Approved: March 8, 1993
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson William Bryant at 3:30 p.m. on February 23, 1993 in Room 527-S of the Capitol.

All members were present except: Representative Bruns, Excused

Committee staff present: William Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee:
Representative Joan Wagnon
Roland E. Smith, Wichita Independent Business Association
James Schwartz, KECH
David Gates, BMA
Bill Sneed, HIAA

Others attending: See attached list

Representative Vernon Correll moved for the approval of the minutes of February 22, 1993. Representative Allen seconded the motion. The motion carried.

Hearing on HB 2370 : Community Ratings

Representative Joan Wagnon distributed copies of a memo from Emalene Correll, Research Associate, regarding the bill (Attachment 1). This bill would phase in community rating for small employer groups of 25 or fewer employees , beginning with policies issues or renewed after January 1, 1994. Under the provisions of the bill, rates for small employer groups would be based on the aggregate loss experience of all small employers insured by a carrier, but could vary with the number of person in a covered family and from employer to employer by no more than 75 percent above the community rate for a policy issued within a year of January 1, 1994, no more than 50 percent in the following year, and no more than 25 percent during the third year. In the fourth and subsequent years, rates could not be greater than the community rate, a term defined in the bill. Representative Wagnon stated in her testimony that the proposed bill was almost identical to HB 2001 except it calls for a 4-year phase-in of the rate structure (Attachment 2).

Roland Smith, Wichita Independent Business Association, spoke in support of the concept of "community rating for small business health insurance plans" (Attachment 3). WIBA requests a clarification in language regarding carriers to modify the community rate based on unspecified criteria from employer to employer for four years or more. He also requested a provision for associations with businesses with fewer than 25 employees to have a common rate for all members.

Jim Schwartz, Kansas Employer Coalition on Health, Inc., supported the bill with modifications (Attachment 4). Reliable estimates should be obtained on the effect of community rating on the number of uninsureds. The potential problem of risk skimming by insurers should be investigated even though it is addressed somewhat in SB 561.

David Gates, Chairman of the Kansas Small Employers Health Program of BMA, appeared before the Committee. SB 561 has just gone into effect and the full impact is not known. Insured use most of their health benefits the last six weeks of their lives.

Terry Leatherman, Executive Director of the Kansas Industrial Council, a division of the Kansas Chamber of Commerce and Industry, presented testimony in support of the bill (Attachment 5). Along with community rating, he recommended that the Committee also consider health insurance reform concepts which increase health insurance affordability and availability, such as the repeal of state mandated benefit coverage, greater tax deductibility of employer contributions to employee insurance, prudent medical malpractice reforms, and standardizatin of insurance claim procedure and administration.

Bill Sneed, HIAA, spoke in opposition to the bill because it will only affect those insurance companies that can be regulated (Attachment 6). The implementation of a community rating type bill would be inappropriate inasmuch as the small employer bill and the uninsurable pool bill have not yet been effected and such a

dramatic change in the marketplace could have an adverse affect at its implementation. The community rating aspect should be delayed until the Legislature has determined the federal government is going to do on health care.

The meeting adjourned at 4:55 p.m. The next meeting will be held on February 24, 1993.

GUEST LIST

COMMITTEE: House Ins Ctte DATE: 2/23

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIO
HARRY SPRENG	KC.	HUMANA
Terry Leatherman	Topeka	KCCI
Dick Brock	"	Ins Dept
Toby Brown	WICHITA	WIBA
Don Lynn	Topeka	BC/BS of KS
John Peterson	Topeka	Kaiser Permanente
Chuck Stones	"	KBA
JEFF SONNICK	TOPEKA	KNLSI
Bill Sneed	TOPEKA	KIDA
Ed Roling	Wichita	Dena Donzac
ALBERT DENNY	WICHITA	WIBA
George Goebel	Topeka	AARP-SCCCTF
Kenneth Harnett	Wichita	WIBA
DUAYNE SHANNON	✓	✓
Rick Friedstrom	Topeka	Kansas Association of Life Underwriters
Danielle Lee	Topeka	Delta Dental

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

300 S.W. 10th Avenue
Room 545-N -- Statehouse

Phone 296-3181

February 22, 1993

TO: Representative Joan Wagnon Office No. 272-W

RE: Community Rating of Health Insurance

As individual states have considered and enacted market reforms in the health insurance market in recent years, one of the most troublesome from a legislative perspective has been community rating for the purposes of establishing group and individual health insurance rates. Under community rating, an entire universe of insureds is used as the base for actuarial purposes in establishing premium rates for health insurance policies. Once an established basis of rate setting in the insurance industry, the market moved away from community rating as the cost of health insurance, fueled by increased costs of health care, began to escalate steeply. In order to remain competitive and in order to hold down rate increases for some of their insureds, companies moved toward rate making based on individual group experience. This has become a common market practice in the last several decades.

In general, the market most affected by moving away from community rating has been the small employer group market. Since an adverse (high cost) health experience or the diagnosis of a disease or condition that is potentially costly to treat on the part of even one employee in a small group can expose the insurer to greater liability than is the case when the risk is spread among a large number of employees, the affect of experience rating has resulted in extreme rate increases for some small employer groups. This, in turn, led to other market practices such as excluding an otherwise eligible employee from a group in order to keep costs down or the exclusion of coverage for preexisting health or disease conditions. Finally, some small groups with adverse experience found they were unable to find insurers who would cover the group. Kansas has addressed exclusion of an otherwise eligible group member, coverage for preexisting conditions, and mandated offering of coverage for small employer groups in the past two years through enactment of H.B. 2001 in 1991 and S.B. 561 in 1992. (See *Report of the Joint Committee on Health Care Decisions for the 1990s* for discussion of these bills.)

Kansas and Community Rating

Kansas has also considered mandating community rating over the past several years. A special interim study committee on health insurance considered the issue, among other market reforms, in the interim prior to the 1991 Session. H.B. 2001 as introduced in 1991 would have

House I.S.L.
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Attachment 1

mandated community rating. Testimony on this aspect of the bill indicated that community rating, even if phased in over a period of several years, would result in steep rate increases for some small groups because they had good experience records. In some instances, these are also groups that have emphasized wellness programs, preventive care, employee education, and other measures to keep health care costs down. Other groups that are sometimes composed of older, less healthy members would experience, if not actual rate decreases, a slowing in the increase of premium rates. After considerable consideration by both the House and Senate committees to which H.B. 2001 was assigned, mandated community rating was removed from the bill prior to its enactment.

1992 S.B. 561, which as introduced was the work product of a special task force appointed by the Commissioner of Insurance, did not mandate community rating. The 1992 legislation does however contain provisions relating to ratemaking for small employer group plans that are intended, over a period of three years, to stabilize the premium rates for all small groups and to compress the premium differences between small groups. The rating restrictions contained in the 1992 legislation became effective for all new health benefit plans January 1, 1993, and for all existing plans on the annual policy anniversary date of the plan following January 1, 1993.

In essence, S.B. 561 allows carriers offering small group accident and sickness benefit plans to create no more than nine separate classes of business. If the carrier creates classes, they may reflect only the differences set out in the bill: they may not reflect health status or past claims of the group. The 1992 legislation also prohibits a premium rate differential between classes of business that exceeds 20 percent. Within a class of business, rates charged small employer groups (generally 25 or fewer employees) with the same characteristics and the same or similar coverage may not vary by more than 25 percent of the index rate. The percentage of premium rate increase that may be charged a small employer group is also regulated by the 1992 legislation which also requires that the same rating factors be used for all small employer groups in a class and prohibits the health status of a member of the group or a covered dependent of a member of the group from being used to establish the premium rate. In essence the net effect of the changes arising from 1992 S.B. 561 is that the highest premium a carrier may charge will be no more than two times its lowest premium for groups with similar characteristics.

The goal of 1992 S.B. 561, which was the subject of intensive debate that involved a number of insureds and insurers and their representatives, is to stabilize the premium rates for all small groups within a three-year period by spreading the claims risk over a carrier's entire small employer group business in Kansas rather than allowing the practice of rating a small group on the basis of the group's own experience. The 1992 legislation may result in a higher premium rate for some small employers in the initial stages of the new rate setting procedure, but it is anticipated that the rating restrictions contained in the legislation will, over time, promote stability in the small group market. The legislation will protect a small employer group that has an unfavorable claims experience based on even a moderately expensive injury or illness of a group member from experiencing an astronomical increase in rates at the next policy renewal.

Activity in Other States

Two methods of restricting rates in the small employer group health insurance market have been particularly popular as the states have considered market reform. One such method is the use of the National Association of Insurance Commissioners (NAIC) rating class model which is the basis of the 1992 Kansas legislation set out in S.B. 561. A variation on this approach is the Health Insurance Association of America (HIAA) rating band approach. Like the NAIC model, the HIAA

rating band model allows the setting of rate bands that limit the variation around an index rate for groups with similar characteristics.

The second area of interest has been community rating. New York, New Jersey, Vermont, and Maine have all passed community rating legislation.

It should be noted that while 20 years ago Blue Cross-Blue Shield plans that community rated dominated the health benefits market, to protect themselves in competition with aggressive commercial carriers that experience rate many Blue Cross-Blue Shield plans have begun to adopt experience rating with prices based on prior claims. Without doing so, Blue Cross-Blue Shield plans may find themselves with open enrollment and a de facto position of a high risk pool covering the groups with the worst experience and rising rates. According to a recent report, fewer than half the Blues plans still community rate. Maine, Vermont, New Jersey, and New York, the four states that have enacted community rating, all have Blues plans that were in danger of collapse. Community rating puts all carriers on the same footing as the Blues in these states in terms of rate setting. Vermont, the only state to have enacted community rating for group business in 1991, expanded the law to cover individual policies in 1992, but only after an agreement written into the legislation under which Blue Cross-Blue Shield of Vermont will be a guarantor of coverage if other carriers leave the individual health insurance market in Vermont as a result of the community rating mandate. Community rating, is of course, not currently a competitive factor for Blue Cross-Blue Shield of Kansas, since it is now a mutual insurance company rather than a not-for-profit medical and hospital service corporation.

Community rating is controversial because of concerns over how it will affect the current groups paying lower premiums than the average during any transition to community rating. When moving to community rating, more people are expected to see an increase in rates than a decrease because of how rates have been skewed by the market. Many carriers are concerned about how they can adapt to a changed market in terms of their total "book" of business and what they see as increased exposure that may not be reflected in rates. Some see community rating as unfair to younger, healthier groups who are expected to subsidize older less healthy groups, although this is countered by those who note that spreading risk is the traditional purpose of insurance. There is also concern that increased rates resulting from community rating may encourage groups not to insure, especially younger healthier groups.

To respond to concerns, the states that have enacted community rating mandates have developed innovative ways of dealing with the transition in the market.

Vermont. Vermont passed the first community rating law in 1991. The Vermont legislation requires small group carriers to guarantee the issue of community rated policies for businesses smaller than 50. Vermont's plan does allow commercial carriers to vary rates by 20 percent from the community rates, based on factors approved by the state's insurance department except that health may not be a factor in any rate variation. The Vermont law, although enacted in 1991, did not become effective until July 1, 1992, allowing carriers time to plan for the transition. The legislation was initiated by Blue Cross-Blue Shield of Vermont and had the support of the Governor. As of July 1, 1992, 12 companies making up most of the small group carriers in Vermont had filed community rated plans with the Commissioner of Insurance. Golden Rule is the major carrier that has left the state and, of the other carriers who chose to leave, several sold their book of business to carriers that decided to stay in the market. A bit of caution should be noted in considering the Vermont experience. One, it is too early to measure the impact of the new law on small group rates. Two, the Vermont experience may not be a good measure of whether carriers will

decide to leave the small group market if community rating is mandated since the Vermont population is very small and thus does not make up a significant part of any carrier's book of business. For this reason, carriers may have concluded that any added exposure arising from its business in Vermont will have a minimal impact on their total business.

One part of the Vermont health care reform legislation enacted in 1992 extended community rating to individual health insurance. As noted earlier, Vermont Blue Cross agreed to act as a safety net for individuals whose carrier may decide to leave the Vermont individual health insurance market. Blue Cross offers two options in the safety net program. One matches benefits and charges no more than 15 percent over the current rate. The second is the Blue's own "Vermont Freedom Plan." Although other carriers could participate in the safety net, only the Blues are participating at this time. I have no information on what the impact of community rating for nongroup policies is expected to be, although one major nongroup carrier indicated to its customers that their rates would increase fourfold if community rating were imposed.

New York. New York enacted legislation in July of 1992 that is the first to require community rating for all groups of less than 50, for individual policies, and for Medicare supplement policies. The New York legislation is also the only enactment to require strict community rating with no variation except for geographic differences. (Both the Vermont and Maine legislation that mandates community rating for small groups and that preceded New York legislation allow variation from a single rate based on some demographic factors.) The new law takes effect April 1, 1993, and a technical advisory committee has been appointed to develop regulations to stabilize the market and premium rates. The advisory group is looking at how to equalize high cost claims across all carriers. Although there was recognition of the need to spread poor risks so those carriers that end up with them do not suffer damage in the market, the legislation did not establish a reinsurance pool as other states have done. Thus, it will be up to regulatory action to develop a mechanism to spread risk.

Two factors that may have influenced the New York decision to legislate mandated community rating for small groups should be noted. One such factor was the extremely precarious status of Empire Blue Cross-Blue Shield, a major New York carrier of health insurance that still community rated its coverage. A second factor is a tradition of community rating. Large corporations in some major metropolitan areas of New York have voluntarily remained in community rated pools even though their own experience might have entitled them to more favorable rates because of the size of the individual pools they represented.

I have received no information on the status of the rather extensive regulations that are expected to be adopted prior to implementation of the New York legislation.

Maine. Maine enacted mandated community rating for groups with less than 25 members in the spring of 1992. The Maine laws prohibit the use of health status, claims experience, or policy duration in the establishment of premium rates for groups with 25 or fewer members, but allow carriers to take family status, smoking status, or participation in wellness programs, as well as group size into account in rate setting. The law becomes effective on July 15, 1993, and between then and July 14, 1997, age, gender, occupation, and industry may also be taken into account in rate setting on a gradually decreasing basis (beginning with a plus or minus 50 percent variation until a flat rate is reached by July 15, 1997). There is also an automatic sunset at the end of the first year (July, 1994) in the law. A major loophole is thought to be that carriers can avoid community rating by issuing individual policies to employees.

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The Maine Bureau of Insurance was required to report to the legislature by January 1, 1993, on how high risks should be spread among small group carriers. No reinsurance mechanism was written into the 1992 legislation, purportedly because Blue Cross of Maine was opposed to a reinsurance pool because it is currently in serious financial difficulty due to its continued community rating for small groups which has resulted in a disproportionate share of risk. According to one source, Blue Cross opposes a reinsurance mechanism because it believes that such a mechanism would preserve the status quo rather than result in the relief that Blue Cross expects from community rating.

New Jersey. New Jersey enacted legislation in November of 1992 that covers both small group and individual policies. Currently, I have neither a copy of the New Jersey legislation nor a summary of the legislation.

House Bill No. 2370

H.B. 2370 would phase in community rating for small employer groups of 25 or fewer employees, beginning with policies issued or renewed after January 1, 1994. The bill would amend K.S.A. 1992 Supp. 40-2215 and repeal two of the 1992 statutes created by S.B. 561 that concern rate compression. Under the provisions of the bill, rates for small employer groups would be based on the aggregate loss experience of all small employers insured by a carrier, but could vary with the number of persons in a covered family and from employer to employer by no more than 75 percent above the community rate for a policy issued within a year of January 1, 1994, no more than 50 percent in the following year, and no more than 25 percent during the third year. In the fourth and subsequent years, rates could not be greater than the community rate, a term defined in the bill. The bill also provides that in the case of policies in effect prior to the effective date of H.B. 2370 for which the premium rate is in excess of the premium rate allowed under the bill, no rate increases could take place until the beginning of a rating period in which premium rates would be lower than the premium rate allowed under the bill.

K.S.A. 1992 Supp. 40-2209g, which would be repealed by H.B. 2370, is the 1992 statute that allows a small business carrier to establish up to nine classes of business for the limited purposes set out in the statute. K.S.A. 1992 Supp. 40-2209h, which would be repealed by H.B. 2370, is the statute that sets out limitations on rate setting for small employer groups and phases in the rate limitations.

Should you need additional information, please contact me.

Emalene Correll
Research Associate

93-5094/EC

5-91

STATE OF KANSAS

Wagnon
BRUCE F. LARKIN
REPRESENTATIVE, DISTRICT SIXTY-THREE
R.R. 1
BAILEYVILLE, KANSAS 66404

TOPEKA

COMMITTEE ASSIGNMENTS

MEMBER: EDUCATION
TAXATION

HOUSE OF
REPRESENTATIVES

AGENDA CHAIR

Community Rating H 2370

Health care reform has now risen to the top of government's agenda at the federal level. One of the concepts being promoted as part of any federal reform strategy is inclusion of innovative state strategies. Kansas, because of efforts in last few years could be among the group of state known as innovative in the health area. I'm speaking on behalf of the bill's sponsors who believe that the time is right to have a vigorous debate in Kansas over the various aspects of health care reform.

Community rating is a concept that must be part of that discussion. Under community rating, an entire universe of insureds is used as the base for actuarial purposes in establishing premium rates for health insurance policies.

The attached memo outlines Kansas' current efforts to pass community rating and what other states have done on this issue.

HB 2370 is almost identical to provisions of 1991 HB 2001 except it calls for a 4-year phase-in of the rate structure.

The limitation to employee groups of 25 or less is arbitrary. It could be 30-50 or any number. Keep in mind the problem of escalating rates is usually worst in small groups. As an employer at YWCA, we have consistently experienced rising health care premiums. We have changed carriers each time rates have increased to avoid rising premiums. This past year's experience is a good example: 1 premature baby and our premium jumped 43%.

Twice the legislature has considered community rating: in 1991 with HB 2001 (the provision was deleted); in 1992 with SB 561. The legislature substituted a fairly complicated rate scheme by establishing 9 classes of business. Maybe 1993 can be the year we implement it fully. I urge your favorable consideration.

Human Res.
Attachment 2
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WICHITA INDEPENDENT BUSINESS ASSOCIATION
Riverview Plaza Suite 103 • 2604 W. 9th St. N. • Wichita, Kansas 67203-4794
(316) 943-2565 FAX (316) 943-7631

ROLAND E. SMITH, *Executive Director*

STATEMENT TO THE KANSAS HOUSE FINANCIAL INSTITUTION AND INSURANCE COMMITTEE, FEBRUARY 23, 1993

SUBJECT: HB 2370

Chairman Bryant, members of the committee and staff, I want to express our thanks for the opportunity to come before this committee and express our views on House Bill No. 2370. I am Roland Smith, Executive Director for the Wichita Independent Business Association. WIBA is an association of over 900 locally owned businesses in the Wichita trade area. There are over four hundred types of businesses that makeup the WIBA membership. Over 95% of the businesses have fewer than 25 employees and most have fewer than 5 employees. In the state of Kansas 88.9% of all the businesses have fewer than 25 employees and 88.1% have fewer than 10 employees. Those businesses with 25 or fewer employees in Kansas account for 50 to 55% of all the employees in Kansas.

It is with this perspective that I address the provisions of this bill.

WIBA supports the concept of "community rating for small business health insurance plans" and the definition of community rating in the bill. The phasing in of community rates is a practical approach.

The latitude the insurance companies have in the defination is of concern and may be unclear. The application of the community rates in lines 1 and 2 on page 3 of the bill appears to allow the carriers to modify the community rate based on unspecified criteria from employer to employer for four years and maybe more if not clarified. The carrier could vary the family rate based on the number of children in a family plan, but there appears to be no language in the bill to restrict the carriers from making their community rates within age brackets or occupations as it can vary from employer to employer in line 2. A more clear language in this bill would close up what appears to me to have many possible loop holes.

I assume that this bill applies to indemnity and preferred provider health insurance plans offered by insurance companies only and does not apply to non-insurance companies' health maintenance organizations. WIBA offers an HMO and it already has a community rate modified by the demographics of the organization with the same rate for all association member businesses.

There is no provision, as I understand the language in the bill, for associations with businesses with fewer than 25 employees to have a common rate for all members. This would be essential to help the self-employed persons. Also,

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provisions of HB 2001 passed two years ago would still apply to individual businesses within an association and some could be turned down. It should be made to apply to the entire association as a group to be effective.

If the definition of a group in Kansas remains at 5 employees then is it fair to assume this is a bill for employers with 5 to 25? Or is it from 1 to 25 as the language appears?

WIBA supports the concept of community rating for small businesses and this bill appears to be a first step in that direction. WIBA supports HB 2370 with modifications that will improve its ability to adequately help more small businesses in Kansas.

If the committee desires, I will provide suggested amendments in a balloon version for you to consider.

I will be glad to answer any questions that I can and assist you in any way to make this bill more effective for the small independent business, for whom it is directed.

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

Testimony to House Financial Institutions and Insurance Committee

on HB 2370

(Requires community rating for small groups)

by James P. Schwartz Jr.
Consulting Director
February 23, 1993

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The Coalition is 110 employers across Kansas who share concerns about the cost of health care for our 350,000 Kansas employees and dependents.

The Coalition has earned a national reputation for a strategy to reform America's ailing health system. That strategy includes community rating as the ideal way to implement one of our principles: that the cost of health care should be spread across the broadest practical base.

HB 2370 embodies that principle, and as such earns our tentative support.

We believe, though, that several issues should be resolved before passing HB 2370 into law. First, reliable estimates should be obtained on the effect of community rating on the number of uninsureds. In the absence of a requirement for universal coverage (as in our strategy), there is a probability that community rating could lead to a higher incidence of uninsureds. That problem comes about because groups having to pay higher premiums to comply with the community rate would have more incentive to go bare. Last year the KS Insurance Dept. estimated that the rate compression mechanism in SB 561 would lead to a 4% decrease in the number of insured small groups. We need to know what that figure might be under pure community rating.

A second issue to be resolved is a potential problem in terms of risk skimming by insurers. Even though SB 561 guarantees acceptance by insurers, insurers still have latitude to seek healthier groups for their lower costs and to avoid sicker groups. This incentive to avoid poor risks is intensified by community rating, because insurers cannot

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Attachment 4

offset the cost of sicker groups through rating. To overcome this obstacle and make sicker groups attractive to insurers, most national proposals for community rating include some form of "risk adjustment." This means that insurers who accept sicker groups will receive some adjustment in income through a pooling mechanism, to which all insurers subscribe. I must add that the science of making these adjustments is presently inexact and under development.

To immunize HB 2370 from criticism on grounds of risk skimming, there needs to be language in the bill to create a mechanism for risk adjustment.

If these two issues can be satisfactorily resolved, the Kansas Employer Coalition on Health can support HB 2370.

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

500 Bank IV Tower One Townsite Plaza Topeka, KS 66603-3460 (913) 357-6321

A consolidation of the Kansas State Chamber of Commerce, Associated Industries of Kansas, Kansas Retail Council

HB 2370

February 23, 1993

KANSAS CHAMBER OF COMMERCE AND INDUSTRY
Testimony Before the
House Committee on Financial Institutions and Insurance
by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

My name is Terry Leatherman. I am the Executive Director of the Kansas Industrial Council, a division of the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to explain why the Kansas Chamber supports HB 2370.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

It comes as no surprise that the cost of health care insurance is growing for all employers. However, while large employers maintain some ability to grapple with soaring costs, the smaller employer is less able to cope. In President Bush's Comprehensive Health Reform publication released last year, statistics indicated that of 25.4 million

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u ,ured Americans in 1987, 17.2 million were employees or dependents of businesses employing less than 25, and 21.5 million were employees or dependents of businesses employing under 100 people. Clearly, when a small employer is left to tackle health insurance alone, their size will lead to health insurance becoming too costly.

To address this critical area, the Kansas Chamber will support reform within the current health insurance marketplace which will make insurance policies more available and affordable to the small employer. One method which KCCI supports to accomplish this is applying community rating concepts.

In promoting the community rating concept, KCCI recognized this one step does not provide the total cure for the troubled health insurance process. In fact, greater cost socialization through community rating will cause many employer sponsored health insurance plans to have higher premiums. Along with community rating, this committee may also consider other health insurance reform concepts which increase health insurance affordability and availability, such as the repeal of state mandated benefit coverage, greater tax deductibility of employer contributions to employee insurance, prudent medical malpractice reforms, and standardization of insurance claim procedures and administration.

Thank you for this opportunity to explain why the Kansas Chamber has endorsed the concept of community rating, which is proposed in HB 2370. I would be happy to attempt to answer any questions.

MEMORANDUM

TO: The Honorable William Bryant
Chairman, House Financial Institutions and Insurance Committee

FROM: William W. Sneed
Legislative Counsel
Health Insurance Association of America

DATE: February 23, 1993

RE: House Bill 2370

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America ("HIAA"). The HIAA is a health insurance trade association consisting of over 300 insurance companies that write over 80% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to H.B. 2370.

Although there is some interest in establishing mandatory community rating like that which is found in H.B. 2370, we believe that this bill, at the current time, is inappropriate and would cause more disruption in the marketplace than its attempted cure.

First, as this Committee is aware, implementation of the small employer group bill and the uninsurable pool bill are to be effective within the very near future. We contend that implementation of a community rating type bill would be inappropriate inasmuch as these two programs have not yet been effected, and such a dramatic change in the marketplace could have an adverse affect at its implementation.

Second, inasmuch as we still have not received the final outline from the federal government relative to health care, we believe the community rating aspect should

House F.I.I.
Attachment 6
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be delayed until the Legislature has determined what, if anything, the federal government is going to do on health care. As you are all well aware, there are a multitude of plans floating around, and until the administration comes out with its final program we believe it would be premature to look at a community rating bill in Kansas.

Third, it is important to remember that any community rating bill would only affect insurance contracts in which the Kansas Legislature has direct oversight. Thus, none of the self insured or ERISA plans that are currently in the State of Kansas would be affected by this bill. We are concerned that implementing such a dramatic change in the rating structures only on a small segment of the health insurance found within the State of Kansas would simply squeeze that portion of covered Kansas residents who now have their health care covered by commercial type health policies.

This is compounded by the fact that those entities that currently enjoy a relatively low rate for health insurance may be forced to pay extremely high rates to be covered under a community rating bill, and those entities who have been able to avoid state regulation through ERISA type programs will continue to do so, and perhaps even grow. Thus, it may in fact cause the insured population to diminish, and again, the compounding effect would be even more dramatic.

Therefore, it is my client's position that H.B. 2370 should not be passed at this time. Certainly after we have a better understanding of the types of programs the federal government will be implementing and the effect of the small employer group bill

and the uninsurable pool bill, we will at that time be able to make a better analysis as to the effect of a community rating bill.

Once again, on behalf of my client I appreciate the opportunity to testify on this bill. I have attached to my comments two documents which more fully analyze the community rating issue, and if you have any additional questions or comments, please feel free to contact me.

Respectfully submitted,

William W. Sneed

William W. Sneed

HIAA

Health Insurance Association of America

THE ADVERSE CONSEQUENCES OF FLAT COMMUNITY RATING

Under flat community rating, an insurer would be required to charge the same premium rate for all employers in a community, without distinguishing for the cost differentials associated with age, gender or health status. (A community could be as small as a Metropolitan Statistical Area.) HIAA opposes flat community rating because extreme rate restrictions do not effectively contain costs nor increase access to coverage.

Instead,

- Flat Community rating will increase the number of uninsured because
- It will increase premiums for most small employers and their employees.

Flat Community Rating Increases Premiums for Most Employers

- 69 percent of employers will receive rate increases of over 10 percent with flat community rating. 30 percent of employers will receive rate increases of over 35 percent.
- As lower risk employers "drop out" rather than subsidize the rates of higher risk employers, rates will increase for those who remain, then more will drop coverage, then rates will rise, and so on.

Flat Community Rating Increases the Number of Uninsured

- Of the 30 percent of employers that receive rate increases of more than 35 percent under flat community rating, almost a third of them are expected to drop their coverage.
- Most uninsured are young with low incomes and low health care costs. Flat community rating will increase rates for these individuals encouraging them to drop coverage.
- Flat community rating will increase costs for populations least able to pay, cause more workers to be uninsured, and allow the higher income population to be subsidized by lower income employees and their families.
- Thus, under flat community rating, rates will be raised for the younger, lower-income population that is already the least likely to be insured in order to subsidize premiums for an older, higher-income population who mostly already has coverage.

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Additional Comments

- By requiring that all applicants be charged the same rate, community rating breaks the linkage between an employer's costs and what it pays in premiums.

- Flat community rating will encourage some employers that currently have group coverage to move toward other alternatives such as individual or self-insured coverage instead.

- The amount that rates are compressed by tightening rating restrictions is the major factor affecting how much premiums will rise and how many persons will lose their health insurance coverage.

- Community rates should definitely be adjusted for geographical differences within the state. Residents in Pueblo should not have to pay higher premiums to subsidize health care costs in Boulder which are 12 percent higher.

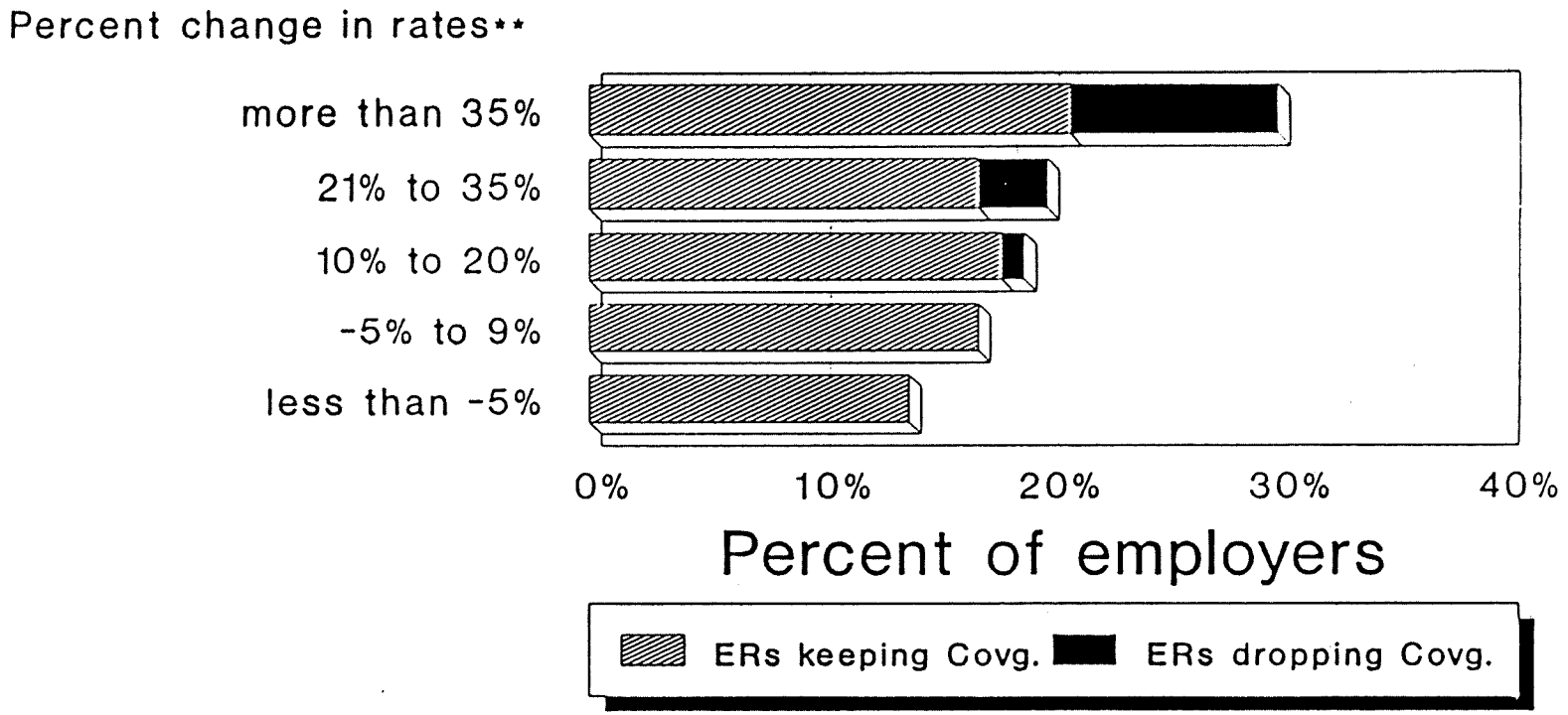
- 80 percent of large employers pay different rates for their single employees and their employees with families. They also may pay different rates for each of their employees based on broad actuarial risk categories. In addition, the employer's total premium is usually based upon the claims experience of its own employees and their families. Many large employers self-insure their own claims, too. Thus, large employers do not community rate. In fact, large employers would fail even the most basic definition of community rating which is that premiums are not to be based on one's own health status or claims experience.

- It is unfair to charge single individuals and couples the same rate as families. Even in Vermont and New York where community rating laws have already been passed, this has been recognized as unfair. In fact, the tendency is to require more rating categories based on family status, not fewer. In Vermont, insurers are required to offer separate rates for individuals, couples and families. Even the couples category is sometimes segmented into single parent and childless couples.

- Vermont also allows insurers to recognize other actuarial risk categories--such as age and gender--within the acceptable rating limits. Using flat community rates will force unfair subsidies between groups with very different health care risks and costs. This approach also perpetuates the myth that insurers are not spreading the risk when they charge different rates to different age groups.

- Whether dealing with 20-year olds, 60-year olds, males, females or any other actuarial risk category, something like 80 percent of the health care costs are incurred by only about 20 percent of insureds in the risk category. Thus, no matter which risk category one is examining, insurers spead the risk within that risk category.

Distribution of Rate Changes for Currently Insured Small Employers* Under Flat Community Rating



Source: HIAA

* (2-25 employees)

** Includes 15% increase in mkt avg rate

Note: For example, 30% of employers would receive an increase of more than 35%: 21% would retain their coverage and 9% would drop their coverage.

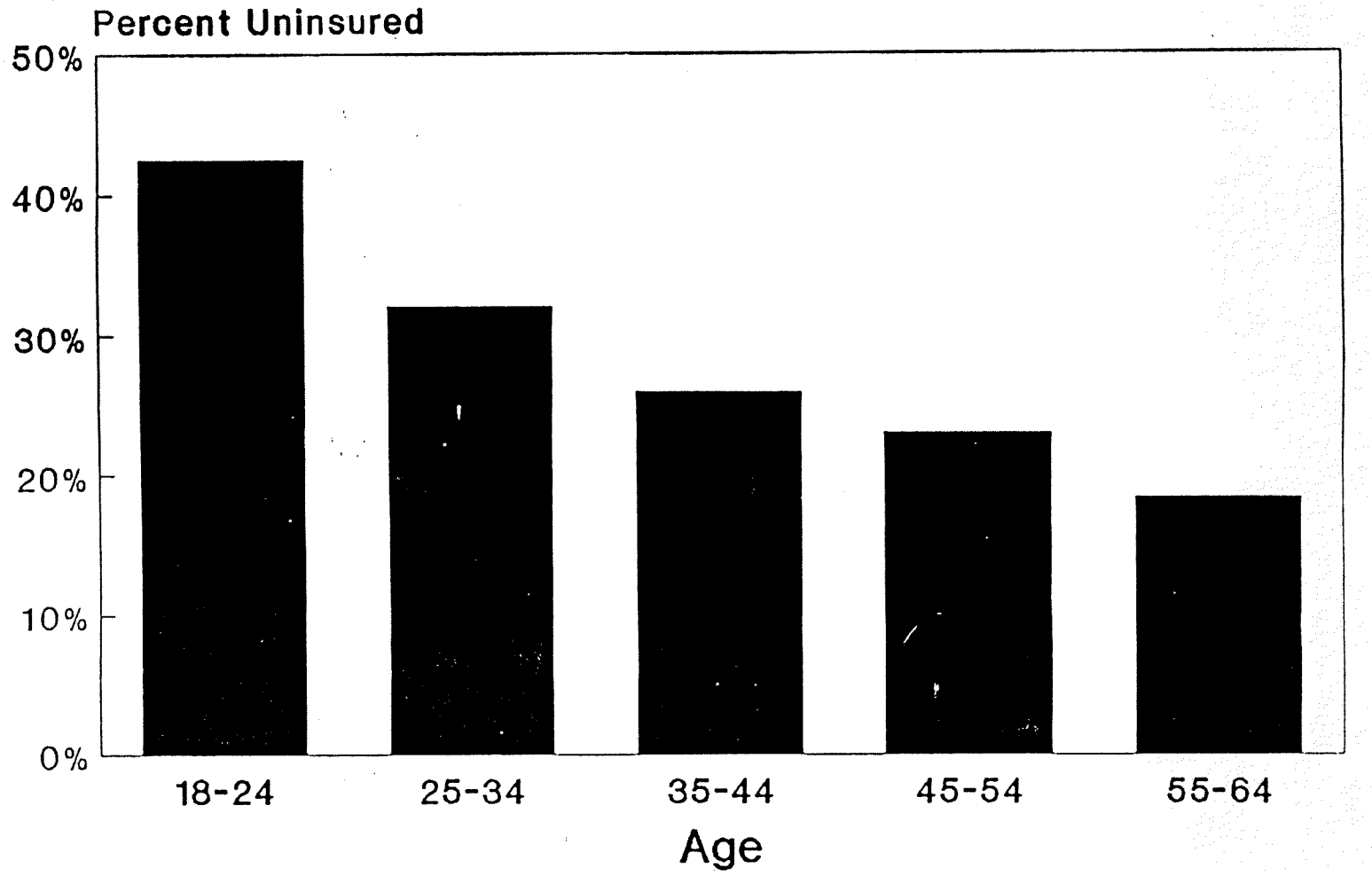
fig 6

Derived from an analysis of a random sample of actual small employer group data from five different HIAA member companies. This data was run through an actuarial model which recalculated the premium each insurer would have to charge each of the 3,750 small employers in the sample using the HR3626 rating restrictions.

The insurers chosen for this study represent five insurers with significant sales in the commercial, small employer, group health insurance market, including insurers with broad and tight underwriting practices. While aggregated estimates are provided, you should note that there were large variations between insurers. This suggests that the effect of rate limits will vary greatly from one insurer to another. Further, while an effort has been made to get a fairly representative group of carriers, there was no way to accurately determine how representative these carriers are of the entire market. Therefore, the estimates should not be considered "industry" estimates but rather as the composite experience of five companies.

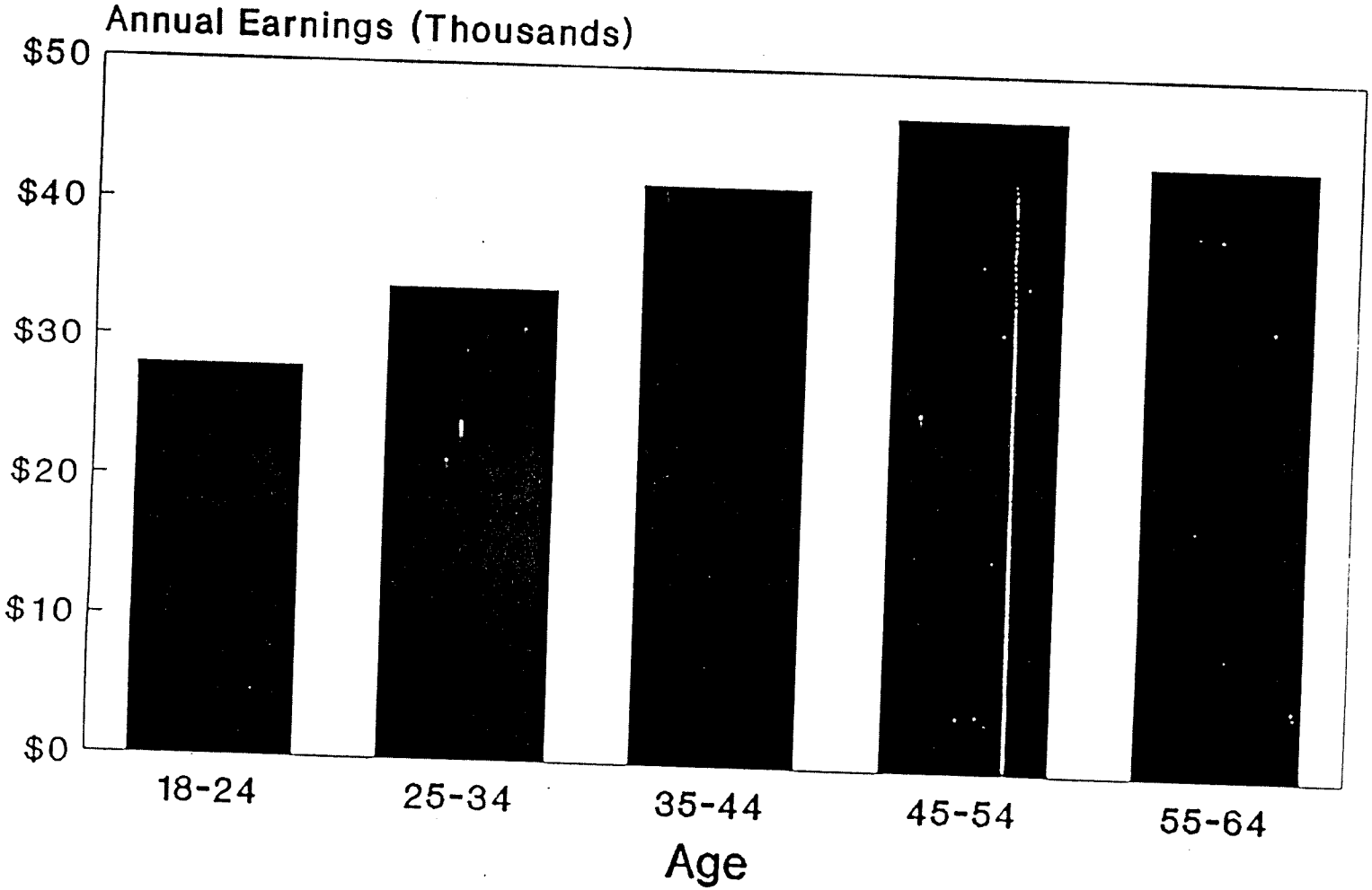
The sample included employer groups of 2-25 employees rather than the 2-50 employee definition used in HR3626 because a credible database of 2-50 employee groups was not available whereas a 2-25 employee database was. While the quantitative estimates contained in this report would be slightly different if 2-50 employee group data were used, the direction and general order of magnitude would be very similar. In addition, it is believed that this difference does not materially affect the qualitative conclusions of this study.

PERCENT UNINSURED BY AGE
Full-Time, Full-Year Principal Earners



SOURCE: Tabulations of March 1990 CPS

ANNUAL EARNINGS BY AGE
Full-Time, Full-Year Principal Earners



SOURCE: Tabulations of March 1990 CPS

Pure Community Rating: A Quick Fix To Avoid

Insurance coverage denial and excessive premium rates have made the small employer health insurance market a popular target for sweeping reforms. Many proponents of small market insurance reform have advocated pure community rating by requiring carriers to charge the same rate to all of their customers as a solution. But legislating the use of pure community rating could do more harm than good in solving the problems of cost and access. A more sensible approach would limit rate differences through either rating bands or community rating by class.

By William R. Jones, Charles T. Doe, and Jonathan M. Topodas

Because small employers often find health insurance unaffordable or face excessive premium increases or coverage denials by some carriers, the small group market has become a target for significant change in a number of state and federal health care reform proposals. Several reform proposals include requirements for pure community rating, simply defined as requiring carriers to charge the same rate for all of their small employer customers with the same coverage.

Pure community rating would initially simplify some aspects of the small group market by ensuring that all customers receive the same rate increase. However, a pure community rating requirement would create a host of new problems in both the availability and affordability of coverage for many small employers. Moving to this kind of system also may cause some, possibly many, small employer carriers to withdraw altogether from this market.

William R. Jones and Charles T. Doe are actuaries in the health issues and small business market areas of Aetna Life & Casualty. Jonathan M. Topodas is a lawyer in the government relations department at Aetna.

The Issue

Without question, the small group market requires reform. The key issues reformers must address are the availability and affordability of adequate health care coverage. Between one-half and two-thirds of the 34 million Americans without health care coverage are employees, or their dependents, of small employers.

We all have heard stories about individuals having their coverage terminated when they needed it the most. Some individuals who work for small companies are subject to annual premium increases of 50 percent to 100 percent, making coverage difficult to afford. Others cannot buy coverage at any price.

Under a pure community rating approach, each carrier would be required to charge the same rate to each small group customer in a given geographical area for a particular plan of benefits based on that carrier's "average" experience for its book of business. No premium variations would be allowed for age, gender, industry, size, previous claim experience, health status, duration since policy issue, or other traditional risk variables.

Those supporting pure community rating argue that this system forces carriers to compete based on efficiency and claim management skills, not by selecting only healthy risks. As a result, the argument goes, coverage would become more available and affordable for these employers. In fact, availability and affordability are likely to be reduced for many of these employers.

New Problems

Our findings are based on an analysis of Aetna Life & Casualty's small group book of business that applies to customers with 2 to 49 employees. Aetna is a significant insurer in this market with more than $500 million in premiums. The results shown in Figures 1, 2, and 3 are based on renewal rate levels and the assumption that total claims and premiums remain unchanged after the switch to pure community rating.

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Despite the relief pure community rating promises, it also would create new problems. Pure community rating would lower costs for those employers who previously had high expected claim levels and high premium rates, but it will also raise rates for those employers with younger or healthier employees who traditionally paid lower premium rates because of lower expected claim levels (see Figure 1).

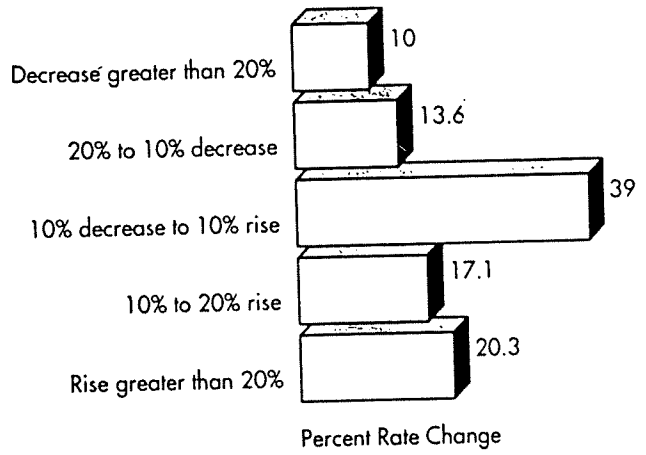
As a result of switching from the current rating environment to pure community rating, more than 20 percent of covered lives would receive rate increases of 20 percent or higher (Aetna Life & Casualty, 1992). More than 37 percent would receive rate increases of 10 percent or more. These increases are on top of annual medical insurance cost increases that range between 10 and 20 percent. Medical insurance costs are higher than the medical care component of the consumer price index because they factor in such things as increased use of health services, new technology, and cost-shifting from public to private health insurance programs.

Proponents of pure community rating should also note that employers with fewer than 10 employees will experiences changes even more dramatic than the 10 to 20-percent range. This is because many employers can afford coverage only by receiving credit for their younger or healthier employees.

Employers with traditionally low costs faced with large premium increases resulting from a switch to pure community rating would be strongly motivated to avoid subsidizing those employers with higher costs enjoying a drop in their premiums.

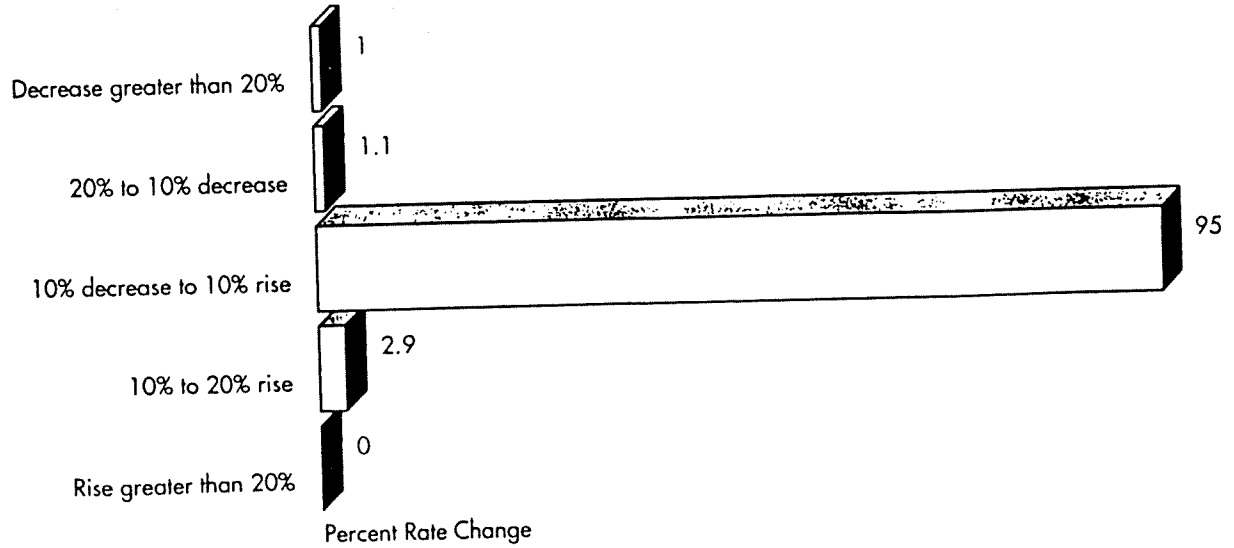
Figure 1

Rate Changes Under Pure Community Rating



Source: Aetna Life & Casualty 10/92

Figure 2 **Rate Changes Under Rating Bands**



Source: Aetna Life & Casualty 10/92

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They have several choices. They can reduce benefit levels or drop coverage altogether; obtain some form of self-insurance and pay only for their own claims; or enter into other "innovative" arrangements, such as forming low-cost groups or enrolling fictitious employees to exceed the size limit contained in any pure community rating legislation. Once the low-cost employers drop out of the small group market, the community rate for those remaining would increase.

Furthermore, some high-cost employers that were previously uninsured would want to purchase coverage, because under pure community rating their rates would be lower than their current expected claims. Some larger employers are likely to create ways to "dump" their more expensive employees into the community pool intended for smaller employers. Both these actions would drive up the cost of the community rate even further.

It is difficult to anticipate in advance which employers would drop or add coverage; however, several independent actuarial studies have been conducted to quantify the impact of proposals advocating pure community rating. Results indicate that many employers facing large premium increases will terminate their coverage completely and that premium rates for those remaining insured will increase by an additional 5 percent to 25 percent.

Even with a significant transition period to fully implement the rate changes required by pure community rating, many employers may no longer be able to afford continued coverage, further increasing the number of uninsured. Even worse, pure community rating does nothing to reduce the underlying cost of health care. This hardly seems like a solution to the access and affordability problems that small employers currently face.

Skewed Incentives

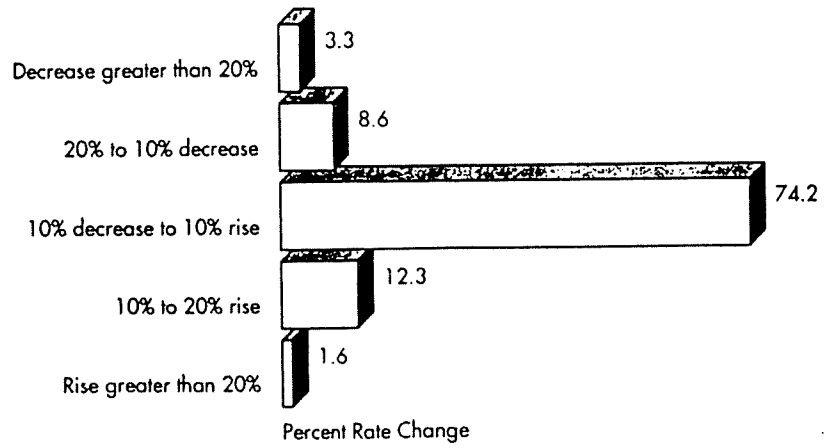
Pure community rating creates a host of other problems for both carriers and employers. While those supporting pure community rating argue that underwriting and coverage denials by carriers could more easily be eliminated by requiring carriers to guarantee the issue of coverage, carriers will be under enormous financial pressure to act otherwise. Since attracting low-cost groups will make carrier rates more competitive and profitable, innovative marketing arrangements will arise to attract low-cost customers while seeking to avoid those with higher than average expected claim costs. An even greater danger is the strong incentive for some carriers to offer poor service on large claims to encourage sicker customers to seek coverage elsewhere.

Under pure community rating, employers would have less incentive to encourage their employees to adopt healthy lifestyles because they will not receive credit for managing their claim experience. Any extra claims will be shared by all of the carrier's small employer customers, so there is no reason to be concerned about health care utilization.

Pure community rating also generates enormous and unfair cross-subsidies among entirely different employer groups. Those with younger, healthier employees would be forced to subsidize those with older, less healthy employees or those employers that obtain coverage for sick friends and relatives by hiring them. This is a regressive form of financing health care because the young generally have lower incomes as well. Employers in risky industries like coal mining or construction with high medical costs would be subsidized by those in safer industries.

A move to pure community rating brings more risk to carriers, which could require them to increase their risk margins. If a carrier finds itself having an above-average group of risks, either through poor luck or the less scrupulous actions of others, it would have to either raise rates

Figure 3
Rate Changes Under Community Rating By Class



Source: Aetna Life & Casualty 10/92

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for both new and existing business or lower rates below financially prudent levels.

With higher rates, the same carrier would not attract new business, and many existing customers would seek coverage elsewhere. This inevitably leads to a downward spiral resulting in an insurer's eventual withdrawal from the market or possible insolvency. Pure community rating makes it virtually impossible for such a carrier to work out of this situation, because rates cannot be varied based on the risk characteristics of the case.

A return to pure community rating would present more problems than solutions.

Faced with solvency concerns and competitors who may selectively market to low-risk carriers and encourage high risks to go elsewhere, many carriers would prefer not to compete in such an environment. The decline in the number of carriers competing for employers' coverage may further exacerbate availability and affordability problems, especially if certain geographic areas are left without a choice of competing carriers.

Advocates of pure community rating frequently point to Blue Cross plans and HMOs that appear to compete effectively in today's market using community rating. This simply is not true. Most Blue Cross plans abandoned pure community rating many years ago. The few that still use this system often have dominant market shares and hospital discounting arrangements not available to other carriers that allow them to overwhelm most competitors. Additionally, many HMOs also adjust rates based on the demographic or other characteristics of the employer, and many refuse to cover all or certain small employer groups. In fact, even federally qualified HMOs are allowed to vary rates based on the demographics of individual employers and are not required to cover employers with fewer than five employees.

A Better Alternative

Because a return to a pure system of community rating would present more problems than solutions, policymakers should focus their attention on reforms that can genuinely improve availability of insurance and control costs. Rate reforms only determine how to allocate health care costs among employers, but nothing to control increases in health care costs. Reforms should:

- Encourage employers to join managed care arrangements and repeal laws that hinder the development of strong managed care plans;
- Provide portability of coverage when employees change jobs;
- Guarantee issuance of coverage for all employees of all small employers, with appropriate preexisting conditions exclusions;
- Guarantee renewability of coverage for all employers except under specified circumstances, such as fraud or nonpayment of premiums;
- Reform the medical malpractice system;
- Expand anti-fraud activities;
- Experiment with purchasing pools that may allow small employers to achieve some of the economies of scale enjoyed by larger employers;
- Encourage carriers to become more efficient and reduce their expenses by using standardized forms and extending electronic network: to more providers.

Another important element i righting the wrongs of the healtl system requires insurers to elimi nate excessive premium increase based primarily on the employer' claims experience, a practice fel most acutely by small employer: Rate reforms that can be enacte with fewer problems than pure com munity rating include using ratin bands or community rating by clas:

Rating Bands

Rating bands limit the annual i crease in rates due to policy dur tion and previous claims experienc to no more than 5 percent to 15 pe cent each year and establish an ove all rate band so that the ratio of t highest to lowest premium rate f similar groups is 1.5 to 1, or lowe Demographic adjustments such area, age, gender, and industry a permitted outside this band.

Figure 2 illustrates the impact switching from the current enviro ment to an overall rate band of 1. to 1 for similar groups. As a result implementing this proposal, virtu ly no employee experiences a ra increase of 20 percent or more ov the rate of medical insurance infl tion. In fact, fewer than 3 perce experience an increase of more th 10 percent over medical insuran inflation.

A rating band proposal can be p into place with minimal disruptic In contrast, pure community rati requires a much longer transition implement the large rate increas needed for many employers that p viously had low rates due to th low-risk characteristics and low pected claims.

In addition, a rating band syst avoids the excessive premium

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creases, cross-subsidies, and loss of coverage associated with a shift to pure community rating. It also reduces the magnitude of most of the other problems previously outlined. The rate bands and experience limitations must be chosen with care to ensure that unfair rating practices are eliminated while retaining some employer incentives to control costs. As the rate bands and experience limitations are compressed further, the impact of this proposal becomes more similar to pure community rating.

Community Rating by Class

A second preferred alternative to pure community rating is community rating by class. Figure 3 illustrates the impact of switching from the current environment to community rating by class. Community rating by class means that carriers can vary premium rates only by actuarially justified demographic variables, such as area, age, gender, and industry. Even some of these demographic variables may be subject to individual limits, such as restricting industry adjustments to within 15 percent of the average and limiting annual changes in these factors.

Under community rating by class, employer rates may not differ based on claim experience, health status, or duration since a policy was issued. It also eliminates many of the extreme cross-subsidies created by pure community rating. Figure 3 indicates that fewer than 2 percent of employees receive rate increases of 20 percent or more as a result of implementing this proposal. In fact, fewer than 14 percent receive an increase of more than 10 percent over medical insurance inflation. This approach is far less traumatic to small employers with good risk characteristics and experience than pure community rating.

More important, community rating by class allows for significant reform of carrier sales and marketing practices. For example, carrier underwriting for health conditions before sale could be completely eliminated with a guaranteed issue requirement. This would further reduce administrative expense and hassle, a primary area of concern in this market.

This modified form of community rating shares a number of the benefits of pure community rating without the severe rate changes. Under community rating by class, small employers' rates would be much more stable from year to year. Simplified rating practices and reduced turnover of this business could also produce modest administrative expense savings.

Experience may not even be a credible predictor for the very smallest employers. While knowledge of past conditions may help identify some high-risk groups, one or more years of good claims for a small group would offer almost no insight into future experience.

Community rating by class allows better and easier insurance department monitoring of market practices. It also reduces the number of ways to circumvent the intent of rate reform laws. And it has the public policy benefit of reducing employer incentives to discriminate against employees with health problems in hiring and retention or in the availability of coverage.

Combined with guaranteed issue, the greatest benefit of community rating by class is that it significantly improves and simplifies the process small employers must go through to obtain coverage. It does away with the extreme cross-subsidies and reduces carrier incentives to avoid most high-cost employers.

One cautionary note, however. Community rating by class shares some of the problems of pure community rating, although to a lesser extent. For example, there is little incentive for an employer to control its own claim experience, and there are potential incentives for carriers to avoid or provide poor service to employers with adverse claim experience. These issues can also arise with tight rate bands used to limit experience adjustments.

If policymakers want to improve the availability and affordability of adequate health care coverage for small employers, they should focus on reforms that address those issues more effectively than changes in rating practices.

Reducing or eliminating the use of experience and moderate limitations on rate differentials, such as rating bands or community rating by class, would allow for significant reforms and improvements to the entire small group market without creating a host of new problems for employees, employers, and carriers.

We must also recognize that none of the rating proposals deal with the fundamental problem of increasing health care costs. Rating restrictions only affect differences in relative rates between groups. Our ongoing priority must be to manage the cost and amount of care provided to slow down the overall rate of increase in health care spending.

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Aetna Life & Casualty, small business market estimates, 1992. ☆

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