REPORT ON

THE EFFECTIVENESS OF

RHODE ISLAND GENERAL LAWS §§ 27-50-1 *et seq.*

SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT

IN PROMOTING

RATE STABILITY

PRODUCT AVAILABILITY

AND

COVERAGE AFFORDABILITY

June 30, 2002

Lautzenheiser & Associates

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June 30, 2002

Honorable Marilyn Shannon McConaghy
Director
Department of Business Regulation
State of Rhode Island

Dear Director:

In accordance with your instructions and pursuant to the requirements of R.I. Gen. Laws § 27-50-9, the attached report contains the results of an actuarial study conducted by Lautzenheiser & Associates of Hartford, CT of the effectiveness of R.I. Gen. Laws §§ 27-50-1, *et seq*, the Small Employer Health Insurance Availability Act ("the Act") in promoting rate stability, product availability, and coverage affordability.

The study incorporates findings from market conduct examinations conducted this year of compliance with the Act by Rhode Island small employer carriers, surveys of Rhode Island small employers and producers of small employer insurance, and other interviews and research as necessary to support the conclusions reached in the report.

Respectfully submitted,

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Executive Summary

The overall effectiveness of the Small Employer Health Insurance Availability Act ("the Act") and the Regulation promulgated pursuant to the Act ("Regulation 82") in promoting rate stability, product availability, and coverage affordability was deferred and diminished, because the Rhode Island small employer insurance carriers delayed, or failed in their efforts to comply with, the Act. The ultimate effectiveness of the Act cannot be determined until there has been full compliance with the Act for a significant period of time to allow the small employer market to be evaluated.

The major Rhode Island carriers, Blue Cross & Blue Shield of Rhode Island and its affiliate, Coordinated Health Partners, Inc., (together "Blue Cross"), and United HealthCare of New England and its affiliate, United HealthCare Insurance Company, ("United"), provide virtually all the small employer group health plans in Rhode Island.

Both Blue Cross and United delayed renewing a significant portion of their small employer groups to avoid compliance with the Act until October or November 2001. This resulted in these small employer groups being under the Act for only four to six months before the evaluation of the Act's effectiveness began. More significantly, the small employer groups affected were the smallest of the small employer groups – the groups most likely to be in need of rate stability, product availability, and coverage affordability. The average size of these groups was 1.6 to 2 employees.

In addition, important provisions of the Act were either not implemented or implemented incorrectly by the carriers, which affected all of the small employer groups.

Determination of the Effectiveness of the Act Requires Full Compliance with the Act

Although full compliance with the Act has not been in effect, some progress has been made in its implementation. Health insurance risk has been spread more broadly by

bringing all insured small employers, including members of associations, into one insurance risk pool, and premium rate variability among small employers has been limited. However, full compliance is necessary to determine the total overall effectiveness of the Act. Like a fine-tuned windup clock, all parts have to be working. If one part is not, it cannot function correctly. Even more importantly, all parts have to be working well to determine if the clock is effectively keeping the correct time. Such is the case with this Act.

There is a built-in tension in the Act in that accomplishment of some portions of the Act defeats the ability to accomplish other portions of the Act. The greatest of these tensions is that in order to make health insurance more available and affordable to the older and less healthy by equalizing the premiums for all, it becomes less affordable and less available for the younger and healthier. Thus one group of uninsured individuals becoming insured can result in another group of insured individuals becoming uninsured.

This is particularly critical since this Act involves covering the employees of small employers who are generally more healthy than the general population, since they are working. The health status of their dependents is unknown. The provisions of the Act can and are intended to encourage more of the older, less healthy employees and dependents to have insurance available to them. Inclusion of that population in the insurance pool could increase costs to all.

A majority of small employers who do not currently provide insurance for their employees reported in the employer survey conducted in support of the study that cost is their primary deterrent. It is reasonable to expect that the greatest number of new small employer groups covered will be the smallest of the small employers. For these smallest of the small employers affordability has been a critical factor. It may be even more so in today's economy when profits of the employer and in some cases even survival of the employer are being challenged.

Full compliance is therefore necessary to evaluate the interactions of these tensions so that the effectiveness of the Act on rate stability, product availability and coverage affordability can be evaluated.

Determination of the Effectiveness of the Act Requires Full Compliance with the Act Over an Extended Period of Time

During the 2002 legislative session, the Legislature delayed until October 1, 2004 the implementation of certain scheduled changes to the Act's restrictions relating to premium rates.

The rating portions of the Act contain two phases of implementation in increasing a carrier's premium rating requirements. The first phase began on October 1, 2000, and included requirements to limit the spread of rates to a range of four-to-one from highest to lowest (4-1 rate compression), and to limit the rate adjustments for health status to 10% up or down from the adjusted community rate. The second phase of the rate implementation was originally scheduled to begin July 13, 2002 and is now scheduled to begin October 1, 2004. It further limits the spread of rates to a range of two-to-one from highest to lowest (2-1 compression) and eliminates the use of health status in rating. This two-phase incremental transition was designed to mitigate the impact of the premium changes on employers and employees.

With delay in the implementation of the second phase of the Act's rating restrictions until October 1, 2004, there will be more time for the effects of the first phase of the Act to be fully implemented, absorbed by the market, and evaluated before moving to the second phase.

Rate Stability, Product Availability and Coverage Affordability were Affected by Noncompliance

Rate Stability and Coverage Affordability were Affected by Noncompliance

Rate stability and coverage affordability were affected by the provisions of the Act and Regulation 82 requiring that rate variability be based on:

- Four family groupings (known as "four-tier" family composition),
- Restriction of the range between the highest and lowest premium for a family composition tier (known as the "4-1 rate compression"),
- Limitation on the use of health status as a means of determining an employee's premium,
- A "second calculation" – a transition calculation which restricts the increase of a group's premiums to mitigate the impact of the premium changes caused by the Act, and
- Rate manual maintenance.

Four-Tier Family Composition Rates

Blue Cross failed to comply with the requirements of four-tier family rates by delaying its implementation until renewals of April 1, 2001. It was not until March 2002 that all Blue Cross rates were on a four-tier family composition basis. As a result of Blue Cross' delay in implementing the four-tier rating basis, certain of Blue Cross' small employer groups paid more and other small employer groups paid less than they would have if Blue Cross had been in compliance with this provision of the Act on a timely basis.

Blue Cross' noncompliance, coupled with the compliance of United, resulted in differences on a group-by-group basis that created incentives to switch carriers, depending on the family composition of the group. Responses to the producer survey conducted in support of the study indicated that some groups did switch carriers because of the way they were affected by the difference between two-tier and four-tier rates. This

situation may have contributed to instability in the market, and was detrimental to both carriers. However, the overall impact of this temporary source of instability was not significant. All of the carriers now comply with the requirement to offer only four-tier family composition rates.

When Blue Cross delayed its implementation of the four-tier rating system, it also on April 1, 2001 changed the slope of its age factors and the relative relationships of the employee and family rates. The combination of these two changes resulted in significant rate increases for some groups and decreases for others. The groups that experienced the largest rate increases were groups with a high percentage of family enrollment, since family rates went up, and groups that contained Medicare eligible employees, since Blue Cross raised its rating factors for Medicare eligible employees by approximately 80%.

Four-to-One Rate Compression

The basis of premium rates under the Act is adjusted community rating. Adjusted community rating attempts to blend the goal of a broad spreading of insurance risk with issues of affordability. Under the Act, adjusted community rating takes the form of limiting the kinds of rating (pricing) variables allowed, and the range over which they can vary. The Act permits only age, gender, family composition and health status as rating variables. It limits the overall spread of rates from lowest to highest, and limits the rate adjustment allowed for health status within a defined ratio range.

With an adjusted community rating system there are "winners" and "losers" as compared to a more open, unregulated market which has its own winners and losers, some of whom would stand to lose access to coverage entirely. Under the Act, the "winners" are the older and higher cost, higher risk groups, while the "losers" are the younger and lower cost, lower risk groups.

To limit the overall range of rates, the Act requires that, for any small employer health benefit plan offered by a carrier, the highest rate for a given family tier cannot be more

than four times the lowest rate for that family tier. This requirement is referred to as "4-1 rate compression."

All carriers complied with the rate compression requirement. However, Blue Cross and United each implemented rate compression differently. Although both approaches were in compliance with the Act, because they were different they contributed to potential rate instability. On a relative basis, Blue Cross reduced rates for older groups, and adjusted for that by an across-the-board increase, making their plans more attractive for the youngest and the oldest groups. United, on the other hand, increased rates for younger groups to adjust for a decrease for older groups making its rates relatively more competitive for groups in the middle. For both carriers, about 10% of small employer groups were affected.

Thus far, the 4-1 rate compression has had a modest impact on the small employer market. A 2-1 rate compression, currently scheduled for October 1, 2004, would affect many more groups. Based on a sample of groups reviewed, it could affect as many as one-quarter to one-third of all groups if implemented on a revenue neutral basis, with increases of as much as 67% for the youngest group in addition to normal cost and utilization trend. Without a wider range of rates, younger, healthier groups could choose to remain uninsured or become uninsured.

The effects of the 4-1 rate compression should be known prior to the movement to the 2-1 rate compression since another actuarial report of the effectiveness of the Act is scheduled for December 31, 2003.

Limitations on the Use of Health Status as a Factor in Rating

Utilization of health status is allowed in the initial phase of the Act to provide transition into adjusted community rating on an incremental basis. United failed to comply when it continued to moderate rate increases and decreases (on a basis not permitted by the Act) after the effective date of the Act by using the health status adjustment in a way that did

not comply with the Act. However, United's approach, although not in compliance with the Act, has moderated rate increases.

United also used the health status adjustment to increase rates for employers with fewer than six employees, which does not comply with the Act. Analysis of United's small employer renewals found that 88% of the small employer groups experienced increases because of health status adjustments, while 8% experienced decreases, and only 4% of the groups were unaffected. As a result of the market conduct examination; United has agreed to comply with the requirement to apply health status rating factors only to reflect health status. Compliance will be verified with follow-up work to the examination.

Health status adjustments made by Blue Cross were more evenly split between increases and decreases, but health status adjustments in aggregate contributed about 2% to premiums, which was offset by an adjustment to its base rates.

As stated before, it is not possible to determine the ultimate impact of these changes until all elements of the Act are in place for a significant period of time. At the beginning of this evaluation, one-third of the groups (the smallest of the small who are more price sensitive) had been under the Act for less than six months.

At the next evaluation due to be completed on December 31, 2003, insureds under small employer groups will have been under the Act for more than two years. This next evaluation is critical since on October 1, 2004 2-1 compression will be put in place and use of health status as a rating factor is scheduled to expire causing a significantly greater impact.

Health status rating permits the lowest possible rates to healthy groups, thereby improving affordability for those groups. If healthy groups are required to subsidize less healthy groups without some recognition of better health status, some of them may find health insurance less affordable, and therefore decide to opt out of the small employer

health insurance pool, or opt out of insurance entirely. This provision then could also increase the number of uninsured persons.

Second Calculation

The second calculation is a transitional requirement in the Act that limits the renewal rate increase for any group, to cost and utilization trend plus 10%, adjusted for any changes in the demographics or plan design of the group. This requirement, like the two preceding requirements, is not scheduled to expire until October 1, 2004. This will allow time to evaluate the need for it in maintaining rate stability.

Despite the language in the Act and in Regulation 82, public hearings regarding Regulation 82, and DBR-sponsored meetings attended by both Blue Cross and United to discuss the rating requirements of the Act, neither carrier developed a complete understanding of the required mechanics of this element of the Act, or of the reasoning behind its implementation, that is, to maintain rate stability during a time of required changes in rating structure. Neither carrier implemented this provision correctly. As a result, certain groups paid higher renewal rates than they would have if the second calculation had been correctly implemented.

Both Blue Cross and United attempted to apply the second calculation as they understood it, and both carriers did so by limiting the change in health status that applied in any one year to 10%. This contributed to rate stability, but did not mitigate a number of other rate increase elements, including changes related to rate compression, the introduction of four-tier family composition rates, and contemporaneous changes in rate structure. Both carriers had difficulty in separating changes in demographics of a group (a permitted pass-through to rates in full) from any changes in rating structure (intended to be limited by the second calculation). Separating demographic changes from other changes was difficult for the carriers because of limitations in the way they had maintained demographic data in their rating systems.

A sample of Blue Cross' renewals indicated that approximately 25% of renewing groups would have experienced lower renewal rates if the second calculation had been correctly implemented. Although a significant percentage of the renewing groups should have received a benefit of the second calculation requirement, the average benefit to any one of these affected groups is relatively small, i.e., under 5% of premium. Both Blue Cross and United have provided documentation of the methods that they intend to use for the second calculation going forward. Those methods are in compliance.

The methods the carriers used to approximate the second calculation contributed to some degree of rate stability, although stability would have been enhanced if they had used the correct methodology.

As stated before, the long-term impact of the correct implementation of the second calculation is yet to be determined.

Rate Manual Maintenance

Rate manual maintenance is required by the Act. This enables a new or renewal rate to be calculated without further information. This assures continuity and consistency of calculations of the rates, regardless of changes in carrier personnel. It also enables the periodic actuarial evaluation of compliance under the Act. None of the carriers maintained rate manuals that were adequate to enable a rate to be calculated for a new or renewal group without further information, nor had they developed complete enough documentation of their base rate to enable actuarial review of the methodology and assumptions. The carriers have been ordered to comply, and have submitted revised rate manuals to the examiners. The revised manuals are in the process of being evaluated for compliance.

Premium Changes To Date

There may be a perception that the Act contributed to large rate increases for some employer groups. Analysis indicated that any such increases to date have resulted primarily from changes in demographics, changes in age factors by one of the carriers, and failure to apply the second calculation correctly, but not from the Act itself.

To date, average small employer health care premiums have increased in Rhode Island, primarily because of increases in the cost and utilization of medical services. The rates of increase have been comparable to regional and national trends. The Act itself has not affected the overall cost of small employer health benefits, although rates for individual small employer groups have been affected either up or down.

Product Availability was Affected by Noncompliance

Product availability was affected by the provisions of the Act and Regulation 82 related to:

- Marketing and renewability,
- Availability of the low cost statutory plans,
- Underwriting based on an individual's health status, and
- Utilization of pre-existing conditions restrictions.

Marketing and Renewability

Marketing is the means by which small employers, especially those not previously insured, learn of the enhanced availability of coverage as the result of the Act and Regulation 82. Renewability is the means by which small employers have the option to continue to provide insurance to their employees. One or more Rhode Island small employer insurance carriers failed to comply with requirements in the Act to:

- Establish and maintain a toll-free service to provide information to small employers,

- Offer all of their small employer health plans to any small employer who wanted them,
- Offer all of their small employer health plans to any small employer regardless of size,
- Disclose:
    - ♦ the carrier's right to change premium rates and the factors that affect premium rates, and
    - ♦ renewability to the same small group health plan,
- Notify the formerly small, but now large employer (due to the increase in the size of the group to more than 50 eligible employees) of the potential loss of guaranteed renewability by not renewing to the same small group health plan,
- Notify the formerly large, but now small employer (due to the reduction in size of the group to 50 or fewer eligible employees) of their rights and options as small employers under the Act, and
- Collect data for determination of, and proper interpretation of, the definition of small employer and eligible employees.

To date, without full compliance, the impact of the Act in these areas has been negligible. Its ultimate impact is yet to be seen.

Low Cost Plans Were Not Available

The Economy and Standard plans were included in the current Act, and also in the law in effect prior to the Act, to provide more affordable, low cost alternatives to the most common health plans. As previously stated, a majority of small employers who do not currently provide insurance for their employees reported cost as the primary deterrent. The Economy and Standard plans were required to promote availability through affordability.

None of the carriers complied fully with the Act's requirement to market the Economy and Standard plans on an equal basis with their proprietary plans. Since these plans were not marketed, they have not had an impact. Thus their effectiveness cannot be evaluated.

Awareness of these plans, as reported by employers, is relatively limited. Carriers reported only eight of these plans sold since the effective date of the Act. Carriers have introduced their own lower cost plans with success, but those plans are still more expensive than the Economy and Standard plans.

Marketing and promoting of these plans should ultimately have a positive impact on coverage affordability for both the younger and older small employer groups, decreasing the number of those who are uninsured.

Underwriting on an Insured's Health Status and Utilization of Pre-existing Condition Exclusions were in Compliance

The Act requires that the carriers make all small employer health plans, including the Economy and Standard health plans, available to all small employers without regard to health status.

The Act prohibits the following practices:

- Excluding high-risk individuals from coverage, and
- Non-renewal of groups due to poor claim experience.

The Act also has limitations on the utilization of pre-existing condition exclusions. No evidence was found of these practices or any similar practices by any of the carriers.

Overall Impact of the Act in the Area of Product Availability

The overall impact of the Act in the area of product availability without full compliance has been negligible. The number of Rhode Island small employers covered under small employer health plans has not changed significantly since the effective date of the Act. Seventy-eight percent of small employers in Rhode Island reported employer-sponsored group health coverage in response to the employer survey conducted in support of this

study. In addition, the survey indicated that approximately five percent of employers subsidized individual plans for their employees. Based on national surveys related to employer-sponsored health plan coverage, Rhode Island has a relatively high percentage of small employer employees and dependents with health insurance. In addition to those enrolled directly, a majority of small employers without their own health insurance plans reported that most of their employees had coverage through other sources. This relatively high percentage of Rhode Island small employer employees and dependents that already had health insurance does make it harder for any health insurance reform act to have a substantial impact.

It is also unlikely that there will be other carriers entering the Rhode Island small employer market in the foreseeable future. With only 130,000 small employer group members, the Rhode Island small employer market is less attractive than a larger market state would be to companies not now active here. In addition, carriers without established provider networks would be at a disadvantage to entrenched competitors. The effort to learn about and comply with small group laws in a state is a factor for a carrier considering entering the market, but based upon interviews with representatives of carriers not now in the Rhode Island market, the Act itself is a relatively small consideration as compared to the other reasons that carriers may not be inclined to become active in Rhode Island.

Given that it is unlikely that new small employer carriers will enter the state, it is prudent to consider the potential effects of any changes in small employer laws on the carriers that are now active in the Rhode Island small employer market, as a part of an overall public policy strategy.

Carriers' Commitment to Compliance

Although this first actuarial report identified significant noncompliance, all of the carriers have either already moved into compliance or indicated their intent to do so. This first market conduct evaluation is the first opportunity to identify misunderstandings and confusion. The carriers did report finding the requirements of the Act confusing. In some instances, this resulted in incorrect implementation of the Act. Although diligent analysis of the Act by trained people should yield adequate understanding, many of the requirements are relatively complex.

Determination of the Effectiveness of the Act Requires Enforcement of the Act and Control Over Mechanisms that can Segment the Small Employer Market

For determination of the overall, long-term effectiveness of the Act, it will be necessary to enforce compliance with the Act. It will also be necessary to prevent mechanisms which are not subject to the Act and are not subject to the scrutiny of the DBR. Such mechanisms are designed to segment the small employer market by selecting the better risks out of the small employer insurance pool. These mechanisms might include out-of-state associations, professional employer organizations (PEOs) self-insurance schemes coupled with low stop loss plans, and/or exclusion from the Act of one or more associations. These mechanisms have not been factors in Rhode Island to date, but may develop greater importance as full compliance with the Act and scheduled rate compression changes and expiration of the utilization of health status and the second calculation create greater incentives for young and healthy groups to opt out of the small employer market. As such mechanisms emerge, it may be important to take legislative and/or regulatory steps to control their impact.

RIte Share

RIte Share is the program designed to assist employed persons eligible for RIte Care to participate in employer-sponsored health plans. The Basic health benefit plan has only

been required since January 1, 2002. However, it does not appear that the Basic plan will be effective in promoting the success of the RIte Share premium assistance program unless significant changes are made in the requirements for providing the Basic plan and in the operation of the RIte Share program.

Summary of Recommendations

The following recommendations were developed based on observations made in the course of preparing this report:

- Continue to enforce compliance with the Act.
- Continue to monitor and evaluate the effectiveness of the Act.
- Monitor sales of low cost plans, particularly the Standard and Economy plans, to determine if they are bringing more small employers into health plans.
- Amend the Act to provide for jurisdiction by the DBR over out-of-state associations or trusts insuring Rhode Island small employers, and over mechanisms that may arise that are not now under the Act or the jurisdiction of the DBR.
- Increase the stability of the small employer group insurance pool by reducing migration of employers between small employer individual and group coverages. This can be accomplished by identifying small employer groups that are utilizing individual coverage (individual coverage for small employer groups is covered under the Act), and by promoting greater parity in premium rates between individual coverage and small employer group plans.
- Amend the Act to facilitate the withdrawal by carriers of obsolete benefit forms.
- Identify and implement opportunities to facilitate the workflow of the RIte Share program with the goal of enhancing enrollment and reducing the administrative burden associated with the program. Such opportunities may include utilization of a standard benefit plan for RIte Share enrollees and access to certain carrier data.

Introduction

This report is presented to the Rhode Island Legislature pursuant to R.I. Gen. Laws § 27-50-9, which provides for an independent actuarial study of the effectiveness of the Small Employer Health Insurance Availability Act ("the Act"). The Director of the Department of Business Regulation ("DBR") retained the actuarial consulting firm Lautzenheiser & Associates ("L&A") to perform the actuarial study and prepare this report.

In addition to the purpose of the study and report to analyze the effectiveness of the Act in promoting rate stability, product availability, and coverage affordability, the report also:

- Addresses whether carriers and producers are fairly and actively marketing and issuing health benefit plans to small employers in fulfillment of the purposes of the chapter; and
- Contains certain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the Rhode Island small employer group health insurance marketplace.

In order to gather information for the study, the Director directed L&A to perform market conduct examinations of the small employer carriers active in the Rhode Island market. Market conduct examinations were conducted during the first quarter of 2002. They covered the period from the effective date of the Act (July 13, 2000) through March 31, 2002. The market conduct examinations resulted in a number of recommendations for the carriers to come into compliance with the Act. The carriers have responded to the market conduct examinations, and have agreed to come into compliance. Subsequently, market conduct orders were issued by the DBR related to future compliance and past failure to comply. Blue Cross has filed an appeal of the market conduct orders under the Administrative Procedures Act. United has until July 31, 2002 to file a similar appeal, if it chooses to do so. Market conduct orders for the other carriers involved in the examinations were issued more recently, and those carriers have not indicated whether they will appeal those orders.

In addition, the Director commissioned surveys of Rhode Island small employers, and of producers of Rhode Island small employer health insurance, in order to develop insight into the attitudes, perceptions and experience of these constituents under the Act. The surveys were developed by and conducted under the direction of The ROME Group, LLC.

In the course of gathering information for this study, L&A studied the Act and the Regulation promulgated pursuant to the Act in detail, reviewed legislation in adjacent states, and interviewed insurance executives and regulators both in Rhode Island and in adjacent states. Regulation 82 was originally promulgated pursuant to the small employer health insurance law in effect prior to the Act, and was amended on August 2, 2001 and again on November 6, 2001 to reflect the new requirements of the Act.

L&A wishes to acknowledge the cooperation and assistance provided by the DBR in the development and preparation of the focused market conduct examination reports and this report, the assistance provided by the small employer carriers in the course of data collection for the focused market conduct examination reports and this report, and the assistance provided by Michael P. Fleck of The ROME Group, LLC in the development, preparation and interpretation of the employer and producer surveys.

Overview of Adjusted Community Rating

The Act prescribes that small employer group premiums be determined by adjusted community rating. Community rating is an approach under which all insured risks are pooled, resulting in a single premium rate for all participants. Under this system, with insurance more affordable for older and less healthy applicants and less affordable for younger and healthier applicants, it is presumed that insurance is less available for younger and healthier applicants and more available for older and less healthy applicants. The opposite of this approach is cost-based pricing, under which premium rates are developed based on the expected experience of each group or participant. This is usually

based on rating factors such as age, gender, group size, industry, geographic area, health status and prior claim experience, and underwriting rules. The effects of a cost-based pricing system are the reverse of a community rating system. Under cost-based pricing, insurance is more affordable to the younger and/or more healthy applicants, but less affordable and less available to the older and/or less healthy applicants.

Adjusted community rating is an intermediate method between the above two systems. It attempts to blend the goal of broad spread of risk with affordability to participants in the market. Under the Act, adjusted community rating in Rhode Island takes the form of limiting the kinds of rating (pricing) variables allowed, and the range over which they can vary. The Act permits only age, gender, family composition and health status as rating variables by which pricing can vary. It limits the overall spread of rates from lowest to highest, and limits the rate adjustment allowed for health status within a defined ratio range.

Even under adjusted community rating system there are "winners" and "losers" as compared to a more open, unregulated market. Under the Act, the "winners" continue to be the older and higher cost, higher risk groups, while the "losers" continue to be the younger, lower risk groups. Adjusted community rating is a compromise that tries to find an acceptable middle ground between the extreme "losers" in the unregulated market (who may not be able to get coverage at all) and the extreme "losers" in community rating (who may find the cost unaffordable).

Adjusted community rating requires regulation to be successful. The Act requires that an independent actuarial study and report be conducted. In the absence of regulation and enforcement, it is possible for small employers and/or insurers to follow their own economic interests and segment the market into better risks and poorer risks. Such segmentation undermines the ability to spread the risk as much as possible and to make it as affordable as possible for small employers and their employees. Even with regulation and enforcement, employers, especially the very small employers with healthy employees, can and will act in their own economic interests and cease providing

insurance to their employees and even for themselves, the owners, because coverage is deemed too expensive or unnecessary. The result can be a greater number of uninsured.

The Act provides for a two-phase implementation process, which incrementally increases the degree of adjusted community rating required of the carriers. This was done to mitigate the impact of the changes on employees and employers affected by the Act. The degree of adjusted community rating to be required in the second phase is a public policy determination that should be made only after analysis of the impact of the Act after there has been full compliance with the requirements of the first phase of the Act. The Legislature wisely required that the requirements of the second phase be deferred so that impact of the requirements of the first phase could be evaluated. Thus, the provisions of the Act requiring movement toward 2-1 rate compression and eliminating health status as a rating factor have been postponed until October 1, 2004.

The considerations involved in determining the appropriate degree of adjusted community rating include how important it is to make health insurance even more affordable for the older and less healthy groups, versus how to keep the younger, healthier groups in the market at a rate affordable to them.

There is no single right or wrong way to achieve balance in making health insurance affordable for all groups. The current level of compliance with the first phase of the regulation has had a modest but noticeable effect on moving toward a community rate.

While the carriers responded differently to the rating requirements of the Act, about 10% of small employer groups were affected by changes in premium rates directly attributable to the adjusted community rating provisions of the Act. These effects were most noticeable for the oldest and least healthy groups, some of whom experienced decreases in premium of as much as 40% attributable to the changes, offset by other increases based on cost and utilization of medical services generally. One of the major carriers compensated for this by using an across the board adjustment to all small employer

groups, while the other major carrier decreased rates for about 5% of the highest cost groups and increased rates for about 5% of the lowest cost groups.

The next steps envisioned in the second phase of the Act, if taken, would affect rates for a larger number of groups, probably about 25 to 30% of all groups. For the youngest groups, the increased premium cost of moving to 2-1 rate compression may be as much as 67%, in addition to normal cost and utilization trend. This may lead to some segmentation of the market and an adverse effect on the entire market if younger, healthier groups find the new rates unaffordable, stop participating in small employer plans, and so remove their subsidy from the pool. This can happen if out-of-state associations or out-of-state trusts or other mechanisms not subject to regulation under the Act are available on a basis that rates groups on a cost-based rating system, or worse yet, as stated before, if younger, healthier groups simply decide coverage is just too expensive and go without coverage.

Small Employer Carriers Active in Rhode Island

The Rhode Island small employer health plan marketplace is primarily served by two entities, Blue Cross and United. Blue Cross provides insurance to Rhode Island small employers through Blue Cross & Blue Shield of Rhode Island and its HMO affiliate, Coordinated Health Partners, Inc. United makes group health plans available to Rhode Island small employers through its Warwick, Rhode Island-based HMO subsidiary, United HealthCare of New England Inc. and its Hartford, Connecticut-based life insurance company affiliate, United HealthCare Insurance Company. In addition to United and Blue Cross, Neighborhood Health Plan of Rhode Island, Inc. ("Neighborhood") and The New England Life Insurance Company ("New England") have a minimal number of small employer health plans inforce. All of these insurers were subject to market conduct examinations during the first quarter of 2002.

Blue Cross insures about 13,500 small employer groups, or about 90% of the small employers covered by small employer group health plans. United insures about 1,500

small employer groups, or about 10% of the market. During the period covered by the market conduct examinations, Neighborhood insured only five groups, all members of a single association. New England insured only one group during the market conduct examination period.

Neighborhood's approach to insuring small employer health plans is to accept groups that are part of associations with which Neighborhood has a long-term contract. This approach is not in compliance with the Act. Based on the results of the market conduct examination, it appears that Neighborhood does not at this time have the resources to offer health insurance to all small employer groups on a basis that does comply with the Act. Pursuant to the market conduct examination, Neighborhood has been ordered to comply with the provisions of the Act that require it to offer its health plans to all small employer groups. Based on the Act and the order, Neighborhood must either comply or withdraw from the small employer market.

In addition, several respondents to the producer survey reported marketing individual coverage to small employer groups through John Alden Life Insurance Company ("John Alden"), a division of Fortis, Inc. ("Fortis"), or through Celtic Life Insurance Company ("Celtic"). Fortis, on behalf of its subsidiaries, has filed notice with the DBR of its intent to withdraw from the Rhode Island individual and small group health insurance market.

Respondents to the employer survey did not mention either of these individual companies as providing current coverage, although some identified John Alden as a prior carrier. Of 501 responses included in the results of the employer survey, one response each came in for Harvard Pilgrim Health Care of New England, Inc. ("Harvard"), Oxford, AFLAC, and MEGA Life, and one identified both Lifeguard and Kaiser, which are both out-of-state HMOs. Harvard ceased doing business in Rhode Island effective December 31, 1999, and is therefore not active in the state. It is possible that the survey respondent in fact has coverage from Harvard Pilgrim, the Massachusetts corporation. We found no reason to believe that Oxford, Lifeguard or Kaiser operates in Rhode Island. AFLAC offers supplemental products on a payroll deduction basis. It is our understanding that a

carrier of supplemental products only is not subject to the Act. MEGA Life is a direct marketer that offers insurance via 1-800 numbers posted on telephone poles around Rhode Island. It is possible that MEGA Life operates through an out-of-state trust, not subject to the Act in its current form.

Small employer carriers in Rhode Island were required by the Act to file a Basic plan with the DBR as of January 1, 2002 as a condition of participating in the small employer market. Market conduct examinations were conducted of all carriers who filed Basic plans. None of the carriers discussed in the preceding two paragraphs filed a Basic plan, hence they cannot participate in the Rhode Island small employer market. There is no evidence that any of those carriers have in fact engaged in any activities in Rhode Island since January 1, 2002 that would make them subject to the provisions of the Act. Therefore, no market conduct examinations were done of those carriers.

The neighboring states have a greater number of active small employer carriers than there are in Rhode Island. Massachusetts listed 40 carriers (including multiple entities with common ownership) on its report of membership in small employer group plans as of December 31, 2001, and a total small employer health plan membership of 815,000. Of these carriers, about 20 have membership of more than 1,000 members. Eighty-five percent of small employer members are covered through HMOs in Massachusetts. Connecticut has approximately 30 small employer carriers. By comparison, Rhode Island has six small employer carriers, with a total membership of about 130,000. Of the six entities, only Blue Cross, its affiliate Blue Chip, and United HealthCare of New England have 1,000 or more small employer members.

It is unlikely that there will be other carriers entering the Rhode Island small employer market in the foreseeable future. There has been a great deal of consolidation in the industry, and there are fewer carriers operating in small employer insurance in all markets, not just in Rhode Island. A number of carriers who are active in other markets would be relatively unlikely to enter Rhode Island for several reasons, primarily the size of the market. With only 130,000 small employer group members, the Rhode Island small

employer market is less attractive than a larger market state would be to companies not now active here. In addition, carriers without established provider networks would be at a disadvantage to entrenched competitors.

Most states regulate small employer group health insurance. Some states have small group laws that are more stringent than Rhode Island's, while some others have small group laws that are less stringent. The effort to learn about and comply with small group laws in a state is a consideration for a carrier considering entering the market, but based upon interviews with representatives of carriers not now in the Rhode Island market, the Act itself is a relatively small consideration as compared to the other reasons that carriers may not be inclined to become active in Rhode Island.

It is unlikely that new small employer carriers will enter the state. Therefore, as a part of the development of an overall public policy strategy, it is prudent to consider the potential effects of any changes in small employer laws on the carriers that are now active in the Rhode Island small employer market.

Availability of Health Insurance Coverage in Rhode Island

The number of Rhode Island small employers covered under small employer health plans has not changed significantly since the effective date of the Act. According to data from the market conduct examinations, approximately 15,000 groups with 130,000 lives are covered under small employer plans in Rhode Island.

Seventy-eight percent of small employers in Rhode Island reported employer-sponsored group health coverage in response to the small employer survey on health plans commissioned in support of this study. In addition, approximately five percent of employers reported subsidizing individual plans for their employees. In addition to those enrolled directly, a majority of small employers without their own health insurance plans reported that most of their employees had coverage through other sources.

Nationally, based on a Health Insurance Association of America study, approximately 67% of the non-elderly population is covered by employer-sponsored health plans. This varies greatly by size of group, with only 50% of groups with fewer than ten employees offering health plans. A 1999 Survey of Rhode Island Employers on Health Insurance Coverage reported by the Rhode Island Department of Health compared results for Rhode Island employers with results from a similar national survey. It showed 79% of Rhode Island employers offering health insurance. By size of group, 68% of Rhode Island employers with three to nine employees offered health plans, compared to 55% nationwide. Among employers with ten to 24 employees, 89% of Rhode Island employers had health insurance plans, compared to 72% nationally. Among employers with 25 to 49 employees, the percentages were 93% for Rhode Island and 86% nationally. Rhode Island therefore already has a relatively high percentage of small employer employees and dependents with insurance. Gains in enrollment because of improved access and availability will therefore be relatively modest, because so many are already covered.

Principal Features of the Act

The Act requires small employer carriers to establish their rate structure based on the experience of their overall book of small employer business. Prior to the Act, a carrier could segment its small employer business into classes with distinct rates for each class, based on the experience of that class of business. This feature of the Act supports the public policy goal of spreading health risk cost more broadly. However, it also has had the effect of increasing premiums for some groups that had previously been in a lower rated class of business, thereby decreasing the relative affordability for those groups.

The Act requires carriers to use four-tier rates for their small employer health plan business. The four-tier rate requirement results in separate and distinct rates for the following family composition categories: employee only, employee and spouse, employee and child(ren), and full family. Prior to the passage of the Act, the major

carriers used either two-tier composite rates (employee only or employee and family) or two-tier table rates applied on an individual subscriber basis.

Table rates are premium rates applied from a table to each employee of an employer, based on the employee's age, gender and family status. Composite rates are average rates developed based on the average age, gender and family status distribution of the employees of an employer, which are then applied to each of the employees within a group, regardless of the age or gender of the individual employees.

Association business is subject to the Act. Regulation 82 requires that small employer groups who are members of an association be treated the same as any other small employer groups and that they be rated within a carrier's entire small employer pool. Prior to the effective date of the Act, a carrier could treat an association as a single class of business and set its rates based on the claims experience of the association.

The Act prohibits the use of health status as a rating variable, except that carriers who used health status as a rating variable as of June 1, 2000 were allowed to use health status in a limited way in the first implementation phase of the Act. Both Blue Cross and United used health status on June 1, 2000 as a rating variable and as a result were allowed to continue the use of health status as a rating variable. The Act limits the ability of qualifying carriers to adjust rates for the health status of individual participants to a band of +/-10% around a base rate. As previously noted, during the 2002 legislative session, the Rhode Island legislature amended the Act to extend the use of health status as a rating variable until October 1, 2004. Thus, utilization of health status as a rating variable will continue until the effects of the Act's first phase can be fully evaluated. Prior to the effective date of the Act, the major carriers had varied rates for health status up to a total range of 40% for one carrier and 60% for the other as opposed to the 20% range currently allowed under the Act.

The Act requires that, for any health benefit plan offered by a small employer carrier, the highest rate for a given family tier cannot be more than four times the lowest rate for that

family tier. This requirement is referred to as "4-1 compression." Under the Act "2-1 compression" was to replace "4-1 compression" on July 13, 2002. Under the 2002 amendment to the Act, "4-1 compression" is extended until October 1, 2004 when it is scheduled to be replaced by "2-1 compression."

In order to mitigate the effect on small employer rates resulting from the implementation of the rating provisions of the Act, the Act specified that renewal rates for a given group cannot increase over current rates at renewal by more than cost and utilization trend plus 10%, adjusted for any changes in demographics or plan of benefits of the individual group. This provision is known as the "second calculation." It was scheduled to expire October 1, 2002, but the 2002 amendment to the Act postponed the expiration of this provision until October 1, 2004, thus allowing time to determine the impact of this requirement when the full effect of implementation of the first phase of the Act can be evaluated.

Prior to the Act, both United and Blue Cross used a system of maximum and minimum rate increase percentages to manage the level of renewal premium rates so that rate increases did not exceed a certain level, and so that rate decreases were generally avoided. This was done primarily to promote rate stability. Because this practice resulted in rates that might vary between otherwise similar groups, and rates that could not be calculated from the rate manual, it is not permitted by the Act. The Act established specific standards for promoting rate stability through the operation of the second calculation.

The Act requires that carriers disclose their practices with respect to rating and renewability as part of any new business proposal or renewal. Carriers are limited in their ability to non-renew a small employer health plan.

The Act requires small employer carriers to offer a Basic plan. The Act, in R.I. Gen. Laws § 27-50-10(d), provided that the Basic plan would be defined by the DBR in consultation with the Department of Human Services. The requirements of the Basic plan

are set forth in Regulation 82 section 13. It should be noted that the benefits required under the Basic plan are not "basic" in nature, but rather are comparable in level to the most "popular" plans written by small employer carriers in Rhode Island. Small employer carriers are required to market the Basic plan on a basis equal to their other plans effective January 1, 2002.

The Act requires that carriers make all small employer health plans, including the Economy, Standard and Basic statutory health plans, available to all small employers without regard to number of employees or health status.

The Act prohibits the following kinds of rating practices that are generally considered to be abusive practices:

- Non-renewal of groups due to poor claim experience,
- Increasing rates based on the duration since the effective date,
- Rating for full recovery of projected claim cost on high-risk individuals, and
- Excluding high-risk individuals from coverage.

No evidence was found in the course of the market conduct examinations of these practices or any similar practices by any of the carriers that could be considered as abusive. Because a carrier may not non-renew a group with adverse experience, and because the ability to reflect the expected claim experience or health status of a small employer group in that employer's rate has been reduced, health insurance is more accessible and more affordable to small employers with high cost or high-risk employees or dependents. Because health insurance is now more affordable for high cost or high-risk groups and individuals, those costs are being spread across the entire pool of small employers.

Availability and renewability of health insurance coverage to Rhode Island small employers regardless of their health status or claims experience has been enhanced under the Act. While the law in effect prior to the Act provided access to health insurance for all eligible small employer groups, higher risk groups and smaller size groups paid a significant premium as compared to other groups in order to obtain health insurance. The

current Act eliminates that extra premium based on group size, and greatly limits the amount of premium based on health status or group experience. However, there is an opposite impact on younger and healthier groups, making health insurance less affordable for them.

While there has not been a significant increase in the number of people covered under small employer health plans since the effective date of the Act, the fact that carriers have, for the most part, complied with the premium rating provisions of the Act related to size and health status has contributed to greater availability and relatively increased affordability of health insurance for those higher risk groups. However, there has been relatively reduced affordability of health insurance for younger and healthier groups.

Because of the changes under the Act, health risk has been spread more broadly by bringing all small employers, including members of associations, into one insurance risk pool, and by limiting premium rate variability among small employer groups. However, not all of the impacts of the Act will be known until carriers have been in compliance for a significant period of time. The long-range impact on relative affordability for various groups and thus on participation in the small employer pool cannot yet be determined.

Perceptions of the Effects of the Act

There may be a perception that the Act contributed to very large rate increases experienced by some employer groups. However, the market conduct examinations revealed that any such increases to date resulted primarily from changes in demographics, changes in age factors by one of the carriers, and failure to apply the second calculation correctly, and not from the Act itself. The long-range impact of the Act on rate increases cannot be quantified until it is determined, after a significant period of time with full compliance, whether the Act has contributed to changes in the risk profile of the small employer pool by bringing in more older and/or higher-cost groups, or driving out younger and/or lower-cost groups, or both.

In the course of the market conduct examination, anecdotal information was provided concerning rate increases as high as 100%, allegedly attributed to implementation of the Act. In response to a request for actual examples, the affected carrier was able to provide information on only one group with a rate increase as high as 100%. This group was renewed in the fourth quarter of 2000 with two single subscribers, both under age 30. When the group was renewed again in the fourth quarter of 2001, it had 12 subscribers, and an increase in the age/gender factor of over 100%. Under their old rules, this carrier would have moderated this rate increase, even though it was purely the result of demographic changes.

Results of the producer and employer surveys commissioned in connection with this study indicate a generally low level of understanding and awareness of the features of the Act. In addition, perceptions related to likely employer behavior were different between the employer and producer populations.

Among employers, only 23% indicated an awareness of the Act. A significant portion of employers who do not currently offer insurance plans felt that a pre-existing condition for one or more of their employees was a barrier to offering health insurance. This is a misperception, in that the major carriers do not limit coverage for pre-existing conditions, and the maximum extent to which health status can be reflected in premium rates is only 10% of premium. If a significant number of groups that had previously stayed out of the small employer market because of health issues find health insurance more affordable under the Act, average health care cost in the small employer pool could increase, with resulting premium increases.

Among producers, a great majority of respondents reported a perception that the Act made health insurance in Rhode Island less accessible and less affordable. This perception is not consistent with the nature of the Act, nor with the data collected in the course of the market conduct examinations. A significant number of producers indicated that employer groups had dropped coverage because of the effects of rate compression. The employer survey, on the other hand, did not report such an effect.

Producers reported that approximately equal numbers of their clients thought four-tier family composition rating was an improvement over the prior two-tier rating method, as compared to those who thought it was worse. This is understandable, since an approximately equal number of groups should have seen lower rates as those who would have had higher rates under the change to four-tier rating.

In response to questions regarding the likely reaction to significant rate increases, producers and employers responded somewhat differently. Producers thought it more likely that an employer would pass the entire cost along to employees, change the plan or drop coverage. Employers thought it more likely that they would pay the additional cost themselves.

Associations and Intermediaries

Prior to the Act, many Rhode Island small employers obtained health insurance through associations. Blue Cross, in particular, rated associations as separate classes of business, and the various member small employers within an association were pooled within that association's class of business, but not with other classes of business. Blue Cross underwrote several associations, including the Rhode Island Builders' Association and associations representing the Rhode Island Bar, Rhode Island Food Dealers, Rhode Island Truckers, Rhode Island Dental Workers and Rhode Island Nurserymen. In addition, Blue Cross and United wrote a number of small employers through the Chambers of Commerce ("Chamber groups").

Membership in these associations has not strictly been related to a specific type of business. Some employers apparently have been members of different associations at different times, reflecting where they could get the most favorable rates for coverage. For example, some members of the Rhode Island Builders' Association are not employed in fields related to the building trades.

Groups that purchased health care benefits through associations in Rhode Island have generally been very small, with an average size of about two enrolled employees. The Chamber groups average only about 1.6 enrolled employees. Prior to the Act, these groups were all table-rated. That is, premiums were developed on an individual employee basis, considering the employee's age, gender and health status, and whether the employee had single or family coverage. The employer's monthly premium was the sum of the premiums developed for each of the employer's employees.

The Act required that association member groups be rated as individual groups within the overall small employer pool. In order to comply with the provision that all groups be rated alike, both major carriers changed from table rating to composite rating for their association and Chamber business.

When the Chamber business was rated as one group, it had an October 1 renewal date for both Blue Cross and United. Both carriers delayed the impact of the Act on Chamber groups by preparing an early renewal as of September 30, 2000, thereby keeping the Act from applying to these groups until the October 1, 2001 renewal. This affected about 4,200 Blue Cross groups and about 950 United groups. This represents approximately 1/3 of all Rhode Island small employer groups, and about 15% of Rhode Island small employer employees.

About three-quarters of Blue Cross' Chamber groups and virtually all of United's Chamber groups are written using the services of intermediaries who provide assistance with marketing, enrollment and billing. Prior to the Act, these intermediaries were not directly compensated by the carriers, but rather were allowed by the carriers to add a fee of $15 per employee per month to the bill for insurance premiums. This fee was not generally shown separately to the customer. As far as the customer was concerned, the fee was part of the premium paid for health insurance coverage. Regulation 82 limits the fees that can be charged to a health plan customer to $5 per employee per month, and requires that the basis for charging fees be the same for all customers. This was also a requirement of the prior version of Regulation 82.

When groups represented by intermediaries were brought into the small employer pool in October 2001, Blue Cross instituted a program of paying producer compensation to the intermediaries, and withdrew permission for the intermediaries to charge separate fees. United continued to not compensate the intermediaries directly, and continued to allow intermediaries to charge separate fees of $15 per subscriber per month until April 1, 2002. Beginning April 1, 2002, the administrative fee charged by the intermediaries was reduced to $5 per subscriber per month. As of July 1, 2002, United will handle billing for Chamber groups internally, and no administrative fees will be charged to small employers. Market conduct orders issued by the DBR in response to the examinations have directed United to identify any groups charged fees in excess of those allowed by the Act.

During the course of market conduct examinations, the examiners called intermediaries to gather information. In the course of one of those calls the intermediary stated that Blue Cross insurance would be lower cost than United insurance. That is consistent with information obtained during the market conduct examinations that United's marketing approach involved an additional fee structure, and that United's rating approach resulted in higher rates for the smallest groups.

Blue Cross' largest association, the Rhode Island Builders' Association, was scheduled for renewal on November 1, 2000. In order to delay the impact of the Act for the Builders' Association, Blue Cross prepared an early renewal as of September 1, 2000, to be in place for 14 months, thereby keeping the 1,100 Builders' Association groups from coming into the small group pool until November 1, 2001.

Blue Cross' other association groups include about 1,500 groups, which were brought into the small group pool on their scheduled renewal dates in 2001.

Because the groups that obtained insurance through associations are generally very small employers, their premium rates are easily affected by demographic changes. Therefore, there is a wide variation in rates at renewal. On average, Blue Cross' Chamber groups

experienced an increase in premiums of about 7% at their purported September 30, 2000 renewal. At the October 1, 2001 renewal, however, they experienced an average decrease in rates. In addition, they no longer had to pay the intermediary fees that they had previously paid. The effect was that the combined cost of health premiums and associated fees decreased by an average of 9% for direct written Chamber groups, and 4% for those that came in through intermediaries. This increase analysis is based on the average premiums charged, and does not adjust for any changes in demographics or benefits. United's Chamber groups experienced an average rate increase at the October 2001 renewal of about 5.5%, and continued to pay intermediary fees, although those fees are in the process of being phased out, as described above. Of these groups, approximately 25% experienced absolute decreases at their October 2001 renewal, while only about 1% had increases as large as 25%.

The Rhode Island Builders' Association groups experienced an average rate increase of approximately 7% in 2000, but an average increase of 16% in 2001, their first renewal within the small employer pool. This increase analysis is based on the broad average premiums charged, and does not adjust for any changes in demographics or benefits of the Builders' Association groups. This increase was higher than for other small employer business because the Builders' Association had previously been underwritten as a distinct class of business with its rates based on its own relatively favorable claim experience. Under the Act, they were required to be rated as part of the overall small employer pool. Certain groups within the Builders' Association received higher than average rate increases that should have been mitigated by the "second calculation" provision of the Act that limits increases to cost and utilization trend plus 10% plus demographic and plan changes. Blue Cross did not apply this provision correctly, resulting in some Builders' Association groups receiving increases higher than the Act intended. The ultimate effect of the Act on the Builders' Association cannot yet be determined because it has only been rated in compliance with the Act since November 1, 2001.

Prior to being renewed under the Act for the first time effective November 1, 2001, members of the Builders' Association had a lower rate basis than other small employers,

at least partly because of favorable demographics and health cost experience as compared to the entire small employer pool.

Individual groups that obtain insurance through the associations may or may not be better off than they were before. Chamber groups have lower rates than they would have had as a separate pool, as do members of at least some of the trade associations other than the Builders. Being freed from paying intermediary fees is an important benefit to the Chamber groups. On the other hand, rates did go up for the Builders when they were included into the carrier's small employer insurance pool.

Associations generally, and the Rhode Island Builders' Association in particular, were disadvantaged by the Act, because it reduced their role in obtaining insurance for members. The effects of the Act may thereby reduce the revenues of the Associations and their opportunity to be seen as providing value to their members. The Legislature passed an amendment to the Act during the 2002 legislative session, allowing the Builders' Association to be exempted from the section of the Act that regulates premium rates, effective October 1, 2003. The bill as originally introduced would have exempted "associations." That bill was amended during the legislative process to be limited to the Builders' Association.

This amendment may have advantages for members of the Builders' Association, but has unfavorable implications for the remainder of the small employer pool. To the extent that premium rates are reduced for the Builders' Association, and entry into the Builders' Association is not limited, there may be incentives for groups with favorable risk characteristics to join the Builders' Association, leaving groups with less favorable characteristics in the small employer pool. For example, the Builders' Association would be free to use health status or other rating variables to create a select pool of lower cost groups. It would also be free to use rate structure to favor younger groups, since the amendment frees it from rate compression requirements that apply to the small employer pool. This amendment therefore has the potential of creating segmentation in the market, and undermining the Act's purpose of generating a broad spread of risks. The impact of

this segmentation will not be known as of the next scheduled evaluation of the Act, scheduled for December 31, 2003, as the amendment does not begin to take effect until October 1, 2003.

As rate compression progresses from 4-1 to 2-1, there will be pressures to allow low cost segments of the market to opt out. An out-of-state association or a multiple employer trust (MET) is an example of a mechanism that could be used to sign up Rhode Island small employer groups and provide them insurance outside the Act. The Act does not, in its current form, provide jurisdiction to the DBR over such associations or trusts.

In order to help understand how small group laws might create an environment in which there are pressures for segmentation, and in order to see how neighboring states deal with the potential for segmentation, inquiries were made regarding small group laws, regulations and experience in Massachusetts and Connecticut. Insurance executives and a representative of the Massachusetts Division of Insurance were interviewed to obtain insight into how Massachusetts deals with issues similar to those that may occur in Rhode Island.

Massachusetts has written its law to provide Massachusetts regulators authority to regulate insurance provided through an out-of-state association or trust. The law permits regulation of insurance provided to Massachusetts groups, regardless of where the association or trust that provides the insurance is located.

Massachusetts allows intermediaries to be used to aid with marketing and administration of small employer plans, and allows carriers to require groups with fewer than six employees to go through intermediaries. The Massachusetts small employer law does not regulate the activities of the intermediaries. It does require the insurer to file information about its practices regarding intermediaries, including a schedule of the fees charged by the intermediaries, but does not specifically limit the amount of those fees.

Connecticut allows small employer carriers to use associations or MET administrators as their licensed representatives, but considers them to be extensions of the insurance carrier. It explicitly requires association business written by a carrier to be included in a carrier's overall small employer pool.

Rate Increase Components

Premiums charged to small employer groups are composed of base rates reflective of the plan of benefits, and adjustments to reflect permissible rate variables, including age, gender, family composition and health status. Base rates include a provision for health care claims cost, and provisions for marketing and administrative expenses and contribution to reserves or profit. Carriers typically update their base rates monthly or quarterly to take into account changes in health care cost and utilization, changes in administrative or marketing costs, and adjustments to correct for variance between prior pricing decisions and actual experience. In connection with the implementation of the Act, it was necessary for carriers to make overall adjustments to base rates to normalize rates for the effect of required rating provisions, including rate compression, the loss of group size as a rating variable, and limits on the use of health status factors.

The carriers that were subject to the market conduct examinations did not provide sufficient detail of their base rate development to allow L&A to determine in detail the source of changes in base rates. Market conduct orders have been issued for the carriers to provide the necessary information. Follow-up examination work will verify their compliance. Based on the information that was available, it appears that administrative and marketing expense, together with contribution to reserves (profit margin), amount to about 12% to 20% of health care premiums in the Rhode Island small employer market.

Health care costs therefore appear to constitute approximately 80% to 88% of the premium cost in Rhode Island. Health care cost and utilization trend is the most significant contributor to changes in a carrier's base rates and hence in the rates charged to employers and employees. Cost and utilization trend takes into consideration the effect

of change in the frequency of the utilization of health care services, the cost per unit of service, and the impact of new technology. Cost of health care and changes in the cost of health care can vary on a carrier-by-carrier basis due to differences between carriers in provider contracting and in managing and channeling the utilization of health care services.

In aggregate, Rhode Island small employer premiums have increased faster in the last two years than they had previously. This increase is reflective of increases in health care cost and utilization trend throughout New England and nationally. Based on informal surveys of actuaries active in health care, annual medical care cost and utilization trend during the last year is in the range of 11 to 15% on average. For plans with pharmacy benefits, the range is 1.5 to 2% higher. Prior to 2000, national and regional cost trends were approximately 10% annually. It is possible that full compliance with the Act could lead to a pattern of higher increases than have occurred to date, if it leads to an increase in coverage of older, higher-risk groups, and a decrease in affordability for younger, lower-risk groups.

Annual base rate increases for Blue Cross small employer business have averaged about 13% since the effective date of the Act. However, the range has been from about 7% to about 21%, with the largest increases coming in the first two quarters of 2002. Information about second quarter 2002 rate increases was available during the market conduct examination because those rate increases were determined approximately three months ahead of renewal dates, as is Blue Cross' customary practice. There has been considerable variation from group to group because of changes in rating structure, e.g., a decrease for Chamber groups and a 16% increase for the former Builders' Association groups, and there have been different patterns of increase for Blue Cross and Blue Chip. United small employer base rates have increased by about 11% to 15% annually since the effective date of the Act, with the larger increases in the current year. Respondents to the employer survey indicated an average most recent rate increase of 16.9%, but this average was based on underlying responses that varied widely. This pattern of increase is not necessarily indicative of what will occur in the future. That will not be determined

until there is full compliance with the Act, and adequate time for small employers to react to the impact of the Act on affordability.

Rhode Island health care utilization is relatively high compared to some other states. Based on statistics observed during the course of the market conduct examinations, the number of hospital bed-days per year for 2001 was in excess of 280 per 1,000 members insured under employer sponsored programs. This is within the average range of a loosely managed network, but more than twice the level of a tightly managed network. For comparison, a California company reported utilization in the level of 180 to 190 bed-days per year.

While there may be opportunity for reducing utilization in Rhode Island, and thereby improving the affordability of small employer health plans, that is outside the goals of the Act. The Act does not focus on either the unit cost or the utilization of health care services.

Because of the complex dynamics of changes in rating structure and changes required by the Act, average renewal rate increases do not always correspond to the changes in base rates. Blue Cross' renewals averaged 10-13% in the last two quarters of 2001 and the first quarter of 2002. However, within this population, almost 20% of groups received rate decreases, 25% had rate increases of less than 10%, 30% between 10 and 20%, and 15% between 20 and 30%. Ten percent of groups experienced rate increases of 30% or higher. The overriding reason for a group to receive a very high or very low rate increase at renewal is that the group experienced significant changes in the age, gender and family composition (i.e., the demographics) of the employees within the small employer group.

United's renewal rate increases have averaged about 11% in 2001 and 2002, but also with fairly wide variation, with some groups getting decreases, and the highest increases generally under 25%. United controlled rates (though not in a manner in compliance with the Act) for some of the groups whose increases deviated greatly from the average through the use of health status adjustments based on rate increase level. Rate increases

averaged 5% on groups of fewer than six employees. Prior to the Act, these groups had been subject to a 20% premium rate addition based on group size. Under the Act, group size is no longer a permitted rate variable. Therefore, the first renewals for these groups under the Act incorporated rate changes that were a combination of a decrease because of the removal of the prior 20% load and an increase for cost and utilization and other changes. Rate increases averaged 16% for small employer groups with six or more employees.

Compliance with Rating Provisions of the Act

The Act requires small employer carriers to establish their rate structure based on the experience of their overall book of small employer business. Prior to the Act, a carrier could segment its small employer business into classes with distinct rates for each class, based on the experience of that class of business. Prior to the Act, Blue Cross also rated some of its association business, including the Rhode Island Builders' Association, as separate classes of business.

Four-Tier Rates

The Act requires carriers to use four-tier family composition rates for their small employer health plan business, resulting in separate rates for the following family categories: employee only, employee and spouse, employee and child(ren), and full family. Prior to the passage of the Act, the major carriers used either two-tier composite rates (employee and family) or individual subscriber table rates, also on a two-tier, employee and family basis. United implemented this requirement of the Act on a timely basis. Blue Cross reported confusion about this provision, and originally claimed that the provision was optional. After being informed by the DBR that it was mandatory, Blue Cross delayed implementation of four-tier rates until renewals of April 1, 2001 and later. Because of the delay and Blue Cross' renewal cycle, it was not until March 2002 that all Blue Cross rates were on a four-tier basis.

As a result of Blue Cross' delay in implementing the four-tier rating basis, certain small groups paid more and other small groups paid less than they would have if Blue Cross had complied with this provision of the Act on a timely basis. There is an ongoing proceeding before the DBR to determine what administrative action is appropriate under the circumstances.

During the period from October 2000 through March 2001, United quoted new business on a four-tier rating basis and Blue Cross quoted new business on a two-tier rating basis. This resulted in differences on a group-by-group basis that created incentives to switch carriers, depending on the family composition of the group. Responses to the producer survey indicated that some groups actually did switch carriers because of the way they were affected by the difference between two-tier and four-tier rates. This situation may have contributed to instability in the market, and was detrimental to both carriers. However, the overall impact of this source of instability was not significant.

At the same time that Blue Cross implemented the four-tier rating system, as of April 1, 2001, it also changed the slope of its age factors and the relative relationships of the employee and family rates.

The net effect of the transition from a two-tier to a four-tier rate structure in conjunction with Blue Cross' contemporaneous realignment of employee and family rates created the following changes in premium rates, by company:

- Employee-only rates decreased 6% for Blue Cross and were relatively unchanged for United.
- Employee and spouse rates decreased about 3% compared to former family rates for Blue Cross and decreased about 15% for United.
- Employee and child(ren) rates decreased about 34% for Blue Cross and about 20% for United.
- Full family rates increased about 9% for Blue Cross, and 8% for United.

The effect of the increase in family rates for groups with a predominance of full family coverage would have been dampened by the second calculation, if the second calculation had been applied as intended by the Act.

While rates for the employee and child(ren) tier are significantly lower under four-tier rates than they would have been under the two-tier system, only 3% of subscribers fall into this category.

One of the purposes of the four-tier rating requirement was to support the RIte Share program and to make coverage more affordable for single parents. Four-tier rating both helped and hurt RIte Share. It helped because RIte Care covers a significant number of single parents with eligible children, but it hurt because it increased rates for full family groups, who constitute the majority of RIte Share eligibles. Additionally, Blue Cross' realignment of employee/family rate factors was unfavorable for RIte Share, because it increased family costs.

Permitted Rating Variables

The permitted rating variables are age, gender, family composition, and health status. Health status can only be used as a rating variable by carriers who used it as of June 1, 2000. It is limited to a range of +/-10% from adjusted community rates. All eligible carriers generally complied with this limitation on rating variables, although one carrier applied adjustments described as being for health status in a way that rated groups based on size of group, which is not a permitted factor.

Health Status

All carriers observed the 10% limitation on health status as a factor. Because Neighborhood did not write commercial business as of June 1, 2000, it is not permitted to use health status as a variable, and does not. Prior to the Act, one of the major carriers had rate structures that allowed health status rating factors up to 30% above standard

rates, and health status discounts up to 20% below standard rates, while the other had health status rating factors ranging from 50% above to 10% below standard rates.

Utilization of health status is allowed in the initial phase of the Act to support a transition into adjusted community rating on an incremental basis. Health status was scheduled to be eliminated as a permitted rating variable as of October 1, 2002. The 2002 amendment to the Act allows health status to be used as a rating variable until October 1, 2004. This will allow time to evaluate the use of health status in rating.

Prior to the Act, United moderated large rate increases and decreases using methods not permitted by the Act. United continued to moderate rate increases and decreases after the effective date of the Act by using the health status adjustment in a way that did not comply with the Act. It also used the health status adjustment to increase rates for employers with fewer than six employees. This practice also does not comply with the Act. Analysis of United's small employer renewals found that 88% of groups experienced increases because of health status adjustments, while 8% experienced decreases, and only 4% of groups were unaffected. In response to the market conduct examination, United ceased this non-complying practice.

Health status adjustments by Blue Cross were more evenly split between increases and decreases, but health status adjustments in aggregate contributed about 2% net to Blue Cross premiums, which was offset by an adjustment to its base rates.

Insurance carriers generally favor the continued use of health status as a rating variable, in order to promote underwriting flexibility. With all carriers operating under the same rules, there would appear to be no real advantage for a carrier to use health status rating, because it should not affect which small employer groups a carrier enrolls.

The Act does not permit Neighborhood to use health status as a rating factor, since Neighborhood was not a small employer carrier on June 1, 2000, and so did not meet the prerequisite of using health status as a rating factor on that date. Therefore, if

Neighborhood were to offer health plans to all small employers, as is required by the Act, they might be at a disadvantage because they would tend to attract the least healthy groups. Having one carrier prohibited from using a rating variable that is available to the others has the potential of encouraging segmentation because the poorer risks would be attracted to the carrier that does not use health status as a rating variable and the lower cost risks would be attracted to the carriers that do use health status rating. The market would therefore have the potential of being more stable if the same rules for health status rating applied to Neighborhood as to the other carriers. This concept would also apply to any new entrants into the market. Since health status is a permitted rating variable until October 1, 2004 under the current amendment to the Act, this inequality among carriers will continue to be a potential issue until that time.

Health status rating permits carriers to present the lowest possible rates to healthy groups, thereby improving affordability for those groups. If healthy groups are required to subsidize less healthy groups without recognition of better health status, it is possible that some of them may find health insurance less affordable, and therefore decide to opt out of the small employer health insurance pool.

Health status rating is not permitted under either Massachusetts or Connecticut small employer health insurance law.

Rate Compression

The Act provides that rates for any health benefit plan offered by a small employer carrier can only vary such that the highest rate cannot be more than four times the lowest rate for a given family composition type. This requirement is referred to as "4-1 compression." This range was scheduled to be narrowed to a range of 2-1 effective July 13, 2002, but the recently passed amendment has extended the 4-1 compression provision until October 1, 2004. This extension should allow time to evaluate the effect of the 4-1 rate compression on the market.

All Rhode Island small employer carriers have complied with the rate compression requirement. However, Blue Cross and United implemented rate compression differently from each other. Blue Cross compressed rates from the top of the scale only, and made a normalization adjustment to its base rates to compensate. United compressed rates from the bottom and top of its scale on a revenue neutral basis. Blue Cross' and United's approaches were in compliance with the Act, but because they were different, they had the potential to contribute to instability, since, on a relative basis, Blue Cross reduced rates for older groups, and adjusted for that by an across the board increase, while United increased rates for younger groups to compensate for a decrease for older groups. United's method resulted in less significant decreases for the oldest groups than did Blue Cross' method.

Neighborhood and New England both satisfied the 4-1 rate compression requirement of the Act by default, due to the limited number of small employers covered. Because New England only had one insured small employer, its rates by definition were in a compression ratio of 1-1. Neighborhood had only five insured small employers, and a relatively compressed rate schedule. It therefore did not have to make any adjustments to its rates in order for groups to be rated within a 4-1 range.

For both Blue Cross and United, about 10% of the small employer groups were affected by the 4-1 rate compression. As a result of the difference in the approaches used to achieve the rate compression, Blue Cross may be relatively more attractive for the youngest groups, who were not compressed upwards, and the oldest groups, who were compressed further down than United's oldest groups. United may be relatively more competitive for groups in the middle, since they did not need a normalization adjustment to recover the cost of compression.

While the 4-1 compression has had a modest impact on the small employer market, 2-1 compression will affect many more groups when it is implemented. Based on a sample of groups reviewed, it could affect as many as one-quarter to one-third of all groups if implemented on a revenue neutral basis. As previously noted, for the youngest groups the

increased premium cost of changing to a 2-1 rate compression may be as much as 67%, in addition to normal cost and utilization trend.

Insurance carriers generally prefer a wider range of rates, in order to keep insurance affordable for younger, healthier groups. Without a wider range of rates, younger, healthier groups could choose to remain uninsured or become uninsured. Also, a narrower range of rates will require a greater degree of vigilance by the DBR to ensure that the small employer health insurance market operates as intended and is not subverted by non-regulated entities.

Massachusetts small group law provides for 2-1 compression. Massachusetts began with 4-1 compression, and went in annual steps to 3-1 and then 2-1. Based on conversations with an executive of a Massachusetts small employer carrier, and with the Massachusetts Division of Insurance, 2-1 compression has been accepted by the market and has not caused undue affordability-related problems. However, the Massachusetts law had provided for another change to 1.5 to 1 compression. Based upon available information, the law was amended to maintain compression at 2-1.

Connecticut, on the other hand, does not limit the spread of premium rates by age and gender. It does maintain some internal limits on rate variation by size of group and by industry. Neither of these is a permitted variable in Rhode Island.

Second Calculation

There is a transitional requirement in the Act that limits the renewal rate increase for any group to cost and utilization trend plus 10%, adjusted for any changes in the demographics or plan design of the group. This requirement was defined further in Regulation 82 and is referred to as the "second calculation." Under the Act, this provision, since it was transitional in nature, was scheduled to expire October 1, 2002, but it has been extended by the amendment to the Act to October 1, 2004.

Despite the language in the Act and in Regulation 82, public hearings regarding Regulation 82, and DBR-sponsored meetings attended by both Blue Cross' and United's actuaries to discuss the rating requirements of the Act, neither Blue Cross nor United developed a complete understanding of the required mechanics of the second calculation, or of the reasoning behind its implementation, that is, to maintain rate stability during a time of required changes in rating structure. Neither carrier implemented this provision correctly. As a result, certain groups paid higher renewal rates than they would have if the second calculation had been correctly implemented.

Blue Cross and United both attempted to apply the second calculation by limiting the change in health status that applied in any one year to 10%. This contributed to rate stability, but did not mitigate a number of other rate increase elements, including changes related to rate compression, the introduction of four-tier rates, and contemporaneous changes in rate structure. Both major carriers had difficulty in separating changes in demographics of a group (a permitted pass-through to rates in full) from any changes in rating structure (intended to be limited by the second calculation). Separating demographic changes from other changes was difficult for the carriers because of limitations in the way they maintain demographic data in their rating systems.

A sample of Blue Cross renewals indicated that approximately 25% of renewing groups would have experienced lower renewal rates if the second calculation had been correctly implemented. Because Blue Cross implements rate changes on a revenue neutral basis, the aggregate premiums for the entire small employer pool were not affected. Impacted groups tended to be those that experienced large changes in age/gender factors due to changes in the factor tables, groups with changes in health status, and groups with a large number of enrollees with family coverage who were affected by the change to four-tier rates. In addition, because of the manner in which Blue Cross implemented the 4-1 rate compression, many groups whose rates were compressed during the second quarter of 2001 were less compressed at their renewals in 2002. This contributed to increases that should have been mitigated by the second calculation. Although a significant percentage of the renewing groups should have received a benefit of the second calculation

requirement, the average benefit to an affected group is relatively small, i.e., under 5% of premium.

A similar estimate could not be made for United's business because they do not keep census data in their renewal file, but only keep the current age/gender factor.

Prior to the Act, both carriers used a renewal rating practice that limited the maximum renewal rate increase for a group. Under this practice, there was also a minimum rate increase applied. This practice was applied, even if the reason for the increase was related to a large change in a group's demographic profile. The practice of using a minimum or maximum rate increase factor is not permitted by the Act, because of the requirements that rates be calculated from the rate manual, and that similar groups be rated alike. In effect, United continued this practice in a limited way since the effective date of the Act by its application of health status factors, which was based, in part, on the size of the manual rate increase calculated for a group.

Both carriers had found the practice of minimum and maximum rate increases useful, and would like to continue to use it. Properly administered, the use of this practice would not affect many groups, and it would contribute to rate stability. It would not be an unreasonable accommodation to the carriers to amend the Act to allow this practice, with appropriate review by the DBR. Over the course of time, groups with large changes in demographics would be returned to manual rates, most within two years.

Group Size

Prior to the effective date of the Act, group size could be used as a rating variable. United used group size as a rating variable and loaded rates for the smallest small employer groups by 20%. The Act does not permit group size as a rating variable. Upon the effective date of the rating provisions of the Act, United eliminated the 20% load for the smallest groups but instituted a system that increased the health status adjustment for groups with fewer than six employees. This meant that the average amount of the prior

load that was passed back to the groups was only about 10%. This use of health status adjustments did not comply with the Act. United has ceased this practice.

Both Connecticut and Massachusetts permit rating by group size, within limits. In Massachusetts, group size rating factors are included within the overall 2-1 rate compression limits.

Rate Manual Maintenance

None of the carriers subject to the market conduct examinations maintained rate manuals that were adequate to enable a rate to be calculated for a new or renewal group without further information. In addition, none of the carriers presented complete enough documentation of their base rate development to enable actuarial review of the methodology and assumptions. Market conduct orders have been issued to require the carriers to maintain complete documentation of base rate development. Follow-up examination work will verify compliance.

Compliance with Other Provisions of the Act

Actively Market All Health Plans to All Small Employers, including the Statutory Plans

Small employer carriers are required to offer all their small employer health plans to all small employers as part of every proposal and renewal, although a specific health plan can be restricted to members of an association as long as it is rated consistently with the entire small employer pool. Small employer carriers must offer at least the Standard, Economy and Basic plans to all small employers. The two major carriers make all their proprietary health plans available to all small employers, regardless of health status or claims experience.

One other small employer carrier, Neighborhood, has limited its marketing to employer members of associations with whom it has established a contractual relationship. This practice does not comply with the Act.

United has engaged in certain non-complying marketing practices that are likely to have discouraged applications from the smallest small employers. These practices included using a commission scale that pays only 2% (changed to 3% effective 1/1/02) of the first $15,000 of premium but 5% of the next $60,000 of premium, thereby paying a lower percentage of premium to producers of the smallest small employer groups. On average, $15,000 corresponds to a group of about three to four employees. United also required groups with fewer than three enrolled subscribers to go through an intermediary to obtain coverage, and, for a period of time, United declined to provide coverage to small employer groups with only one enrolling employee. Despite these practices, United has a higher percentage of groups with fewer than six employees than does Blue Cross.

Toll-Free Phone Line

Regulation 82 requires that a small employer carrier establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health benefit plans.

The market conduct examination reports, based on calls made to carriers' toll-free numbers, identified long waits, incorrect transfers, and inconsistent and/or incorrect information provided in response to inquiries to the carriers. No one carrier's service displayed all of these problems. For example, Blue Cross' toll-free service provided complete and accurate information, although it suffered from some of the other problems. In response to the market conduct examinations, the carriers are amending their practices to come into compliance.

Disclosure of Rating Practices

The Act requires that carriers disclose provisions of the health plan that relate to the carrier's right to change premium rates and the factors that affect changes in premium rates. None of the carriers provided the required information as part of their new business proposals and renewals. In response to the market conduct examinations, the carriers are amending their practices to come into compliance.

Availability of the Standard, Economy and Basic Health Plans

Carriers are required to offer the Standard, Economy and Basic health plans on a basis that is comparable with how their other small employer health plans are promoted. The Standard and Economy health plans have been required under prior law as part of a small employer carrier's portfolio since approximately January 1, 1993. The Act provides for the development of the Basic plan by the Director of the DBR in consultation with the Department of Human Services ("DHS"). The Basic plan was developed and its requirements set forth in Regulation 82.

All of the small employer carriers have Standard, Economy and Basic health benefit plans on file with the DBR. The carriers have not promoted the Economy and Standard plans in a manner comparable to the marketing of their other small employer health benefit plans. The Basic health benefit plan has only been required since January 1, 2002.

Blue Cross has included rates for the Standard and Economy health plans into all its proposals and renewals, but it has failed to include these plans in benefit comparisons, as it does with its other plans. United did not have the Standard, Economy and Basic plans available prior to February 2002. Neighborhood and New England have not included these plans in any of their proposals. All carriers have been ordered to market the Standard, Economy and Basic plans on a comparable basis with their proprietary products.

Very few of the Standard, Economy and Basic plans have been sold. This may be a result of failure to market them actively, but it cannot be determined how many plans would have been sold with active marketing. Based on the most recent report filed with the DBR, Blue Cross had eight statutory plans in force as of December 31, 2001 (all either Standard or Economy). United has written no Standard or Economy plans, and only one Basic plan. That plan had an effective date of April 1, 2002. Neither Neighborhood nor New England has any statutory plans in force.

Renewability of Coverage

The Act requires that provisions related to renewability be disclosed as part of any new business proposal or renewal. While the required disclosures have not been made in all instances by all of the small employer carriers, the carriers have allowed renewal into either the same or "similar" health plans. All small employer carriers have been offering renewal on an equal basis to all renewing policyholders. United automatically renewed health plans into updated versions of their plans unless the employer requested otherwise. Blue Cross did this in one instance, where they wanted to move customers to a new pharmacy plan. While this practice does not comply with the provisions of the Act, no evidence was found that any employer or beneficiary has been significantly disadvantaged or affected by this practice to date. Market conduct orders issued by the DBR require the carriers to demonstrate compliance. Follow-up work to the examinations will verify compliance.

Limit the Use of Pre-existing Condition Exclusions

The Act allows a small employer carrier to limit coverage for a pre-existing condition, but only for up to six months. Blue Cross, United and Neighborhood do not use pre-existing conditions exclusions in their health plans. They therefore exceed the requirement of the Act in this area. Only New England uses a pre-existing condition exclusion in its contract. New England's pre-existing condition provision did not comply

with the Act. Pursuant to the market conduct examination and orders, New England is filing an amended pre-existing condition provision that complies with the Act.

Collection of Data to Support Compliance

Compliance with the Act and with Regulation 82 requires collection of data from employers. All carriers were deficient in this area. Data that was collected, in certain instances, was based on incorrect definitions of, for example, "small employer" and "eligible employee." Information required to determine the need for notification to employers was not adequate. Based on recommendations in the market conduct examination reports, the carriers have agreed to re-evaluate their current processes to bring them into compliance with the requirements of the Act.

Information Regarding Individual Policy Applications

Individual health policies for which the employer pays a portion of the premium, whether directly or indirectly, are subject to the Act. Regulation 82 requires that a carrier obtain information from applicants for individual policies about whether the policies are being subsidized by an employer.

Of the carriers that were subject to these market conduct examinations, Blue Cross is the only carrier that markets individual products. Blue Cross has not collected adequate information as part of its application process to satisfy the requirement that it determine whether a policy is employer sponsored, and is therefore subject to the Act.

Blue Cross has agreed to amend its individual health application form to collect this information. This information is needed to assure that individual policies sold in connection with small employer plans are in compliance with the Act, and to prevent segmentation of the small employer market.

Proposal Turnaround Standards

Regulation 82 requires that a carrier respond to a request for a new business proposal within ten working days of receiving the request and the required information, and respond within five working days with a request for additional information when necessary.

Blue Cross and United satisfy this requirement. Neighborhood and New England have not maintained a log reflecting this information, but as a result of the market conduct examination results, both carriers are in the process of establishing one.

Minimum Participation Requirement

The Act allows but does not require carriers to establish minimum participation requirements that cannot be more stringent than 100% participation of eligible employees of groups of ten or fewer employees and 75% participation of eligible employees of groups of more than ten employees. The underwriting provisions of Blue Cross and United comply. Neighborhood does not have a minimum participation requirement, which also complies. New England had a minimum participation requirement which was not permitted by the Act. In response to the market conduct examination New England was ordered to come into compliance and has agreed to do so.

Areas of Carrier Concern or Confusion in Compliance

The market conduct examinations revealed a number of areas where carriers failed to implement elements of the Act correctly. In some of those areas, the carriers reported finding the requirements of the Act confusing. While diligent analysis of the Act by trained people should yield adequate understanding, many of the requirements are relatively complex. The following areas were ones in which the carriers reported some confusion.

Four-tier Rates

The Act required the carriers to adopt a four-tier family composition rating structure effective October 1, 2000. Blue Cross reported that its initial understanding of that requirement was that it was optional. Upon being informed by the DBR that it was mandatory, Blue Cross challenged the DBR's interpretation in administrative proceedings, and appealed administrative decisions upholding the DBR's interpretation of the meaning of the four-tier elements of the Act to the Superior Court. After the DBR's interpretation of the Act was confirmed by the Superior Court, Blue Cross modified its billing system to accept four-tier rates and implemented them effective April 1, 2001. Administrative proceedings are pending before the DBR with respect to what administrative sanctions are appropriate for the period during which Blue Cross was not in compliance.

Second Calculation

The second calculation is the provision of the Act that limits the increase in a group's premiums at renewal to cost and utilization trend plus 10%, adjusted for changes in the demographic composition of an individual group. Both major carriers reported difficulty in understanding the requirements of the second calculation. Each of the carriers attempted to implement this requirement on a different basis, neither of which complied with the Act or with Regulation 82.

Blue Cross attempted to satisfy the requirement of the second calculation by limiting the change in health status to 10% in any one year. This approach failed to comply with the Act since it allowed various changes caused by compliance with the Act and contemporaneous changes in the carrier's rating structure to flow through to the employer without the intended mitigating effect.

United's approach was to put an overall cap on the annual increase equal to 10% plus United's trend factor, but not to take into account changes in demographics of the group that might result in a lower rate.

Both carriers failed to comply with the specific requirement of the Act. However, their approaches to it had the effect of reducing some large rate increases, and so fulfilled in part the objective of the second calculation to maintain rate stability and fairness in implementing changes in rate structure. The second calculation is relatively simple in concept, but correct application would have required the carriers to maintain and analyze data involving prior and current rate manuals and prior and current census data for each group. This required developing new models for analysis, and gathering data in ways not previously used by the carriers for rating. In response to the market conduct examinations, the major carriers have developed appropriate analytical capabilities to perform the second calculation correctly.

Health Status

The Act allowed carriers who used health status as a rating variable as of June 1, 2000 to continue using health status in a limited way. The health status adjustment was limited to a band of +/-10% around a community rate. United understood the +/-10% band to be a range for general rating adjustments, including health status and other adjustments that they might find appropriate. United, therefore, used the +/-10% band to charge higher premiums to groups smaller than six employees, and to help manage renewal premium rate increases within acceptable levels. This practice is not permitted by the Act. United has changed this practice in response to the market conduct examination. Blue Cross understood and implemented health status adjustments correctly as provided by the Act. Neighborhood was prohibited from using health status rating as it had not done so prior to June 1, 2000. New England's use of health status rating was found not to be in compliance with the Act. They are in the process of filing a revised rate manual, which will be examined to verify compliance with this provision of the Act.

Definition of Small Employer Group

Both major carriers used imprecise language in their underwriting documents when defining an "eligible" group under the Act. This resulted in difficulty on the part of those carriers in collecting information necessary to establish eligibility. In addition, both carriers had inexact methods of tracking small employer groups that grow to more than fifty eligible employees and large employer groups that shrink to fifty or fewer eligible employees. Thus both carriers had difficulty in providing such groups with proper notification of their rights and options as small employers under the Act. The definitions are relatively complex, and careful attention to detail combined with a process to collect appropriate data from all small employers would minimize any confusion. Market conduct orders were issued requiring the carriers to demonstrate their proposed procedures for collecting the appropriate information to determine small employer status, and for providing notification as required. These revised procedures will be examined to verify compliance.

In collecting the data that they did collect, both carriers provided definitions of "small employer" to their employer customers that could lead to incorrect responses and result in an incorrect classification.

The Act defines small employer in terms of the number of eligible employees and specifies inclusion of groups with at least two eligible employees. A small employer may have only one employee who participates in the health plan, because other employees have coverage through a spouse's plan. For a relatively short period of time, United misinterpreted the definition of small employer under the Act and denied coverage to small employers with only one health plan subscriber, even if they qualified as small employers under the Act because they had more than one eligible employee. When they were made aware of this error in connection with the market conduct examination, United corrected this practice.

Guaranteed Renewability

When the carriers make changes to benefit plans, they prefer to retire older versions of those plans to avoid confusion and to limit the administrative expense involved with maintaining large numbers of plans that vary only slightly from each other. The Act has a provision for declaring a plan obsolete and withdrawing it from the market. That provision involves a six-month prior notice period to the DBR and to the employers and the employees and dependents affected, and prior notice to commissioners of insurance in every state in which the carrier is licensed. This procedure is cumbersome, and the carriers have not used it. Renewal activity for small employer business starts more than three months ahead of the renewal date. In order to provide a six-month notice of the retiring of a benefit plan, the carrier needs to decide to do so nine months prior to the renewal date. This places an unreasonable requirement on the carrier.

With the single exception of automatically renewing groups into a new prescription drug plan, Blue Cross has generally provided automatic renewal into the existing policy form, and provided information about new forms that may lead employers to choose the newer form. In the case where the automatic renewal was into the newer drug plan, Blue Cross also provided employers with premium rate information for the old plan, and allowed renewing groups to affirmatively request the old plan. Blue Cross' approach complies with the Act, but leaves Blue Cross with a proliferation of older plans on the books.

Blue Cross inquired about the proper procedure to follow in the situation where it added municipal ambulance coverage to all its plans. This change was a benefit enhancement that did not require a new policy form. In order to comply with the Act, Blue Cross provided sufficient information in its renewal package for the small employer to elect the plan options that would replicate the prior plan, without municipal ambulance benefit.

United has interpreted the Act to allow "minor" changes in the plan at renewal, although no such *de minimis* concept appears in the Act. United has renewed all its business automatically into current versions of its plans. Therefore, none of their groups still use

the old plans. United has not gone through the process of requesting that its old plans be declared obsolete. United provides a notification at renewal that a customer who wants the old plan can request a quote, but does not automatically provide information about what the old plan is or what the rate would be unless it is specifically requested. This practice is not in compliance with the Act, however, the market conduct examinations did not find any evidence that customers requested such quotes, or that any customers complained about this practice.

It would be reasonable to amend the Act to streamline the process to withdraw obsolete plans, requiring notice only to employers and the DBR, and requiring a shorter notice period. This would allow orderly retiring of obsolete forms, and make it easier for the carriers to comply. To the extent this reduced costs for the carriers, it would ultimately reduce costs for policyholders.

The issue of guaranteed renewability of existing coverage under the Act also has implications for small employers who grow to more than fifty eligible employees. If an employer who grows to more than fifty eligible employees elects a benefit enhancement (like municipal ambulance coverage), a strict reading of the Act would result in that group losing the protections of the Act because the plan at renewal was not the exact same plan as the group's prior plan. If this is not a reasonable result, and/or not the intent of the Act, an amendment to clarify both the procedure and the intent should be considered by the Legislature.

RIte Share

The state of Rhode Island has engaged in significant public policy initiatives toward providing access to health care. RIte Care, the program to provide health coverage to low-income children and families, was established in August 1994. Enrollment in the program was 71,000 members in December 1995. Expansion of the definition for eligibility and Department of Human Services ("DHS") outreach programs have increased enrollment in the RIte Care program to 118,000 as of February 2002. As a

result, state expenditures have increased significantly and the growth of the program has been a topic of budget discussions.

The RIte Share program was developed in 2000 to encourage RIte Care eligible individuals and families who are also eligible to participate in employer-sponsored health benefit plans to enroll in the employer-sponsored plan instead of in RIte Care, with a premium assistance subsidy designed to pay the employee share of the premium for the employer-sponsored plan. In order for RIte Share to coordinate with an employer-sponsored plan, the plan must provide adequate benefits so that the supplement required to provide full Medicaid level benefits is relatively small, and administratively feasible. The cost for premium assistance and supplemental benefits must be less than the cost to include the eligible members in RIte Care. In order to assist the RIte Share program in meeting these needs, the Act contains a requirement that small employer carriers offer a Basic health benefits plan, and that rating of health benefits plans be limited in range of variability (a 4-1 compression, to be followed by a 2-1 compression effective October 1, 2004).

DHS begins a RIte Share inquiry by identifying a RIte Care approved family with a working adult. If the employer of the working adult has a health insurance plan, DHS obtains the plan, eligibility, and employee contribution data from the employer. DHS then makes a determination if the employer's health plan meets its minimum standards for level of benefits. DHS also needs to be able to integrate with the employer plan to provide appropriate supplemental benefits to bring the employer plan up to Medicaid standards. DHS has reported that it is able to integrate with Blue Cross' and Blue Chip's plans but that it has been unable to integrate with United's plans because those plans contain an overall deductible that makes it hard for DHS to administer the supplemental benefits.

If DHS can administer the employee plan, DHS conducts a cost-benefit analysis. DHS will transition an individual who is eligible for RIte Care to the employer-sponsored plan if the required employee contribution is less than $150 per month. For a RIte Care

eligible family with an adult(s) and child or children, DHS will transition the family to the employer-sponsored plan if the required employee contribution is less than $450 per month. If only the child (or children) is eligible for RIte Care because the working parent's income exceeds 150% of the federal poverty level, the entire family will be enrolled in the employer-sponsored health plan under RIte Share if the required employee contribution is less than $130 per month.

The RIte Share program included 200 members as of February 2002 and 2,000 members as of June 2002. While DHS does not maintain separate records by size of employer, it is likely that the majority of RIte Share enrollees are from large employer plans. DHS currently has a goal to increase enrollment to 6,000 by June 2003.

The statutory Basic plan was developed to support the RIte Share program in assisting employed individuals and families eligible for RIte Care into employer-sponsored programs. The Basic plan has not yet contributed to the success of the RIte Share program, because marketing the Basic plan was not required by the Act until January 1, 2002. However, there is also no requirement for a carrier to offer the Basic plan on a multiple option basis (whereby RIte Share employees may have the Basic plan, and other employees a different plan). There is also no requirement for an employer to purchase the Basic plan for RIte Share eligible employees, whether other employees also enroll in the Basic plan, or in another plan. In the absence of a standardized plan to be used for all RIte Share enrollees, DHS has operated in an environment with many different health plans.

DHS staff evaluates and coordinates benefits with each existing individual employer-sponsored health plan. DHS staff also is required to update its records on an ongoing basis to take into consideration changes in benefit plans and changes in required employee contributions.

It is reasonable to expect that employers would have some resistance to the RIte Share program, since its effect is to shift some of the cost of a public program to the employer.

DHS reports, however, that they have encountered very little employer resistance in their efforts to expand the RIte Share program.

The process by which DHS enrolls people into the RIte Share program is cumbersome. If the Legislature decided to expand the reach of RIte Share, it would have to consider enhancements that would promote the use of a standardized product (like the Basic plan) to be made available by the carriers and purchased by the employers on a multiple option basis, so that all RIte Share eligible subscribers and dependents would be enrolled in a common plan. If the Basic plan is not going to be used in this manner, the Basic plan does not appear to have a function in promoting RIte Share, and it is recommended that the Act be amended to remove it as a required carrier offering.

It might also facilitate DHS's analysis of health plan data if carriers were required to provide health plan data by employer to DHS in electronic format.

Risks to the Small Employer Market

A stated purpose of the Act is to prevent segmentation of the small employer market based on health risk and, consequently, to spread health risk more broadly.

The Act requires that rates for small employer health plans be based on the combined experience of a carrier's entire small employer block of business. It requires that the rating factors be applied in such a manner that premiums for groups with identical rating characteristics differ only by amounts attributable to benefit design, provider network, and rate effective date.

Prior to the effective date of the Act, Blue Cross had segmented its small employer business into "classes of business," a practice that was then allowed by law. Since the effective date of the Act, Blue Cross has based its rating factors on the combined experience of its small employer business, except that it has rated its Blue Cross and Blue Chip business on separate experience. Since Blue Cross has elected to treat its Blue Cross and Blue Chip businesses as one carrier under the Act, using separate experience to

develop rates is a violation of the Act. As part of the market conduct examination process Blue Cross and Blue Chip have been ordered to correct this practice, and follow-up examination work will verify their compliance.

The Act placed limitations on the rating factors that carriers are allowed to use. Adjustments for health status are limited to a band of +/- 10% and the 4-1 compression requirement places overall limits on carrier rate variability. The implementation of these rating limitations results in younger, healthier groups paying more for their health plan and older, less healthy groups paying less for their health plan than they would if each were rated only on the experience of similar groups. This subsidy process will become more significant and more pronounced if the rating changes scheduled for October 1, 2004 are implemented, namely a 2-1 compression and removal of health status as a rating variable.

The subsidy process described in the preceding paragraph, although consistent with public policy goals expressed in the Act, may lead to affordability problems for certain groups. These groups may be motivated to opt out of the small employer risk pool with small employers either not offering a health plan to employees or accessing other means to obtain health coverage for employees. If younger and healthier groups leave the small employer insurance pool, it will necessarily result in more uninsured individuals as well as increased rates for the remaining groups. This additional cost burden to the remaining insureds could then encourage the next lowest cost groups to leave the small employer insurance pool, further increasing the number of uninsured individuals and precipitating yet another round of increases in rates for the then remaining groups. This process is referred to as an "assessment spiral." This is considered one of the major problems in the individual and small group health insurance markets in the United States today.

There is no evidence that such a process has begun to take place in Rhode Island as of this time. The 4-1 rate compression has not been an important factor in rate levels. The number of groups covered in the small employer pool has been relatively stable. Analysis of one carrier's block of business indicates an increase in average age factor of about 2%,

but that is at least partially explainable in terms of the entry into the pool of trade association groups with relatively older members. Respondents to the employer survey reported that their most likely response to a large rate increase (defined as 20% or more) would be to divide the cost between the employer and employee shares, and that there was little likelihood they would drop coverage altogether. The ultimate impact of these factors will not be known, however, until compliance has been in effect for a reasonable period of time.

Employers' alternatives to health plans obtained from small employer carriers could include:

- No health plan coverage (possibly relying on the guaranteed issue provision of the Act to obtain coverage when the need arises),
- Individual (Direct Pay) health plans,
- Associations or multiple employer trusts (METs) using policies issued in a state other than Rhode Island,
- Self insured programs with low stop loss levels,
- Multiple Employer Welfare Associations (MEWA), and
- Self-insured schemes marketed on behalf of purported labor unions.

The principal carrier for individual coverage in Rhode Island is Blue Cross. Premium rates for Blue Cross' Direct Blue and Select Blue direct pay plans are subject to review by the DBR and the Attorney General's office. The DBR monitors Blue Cross' direct pay rates to assure that they are consistent with the proper conduct of Blue Cross' business and with the interest of the public, and the Attorney General represents the interests of consumers. Blue Cross recently obtained approval for a 20% increase in Direct Blue and Select Blue premium rates. Even with this increase, Direct Blue and Select Blue premiums are significantly lower than small employer group premiums, and appear not to be adequate to cover the anticipated claim cost and administrative expenses. Select Blue plans are subject to medical underwriting, and may be lower cost for those who can qualify for them. As a result, Blue Cross' Select Blue policies may be an attractive alternative to employer-sponsored group coverage for members of younger and healthier

groups. That would remove those groups from the small employer pool, with the ultimate effect of increasing small employer costs for the remaining groups.

Under the Act, Blue Cross is required to collect information from direct pay customers to determine whether the plans are being used as part of employer-sponsored plans. If they are, the direct pay plans must comply with the requirements of the Act. Blue Cross has not collected the required information with applications submitted for its Direct Blue and Select Blue plans to determine whether those plans are being used as part of an employer sponsored plan. It may be, therefore, that some employers are opting out of the small employer pool through the use of direct pay products. However, since Blue Cross has not collected pertinent information that is required to comply with the Act, the extent of that activity has not yet been determined. The market conduct order requires Blue Cross to collect information to allow it to determine if direct pay products are being purchased as part of a small employer plan.

Responses to the employer and producer surveys conducted in connection with this report indicated that a small but significant number of small employers pay all or part of the cost of individual policies for their employees. While most of these policies are likely to be underwritten by Blue Cross, other companies mentioned as providing individual coverage in the state include Fortis (John Alden), Celtic and MEGA Life. Policies provided by these last three companies are likely to be offered subject to medical underwriting.

Associations and METs that use policies issued outside Rhode Island are not subject to the Act and are not subject to regulatory scrutiny of the DBR. Self-insured plans are also not subject to the regulatory scrutiny of the DBR and are able to select through rating practices the healthiest risks from the small employer risk pool. The market conduct examinations and the surveys conducted in connection with this report did not find evidence that out-of-state associations, out-of-state trusts or self-insurance schemes are presently a factor in the Rhode Island small employer market.

Professional employer organizations (PEOs) represent another threat to the small employer pool. Such organizations could attempt to create an employment relationship with the employees of a number of small employers, creating the appearance of a large group. No such organizations currently operate in Rhode Island. If one or more of these were to operate in Rhode Island, it could recruit younger or healthier risks, and remove them from the small employer pool, with the result of reducing the spread of risk in the insurance pool, contrary to the goal of the Act to broaden the spread of risk.

Any mechanism that allows certain segments of the market to opt out of the small employer insurance pool will impair the ability of the small employer insurance pool to spread health insurance risk more broadly, and impair achievement of this goal of the Act.

Massachusetts has addressed the concerns expressed in this section by providing authority to its Division of Insurance to regulate any health insurance policy that provides coverage to employees or dependents of a Massachusetts small employer. Even with this authority, the Division of Insurance is concerned about the potential effect of non-insurance schemes, which would not be subject to Division of Insurance regulation. Massachusetts has also addressed the concern associated with migration from small employer group health plans to individual health plans by requiring all small employer carriers with 5,000 or more members to offer a standard individual health plan available on a guaranteed issue basis if applied for on a timely basis and with prior creditable coverage. The premium rates for the standard individual health plan are subject to the same 2-1 compression requirement as the small employer health plans, thus reducing the advantage of selecting an individual health plan as opposed to a small employer group health plan. Such an offer, however, is a solution only for the older, less healthy, not a total solution, because it still involves younger, healthier individuals paying higher premiums than they would under a cost-based pricing system. No solution is available to resolve the option of the younger, healthier small employer group to discontinue coverage for his or her employees (and even for him or herself) should the costs of the small employer plans (through group or individual coverage) be deemed unaffordable.

This potential impact of increasing the number of uninsured individuals is an equally significant public concern.

Conclusion

The overall effectiveness of the Small Employer Health Insurance Availability Act in promoting rate stability, product availability, and coverage affordability was deferred and diminished, because the Rhode Island small employer insurance carriers delayed or failed in their efforts to comply with certain requirements of the Act. The ultimate effectiveness of the Act cannot be determined until there has been full compliance with the Act for a significant period of time to allow the small employer market to be evaluated.

Although full compliance with the Act has not been in effect, some progress has been made in its implementation. Health insurance risk has been spread more broadly by bringing all insured small employers, including members of associations, into one insurance risk pool, and premium rate variability among small employers has been limited.

To date, average small employer health care premiums have increased in Rhode Island, primarily because of increases in the cost and utilization of medical services. The rates of increase have been comparable to regional and national trends. The impact of the Act on the overall cost of small employer health benefits to date is not significant in the aggregate, although there have been some significant changes for individual groups.

The basis of premium rates under the Act is adjusted community rating. Adjusted community rating attempts to blend the goal of a broad spreading of insurance risk with issues of affordability. Even under an adjusted community rating system there are "winners" and "losers" as compared to a more open, unregulated market. Under the Act, the "winners" continue to be the older and higher cost, higher risk groups, while the "losers" continue to be the younger, lower risk groups. Adjusted community rating is a compromise that tries to find an acceptable middle ground between the extreme "losers"

in the unregulated market (who may not be able to get coverage at all) and the extreme "losers" in community rating (who may find the cost unaffordable).

Future evaluation of the effectiveness of the Act on rate stability, product availability, and coverage affordability should not only determine the impact on the Act at that date, but future impacts as well. Future evaluation should therefore determine what additional uninsured groups may be brought into the small group market by continued rating adjustments, and the continued requirements to offer low cost plans. It will also need to determine what groups, if any, (presumably younger, healthier groups) may be at risk of being priced out of the market because of continued movement toward community rating.

It will continue to be important to monitor compliance with the Act and to identify and control activities or mechanisms that may serve to segment the market and undermine the ability of the Act to provide rate stability, product availability, and coverage affordability for Rhode Island small employer groups.