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

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I. EXECUTIVE SUMMARY

This study evaluates how well North Carolina's health insurance market reforms have met their objectives and whether they have avoided possible harms and failures. The primary focus s the state market reform law, but this report also provides insight into the small-group portions of the federal Health Insurance Portability and Accountability Act (HIPAA). This is art 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, and (5) reinsurance. A separate report evaluates Caroliance, the public purchasing cooperative. 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.

Overall, the small-group reform law in North Carolina has been successful, but its success has been fairly muted. Most interview subjects thought this law had an overall positive effect, even if they did not like some of its particulars. Prior to this law, the small-group market was considered by many to be in distress, and enrollment was dropping. Since enactment, the market is vibrantly competitive, and the number of employers offering insurance grew for several years. The law appears to be especially successful in stimulating sales for micro groups. Also, price increases have stabilized, and there has been a pronounced shift to managed care, which indicates increased competition based on managing costs rather than selecting risks. It is impossible to know which of these effects can be fully attributed to the law, but certainly some of them can, and fears that these laws would cause the market to deteriorate through adverse selection have not materialized. The portability provisions and the limits on preexisting condition exclusions have been especially popular.

However, North Carolina's small-group reform law has failed to meet certain expectations. The proportion of small-group employees with private insurance coverage has not increased substantially, and the overall percentage of uninsured in the state has worsened somewhat. Also, employees are increasingly opting not to pay for dependent coverage. The standardized, statutory plans in particular have not been a success. These plans are not being actively marketed, very few of these plans have sold, and the burden of carrying these higher-risk subscribers fell unevenly among insurers, at least prior to HIPAA's requirement of guaranteed issue for all small-group products. Although price increases were remarkably subdued during the first few years under reform, prices are

beginning to rise rapidly once again to make up for the recent period of low profits or losses. These price trends appear to be driven by underlying market conditions, however, rather than a result of the reform law.

Looking to the future, we asked our interview subjects how they might improve the law. Somewhat surprisingly, a good number thought that expanding guaranteed issue to cover all small-group products, as required by HIPAA, is a good idea. Some also felt that the rating bands could be tightened, and no one we spoke to thought they were currently too tight. Few subjects believed that the reinsurance mechanism was serving an important function, so its function might be reevaluated. Also, serious consideration should be given to whether the statutory plans need to be retained, or whether they might be revitalized in some fashion. Now that guaranteed issue is required for all plans, several subjects think the statutory plans are no longer needed, although they still serve an important function for the self-employed. Also, standardized plans might help to facilitate price comparisons, but so far they have not been very useful in this regard. Finally, additional attention should be given to whether rating rules are being followed with respect to benefit differentials among plans, and whether field underwriting and differential commissions are widespread enough to be a matter of serious concern.

II. BACKGROUND AND METHODS

A. Methods

The primary sources of information for this study are various components of the insurance industry. In North Carolina, we conducted 13 in-person interviews of 18 people in the spring, summer and fall of 1997, and a second round of eight interviews with 10 of these people in the spring of 1998. Included in this interview pool were three officials with the North Carolina Department of Insurance (DOI), two independent agents active in small-group sales, 10 staff members at six insurers (representing both indemnity and HMO products and holding 42% of the market in 1996), a manager of a third-party administration (TPA) firm active in the small-group market, an administrator of a public purchasing cooperative, and an independent consultant in the insurance industry. These were semi-structured in-depth interviews, most lasting approximately 1-2 hours each. However, five of the insurer subjects were national companies located out of state, and the interview touched only briefly on North Carolina topics. 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, sales literature, and newspaper articles. This included data from the DOI's annual Small Employer Activity Reports for 1992-1997, a computer search of newspaper articles contained in the Nexis database, and brochures and operating statistics from prominent carriers in the market. These multiple sources of information and data were analyzed using both qualitative and quantitative techniques.

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

Before we begin, a word or two is required about terminology. Health insurance, like any other industry, has a specialized vocabulary with terms of art that sometimes differ from common understandings, and that often are used inconsistently even within the industry, due in part to regulatory differences among the states. For our present purposes, we value simplicity over precision, so we will use a lay vocabulary that glosses over many of the distinctions that are important within the industry. Thus, we use "insurer" to include, generically, both indemnity carriers and health maintenance organizations (HMOs). We use "managed care" to refer primarily to HMO plans, including point-of-service, 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.

B. Content and Purpose of Reform

North Carolina first enacted small-group health insurance reforms effective January 1992. Initially, the reform law applied only to groups of size 3-25 employees, but it was expanded in January 1994 to reach group sizes of 2-49. It was further expanded in January 1995 to reach so-called one-life groups, that is, self-employed individuals. More recently, in July 1997 North Carolina adopted amendments to bring its law in compliance with HIPAA. These reform laws have the following major components.

The starting point of reform is to make sure that any willing purchaser has access to insurance and can retain that insurance through subsequent renewal periods. "Guaranteed issue" requires all insurers who participate in the small-group market to accept any applicant. An important distinction exists between states like North Carolina that, prior to HIPAA, required only designated policies to be issued, and those that required guaranteed issue of all policy types marketed by a carrier. Following HIPAA, all states now require guaranteed issue of all small-group policies. However, HIPAA applies only to groups of 2-50 employees, and so North Carolina still retains the limited guaranteed-issue requirement for one-life groups.

The more limited guaranteed-issue requirement applies only to a set of standardized plans whose benefits are set by a government committee. These "state-mandated" plans come in a basic, "bare bones" version, and one with a more standard or common benefit package. Versions of each exist for indemnity, PPO, and HMO products.

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

The reform law promotes continuity of coverage in three ways. First, insurers are prohibited from refusing to renew insurance except for fraud, nonpayment or similar malfeasance. The second aspect of continuity is to regulate the use of preexisting condition exclusion clauses. Insurers are prohibited from ridering out specific health conditions altogether. They are allowed to place only an initial 12-month preexisting exclusion on any condition manifested within six months before the date of coverage. Third,"portability" or continuity of coverage is promoted by requiring that subscribers, once enrolled, be able to transfer coverage to a new insurer either by changing jobs or changing insurers within the same workplace, without undergoing a new exclusion period, so long as the gap in coverage does not exceed two months.

The second major component of the reforms is to restrict the degree of price variation among

subscribers. These rating restrictions both: (1) limit the amount insurers may increase the price for a specific subscriber over time; and (2) compress the range of prices that the insurer can charge across its entire block of business at any given moment in time. North Carolina follows the National Association of Insurance Commissioners' (NAIC) model by limiting year-to-year premium increases for any given group to 15% above the insurer's "trend." Trend is defined as the increase in insurers' rates for new business. The concept is to allow market-wide cost increases that are driven by technology advances, inflation in the medical sector and the like, but to limit those increases that reflect group-specific health risk. (Trend is keyed to new business rates because this is where insurers are the most competitive.)

The second component of the rating reforms prevents any insurer from varying its prices among subscribers at any point in time more than a defined amount above or below its midpoint for policies with similar benefits and "case characteristics." North Carolina originally allowed a range of +/- 25% and allowed separate bands for different blocks of business. But in 1995 it began to phase in modified community rating, which would have moved to 0% variation for health status or claims history across all blocks of business, allowing adjustment only for age and gender. However, the phased-in tightening of the rating restriction was halted by subsequent legislative amendment at +/- 20% across all blocks of small-group business. This is where the rating band remains. In addition, insurers may adjust rates to reflect the actuarial value of differences among benefits in different plans. As a consequence, considerable rating flexibility remains. Because each allowable factor can, in theory, be added to each of the others, and because demographic factors can be very large, at the extreme these restrictions can still allow more than a tenfold difference in the rates charged two groups at either end of the possible combinations of factors. On the other hand, these distant outliers might be very rare.

The third major component of the small-group market reforms is an administered reinsurance mechanism that allows insurers to reinsure any risks that are expected to generate costs exceeding the prices they may charge. The principal funding for the reinsurance entity is from the reinsurance premium paid by the ceding insurer. Insurers may prospectively reinsure either whole groups (of up to 25 members) or high-risk individuals within groups. North Carolina follows the NAIC model, which sets the premium to reinsure high-risk groups at 150% and for individuals at 500% of the marketwide average for a policy of similar coverage and case characteristics. Since insurers will reinsure only those groups and individuals they predict will have higher expenses than these prices, the reinsurance entity is expected to suffer losses, which are spread back to the insurance market through assessments against participating insurers based on their small-group market share. Insurers can choose whether or not to participate in this reinsurance system.

The final component of the small-group reforms in North Carolina is the creation of a system of public purchasing cooperatives known as Caroliance. This component is addressed in a separate report.

C. The Dangers of Reform

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

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

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

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

by following the interwoven threads of information in this complex tapestry, it is possible to draw some solid conclusions about whether these reforms have worked as intended, and, if so, why, and, if not, why not.

III. THE EFFECTS OF HEALTH INSURANCE MARKET REFORMS

A. Availability

1. Enrollment Generally and for Micro Groups

Insurance market reforms have not reduced the total level of uninsured people in the state. During the first four years of reform, the percentage of nonelderly North Carolinians without insurance fluctuated but remained below the national average (Table 1). In 1996, however, the percentage of uninsured increased sharply, and in 1997 North Carolina had approximately the same percentage of uninsured as the whole nation.

A better measure of the law's effect is to look at the aggregate and proportionate coverage in the portion of the market the law targets: small employer groups. Measured as a proportion of the nonelderly population, private insurance coverage among small groups has held mostly steady following reform. (Table 2 and Figure 1), as measured by the March Current Population Survey (CPS). Year-to-year fluctuations are most likely statistical anomalies due to the sample size in a state this size or due to changes in the wording of questions that occurred in 1994. None of these year-to-year changes in the CPS measure of small-group coverage are significant under standard statistical tests (at the 95% confidence level). It does not appear, then, from this measure that small-group reforms have significantly improved the level of private insurance coverage.

Judged from another source, however, small-group reforms appear more successful. The North Carolina DOI collects annual reports from insurers of their enrollment and premiums in the small-group market. The portion of the market for which the laws have been in effect the longest (since 1992) encompasses employers with 3-25 workers. For this segment, enrollment increased an average of 6% a year during the second, third, and fourth years of reform, but has leveled off over the following two years (Table 3). The law has included groups of one and 26-49/50 for a shorter time, but in these market segments there is also a modest upward trend, although enrollment has now leveled off or dipped for larger groups. One important caveat about these enrollment counts is that they are expressed in terms of the number of employees rather than in terms of total covered lives. Data for covered lives exist only for 1996 and 1997, and these data show a disturbing trend. Whereas the number of enrolled groups increased 4% from 1996 to 1997, the number of total lives in the small-group market dropped an alarming 25%, from 689,297 to 552,853. This appears to be due to an increasing trend, reported nationally, of employees who opt only to cover themselves but not their families, due to employers' increasing the amounts that workers must contribute to health insurance, especially for dependent coverage. This shift from family to single coverage is also shown by the statistic that, from 1996 to1997, the average number of employees per group dropped only slightly, from 5.7 to 5.0, whereas the average number of covered lives per group dropped sharply, from 10.8 to 8.3. Thus, in 1996, on average each employee accounted for approximately two covered lives,

Table 1

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

	1992	1993	1994	1995	1996	1997
North Carolina						
Nonelderly population	5,850,681	5,754,193	5,751,587	5,920,457	6,219,974	6,321,978
With employer coverage	63.1%	62.8%	66.4%	65.8%	68.7%	65.9%
With individual coverage	8.2%	8.8%	6.6%	5.9%	4.2%	5.8%
Uninsured	16.6%	17.0%	15.7%	16.7%	18.6%	18.0%
United States						
Nonelderly population	223,791,925	226,228,966	228,092,631	230,275,591	232,476,381	234,691,115
With employer coverage	61.9%	60.8%	64.8%	65.0%	65.1%	65.3%
With individual coverage	8.5%	9.2%	6.3%	6.0%	6.0%	5.8%
Uninsured	17.8%	18.1%	17.3%	17.5%	17.8%	18.4%

* < 65 and not active military

Source: Alpha Center analysis of March Current Population Survey

Table 2: Private Health Insurance Coverage in North Carolina by Group Size, 1991-1997

Percentage of Workers

Group Size	1991	1992	1993	1994	1995	1996	1997
Self-employed	75.33	72.77	70.06	65.06	76.30	68.52	66.35
<25	65.61	65.66	67.37	66.27	65.41	63.98	63.95
25-99	72.28	73.75	78.97	79.41	72.26	74.33	75.46

Source: Analysis of March Current Population Survey by Reenie Wagner

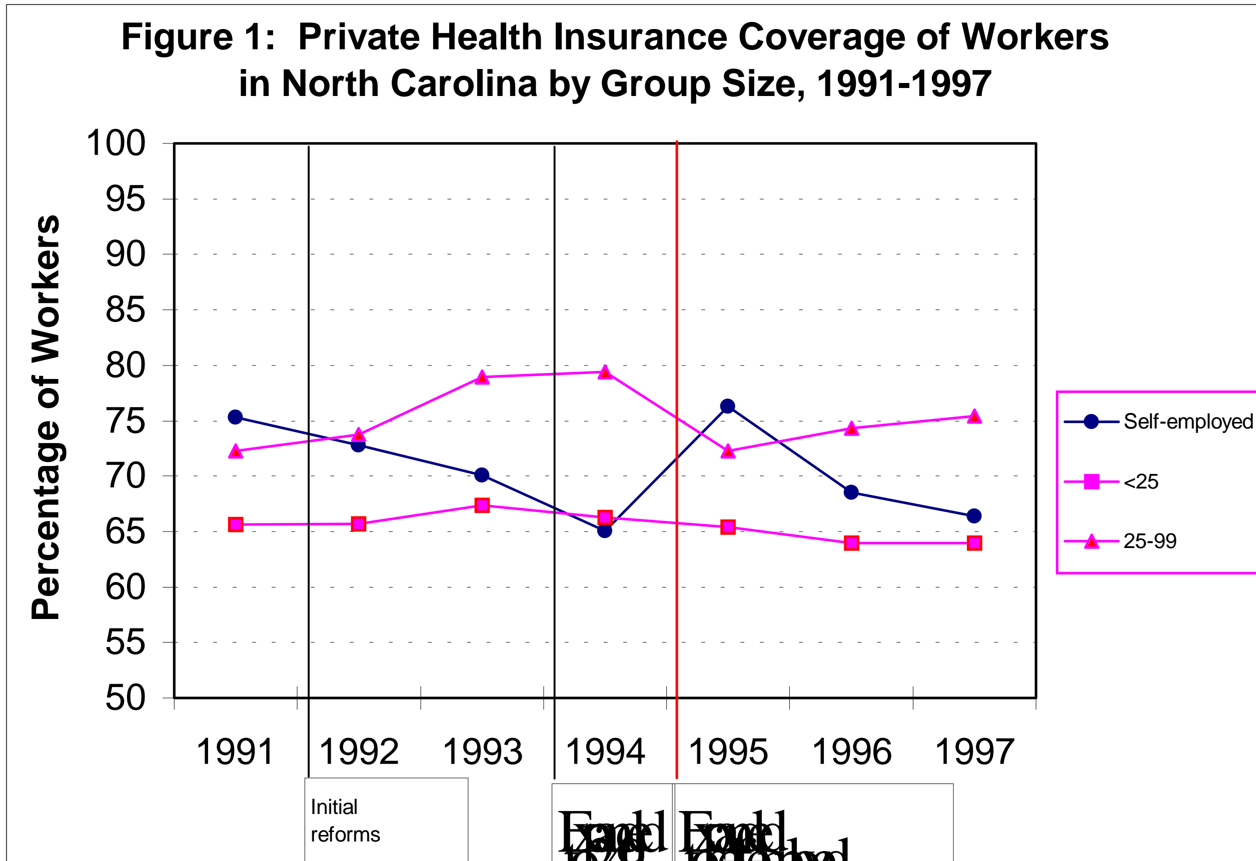

Figure 1: Private Health Insurance Coverage of Workers in North Carolina by Group Size, 1991-1997

Table 3

North Carolina Small-Group Enrollment, 1992-1997*

Group Size	1992	1993	1994	1995	1996	1997
3-25						
Groups	23,754	26,597	25,955	27,639	28,976	29,938
Employees	168,341	186,887	194,394	198,306	188,939	200,692
Average Size	7.1	7.0	7.5	7.2	6.5	6.7
2-49/50**						
Groups			34,464	38,577	39,057	40,443
Employees			283,068	289,463	340,835	306,048
Average Size			8.2	7.5	8.7	7.6
1-person						
Groups				23,712	24,876	26,341
Employees				23,712	24,876	26,341
Average Size				1.0	1.0	1.0

* Not including sales through Caroliance ** Upper limit on small-group size increased to 50 on 7-1-97

Source: NC Dept. of Insurance Small Group Annual Activity Reports

whereas in 1997 the ratio of covered lives to employees dropped to 1.66. This distinction between covered employees and covered lives may also explain the apparent discrepancy between the CPS figures reported above that show flat enrollment trends and the DOI figures which show increasing enrollment until recently. (Also, the CPS figures are a proportion of the population whereas the DOI figures are absolute enrollment counts, and so growing population accounts for part of this discrepancy.) Also, it is important to note that enrollment data from insurers are not audited and may contain significant errors. Therefore, great importance should not be attached to enrollment growth

that occurs in a single year.

Regardless, the DOI enrollment figures since 1992 indicate a healthy market. Another indication is the dramatic increase in the number of groups with *newly-issued* coverage each year. Newly-issued coverage for groups of size 3-25 increased from 6,000-7,000 in the early years of reform to over 12,000 in 1997 (Table 4). Similar increases have occurred in the other market segments. The sharp increase in newly-issued coverage coupled with only a moderate increase in total number of insured groups suggests either that some previously insured employers are dropping out of the market or that employers are switching from one insurer to another more frequently, or both. Nevertheless, an increasing number of groups and employees have coverage.

Some of this increased enrollment may not reflect net increases but merely movement from one market segment to another. Prior to reform, small-group insurers tended to avoid "micro" groups of five and under, viewing them as inherently higher risks due to greater adverse selection and also as much more costly to sell and administer due to higher transaction costs per person. Thus micro groups in the past frequently purchased insurance in the individual market. Extending the small-group law down to employer groups of one (i.e., to the self-employed) requires insurers to market their small-group products to this segment, which offers the prospect of better coverage at lower prices than are available through the individual market. This might result in considerable migration from the individual to the small-group market. We were not able to establish this directly. It is suggested by the CPS data in Table 1, which shows a drop in individual coverage. But most of this occurred in 1994, and so is most likely due to a change in the survey questions. The drop in individual coverage in North Carolina is no greater than that nationally, and individual coverage remained essentially the same since 1994, during the time North Carolina's law was extended to groups of two and one. However, one agent noted that the small-group law was especially successful in stimulating sales for micro groups, which previously the agent had not viewed as profitable business.

It is notable, though, that micro groups are concentrated in statutory plans. The average group size for statutory plans in 1996 was only 2.4 employees, which was much lower than the 5.7 average for the small-group market as a whole. Also, one-life groups purchase statutory plans at over twice the rate as do groups of size 2-49/50, and 50-60% of the statutory policies are sold to one-life groups (Table 4). These statistics indicate that one-life groups are still being shunned by insurers to some extent. Our interviews confirmed that some insurers are still refusing to sell medically-underwritten plans to one-life groups, opting instead to offer them only the state-mandated plans. This is done to minimize the underwriting losses produced by these groups since the rating rules, discussed below, do not allow rates to be adjusted based on group size. However, at least one large insurer has chosen to guarantee issue all of its plans to groups of one rather than treat them differently than other small groups.

Table 4

Newly Issued Small-Group Coverage, by Plan Type 1992-1997*

Group Size	1992		1993		1994		1995		1996		1997	
3-25												
Plan Type	**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**
Basic	9	33.3%	10	90.0%	10	50.0%	36	13.9%	23	26.1%	30	3.3%
Standard	63	63.5%	213	43.7%	192	54.7%	372	34.9%	263	22.4%	204	18.1%
Subtotal	72	59.7%	223	45.7%	202	54.5%	408	33.1%	286	22.7%	234	16.2%
Traditional	5,788	34.5%	7,030	33.2%	6,450	43.6%	6,385	30.9%	10,216	22.8%	12,597	22.7%
Total	5,860	34.8%	7,253	33.6%	6,652	44.0%	6,793	31.0%	10,502	22.8%	12,831	22.6%
2-49/50**												
Plan Type					**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**
Basic					14	64.3%	61	26.2%	49	32.7%	49	4.1%
Standard					306	56.5%	639	42.4%	496	25.0%	308	13.3%
Subtotal					320	56.9%	700	41.0%	545	25.7%	357	12.0%
Traditional					8,716	44.5%	12,795	28.0%	14,389	21.7%	16,114	20.8%
Total					9,036	44.9%	13,495	28.6%	14,934	21.8%	16,471	20.6%
1												
Plan Type							**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**	**# Groups**	**Prev Unins**
Basic							49	36.7%	90	42.2%	87	16.1%
Standard							755	48.7%	770	47.9%	531	21.1%
Subtotal							804	48.0%	860	47.3%	618	20.4%
Traditional							9,694	39.8%	10,609	31.0%	12,077	17.4%
Total							10,498	40.4%	11,469	32.2%	12,695	17.5%

* Not including sales through Caroliance

** Upper limit on small-group size increased to 50 on 7-1-97

Source: NC Dept. of Insurance Small Group Annual Activity Reports

2. Statutory Plans and the Previously Uninsured

Other than the micro segment, we cannot determine for sure whether and to what extent increased small-group enrollment is due to the reform law or instead to underlying economic and labor market conditions. Some insight is possible, however, by observing how many new policies are issued to previously-uninsured groups and how many policies were being issued as state-mandated guaranteed-issue plans (or "statutory plans") prior to 1997 when only these plans were sold on a guaranteed-issue basis. Focusing on the first measure, previously uninsured is defined by the DOI as lacking group insurance during the month prior to enrollment. This can include groups that were chronically uninsured, new businesses, groups whose previous insurance lapsed for only a short time, and previously-insured individuals switching to small-group coverage. Given the loose nature of this definition, and questions about the accuracy of insurers' data, there is serious doubt about how meaningful the following statistics are. Nevertheless, it is noteworthy that, in the initial years of reform, 30-40% of new subscribers were reported as being previously uninsured, while 20% are reported to be previously uninsured in recent years (Table 4). Selling a sustained 20% of newly-issued coverage to previously-uninsured groups is remarkable; however, we do not have confidence that this statistic is accurate and meaningful.

Another important indication that the law has not increased availability is that only a small number of groups purchased statutory plans during the time these were the only plans that were required to be guaranteed-issue. Statewide, only 4,500 statutory plans have been sold from 1992 to 1997, and over half of these sales have been to one-life groups since 1995 (Table 4). Over the years in market segments other than the self-employed, only 2-5% of new sales have been statutory plans. And even for the self-employed, statutory plans have accounted for less than 10% of sales. The basic (low benefits) plan has been particularly unsuccessful, with sales to only about 418 groups over the entire six-year period of reform (Table 4). One agent, who is active in the small-group market, told us he has never sold a single one of these plans, and has offered them only twice. One national commercial carrier had sold only three statutory plans through 1996.

Various explanations are available. First, there may be low demand for these products, even by groups that traditionally cannot obtain insurance. It is notable that, prior to HIPAA, only about 40-50% of the statutory plans were issued to groups previously without insurance, and this percentage drops into the mid-20s by 1996, except for the self-employed (Table 4). It may be, however, that some or most of those who purchased these plans who previously had other coverage were doing so because high rate increases from their previous insurer forced them to switch, and without the guaranteed-issue plan they would have dropped coverage.

It is puzzling, though, that even prior to HIPAA, the percentage of previously-uninsured purchasers was about the same for medically-underwritten policies as for the guaranteed-issue plans, and the difference narrowed over time, for instance, 26% vs. 22% for groups of 2-49 in 1996 (Table 4). This is in accord with the views of some interview subjects who said that, because insurers preferred to sell their traditional benefit plans rather than being forced to offer statutory plans, the guaranteed-issue requirement

caused them to loosen their underwriting criteria for their medically-underwritten plans. In other words, borderline applicants who previously would have been turned down were being accepted in medically-underwritten plans rather than being offered statutory plans, in order to avoid having to sell and service a plan that did not fit the insurer's normal benefit structure. Other interview subjects said the contrary, however, namely, that the availability of the statutory guaranteed-issue plan encouraged insurers to tighten their underwriting criteria and to send all questionable risks to the guaranteed-issue pool. Or they said that underwriting criteria have not changed.

There are other explanations for the fairly even distribution of previously-uninsured purchasers among guaranteed-issue and medically-underwritten policies prior to HIPAA. First, groups previously without insurance are not necessarily high risk. As noted above, the period without insurance is only 30 days, and many new purchasers are healthy groups that are new businesses or that simply decide for the first time to offer insurance. Second, those new purchasers who are higher risk often shopped around until they found a carrier that would issue an underwritten plan. Both insurers and agents told us that rejections of underwritten coverage and the automatic offer of a statutory plan rarely resulted in a decision to purchase the statutory plan. Instead, agents took the application to other insurers hoping to find underwritten coverage.

A further possible explanation for the low sales of statutory plans is that they may have been priced so much higher than underwritten coverage that no one with a choice would buy one, and those without a choice would still have found statutory plans too expensive. Rating restrictions are intended to avoid this result, but there is considerable evidence that it was occurring nevertheless. First, rating rules allow a +/-20% spread based on health risk or claims experience. On first appearance, one might think that statutory plans therefore could never be more than 20% higher than average underwritten plans, but that is not the case. In order to make maximum use of the allowable spread of 40 percentage points between high and low risks, actuaries often rate standard-risk applicants near the bottom end of the spread, not the middle, thereby allowing an increase of almost 50% based on health risk. For example, one might think that a rate of $100 for average-risk subscribers would yield a spread of rates from $80 to $120 for low- and high-risk subscribers. However, if an insurer uses $100 as its lowest rate by refusing to issue any preferred rates, it could charge high risks up to $150 for identical coverage and demographics.

Although we encountered no insurers who went to this extreme, some we spoke to came close by issuing most of their coverage within 10% of the bottom of the rate band. One agent said that expanding guaranteed issue to all plans in 1997 "didn't change anything," because the ability of insurers to increase rates this much for higher risks does almost as much to discourage purchase as did refusing coverage prior to HIPAA. This agent noted that, as a result of HIPAA, insurers were intensifying their medical underwriting for traditional plans and asking for more medical information, in order to make better use of the leeway in the rating bands.

Second, rating rules also allow adjustments for actuarial differences in benefits among different plans. Valuing benefit differences is a matter that entails actuarial judgment, and for which there are different techniques. One technique is to declare that benefits are worth the claims cost they generate, so

that different benefit packages are rated accordingly to the claims experience for the entire pool of subscribers to each package. The difficulty 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. Following solely the 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.

Actuarial anomalies appear to have affected rates for the statutory plans in North Carolina. The standard statutory plan contains somewhat leaner benefits than are contained in most insurers' medically-underwritten plans, and the benefits of the basic plan are considerably leaner. Nevertheless, a compliance study performed by the DOI Market Examination Division at the end of 1993 found that insurers on average were charging <u>more</u> for both basic and standard statutory plans than they were for their underwritten coverage. The rate differences were sometimes dramatic. One carrier charged $209 for the standard statutory plan, $153 for the basic plan, but only $71 for its underwritten plan. For another, the rates were $145 and $101 for standard and basic, versus $70 for underwritten, and there were several other examples of a similar magnitude.

Data do not exist to determine conclusively whether this same pattern continued into subsequent years, but there are indications it did, only to a lesser extent. Two actuaries we spoke to said that product-specific claims experience can be and is used to price statutory plans, but three others said this was improper, contrary to the law, or prohibited by the DOI. We performed a data analysis that provides an approximate comparison of rates for statutory and underwritten plans in 1994 and 1998. Statutory rates were obtained in surveys conducted by the DOI in 1994 and 1998, for different age and family compositions. We used rates for an employee in his/her 30s with coverage for the spouse but no children. We compared these standard plan rates with an average market rate for each carrier constructed from aggregate premium and enrollment data. This constructed average rate was done by dividing total small-group premiums by the total number of employees covered, to produce an average premium per covered employee. We do not know whether this average is in fact comparable with the age and family assumptions in the DOI survey, but this rough approximation is the only one available to us. Based on this comparison, it appears that carriers are using widely different rating strategies for standard statutory coverage versus traditional coverage (Table 5). In 1994, looking at the top eight carriers for which data were available, two charged significantly less for the statutory coverage ($30 and $41 less per month) whereas four charged significantly more ($21-$45 more per month) and two charged about the same for each type of coverage. In 1998, these disparities widened. Of the top 11 insurers, three charged about the same and two charged significantly less for statutory coverage ($29 and $48 less per month), but two charged significantly more ($24 and $32 more per month) and five charged substantially more ($86-$146 more per month).

It does not appear that the DOI closely scrutinizes rate filings to ensure compliance with the rating rules. Insurers must file actuarial certifications with their rates that contain the following or similar

language: "Rate differences due to differences in plan design only reflect benefit differences," and "Neither rates nor rating factors associated with the statutory standard and basic plans give recognition to the guaranteed-issue feature of those plans." This language addresses this concern to some extent, but it only prevents actuaries from explicitly including health status and selection factors in their rates. It does not prevent their using other factors that serve as proxies for selection and health status effects, nor does it resolve the contention that one legitimate way to measure benefit differences is to refer to actual utilization for each product. Moreover, we found no indication that the DOI requests or scrutinizes the data and actuarial philosophies that underlie these certifications.

Table 5

Comparison of Average Premiums and

Standard Plan Rates for Top Small-Group Carriers*

1994		
	Standard Plan	
Carrier	**Rate**	**Difference**
Blue Cross	$ 215	$ 30
Fortis	172	(30)
Guardian	231	21
John Alden	162	5
Kaiser	292	2
Mid-South	167	30
Prudential	196	(41)
Travelers	192	45

* Top carriers by premium volume in 1994

Pursuing further the low sales of statutory plans, it was observed above that these plans are unpopular with insurers, and that agents also tend to avoid them in favor of traditional plans. We inquired

into the source of this unpopularity. To some degree, it is simple philosophical antipathy to government intervention in the market. Of course, it is not just the government that constructed the benefit package; this work was done by a committee composed of insurers and agents. But it is the government that imposes the mandate, and so the plans carry an ideological taint for some. Agents tend to describe them to their clients as "state-mandated" plans. Also, both insurers and purchasers like to individualize their benefit packages. For insurers, this is one way to express their product and corporate identity and so attempt to distinguish themselves from their competitors. One agent also observed that, because the industry considers the statutory plans as being designed for "inferior" or "substandard" groups as "coverage of last resort," they are also unpopular with purchasers, who view these characterizations as an insult or unflattering.

Another explanation we were given is that administering the statutory plans is difficult and expensive. When insurers create and modify their own benefit packages, they make certain system changes that help to automate rating and claims processing decisions. This comes at an expense, and if it is not done, rating and claims processing by hand is much more time consuming. Being forced to add another benefit plan, however minor the differences, adds to the system costs, not simply because it is yet another variation, but sometimes because the benefit structure is incompatible with the insurer's system. For instance, hospital benefits might be structured by days, dollar amounts, or diagnosis. A system designed for one structure does not adapt well to a different structure in benefits. However, we did not determine whether inconsistencies in benefit structures are fundamental, widespread, or significant.

These explanations can be compared with the more obvious reason to disfavor the statutory plans, namely, that because prior to HIPAA in 1997 they were the only guaranteed-issue plans, they were bound to attract much higher risks and the rating restrictions ensured that carriers would experience a high loss ratio for these plans. Some preliminary indication that this is not the sole basis for disfavoring these plans is that, in 1997, the first year that all plans were guaranteed issue, the proportion of newly-issued coverage that went to statutory plans did not improve but in fact dropped almost in half. (Table 4). Much of this decline was certainly due to the fact that guaranteed-issue business is now going to all plan types, as indicated by the 50% drop in the portion of statutory plans going to previously-uninsured groups. But, this slack created by the redistribution of high risks was not taken up by increased sales of statutory plans to average or low risks. So, for whatever reason, statutory plans remain unattractive.

As a consequence, insurers take a number of steps to keep a low profile in the market with respect to these plans. First, they do not actively market or advertise them. Prior to HIPAA, the statutory plans were usually offered only as an alternative once coverage was declined for a traditional plan. This offering was not made with the slick, color brochures that insurers usually use; at best, insurers sent a plain, single-page summary of benefits, or sometimes they sent nothing at all, leaving to the agent the task of explaining the plan contents. As a result of this "planned lack of response," one agent observed that, from an agent's perspective, "it's as if these plans don't exist."

Insurers also discourage the sale of statutory plans by lowering the commissions they pay. Typical is a 5% commission on statutory plans, compared with 8-10% for medically-underwritten plans. In defense of this practice, insurers argue that since they offered these plans as a public service and were losing money

on them, agents should also make some sacrifice for the public good. Moreover, to the extent that high-risk groups can be charged higher premiums, net commissions are not all that much lower even though the commission rate is lower (that is, 5% of a higher premium may be almost as much as 7% of a lower premium). Insurers also observe that it is standard industry practice to pay different commissions for different products and in different parts of the market, according to expected profitability. On the other hand, the legislation requires fair marketing of the statutory plans. However, the DOI has declined to interpret this as requiring the same commission level. Traditionally, it has lacked authority to regulate commissions, and the small-group law does not specifically give it this authority. The DOI believes that its authority is restricted to situations where insurers penalize or reward agents directly in proportion to the loss ratios experienced on their clients. Moreover, the statutory requirement of fair marketing applies only to the standardized plans, so insurers are free to engage in selective marketing so long as the statutory plans are treated no differently. Thus, for instance, the DOI believes it is permissible to lower commissions for micro groups of one or two employees if this is done consistently for both statutory and traditional plans.

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

Does it occur in North Carolina? We found several indications that it does, confirming similar findings by the DOI in its 1993 market conduct exam. Most subjects conceded that some forms of field underwriting occur, defined as discouraging or steering away higher-risk applicants. One agent referred to a :planned lack of response" by some insurers to requests for information about their offerings to high-risk clients. This agent said in addition that some insurers encourage agents to send these applicants to other insurers who put up less resistance. Another subject, who is also involved in sales, said that, prior to HIPAA, some carriers did not let bad applications go to home office underwriting; instead, field representatives screened out applications from agents that clearly would never meet underwriting requirements, or told agents not to bother to send such applications in. As a result, the statutory requirement of offering a statutory plan was never triggered. One insurer subject conceded that this happened at the subject's own company, and speculated that some of its competitors were slow to act on unfavorable applications.

Whether by design or by accident, it is clear that the burden of selling guaranteed-issue plans does not fall evenly across the market. One agent commented that some insurers, such as Blue Cross, the HMOs, and some of the larger commercial carriers, have a reputation for being more "socially oriented," and

therefore resisting guaranteed-issue plans less. When agents have uninsurable or high-risk clients, they tend to send them down these paths of least resistance. Our analysis of the data confirms this is the reputation of the leading HMOs, but reveals somewhat to the contrary that Blue Cross and other top indemnity carriers issued a disproportionately low number of guaranteed-issue plans (Table 6). In 1996, statutory plan

Table 6

Statutory Plan Enrollment for Top Small-Group Carriers, 1996*

Carrier	Basic Lives	Standard Lives	Statutory Lives	All Lives	Statutory as % of All Lives
Blue Cross/Blue Shield	9	1,120	1,129	285,127	0.40%
Employers Health	1	77	78	16,715	0.47%
John Alden	5	369	374	46,451	0.81%
Kaiser	59	823	882	13,179	6.69%
MAMSI	39	-	39	27,933	0.14%
Mid-South	1	651	652	20,450	3.19%
New York Life	-	192	192	13,754	1.40%
PFL Life	59	226	285	17,716	1.61%
Principal Mutual	-	969	969	58,647	1.65%
TMG Life	-	101	101	11,438	0.88%
Trustmark	-	123	123	12,346	1.00%
United HealthCare	4	733	737	29,372	2.51%
United HealthCare of NC	85	316	401	26,731	1.50%
Total	262	5,700	5,962	579,859	1.03%

* Top carriers by covered lives; not including sales through Caroliance

Source: NC Dept. of Insurance Small Group Annual Activity Reports

enrollees accounted for almost 7% of Kaiser's small-group enrollment and more than 2% of United HealthCare's. All of the other insurers had less than this, except for Mid-South, at over 3%. Blue Cross and Employers Health are notably low, at less than 0.5%, and MAMSI is by far the lowest at .14%. We stress, however, the point made earlier that some insurers such as Blue Cross claim that they liberalized their underwriting criteria for their traditional plans rather than issuing statutory plans that do not fit well within their administrative structures. Therefore, these figures may not reflect how well these insurers are meeting their social responsibility overall. For instance, the overwhelming majority of business sold by PFL Life in 1995 and 1996 was to one-life groups, although less than 2% of its enrollees in 1996 were in statutory plans.

3. Portability, Renewability, and Preexisting Condition Limitations

The portability and preexisting condition provisions in the law are widely popular among our interview subjects and appear to have been implemented without much difficulty. No one complained that the preexisting limits were too short or too long. Presaging HIPAA, the portability provisions were expanded in 1996 to include movement into small-group coverage from individual, large-group and government insurance, and no one voiced any concern about this expansion. Several interview subjects pointed to these provisions as being the most successful and beneficial aspects of the reform law. The only concerns raised had to do with interpreting these provisions, for instance, administrative questions about what types of prior coverage are similar enough to qualify, but this concern was not widespread.

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

4. Overall

On balance, the insurance reforms in North Carolina have produced mixed and muted results with respect to the availability criterion. These laws have not produced a huge influx of new subscribers. However, there has been a significant increase in the number of small employers offering coverage. Whether this is attributable to the law or instead to economic and demographic factors is difficult to disentangle. At least it can be said that the deterioration in this market that preceded these laws has been halted, and possibly reversed.

In addition, coverage is now more available for high-risk groups. Prior to HIPAA, availability was hampered, however, by several factors that discouraged the purchase of the statutory plans. Several of these factors appear to be the result of manipulating, circumventing, or perhaps outright violating the law. This situation is altered to some extent by changes in the law to comply with HIPAA, but not entirely. Making all small-group products guaranteed issue can be expected, over time, to even out differences in risk pools

among products and diminish the role of the statutory plans. However, the ability to avoid high risks or to segregate risk pools through selective marketing, field underwriting, and differences in benefit structures will remain, as will the potential for reflecting risk selection effects in rates under the guise of benefit differences.

B. Affordability

1. Prices

Health insurance costs for small employers have held remarkably steady over the initial years under reform, especially compared with the double-digit increases that were common in the late 1980s, but rates have begun to increase sharply once again. We computed the average premium per employee for each of the top 10 insurers in the 2-49 small-group market for 1994 to 1997. This is an average across all small groups and all products for each insurer, unadjusted for any differences or changes in benefits or in the age, gender, or family composition of the risk pools. Thus, changes and differences might reflect these factors rather than underlying price value. Still, these are the best indicators available of average market trends.

The median premium per employee among these top insurers decreased slightly over the first three years, but then jumped 25% in 1997 (Table 7). Similarly, agents and insurers reported level prices or only modest increases in earlier years, but much sharper increases of 10-15% in 1997. As one actuary put it, "The good times are over."

Whether the earlier price restraint or the recent price increases are due to the reform law is a separate question. Premium increases were similarly subdued across the country, in large part due to the shift to managed care. The shift to managed care not only potentially held down medical costs, but also created an intensified competitive dynamic (discussed more below) in which insurers were sacrificing profit in order to gain market share. Several interview subjects referred to insurers who have been aggressively "buying market share" in this fashion, but who now are having to make up for declining loss ratios. Similar accounts were heard in many other locations throughout the country.

In any event, it is clear the reform laws have not driven up prices to the extent that some opponents feared would happen. Rating restrictions have this potential by increasing costs for healthier subscribers, thereby at the margin driving some from the market, and by lowering costs for higher risks, thereby attracting more into the market. This rate compression, coupled with guaranteed issue, was expected by some to increase average prices noticeably, but our data show few signs of adverse selection against the market. Subjective opinions from our interviews largely confirm this picture. For instance, actuaries said they did not add anything into their 1997 rates to anticipate increased adverse selection due to making all products guaranteed issue. However, a few subjects continue to say that there is adverse selection against the small-group market. One indication is that median claims cost per employee is increasing noticeably, from $133/month in 1994 to $181/month in 1997, an average of 12% a year (Table 7). Assuming benefits and family composition remain steady (which they have not), this indicates a worsening of the overall health status of the insurance pool.

Table 7

Market Data for Top Small-Group Carriers in the 2-49/50 Market, 1994-1997*

1994					
Carrier	**Market Share**	**Prem/ Employee**	**Difference From Median**	**Claims/ Employee**	**Loss Ratio**
Principal Mutual	16%	$ 128	$ (56)	$ 111	87%
Mid-South	3%	137	(47)	113	83%
Travelers	6%	147	(37)	99	68%
John Alden	12%	157	(27)	124	79%
Lincoln National Life	5%	183	(1)	140	77%
Blue Cross/Blue Shield	44%	185	1	163	88%
Fortis	2%	202	18	133	66%
Guardian	6%	210	26	162	78%
Prudential Ins.**	3%	237	53	143	60%
Kaiser	3%	290	106	UN	UN
Total	100%				
Median Prem/Employee		**184**			
Mkt Share at/below Median	**43%**				
High Prem/Low Prem		**2.3**			
Median Claims/Employee				**133**	

1995					
Carrier	Market Share	Prem/ Employee	Difference From Median	Claims/ Employee	Loss Ratio
Trustmark	3%	$ 149	$ (31)	$ 134	90%
Travelers	7%	153	(26)	138	90%
Principal Mutual	18%	168	(12)	143	85%
Mid-South	4%	169	(11)	132	78%
John Alden	13%	171	(9)	148	87%
Employers Health	3%	189	9	152	80%
Blue Cross/Blue Shield	41%	197	17	180	91%
Guardian	5%	223	43	179	80%
Kaiser	4%	325	145	UN	UN
Prudential Ins.	3%	353	173	258	73%
Total	100%				
Median Prem/Employee		**180**			
Mkt Share at/below Median	**45%**				
High Prem/Low Prem		**2.4**			
Median Claims/Employee				**148**	

* Top carriers by premium volume; not including sales through Caroliance;

upper limit on small-group size increased to 50 as of 7-1-97

** Includes Prudential Health Care Plan in 1994

UN=Unknown

Source: NC Dept. of Insurance Small Group Annual Activity Reports

1996					
Carrier	Market Share	Prem/ Employee	Difference From Median	Claims/ Employee	Loss Ratio
Blue Cross/Blue Shield	44%	$ 132	$ (43)	$ 120	91%
United Healthcare of NC^	5%	144	(31)	102	71%
Mid-South	4%	170	(5)	126	74%
MAMSI	4%	170	(4)	172	101%
TMG Life	3%	171	(3)	159	93%
Travelers/United Healthcare	6%	177	3	171	97%
Trustmark	3%	192	18	166	86%
Principal Mutual	16%	226	52	171	76%
John Alden	11%	227	53	191	84%
Kaiser	4%	288	114	UN	UN
Total	100%				
Median Prem/Employee		**174**			
Mkt Share at/below Median	**60%**				
High Prem/Low Prem		**2.2**			
Median Claims/Employee				**166**	

^ PHP before 1996

1997					
Carrier	Market Share	Prem/ Employee	Difference From Median	Claims/ Employee	Loss Ratio
Employers Health	5%	$ 88	$ (130)	$ 73	83%
MAMSI	8%	122	(97)	182	150%
Principal Health Care	3%	137	(81)	98	71%
United Healthcare of NC	10%	156	(62)	121	77%
Fortis	3%	204	(14)	180	88%
Principal Mutual	12%	232	14	177	76%
TMG Life	3%	234	15	183	78%
Blue Cross/Blue Shield	49%	243	25	229	94%
Guardian Life	3%	266	47	193	73%
Trustmark	5%	293	75	265	90%
Total	100%				
Median Prem/Employee		**218**			
Mkt Share at/below Median	**28%**				
High Prem/Low Prem		**3.3**			
Median Claims/Employee				**181**	

Summary	1994	1995	1996	1997
Median Prem/Employee	$ 184	$ 180	$ 174	$ 218
Mkt Share at/below Median	43%	45%	60%	28%
High Prem/Low Prem	2.3	2.4	2.2	3.3
Median Claims/Employee	$ 133	$ 148	$ 166	$ 181

2. Rating Practices

Apart from effects on the average are the effects at the extremes. Rating bands require price reductions for some groups but price increases for others. We inquired whether the move to rating bands and the tightening of the bands resulted in any "rate shock" in which some subscribers received large increases and decided to drop coverage. Most subjects responded that they heard of a number of vocal complaints at the time the +/- 20% rating bands took effect, and could remember some "horror stories" where some groups in lower-risk blocks received rate increases as high as 70-100%. Groups that were covered through professional trade associations were the hardest hit because they had the most select risks. Some of the outcry was precipitated by insurers and agents who, when they sent out notices of rate increases to subscribers, explained that the increase was mainly due to the recent small-group reform, and encouraged subscribers to write their legislators and call the insurance department if they did not like it. However, few of our subjects thought that this resulted in groups dropping coverage. Usually, after "hollering and screaming," these groups came to understand the reason for the increase and learned that they could not obtain better prices elsewhere, so most of them ended up keeping their coverage, perhaps opting for lower benefits or for a managed care plan. It may be possible, though, that rate increases caused some individuals within covered groups to decline coverage offered by their employer.

One negative mark on affordability is the point explained above that rating rules for the statutory plans were manipulated by some insurers to produce prices for the guaranteed-issue plans that were significantly higher than market averages. This may have discouraged higher-risk groups from obtaining this coverage, as suggested by the fact that these plans attracted about the same percentage of previously-insured enrollees as did medically-underwritten plans (Table 4).

Also, most subjects said the 15% limit on rate increases above trend does not have much effect. If trend is 5-10%, this still allows rate increases for some plans as high as 20-25% each year. The ability to compound these rate increases year after year is limited to some extent by the rating bands. But some insurers create the maximum room for upward movement by setting their standard rate near the bottom of this spread rather than at the middle, thus allowing a particular group to be moved up almost 50% on top of trend over several years if it experiences high claims. Agents said that, as a result of these tactics, some of their clients still complained about rate increases, even in years when marketwide prices were very stable. No one complained that the 15% restriction is too stringent.

C. Market Competition

1. Market Concentration and Volatility

As noted above, the insurance market for small employers has been a highly competitive one over the past several years. This can be seen in several ways. Looking first at structural features, there are a large number of insurers still in the market, and the market has not become excessively concentrated. The total number of carriers registered to sell small-group insurance grew from 60 in 1992 and1993 to 73 in 1996 and 1997. Although a number of prominent insurers have left recently and others have consolidated, several

new insurers, including HMOs, have entered the market. Over this time, market concentration (meaning the market share possessed by the largest companies) has remained virtually the same. In 1992, the top 10 insurers had 77% of the market and the top three had 55%, compared with 73% and 53% in 1997. There is also movement in and out of the top 10, indicating that the market is fluid. Only four companies have stayed consistently in the top 10, although the top two companies, Blue Cross and Principal Mutual, have remained unchanged. It is important to stress that effective competition in any given location may be much slimmer than is suggested by the total number of insurers in the state, since many of these insurers do not offer competitive rates and they often concentrate in only certain regions. Also, some insurers were able to use the transition to all-products guaranteed issue under HIPAA to stop selling new coverage altogether without having to officially withdraw and cancel all their existing subscribers. Perhaps reflecting these developments, one agent said in 1998 that the small-group market in his medium-sized city is down to just one or two good companies, mainly HMOs, in contrast with the 6-8 companies he offered a couple of years ago.

Some companies have had substantial increases or decreases in small-group business, and for some their small-group business has fluctuated dramatically. MAMSI stands out as a company that suddenly appeared among the top ranks of the small-group market, showing up as number six in 1996 and number four in 1997. Some interview subjects attribute this to MAMSI's aggressive pricing, which was described either as "low balling" or "buying market share." Others observe that new market entrants are inherently able to offer lower premiums because, all things being equal, newer risk pools are healthier than older ones. This is due to three factors: new subscribers are still subject to preexisting condition exclusions; freshly-underwritten groups are uniformly healthier than a pool that contains groups that have renewed over a number of years; and people with health problems are reluctant to switch insurance in the midst of treatment. So even without underwriting, new subscribers tend to be healthier than renewing subscribers.

As a consequence of these advantages, new market entrants were able to quickly gain market share by pricing aggressively. Some insurers try to seize on this advantage by creating new subsidiaries or product offerings to separate their new subscribers from their existing pools. This results in a situation that some subjects view as an unhealthy degree of market volatility. Others, naturally, might view this as favorable price and product competition.

Regardless, it is not clear whether this market activity is a consequence of these reform laws. It clearly existed to some degree before these laws, but the laws appear to amplify it to some extent. First, portability makes it easier for subscribers to switch insurers in order to save a few dollars. Most insurers report that their retention (or persistence) rates (the percentage of subscribers that renew, or the length of time they stay with the carrier) have dropped significantly following enactment of these laws. Second, guaranteed renewability ensures that unhealthy subscribers can keep their coverage, thereby magnifying the difference between newly-enrolled and renewal subscriber pools. Third, rating bands limit the extent to which insurers can establish different rates for different risk pools if the benefits are the same, which hampers existing insurers from competing directly with new market entrants by offering lower rates for newer business.

It is debatable how serious a problem this is. Undoubtedly, some insurers are hit harder than others, which is unfair and undermines the goal of using competitive forces to promote true economic efficiency. On the other hand, the effects of initial underwriting wear off rather rapidly, and so new insurers often find that they have to raise their rates steeply after just a year or two, especially if they underpriced initially relative to the risks they received. Notice, for instance, the very high loss ratio for MAMSI in 1997 (Table 7). This will lead to rapid enrollment declines since existing healthy subscribers will leave and the insurers will not attract new enrollees. Moreover, the fact that rating bands allow some rate flexibility means that existing insurers can respond to some degree by offering preferred rates, so long as their normal pricing is in the middle of the bands (which it may not be due to other strategic concerns mentioned above).

Nevertheless, there have been substantial shifts in market share among top insurers following enactment of the small-group laws. Although Blue Cross remains the market leader, some indemnity insurers have fallen, at times precipitously, while others have risen, occasionally dramatically. This is viewed by some people as an unhealthy level of market volatility, and by others as a sign of a healthy degree of competitive fluidity. Fluidity or volatility might also be used to characterize the movement of groups among insurers, even if market share holds steady. As noted above, the rapid increase in the amount of new business that carriers report each year, compared with the more modest increase in overall market enrollment (Tables 3 and 4), indicates that a good bit of new business comes from groups that switch insurers. This is confirmed by our interview subjects, who say that small employers are very price sensitive and are willing to switch insurers to save even modest amounts.

2. Price Competition

It could be expected that this price competitiveness would be reflected in data about insurers' relative prices. In 1994, the DOI conducted a price comparison for all insurers, based on the standard statutory plan for an employee age 30-39. The DOI was surprised to find that rates varied 3-4 fold, and it took this as a sign that purchasers were not shopping around enough; otherwise, insurers whose prices were this much out of line could not sustain such large disparities. However, this may not be the correct conclusion to draw. First, this survey only included the standard "statutory" plan, which as explained above insurers are not eager to sell. Prices might be much more in line with each other for the more favored products. Second, by looking at all 60-plus registered insurers and giving each equal weight, this survey includes many insurers who are not active in the small-group market, and it does not reflect whether most sales are being made by the lower-priced companies. For various business strategic reasons, some insurers are theoretically in the market but are not actively seeking new business, and so do not price their products competitively. In some cases this happens because in a prior year, the insurer was <u>too</u> price competitive and suffered heavy losses it is now trying to recoup.

To provide a more revealing picture of the price competitiveness of the small-group market, we performed a different analysis. We looked at insurers' average premiums for all small-group products (except one-life groups), not just the statutory plans, and we looked only at the top 10 insurers in order to focus on the three-quarter portion of the market where most insurance is sold. We then examined how close each insurer's average premium was to the median figure for the top 10, and observed whether there was

any relationship between relative market price and market share. These figures are displayed in Table 7. One important caveat: these premium averages are only approximations of relative price, since they do not account for differences in benefit packages among insurers, or for differences in their respective risk pools (e.g., having relatively younger or older policyholders or different family compositions). Therefore, these figures do not, strictly speaking, compare apples to apples. Nevertheless, they are the best insight we have, and we think they are reasonable approximations.

Examination of Table 7 reveals several interesting facts. First, there is surprising spread of over twofold in average premiums even among the top 10. Second, observe that most of the enrollment among these top 10 is in plans that are priced near or below the median most years. In years where this is not the case, it is because Blue Cross, the market leader, was higher than the median. But in most of those years. Blue Cross is close to the median. The exception is 1997 when Blue Cross is more than 10% above the median. Third, observe that those insurers that start this time period at or below the median (Travelers, Principal Mutual, John Alden, and Blue Cross) tend to remain market leaders, whereas those who start above the median (Guardian, Prudential, Fortis, and Kaiser) tend to remain at the bottom or drop out of the top 10. In other words, lower-priced carriers retain market share and higher-priced carriers lose market share or do not gain.

Another indication of price competition comes from the DOI's 1998 rate survey. This data is much more precise because it allows us to compare exact rates, not just premium averages, for specified age and family compositions for the standardized plans. As shown in Table 8, HMO rates among market leaders vary over a range of only 1.22:1 and PPO rates range from 1.46:1. The overall impression, then, is that this is a competitive and rational market with respect to price, although there are signs of diminishing competition in 1997.

It is debatable whether the reform law is responsible for these competitive conditions. Most interview subjects opined that it is not, since they viewed price competitiveness as being due mainly to the movement to managed care, which is happening nationwide and independent of these laws. These subjects viewed the small-group market as simply the next logical place for HMOs to look for sales growth after the large-group market began to become saturated, and price competition was intensified by the struggle for foothold market shares. On the other hand, this movement largely coincides with these laws, and the laws are also nationwide. There are several possible theories about why the law might have helped to precipitate the move to managed care and the resulting price-competitiveness. First, HMOs are accustomed to offering open enrollment and modified community rating; these laws helped to level the playing field by requiring other insurers to do business on the same terms. Second, to the extent these laws caused any rate shock effect, they may have provoked subscribers to look around for alternatives more quickly than if prices had continued to climb at a more gradual pace. Their ability to do so is attributable in part to the portability provisions in the law.

Table 8

1998 Standard Plan Rate Comparison of Top Small-Group Carriers*

Carrier	HMO	PPO	Indemnity
Blue Cross	$ 339	$ 280	$ 369
Healthsource	415		
John Alden		405	473
Kaiser	388		
MAMSI		353	407
Mid-South		331	363
PFL Life		365	477
Principal Mutual		304	450
Trustmark		391	403
United HealthCare		321	423
United Healthcare of NC	390		
United of Omaha		408	588
High Rate/Low Rate	**1.22**	**1.46**	**1.62**

* Top carriers by premium volume in 1996; rates shown are statewide averages of monthly preferred rates for family coverage for a 30-year-old employee in a new group purchasing a statutory standard plan effective March 1, 1998.

Source: NC Dept. of Insurance 1998 Premium Survey

Another way the reform law might promote price competition is by creating standardized benefit packages that serve as reference prices. Historically, one problem with price shopping is that intricacies in benefit packages make it extremely difficult to evaluate comparable products. Seemingly minor differences in benefits can account for significant differences in price. In theory, statutory plans could help to reduce this problem. Even though they are not selling well, they might serve as a barometer of each insurer's relative price competitiveness, so purchasers have some idea of whether the medically-underwritten policies are a good value. In North Carolina, the statutory plans are not serving this function, however. First, due to the various rating strategies and discrepancies discussed above, it is very questionable how revealing an insurer's statutory rate is about its rates for more popular plans. Second, comparative rate information is not regularly collected and disseminated by the DOI. In its 1994 rate survey, the department stated that it would repeat the survey if it proved useful, but this was not done again until 1998, and we have seen no indication that the results are being widely disseminated. In 1997, calls to the department's 1-800 number for small employers produced only limited information, namely, a list of all 60-plus companies that offer small-group health insurance and phone numbers to contact them, but no comparative information about prices, benefits, market share, or consumer complaints.

Still, meaningful price comparisons are feasible even without standardized benefit plans because of the role that insurance agents play in advising purchasers. As discussed below, small employers traditionally have relied heavily on independent agents for advice, and they continue to do so even where direct-purchasing options exist. Agents bring considerable expertise to bear on judging the relative value of different benefit packages and their pricing, thereby greatly simplifying purchasers' decisions.

3. Non-price Competition

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

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

What is noticeably absent in the small-group market is any form of competition based on outcome measures of quality. As explained by one agent, "quality" in his vocabulary refers to the quality of the benefits, that is, how comprehensive they are, and to the quality of the insurer's claims service, that is, how promptly and easily it pays claims, not to the quality of care delivered. We reviewed the sales literature from leading insurers, including HMOs, that is targeted to the small-group market and found no reference to outcome measures of quality such as the HEDIS measures developed by National Committee on Quality

Assurance. 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. Much of insurers' strategic market positioning appears focused on differences in benefit packages. Most sales brochures offer a dizzying array of ways to mix and match various components of coverage such as deductibles, co-payment levels, maximum payouts, and various riders for prescription drug benefits or mental health coverage. However, several subjects noted that the complexity of benefit plans has been greatly reduced following HIPAA, because insurers had a number of benefit plans they were not willing to offer on a guaranteed-issue basis. One insurer spoke of "cleaning house" as a result of HIPAA, by reducing the number of benefit designs from 120 to 30.

Some subjects observed that insurers add or subtract benefits to strategically attract healthier subscribers or discourage unhealthier ones. Adding health club membership is an example of the former, and reducing prescription drug coverage and raising deductibles are examples of the latter. One agent complained bitterly of another tactic with respect to benefits that the agent viewed as unfair: offering good coverage for very attractive prices, but only to the extent of the insurer's limited fee schedule, which the agent thought was not adequately disclosed to subscribers, thus leaving them exposed to much greater payment liability than they realized.

Insurers still compete to a considerable extent based on their medical-underwriting abilities. Despite the purpose of these reforms to minimize medical underwriting, it still occurs to almost the same extent as before. Through the middle of 1997, insurers were still allowed to decline coverage for their primary plans. Even the guaranteed-issue plans require medical underwriting in order for the insurer to evaluate the extent of risk it is receiving, to use the +/- 20% allowance in the rating bands, and to determine whether to reinsure. Accuracy in these endeavors still determines profitability to a considerable extent.

As a consequence, the composition of different insurers' risk pools still varies a great deal. This can be seen in the statistics on average claims per enrollee, reported in Table 7. Although differences in these figures among insurers in any one year reflect in part differences in benefit packages, trends in average claims from year to year for a given insurer more clearly point to possible changes in the composition of the risk pool. Whereas the market median increased 25% from 1994 to 1996, the pattern for particular insurers was markedly different. On the high side, Traveler's average claims increased 73% from 1994 to 1996, and Principal Mutual's and John Alden's each increased 54% over this time. On the low side, Mid-South's average claims increased only 12% over these two years, and Blue Cross's dropped precipitously in 1996, for a net decrease of 26% from 1994, only to skyrocket 90% in 1997, according to reported data.

D. Administrability

1. General Compliance and DOI Enforcement

Finally, we address a series of concerns about the administrability of these laws. The Department of Insurance (DOI) has been moderately proactive in administering these laws. One highly knowledgeable and long-term member of the staff has considerable expertise and insight regarding these laws. The department

enforces reporting requirements that generate thorough data on market activity, which is helpful in monitoring market conditions. The department also has made some effort to publicize the law, through a brochure, through periodic press releases, and by maintaining a 1-800 number where the public can reach "consumer information specialists." And, the department did a market conduct investigation in 1993 and rate surveys in 1994 and 1998.

In other respects, however, the department has not been fully effective. Due to turnover and multiple assignments for staff, not everyone we spoke with had accurate knowledge of the law and its effects. The information available through the 1-800 number is not very helpful. The department provides no easy-to-digest information about comparative prices, consumer complaints, or relative market share that might readily assist a consumer in choosing among its list of 60-plus companies, many of which are not really active in the market.

The department also has not initiated much enforcement or monitoring activity with respect to these laws since the initial market conduct exam. Its enforcement is almost entirely reactive, by responding to complaints. Most complaints from consumers are motivated by price increases, which usually are within the bounds of the law. Consumers generally are not aware of the nuances of the law and therefore may not know on their own to complain if they are not offered statutory plans or if the portability provisions are misapplied. This knowledge usually comes from the agent, but the agents we spoke to are reluctant to complain to the department since they have the view that this seldom produces any action. Instead, they complain directly to the responsible insurer. Agents are especially reluctant to complain to the DOI about an insurer they do a lot of business with, for obvious reasons. Even when this is not the case, one agent said he would feel "outgunned" politically if he were to file a complaint against a very large insurer. In this agent's view, "it's not even worth the effort to pick up the phone" to call DOI.

The other possible source of complaints that might result in enforcement activity is from insurers themselves as they observe unfair or illegal tactics by their competitors. Although insurer subjects we spoke with frequently alluded to such behavior by their competitors, they were also not inclined to lodge complaints with the department, the stated reason again being the perception that this generally does not result in any action. For its part, a DOI representative told us that, too often, complaints do not provide sufficient specific evidence of wrongdoing to warrant an investigation. Simply alleging a suspicion that a certain company is engaging in a practice fails to provide concrete evidence about who, when, where, and how.

We found no indication that the law's implementation was being hampered or undermined by lack of knowledge. Almost all interview subjects were very knowledgeable about the law's requirements. Agents for the most part gain this knowledge directly from the insurers, who send frequent operational instructions and updates with respect to their products and procedures. The insurers we spoke with have well-staffed regulatory compliance positions to track legal developments and carry out corporate compliance. Thus, although the DOI and the agents' professional associations take only limited steps to publicize the law and determine knowledge and compliance, basic knowledge and compliance appear to us to be fairly accurate within the industry. This is true despite the fact that knowledge and enforcement of the small-group law has

been made somewhat more difficult by frequent legislative amendments. Since its original enactment in 1991, the law has been revised 11 times, three times to add additional covered benefits to the statutory plans, three times for various technical corrections, and five times to implement significant substantive changes.

2. Border Problems and Fraud

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

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

The reform law prohibits list billing, following the philosophy that employers should treat their employees equally, and out of the pragmatic concern that if it were allowed to continue, employers with low-risk profiles would circumvent the rating rules by purchasing non-group insurance, thus bleeding good risks out of the small-group market. We found no evidence that this was happening. All subjects believed that the law's prohibition of list billing was being enforced. However, a couple of subjects thought this was bad public policy. They viewed list billing not as circumvention but as an attractive convenience that facilitates insurance coverage for at least some employees when an employer is unwilling to purchase group coverage for all employees.

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 various association purchasing arrangements, the variety of which are too complex to describe thoroughly. In the past, they have gone under the acronyms of MEWAs or METs. Associations also might be used to cross the border at the small end, by taking high-risk individuals and presenting them as an employer group. We found no indication that either was happening. The law appears to be effective by looking past the association exterior to determine the nature of the groups or individuals purchasing through the association.

Self-insurance. Yet another border crossing concern is the threat that this law would induce medium-sized groups, those in the 25-50 range, to self-insure. This might occur if a group of good health risk felt it could save money by avoiding the rating bands. It is primarily for this reason that rating rules are not extended to groups any larger than 50. We found, however, no indication that groups of 50 or fewer are self-insuring at a significant rate. In part, this is due to the way the department regulates stop-loss insurance. Self-insurance for a group this small is not feasible without stop-loss insurance that attaches at a fairly low point, but North Carolina law prevents attachment points any lower than $25,000.

Employer Fraud. Other potential circumvention techniques are not as structurally sophisticated, and they are perpetrated primarily by employers, not insurers. An employer with a sick family member or friend might falsely claim the person as an employee in order to take advantage of guaranteed issue or rating limitations. Or an employer who truly employs a person with sickness in the family might try to avoid the cost by "hiding" the person off of the payroll. Several subjects observed that, if circumvention and fraud is occurring in this market, it is probably of this nature, initiated by employers, rather than the forms initiated by insurers. One agent said that employers are becoming "savvy" about "manipulating" the system. It appeared to us, however, that agents and insurers are sensitive to this potential and take steps to prevent it by requesting payroll and tax documentation, so that if this activity is occurring, it is not widespread. Both agents and insurers have strong motivation to follow the rules, since, in a regulated industry, they have strong incentives to stay on the good side of regulators.

This is not to say, however, that agents do not assist employers in doing everything they can within the letter of the law. One technique that was related to us, which appears legal but bends the rules, concerns a start-up company seeking new coverage where one employee is high risk. Rather than be forced to take the statutory plan which was viewed as too costly and unattractive, this agent advised the employer to delay hiring the high-risk employee until a good, medically-underwritten plan was issued, and then take advantage of the provision in the law which guarantees coverage for newly-hired employees under any plan. This technique is moot now that the law requires guaranteed issue of all plans, not just statutory plans.

3. Reinsurance

A final feature of the law that cuts across several of our categories of discussion is reinsurance. The voluntary reinsurance pool created by the law is intended to provide a relief valve for insurers who are forced by guaranteed issue or rating restrictions to accept risks they believe are not adequately covered by the allowable premiums. Insurers can cede to the pool either high-risk groups with fewer than 25 employees or individuals within these groups, on payment of a reinsurance premium that for groups is 150% and for individuals is 500% of the market average for the statutory standard benefit plan with the particular case characteristics in question. 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 under-25 market share. This opportunity to cede bad risks is intended to protect insurers from adverse selection and to reduce their incentive to engage in covert risk selection, thus minimizing many of the gaming and policing problems that might otherwise arise under the law. Insurers can elect to either participate or to opt out of this reinsurance mechanism; the latter insurers are referred to as "risk assuming."

Only about half of the insurers in North Carolina opt for reinsuring status. In 1995, 48 of 82 insurers opted for reinsuring status, and these were somewhat more concentrated among the insurers with smaller market shares. In 1996, five out of top 10 insurers and 11 out of the top 20 were risk assuming, constituting 56% and 62%, respectively, of the small-group market. It is expected that, after the initial five-year period for making the election expires, even more large insurers will opt out of reinsurance. In the words of one subject, "the word is out" that reinsurance did not work.

Larger insurers fear that smaller insurers will use the reinsurance mechanism more aggressively, thereby forcing the larger ones to pay assessments out of proportion to their use of the reinsurance pool. However, as it turns out, participating insurers have used reinsurance much less than was expected. At the end of 1995, only 19 of the 48 reinsuring carriers had any ceded lives in the pool, and the total number of lives reinsured was only 401, up from approximately 300 each of the prior two years. This pool of 401 is composed of approximately one-third who were reinsured as groups and two-thirds as individuals. The use of reinsurance for individuals increased from 147 people in 1993 to 264 people in 1995.

There are several reasons why participating insurers seldom reinsure. First, the discussion above reveals that insurers are not issuing coverage to very many uninsurable groups. Second, it is difficult and costly to evaluate in borderline cases whether reinsurance is worth the cost. The initial experience of most participating insurers is that they were reinsuring too readily, and therefore ceding risks whose eventual claims payout was less than the reinsurance premium. From the inception of the reinsurance pool in mid-1992 through June 1996, it had received $3,259,981 in reinsurance premiums but had paid out only $1,268,331 in claims, for an enviable loss ratio of 39%. As a consequence, an assessment against participating insurers had not been levied through 1996.

Some interview subjects observed, however, that reinsurance might be serving useful functions even if it is not much used. It might in fact encourage them to take borderline risks, even though the insurer decides not to initially reinsure these plans. The decision to reinsure can be made at any point in the life of the policy, and so insurers are protected for a group whose claims might go in either direction, knowing that they can limit their downside risk through reinsurance if claims experience drastically worsens. This possibility is substantiated by the fact that roughly equal numbers of traditional and statutory plans have been reinsured. This is attributable to the fact that most reinsurance activity is for individuals within groups. Prior to HIPAA, the ability to reinsure one sick worker or family member within a group may have induced an insurer to issue the group a medically-underwritten plan of its choice rather than forcing the group to purchase only the statutory plans. On the other hand, reinsurance provides another continuing opportunity for insurers to compete and profit using underwriting and risk selection techniques rather than with more efficiency-enhancing innovations.