insurer's share of the reinsurance pool grows to 20%, it starts to get nervous about its exposure to assessments. Like a game of musical chairs, no insurer wants to be the largest one standing when the music stops. Accordingly, participating insurers in most states account for less than half of the small-group market.

It is for this reason that the same mechanism is not feasible in the individual market, where it is perhaps more necessary. Market concentration tends to be much greater in the individual market, and there are many fewer market participants, so the largest insurers would in effect be reinsuring the others, or if they withdrew, the remaining base would be too thin to support a pooled structure. Accordingly, it is rare to have reinsurance or risk adjustment in the individual market except in large states like New York and New Jersey in which participation is mandatory.

In the small-group market, where reinsurance participation is usually voluntary, most all of the smaller insurers that we spoke to have remained in the reinsurance pools. Nevertheless, most do not look on them with great favor. Most feel that they have lost money on balance with the groups and individuals they have reinsured, and those that have made money feel that the amount of protection is not substantial, perhaps accounting for only 1-2% of their loss ratios. One small insurer called reinsurance a "shell game" that smooths out some of the worst risks but has no long-range impact on costs or profitability, and another explained that this is exactly how it is meant to function. Both large and small insurers fear that their competitors will use the reinsurance mechanism more aggressively or accurately than themselves, thereby forcing them to pay assessments out of proportion to their use of the reinsurance pool. One subject explained that insurers engage in "defensive ceding," because to come out ahead an insurer has to cede more than the assessments it will receive based on its market share and the risks ceded by others. Other subjects explained that it is not so much the volume of ceding that determines success but its accuracy, which requires "keen underwriting" and a much more hand-picking type of assessment than some insurers are accustomed to. Larger insurers complain that this is a type of underwriting that smaller insurers have more mastery of than they do and so their chances of "hitting the jackpot" are lower, or they have to "double underwrite" in order to make sure they are not missing bad cases that others are picking up. The same complaint was also heard from some smaller insurers. This is not simply an issue of rivalry within the industry, however. Because reinsurance naturally tends to favor insurers with better risk selection skills, it is contrary to one of the purposes of small-group reform. It also adds administrative costs and detracts resources and attention away from managing the costs of care.

Nevertheless, there has been much less reinsurance activity than was initially expected. We heard several explanations for this. First, guaranteed issue is bringing fewer very bad risks into the market than insurers imagined. Insurers' worst fear was a flood of previously uninsurable groups, and so it was expected that the reinsurance pool would grow to be a substantial portion of the market, but this has never come close to materializing. Second, it is difficult and costly to evaluate in borderline cases whether reinsurance is worth the cost. All of the larger insurers and two smaller insurers decided the administrative costs of the intensive review needed to make good ceding decisions simply was not worth the payoff, and so withdrew from or avoided the reinsurance pools. For those who participate, their initial experience was that they were reinsuring too readily, and therefore ceding risks whose eventual claims payout was less than the reinsurance premium. Some insurers initially reinsured any case automatically that they previously would have rejected, but they quickly found this is not economical. One large insurer said that it expected a loss ratio of 200% from reinsured cases but ended up with less than 100%. Likewise, the reinsurance pools in most states have loss ratios well below 100%. As a consequence, insurers have become much more selective about which cases to cede to the pool. One insurer observed that, because of the substantial premium and the large deductible, one has to be certain of incurring $10,000-15,000 of claims in the first year for an individual or $20,000-25,000 for a group before reinsuring pays off.

Some interview subjects observed, however, that reinsurance might be serving useful functions even if it is not much used. First, it might encourage carriers to take borderline risks even though the decision to reinsure is not clear, since a few states allow insurers to defer the decision to reinsure until later in the life of the policy or they allow insurers to uncede cases once they learn that a potential risk does not materialize. Also, the ability to reinsure one sick worker or family member within a group may induce an insurer to issue the group a plan of its choice rather than forcing the group to purchase only a statutory plan. Second, the reinsurance premium serves as a modulating device that regulators can use to tighten or loosen incentives for the industry as a whole. If reinsurance appears too expensive and regulators detect increasing signs of covert risk selection, they can lower the premium to take pressure off insurers and encourage taking more risky groups. Or, if the reinsurance pool is being used excessively and assessments are mounting, the reinsurance premium can be raised. Third, reinsurance might be important to insurers with small market shares remaining in a state, so they can continue trying to compete in a guaranteed-issue environment without too much fear that they will suddenly receive a disproportionate batch of bad risks. One insurer with small market shares said that it did not remain in markets with adjusted community rating unless there was a reinsurance or risk adjustment mechanism; for instance, it withdrew from Vermont but remained in New York and New Jersey. Another small insurer confirmed that reinsurance is an important factor in its decisions about which states to compete in. Other insurers, however, did not appear to enter or leave markets based on reinsurance. One, who said it does well under reinsurance, also said reinsurance has "no influence" on its strategic marketing decisions.

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

The alternative to voluntary reinsurance is a mandatory system of risk adjustment, which creates an administrative formula for measuring insurers' relative risk pools and requires transfer payments to be made to equalize risk pools. Several interview subjects said that, in theory, this could be superior to reinsurance if a good risk adjustment measure were developed, but so far the ones in use are flawed. Also, the larger insurers felt that, in practice, in the states where risk adjustment is used, this system always results in transfer payments from them to Blue Cross.