

AN EVALUATION OF VERMONT'S HEALTH INSURANCE REFORM LAWS

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I. EXECUTIVE SUMMARY

This study evaluates how well Vermont's health insurance market reforms have met their objectives and whether they have avoided possible harms and failures. This is part of an intensive case study of seven states that have enacted varying reforms, funded by the Robert Wood Johnson Foundation. This multiple-case study consists primarily of two rounds of structured, in-depth, open-ended interviews, as well as an analysis of documentary and secondary data. The principal reforms we evaluated are the 1992 (small group) and 1993 (individual market) laws that provide for: (1) guaranteed issue of all products, (2) renewability and portability of coverage, (3) community rating, (4) restrictions on underwriting practices such as risk selection and pre-existing condition exclusions, (5) a reinsurance mechanism, and (6) purchasing through business associations. This report is intended to inform lawmakers, market participants, and the public policy community whether and how these 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.

A. Enrollment

There is no clear indication that Vermont's insurance market reforms have increased enrollment, and they may have resulted in some decline. Statewide, the percent uninsured has fluctuated from year to year and may have decreased substantially since reform, but most of this improvement comes from expansions in Medicaid programs. However, insurance market reforms were not intended, by themselves, to achieve universal coverage. Instead, they were meant to stabilize enrollment as a precursor to anticipated comprehensive reform with a mandate for universal coverage, which never occurred. For the most part, the reform law appears to have met its more modest goal of market stabilization.

Enrollment in the individual market has not declined as significantly in Vermont as nationally or as in some other states with similar reforms. Small-group enrollment has held steady by most measures. Although some measures show significant decline in small-group enrollment in the most recent years, most indications are that enrollment has not dropped below pre-reform levels. Also, it is notable that enrollment trends are similar in the two market segments, in contrast with other states that have reformed both markets. In such cases we usually find that the individual market performs noticeably worse than the small-group market.

B. Availability

The reform law has greatly enhanced insurance availability for high-risk groups and individuals. As one regulator observed, before reform, "It was common to get complaints from parents, sobbing because they learned their newborn child was not covered by their insurance. We don't get those calls anymore. It may be hard to quantify this real-life change, but it is very,

very real." Several agents said they are not eager to sell individual coverage because of the low commissions and the amount of work involved, and most agents said that insurers try not to attract high-risk business. Nevertheless, we encountered no difficulty in our market testing study finding agents and insurers who are willing to sell to an unhealthy group or individual. Insurance availability in Vermont is especially favorable for micro-size groups of five or fewer workers.

C. Prices

Prices for both individual and small-group insurance have risen significantly following reform. Most years, most insurers have increased rates in the 12-15% range. In some years, however, the market leaders have increased rates only 2-3%, or not at all, in both market segments. For the small-group market, these increases are steeper than in other states, but Vermont's individual market compares more favorably with other states because its rate increases have been largely in line with the small-group market, whereas in other states with community rating the individual market has seen steeper rate increases than the small-group market.

In 1998, a family of four without employer-sponsored insurance looking for coverage anywhere in Vermont could, regardless of their health, choose between two HMOs with rates of about \$7,000, and between two indemnity insurers with rates ranging from about \$6,000-\$9,000 a year (depending in part on age and gender). Remarkably, one insurer sells the indemnity coverage for \$3,500-\$5,000. These rates are similar to the range of rates in the small-group market for similar coverage, although in that market there are twice as many active insurers. Most (including the HMOs) have mid-range prices of about \$5,000, and two of the higher-priced insurers (Blue Cross and CIGNA) offer substantial (25-33%) discounts through associations.

D. Rating Flexibility, Association Exemption, and Reinsurance

The flexibility that commercial indemnity insurers have to vary their rates +/- 20% has helped to keep these insurers in the market and to counter possible adverse selection. However, it has created an unlevel competitive field in which the worst risks end up with Blue Cross and the HMOs. It is difficult to know how to resolve this dilemma without driving more insurers from the market or further undermining the objectives of community rating.

Similar problems are created by the exemption for small-group sales through business associations. Insurers can price their association products based on the claims experience for the pool of employers that purchase through each association. This sales vehicle has seriously eroded the portion of the market that purchases community-rated group products, and has created an unstable competitive dynamic in which association rates and enrollment have sometimes fluctuated dramatically as employers shop for lower rates by switching associations.

Vermont is the only state we are aware of with nearly-pure community rating in both the individual and small-group markets that has no administered reinsurance or risk adjustment mechanism. This indicates that these reforms have not caused the degree of serious disruption that critics feared. On the other hand, if such a mechanism existed, it would counteract to some

extent the incentives and opportunities for risk selection just noted that have proven to be controversial and divisive.

E. Competitors and Benefit Packages

Despite a large number of insurers withdrawing from each market segment at the time of reform, market composition has remained stable since reform, and there is still a range of choice in each market. However, in the individual market, there are only four insurers with significant market presence and so any defections from this market could do serious damage. There is substantially more competition in the small-group market and several new insurers have entered that market or have become noticeably more competitive in recent years.

To counter adverse selection, insurers have pared back benefits in the individual market, so that now the lowest deductible available for an indemnity product is \$1,000. HMOs still offer comprehensive coverage, but at substantially higher rates. There is more product diversity in the small-group market, where benefit reductions have come only in response to consumer demand. However, the small-group standardized benefit plan has not served any useful function.

HMOs have increased their small-group market share following reform, but not to the same extent as in other states. There are differing views on whether the reform law is responsible for either the increase or the lesser degree of increase, but most subjects believe that it is difficult to maintain competing managed care networks because of Vermont's small population.

F. Administration

Administratively, Vermont's insurance reforms have not imposed a large burden or created serious problems. Although insurers have used to their advantage the flexibility that remains in the rating rules and the control they have over marketing and over their agents, there are inherent limits to how far they can carry these risk selection strategies. We found no evidence of widespread and continued noncompliance with the basic requirements of the law, and regulators have taken a proactive enforcement stance. Sufficient incentives and checks appear to be in place to keep this set of regulations functioning reasonably well without intensive monitoring.

However, two problems exist relating to defining the regulatory boundaries. First, most subjects think that regulators have allowed the association exemption to expand too much, such that most small-group insurance is no longer community rated. Second, self-insurance arrangements appear to be a prominent and growing feature in the small-group market, in part as a way to circumvent community rating.

G. Vermont's Lessons for Other States

Vermont's reform law appears to stand out as a qualified success because it has implemented nearly-pure community rating in both the individual and small-group markets without causing

the destruction or crippling of the market that a number of critics predicted. Vermont's adoption of nearly-pure community rating has not been without problems and controversy, but so far this has caused less disruption and turmoil than in other states that have tried the same thing. It is worth considering why this is so, whether it is likely to continue, and whether it might be replicated elsewhere. The following features distinguish the environment and structure of Vermont's reform from other states:

- Vermont is a small state with a homogeneous population in relatively good health and with lower health care costs, and it lacks the urban concentrations and other social factors that create large high-risk populations.
- The insurance market has a dominant carrier, Blue Cross, which historically has engaged in guaranteed issue and community rating in these market segments.
- A generous Medicaid program keeps some of the worst risks from entering the market and covers many of those who cannot afford private insurance.
- The law was enacted in two stages, each with a year lead time, giving insurers a chance to adjust.
- Some rating flexibility was preserved, for some insurers.
- The safety net program sheltered low-risk people with cheap individual rates from an abrupt transition to community rating.
- Insurers may have been especially cooperative and restrained in their initial reactions to reform because of the political environment at the time, in which the legislature was considering an even more threatening move to a single-payor system.
- Some insurers may have been willing to absorb more losses than they ordinarily would simply because Vermont's individual market is too small to worry much about.

As can be seen, many of these features cannot be replicated easily or at all in other states because they are unique to Vermont or they are historically unique. Other features might be replicated in the design of the reform law, such as the safety net or the rating flexibility, but these are ones that many interview subjects complained about the most. So, although community rating has worked better in Vermont than elsewhere, this gives only limited guidance to other states.

An additional note of caution was sounded by several interview subjects. They observed that, although Vermont's market has held up reasonably well, the reform law is "only four years young," and the individual market is very thin. If only one or two key competitors were to withdraw from either market segment, the picture would completely change and the individual market would likely collapse. This foreboding tone was noticeable in several of the 1998 interviews. Although most subjects were at least somewhat positive about the law, between 1997

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and 1998 several key subjects shifted from guarded optimism to a distinctly more nervous or ominous sense that the jury is still out.

II. BACKGROUND AND METHODS

A. Methods

The primary sources of information for this study are various components of the insurance industry. In Vermont, we interviewed 29 subjects in 20 interviews in the fall of 1997, and an additional round of 18 interviews was conducted with 21 of these same people in the fall of 1998. Two subjects were with the Vermont Department of Banking, Insurance, Securities and Health Care Administration, six were independent insurance agents, one was a representative of an employer organization, and the remainder were with insurers that represent 97% of the individual market and 90% of the small-group market. Most interviews lasted 1-2 hours, except for eight that were conducted out of state (covering a total of 15 of the interview subjects), in which Vermont issues were addressed only briefly. We also collected quantitative and documentary information in the form of market activity data, sales literature, and newspaper articles. Finally, we conducted a market testing study in May 1998 to determine the ability of an actual small employer and unhealthy individual to obtain insurance. An employer with three employees contacted 10 agents throughout the state to inquire about the availability of health insurance for the group of three as well as for a group of two plus individual coverage for one unhealthy employee. These multiple sources of information and data were analyzed using both qualitative and quantitative techniques.

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

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

A final piece of background information is to note the important ways in which Vermont

differs from other states. It is a small rural state that is much more racially homogeneous than national averages. A greater portion of its economy is concentrated in small firms and self-employed individuals than elsewhere. Health statistics and health care spending are better than national averages, and Vermont entered the reform era with fewer people uninsured (10.7% in 1992, versus 15.8% nationally), but those lacking insurance were more concentrated in small firms.

B. Content and Purpose of Reform

The first installment of Vermont's insurance market reforms came in Act 52, effective July 1992, which applied to small employers. A year later, Act 160, effective July 1993, extended these reforms to the individual market, as part of a larger effort to achieve universal coverage within a few years. The larger effort did not succeed, as the subsequent legislative proposals were not enacted, but the insurance market reforms remain in place.

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 or individual markets to accept any applicant for any of its policies. In addition, each small-group indemnity insurer must offer a standardized plan whose benefits are set by a government committee, in order to facilitate price comparison.

The reform law promotes continuity of coverage in three ways. First, insurers are prohibited from refusing to renew insurance except for fraud, nonpayment or similar malfeasance. The second aspect of continuity is to regulate the use of preexisting condition exclusion clauses. Insurers are prohibited from riding out specific health conditions altogether. They are allowed (for small-group insurance) to place only an initial 12-month preexisting exclusion on any condition manifested within six months before the date of coverage. Third, "portability" 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 variation in price among subscribers. Vermont is one of a handful of states that has adopted community rating, which eliminates most conventional rating factors, including age/gender factors and geographic location. Vermont's version of community rating is not totally "pure," since rating rules allow commercial indemnity insurers to vary rates +/- 20% for demographic and other permissible factors, including age and gender. However, this is far less than the five-fold or more variation that exists in states with modified community rating. (Initially, the law allowed a +/- 40% variation for individual policies, but this was reduced to 20% two years later. HMOs and Blue Cross are not allowed to use this rating flexibility.)

Vermont lacks the other components of insurance reform laws that exist in many other states. Most states have an administered reinsurance mechanism that allows insurers to reinsure any risks that are expected to generate costs exceeding the prices they may charge. Vermont's

law calls for a reinsurance mechanism, but for reasons discussed below, one was never established, nor is there any risk adjustment process. In this respect, Vermont is unique as the only state to our knowledge with guaranteed issue and nearly-pure community rating of all products, both individual and small group, without any risk adjustment or reinsurance mechanism.

The Vermont reform law also calls for the creation of a public purchasing cooperative, but this too was never established. However, private associations for insurance purchase proliferate in Vermont's small-group market. Primarily, these are industry association groups such as those sponsored by chambers of commerce or professional trade associations, that contract with an insurer to offer coverage to members at favorable rates. These private associations differ from public purchasing cooperatives in several crucial respects. First, sponsorship and management is private, not public. Second, membership may be restricted to employers in certain industry or professional groups. Third, these private associations usually contract only with a single insurer, rather than providing the multiple choices available in most public cooperatives.

C. The Dangers of Reform

These reforms have attracted some vocal critics that 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, especially in response to pure community rating, which causes the most severe rate compression and therefore has the greatest potential to drive out younger, healthier subscribers. This, critics fear, will result in not simply a one-time loss in coverage but an escalating, destabilizing dynamic that may destroy the market. When the first round of subscribers drop out and the community rate increases, this might force still more cycles of subscribers to drop out and subsequent price increases, thus setting into effect an adverse selection spiral that eventually could result in insurance that is so expensive almost no one would buy it.

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 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 primarily affect affordability, might result in less insurance being purchased. Many components of the 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

There is no clear evidence that Vermont's insurance market reforms have increased enrollment or decreased the overall level of the uninsured, either statewide or in the individual or small-employer markets. *Statewide*, the percent uninsured measured by the Current Population Survey (CPS) has fluctuated from year to year but remains essentially the same as in 1992, as does the national average (Table 1). In the individual market, the number of Vermonters reporting private health insurance coverage from nonemployer sources increased sharply the first year of reform (1993), even though the reform took effect only in the middle of the year, but then declined in the following two years, only to increase again in 1996 and decline again in 1997. These year-to-year fluctuations are most likely statistical artifacts of the small samples in a state of Vermont's size, and may also result from changes in 1994 in the wording of the CPS insurance questions. It is notable, though, that individual coverage, measured by the CPS, appears consistently better in Vermont than nationally from 1993 on.

Enrollment figures reported by the Vermont Division of Health Care Administration, collected through annual reporting from insurers, are less encouraging, however. They show a 17% decline in covered lives in the individual market from 1994 to 1997 (Table 2). Data for other years are incomplete or unavailable, and may not be accurate even for these years. Nevertheless, this decline is substantially less than the 33% decline reported nationally (Table 1), and some portion of the Vermont decline is undoubtedly due to self-employed workers who previously purchased individual coverage now being able to obtain more attractive benefits and rates as group purchasers.

The picture in the small-group market is also mixed. In the Current Population Survey, the percent of workers with private insurance has fluctuated for various categories of small firms: fewer than 25 employees, 25-99 employees, and the self-employed (Table 3, Figure 1). Year-to-year fluctuations that appear significant are not (at a 95% confidence level) because of the small sample sizes in Vermont, with the exception of coverage in firms under 25. The 11 percentage point decline in coverage from 1994 to 1997 is statistically significant at the $p < .05$ level.

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

State	1992	1993	1994	1995	1996	1997
Vermont						
Nonelderly population	514,084	524,113	524,712	535,143	522,682	508,248
With employer coverage	71.2%	61.9%	73.7%	68.4%	65.8%	67.6%
With individual coverage	6.9%	11.7%	8.0%	7.0%	9.5%	8.4%
With Medicaid	13.2%	14.0%	11.2%	14.0%	17.1%	17.4%
With other public coverage	2.4%	1.5%	3.0%	2.0%	2.2%	4.5%
Uninsured	11.1%	14.6%	9.6%	14.6%	12.4%	10.8%
Total	104.7%	103.5%	105.6%	106.0%	107.0%	108.6%
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%
With Medicaid	11.8%	12.8%	12.6%	12.6%	12.1%	11.1%
With other public coverage	3.5%	3.3%	3.7%	3.4%	3.3%	3.2%
Uninsured	17.8%	18.1%	17.3%	17.5%	17.8%	18.4%
Total	103.5%	104.2%	104.7%	104.4%	104.3%	103.7%

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* < 65 and not active military

Note: Totals exceed 100% due to double counting

Source: Alpha Center analysis of March Current Population Survey

Table 2
Vermont Individual Health Insurance Market,
Registered Carriers: 1994-1997*

Company	Covered Lives	Market Share (Lives)	Average Premium	Average Claims Paid
Blue Cross				
1994	15,846	50.7%	\$1,022	\$1,162
1995	13,268	49.7%	1,189	1,133
1996	10,381	42.2%	1,441	1,210
1997	8,871	34.0%	1,471	1,210
Time/Fortis				
1994	6,153	19.7%	664	267
1995	8,338	31.3%	747	346
1996	9,833	39.9%	887	491
1997	13,025	49.9%	759	579
Mutual of Omaha				
1994	6,487	20.8%	403	300
1995	3,047	11.4%	662	581
1996	2,929	11.9%	664	433
1997	2,847	10.9%	691	430
Kaiser/CHP				
1994	1,196	3.8%	1,295	1,140
1995	1,220	4.6%	1,365	868
**1996	1,250	5.1%	1,852	1,194
1997	1,138	4.4%	1,964	1,668

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Bankers Life

1994	1,573	5.0%	474	324
1995	795	3.0%	742	449
1996	60	0.2%	NA	NA

Nationwide

1996	138	0.6%	846	NA
1997	147	0.6%	1,107	NA

Mohawk Valley

1997	71	0.3%	NA	853
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Harvard Community Health Plan

1994	2	0.0%	1,526	1,381
1995	12	0.0%	1,652	1,503
1996	25	0.1%	1,122	1,021

Total

1994	31,257	100%	\$806	\$764
1995	26,680	100%	986	792
1996	24,616	100%	1,139	826
1997	26,099	100%	1,043	825

Source: Vermont Department
of Banking, Insurance,
Securities and Health Care
Administration

* Included are only those
carriers for which market
data were available.

** Based on carrier's
estimate of covered lives.
Exact figures not available.

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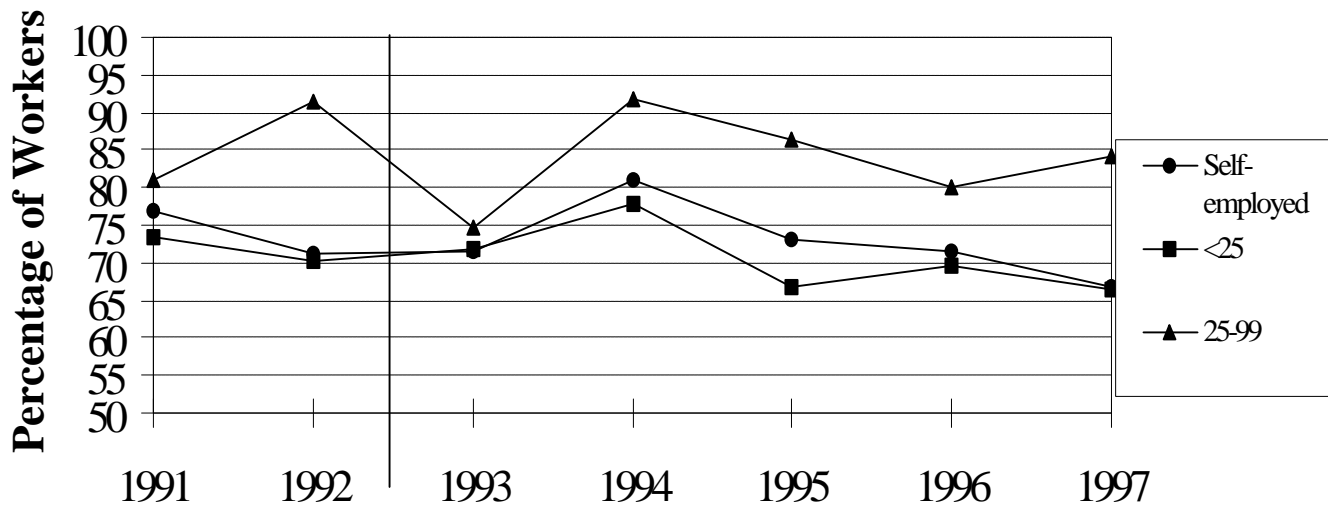
NA = Not available

Table 3:
Private Health Insurance Coverage in Vermont by Group Size,
1991-1997

Group Size	Percentage of Workers						
	1991	1992	1993	1994	1995	1996	1997
Self-employed	76.89	71.27	71.42	80.99	73.23	71.48	66.92
<25	73.26	70.36	71.96	77.73	66.83	69.61	66.44
25-99	81.07	91.33	74.63	91.89	86.28	79.92	84.05

Source: Analysis of March Current
 Population Survey by Reenie
 Wagner

Figure 1:
Private Health Insurance Coverage in Vermont
by Group Size, 1991-1997



7/92
 Reform Begins

Source: March Current Population S

Similarly, enrollment figures collected by regulators from insurers' annual reports show a 16% decline in the small-group market from 1995 to 1997 (Table 4). However, these figures are incomplete and unaudited and may contain significant errors.

Another important data source comes from a specialized survey conducted by other researchers in 1993 and 1997, targeted to Vermonters and with a sample size several times greater than the CPS. The 1993 survey was conducted by the RAND Corporation, under a grant from the Robert Wood Johnson Foundation, to set a baseline for measuring the effects of anticipated comprehensive reform, which was never enacted. This survey was repeated in 1997 by the Vermont Department of Banking, Insurance, Securities and Health Care Administration. The 1997 survey found that the percent of the population without insurance fell by over a third, from 11.0 to 6.8%, over this four years (Table 5). Because almost all of this improvement came from expansions in Vermont's Medicaid program, the study found no change in the percentage of employers offering insurance (69%), or in the percentage of workers with employer-sponsored coverage (60%). Likewise, there was virtually no change in the percentage of employers with fewer than 50 and with fewer than 10 workers offering insurance (Table 5). Although there appears to be a slight increase in the portion of the population with individual coverage, the report does not clarify whether these figures include private coverage through COBRA or retirement plans.

There is no clear indication, then, that insurance market reforms have increased enrollment, and they may have resulted in some decline. There is some basis for concern in the small-group market over whether the downward trend in the most recent years will continue. However, most indications are that enrollment has not dropped below pre-reform levels, and it is notable that enrollment trends are similar in the two market segments, in contrast with other states that have reformed both markets where we usually find that the individual market performance is noticeably worse than in the small-group market.

Table 4: Vermont Small-Group Enrollment, Leading Companies and Market Totals: 1992-1997

Company	Covered Lives	Market Share	Average Premium	Average Claims Paid
<u>Blue Cross (Non-Association)</u>				
1992	18,976		\$ 1,486	\$ 1,093
1993	16,663		1,866	1,468
1995	9,446	7.2%	2,019	1,832
1996	6,985	5.8%	1,761	1,512
*1997	3,000	2.7%	NA	NA
<u>CHP/Kaiser</u>				
1992	16,631		1,064	953
1993	21,216		1,111	1,209
1995	30,443	23.1%	1,365	824
1996	27,008	22.3%	1,428	921
*1997	25,000	22.6%	NA	NA
<u>John Alden</u>				
1992	3,166		732	329
1993	4,038		974	638
1995	6,012	4.6%	915	617
1996	6,401	5.3%	1,190	831
1997	2,005	1.8%	3,339	1,933
<u>Guardian Life</u>				
1992	2,846		1,044	705
1993	2,964		1,098	976
1995	1,748	1.3%	1,514	1,600

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1996	653	0.5%	3,114	2,847
1997	308	0.3%	4,239	2,759
<u>Time/Fortis</u>				
1992	746		683	261
1993	1,123		864	530
1995	1,202	0.9%	1,126	699
1996	763	0.6%	1,893	1,134
1997	340	0.3%	2,600	2,068
<u>TMG Life</u>				
1992	1,023		583	317
1993	895		790	485
1995	1,192	0.9%	1,627	1,413
1996	1,058	0.9%	2,324	2,580
1997	0	0.0%		
<u>CIGNA</u>				
1992	785		567	346
1993	1,187		1,170	990
**1995	1,200	0.9%	NA	NA
1996	1,209	1.0%	1,221	758
**1997	1,200	1.1%	NA	NA
<u>Mohawk Valley</u>				
1993	160		\$ 150	\$ 366
1995	844	0.6%	949	762
1996	2,194	1.8%	1,217	1,106
1997	8,976	8.1%	1,169	1,059
<u>Non-Association Subtotal</u>				
1992	46,644		1,181	901

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1993	50,119		1,317	1,167
1995	52,286	39.7%	1,431	1,020
1996	46,547	38.5%	1,480	1,067
1997	42,399	38.3%	NA	NA
<u>Blue Cross Association</u>				
1995	77,608	58.9%	1,450	1,385
1996	72,834	60.2%	1,345	1,356
1997	67,534	61.0%	1,652	1,570
<u>Other Association</u>				
1995	1,908	1.4%	683	521
1996	1,515	1.3%	750	711
1997	787	0.7%	1,553	1,227
<u>Total Small Group</u>				
1995	131,802	100.0%	1,432	1,230
1996	120,896	100.0%	1,389	1,237
1997	110,720	100.0%	NA	NA

Source: Vermont Department of Banking, Insurance, Securities and Health Care Administration

Notes: (1) Based on data for 10 leading carriers in the small-employer market (99% of market) and 10 leading carriers in the association market (99% of market). (2) 1994 data not available. (3) 1992 and 1993 association data not available. (4) Data in other years are unaudited and partially incomplete and may contain significant errors or omissions.

* Based on estimates from carriers. Precise figures not available.

** Estimated from historical trend. Precise figures not available.

NA = Not available

Table 5

Vermont Health Insurance Coverage, 1993 and 1997

Coverage Source	1993	1997
Total population	567,476	585,973
With private coverage	66.4%	68.0%
With employer coverage (approx)	(59.5%)	(60.0%)
With Medicaid	9.8%	10.2%
With Medicare	12.7%	15%
Uninsured	11.0%	6.8%
Total	100.0%	100.0%
% of Workers Offered Coverage, by Employer Size		
1-9	26.9%	27.4%
10-24	68.3%	76.9%
25-49	81.4%	87.8%
1-49	45.0%	46.4%
All sizes	68.0%	69.2%

Source: Vermont Department of Banking, Insurance, Securities

2. Agents' Views

It is not possible to know whether the trends experienced following reforms are due to the law or instead to underlying social and economic conditions. Some insight can be gained, however, from the views of informed observers of or participants in the market. A few interview subjects, such as the following agent, were generally enthusiastic about the guaranteed-issue aspect of the reform law:

Q: What has been your experience with guaranteed issue in your agency?

A: *Good. Good. Of all the features of health care reform, that was the one that I liked the best. I felt that guarantee issue was certainly a way, even though there was a cost to it, that Vermonters . . . really benefited from not having to worry about being diabetic or overweight or whatever the case might be. I can tell you what happened was my life became easier. Medical underwriting for anyone in the life and health business is the biggest pain in the ass we have in this business. . . . I still experience that [medical underwriting] on disability and life insurance. I understand it. I know it can work, but [in] the public [view] . . . health insurance has become something socially [important] unlike the 1950s. Today it is expected to be able to get it, and I've talked to many people who gave a sigh of relief because they have [been able to]. It could have been a bad knee or it could have been something more serious, but they could get the insurance and not have to worry about that being written out or being declined for it, and they have the resources to buy the insurance and for whatever reason -- being self-employed or a very small business -- they didn't have [insurance] before, so that worked.*

More typically, these positive remarks were reserved for the small-group, not the individual, market. Some agents, such as the following, viewed the reform law as responsible for making the small-group market a more attractive source of business:

One thing that strikes me about the under-50 [group size] market in the state of Vermont is the brokers do very well selling those products. I mean there is a big incentive to be in that market . . . because the commission rates are so good. I make more money on a 40-person group than I will . . . on some of my 100-to-150-person groups. . . . Agents benefited greatly from this [law] because, really, prior to this, I was only looking for over-50. I didn't want to deal with the under-50. The commissions were not that good. It was a lot of hassle. It wasn't my expertise. . . . This [law] basically got us into the under-50 market. We don't really have to do much to sell an under-50 case right now. There's no work involved. You don't have to send it to the carrier. If I look at a group of 75 people, that's a huge undertaking. We have to . . . get all of this experience data, census information, send it out to the carriers, wait to get back all these plan design choices. Under-50, you take out a sheet. Here are our four plans. Here are the rates until next January 1. . . . [The client picks a plan.] This is what it costs. You send the stuff. It means empowerment. My [agency] people convinced me that we needed to stay in [the small-group market] because it was so profitable. I'm telling you it definitely is.

Nevertheless, other agents noted that, when an employer offers coverage, some eligible employees are not opting to enroll themselves or their families, in part because employers are lowering their contribution to premiums, especially for dependent coverage, a trend that is occurring nationally:

I seem to see more situations where I run into people who individually have group health insurance because that is what the employer pays for. But they don't choose to have their family insured. So, I have people coming to me saying they want to buy Time health insurance for their family, but they have group insurance.

Workers who drop employer coverage for their family members are also able to enroll in an expanded state program known as Dr. Dinosaur, which subsidizes families above the poverty line who want to pay to enroll their children in Medicaid. One subject commented that this new program was created at the same time as the insurance reform law and so may have made it easier for people to drop private coverage. Another agent commented that employers are also reducing eligibility by lengthening grace periods, in order to save costs:

I actually had an experience that . . . is very instrumental in developing the attitude that I have now. . . . There were several people in the group that had health issues and so there were either modification restrictions or rejections [six weeks prior to the reform law's July 1 effective date]. . . . We rewrote the group in June for a July 1 effective date, and the premium was [much higher than] it had been within six weeks differential. And what ended up happening was, . . . the employer, which I actually thought was a pretty bright solution, he literally couldn't afford that premium and he did want to do something for his employees. So what he did was change his waiting period from 60 days to a year. By doing that he eliminated 60% of the lives and therefore ended up with a price that was very similar to what he would have been paying to start with. But as a result of that those other people didn't have coverage. And that I saw very commonly being done in the marketplace. Once I saw that I suggested it to other people. I thought that was a really good idea. I mean I don't like the idea of having people not covered, but I like the idea of being able to offer people something they can afford. So this, if you want to call it a strategy, is one of about five or six strategies that have been employed pretty commonly in the marketplace to avoid the impact [of guaranteed issue]. You end up spending more per person but your total dollars are still roughly the same.

With respect to the individual market, agents' comments were generally negative. In large part, this is because several of the leading insurers pay no commissions for guaranteed-issue products sold in the individual market:

Blue Cross does not . . . pay any commission [for individual insurance]. So,

basically if somebody came to me and Blue Cross was the market, I would give them the 800 number for Blue Cross. I would not handle it. . . . I would tell them you can buy Time Insurance from me at this price, and here is the plan of benefits, and you get me [to serve as your agent]. Or, I just happen to have in my drawer the Blue Cross plan of benefits and their prices. Here they are. But, if you want them, you gotta deal with them.

HMOs also pay no agent commission for the sale of individual insurance. Time Insurance is one notable exception as a company that pays a substantial commission (about 10%) for a comprehensive individual product. But several agents noted that this market is still not very attractive or profitable. One agent explained:

I'll tell you what we do when someone calls my office [for individual insurance] -- this is how much of a hassle it is. [I] refer them to my staff. They go on line with Time, give them [the purchaser] a rate, and then I give [the purchaser] a number at Blue Cross Blue Shield and have them call . . . the number, direct. Because I could write a hundred [individual policies] a year, that might inflate to a couple of thousand of commissions. It's not worth that one phone call that we have to spend time on. It's just not worth it for the size of the book of business that we have. It just doesn't equate to enough. So that's why I know very little about the individual market.

Another agent, one who deals mainly with medium and large groups, had this to say about selling individual insurance:

Q: Do you sell any individual health insurance at all?

A: *Not if we can help it. . . . It's a pain in the neck. . . . It is guarantee issue, but . . . it's not like it's a standard group policy. . . . Certain things aren't covered. Benefits are limited, and . . . when you work exclusively in [the] group [market], you've got to decipher all of these provisions of these individual policies. That's where it really gets to be a pain in the neck.*

One agent, however, said that guaranteed issue made selling individual insurance much easier, and so justified lower commissions:

When I was first in the business, individual health insurance would pay a 25-30% commission. In those days . . . you needed a 25 or 30% commission because you had a hell of a lot of work to do because of the medical underwriting. Now, I would tell you, they typically pay 10% or less. The reason is that it is pretty easy when you can't get turned down. Do you have paperwork to fill out, money to collect and plans of insurance to explain? Yes you do, but you don't have all that back room struggle, going back and forth with medical care providers to furnish information

and try and negotiate with company underwriters to get them to accept groups.

3. Active Marketing and Field Underwriting

Agents' lack of enthusiasm for individual insurance might be overcome if insurers actively marketed these products, but insurers we spoke to do not advertise for nongroup business. Insurers explained that the individual market is simply too small and too unprofitable to justify any sales effort. One leading insurer commented that, for the most part, the only people purchasing individually are those in the small set who have no job, need insurance, and have money. Another leading insurer believes there is so little actual or potential business in the individual market that it simply folds this market into its group market for purposes of pricing and accounting. Even though they are certain they lose money on their individual business, it's not worth their effort to put through separate rate increases or to "dream up ways to grow the market." An agent commented that the leading insurers "never wanted to really invest in . . . that product line because it's always been a pretty substantial loser, into the millions, year in and year out. . . . So why invest in marketing or paying commissions on a product line that consistently loses money?"

There is one notable respect, however, in which individual market reforms have increased availability of coverage. Prior to reform, people with health problems could obtain individual coverage only from Blue Cross, which offered open enrollment and community rating in the individual market. Following reform, this coverage was available from any insurer active in that market. Thus, one notable impact of reform has been to shift enrollment from Blue Cross to Time/Fortis. From 1994 to 1997, Blue Cross' individual market share dropped by a third while the market share of Time/Fortis more than doubled (Table 2).

Spreading high-risk individual enrollment across more insurers than just Blue Cross was one of the objectives of reform, and so to this extent the reform law has partially succeeded. However, this objective has been frustrated to some extent by various techniques of "field underwriting." This term refers to a practice of encouraging agents to screen out applicants they know or suspect are higher risk. In other lines of insurance, this practice efficiently avoids unnecessary work for the insurer and agent, and helps to steer subscribers to the plans and carriers that are most likely to offer affordable coverage. This practice also helps to detect when applicants are not being truthful about their risk factors. In part, this practice and these reasons explain why agents refer to themselves as underwriters in their professional certifications and trade association names, even though they do not perform the full underwriting function that insurers do in the home office. Property and casualty insurers, for instance, give their lead agents field manuals or software programs that contain the general underwriting parameters so agents will know whether it is worth their effort to submit applications. Insurers or general agents also give field agents informal, "pre-screening" opinions over the phone for the same purpose. As a result, for products that are not guaranteed issue, many applications from uninsurable clients never come in to the home office for a formal decision.

Many interview subjects acknowledged that field underwriting in various forms occurs for health insurance, and none denied it. Although this practice may be legitimate and efficient for most lines of insurance, it undermines guaranteed issue by discouraging agents from taking higher risk clients. It also creates an uneven playing field by encouraging agents to send higher-risk clients to one insurer rather than another. Several agents commented candidly on this phenomenon:

Q: I'm curious [whether] carriers engage in any sort of tactics to essentially attract better risks or discourage higher risks? One thing . . . that occurs to me would be essentially trying to encourage brokers to send their bad business somewhere else.

A: *Well, you know what? To be perfectly honest with you, I'm not going to give [EFG Insurance Company] a bad piece of business if it's currently with another company because I know I can save the money. I could make more money for my agency that way. And so if there is any of that going on, it's not at the carrier level saying we want this account, not another account. But absolutely at the broker consultant level there is some of that selection going on*

Q: So what do you do with the bad risks? Blue Cross is always there.

A: *Blue Cross is always there. I mean, I'm not saying that I take a bad risk and dump it on Blue Cross Blue Shield. But I'm telling you right now I'm careful, especially in the over- 50 [market], to not take the shit piece of business and dump it on one of my best carriers. . . . That burns my bridges with those guys. But I would have to say I never consciously think, okay, I'm going to take this bad piece of business and give it to Blue Cross. I would more likely try to keep them right where they were. So it all should come out in the wash. But you know what, there's probably some of that going on.*

Another agent commented:

A: *Agents will always, fortunately or unfortunately, keep their own well-being in mind. That means a couple of different things. First of all it means, if I know that garbage haulers have horrendous health insurance experience and my carriers have told me, "We are not interested in writing garbage haulers. They have horrendous experience," am I gonna run around and try to sell insurance to garbage haulers? Probably I am not.*

Q: Now what would the carrier do if you did?

A: *They can't do anything.*

Q: They wouldn't cut back your commissions if they started getting a lot of garbage

hauler business?

A: *They can't, but they can make life unpleasant for me. It is still a quasi-voluntary marketplace. Do those kind of things go on? I would tell you, to some degree or other, they are always going to go on.*

One agent said, though, that he resists insurers' pressures to steer business in this fashion:

The only thing that I've even seen that smacks of any kind of risk avoidance strategy -- I'm trying to figure out the right wording for this -- [is] I've been to some seminars from [ABC Insurance Company] where they say, "Look, the only way that we can try and help ourselves is you're our field underwriters. We expect you to give us good business," and stuff like that. And I'm always the token heretic in the crowd that says . . . "Well, my understanding is we have to accept everyone and we don't even have to ask health questions, so what are you talking about?" And they say, "Well, we just want you to keep your eyes open." They're not coming out and saying, "Don't sell this stuff to bad people," but that's essentially what they're saying. I understand why they feel that way, and I also don't agree with the way the law is structured currently. But it's the law.

This same agent, as well as others, explained however that some insurers maximize the incentive and opportunity for field underwriting by "soft marketing," meaning they sell only through agents rather than using general advertising. And they are highly selective about which agents they use:

Q: Is [XYZ Insurance Company] actively marketing [individual coverage]?

A: *. . . Its agents are marketing the coverage; they themselves are not. They don't push it either. In fact they have been trying to do everything they can to slow us down with it. In order to be an agent with them now you have to have a certain amount of life [insurance] volume. There's a lot of other requirements that they have. If you're selling less than so many cases a year, they make you go away to a school to learn about it. I mean they're really trying to get rid of the marginal producers. I think what that's all about is that they're getting a lot of risk on the books and they're not happy with it. For some reason their prices are still reasonable though.*

Another agent explained:

Q: So how does marketing work in the small group then? Do you see billboards or ads in the trade magazines?

A: *No, it's kind of word of mouth, . . . very little by way of advertising. You don't see, for instance, a local newspaper [ad].*

It is difficult to assess how significant these concerns are. They are no greater in Vermont than in other states we have studied. Also, the Division of Insurance (DOI) has taken steps to prevent insurers from overtly encouraging agents to avoid high-risk business, by prohibiting basing commissions on loss ratios or claims experience. Where commissions are paid, agents are well positioned and well motivated to enforce the basic requirements of the law. And, the DOI has not received any complaints from consumers related to field underwriting. On the other hand, Table 2 clearly reveals that Blue Cross and Kaiser/CHP are receiving much worse risks in the individual market than are indemnity insurers, since their premiums and claims are more than twice as high.

In order to gauge the ability of less desirable subscribers to find coverage, a market testing study was conducted in which an actual small employer with three employees contacted 10 agents throughout the state to inquire about the purchase of health insurance. The group was composed of two people in good health and one with juvenile diabetes. The employer inquired about coverage for group sizes of both three and two, as well as about individual coverage for the person with diabetes. Vermont agents performed almost flawlessly. None of the 10 agents indicated that coverage would be unavailable for either of the group sizes or for the unhealthy individual, and none indicated any reluctance, either on their part or on the part of insurers, to cover any of these subscriber units. Also, the agents contacted in Vermont were highly responsive. All 10 gave price quotes, and only one was sluggish in responding.

4. Micro Groups

This market test reveals another aspect of Vermont's reforms that appears to be successful: the treatment of very small groups, those with fewer than 10 employees. Vermont requires group insurers to extend guaranteed issue down to groups of one, that is, the self-employed. In other states, insurers have strongly resisted selling to group sizes below five at the same rates as larger groups because both adverse selection and pro rata administrative costs are so much greater for these group sizes. In an attempt to recoup some of these costs or to discourage enrolling these groups, insurers usually seek to apply a group size rating factor, or they sometimes lower commissions for the smallest groups. In Vermont, neither tactic is allowed, yet we detected no concern among insurers about this portion of the market. One explanation given was that Vermont has a heightened social consciousness and strong sense of community. Another explanation is that in Vermont, such a large portion of the market consists of very small groups. One-third of the workforce is in groups smaller than 10 and two-thirds of the small-group market (firms of 50 or fewer) are in groups with fewer than 10. Accordingly, insurers would not do well if they discouraged these groups, since, as one insurer subject noted, "That's where the market is." Finally, the law gives insurers some control over which small groups they enroll because insurers may require that 75% of an employer's eligible workers participate in the group policy. Thus, if even one member of a group of three does not opt for coverage, an insurer can decline the group despite the guaranteed-issue requirement.

Despite these apparently harmonious conditions, employer-sponsored coverage among very small groups in Vermont appears to lag behind most other states. According to the 1993 and

1997 Vermont insurance surveys mentioned above, the portion of groups smaller than 10 members offering health insurance has remained at 27%. This is much lower than national averages measured through different employer surveys, which show approximately 42% of firms under 10 offering health insurance, up from about 35% in 1989.

5. Summary

On balance, Vermont's insurance market reforms have produced mixed results with respect to the availability criterion. High-risk groups and individuals can now obtain coverage from many more insurers than before reform, and they are able to keep their coverage and switch insurers regardless of health status. As one regulator observed, before reform, "It was common to get complaints from parents, sobbing because they learned their newborn child was not covered by their insurance. We don't get those calls any more. It may be hard to quantify this real life change, but it is very, very real." Nevertheless, some quantification is helpful to put these successes in perspective.

These laws have not produced a huge influx of new subscribers, nor have they reduced the overall level of uninsurance statewide, but this was never the expectation. Instead, these reforms were intended to stabilize enrollment in private insurance as a precursor to anticipated universal coverage, which never occurred, in which an extended Medicaid program or an employer mandate would have expanded coverage. While there are several indications that insurance is widely available and enrollment has stabilized, there are other indications that field underwriting and soft marketing may be hampering access to some insurers or skewing risk pools to some extent, and enrollment may be declining in recent years. As summarized by one agent, however, the failure to increase enrollment is due more to problems of affordability than to any barriers to availability:

I do think the reforms have largely achieved their objectives. I think the lingering problem of uninsured individuals is still a real problem. If people are determined not to have health insurance, this is not socialized medicine. They don't get it through their employer or if they are required to participate in the cost with their employer, which many people are, and they are determined not to have it, they are not going to have it. Certainly as rates go steadily upward and seem to go up faster than income goes up, there is pressure on small employers and on individuals in that way.

Whether these positive and negative indicators are attributable to the law or instead to economic and demographic factors is difficult to disentangle. We will attempt to do so by next examining trends and variations in prices following reform.

B. Affordability

1. Prices

There are several indications that premiums for both individual and small-group insurance have risen significantly following reform. Precise rate data are not available for each year following reform, but aggregate premiums are available for several years in each market segment. Since Vermont is a community-rated state, calculating average premiums per covered life gives a good approximation of rate trends. Average premiums fail to adjust for changes in benefit packages, but they are still the best indication available of marketwide trends in the risk pool. These data are supplemented by the impressions of our interview subjects.

In the *individual market*, rates for the two leading indemnity insurers, Blue Cross and Time/Fortis, increased an average of 14-18% a year over the two years from 1994 to 1996. But over the next two years, Blue Cross rates increased less than 5% a year. Rates at Time/Fortis did not increase at all. Time/Fortis was granted a 20% rate increase that will take effect January 1999. Rate comparisons for Kaiser/CHP, the leading HMO, are not available prior to 1996 due to significant changes in the benefit packages, but in the two-year period 1996-1998, its rate increases averaged 12% a year. Similar increases can be seen in the average premium figures in Table 2. Marketwide, average premiums increased 16% a year in the two-year span from 1994 to 1996, and they increased sharply for each of the major insurers. But in 1997, the marketwide average held steady.

The 1994-1996 increases are significant, compared to the single-digit increases elsewhere in the country. However, double-digit increases have not occurred every year or for every insurer in Vermont. And when they have occurred, they have not been much different than the rate increases in Vermont's small-group market, discussed below.

Additional insight comes from comments by agents. Several noted that extremely low rates available to young, healthy subscribers prior to reform are no longer available. According to one, "I have always had mixed emotions about Golden Rule. I didn't necessarily like selling it, but Jesus, you could sell a 25-year-old young guy who didn't have health insurance and his premium might be thirty bucks a month. . . . So I kind of love to hate them, so to speak." Rates this low were achieved in part by full use of risk rating and by "ridering out" specific conditions that might generate claims, both of which the reform law prohibits. Therefore, it is no surprise that rates increased for a number of subscribers. Also, at the time reforms were adopted, Golden Rule had pending a request for a 25% rate increase, so its rates were clearly underpriced at the time and its subscribers would have received a substantial rate shock in any event, according to regulators.

In the *small-group market*, price increases have been almost as significant as in the individual market, contrary to the experience in some other states. Rates for most of the market leaders (Blue Cross, Kaiser/CHP, John Alden, and CIGNA) increased an average of 12-18% a year over the three year period from 1994 to 1997, and increases in 1998 were in the range of 15-

20% except for two indemnity insurers selling PPO products (North American and John Alden), which increased rates only 3-8% in 1998. Although increases at the leading HMO (Kaiser/CHP) have been somewhat lower over time and nearly flat in some years, they have still averaged in the low double digits, unlike other states where HMO rates for small groups have increased only in the low-to-mid single digits.

These rates are for sales in the community-rated market, but as noted below, the majority of small-group sales occur through business associations, which are experience rated. It is much more difficult to obtain systematic information about association rates, but, as discussed below, interview subjects explain that these rates have also fluctuated quite a bit. It is notable, though, that rate increases in the largest association have been extremely low, in the 2-3% range, over the period 1996-1998, as have rate increases for some of the insurers that do not sell through associations and so must compete with these favorable rates.

Again, agents' views confirm this picture. Agents uniformly commented that the small-group market is highly price competitive:

What basically happened was, whether by luck or by draw, the competition in the under-50 market all of a sudden became very polarized. It's like three or four carriers are competing for all this business. And it's very rate driven. And so it did stabilize the rates significantly. Although, again, I think it was . . . definitely market pressure that drove the rates. . . . So it really has stabilized the rates. And I guess the million-dollar question is how did that actually happen? And I bet you there is not a good reason financially for that happening. But it was a lot [in order] to build market share and [some carriers] I know did eat increases.

.....

There hasn't been a big brouhaha about health insurance cost the last few years . . . as there was [prior to reform]. . . . I don't know if it's because we have done a good job of controlling the inflation. Politically and whatever, it hasn't become a big issue. It will again because CHP raised their rates by 15% this year [1997]. . . . We're having inflation in health care. Insurance costs are dramatically higher than the 3% or so inflation we reportedly are having in the rest of the sectors. One of these days someone is going to jump on that and make a big story of it and it's going to be a big stink.

Agents also noted that price wars have erupted on several occasions. The latest was precipitated by North American Preferred, which in late 1997 began to offer highly attractive rates for PPO coverage, substantially below even the discounted rates available through associations. In our market testing study, 38% (3/8) of the independent agents said this company offered the best prices. Some agents and actuaries, however, warned that these favorable price levels cannot be sustained, and the market is likely to "bust loose" in 1999. Several subjects

commented in particular that they are waiting for "the sky to fall in" on North American Preferred because its rates are "too good to be true."

On balance, the overall impression is that, while rate increases in both market segments have been moderate and the small-group market is price competitive, rate increases have been higher in Vermont than in other states, especially in the small-group market. On the other hand, Vermont's individual market compares more favorably than in other states because its rate increases have been largely in line with the small-group market whereas in other states with community rating the individual market has been hit harder than the small-group market.

There are several possible, speculative interpretations of these comparative patterns. It may be that small-group rate increases have been higher in Vermont, not because of any failing of reform, but simply because HMOs have not taken hold as strongly here as elsewhere (for reasons discussed below), and HMOs have been the major force for price competition in other small-group markets following reform. In addition, because of the small size of Vermont's market, it appears that some of the leading individual insurers make uniform rate increases for both individual and small-group products, meaning they may use profits from small-group sales to subsidize individual market losses more than occurs elsewhere. If so, then small-group reform may appear less successful than it is and individual reform may appear more successful, with respect to the impact on prices. We stress, though, that these are only speculative interpretations.

It is a separate question whether and which of these mixed results are attributable to the reform law or to underlying market conditions. The intensely competitive environment that kept marketwide averages down in the small-group market generally exists across the country. Elsewhere, this is due in large part to the shift to managed care, which has not been as pronounced in Vermont as elsewhere, a topic we discuss below. For now, we turn our attention to more direct impacts of the reform law on average prices.

2. Adverse Selection Against the Market

We evaluated the extent to which the reform law may have increased average prices and destabilized the market by causing adverse selection against the market as a whole. Community rating has 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. Nearly-pure community rating, coupled with guaranteed issue, was thus expected to increase average prices dramatically. One agent, who is generally hostile to market reforms, speculated that this was the case in Vermont:

Younger people are now paying the same premium that older people were paying. There was a real shift in that, if anything happened, I would say it was a bigger tendency for younger people to be uninsured because their cost went way up. Older, sicker people's costs for insurance went dramatically down. There was a shift in who was insured and who was uninsured. Whether the absolute numbers changed, I couldn't tell you. I

would say as a generalization though that there was a shift to having more of the people who needed the insurance insured because of it being older people and people who tended to have more pre-existing conditions and ongoing health issues.

From most indications, however, this did not happen nearly to the extent that critics predicted.

One indication of trends in the average health status of the risk pool is the average claims paid each year. Again, this figure reflects the benefit packages as well as the risk pool, but this is a good starting point to determine whether the market as a whole might have suffered from adverse selection. Tables 2 and 4 reveal that there have been only modest increases in average claims paid, averaging 1-4% a year in different market segments most years. In the small-group market, there was an initial 30% increase in average claims after the first year of reform, but average claims dropped in subsequent years. Another indication that good risks did not leave the market in large numbers is the relatively modest number of complaints received by the DOI from subscribers who could no longer afford coverage.

There is some indication that the individual market has a worse risk pool than the small-group market since the leading insurers' individual rates are 30-40% higher than their small-group rates for similar coverage. These rate differentials are significant, but they have not increased since 1994. And for the two leading HMOs, the differential has decreased from the 50-70% range.

This stable risk pool is consistent with what we have seen in the small-group market in other states with community rating and guaranteed issue, but the lack of serious disruption to the individual market is fairly unique. We inquired why Vermont did not experience precipitous price increases resulting from large numbers of younger, healthier subscribers leaving the individual market, as reportedly occurred in New York or Washington state, for instance. One explanation is that Vermont law initially allowed a +/- 40% rate variation in the individual market, reduced two years later to +/-20%. However, as noted below, several of the leading insurers have never used this rate flexibility. A second explanation is that Blue Cross, the leading insurer, was already using community rating, and so a large portion of the market had already adjusted to this type of pricing. A third explanation is that insurers can impose a pre-existing exclusion period of 12 months, which is longer than in some other states. Also, as discussed below, Vermont allows insurers to construct their benefit packages much as they deem fit, in part to ward off the adverse selection that comes from sicker patients seeking out richer benefits. A final explanation is that adverse selection is occurring, only more slowly than anticipated. One actuary explained that insurance market reform is "only four years young," and that even if there is only a "slow trickle" of better risks leaving the market, this can still result in an adverse selection death spiral over a span of 10 years. The most significant factor that appears to have kept low risks in the market, however, is the "Safety Net" program.

3. The Safety Net Program and Benefit Reductions

The "Safety Net" was created late in the legislative process as a response to the threat by

several leading individual insurers (most notably Golden Rule) to pull out of the state if individual market reforms were enacted. These were insurers who had used aggressive medical underwriting to select the best risks and therefore offered extremely attractive rates, as low as \$25/month, far below what was available from Blue Cross. To avoid large numbers of these low-risk subscribers from leaving the market, Blue Cross agreed to a requirement that it act as a safety net by continuing the coverage of any subscriber with a company that leaves the market. It agreed to not increase rates any more than 15% a year. Golden Rule and several other indemnity insurers in fact left the market, and enrollment in the safety net rose to over 5,000, about one-sixth of the market total. Essentially, these subscribers were grandfathered into a lower community rate than the rest of the market to shelter them from the rate shock that would otherwise have resulted. This occurred only for subscribers whose insurers withdrew from the market, but these insurers happened to be the ones with the lowest risks.

Although the safety net may have been an initial success, it now has many critics and almost no defenders. From the consumer perspective, persistent complaints by safety net subscribers about very large rate hikes led the *Burlington Free Press*, which initially gave strong endorsement to these reforms, to retract its position in 1995 and to call for the repeal of the community rating law, at least in the individual market. Blue Cross competitors see this as a windfall to Blue Cross because these younger, healthier subscribers are desirable business. Blue Cross, however, views itself as paying a heavy subsidy to these select risks because their rates were so severely underpriced. Blue Cross found that many of these subscribers had low rates only because actual or potential serious health problems had been excluded from coverage using "laser riders," which target specific diseases or body parts. These are illegal under the reform law, so Blue Cross had to offer full coverage for known health conditions but at rates based on very clean risks, a turn of events one subject described as a "huge fiasco" financially for Blue Cross. Blue Cross lost over \$1 million dollars a year on the safety net pool until it was allowed a one-time extraordinary rate increase of 37%. This has not completely stemmed the losses, however, since it prompted some number of healthier safety net subscribers to leave the pool. Thus, it might be concluded that the safety net program only delayed, but did not avoid, the inevitable rate shock that comes from converting to community rating. State regulators say that, if they were to do this again, they would limit the pool's duration and they would allow for rate increases to keep pace with actual claims costs. Nevertheless, the safety net did succeed in initially keeping many low-risk subscribers in the market.

4. Rating Practices and Associations

Before concluding our discussion of community-rating issues, we need to mention some technical aspects of how rating is done and some important ways in which some insurers use rating techniques and exceptions to their advantage. There are three issues: (1) use of the +/- 20% rate variation; (2) the exception to community rating for small-group associations; and (3) adjustments to community rates to reflect benefit differentials.

Rating Flexibility. As noted above, Vermont is not a "pure" community-rating state because the reform statute gives regulators authority to allow some rating flexibility. The DOI

initially allowed +/- 40% rate variation in the individual market, and +/- 20% in the small-group market, but the individual market was also compressed to +/- 20% two years after reform. This rating flexibility can be used to reflect only allowable rating factors, such as demographics, but not individual health status. This was an important transitional measure to help keep better risks in the market when community rating took effect. It was also critical to some indemnity insurers' decisions to remain in the individual and small-group markets. However, because this rating flexibility cannot be used by all insurers, it has created adverse selection among insurers and so has prompted considerable controversy.

The DOI denied requests by Blue Cross and Kaiser/CHP, two market leaders, to allow them the same rating flexibility because it views this as inconsistent with their nonprofit status. Indemnity insurers, however, are allowed to vary rates not only for their PPO products but also for "HMO look-alike" products, which add HMO-type restrictions to a PPO network. CIGNA, for instance, is registered in Vermont as an indemnity insurer but it sells a product that is virtual HMO coverage. As a result, HMOs and Blue Cross, as well as agents, believe that commercial indemnity insurers are receiving a more favorable selection of risks. One subject noted that some insurers are "very sophisticated and disciplined in their exploitation" of this rating flexibility. Another said these insurers are "speed boats" that are very good at "nipping off" the best risks, and there is "no limit to how clean they can pick" the market. He continued, explaining that when some insurers can vary rates and other cannot, making money through risk selection is "as easy as falling off a log." Another subject commented that Blue Cross is being "pillaged by the competition," and another source commented that 20-40% price differences are more than enough to discourage higher risks from purchasing, which means that insurers who use the rating flexibility have almost as much underwriting impact as they did when they could decline applicants outright. Evidence of this can be seen in Table 2, which strongly suggests that the leading indemnity insurers are receiving much better risks in the individual market than are Blue Cross and Kaiser/CHP, since these indemnity premiums and claims have been less than half as much.

To some extent, these disparities are self-correcting because purchasers are able with guaranteed issue and portability to seek out the best rates by changing risk pools. Therefore, insurers that initially select favorable risks with deeply discounted rates often end up with steep rate increases a year or two later, causing a downward spiral in enrollment and even steeper increases in following years as only the worse risks remain. One subject suggested that this scenario is about to play out in Vermont's small-group market, and we have observed it in other states. Even though the most aggressive risk selectors might suffer this downfall, however, this dynamic causes a great deal of market turmoil.

Accordingly, it appears to be increasingly difficult to maintain the unlevel playing field created by the differential rating rules. One source at Blue Cross commented that, having failed to force the rest of the market to compete as Blue Cross traditionally did, he would now prefer to see Blue Cross behave more like the competition and start to use risk rating, but it is legally precluded from doing so. This source suggested that it is not beyond contemplation that Blue Cross might withdraw completely from the individual market, as happened recently in New

Hampshire, or might adopt risk rating, even if this meant sacrificing its tax exemption. Another source observed, though, that another way to level the playing field is for the insurance commissioner to use the discretionary authority under the law to eliminate rating flexibility for all insurers, rather than to grant it to all insurers. However, doing so might end up driving out the few commercial insurers that remain in the individual market, so the best resolution of rating equity remains a tough dilemma.

The Association Exception. A second form of rating flexibility arises through an exception to community rating that is allowed for sales through small-group associations. This exception applies to associations that have been in existence for more than a year (even those created after the law took effect) and that are formed for non-insurance purposes. Examples include professional and trade associations, and business groups such as chambers of commerce. If approved by regulators, they are allowed to offer small-group insurance to their members of any size, at whatever rates they negotiate with the insurer, without regard to the insurer's community rates. However, associations must still offer guaranteed issue and uniform rates within their membership, and membership criteria cannot be used to exclude higher risks. Despite these safeguards, the association exemption creates the potential for eroding or undermining the broader community-rated market. Also, allowing associations to price insurance based on experience rating might cause a degree of market volatility, as employers switch back and forth among associations searching for artificially healthier but unstable risk pools.

Some aspects of each of these possibilities have occurred in Vermont. Associations are a very prominent feature of the Vermont small-group market. There are 15-20 large, prominent ones, some of which are restricted to particular trade or professional groups, but others of which are open to any employer. These associations account for over 60% of small-group enrollment marketwide, and over 95% of Blue Cross' small-group enrollment, which is by far the largest small-group carrier (Table 4). The portion of small-group business sold as community-rated plans is shrinking at such a rate that one subject described the small-group market as "disappearing" into associations, and two others said that the only people who continue to buy outside of associations are those who are "too befuddled" to have "figured it out yet." We found in the market testing study that, of eight independent agents who gave quotes, half quoted association products.

Allowing associations to base their rates on the claims experience of enrolled members has created large differentials between community rates and association rates at some insurers. One subject said that the same coverage from the same insurer sometimes is 100% more expensive outside than inside an association, but other subjects saw the rate differential as more like 15-30%. Our review of sample rates in 1996 and 1998 found that community-rated products from some insurers were 30-50% higher than their association rates for the same products. Although this is significant, it is no greater than the 50% range over which commercial indemnity insurers may vary their rates outside of associations, and some of the non-association insurers are offering rates significantly lower than association rates. Therefore, it cannot be said that the association exception has completely undermined the community-rating law. The association exception has allowed insurers like Blue Cross who otherwise may not vary their

community rates to offer discounts commensurate with those permitted by commercial insurers. Still, published community rates are essentially irrelevant for many insurers since the more competitive rates can be found only in associations. Some subjects believed this rate differential is increasing, but most thought it is diminishing over time as more purchasers "figure out" how the system works. We observed a somewhat greater differential in 1998 (40-50%) than in 1996 (30-40%), however.

Views differed over whether this is a good market structure. One way to describe the result is that the small-group market has been converted from one of community rating to one composed of large, experience-rated associations, which functions essentially like the large-group market. That is not what was intended by the law, but it does achieve the purpose of aggregating purchasing power and therefore lowering prices through economies of scale and increased bargaining power. One insurer regretted that associations had taken away the "sweet spot" of the market that previously existed between unprofitable individual business and highly competitive larger-group business. Another advantage that was noted of bulk purchasing is that this creates a foothold for new insurers to quickly build market share, and it gives insurers an incentive to invest in developing managed-care networks. CIGNA's entry into the market via an association was cited as a prime example. Experience rating also rewards employers for health promotion activities, which usually are rare in the small-group market but which some Vermont associations have adopted.

Most subjects, however, view the dominance of associations in negative terms. Several described these associations as a "scam" that undermines the purpose of the law, fragments and destabilizes the market, and allows insurers to compete by cherry picking. One subject at an insurer described its embrace of associations as a "devil's pact," because this way of competing diverted the company's attention and resources away from developing stronger managed-care products. An insurance regulator said that associations had been the "most disruptive" aspect of the reform law. Another subject noted that this bifurcation of the market results in a concentration of higher risks in the community-rated pool since any plan offered through an association must also be offered in the community-rated market, even if the association's membership is limited. This prevents insurers from trimming benefits in their community-rated plans to counter adverse selection. Several subjects complained that Blue Cross dominates the association market, and it imposes restrictive rules that prevent associations from offering plans from competing insurers.

Adjusting for Benefit Differences. A final aspect of community rating that is subject to some degree of manipulation is the adjustment in rates to reflect the actuarial value of different benefits. Difficulty arises from the judgmental nature of the actuarial techniques used to estimate the value of benefit differences. One technique is to simply reflect the claims experience that results from different benefit packages, but this captures both benefit differentials as well as differences in the health status of the risk pools that select different benefits. Sicker patients naturally tend to prefer a more comprehensive set of benefits than healthier patients. Therefore, the higher claims experience for a low-deductible plan may result as much from the sicker population than from the fact that the insurance covers more. Community rating is supposed to

reflect only the latter factor, not the former, but there is no settled way to disentangle these combined effects.

Insurance regulators claim that they avoid any gaming in this regard by requiring insurers to pool their claims experience for all benefit variations within a plan type and then to make rate adjustments based on objective criteria. However, the end results indicate this has not succeeded. We observed several instances in which two plans that differ only in the amount of their deductibles have premium differences greater than the difference in the deductibles, for instance, a plan with a \$100 rather than a \$500 deductible costing \$600 more. There is certainly no actuarial justification for charging \$600 more for benefits that are worth \$400 unless the benefit differentials are a proxy for selection effects, that is, unless the difference in premiums reflects in part the different health-risk characteristics of the people who choose these different plans. Although this partially undermines the purpose of community rating, one might view this as a small and acceptable deviation from the spirit of that law to avoid undue adverse selection and therefore to keep available more generous benefit packages that otherwise might have to be eliminated entirely from the market.

C. Market Competition

1. Individual Market Structure and Product Offerings

From most indications, the small-group market in Vermont remains healthy and competitive, and the individual market is surviving adequately. We will examine each market segment separately.

In the individual market, as of 1998 there were seven registered insurers, three of which were HMOs. This is a thin but adequate market structure that has diminished only slightly since 1994, although it is worrisome that only four insurers have substantial enrollment (more than 150 lives). Several subjects, such as the following agent, commented that, despite insurers dropping out of the individual market, some degree of competition and choice remains:

What has happened over time, and it actually happened fairly quickly, was other players came into the individual market. Time Insurance came in. . . . Their rates are relatively competitive. Not as competitive as they were in the old days when they could medically underwrite, but they have stepped up to the plate. They have written a lot of business for other carriers. Mutual of Omaha was out of the market for a while. They are back in, at least, on some level. There are other players as well.

However, the individual market has substantially fewer competitors now than prior to reform. When individual reform was enacted, several individual insurers with substantial blocks of business withdrew from the market, notably Golden Rule and American Republic, and many others with much smaller blocks stopped taking new enrollees. Several agents said this "exodus" proved to be very disruptive:

What happened initially, when the guaranteed standard issue was initially passed, there was tremendous restriction in the market. Companies pulled out. Golden Rule Insurance had been a big writer of individual health insurance in Vermont, like they were in many states in individual and small group. They just pulled out of the state. There was quite a bit of market disruption that went on initially. A lot of people had to go buy individual Blue Cross plans who had Golden Rule plans, and they to pay a lot more for them.

.....

Q: The individual market . . . was hit harder, I take it. In other words there is less choice there now?

A: . . . *That's true, although quite frankly . . . there was always much less choice. It was more like there were nine providers before and now there are three or four. What really changed was the two primary providers outside of Blue Cross left the state and that created what is generally perceived to be a vacuum in the marketplace. . . . It was probably [18,000] lives that were impacted by the exodus of carriers on the individualside and those people were being subjected to rate adjustments that could have been very substantial. And there was a big outcry about that.*

Agents comment that, now, only Time/Fortis offers an attractively priced comprehensive product, and the only other insurers with substantial enrollment are Blue Cross, Kaiser/CHP, and Mutual of Omaha. Other HMOs are in the market only because state law requires them to offer at least one individual product in order to maintain nonprofit tax-exempt status. They do not all have statewide networks, and they do not actively market their individual products. The other indemnity insurers either sell only catastrophic level coverage or do not have an extensive agent network and so have very limited market presence.

Also, product selection has diminished in that benefits have been pared back to the extent that low-deductible coverage is available only through the HMO offerings. Before reform, indemnity insurance could be purchased with deductibles as low as \$50, but in 1998 the lowest available deductibles are now \$1,000 for single coverage. Drug benefits have also become leaner, and some insurers are using fee schedules that pay substantially less than providers' normal charges, leaving some subscribers subject to balance billing that greatly exceeds the stated co-insurance amounts. These reductions have built over time and are still occurring, indicating that they have come in response to what other competitors are doing, in order to avoid being the most attractive plan in the market. Insurers may try to increase minimum deductibles even more, although the Insurance Department would resist this.

Requiring a standardized benefit package would have prevented this erosion in benefits, but the law's requirement of a standardized plan was never implemented in the individual market

because it was felt that product offerings were adequate and there were too few competitors to merit the effort. As a consequence, Vermont, unlike states with standardized benefit plans, allows insurers to construct their benefit packages pretty much as they deem fit, in part to ward off the adverse selection that comes from sicker patients seeking out richer benefits. The downside to this tactic is that it may produce a "race to the bottom," in which no insurer wants to be left with the richest package and so even healthy subscribers lose the option to purchase comprehensive coverage. As noted below, benefits have not been reduced in the small-group market to the same extent, where a standardized benefit plan is in place for indemnity coverage. It is notable, however, that several HMOs in the individual market offer very generous comprehensive coverage, which accordingly is priced higher than several of the indemnity offerings. Insurance regulators are trying to persuade these HMOs to offer a more affordable individual product. But one HMO told us that doing so is not worth the effort, despite the concern over adverse selection, because the market is so limited in size.

Despite these drawbacks, individual market reforms have greatly increased market options for higher-risk subscribers. Prior to reform, people with health problems could obtain individual coverage at community rates only from Blue Cross. Following reform, this coverage was available from any insurer active in that market. Thus, one notable impact of reform has been to shift enrollment from Blue Cross to Time/Fortis. From 1994 to 1997, Blue Cross' individual market share dropped by a third while the market share of Time/Fortis more than doubled (Table 2). Spreading high-risk individual enrollment across more insurers than just Blue Cross was one of the objectives of reform, and so to this extent the reform law has partially succeeded. Another feature, viewed positively by many, is that catastrophic policies, some coupled with medical savings accounts, have become more popular in the individual market.

2. Small-Group Market Structure and Insurers' Strategic Decisions

The competitive picture in the small-group market is much more favorable than in the individual market. Although a large number of small-group insurers also withdrew or stopped enrolling when small-group reform was enacted, including some very large national insurers such as Aetna and Travelers, none had very significant market shares in Vermont, and most had microscopic enrollment. As of 1998, 11 companies sell in the small-group market, 60% more than in the individual market. The effective competition is much stronger than this comparison reveals since more of the small-group insurers are actively marketing and offering attractive rates. Several small-group insurers have entered this market or have become much more aggressively price competitive following reform. Several subjects commented that competition for small-group business is more intense now than before reform, and that there is greater choice of product options. Benefits have not been reduced in the small-group market to the same extent as in the individual market. Deductibles as low as \$100 are still readily available, and reductions in covered benefits have been in response to consumer demand and cost-containment concerns rather than an attempt to avoid higher risks. On the other hand, several small-group insurers have withdrawn in the past year or two, so that the number of registered insurers has dropped about 25%, and only about eight are actively marketing across the state. One informed subject made

the alarming prediction that several more small-group insurers are likely to withdraw or become effectively inactive, so that in a year or two there may be only 2-3 insurers left in the market. This subject noted the irony that Vermont may eventually collapse to a virtual single-payer market by default; after the full effects of reform are eventually felt, only one or two socially oriented, nonprofit companies may remain.

Vermont was one of the earliest states to adopt nearly-pure community rating and guaranteed issue for both the individual and small-group market. Because this occurred during the national debate over universal coverage and comprehensive reform, the decision to withdraw by at least half the insurers in the state received significant publicity. Much of this publicity focused on Golden Rule's highly visible opposition to the reform law and the disruption caused by its immediate withdrawal. Accordingly, we solicited views on what prompted other insurers to withdraw and why some chose to remain.

We spoke to three national insurers who chose to remain in the Vermont market despite their general opposition to its rating and issuance rules. We heard a number of interesting and revealing perspectives. First, we were told that the +/-20% flexibility in the community rate is important to remaining in the state, as is the fact that Blue Cross and the HMOs are not permitted to use this flexibility. One insurer explained that it has more maneuvering room in Vermont than in other states to avoid higher risks because it can alter its benefit package to deter adverse selection and because Blue Cross is still "acting like a carrier of last resort." Also important was the reputation of regulators for allowing adjustments in the community rate necessary to keep up with increasing claims. As one regulator said, "I promised [these insurers] to always give them their rates if they are justified," an assurance insurers feel they don't have in other states with highly politicized processes for prior rate approval. Another insurer said that the small size of Vermont cut in favor of remaining in the small-group market; it chose to use this as a test state to see whether it could survive in a market of community rating and guaranteed issue. Its generally favorable experience in Vermont convinced it to remain in other small-group markets that adopted similar rules. However, it has since effectively withdrawn from Vermont by increasing its rates far higher than the competition.

Some of these conditions favorable to indemnity insurers are beginning to change, especially in the individual market. As noted above, there is increasing pressure to level the playing field with respect to use of the +/- 20% rating flexibility. Also, Blue Cross pared back its individual benefit package in 1997 in order to counter some of the adverse selection it was receiving, with some success. Blue Cross raised its minimum deductible to \$1,000 and cut back the generosity of its drug benefits in its individual indemnity products. Although its individual enrollment has fallen as a result, its loss ratio has improved, suggesting that it is shedding more of its higher risks. Simultaneously, Time/Fortis, the leading indemnity insurer, has seen its enrollment greatly increase and its loss ratio worsen (Table 2). One indemnity insurer said that its loss ratio increased by 20 points during 1998.

These developments suggest two troubling possibilities. If Blue Cross were to withdraw from the individual market because it continues to attract higher risks, as occurred in New

Hampshire, some or all of the commercial indemnity insurers would almost certainly leave as well since they would not want to pick up this higher-risk business. However, if Blue Cross is successful in countering adverse selection, for instance by using the +/- 20% rating flexibility, and so stays in the individual market, some of the other insurers might still withdraw because they would no longer be receiving better risks to the extent they have so far. In short, the previous market structure owed its existence to Blue Cross' receiving most of the worst risks, but Blue Cross is increasingly not able and not willing to be the only carrier to play this role. A similar dynamic resulted in the virtual collapse of the New Hampshire individual market in 1998.

3. Managed Care

One notable change in the nature of market competition in Vermont is the movement to managed care in the small-group market. Although Vermont was slower than other states to embrace HMOs, many interview subjects noted that HMOs have become prominent in recent years. This movement indicates that insurers are beginning to compete more based on their ability to manage the costs of care rather than their ability to select and accurately price health risks. Whether this is a positive or negative feature depends on one's view of managed care. In Vermont, unlike some other states, promoting managed care was not one of the primary purposes of reform. Nevertheless, this appears to be one of its effects.

In 1997, HMOs had 80% of the non-association small-group business, more than double the 36% in 1992 (Table 4). This is similar to national trends, but it fails to reflect the larger portion of the small-group market that is sold through associations, most of which is primarily indemnity coverage. Some agents said that HMOs are gaining ground, but slowly. In our market testing study of 10 agents, of the 13 price quotes given, only four (31%) were for HMO coverage. Nevertheless, many subjects noted the rapid increase in Kaiser/CHP's small-group enrollment following reform (almost doubling in three years, see Table 4), and the entry or development of several smaller HMOs in the small-group market, such as Mohawk Valley and CIGNA (which is registered as an indemnity insurer but sells an "HMO look-alike" product). One subject at Blue Cross said that, although its HMO product still has only a small fraction of its total small-group enrollment, the HMO share is quickly growing since HMO products now account for over half of its new business through associations.

There is some debate whether this shift in the small-group market can be attributed to the reform law. The same movement can be seen in most other parts of the country and so may be independent of the law. Both in Vermont and elsewhere, interview subjects commented that HMOs are hungry for "covered lives," and the small-group market simply offered the best potential for market expansion as the large-group market began to become saturated in the early-to-mid 1990s. Also, some subjects observed that much of the small-group movement to HMOs in Vermont happened only recently, several years after the reform law was enacted. (This is more true for Blue Cross, CIGNA, and Mohawk Valley than it is for Kaiser/CHP, which is the largest HMO. It was only in 1997 that Blue Cross offered its HMO product statewide and through small-group associations.) Thus, most subjects thought this trend is independent of the reform law, driven primarily by the desire to contain costs. Also, a number of subjects commented that

Vermont's market is not well suited to the formation of HMO networks since it is mostly rural and the major hospitals have virtual monopolies in their service areas.

A contrary view, however, is that the law may have precipitated or facilitated a movement to managed care. This view had a few adherents in our Vermont interviews. They observed that the reform law creates a set of market rules that are more compatible with how HMOs were already operating and so the law creates more of a level playing field with indemnity insurers, which now find it much more difficult to compete since the mechanisms for risk selection are greatly reduced. Also, they observed that the reform law might have precipitated movement to HMOs to the extent that healthier, lower-rated groups with indemnity coverage experienced a rate shock when community rating was imposed, prompting them to shop around for more favorable rates, which they found from HMOs. Also, it is important to note that the portability provisions of the law make it easier for groups so inclined to switch to a different type of insurance.

4. Price Competition

These structural features of the small-group market have produced price competitive conditions. In our market testing study, a small employer requested price quotes for coverage that most closely matched a specified set of benefits, and all 10 agents provided quotes. These revealed a fairly tight clustering of prices. Quotes for indemnity PPO coverage were spread over a range of 1.4:1, and for HMO coverage, the range was 1.25:1.

Several subjects commented that small employers are highly price sensitive and will switch plans to avoid even small price increases. Others saw this issue differently because of the strong "brand-name" loyalty that Blue Cross subscribers have, which keeps them from changing insurers even to save 20% or more in premiums. However, others said this brand-name loyalty is diminishing, and regardless those who keep Blue Cross insurance are said to be very willing to change benefit plans or switch to different associations to achieve small price advantages.

This fluidity and price sensitivity makes for a competitive market, but it also has some negative consequences by making the market extremely volatile. This is especially so with respect to sales through associations. We heard from many subjects that the association market has experienced great turmoil because many small employers join associations primarily only to buy insurance and so are willing to switch associations frequently to find the same insurance (usually Blue Cross) at slightly lower rates. This produces a market dynamic that can result in wild swings in both association membership and in the rates for their health insurance plans. The following cycle has occurred for several of the associations: An association that begins with a small and more select membership finds that its lower insurance rates are a strong draw for new members (who bring in association dues), and so the association uses its low insurance rates to advertise aggressively for even more members. As small employers flock in droves to the association, its membership multiplies (as much as 20-fold), but its risk pool becomes less select, and so the insurer imposes a steep (20-35%) premium increase. This causes a "melt-down" in which either employers switch associations looking for a better risk pool, or the association

switches insurers to keep rates lower. However, because of the strong loyalty to Blue Cross just noted, switching to another insurer (usually an HMO) generally means the association will quickly lose much of its membership in any event. This tumultuous cycle occurred for at least two of the major associations in the first four years following small-group reform. However, it has not occurred since 1996, in large part because the largest associations have maintained remarkably level premium rates in recent years. Therefore, it may be a one-time phenomenon that resulted from the market's adjustment to the new rating rules. However, one very knowledgeable source said these associations are still "ticking time bombs" waiting to "implode."

This form of price shopping is obviously not the type of competitive environment envisioned by market reformers. For the most part, small employers are careening from one association to another simply to find the lowest price for Blue Cross coverage. Almost no association offers a choice among multiple carriers, in part because Blue Cross participation rules do not allow this. Some associations have switched from Blue Cross to competing HMOs, but not many. Using experience-rated association pools to price Blue Cross coverage makes for an unstable market dynamic because, unlike larger employer groups, there is nothing that binds the existing membership to a particular association. Blue Cross has attempted to lessen this turnover by restricting how easily employers can switch associations and still stay with the same plan, but its ability to do so is hampered by the reform law's portability guarantee. Thus, the resulting competitive dynamic appears to be more of a churning among artificial risk pools rather than any real efficiency-generating price signal about which insurer offers the best value.

5. Standardized Benefits

Another feature of the reform law intended to promote competition is the requirement that insurers offer one or more standardized benefit plans, in order to facilitate "apples-to-apples" price comparisons among insurers. This aspect of the law has not succeeded. In the individual market, the law's requirement was never implemented because it was felt that product offerings were adequate and that there were too few competitors to merit the effort. No HMO plan was developed in either market because the existing offerings were already so much alike. In the small-group market, a standardized "Act 52" plan was adopted for indemnity products, but its "Noah's Ark of benefits" proved to be so comprehensive and expensive that very few have sold, and so it quickly became irrelevant, even for purposes of reference pricing. Several subjects commented that those who drew up the standardized package were influenced by the social optimism at the time that Vermont would soon adopt a system of universal comprehensive insurance. Now, it is generally felt that revising the standardized plan is not necessary since the market is sufficiently competitive without it and has a good array of benefit options.

6. Quality Competition

Although price and product competition is undoubtedly strong in Vermont's small-group market, what is noticeably absent are forms of competition based on outcome measures of

quality. Naturally, this is relevant only to HMOs since indemnity insurers are not in a position to monitor or influence the quality of care, and one of the selling points of indemnity coverage is that subscribers are free to make their own decisions about which are the best providers. However, even for the HMOs in the market, when we reviewed the sales literature from leading insurers targeted to the small-group market, we found no reference to outcome measures of quality such as the HEDIS measures developed by the National Committee for Quality Assurance (NCQA), with one exception. One HMO that had received high rankings on various measures mentioned this in its literature and included copies of favorable articles in popular magazines. For other HMO and PPO insurers, we found at most only generic references to the quality of providers in the network or to the insurer's accreditation status, but often even this was not mentioned. The dominant focus of the sales literature is on the particulars of the benefit packages, and for PPOs and HMOs, 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.

In summary, although the Vermont small-group market is competitive, it is far from the model envisioned by some reformers. Even though insurers do not use risk selection to the same extent as before, Tables 2 and 4 reveal that substantial risk differentials still exist among insurers, and as discussed above, risk differentials exist among associations offering the same insurer. As a consequence, rate differences still reflect risk segmentation to a considerable extent rather than the underlying efficiency in the form of insurance or the delivery of medical care. Risk segmentation persists for a variety of possible reasons. First, insurers entered the reformed market with varying degrees of risk in their subscriber pools, and these historical patterns have persisted. Second, risk differentials may exist by virtue of subscribers' natural preferences, such as the tendency of sicker people to prefer indemnity over HMO coverage, or the reluctance of sicker subscribers to switch insurers with a resulting advantage for newer market entrants. In particular, we heard from several different sources that Vermonters have a very strong brand-name loyalty to Blue Cross, to the extent that those with Blue Cross coverage are reluctant to switch even to achieve substantial savings in premiums. Third, insurers are able to shape their risk pools to some degree using the various techniques of field underwriting, rating variation, and benefit adjustments described above. Finally, the exception to community rating allowed for associations creates a market dynamic that promotes price shopping based on risk pooling since this results in an experience-rated component of the small-group market without the natural glue that holds large employer groups together.

7. Risk Adjustment

One final notable feature of Vermont's approach to market reform deserves further attention: Vermont is the only state that has implemented community rating in the individual market without any system for reinsurance or risk adjustment. This appears to rebut the assertions by many insurers and public policy theorists who insist that reinsurance or risk adjustment is an

essential feature of any successful market reform that employs community rating. Insurers have remained in the market despite the absence of this protection against adverse selection. It is not safe to draw sweeping conclusions from this example, however, because of the unique attributes of Vermont, discussed below, which make its market and its reform law function more smoothly than is possible to replicate in many other states. Moreover, even though the market has survived without risk adjustment or reinsurance, it does not operate as smoothly as many would like. A reinsurance or risk adjustment mechanism would help to counteract the incentive or opportunity to engage in the techniques of risk selection noted above.

D. Administrability

1. General Compliance and Regulatory Enforcement

Finally, we address a series of concerns about the administrability of these laws. From most indications, the Division of Insurance has been proactive and effective in administering the reform law. Although subjects at one insurer view the Division as lax in responding to complaints or indications of noncompliance, mainly due to being understaffed, another insurer commented that the DOI is "vigilant" and "responsible" in its enforcement activities generally, including the market reform laws. In the early years of reform, the DOI audited all of the small-group insurers to ensure compliance and to correct misunderstandings of the law. The DOI regularly publishes a helpful consumer brochure that describes the law and lists all available insurers and products, along with prices. This type of comparative price and product information is rarely found in other states, in part because other states usually have far too many insurers to make this feasible.

Regardless of the view one takes of the Division's enforcement activities, our impression is that there is widespread compliance among insurers and agents with the fundamental requirements of the reform law. We found that all interview subjects are well versed in the requirements of the law. In the initial years, some insurers were found to be in noncompliance, but in the Division's judgment this was due to misunderstandings about how to interpret the new law rather than purposeful circumvention. Having a full year between enactment and the effective date of the law helped to minimize these problems. The Division considers that all of the major insurers have made good faith efforts to remain in compliance and "play by the rules." However, one insurer complained that some very small competitors remain in the market doing business just as they did before the law, but they are able to escape detection because they have so few subscribers. Indeed, there are a large number of insurers with microscopic blocks of business who are not offering guaranteed issue, but the DOI's understanding is that these insurers are not accepting any new subscribers and are simply continuing to cover renewing subscribers, as the law allows.

2. The Association Exemption

The one area in which the DOI was frequently criticized in its enforcement efforts is with

respect to the small-group associations. These were intended to be an exception to the community-rating rules that was to be kept in bounds by requiring that qualifying associations exist for "non-insurance" purposes, that is, that they be primarily a trade or professional group that happens to offer an insurance plan as one of its benefits. This is true for many of these associations, but for several of the most prominent ones, it is clear that membership is driven primarily by the opportunity to buy cheaper health insurance. Agents say that employers join these associations only at the agent's recommendation, to obtain the insurance. So, regardless of why the association was originally established, the reality is that they owe their current size and scope of operations to offering health insurance. In the view of most subjects, this evades the purpose, and perhaps the letter, of the law. The example most often mentioned is Business Review Services (BRS), which sells Blue Cross insurance. According to one knowledgeable source formerly with Blue Cross:

One of the most popular associations with the Blues is Business Review Services. All you have to do is join them to be eligible. No other qualifications. And that was established when Blue Cross . . . had a falling out with Associated Industries of Vermont [AIV], a big brouhaha. And what the Blues did is they created, along with some clever brokers, a BRS to handle those companies that didn't want to move from Blue Cross Blue Shield that were members of AIV. So that's how that one came about. So it was created specifically for our marketing purpose to have a pool for the fallout from the AIV problem.

An agent took much the same view, although unlike other subjects, he saw these arrangements as diminishing:

Certainly there is a lot more business being written through associations today than there was five or 10 years ago. In the past, there were a few of these small-business-type associations. I don't mean like the Chamber of Commerce, which is a real organization. I mean like the Vermont Business Association or something like that. Essentially, all it was is a scam -- I probably shouldn't use the word scam -- but a group-purchasing organization for insurance. It was not any more of an association than that. . . . They are legitimate. It is just [that] their real sole purpose for being is just to get some kind of group purchasing. . . . Those have kind of fizzled out. Is there some of that still going on? Yes, there is. For the most part, the association business now is real association business . . . [like] the bankers association, the associated general contractors, the auto dealers association, the retail grocers association.

Another subject considers the association exemption to be the one feature of the reform law that did more than anything else to "bail out" Blue Cross, and thinks the DOI was clearly wrong to approve BRS as qualified for the exemption. Yet another subject asserted that

regulators were pressured by the large number of employers who wanted to continue buying their insurance at less- than-community rates.

The DOI believes, with good reason, that these criticisms are overstated or misdirected. In the Division's defense, it strongly opposed placing the association exemption in the law in the first instance. But since it is there, the DOI feels compelled to honor the law as written and the legislative intent. The impact the association exemption might have on the community-rated market was raised and debated before the legislature, yet it chose to allow the exemption. The leading business associations were already in place when the law was enacted, and they clearly established the model for what the legislature intended to allow. Thus, in the DOI's view, these types of associations may qualify and grow to any size as long as they are in technical compliance with the statutory requirements.

3. List Billing and Self-Insurance

We also inquired into particular enforcement issues that might be especially troubling or unanticipated. These include list billing, self-insurance, and employer fraud. These are all concerned with what we refer to as "border-crossing" problems. The potential for these problems arises when one segment of the market is regulated differently than another. This creates possible strategic advantages for low- or high-risk groups or individuals to cross into or out of the market, at either the high-size or low-size ends of the market, thereby unraveling or eroding the market divisions that are necessary to sustain this regulatory structure. The two primary examples are list billing and self-insurance.

List billing. This refers to an arrangement where employers or insurers facilitate workers' purchasing individual, rather than group, coverage. 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 to avoid the costs of insuring an employee or family with health problems. Other forms of list billing were done as an accommodation to employees whose employers were not willing to buy insurance for anyone, but who wanted to facilitate their employees' purchase of insurance through payroll deduction.

The reform law prohibits list billing, following the philosophy that employers should treat their employees equally, and we found little evidence that list billing was happening. Of the 10 agents contacted in our market testing study, none suggested or recommended arrangements under which the unhealthy member of the group would not be covered by the group.

One agent, however, noted that the same effect occurs when employees find themselves priced out of family coverage and so opt on their own to decline group coverage for their family and instead purchase this coverage in the individual market. This agent said that it is common for employers to contribute nothing toward family coverage. Another agent explained that some agents advise employers to facilitate this practice in order to lower their health insurance costs or

to provide fewer benefits to some workers than to others. However, this practice is not rampant:

The interesting issue that [XYZ] Insurance has had in the new world is that because their individual rates are so competitive, in many cases their rates are more competitive than group insurance. They have had . . . small groups [that] have all their employees buy individual plans, . . . [which the insurance company would not allow if they knew this since it] is a direct violation of the law. . . . I hate to say that members of my profession were being unscrupulous, but basically they must have been. That is the only place it could come from. They would go to a small business and say, "Listen Mr. Employer, what I want you to do is . . . to have each of your employees buy an individual health insurance plan, have it . . . billed to them, and you reimburse them for the cost. . . ." I would say that [practice] is going away because [the insurer] now is very strict about . . . making people sign forms saying that is not going on. They go through quite a process to make sure that it is not going on. You have to disclose who your employer is, and they have a cross reference built into their computer, my understanding is. . . . Now can you absolutely stamp that out? Really there is no way to. If someone is determined to engage in fraud and the company denies they are paying for it -- they are doing it under the table, the employees deny that it is happening -- it is pretty tough to prove. Is there a little of that going on? Yes there is, but it certainly is not being rampantly marketed like it once was. . . . There were certainly employers [that] will try anything they think they can get away with. Fortunately or unfortunately, once we got through the transition, there is not a hell of a lot they can do anymore. There really is not. The reforms are in place, and they are working. . . .

One reason this practice died out quickly is that the price advantage that once existed between the small-group and individual market when community rating was first adopted for small groups quickly disappeared once reforms were extended to individual policies a year later. Thus, Vermont does not have the difficulties other states face in policing the regulatory border between small groups and individuals. One agent explained, however, that as a consequence, when workers choose not to purchase family coverage, the spouse typically goes uninsured and the children are enrolled in the state's Dr. Dinosaur program, an arrangement the agent said was fairly common.

Self-insurance. Where border-crossing is more of a problem is at the larger-group end of the market. Because large groups are experience rated, a younger, healthier small employer could obtain a better rate by posing as a large group. In effect, this is what happens when small groups aggregate into a large association, to obtain the exemption from community rates. This might also happen, however, on a group-specific level by self-insuring. Employers who self-insure are protected from state regulation by the preemption provisions of the Employee Retirement

Income Security Act of 1974 (ERISA). This is the main reason that small-group laws usually operate only below a group size of 50, because increasing the group size would only prompt more medium-sized employers to self-insure. For groups below 50, self-insurance is generally thought not to be feasible because the risk would be too great.

However, some insurers and agents have developed a way for small employers to take advantage of the ERISA preemption provisions used by large employers. They have crafted stop-loss coverage with very low attachment points that effectively functions like catastrophic indemnity coverage rather than true reinsurance. Other states block this escape route by regulating the stop-loss insurance as part of the small-group market once the stop-loss attachment point falls to a certain level (\$15,000-25,000). Accordingly, small insurers are not able to avoid community-rating laws unless they are willing to take on a large amount of risk, which few do. In Vermont, however, regulators have not yet regulated stop-loss insurance at any level, and so small employers are free to invoke ERISA preemption in this fashion. According to most of our subjects, a significant and growing number have done so, although some attributed this to a general desire to lower costs rather than to a calculated attempt to avoid the law.

One subject said he had confidential data that one of the most active TPA firms in Vermont has 60% of its enrollment in self-insured small groups, a number that has grown "exponentially" since the reform laws were enacted. An agent said that self-insured arrangements are a "significant" part of the market for groups as small as 10 or 15. Several agents gave these detailed explanations:

Q: Do you see many small groups turning to self-insurance?

A: *More and more.*

Q: Small groups, under 50?

A: *Yes.*

Q: Really, what form does that take?

A: *. . .It again goes back to the element of risk. I'm presenting one this afternoon with 47 people. That's fairly close to the break point. I mean five years ago you wouldn't look at anything under 200. But here's a situation where you can add up what they're currently paying for premiums and weigh that against fixed costs of administration, \$10,000 stop loss, . . . throwing in roughly 30% of the anticipated losses for a reserve . . . and if you can get that within 10% of your fixed costs that you are paying for traditionally funded programs, why not run the risk? Premiums are just so great that these people are saying, hey, I'll take a little risk.*

Q: And how low are the attachment points on those?

A: *You can get them down to \$5,000. Cost you an arm and a leg, but you can do it.*

Q: *So how much of this -- you say you're presenting one this afternoon -- but how much is it moving to the under-50 market?*

A: *I'd say it's accelerating at a pretty rapid rate.*

Q: *And is this in response to this set of laws or just in response to general medical costs.*

A: *The latter, the cost. You reach a point where it's worth taking a little risk.*

.....

Q: *Do you see employers trying to kind of circumvent the reforms by doing more self-insurance?*

A: *Yeah, occasionally, yeah. That's true and that's legit. The law allows it and in some instances, it's not a bad way to go, if it makes sense. Self-insuring with seven people doesn't make a lot of sense. I don't have anyone that has done that, but yeah, that happens. . . . Some say you're crazy if you're less than 100 to do it. And yet I know there are groups of 25 that do it. I don't have anyone, [but] I speak to other agents who shared a lot with me, that encouraged me and said, hey, it's a great dealBut I would say definitely from what I have heard and learned that the size of the groups that have gone to self-insurance have become smaller and smaller. Some of it [is] to get around health care reform. A lot of it [is] with the hopes of saving money. That may be even a bigger motivation than getting around reform.*

.....

A: *I see a lot more of what is called self-insurance in small groups. . . . For instance I will tell you what we do in my business here. We buy a \$2,500 deductible . . . plan. We have a third party administrator who administrates our plan down to a \$100 deductible. We pay that \$2,400 difference out of our own pocket. I mean they pay the claims as if it is a \$100 deductible. We pay the first \$2,400 and [the insurer] pays the difference. We saved a lot of money doing that. There are individuals out there marketing those plans and calling those plans self-insurance. I don't call that self-insurance. . . . There are people doing it down to [groups of] 25 now, which I think is ludicrous. They will do it with much higher deductibles and plans that look more like what I would call real self-insurance plans. You have an individual and an aggregate stop loss and*

all of that. . . .

Q: Do you see more smaller groups doing self-insurance than previously?

A: *Yes. That is because companies are willing to do it and agents are out there selling it as an alternative. It is a way to keep costs down. . . . I would say some of the smaller groups who were buying it don't understand what they are buying. They don't understand their aggregate stop loss is 125 or 130% of the rate that they are paying. It is like everything else. There is certainly some misrepresentation by the marketing community. There is also just a lot of misunderstanding. . . . They see that the cost is lower, and they go for it. But, they don't really understand what risk they are assuming.*

Saving costs by taking on higher deductibles may be a desirable market development, but using this as a vehicle for avoiding regulation has no economic or policy justification, and the result may be to encourage employers to assume greater financial risk than they are prepared to bear. Moreover, this raises serious consumer protection issues, since purchasers may not be aware their policies are nonrenewable. Because most of these policies are written to cover only claims submitted during the policy period, an insurer could cancel coverage after someone has received expensive treatment but before they submit their claims, leaving them with large unreimbursable expenses.