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Actuarial Issues Related to
Transition Rules
Under Health Care Reform

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The American Academy of Actuaries is a national organization that was formed in 1965 to bring together, into a single entity, actuaries of all specialties in the United States.

In addition to setting qualification standards and standards for actuarial practice, a major purpose of the Academy is to act as the public information voice of the profession.

This paper was prepared for the Academy by a 10-member work group.

The precise composition of this group was necessitated by the nature of this project and the importance of the work involved. The Transition Rules Work Group comprises representatives from the entire range of health actuarial practice, including consultants, and not-for-profit and for-profit insurance company actuaries.

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EXECUTIVE SUMMARY

Introduction

This monograph provides a framework for a discussion of actuarial issues related to the transition from the current health care financing and delivery system to the environment expected under health care reform. It refers specifically to provisions in the Clinton Administration's Health Security Act of 1993 proposal. There are alternate proposals which include many of the features of the Administration's plan. The general findings are applicable to any major reform that relies on the private market.

A transition period between enactment of legislation and full implementation will provide opportunities for payors and providers to position themselves for the post-reform environment. Most of the change is likely to be quite positive in moving towards public policy objectives. However, in the short term there may be opportunities for higher than desired gains by some providers and payors. Transition rules should be designed to reduce such opportunities. These rules should not hinder positive change or have an impact on company solvency, nor should they discourage long-term investment of capital in the delivery and financing of medical care.

The purpose of this monograph is to identify issues which should be considered under the proposed transition rules and the possible consequences of those rules from the perspective of the actuary. The monograph focuses on health care coverage, insurer solvency, and insurance market reform.

Fundamental Issues of Transition Rules

Transition rules are designed to avoid premature termination of existing health care coverage resulting from administrative action of the insurer or unaffordable premium adjustments. Because the effective date of the transition rules is critical, it should provide a reasonable time frame to allow for administrative changes since premium rates may be negotiated several months before they are effective.

Another major issue is the wide variation in premiums. In order to help prevent significant shifts in pricing, the existing rate for a group or individual plan should serve as the basis for measuring future rate actions. Transition rules should encourage plans to bring rates closer to the proposed community rates while still recognizing permitted variations.

Conclusion

The most critical element of transition rules must be the ability to limit health plans' ability to act counter to the intent of any health care reform proposal. Health plans, including self-insured plans, should not be permitted to position themselves in a way that creates disadvantages for covered persons. Furthermore, uniform standards need to apply to both insured and self-insured plans to prevent groups with expected good experience from leaving the insured arena and potentially impairing the coverage of individuals.

Responsible regulation will be a key to an effective transition. We strongly recommend giving serious consideration to the need for appropriate transition regulations during enactment of health care reform legislation.



INTRODUCTION

This monograph provides a framework for a discussion of actuarial issues related to the transition from the current health care financing and delivery system to the environment under health care reform. It refers specifically to provisions in the Clinton Administration's Health Security Act of 1993 proposal. There are alternative proposals under consideration in Congress which include many of the features of the Administration plan. The general principles are applicable to any major reform that relies on the private market.

The purpose of this monograph is to identify issues which should be considered under the proposed transition rules and the possible consequences of those rules from the perspective of the actuary. The monograph focuses on health care coverage, insurer solvency, and insurance market reform.

TRANSITION RULES RELATED TO GOALS OF REFORM

The Administration's proposal retains the role of private insurers and competition among them. The proposal makes three fundamental changes in how private insurance is generally provided today. Many of the alternative proposals contain similar reforms.

First, coverage is intended to be both universal and mandatory. Ultimately, all individuals or groups must obtain coverage. This requirement will be phased in, and, hence, a transition period will occur.

Second, all insurers must offer coverage on a guaranteed issue basis. This means that each insurer must accept any applicant and provide continuing coverage as long as the applicant pays the premium. Selection of applicants based on health status or other similar factors is prohibited, and denial of benefits for pre-existing conditions is largely prohibited.

Finally, coverage will be community rated. This means that the price an insurer charges in a given geographic area can vary only by family composition. An insurer cannot vary the price charged based on age, sex, health status, industry or occupation; geographic variation is also limited. Some proposals will permit age and/or sex as allowable risk classes for rating.

Competition among plans is intended to be based on product quality, service efficiency and price. It is intended that insurers will not be able to offer a lower price because they have fewer individuals who have higher expected medical expenses and/or charge these people higher premiums.

One of the primary goals of transition rules is to minimize market disruption. To achieve this goal, the rules should 1) avoid premature termination of coverage; 2) avoid large price changes for consumers; 3) minimize business hardship for insurers; and 4) encourage all parties in the market to take positive actions to prepare for the new system.

There are a variety of health care payors in the present environment and new benefit providers, referred to as "health plans" in the Administration's proposal, will emerge. In the discussion that follows, all financing organizations will be referred to as "insurers." Not all of the following comments will apply to each type of insurer, but the following issues should be considered in the context of changing to the post-reform environment.



FUNDAMENTAL ISSUES OF TRANSITION RULES

Transition rules are designed to limit premature termination of existing health care coverage resulting from administrative action of the insurer or unaffordable premium increases. For the transition rules to accomplish this purpose, the fundamental issues discussed below must be considered.

Effective Date

The effective date of the transition rules is critical because a reasonable time frame is needed to allow for administrative changes and setting premium rates. Generally, premium rates are established several months before they are effective.

There is a need for two dates: an early date for termination rules and a later date for rating rules. The earlier date should be immediate in order to prohibit insurers from purging their blocks of business. The later date depends on the ultimate goal of the reforms. If the transition is expected to last four years, then after eighteen months the rating rules could become effective.

In states that have enacted small group reform legislation which includes guaranteed issue requirements, some insurers have attempted to “clean up” their blocks of business prior to the new law’s effective date through extremely selective underwriting of new business at favorable prices. Furthermore, they have terminated policies and applied significant rate increases to current business deemed too risky. Therefore, termination rules in a transition program must begin early in the reform process, perhaps with an effective date even before enactment, to prohibit such behaviors.

Transition rules on rating reform need to provide for a period of orderly movement to the ultimate community rating basis. They need not be immediate so long as restrictions on use of health status or claim experience are applied to prevent the behavior described above.

Portability

The transition rules in the Administration’s proposal provide that limitations on insuring pre-existing conditions may not exceed six months for group plans. No pre-existing limitations are allowed if prior coverage existed under other benefit programs, including individual and public plans. Coverage of newborns is to be immediate and all waiting periods must be non-discriminatory.

These features are included in many state reform acts and are appropriate and sound.

Benefits

If a benefit package is mandated under a reform proposal, several changes in current benefit programs will be necessary. We suggest a prohibition on reducing benefits below the minimum standard plan be specified in the final legislation. This limitation would provide better protection for insureds and help achieve the ultimate universal coverage objective.

Premium Rates

Premium rates vary widely by product and insurer. In order to help prevent large scale shifts in pricing, the existing rate for a group or individual plan should serve as the basis for measuring future rate actions.

Transition rules should encourage plans to bring rates closer to levels that make compliance with community rating standards reasonably easy, while still recognizing some, and initially perhaps substantial, permitted variations. In no case should transition rules permit rates to move further away from community rating.



The small group reform rules enacted in many states include standards for achieving an orderly transition to community rating. For administrative ease and reduced expense, serious consideration should be given to using those standards, rather than a completely new approach. For example, the ratio between the highest and lowest rate might be limited to 3:1 in year one, 2:1 in year two, and 1.5:1 in year three before reaching the ultimate rate basis.

Transition rules for individual health insurance are somewhat different and are more difficult to apply. Individual products often close off a block of policies and rate the block separately from other business thereafter. Consistency in rating between different forms of individual products often does not exist. Alternative measures to limit increases on current rates for individuals may be more effective. This could include allowing rating by policy form to reflect benefits provided, long term guarantees, and expense amortization. No matter what transition rules apply, consistency between new product rates and renewals is required.

The transition rules for the large group insured sector must be carefully coordinated with the regulation of self-insured plans. It is important to include restrictions on terminating an insured plan and moving to self-insurance.

Risk Adjustment

In the past, most insurers and health plans have used various risk factors to match the price charged to the risk. These typically include age, sex, occupation and industry, and claim experience. These factors are prohibited under the community rating approach in the Administration's proposal, while some, such as age, are allowed under alternative plans. Under the Administration's proposal, certain non-health related rating factors are allowed during the transition period.

If legislation requires that insurers provide coverage through community rating to individuals with different risk characteristics, a method to spread risk among insurers is appropriate. The Administration's transition rules do not include a specific risk adjustment mechanism. To the extent that community rating elements are introduced during transition, some application of risk adjustment among insurers is appropriate. (See the Academy's Monograph Number One, *Health Risk Assessment and Health Risk Adjustment: Crucial Elements in Effective Health Care Reform*.)

Guaranteed Issue

Guaranteed issue requirements are not a significant issue in designing transition rules. Transition rules are designed to protect the insured from losing coverage during the change of environments. However, it is feasible to require guaranteed issue at some point during the transition period. While guaranteed issue may solve some problems in the current market environment, it can create antiselection. It will also create problems in matching price to risk. Insurers will no longer be able to use health as an underwriting factor under guaranteed issue. It is also important to have a risk adjustment mechanism in place as discussed in the previous text.

Insurer Solvency

Health care reform legislation may increase the risk of insurers becoming insolvent, particularly at the outset of health care reform. The greatest risk to insurer solvency will occur during the initial years of implementation. In order to minimize this risk, careful thought must go into the transition rules to ensure that appropriate safeguards are in place to protect consumers from insolvencies. (See the Academy's Monograph Number Four, *Actuarial Solvency Issues of Health Plans in the United States*.)



PRESERVING COVERAGE

As stated earlier, it is essential that there not be a significant loss of coverage during the transition as insurers exit the market or scale back their business. Provisions should be included in the transition rules to avoid and limit premature termination of coverage and reduce market withdrawal. It is also important to have a effective risk adjustment pool, if the transition rules include community rating and/or guaranteed issue.

Termination of Coverage and Market Withdrawal

The Administration's proposal prohibits insurers from terminating coverage under group or individual plans, and requires that new entrants to any group be accepted. This will help provide continuing coverage to those in insured plans. There are exceptions for misrepresentation and non-payment of premium.

There are certain aspects of current insurer practice which allow them to discontinue coverage for reasons not related to health, such as an insured's eligibility for Medicare or cessation of membership in an affinity group or association. It is possible to achieve the desired public policy goals while still allowing these practices but they should be monitored.

The Administration's proposal does not specifically permit a complete market withdrawal by a carrier during transition. It does, however, provide for different rating treatment for acquired blocks of business, and thus contemplates such transactions. This seems to indicate an intent to allow market withdrawal. Both the intent and the rules on market withdrawal during transition should be specifically discussed in any health reform proposal, including the Administration's. One reasonable limitation would be to allow insurers to withdraw from a market and not be permitted to re-enter for several years. The final law should acknowledge that insurers will exit some or all markets.

In addition to withdrawing from the market, it may be desirable to permit insurers to terminate whole blocks of business and offer replacements. Insurers in the current market will have to make changes in benefits and other contract provisions in order to bring their policies into compliance with enacted reform. To accommodate this process, insurers should be allowed to terminate segments of their inforce business and offer replacements which comply with new rules.

If a company withdraws from the market, its enrollees should be allowed to obtain coverage from another insurer. With either a transition pool or a portability requirement, such coverage would be assured.

The Administration's proposal is inconsistent with the goals of transition regarding self-insured plans. The Administration's proposal contains no restrictions on self-insured plans with respect to plan terminations and acceptance of new entrants. Some self-insured plans will be permitted to apply more restrictive rules governing pre-existing conditions and the acceptance of new entrants. It will present a market advantage that may encourage certain groups to shift to self-insurance to the detriment of the individuals insured. This practice must be closely monitored during transition.

National Transitional Health Insurance Risk Pool

The Administration's proposal establishes a transitional national risk pool, coupled to state pools, that will provide a source of health coverage to individuals otherwise unable to obtain coverage due to health status. The individuals would be charged a premium of 150% of that charged an average risk with similar characteristics. The premium also can vary by factors other than health status.

The risk pool specified in the Administration's proposal provides that all payers, both insured and self-insured, participate in funding assessments. Uniform reporting standards for setting assessments will be required.

Reimbursement of providers would be based on Medicare fee schedules and balance billing for the cost of services in excess of the fee schedule would be prohibited. This may limit access to providers as shown in prior experience with respect to availability of service under Medicare and Medicaid. Therefore, careful control of provider behavior and enforcement of provider acceptance of fee schedules are essential.

The risk pool will require individuals to pay sizable premiums and provide only limited benefit choices. Those who elect to join the pool will likely have the financial resources to pay additional out-of-pocket amounts and obtain greater access to services. For some, the cost will be too high.



During the transition period, as provided in the Administration's proposal, insurers are permitted to underwrite risks. That is, an insurer can elect not to cover an individual or group when permitted by state law. Those individuals denied coverage for reasons related to health status could join the transition pool if they desire coverage. At the end of the transition period, insurers would no longer be permitted to select risks. This change would eliminate the need for a risk pool for the medically uninsurable.

It is important to recognize that the national transitional pool is different from a risk adjustment pool, which is designed to spread health risks fairly among insurers. This mechanism is discussed in the Academy monograph on risk assessment and adjustment mentioned above.

It is also different from a solvency pool, which is designed to provide for the failure of a health plan. Under the Administration's proposal, there is limited need for such a pool because an individual is guaranteed coverage and, to the extent balance billing is prohibited, will not be responsible for payments to providers. In fact, a solvency pool will provide greater protection to health care providers from the risk of non-payment than to the consumer.

The need for the national transitional pool is eliminated if a guarantee issue requirement, coupled with an appropriate risk adjustment mechanism and solvency standards, is immediately imposed on insurers. This would provide immediate access to coverage for all without the expense of creating a temporary transition mechanism.

INSURER SOLVENCY DURING TRANSITION

In the current environment, insurers generally position their prices and products so that the prices are sufficient to cover the health risks for those insured. In moving to community rating, insurers will need to make many assumptions about the characteristics of the groups they will ultimately cover. Data on individuals presently uninsured are not generally available. It is unknown if their health status is better or worse than that of current insureds. Furthermore, employers and consumers frequently change plan and payor, creating more uncertainty. Data on differences in health status by geographic area are also limited. Because of this uncertainty in pricing, there is a greater threat to solvency during the transition period and in the early years of reform. (See the Academy's Monograph Number Four, *Actuarial Solvency Issues of Health Plans in the United States*.)

There are important solvency issues to consider when devising transition rules. These include pricing instability, oversight and enforcement, and compliance.

Pricing Instability

Pricing instability may arise when insurers, seeking to gain market share, take greater than normal pricing risks expecting economies of scale to produce ample profits over time. If that strategy fails, insurers that underprice will find it difficult to remain in the market. This strategy could deplete capital, and result in insurers becoming insolvent, and ultimately reducing the number of competitors. Furthermore, there are significant risks regarding retroactive changes in fee schedules, after pricing guarantees have been made.

Oversight and Enforcement

The Administration's proposal calls for the Secretary of the Treasury and the Secretary of Labor to apply the Administration's proposal provisions to ensure maintenance of benefits and coverage during the transition. This includes the establishment of rules to cover the insured if insurers choose to exit the market. The Secretary of the Treasury will apply these rules to insured plans (likely through State Insurance Departments), and the Secretary of Labor will apply the provisions to self-insured plans.

The line between insurance and self-insurance is not well defined. Regulations need to be developed which are uniform between the two types of plans and consistent across the country. Furthermore, to achieve the intended



policy goals, the regulations should limit the ability of groups to switch from insured to self-insured status, and vice versa. If groups are allowed to switch at will, they can effectively recognize good risks directly in their costs, while shifting the cost of bad risks the insured groups.

To achieve the desired results, the same rules that are applied to insured plans should also be applied to the stop-loss coverage provided to self-insured groups. While it is not possible to have a level playing field during the transition, it should be achieved as soon as possible.

Compliance

The transition rules require that each health insurer document the methodology used for rating and periodically certify compliance. These documents would be most effective if they were required to be periodically filed with the state. Where rules reflect future uncertainties, the documentation should include an actuarial certification.

Transition rules should allow sufficient time for insurers to file the required rates and certifications for both group and individual insurance.

PREMIUM LIMITATIONS

The Administration's proposal limits premium increases that an insurer may implement during the transition period. Increases are limited to changes arising from trend, changes in benefits or changes in group demographic composition (e.g. family composition, age and sex).

Rating Rules

The transition rules provide that health status not be taken into account in setting the change factors for rates. These factors are applied to the present rates on a plan, which can reflect duration, health status, and claim experience prior to the enactment date. Thus, differentials that existed at the effective date can be maintained throughout the transition. Consideration should be given to an orderly transition to the final rate base, to avoid calamitous changes in particular groups' rate levels when community rating is implemented.

The goal of the transitional rating rules should be two-fold. First, rate changes should be fairly applied based on permitted factors. The Administration's transition rules provide this equity. Second, the rate movement should be toward the ultimate community rating, which eliminates or limits differentials for such factors as age and sex. The Administration's proposal fails to do this.

The Administration's proposal requires insurers to divide their insured population into three sectors for the purpose of calculating rate increases: individuals, small group (under 100 covered lives) and large group (100 or more covered lives). This recognizes the different underwriting, pricing and issue practices of insurers in these sectors. Many states have defined, for insurance purposes, "small groups" at varying levels. Where allowed, health insurers have split their business in different ways, but differentiations in pricing and underwriting practice have often been made at 10 and 25 lives. Many carriers will have different rating bases reflecting those practices. The transition rules should permit alternative splits that reflect state variations and insurer practices. Sufficient consumer protection could be achieved by limiting changes in the splits. This will help minimize large dislocations in rates at the start of the transition period. There appears to be no policy advantage to replace existing levels with uniform levels.

Individual Premiums. The individual policyholder sector may present the most problems when trying to use a single reference rate. A reference rate for a sector is calculated so that when applied to the rate factors it would approximate the average premium rate charged to those in the sector. Many individual policies include significant pre-funding of expected future medical claims to mitigate later rate increases (prefunded products) while others



policies focus more heavily on initial rate levels (term products). Furthermore, insurers often amortize acquisition costs over time on such policies. Therefore, a single set of rate factors will not treat both policyholder blocks fairly. If rates are changed for a policy form, the determination of compliance with the transition rules will entail a prospective assumption of future rate actions on other policy forms. The treatment of pre-funded plans needs to be specified in order to provide policyholders with the contractual rights and guarantees they purchased prior to the enactment of reform.

Thus, there is a need for separate rate levels for term and for prefunded products.

Also, some contractual agreements might be in conflict with or inconsistent with reform. Transition rules must give guidance for such situations.

Small Group Premiums. For small group plans, many carriers use individual rating, and set rates based upon demographic characteristics such as age, sex, industry and family composition, as well as health status and expense. The Administration's proposal takes this into account in the computation of the reference rate.

Some states have enacted small group reform rules which provide for a "band" of variation, which narrows each year, where all rating factors currently used are gradually compressed to community rating. A ratio approach to achieve this was described earlier. Examples of such states are Minnesota, California, and Florida. If community rating is deemed to be the public policy, we recommend a gradual narrowing of rates to community rating instead of a sudden transition.

Large Group Premiums. Larger groups typically have premiums set based on expected medical claims experience. Services and expenses pertinent to the case are often included. During the transition, recognition needs to be given to differentials for certain unrecovered insurer expenses, especially deficit recovery rights and acquisition costs. The magnitude of these items reflect the marketing practice of the insurer and the historic methods of recognizing experience in the price for larger cases.

Large groups also use rating practices that result in the premium for a year being determined after the end of that year. For example, a minimum premium is set and the final premium is based on actual claims experience with maximum premium liability in the event of poor experience. During the transition, the maximum premium liability (rather than the initial premiums) should be the basis for calculating premium increase limits.

Many employers offer multiple benefit options. The premium charged for these options should be adjustable, reflective of shifts in enrollment and/or employer emphasis for several options. For example, an employer offering traditional fee for service (FFS), Preferred Provider Organization (PPO) and Point-of-Service (POS) HMO options will see shifts in cost over time as insureds change their elections. As insureds shift from FFS to PPO to POS-HMO, overall rates for all of the plans may go up since members select the option that best meets their expected medical needs.

Premium Changes During Transition

The Administration's proposal provides that increases in premiums due to trend, or health care cost and utilization, be the same for all plans in a given geographic area. Credible and reasonable geographic differences are permitted. Variations are permitted based on the claim experience of large groups, where credible, but are subject to an averaging requirement for all plans in the area.

Trend includes the utilization of services and has been found to vary by a number of factors. Larger employers tend to have health programs and on-site clinics in place, while smaller employers do not. Furthermore, individual plans and some smaller group plans also experience adverse selection after issue, where the healthier risk has a greater tendency to cancel, either dropping coverage or finding a cheaper plan.

Furthermore, benefit plan design influences trend, and variation in trend by plan design is appropriate. For example, insureds covered by plans with drug cards utilize more prescription services.

In order to work effectively, we believe the trend value should be allowed to vary by other factors than just geography.

It should be noted that trend variance will not disappear during the transition, but may over time in a reformed environment. A single trend assumption over all sectors for several years is very likely to create market distortions. Not all insurers operate in all sectors, so differences by sector will give some carriers advantages over all others. Consequently, variations in trend assumptions among sectors should be allowed. If necessary, a maximum difference in trend rates could be specified by the Secretary of the Treasury according to a formula designed to address the above concerns with a single trend value.

Rate changes not only reflect expected changes in utilization and medical inflation, but also the extent to which current rates differ from the given target. At any given time, different plans, areas, etc. can be either above or below the expected premium rate. The rate increases for those who are expected to remain above or below the original target should reflect this difference in future expected community values.



CONCLUSION

The most critical element of the transition rules must be to prevent health plans from taking advantage of opportunities counter to the intent of the health care reform. Health plans, including self-insured plans, should not be permitted to position themselves in a way that disadvantages covered persons relative to the purpose of any reform proposal.

Key to this element may be the need to establish several effective dates for different aspects of the transition rules. As soon as the direction of legislation becomes clear, health plans are likely to position themselves favorably relative to the rules. Therefore, a retroactive effective date preceding the date of enactment may be appropriate with respect to termination rules, including excessive rate increases. The effective date for normal rating rules should allow ample time for insurers and regulators to respond to the new rules and to avoid renegotiation of rates presently in effect. The transitional rating rules should use the existing rate for a group or individual as a base and if community rating is the goal, move to the community rating over the transition period.

Uniform standards need to apply to both insured and self-insured plans to prevent groups with expected good experience from leaving the insured arena and potentially increasing the cost of coverage for less healthy groups and individuals.

Responsible regulation will be a key to an effective transition. The American Academy of Actuaries is prepared to provide further analysis of proposed transition rules. We strongly recommend beginning work on those regulations before enactment of health care reform legislation.

TRANSITION RULES UNDER HEALTH CARE REFORM









