

**JOINT HEALTH INSURANCE  
PLANNING COMMITTEE ON THE  
MEDICALLY UNINSURABLE**

**FINAL REPORT  
JANUARY 31, 1992**

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January 31, 1992

COMMITTEE MEMBERS

Senator Cindy Resnick, Co-chair  
Senator James Henderson, Jr.  
Senator Jim Buster  
Susan Gallinger  
Steven C. Barclay  
Kathy Haake  
Barbara Hopkins  
Elizabeth McNamee

Rep. Karen Mills, Co-chair  
Rep. Ruth Eskesen  
Rep. Peter Goudinoff  
Dr. Len Kirschner  
Phyllis Ethridge, R.N.  
Raena Honan  
Andrea Lazar

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## FINAL REPORT OF THE JOINT HEALTH INSURANCE PLANNING COMMITTEE ON THE MEDICALLY UNINSURABLE

### I. Formation and Mandate of the Committee

In 1991, the 40th Arizona Legislature passed House Bill 2049, (Chapter 258). The bill established a 15-member Joint Health Insurance Planning Committee on the Medically Uninsurable.

Laws 1991, Chapter 258, Section 1, required the committee to examine and make a specific recommendation relating to:

1. the feasibility of adopting the recommendations of the National Association of Insurance Commissioners' (NAIC) Health Care Insurance Access Working Group of the Accident and Health Insurance Committee.
2. the participation of medically uninsurable citizens in health insurance benefit programs contracted for or subsidized by this state.
3. the mandatory participation of health insurance carriers licensed to do business in this state in providing coverage for the medically uninsurable.
4. the creation of a risk pool for the medically uninsurable, including specific consideration of medical loss ratios, exclusions, limitations and solvency of existing state sponsored risk pools.

The committee was also charged with identifying specific funding mechanisms to accomplish any of its recommendations.

Senator Cindy Resnick and Representative Karen Mills were selected to co-chair the 15-member committee. Other legislators assigned to the committee were Senator James Henderson, Senator Jim Buster, Representative Ruth Eskesen and Representative Peter Goudinoff. Other members appointed to the committee were: 1) Susan Gallinger, Director, Az. Department of Insurance 2) Dr. Len Kirschner, Director of Arizona Health Care Cost Containment System 3) Steven Barclay, Attorney 4) Phyllis Ethridge, R.N., St. Mary's Hospital and Health Center 5) Kathy Haake, Salt River Project 6) Raena Honan, Programs Analyst, Association for Retarded Citizens of Arizona, Inc. 7) Barbara Hopkins, public member 8) Andrea Lazar, Az. Blue Cross/Blue Shield, and 9) Elizabeth McNamee, Vice-President, Northern Region, Intergroup of Arizona.

## II. Summary of Committee Meetings

### November 12, 1991 Meeting

The Joint Health Insurance Planning Committee on the Medically Uninsurable met initially to hear presentations on alternatives being considered on the state and national levels for providing access to health care insurance for the medically uninsurable.

Susan Gallinger, Director of the Arizona Department of Insurance, presented the National Association of Insurance Commissioners' (NAIC) on-going study on methods for providing access to health coverage for the medically uninsurable. The NAIC is considering two approaches to this health care insurance problem: the Prospective Reinsurance Method and the Allocation Method. Ms. Gallinger informed the Committee that the NAIC was in the process of reworking their draft proposals. The NAIC is expected to adopt final recommendations in December, 1991. Ms. Gallinger stated that the Department of Insurance will be supplying the Committee with a copy of these final recommendations.

The committee heard a presentation by Mr. Frank Chow, from the Joint Legislative Budget Committee, on the feasibility of financing a health care risk pool with lottery revenues. Research by JLBC staff revealed that:

- 1) Additional lottery games designed to finance a high risk pool would cannibalize sales of existing games and the General Fund and the Economic Development Fund would suffer revenue losses.
- 2) Lottery Pick sales are not a stable source of revenues. Lottery revenues declined dramatically in FY 1991 and it is estimated that lottery sales will continue to fall in the future.

Based upon these findings, JLBC staff does not recommend using lottery revenues to supplement financing of a high risk pool. Appendix A contains information JLBC distributed to the Committee.

Mr. Barry Wong, Regional Vice President, Governmental Affairs, Cigna Corporation, reported that Cigna supports the development of pools for the uninsurable. Cigna believes risk pools should be viewed as the insurer of last resort for the medically uninsurable because third parties will have to subsidize the health care costs. Cigna also advocates that excess losses in the pools should be funded by a broad based source, such as general tax revenues.

Mr. Wong presented the Committee with the following statistics regarding risk pools:

- 1) 25 states have risk pools. Collective enrollment is 76,873 people.
- 2) The 17 state pools which have been active long enough to pay claims, pay over \$185 million per year for 67,972 enrollees. Average payment is \$2,726.30.
- 3) For this coverage, enrollees pay premiums of over \$107 million. The \$77

million loss is compensated by subsidies.

Andrea Lazar, Vice President, Government Relations, Blue Cross/Blue Shield of Arizona, informed the Committee that 500,000 people in Arizona have no health insurance. Forty percent of workers in businesses with fewer than 10 employees are uninsured. Blue Cross/Blue Shield of Arizona supports the small group Allocation model. Attachment B contains a summary of Ms. Lazar's slide presentation on the small group market and a comparison of the Allocation and Prospective Reinsurance methods.

Finally, the committee heard a presentation by Doug Hirano, with the Arizona Department of Health Services, on Michigan's AIDS Insurance Assistance Pilot Program. The program is designed to assist AIDS patients who are no longer able to work to retain health insurance coverage. Mr. Hirano informed the Committee that the average cost for AIDS patients is about \$30,000 per year. Attachment D contains a summary of the purpose, restrictions and requirements for obtaining federal monies for a state AIDS Insurance Assistance Pilot Program.

At the conclusion of the meeting Senator Resnick established the following four ad hoc subcommittees and chairpersons and asked that these groups report back to the full committee in early January:

Allocation Method - Cochairmen: Senator Cindy Resnick,  
Representative Karen Mills. Members: Andrea Lazar and Barbara Hopkins.  
Reinsurance Method - Cochairmen: Senator Jim Buster and Barry  
Wong. Members: Don Issacson and Henry GrosJean  
High Risk Pooling - Cochairmen: Representative Ruth Eskesen and  
Raena Honan. Members: Senator Jim Buster, Representative Peter Goudinoff,  
Barbara Hopkins and Phyllis Ethridge, R.N..  
Group Affordability - Elizabeth McNamee and Kathy Haake.

#### January 21, 1992 Meeting

The committee met to hear the subcommittee reports and make its recommendations.

#### Subcommittee Reports

The Group Affordability Subcommittee members were unable to attend the meeting. Instead, they provided written findings (Appendix E). The subcommittee members indicated that insurance reform is a step in the right direction but is not enough in itself to assure the affordability of health care coverage. The subcommittee presented the following health care reform proposals:

- 1) Proposals should define core benefits emphasizing prevention, early intervention and the efficacy of diagnostic and therapeutic services.
- 2) The health care industry should reduce the need for care by promoting healthy lifestyles and providing only necessary services.
- 3) Proposals should streamline administrative processes.

- 4) Individuals should take responsibility for their health.
- 5) Guidelines should define the necessary and appropriate services for a certain condition. Physicians should provide appropriate and cost effective care.
- 6) Align the financial incentives for payors, providers and consumers for efficient use of resources.

The Allocation Method Subcommittee recommended that the legislature consider the NAIC Small Group Health Insurance Availability Act, or Allocation Method. (Appendix F - Allocation Model Subcommittee findings. Appendix G - Summary of NAIC Small Group Health Insurance Availability Act - Allocation Model.) The subcommittee found the Allocation Model will:

- 1) stabilize and moderate rate increases.
- 2) limit and harmonize preexisting condition limitation periods.
- 3) ensure portability.
- 4) require the private health insurance market to integrate high risk groups into their larger risk pool according to each carrier's pro rata market share.

The High Risk Pooling Committee studied several options and made the following recommendations (see Appendix H):

- 1) Regarding a buy-in to the Health Care Group, the subcommittee recommended:
  - a) the expansion of the Health Care Group statewide.
  - b) that Health Care Group permit businesses to purchase Health Care Group coverage without a waiting period when an uninsurable employee or dependent significantly increases the business' health insurance costs or forces the business to purchase significantly lesser coverage.
  - c) that the Health Care Group not compete with private industry.
- 2) Regarding a buy-in to AHCCCS, the committee recommended that the legislature:
  - a) permit individuals and families with no other options to purchase AHCCCS coverage.
  - b) prohibit dumping of medically uninsurable employees by employers who cover their employees

in comparable categories.

- c) establish benefits, coverage and premiums comparable to high risk pools in other states.
  - d) provide for medical case management for very high risk cases.
- 3) Regarding high risk pools, the committee felt the creation of another risk pool would be duplicative. The committee prefers including the uninsurable population in the AHCCCS or state employee pool.
- 4) Regarding a buy-in to the state employee pool, the committee recommended that the state try to save money through bid selection, negotiations or self insurance. The State should use the savings to subsidize health insurance programs for the medically uninsurable.

The Prospective Reinsurance Model Subcommittee recommended that the legislature study and analyze both the Prospective Reinsurance and Allocation Models before either is adopted. (Appendix I - Prospective Reinsurance Subcommittee findings. Appendix J - Summary of the Prospective Reinsurance Model. Appendix K - NAIC Small Employer Health Insurance Availability Model Act (Prospective Reinsurance With or Without an Opt-Out.)

### III. Recommendations of the Committee

The committee agreed that all the subcommittee proposals merit further debate. Instead of endorsing one proposal, the committee recommended that the proponents of each proposal draft legislation. Senator Resnick and Representative Mills assured that the bills would be heard.

The committee also recommended that if one of the NAIC Small Employer Health Insurance Models is introduced, the size of the groups will increase from 3 - 25 to 3 - 50.

**Appendix A**

JLBC Fiscal Analysis of Financing High Risk  
Insurance Pools with Lottery Revenues.

"FINANCING HIGH RISK POOLS WITH LOTTERY REVENUES"  
A PRESENTATION GUIDELINE  
TO  
THE JOINT HEALTH INSURANCE PLANNING COMMITTEE  
ON THE MEDICALLY UNINSURABLE

November 12, 1991  
by JLBC Staff

OUTLINE:

- (1) Fiscal note on House Bill 2310 as introduced during the first regular session.
- (2) FY1990 Scratch game sales. Key point: additional games will cannibalize sales of existing games. General Fund and Economic Development Fund will suffer revenue losses.
- (3) Graph of INSTANT GAME SALES. Key point: sales pattern is not stable.
- (4) Graph of LOTTERY PICK SALES. Key point: sales pattern is not stable and is now declining.
- (5) Graph of GENERAL FUND REVENUES FROM LOTTERY SALES. Key point: revenues declined dramatically in FY1991 and is estimated to fall in the future.
- (6) JLBC staff does not recommend using Lottery revenues to supplement financing of a high risk pool.

## Fiscal Note

**BILL #** HB 2310

**TITLE:** high risk health insurance pools

**SPONSOR:** Eskesen, et al

**STATUS:** As Introduced

**REQUESTED BY:** House

**PREPARED BY:** Brian C. McNeil/Frank S. Chow

	FISCAL YEAR		
	1990-91	1991-92	1992-93
<b>EXPENDITURES</b>			
General Fund	\$ -0-	Cannot be determined.	
Health Insurance Risk Pool Fund	\$ -0-	Cannot be determined.	
 <b>REVENUES</b>			
General Fund - Lottery	\$ -0-	\$(1,600,000)	\$(1,800,000)
Commerce and Economic Development Commission Fund	-0-	(325,000)	(390,000)
Health Insurance Risk Pool Fund - Lottery	-0-	1,950,000*	2,193,800*
Health Insurance Risk Pool Fund - Premiums	-0-	-0-	Cannot be determined.

\* Represents the midpoint of a range of estimates

### FISCAL ANALYSIS

Description

The legislation creates a Health Insurance Risk Pool Board that will design and direct a risk pool for uninsurable Arizonans. The legislation sets forth a general plan of operation, board duties, eligibility criteria, pool administration language, and coverage limitations. The pool is to be supported with premium collections and revenue from 2 new lottery games. The legislation also creates a Health Insurance Risk Pool Fund to consist of the Board's share of revenue from the new lottery games, premium collections, and donations.

Estimated Impact

Given the lack of any actuarial work on this project, the Staff is unable to produce a sound estimate of expenditures. Additionally, without more concrete information on the plan being proposed, we are unable to obtain an estimate of actuarial expenses. In terms of revenue, the Staff assumes that 80-90% of the sales from the additional lottery instant games will occur at the expense of existing games whose proceeds are earmarked for the General Fund and the Commerce and Economic Development Fund. The Staff is unable to determine an amount in FY 1993 associated with premium collections.

(Continued)

### Assumptions

- Beyond claims activity, which would begin in FY 1993 and make up the largest program expenditure, the Staff assumes that the Board will require staffing and actuarial services at least during FY 1992. Based on conversations with other states, a minimum of \$25,000 should be budgeted for actuarial expenditures with additional monies required if there is to be actuary involvement in the development of the plan of operation and/or other program tasks. The amount of staffing for the Board depends on a variety of factors, not the least of which is how much work the Board contracts out to an actuary/consulting firm. If a complete plan is to be presented during the 1992 legislative session, though, we believe that there will probably have to be some staff or consultant expenditures.
- Revenue Assumptions
  - A review of Lottery sales data since FY 1989 revealed an acute substitution pattern between the Economic Development Fund and General Fund instant games. Concomitantly, total sales from both games have not increased significantly from the time period when only the General Fund instant game was played. This suggests that any new sales revenue from the introduction of additional games is probably minimal.
  - Lottery sales from all instant games are projected to remain flat for FY 1992 and grow by 10% in FY 1993.
  - The new instant game will be marketed in the same manner as the Economic Development game in which the first game of the fiscal year is introduced in October and ends in December, while the second game begins in January and continues until June -- lasting a total of nine months.
  - The substitution effect from the new instant game is estimated to reduce General Fund and Economic Development Fund Lottery revenues by 10% each.
  - The effective date of this bill is assumed to be October 1, 1991.

### Local Government Impact

Cannot be determined from available information.

### Other Estimates

The Staff is aware of some preliminary cost estimates done by one of the groups supporting the legislation. The estimates are not supported by any actuarial work and we believe they are, at best, problematic.

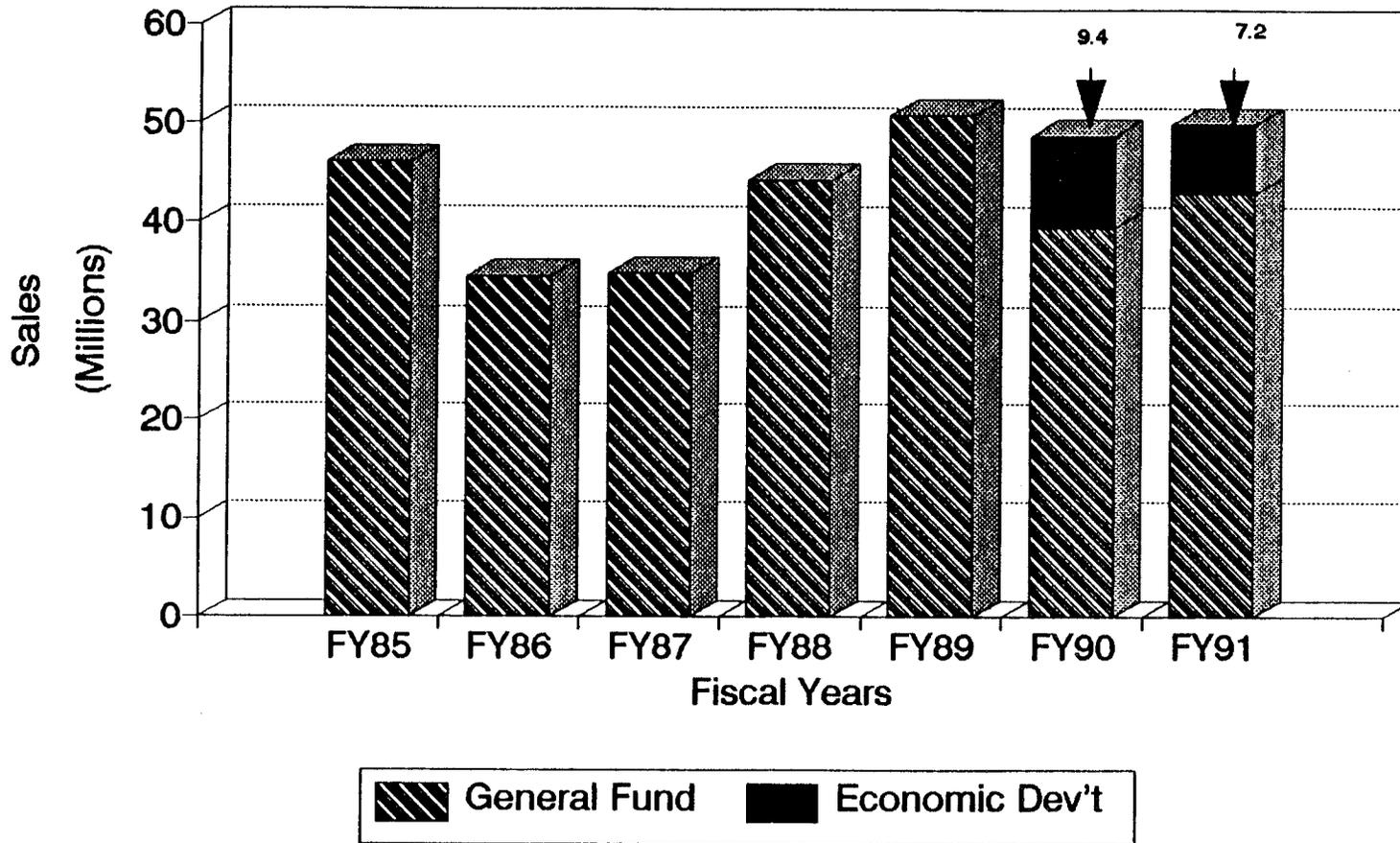
3/8/91

## FY1990 SCRATCH GAME SALES

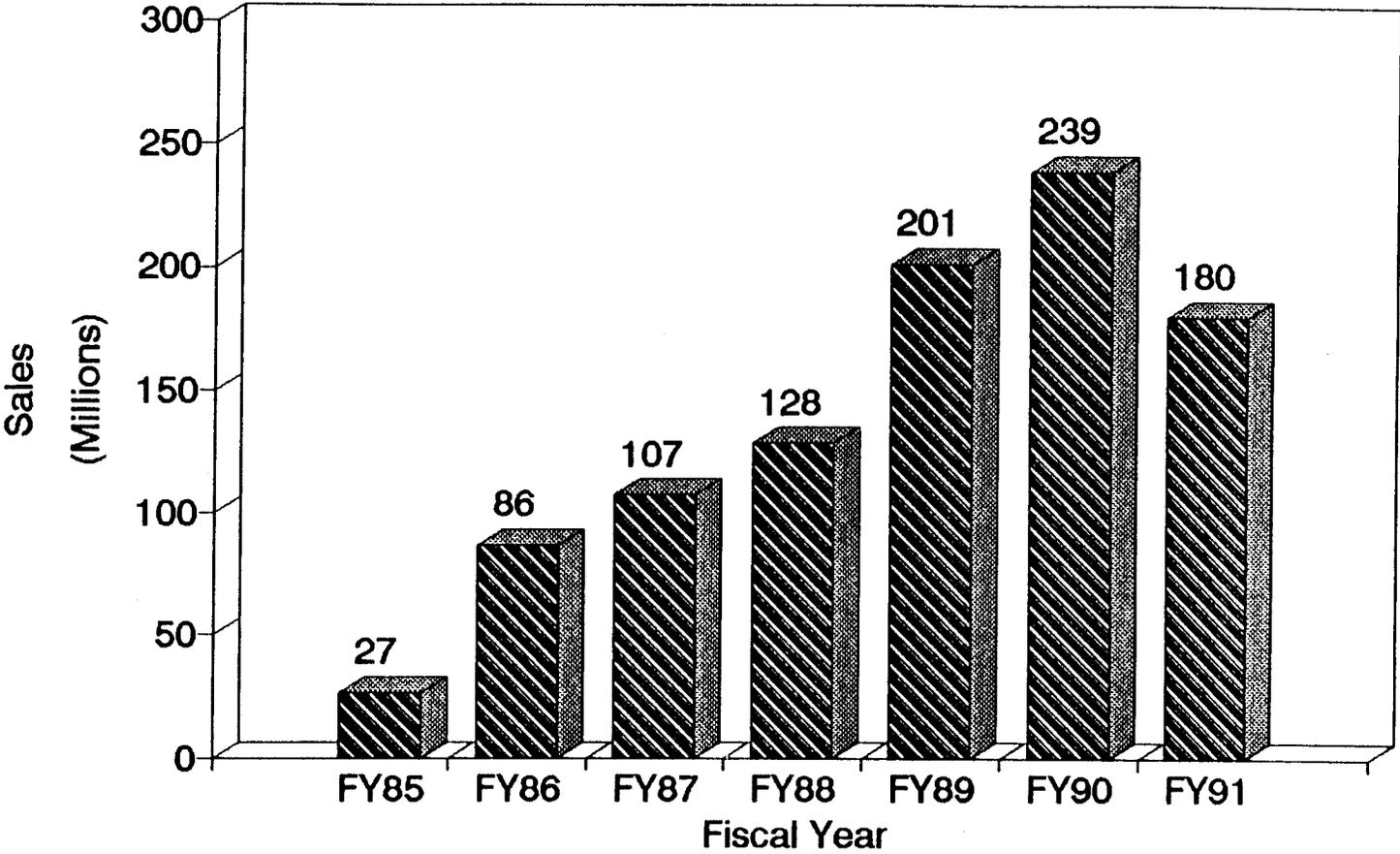
	<u>INSTANT</u>	<u>ECONOMIC DEVELOPMENT</u>
Jul. 1989	3,906,884	
Aug.	3,189,830	
Sep.	3,830,688	
Oct.	2,194,070	3,250,000
Nov.	3,426,745	450,000
Dec.	2,779,840	465,075
Jan.	4,280,516	550,000
Feb.	3,525,366	700,000
Mar.	4,106,069	1,035,000
Apr.	2,985,667	350,000
May	3,401,326	1,700,597
Jun.	1,846,763	927,921

**Conclusion: additional games will cannibalize existing games**

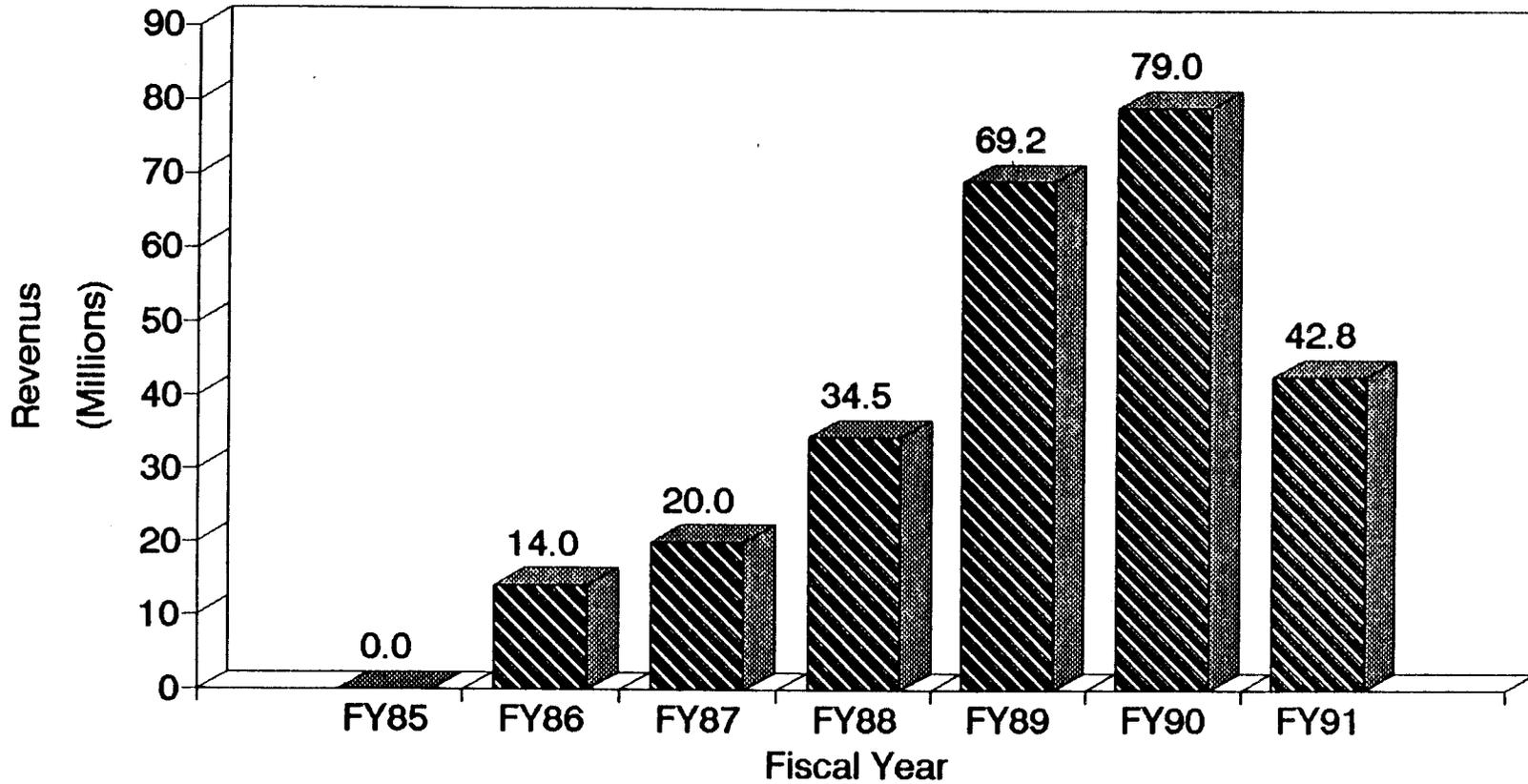
# INSTANT GAMES SALES



# LOTTERY PICK SALES



# GENERAL FUND REVENUES FROM LOTTERY SALES



**Appendix B**

Summary of Blue Cross/Blue Shield of Arizona's Presentation  
on Small Group Markets and the Allocation Method.



**Blue Cross  
Blue Shield  
of Arizona**

## **SMALL GROUP HEALTH INSURANCE MARKET REFORM**

10/91

Of the 500,000 Arizonans who are without health insurance, approximately 80 percent are employed or are the dependents of workers. Most notably, almost 40 percent of those working in a business with fewer than ten employees are uninsured in Arizona.

While the cost of insurance coverage is the primary reason small employers have not purchased an employee benefit plan, some are unable to purchase insurance because of factors such as the health condition of their employees, occupation and geographic location. Key problems are:

- The overall cost of insurance coverage.
- Adverse selection.
- Lack of availability of insurance through rejection of whole groups or individuals within groups.
- Lack of limits on the use of a group's health status or claims experience in setting its rates.
- Lack of assurance of continuity of coverage because of a cancellation of high-risk groups by some carriers.

Blue Cross and Blue Shield of Arizona believes there are a number of private sector initiatives that would help address these problems and ensure availability and access in the small group market. They are:

- Guaranteed availability through the NAIC's allocation model law.
- Rating reforms that restrict carriers' rating practices in the small group market, such as the NAIC's model act.
- Guaranteed renewability that prohibits cancellation of coverage because of poor claim experience.
- Enforcement is essential along with the inclusion of Multiple Employer Welfare Associations (MEWAs) in any reform measures.
- Availability of lower cost coverage that can be achieved through exemption of state-mandated benefits.

Blue Cross and Blue Shield of Arizona is committed to helping Arizonans receive access to affordable health care services. For more information on these reform programs, we encourage you to contact our Government Relations department at 864-4506.

SMALL EMPLOYER ACCESS TO PRIVATE HEALTH INSURANCE

Blue Cross and Blue Shield of Arizona

September 1991

Of the 500,000 Arizonans who are without health insurance, we know that approximately 80% are employed or are the dependents of workers. Understanding that the size of the work place has a direct relationship to uninsured status, we also know that in Arizona almost 40% of those working in a business with fewer than 10 employees are uninsured.

While the cost of insurance coverage is the primary reason cited by small employers as the reason they have not purchased an employee benefit plan, some small employers are unable to purchase insurance coverage because of factors other than cost, including the health condition of their employees, occupation and geographic location.

Blue Cross and Blue Shield of Arizona believes there are a number of private sector initiatives that, when coupled with legislative reform, would help ensure availability and access to coverage in the small group market.

#### Problems in The Small Group Market.

The problems in the small group market can be tied to two fundamental issues: adverse selection and the high cost of coverage.

To understand why health insurance for small employers has become less available and affordable in recent years, it is necessary to understand the concept of adverse selection. Adverse selection occurs when a carrier enrolls a disproportionate number of people who are higher risk than average - - that is, people who are more likely to use health services.

The small group market is beset by adverse selection for the following reasons:

- Small employers, much more than large employers, tend to purchase coverage because of an immediate or anticipated need for health care services by the employer, a family member or an employee. The employer may drop coverage when that need has passed.
- Small employers tend to contribute less toward the cost of coverage than large employers. As a result, not all their employees elect coverage. Those that do elect coverage tend to have more need for health care services than employees covered by large employers.

Typically, carriers with more liberal enrollment practices experience an "adverse selection spiral." Their enrollment practices attract high-risk enrollees who cannot obtain coverage from other carriers. As a result of the increased cost of covering these enrollees, the carrier must, in turn, charge higher premiums. Then, the carrier's lower-risk subscribers, who can find better-priced coverage elsewhere, leaves the carrier. When the carrier raises premiums again to reflect the higher cost of the higher-risk enrollees that remain, the carrier loses the next lower-risk tier of enrollees to its competitors. In this way, the risk pool of the carrier gradually deteriorates over time.

In a competitive market, carriers that accept all small groups, or have even marginally more liberal enrollment practices, find themselves with a worse mix of risks--and consequently higher premiums--than carriers than have been more selective.

To avoid these high risks, some carriers refuse to cover certain groups or individuals within groups. While many carriers use health status of employees as a basis for rejection, some carriers also reject groups based on their occupation or geographic location, because these factors are perceived as indicators as a group's future utilization.

Concern about adverse selection has resulted in changes in rating practices that have made it more difficult for some small groups to purchase coverage. An early practice of Blue Cross and Blue Shield Plans was to charge every subscriber in a given area the same price for coverage--a practice known as community rating. In this way, the cost of coverage for groups with the poorest health risk was kept at the most affordable level possible. However, under this approach, lower risk enrollees have only subsidized the cost of higher-risk enrollees and paid much more than the cost of services they received.

As competition increased in the health insurance market, commercial carriers began to offer experience-rated coverage for larger employers. That is, they began to set premiums for large groups based on those groups' own costs. This meant that for the first time, lower risk groups could purchase coverage from other carriers at premiums more closely reflecting the cost of their own employees.

This phenomenon occurred first among large employers who had become increasingly unwilling to subsidize the coverage of other groups. Experience rating represented the first step towards segmentation of the health insurance market and the loss of subsidies for the less stable parts of the insurance market.

The passage of the Employee Income Retirement Security Act of 1974 (ERISA) gave large employers another opportunity to lower their health benefit costs by providing incentives to drop insurance in favor of self-funding their health benefits. In this way, employers could avoid costs of state regulation, including mandated benefit and provider laws, premium taxes and subsidies of state risk pools. These incentives further segmented the health insurance market and eliminated almost all remaining cross subsidies. Currently, 40% of the group health insurance market is self-funded.

Until recent years, most carriers used community rating with demographic adjustments or limited experience rating in setting rates for small groups. The demographic factors used to adjust community rates include age, sex, geographic location and sometimes occupation.

By adjusting community rates to account for these factors, more competitive premiums could be offered to some subscribers. For example, on average, 55-year old males cost four times as much to cover as males under age 30. Carriers might balance the need to keep premiums attractive for younger subscribers with the need to keep coverage affordable for older subscribers by setting the premiums for the younger subscribers at half the price available to the older subscribers. These demographic adjustments do not reflect actual health experience of individuals or groups. Rather, they will reflect the historical health care utilization of males and females of younger and older people, of people living in different areas and engaged in different occupations.

Carriers with a disproportionate number of high-risk enrollees need to make these kinds of adjustments to be able to offer competitive premiums. And by attracting and keeping a good mix of risks in the insurance pool, carriers are able to keep premiums affordable for high risk enrollees.

However, the prevalence and intensity of experience rating has accelerated in the small group market in recent years, thereby placing the price of coverage out of reach for some high-risk groups. This change has been propelled by the same interest as in the large group market--namely, the demands of employers for lower premiums. And as overall health care costs have risen, so too have these demands, resulting in a wide range of premiums that can be charged to small groups. While these wide spreads make coverage more affordable for low-risk groups, they also result in premiums for some groups that are unaffordable.

Carriers' renewal practices in the small group market also have evolved over time. While it once was very uncommon for a small group to be dropped from coverage because of poor experience, many carriers now routinely refuse to renew small groups for this reason. These groups may be unable to obtain other insurance coverage if they are considered too high risk to insure.

Similarly, some carriers have entered the small group market in Arizona only to leave it as soon as profit reaches potential. In the more than 50 years Blue Cross and Blue Shield of Arizona has provided insurance coverage to Arizonans, the company has witnessed competitors cancel whole blocks of business.

While some current enrollment rating and renewal practices create coverage problems for small employers, many more small employers have difficulty purchasing insurance coverage because of its cost. In addressing the problem of the underlying cost of coverage, it is important to understand there are many components of health care cost increases. These include: practice patterns of providers, consumer demand for health care services, new technology, demographic changes, cost associated with medical malpractice and excess capacity.

In addition, there are other factors that make the cost of small group coverage in Arizona higher than similar coverage for large groups, including:

- The cost of state mandates. Small employers must purchase insurance that includes coverage of state mandated benefit and provider laws which add to the cost of coverage. In addition, insurance coverage for small employers also includes the cost of state premium taxes. Large employers can avoid these costs by self-funding their health benefits.
- A smaller base of employees and premiums over which to spread expenses. Health insurance contracts entail certain fixed expenses, such as enrollment and marketing costs, resulting in higher expenses as a percent of premium for small groups.
- High turnover of small group contracts. Carriers tend to lose 3% to 5% of small group enrollment per month. This is due in part to the marginal profitability of small business, which results in high failure rates. High turnover also leads to higher administrative costs because groups that drop coverage frequently leave before a carrier can fully recoup the cost of enrollment.

In summary, the key problems in the small group market are as follows:

- The overall cost of insurance coverage.
- Lack of availability of insurance, which arises because some carriers reject whole groups (or individuals within groups) because of health status, occupation or geographic location;
- Lack of coverage that limits the use of a group's experience on health status or claims experience in setting its rates; and
- Lack of assurance of continuity of coverage because of a cancellation of high-risk groups by some carriers.

BLUE CROSS AND BLUE SHIELD OF ARIZONA SUPPORTS A VARIETY OF PROGRAMS TO ADDRESS EACH OF THE PROBLEMS OUTLINED ABOVE.

1. Guaranteed Availability. Blue Cross and Blue Shield of Arizona supports guaranteeing the availability of private coverage for all employers by establishing a program that will require each carrier to accept its fair share of employers that have been turned down for coverage in the marketplace. We believe that the model law being considered for adoption by the National Association of Insurance Commissioners (NAIC) that ensures small group access to coverage by allocating risks among insurance carriers meets three critical criteria: (1) Risk management; (2) Minimize financial impact; and (3) Marketplace equity.
2. Rating reforms. Blue Cross and Blue Shield of Arizona supports imposing restrictions on carriers' rating practices in the small group market, such as those recently adopted by the NAIC in the Model Act on Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Employers.

The NAIC model addresses the problem of risk-based rating which, as noted earlier, can result in rates that are unaffordable for some small groups. The rating reforms do not limit the use of demographic adjustments but they do limit the extent to which a group's own experience can be used in setting its rates. In this way, carriers abilities to set rates that more closely reflect a group's experience will be balanced with a need to subsidize the rates for higher risk groups.

3. Guaranteed renewability. We also support the NAIC Model Act's prohibition against cancelling coverage of groups because of poor claim experience.
4. Enforcement. We believe adequate enforcement is essential to the success of any of these approaches. Of particular importance is the inclusion of Multiple Employer Welfare Associations (MEWAs) in any reform measures. If these entities were not subject to market reforms along with other carriers, more and more of the insured small group market would be encouraged to move to these entities and thereby render any "reform" largely meaningless.
5. Availability of lower cost coverage. In response to the high costs of small group coverage, we strongly support state legislation to exempt insurance sold to small employers from state-mandated coverage, benefit and provider requirements. And we believe that the insurance industry has a responsibility for developing lower-cost products for small employers.

10435/VGOV

**Appendix C**

Summary of Risk Pool Features from 25 States that have  
Implemented a State High Risk Pool Program.

## RISK POOL FEATURES

### California:

Active: 1991

% paid by insured: tba

Funding: cigarette and tobacco products surtax fund

Limits: \$30 million cap

Cost per member: tba

### Colorado:

Active: 1991

% paid by insured: tba

Funding: income tax surcharge of \$2 if income over \$15,000

Limits: 3 years for funding mechanism

Cost per member: tba

Note: Employers are required to contribute the same amount for an employee in the pool as their other workers.

### Connecticut

Active: 1976

% paid by insured: 39%

Funding: assessments to insurance industry

Limits: \$250 benefits for normal labor/delivery

Cost per member: \$5267

Note: Includes non-risk policyholders.

### Florida:

Active: 1983

% paid by insured: 53%

Funding: general fund/assessments to industry

Limits: capped enrollment

Cost per member: \$3929

### Georgia

\*not yet active

Funding not decided upon

Limits: annual cap of \$100,000 in individual benefits

Cost per member: tba

### Illinois

Active: 1989

% paid by insured: 37%

Funding: general fund

Limits: cap on membership @ 4500

Cost per member: \$3131

Note: Includes non-risk policyholders.

Indiana

Active: 1982

% paid by insured: 51%

Funding: assessments to insurance industry w/tax credits

Limits: transplant benefits limited

Cost per member: \$5328

Iowa

Active: 1987

% paid by insured: 65%

Funding: assessments to insurance industry w/tax credits

Limits: maternity is optional

Cost per member: \$3571

Louisiana

\*not yet active

Funding: daily hospital surcharge of \$1 outpatient \$2 inpatient  
for insured patients + lottery if enacted

Limits: tba

Cost per member: tba

Maine

Active: 1988

% paid by insured: 37%

Funding: assessment of all Maine hospitals

Limits: membership cap @ 600

Cost per member: \$3476

Minnesota

Active: 1976

% paid by insured: 50%

Funding: assessments to insurance industry

Limits: PPO

Cost per member: \$2016

Mississippi

\*not yet active

Funding: health insurer \$1 per member per month assessment,  
except governments

Limits: tba

Cost per member: tba

Missouri

\*not yet active

Funding: assessments to insurance industry w/tax credits

Limits: PPO

Cost per member: tba

Montana

Active: 1987

% paid by insured: 96%

Funding: assessments to insurance industry for losses

Limits: no alcohol or drug treatment benefits

Cost per member: \$2166

Nebraska

Active: 1986

% paid by insured: 51%

Funding: assessments to insurance industry w/tax credits

Limits: PPO

Cost per member: \$3004

New Mexico

Active: 1988

% paid by insured: 51%

Funding: assessments to insurance industry w/tax credits

Limits: maternity benefits optional

Cost per member: \$4289

Note: Employers must pay the same amount as their non-risk workers to the pool and provide same benefits to high risk worker's dependents as other dependents.

North Dakota

Active: 1982

% paid by insured: 57%

Funding: assessments to insurance industry w/tax credits

Limits: chiropractic optional

Cost per member: \$2702

Oregon

Active: 1990

% paid by insured: 47%

Funding: general fund start up, then assessments to industry

Limits: \$2 million expenditure limit

Cost per member: \$2359

S. Carolina

Active: 1990

% paid by insured:

Funding: assessments to insurance industry w/tax credits

Limits: \$5 million cap, AIDS excluded

Cost per member: \$1610

Tennessee

Active: 1987

% paid by insured: 76%

Funding: general fund and assessments to insurance industry

Limits: \$3 million cap/2 years

Cost per member: \$3459

Texas

\*not yet active

Funding: assessments to insurance industry

Limits: 12.5% cost limit for administration and fees

Cost per member: tba

Utah

Active: 1991

% paid by insured: tba

Funding: general fund start up costs then self funding

Limits: \$2 million start up

Cost per member: tba

Note: Employers must contribute same amount for a high risk worker as for their other workers.

Washington

Active: 1981

% paid by insured: 57%

Funding: assessments to insurance industry w/tax credit

Limits: n/a

Cost per member: \$2965

Wisconsin

Active: 1981

% paid by insured: 46%

Funding: assessments to insurance industry w/general fund subsidy

Limits: n/a

Cost per member: \$2481

Note: Low income policyholders receive a subsidy.

Wyoming

Active: 1991

% paid by insured: 19%

Funding: assessments to insurers w/tax credit under \$1 million

Limits: sunset provision June 1995

Cost per member: \$1153

Data source: Aaron Trippler, Communicating for Agriculture  
Compilation: Raena Honan, ARC

HIGH RISK POOLS IN THE USA

STATE	GROUP	ADM PER	PRE PER	ADD PER	TOTAL	DEDUT HIGH	POCKET	PLANS	OPT	LIMIT	MAXIMUM
CALIF*	8901	0	0	0	0	500	2000	3	N	Y	500000
COLORADO*	0	0	0	0	0	2000	0	1	N	Y	500000
CONN	2200	258	2044	2965	11587400	2000	2500	1	N	Y	1000000
FLORIDA	5934	474	2097	1358	23314686	2000	1500	1	N	Y	500000
GEORGIA*	0	0	0	0	0	1500	2000	0	N	Y	500000
ILLINOIS	4370	396	2735	4279	32381700	1000	2500	2	N	Y	500000
INDIANA	3080	232	2720	2376	16410240	1500	2500	1	N	Y	NO
IOWA	1971	190	2321	1060	7038441	2000	3000	1	Y	N	250000
LOUISIANA*	0	0	0	0	0	2000	0	0	N	Y	500000
MAINE	400	324	1281	1871	1390400	500	1500	1	N	Y	500000
MINN	25272	121	1018	877	50948352	1000	3000	1	N	N	500000
MISS*	0	0	0	0	0	0	0	0	N	N	250000
MISSOURI*	0	0	0	0	0	1000	0	0	N	N	1000000
MONTANA	304	95	2071	0	658464	1000	5000	1	N	N	250000
NEBRASKA	2904	104	1523	1377	8723616	1000	5000	1	N	N	500000
NEW MEXICO	1303	169	2191	1929	5588567	1000	2000	1	Y	N	NO
NO DAKOTA	1656	123	1553	1026	4474512	1000	3000	1	Y	N	250000
OREGON	1211	309	1100	950	2856749	500	5000	2	N	Y	500000
S. CAROLINA	1072	0	1526	84	1725920	500	1500	1	N	Y	250000
TENN	4121	116	2615	728	14254539	1000	2500	1	N	Y	500000
TEXAS*	0	0	0	0	0	250	2000	1	N	N	500000
UTAH*	0	0	0	0	0	1000	2000	1	N	Y	500000
WASHINGTON	2793	202	1689	1074	8281245	1000	2500	1	N	Y	500000
WISCONSIN	9287	160	1137	1184	23041047	1000	2000	2	N	N	500000
WYOMING	94	73	220	860	108382	2000	3000	1	N	Y	250000

\*operations pending

**Appendix D**

Summary of the Purpose, Restrictions and Requirements of the Title  
II HIV Care Grant Program of the Ryan White Comprehensive AIDS Resources  
Emergency Act of 1990.

## THE TITLE II HIV CARE GRANT PROGRAM OF THE C.A.R.E. ACT

The Ryan White Comprehensive AIDS Resources Emergency (C.A.R.E.) Act of 1990 (Public Law 101-383) adds a new Title XXVI to the Public Health Services Act (42 U.S. Code 300ee et seq.). The C.A.R.E. Act has four Parts. Part B provides assistance to States under what is commonly referred to as the Title II HIV Care Grant Program. Title II is administered by the Bureau of Health Resource Development (BHRD), Health Resources and Services Administration (HRSA), Public Health Service (PHS), Department of Health and Human Services (DHHS). At the State level, the statute specifies that Title II programs are to be administered by the State public health agency.

### TITLE II FUNDING PURPOSES

Title II provides financial assistance to States to enable them to improve the quality, availability and organization of health care and support services for individuals and families with HIV disease. States may use funds to:

- 1) Establish and operate HIV care consortia within areas most affected by HIV disease that shall be designed to provide a comprehensive continuum of care to individuals and families with HIV disease, in accordance with the provisions specified in the Section 2613, Grants To Establish HIV Care Consortia;
- 2) Provide home-and community-based care services for individuals with HIV disease in accordance with the provision specified in Section 2614, Grants For Home-and Community-Based Care;
- 3) Provide assistance to assure the continuity of health insurance coverage for individuals with HIV disease, in accordance with the provisions in Section 2615, Continuum of Health Insurance Coverage; and
- 4) Provide treatments, that have been determined to prolong life or prevent serious deterioration of health, to individuals with HIV disease, in accordance with the provisions specified in Section 2616, Provision of Treatments.

States may use funds awarded under Title II only for the specific program components described above as defined in the C.A.R.E. Act. States are not required to implement all four of these program components.

## CONTINUUM OF HEALTH INSURANCE COVERAGE

**Purpose:** A State is permitted to use funds to establish a program of financial assistance to assist eligible low-income individuals with HIV disease to:

- 1) Maintain a continuity of health insurance; or
- 2) Receive medical benefits under a health insurance program, including risk pools.

**Restriction:** A State is not permitted to use funds to pay:

- 1) Any costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as a part of premium contributions to existing liability risk pools); and
- 2) Any amount expended by a State under Title XIX of the Social Security Act.

**Requirements:** A State which intends to use Ryan White Title II funds to continue health insurance coverage must demonstrate to HRSA that it has established a program which **assures** that:

- 1) Funds will be targeted to individuals who would not otherwise be able to afford health insurance coverage; and
- 2) Income, asset and medical expense criteria will be established and applied by the State to identify those individuals who qualify for assistance. Information concerning these criteria will be made public.

GENERAL INFORMATION ABOUT

THE AIDS INSURANCE DEMONSTRATION PROJECT

Private insurance provides a first line of defense for most individuals in meeting most health care costs. The State of Florida appropriated general revenue funds for the demonstration of State funding of private health insurance premiums for people who are HIV symptomatic or have AIDS. As people who are HIV symptomatic or have AIDS become too incapacitated to work, loss of employment could jeopardize their ability to pay for their own health insurance premium through their employer (Group/COBRA) or a privately purchased (individual) policy.

The AIDS Insurance Demonstration Project (AIDP) is available for residents of Broward and Monroe Counties. The AIDP is being implemented through a Community Based Organization (CBO) in each of the two counties. Center One in Broward County and AIDS Help in Monroe County will be responsible for the collection of information required for participation and for the payment of premiums to insurance carriers. (The maximum assistance available is \$500/month/participant.) Center One and AIDS Help are both not-for-profit CBOs that play an active role in providing their community's AIDS/HIV symptomatic population with an assortment of services ranging from case management to intake, social and financial counseling. With these resources at hand, each agency is equipped to assess eligibility for the AIDS Insurance Demonstration Project.

In addition to having a diagnosis of AIDS or being HIV symptomatic, participants in the AIDP must also meet the following criteria:

- \* suffer a loss of their principal employment;
- \* currently have health insurance coverage under a group, individual or COBRA policy;
- \* have a household income equal to or less than \$1,049/month (\$1,405 for a family of two);
- \* have cash assets equal to or less than \$4,500 (\$5,500 if married);
- \* be willing to sign a Release of Information Statement, a Physician's Statement of Diagnosis and Employability and the Applicant's Data Collection form.

Health Council of South Florida, Inc. (HCSF) is responsible for the administration and evaluation of the AIDS Insurance Demonstration Project. HCSF is a voluntary, not-for-profit corporation serving Dade, Broward and Monroe Counties. The purpose of the Council is to provide effective health planning for the area by promoting development of health services, manpower and facilities which meet identified health needs in a cost effective manner, reduce inefficiencies and implement the area health plan.

(continued)

Research and investigation carried out by the HCSF staff found that similar programs, operated by the Department of Social Services, are currently in various stages of development in other states across the country, such as Michigan, New York and Washington. Although not a new concept, Florida is the first state to implement this type of program through Community Based Organizations which are usually the first source of assistance to persons who are HIV symptomatic or have AIDS.

If you are a resident of Broward or Monroe County and interested in participating in the AIDS Insurance Demonstration Project, you may contact:

CENTER ONE  
2518 West Oakland Pk. Blvd.  
Ft. Lauderdale, FL 33311

(305) 485-7090

AIDS HELP, INC.  
P. O. Box 4374  
Key West, FL 33041

(305) 296-6196

AIDS INSURANCE ASSISTANCE PROGRAM  
PROGRAM DESCRIPTION

INTRODUCTION

The AIDS Insurance Assistance Program is a pilot program operated by the Michigan Department of Social Services (MDSS). The program is designed to assist people who, because of AIDS related disease, are unable to continue working, and thus may lose their health insurance.

The program will assist any qualified person to pay for any health insurance they have. The program does not purchase or provide insurance for people who do not have insurance to start with.

The program began October 1, 1989 in Wayne, Oakland, and Macomb counties.

LEGISLATIVE BACKGROUND

Section 1626 of the DSS Appropriation Act for FY 88/89 (Act 322 of the Public Acts of 1988) required the following:

"The department of social services shall develop a proposal to identify potential medicaid recipients who test HIV positive and pay their insurance premiums so that they can maintain their health insurance policies. The proposal shall be approved by the house and senate appropriations committees before being implemented."

A proposal was developed by the Department of Social Services, and received legislative approval on May 30, 1989.

SIZE OF TARGET POPULATION

The target population is those persons who, because of HIV related disease, may soon be unable to continue working, and thus may lose health insurance provided either through an employer, or privately purchased. With no insurance, and high medical bills most of these would soon become Medicaid eligible. These are persons for whom it would be cost effective for the State to maintain insurance.

The size of the population can be estimated using Michigan Department of Public Health (MDPH) data regarding the number of full blown AIDS cases expected to appear in the future. It can be assumed that virtually all those with full blown AIDS are too ill to work, however in the fairly recent past they would have been, although suffering from HIV related disease, still able to work. We thus estimate the target population for a point in time by looking at how many full blown cases are expected twelve months later.

The target population is those persons with AIDS, with insurance, who would have become Medicaid eligible. To estimate its size we take the expected number of Medicaid eligible AIDS cases, and reduce it to account for cases that probably had no insurance. Data to do this are as follows:

1. MDSS data indicates that about 50 percent of all AIDS cases become Medicaid eligible.
2. MDPH data indicate that IV drug use accounts for about 28 percent of total cases. We assume that these cases never had insurance, and all went on to become Medicaid eligible.
3. MDPH data indicate that pediatric cases account for two percent of all cases. We assume that half of these become Medicaid eligible but would have had no insurance to start with. Pediatric cases who have insurance would have it through a parent, and would not be in a position to lose employment based insurance.
4. MDPH data indicate that about 4 percent of total cases had an undetermined transmission mode. We assume half of these cases went on to become Medicaid eligible, and of the Medicaid eligibles, half had no insurance.

The target population can thus be estimated by taking the total number of cases and removing those who were either non-Medicaid (50%), IV drug users (28%), pediatric without insurance (1%), or undetermined transmission mode without insurance (1%). The result is to remove 80 percent of total cases. Or conversely, the estimated target population equals about 20 percent of new AIDS cases.

The total program population will equal new cases, plus cases that were eligible from previous time periods. For 1990 we assume that all the 1989 eligibles will continue. We assume that half of 1990 eligibles will survive into 1991. Total estimated program population is as follows:

ESTIMATED  
SIZE OF TARGET POPULATION

YEAR	(1) New AIDS Cases*	(2) Size of Target Population (Col. 1 from) Next year X .2)	(3) Cases Carried Over From Previous Year	(4) Total Program Pop. (Col. 2 + Col. 3)
1989		31**	0	31
1990	628	176	31	207
1991	882	236	104	340
1992	1,182			

\*Based on MDPH projections. New cases equals the average of the MDPH pessimistic and optimistic projections multiplied by 70%. About 70% of statewide cases occur in Wayne, Oakland, and Macomb counties.

\*\*The program began October 1, 1989 so we have assumed only one quarter of the annual target population would appear in 1989. The number 31 equals 628 X .2 X .25

COST ANALYSIS

Average total Medicaid cost of treating a patient with AIDS is approximately \$1,600 per month. The monthly premium cost for private insurance will vary greatly depending on the coverages. However, the price for an individual to participate in the State Health Plan available for state employees is approximately \$135.00 per month.

For the buy-in concept to be cost effective for the State, the State must avoid buying in for too many individuals who either would have maintained coverage at their own expense, or individuals who would have been forced to spend-down their own assets before qualifying for Medicaid.

The table below indicates the approximate maximum cost of the program, and also what savings would occur if the program successfully avoided Medicaid expenditures for the target population.

COST ANALYSIS  
INSURANCE ASSISTANCE PROGRAM

COST PROJECTIONS FOR EXPANDING PROGRAM STATEWIDE

Current Number of Potential Eligibles Statewide

As of 6/6/90 there were 41 people enrolled in the program. Data from the Department of Public Health indicates that about 70 percent of all cases of AIDS are in Wayne, Oakland, and Macomb counties. Assuming that the 41 people represent 70 percent of the statewide number, statewide enrollment would be about 59 people. The number would probably be somewhat higher than this because persons who contract AIDS via IV drug use are probably more concentrated in Southeast Michigan than outstate. We have assumed that these persons tend not to qualify for the program because they are less likely to have insurance to start with. The total number of potential eligibles in the state may therefore be about 65.

Future Number of Eligibles Statewide

To date enrollment levels have grown by about five persons per month. If we assume this represents only 70 percent of possible growth, then possible growth would be about seven people per month. During the next twelve months enrollment could therefore rise to about 100 people statewide.

Savings

Assuming there are 100 people in the program per month, total monthly savings would be \$135,796, or annual total savings of \$1.6 million. The State savings would be \$51,784 per month, and \$621,408 per year.

**BASIC DATA**

Total enrollment as of 6/6/90 is 41 people. Since the program began 10/1/89, four enrollees have died, and two have returned to work. One enrollee moved out of state and thus was disenrolled. Total amount paid for premiums is \$38,415.84

SDM  
6/13/90

### COST EXPERIENCE, NOVEMBER 89-APRIL 90

We have used a conservative and simple method of assigning costs based partly on self reporting and partly on the services uniformly needed by a person with AIDS. While this method does not reflect the true experience of the program, it clearly demonstrates the positive benefit to cost ratio. The details of the methodology are described in the attachment.

Each person in the program is required to submit a monthly report form identifying medical services they obtained and describing their financial status. During the months from November through April we received 104 monthly report forms from 29 people. This represented a return rate of about 75 percent.

The report forms indicate that 23 of these people would have been Medicaid eligible, and six would not. The cost analysis assumes that without the Insurance Assistance Program, Medicaid would have paid for the care received by Medicaid eligible persons.

The results for the 104 person months are as follows:

	AZT/ Pentam.	Dr. Visits	Lab.	IPH	Other	Total
Total Costs Avoided	\$28,678.78	\$2,093.50	\$8,700	\$115,101	\$4,302.50	\$158,875.70
Costs Avoided per Per- son month	\$275.75	\$20.13	\$83.65	\$1106.75	\$41.37	\$1,527.65

Total Premium Payments - \$17,647.90

Premium Payments per Person Month - \$169.69

Total Benefit/Cost Ratio - 9:1 (i.e. \$1,527.65 / \$169.69)

Benefit/Cost Ratio on State - 4:1 (i.e. .45 \* \$1,527.65 / \$169.69)  
Dollars

Total Savings per Person Month - \$1,357.96 (i.e. \$1,527.65 - \$169.69)

Total State Savings - \$517.84 (i.e. .45 \* \$1,527.65 - \$169.69)  
per Person Month

## ATTACHMENT

The method of assigning costs outlined below is strongly biased in the direction of understating costs. Reasons for this include:

- Persons who are the sickest are the most likely not to submit a completed report form. Particularly when they are in the hospital.
- Many incurred costs are not included in the analysis because to do so would be very complicated. For example enrollees report receiving a wide variety of home health services, but it is difficult to know which of these would be covered. A wide variety of prescriptions, radiology services and emergency room services are reported. Again, it is a complex matter to assign a cost to these.

Costs are assigned as follows:

**AZT:** For virtually each eligible we know from direct contact they are taking AZT. Average monthly Medicaid per person cost for AZT is \$225.52. This amount is included for every person for each month.

**Pentamidine:** Many of the eligibles report use of pentamidine. Average monthly Medicaid payment for pentamidine is \$117.56. This amount is included for each person that reports use of pentamidine.

**Lab:** Cost of lab work is estimated at \$100 per month. This is the cost of basic lab work that should be done each month for a person with AIDS.

**Physician services:** Each reported physician service is priced based on the Medicaid screen of \$16.60.

**Inpatient Hospital:** Hospital services are priced based on the typical Medicaid payment per discharge for treatment of AIDS related disease. For persons who died and did not submit a report form during the month of death we have included a hospital admission of one half the cost of the average admission.

**Other:** In cases where substantial incurred costs are reported in a category not listed above (e.g. outpatient surgery) we have included half the reported cost of the service.

ARIZONA HIV INFECTION SURVEILLANCE REPORT  
 Arizona Department of Health Services  
 Division of Disease Prevention  
 Oct 1, 1991

**Acquired Immunodeficiency Syndrome (AIDS\*) Summary**

1. Disease Category**	Adult/Adolescent		Pediatric		Total	
	Cases ( %)	Deaths ( %)	Cases ( %)	Deaths ( %)	Cases ( %)	Deaths ( %)
PCP	791 ( 53)	473 ( 60)	1 ( 10)	0 ( 0)	792 ( 53)	473 ( 60)
Other Disease w/o PCP	608 ( 41)	326 ( 54)	9 ( 90)	4 ( 44)	617 ( 41)	330 ( 53)
KS Alone	93 ( 6)	40 ( 43)	0 ( 0)	0 ( .)	93 ( 6)	40 ( 43)
Total	1492 (100)	839 ( 56)	10 (100)	4 ( 40)	1502 (100)	843 ( 56)
[% of all cases]	[ 99]		[ 1]			

2. Age	Cases ( %)	3. Race/Ethnicity	Adult/Adolescent Cases ( %)	Pediatric Cases ( %)	Total Cases ( %)
Under 5	6 ( 0)	White, Not Hispanic	1253 ( 84)	6 ( 60)	1259 ( 84)
5-12	4 ( 0)	Black, Not Hispanic	62 ( 4)	2 ( 20)	64 ( 4)
13-19	7 ( 0)	Hispanic	150 ( 10)	1 ( 10)	151 ( 10)
20-29	363 ( 24)	Asian/Pacific Is.	7 ( 0)	0 ( 0)	7 ( 0)
30-39	657 ( 44)	Native American	11 ( 1)	1 ( 10)	12 ( 1)
40-49	318 ( 21)	Unknown	9 ( 1)	0 ( 0)	9 ( 1)
Over 49	147 ( 10)	Total	1492 (100)	10 (100)	1502 (100)
Unknown	0 ( 0)				
Total	1502 (100)				

4. Adult/Adolescent Exposure Category	Males ( %)	Females ( %)	Total ( %)
	Homosexual or bisexual Men	1030 ( 73)	0 ( 0)
Intravenous (IV) drug User	97 ( 7)	32 ( 39)	129 ( 9)
Gay/Bi IV drug User	157 ( 11)	0 ( 0)	157 ( 11)
Hemophilic	21 ( 1)	0 ( 0)	21 ( 1)
Heterosexual contact	14 ( 1)	24 ( 29)	38 ( 3)
Transfusion with blood/products	35 ( 2)	19 ( 23)	54 ( 4)
None of the above/Other	55 ( 4)	8 ( 10)	63 ( 4)
Total	1409 (100)	83 (100)	1492 (100)
[% of all cases]	[ 94]	[ 6]	

Pediatric Exposure Category	Males ( %)	Females ( %)	Total ( %)
	Hemophilic	3 ( 43)	0 ( 0)
Parent at risk/has AIDS/HIV	2 ( 29)	3 (100)	5 ( 50)
Transfusion with blood/products	2 ( 29)	0 ( 0)	2 ( 20)
None of the above/Other	0 ( 0)	0 ( 0)	0 ( 0)
Total	7 (100)	3 (100)	10 (100)
[% of all cases]	[ 70]	[ 30]	

Acquired Immunodeficiency Syndrome (AIDS)  
Surveillance Report -Oct 1, 1991

County of Residence	Cases ( % )	Deaths	1990 Census Population	Case Rate***
Apache	5 ( <1)	2	61,591	8.12
Cochise	12 ( 1)	5	97,624	12.29
Coconino	10 ( 1)	5	96,591	10.35
Gila	4 ( <1)	3	40,216	9.95
Graham	4 ( <1)	1	26,554	15.06
Greenlee	1 ( <1)	0	8,008	12.49
La Paz	3 ( <1)	2	13,844	21.67
Maricopa	1118 ( 74)	641	2,122,101	52.68
Mohave	15 ( 1)	7	93,497	16.04
Navajo	4 ( <1)	2	77,658	5.15
Pima	272 ( 18)	143	666,880	40.79
Pinal	13 ( 1)	10	116,379	11.17
Santa Cruz	4 ( <1)	0	29,676	13.48
Yavapai	15 ( 1)	10	107,714	13.93
Yuma	21 ( 1)	12	106,895	19.28
Unknown	1 ( <1)	0	N/A	N/A
<b>Total</b>	<b>1502 (100)</b>	<b>843</b>	<b>3,665,228</b>	<b>40.98</b>

6. Reported Cases of AIDS and Case-Fatality Rates by Half-Year of diagnosis.

Half-Year of Diagnosis	Number of Cases	Number of Deaths	Case-Fatality Rate
Before 1980	0	0	----
1980 Jan -June	0	0	----
July-Dec	0	0	----
1981 Jan -June	0	0	----
July-Dec	1	1	100%
1982 Jan -June	1	1	100%
July-Dec	2	2	100%
1983 Jan -June	5	4	80%
July-Dec	6	4	67%
1984 Jan -June	11	9	82%
July-Dec	17	17	100%
1985 Jan -June	38	34	89%
July-Dec	49	40	82%
1986 Jan -June	72	56	78%
July-Dec	82	66	80%
1987 Jan -June	114	90	79%
July-Dec	140	85	61%
1988 Jan -June	124	86	69%
July-Dec	153	87	57%
1989 Jan -June	158	81	51%
July-Dec	160	80	50%
1990 Jan -June	138	59	43%
July-Dec	113	30	27%
1991 Jan -June	106	10	9%
July-Oct 1	12	1	8%
<b>Totals</b>	<b>1502</b>	<b>843</b>	<b>56%</b>

\* Only cases meeting CDC 1987 criteria are included.

\*\* KS=Kaposi Sarcoma, PCP=Pneumocystis carinii pneumonia

\*\*\* Per 100,000 population based on 1990 Census.

ARIZONA HIV INFECTION SURVEILLANCE REPORT  
 Arizona Department of Health Services  
 Division of Disease Prevention  
 Oct 1, 1991

AIDS RELATED COMPLEX (ARC) Summary

Age	Cases ( % )	2. Race/Ethnicity	Adult/Adolescent Cases ( % )	Pediatric Cases ( % )	Total Cases ( % )
Under 5	1 ( 0 )	White, Not Hispanic	337 ( 85 )	4 ( 100 )	341 ( 85 )
5-12	3 ( 1 )	Black, Not Hispanic	16 ( 4 )	0 ( 0 )	16 ( 4 )
13-19	2 ( 1 )	Hispanic	36 ( 9 )	0 ( 0 )	36 ( 9 )
20-29	133 ( 33 )	Asian/Pacific Is.	0 ( 0 )	0 ( 0 )	0 ( 0 )
30-39	151 ( 38 )	Native American	4 ( 1 )	0 ( 0 )	4 ( 1 )
40-49	83 ( 21 )	Unknown	2 ( 1 )	0 ( 0 )	2 ( 1 )
Over 49	26 ( 7 )				
Unknown	0 ( 0 )	Total	395 ( 100 )	4 ( 100 )	399 ( 100 )
Total	399 ( 100 )				

Adult/Adolescent Exposure Category	Males ( % )	Females ( % )	Total ( % )
Homosexual or bisexual Men	262 ( 73 )	0 ( 0 )	262 ( 66 )
Intravenous (IV) drug User	27 ( 8 )	17 ( 45 )	44 ( 11 )
Gay/Bi IV drug User	30 ( 8 )	0 ( 0 )	30 ( 8 )
Hemophilic	4 ( 1 )	0 ( 0 )	4 ( 1 )
Heterosexual contact	1 ( 0 )	8 ( 21 )	9 ( 2 )
Transfusion with blood/products	6 ( 2 )	10 ( 26 )	16 ( 4 )
None of the above/Other	27 ( 8 )	3 ( 8 )	30 ( 8 )
Total	357 ( 100 )	38 ( 100 )	395 ( 100 )
(% of all cases)	[ 90 ]	[ 10 ]	

Pediatric Exposure Category	Males ( % )	Females ( % )	Total ( % )
Hemophilic	3 ( 100 )	0 ( 0 )	3 ( 75 )
Parent at risk/has AIDS/HIV	0 ( 0 )	0 ( 0 )	0 ( 0 )
Transfusion with blood/products	0 ( 0 )	1 ( 100 )	1 ( 25 )
None of the above/Other	0 ( 0 )	0 ( 0 )	0 ( 0 )
Total	3 ( 100 )	1 ( 100 )	4 ( 100 )
(% of all cases)	[ 75 ]	[ 25 ]	

AIDS RELATED COMPLEX (ARC)  
Surveillance Report - Oct 1, 1991

4. County of Residence	Cases ( % )	Deaths	1990 Census Population	Case Rate***
Apache	1 ( <1)	0	61,591	1.62
Cochise	8 ( 2)	0	97,624	8.19
Coconino	0 ( 0)	0	96,591	0.00
Gila	0 ( 0)	0	40,216	0.00
Graham	2 ( 1)	0	26,554	7.53
Greenlee	0 ( 0)	0	8,008	0.00
La Paz	0 ( 0)	0	13,844	0.00
Maricopa	320 ( 80)	31	2,122,101	15.08
Mohave	0 ( 0)	0	93,497	0.00
Navajo	0 ( 0)	0	77,658	0.00
Pima	61 ( 15)	7	666,880	9.15
Pinal	3 ( 1)	0	116,379	2.58
Santa Cruz	2 ( 1)	0	29,676	6.74
Yavapai	0 ( 0)	0	107,714	0.00
Yuma	2 ( 1)	0	106,895	1.84
Unknown	0 ( 0)	0	N/A	N/A
<b>Total</b>	<b>399 (100)</b>	<b>38</b>	<b>3,665,228</b>	<b>10.89</b>

5. Reported Cases of ARC and Case-Fatality Rates by Half-Year of Diagnosis.

Half-Year of Diagnosis	Number of Cases	Number of Deaths	Case-Fatality Rate
Before 1980	0	0	----
1980 Jan -June	0	0	----
July-Dec	0	0	----
1981 Jan -June	0	0	----
July-Dec	0	0	----
1982 Jan -June	0	0	----
July-Dec	1	0	0%
1983 Jan -June	0	0	----
July-Dec	0	0	----
1984 Jan -June	2	2	100%
July-Dec	0	0	----
1985 Jan -June	0	0	----
July-Dec	23	8	35%
1986 Jan -June	23	5	22%
July-Dec	21	5	24%
1987 Jan -June	38	2	5%
July-Dec	28	0	0%
1988 Jan -June	42	6	14%
July-Dec	67	5	7%
1989 Jan -June	52	1	2%
July-Dec	42	2	5%
1990 Jan -June	23	0	0%
July-Dec	17	0	0%
1991 Jan -June	17	2	12%
July-Oct 1	3	0	0%
<b>Totals</b>	<b>399</b>	<b>38</b>	<b>10%</b>

\* Case rate per 100,000 based on 1990 Census

ARIZONA HIV INFECTION SURVEILLANCE REPORT  
 Arizona Department of Health Services  
 Division of Disease Prevention  
 Oct 1, 1991

HIV INFECTION - ASYMPTOMATIC

1. Age	Cases ( % )	2. Race/Ethnicity	Adult/Adolescent Cases ( % )	Pediatric Cases ( % )	Total Cases ( % )
Under 5	12 ( 0 )	White, Not Hispanic	1918 ( 65 )	11 ( 61 )	1929 ( 65 )
5-12	6 ( 0 )	Black, Not Hispanic	246 ( 8 )	4 ( 22 )	250 ( 8 )
13-19	45 ( 2 )	Hispanic	368 ( 12 )	0 ( 0 )	368 ( 12 )
20-29	1042 ( 35 )	Asian/Pacific Is.	11 ( 0 )	0 ( 0 )	11 ( 0 )
30-39	1008 ( 34 )	Native American	35 ( 1 )	2 ( 11 )	37 ( 1 )
40-49	399 ( 13 )	Unknown	383 ( 13 )	1 ( 6 )	384 ( 13 )
Over 49	133 ( 4 )				
Unknown	334 ( 11 )	Total	2961 (100)	18 (100)	2979 (100)
Total	2979 (100)				

3. Adult/Adolescent Exposure Category	Males ( % )	Females ( % )	Total ( % )
Homosexual or bisexual Men	1372 ( 51 )	0 ( 0 )	1372 ( 46 )
Intravenous (IV) drug User	231 ( 9 )	78 ( 29 )	309 ( 10 )
Gay/Bi IV drug User	162 ( 6 )	0 ( 0 )	162 ( 5 )
Hemophiliac	31 ( 1 )	0 ( 0 )	31 ( 1 )
Heterosexual contact	23 ( 1 )	49 ( 18 )	72 ( 2 )
Transfusion with blood/products	46 ( 2 )	19 ( 7 )	65 ( 2 )
None of the above/Other*	829 ( 31 )	121 ( 45 )	950 ( 32 )
Total	2694 (100)	267 (100)	2961 (100)
[% of all cases]	[ 91 ]	[ 9 ]	

Pediatric Exposure Category	Males ( % )	Females ( % )	Total ( % )
Hemophiliac	3 ( 30 )	1 ( 13 )	4 ( 22 )
Parent at risk/has AIDS /HIV	7 ( 70 )	7 ( 88 )	14 ( 78 )
Transfusion with blood/products	0 ( 0 )	0 ( 0 )	0 ( 0 )
None of the above/Other	0 ( 0 )	0 ( 0 )	0 ( 0 )
Total	10 (100)	8 (100)	18 (100)
[% of all cases]	[ 56 ]	[ 44 ]	

\* This category largely consists of persons who could not be located/interviewed.

HIV INFECTION - ASYMPTOMATIC  
Surveillance Report - Oct 1, 1991

4. County of Residence	Cases ( % )	Deaths	1990 Census Population	Case Rate**
Apache	5 ( <1)	0	61,591	8.12
Cochise	44 ( 1)	0	97,624	45.07
Coconino	19 ( 1)	0	96,591	19.67
Gila	4 ( <1)	0	40,216	9.95
Graham	2 ( <1)	0	26,554	7.53
Greenlee	0 ( 0)	0	8,008	0.00
La Paz	8 ( <1)	0	13,844	57.79
Maricopa	1989 ( 67)	35	2,122,101	93.73
Mohave	26 ( 1)	0	93,497	27.81
Navajo	1 ( <1)	0	77,658	1.29
Pima	537 ( 18)	10	666,880	80.52
Pinal	24 ( 1)	0	116,379	20.62
Santa Cruz	4 ( <1)	0	29,676	13.48
Yavapai	28 ( 1)	1	107,714	25.99
Yuma	59 ( 2)	0	106,895	55.19
Unknown	229 ( 8)	2	N/A	N/A
<b>Total</b>	<b>2979 (100)</b>	<b>48</b>	<b>3,665,228</b>	<b>110</b>

5. Reported HIV Infection by Half-Year of Date Tested.

Half-Year Test date	Number of Cases	Additional*** Anonymous Cases
Testdate not reported	113	
1985 Jan -June	10	
July-Dec	21	
1986 Jan -June	49	
July-Dec	54	
1987 Jan -June	254	
July-Dec	426	
1988 Jan -June	379	
July-Dec	266	
1989 Jan -June	267	135
July-Dec	277	223
1990 Jan -June	312	255
July-Dec	299	211
1991 Jan -June	223	291
July-Oct 1	29	74
<b>Totals</b>	<b>2979</b>	<b>1189</b>

\*\* Case rate per 100,000 based on 1990 Census

\*\*\* On March 15, 1989, the option to receive HIV testing anonymously became available.

January 21, 1992

Senator Cindy Resnick, Co-Chair  
Representative Karen Mills, Co-Chair  
Joint Health Planning Committee on the Medically Uninsurable  
Arizona State Senate  
1700 W. Washington  
Phoenix, AZ 85007

Dear Senator Resnick, Representative Mills and Committee Members:

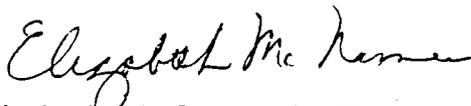
The subcommittee on Affordability of Health Care Reform met twice to discuss cost and its relationship to the availability of health care insurance which is affordable to individuals as well as to society as a whole.

The subcommittee was unanimous in its concern that major changes must occur in the way health care services are provided, used, and financed. Insurance reform, although an appropriate first step, is not sufficient in and of itself to assure the availability of affordable health care coverage. Therefore, we have compiled the attached list for the committee's consideration.

We regret not being able to present our findings in person, as we both are out of town. However, we appreciate the opportunity to present them to the committee and to enter them in the record.

Thank you very much for the opportunity to participate in this subcommittee.

Sincerely,



Elizabeth McNamee, Co-Chair



Kathy Haake, Co-Chair  
Subcommittee on Affordability of Health Care Reform

Attachment

# HEALTH CARE REFORM PROPOSALS

## ESSENTIAL ELEMENTS FOR EFFECTIVE, EFFICIENT CARE

### 1. A DEFINITION OF BASIC HEALTH CARE BENEFITS

Proposals should define core benefits which emphasize prevention, early intervention, and the efficacy of diagnostic and therapeutic services.

### 2. MANAGED, COORDINATED OR ORGANIZED SYSTEMS FOR DELIVERING CARE

Health care delivery arrangements should manage the volume and cost of services used by: a) reducing the need for care through the promotion of healthy lifestyles among their members and b) providing only those services necessary and appropriate to achieving a positive outcome from the care delivered.

### 3. ADMINISTRATIVE STREAMLINING

Simplify administrative processes. Uniformity of enrollment applications, provider numbers, credentialing, accreditation, claims forms, and data systems linkages are all keys to achieving a more streamlined health care administration.

### 4. INDIVIDUALS EDUCATED ABOUT AND INVOLVED IN MAKING HEALTH CHOICES

Individuals have personal responsibility for choosing behaviors which contribute to their health and well being and for using only those health care services which are necessary and appropriate.

### 5. USE OF GUIDELINES FOR CLINICAL PRACTICE

Practice guidelines should be used to reduce the wide variations in the care provided for the same condition when treated by different physicians. Guidelines should define the necessary and appropriate services required to reach an effective outcome for the patient. Practice of defensive medicine due to fear of liability should decline with the onset of practice guidelines. Physicians should foster an ethic of restraint in which they provide the most appropriate and cost efficient care.

### 6. COST CONTAINING FINANCIAL INCENTIVES

The financial incentives for payors, providers and consumers must be aligned to assure effective working partnerships which foster positive patient outcomes through the efficient use of resources.

### 7. REALIGNMENT OF SYSTEM WIDE RESOURCES

The entire health care system must be made more efficient and less redundant. Public policy should support the appropriate mix and distribution of health care personnel, facilities and technology.

JOINT LEGISLATIVE COMMITTEE ON MEDICALLY UNINSURABLE  
SUBCOMMITTEE ON ALLOCATION

Recommendation: Consideration of the NAIC Small Group Health Insurance Availability Act by the Arizona Legislature ("Allocation Program")

Rationale. Implementation of the Allocation program in Arizona will address the following concerns associated with small employer group health insurance:

1. Stabilize and moderate rate increases for high cost small groups who otherwise may be forced to terminate coverage.
2. Limit and make uniform pre-existing condition limitations periods within the small group market.
3. Portability. Employees who change employers may go without coverage for 30 days and not have to satisfy new pre-existing conditions.
4. Demands equity in the marketplace. Requires the private health insurance market to integrate high risk groups into their larger risk pool according to each carrier's pro rata market share.
  - Avoids burdensome and costly administrative requirements associated with a prospective reinsurance mechanism.
  - Avoids difficult, if not impossible, enforcement issues associated with prospective reinsurance.

Appendix G

Summary of NAIC Small Group Health Insurance Allocation  
Availability Act - Allocation Model.

## SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY MODEL ACT

### I. Rating and Renewal Standards

The primary effect of the "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups" model law would be to limit the range of premiums that can be charged for small group health insurance based on claims experience, health status or duration since issue. Limits would be placed on: 1) group-specific annual increases; 2) the maximum allowable difference between an insurer's highest and lowest rates within a class (block) of business; and 3) the variation in rates among all classes of an insurer's small group business.

#### Definition of Terms

**Small group coverage:** All group health insurance policies and contracts issued to small groups with no more than 25 eligible employees.

**Insurer/Carrier:** These terms are intended to include commercial insurers, Blue Cross and Blue Shield plans, multiple employer trusts, HMOs, discretionary groups, association groups, Taft-Hartley plans and similar insurance arrangements.

**Class of business:** All small group contracts in force with an insurer will be considered a single class of business unless one or more of the following requirements are met:

- Classes are marketed by clearly different sales forces;
- A class was acquired from another carrier;
- A class of coverage is provided through an association with membership of small employers that was established for a purpose other than obtaining health insurance; or
- A class meets the requirements for exception to the rating restriction that limits variations in rates between classes of business (described below).

Carriers could establish no more than two additional classes under each of these provisions on the basis of underwriting criteria that are expected to produce substantial variation in health care costs. Carriers also could apply to the insurance commissioner to establish a separate class of business.

Carriers could not involuntarily transfer a group into or out of a class of business unless all groups in the class were offered the opportunity to transfer, without regard to claims experience, health status or duration since issue.

**Base premium rate:** For each class of business, the lowest premium rate charged for the same or similar coverage to any small employer with similar case characteristics, other than claims experience, health status or duration since issue, as determined by the carrier.

**New business premium rate:** For each class of business, the premium rate charged or offered for newly issued coverage that is the same or similar for any small employer with similar case characteristics, other than claims experience, health status or duration since issue, as determined by the carrier.

**Index rate:** The arithmetic average of the base premium rate and the highest premium rate charged for the same or similar coverage to small employers with similar case characteristics other than claims experience, health status or duration since issue, for each class of business.

#### Small Group Rating Restrictions

**Annual Rate Change Limitation:** Within a class, no group can receive an annual rate increase in excess of the percentage increase in the new business premium rate plus 15 percent for claims experience, health status or duration since issue, plus adjustments for any changes in the coverage of the group and/or changes in case characteristics. If a group is in a closed class, then the percentage change in the base premium rate is used in place of the change in the new business premium rate.

**Limitation on Rate Differences Within a Class:** Within a class, rates charged to groups with similar case characteristics can be no more than 25 percent above or below the index rate for that class.

**Limitation on Differences in Rates Between Classes of Business:** If an insurer has two or more classes of business, the index rate for any class of business cannot be more than 20 percent above or below the index rate for any other class of business.

- **Exception for Non-Underwritten Classes:** This rating restriction does not apply to classes of business for which the carrier does not and never has rejected small employers based on claims experience or health status. Such business must be currently available for purchase and these carriers can not more groups from underwritten classes to these non-underwritten classes without the group's consent.

**Application to Existing Business:** For coverage issued prior to the effective date of the model act, rates may exceed the limits on rate differences within and between classes of business for a five-year period. In such cases, annual premium increases would be limited to the percentage change in the new business premium rate plus any adjustments due to changes in the coverage of the group and/or changes in case characteristics. (If that class of business is closed, the percentage change in the base premium rate would be used in place of the change in the new business premium rate.)

The model law allows insurers to ask regulators for permission to deviate from these restrictions, where warranted.

#### Disclosure Requirements

Carriers must disclose the following information in their sales materials:

- Factors used in determining initial and renewal rates, including claims experience, health status, duration since issue and other factors;
- Provisions concerning carriers' rights to change premium rates;
- Description of the class in which a small employer would be included; and
- Renewability provisions.

#### Actuarial Certification

Carriers must maintain detailed descriptions of their rating and renewal underwriting practices, which must be made available to the Insurance Commissioner, upon request.

Carriers must file an annual actuarial certification that they are in compliance with the requirements of the model act, and that their rating and underwriting practices are sound.

- **Restrictions on Renewal Practices**

Carriers could not refuse to renew small group coverage except for nonpayment of premiums, fraud or misrepresentation, noncompliance with plan provisions, failure to meet participation requirements or if the small employer is no longer actively engaged in the business it was engaged in when the coverage was issued.

Carriers would retain the right to cancel whole classes of business. But if they exercise this right, they must give 90 days notice to all of the groups within that class and they may not establish a new class of business for five years, unless approved by the Insurance Commissioner. Additionally, if any group is allowed to transfer into another class, all of the groups in the class must be given the same opportunity to transfer without regard to their claims experience, health status, or duration since issue.

## II. Establishment of an Allocation Program to Spread High Risk Groups

Description: Under the Allocation approach, insurers would be required to accept otherwise uninsurable groups through placement by a state program. Small employers found to be uninsurable by an insurer would register with a state program and be allowed to select coverage under rules set up to assure fair distribution of such groups among all small group insurers in the state. All insurers would have to comply with the rating and consumer protection requirements.

- Eligibility is limited to groups with uninsurable individuals
- Carriers receive allocated groups according to market share.

### Example of How the Allocation Mechanism Would Work

STEP 1. Estimate the first year's allocations.

In 200 groups consisting of 1,000 individuals, 20% (200) are expected to be uninsurable and 80% (800) are expected to be insurable.

STEP 2. Assign small group carriers target number of individuals based on market share.

In the example above, a carrier with a 50% market share could expect an allocation of approximately 500 individuals, of which 100 would be uninsurable and 400 would be insurable. This proportion exists whether the carrier has groups averaging under 5 lives or groups averaging over 20 lives.

STEP 3. Allocation process.

After rejection by two carriers due to medical conditions, an employer would select a carrier from its choice of carriers. As carriers received allocated groups, their totals would be updated. When a carrier reached its target, it would no longer have to take on new groups.

At the end of the allocation period, targets would be revised for the next allocation period. If experience showed that the total number of allocated individuals or the overall proportion of uninsurables to insurables was significantly higher (or lower) than originally estimated, future targets will be revised accordingly. Targets can also be revised based on estimated claims volume attributed to the uninsurable risks.

Rationale:

- This approach provides states with an alternative to guaranteed issue with a reinsurance mechanism. The reinsurance approach is untested, costly to administer and difficult to regulate, and may require additional financing arrangements if the pool gets too large.
- High risk groups would be spread through the insurance market equitable among all small group insurers. The risks are spread directly on the front end, instead of indirectly under a reinsurance approach.
- Carriers would be encouraged to manage the care of high-risk groups and individuals because the entire risk of these cases would be retained by each carrier. This would not be the case with reinsurance.
- Allocation is simple and less expensive to administer because it does not require the establishment of a complex and costly reinsurance mechanism. The administrative costs associated with a reinsurance mechanism are avoided.
- Enforcement is easier because it is simpler and does not require monitoring of the marketing, acceptance and reinsurance processes of carriers that would be required under a guaranteed issue approach.
- The number of current uninsurables are relatively small. In a recent University of Minnesota study, only 2.5 percent of all uninsured individuals were uninsured because they were rejected by insurers. 97.5 percent were uninsured for other reasons -- primarily affordability. The allocation approach addresses this small but important problem without creating a large complex reinsurance mechanism.

Sub-committee on medically uninsurable: individual solutions.

We recognize the medically uninsurable are already a burden to the state. After being refused health insurance, the costs of their care first impoverish the uninsured and eventually qualify them for welfare programs when they become poor or sick enough.

The medically uninsurable cost Arizona businesses, taxpayers and citizens millions each year. The cost of their care is reflected in higher doctors fees, higher hospital costs and growth in the numbers of the AHCCCS Medically Needy/Medically Indigent. This group of public health recipients is often costly and now at risk of being further curtailed in difficult economic times.

The sub-committee examined several solutions for the medically uninsurable who are able and willing to pay for their health care coverage and monitor their health condition in full partnership with providers.

Please note that these recommendations are based upon the assumption that small employer groups' denials of coverage based on medical uninsurability of their employees or dependents will be dealt with by a method that addresses the needs of employer groups of three (3) or more workers.

1. Buy in to Health Care Group

In three Arizona counties (Cochise, Pima and Maricopa) a state subsidized health maintenance organization is available to small employer groups of 1 or more employees: Health Care Group.

Individuals and their families cannot purchase this plan unless they operate a business.

Health Care Group is not permitted to medically underwrite; charging higher rates or refusing coverage to people with pre-existing medical conditions or people who are at risk of developing them.

AHCCCS, its host agency, and Health Care Group are reluctant to allow medically uninsurable individuals a buy in to this health insurance option because of the possible expense and the fact that Health Care Group was not created for this purpose and likely would not be able to sustain the current rates.

Sub-committee recommendations:

a. Health Care Group should not compete with the private health insurance market. It is a publicly subsidized option and should only fill a niche that cannot otherwise be met by the industry; nevertheless, Health Care Group should be established as a statewide option:

b. allow businesses and employers to purchase Health Care Group coverage without any waiting period when an

uninsurable employee or dependent significantly increases their health insurance costs or forces them to purchase significantly lesser coverage than Health Care Group. This recommendation is based on the assumption that groups of 3 or more workers are to be addressed by other sub-committees, so this item is appropriate as an unmet need in the small employer market.

## 2. Buy\_in to AHCCCS

Arizona's statewide Medicaid program: the Arizona Health Care Cost Containment System has over 370,000 members. They are bid geographically as a group for federally mandated and other coverage contained in the State Plan.

AHCCCS is willing to accept medically uninsurable individuals if their costs are recognized separately and borne by funding other than agency allocated general, county and federal funds.

### Sub-committee recommendations:

- a. allow individuals and families who have no other options to purchase coverage from AHCCCS;
- b. prevent dumping of medically uninsurable employees by employers who cover their other workers in comparable categories;
- c. establish benefits and coverage comparable to high risk pools in other states;
- d. establish premium rates comparable to high risk pools in other states;
- e. provide medical case management for very high risk cases.

## 3. High Risk Pool

Arizona is unique in relation to other states as we already have a managed care mechanism that is bid as a pool for our Medicaid population; other states use primarily fee-for-service systems.

Therefore to create an insurance "ghetto" of the medically uninsurable means this group will eventually be expensive as a stand alone population. As such, a high risk pool will need extraordinary cost containment controls and limited choices for participants.

Other states have already limited coverage or capped enrollment. Despite the definition of pre-existing medical condition, some diseases are being excluded or their benefits curtailed.

### Sub-committee recommendation:

- a. we feel the creation of another pool is duplicative and prefer to include this population in either AHCCCS or the

State Employee pool.

4. Buy in to the State Employee Pool

Arizona contracts for health insurance for over 30,000 employees and dependents. The cost for single coverage is approximately \$190 per person per month. The Department of Administration is unable to project the effects of allowing the medically uninsurable to participate in this group. However, the testimony given to the committee indicated that this rate is in excess of what many firms pay.

Sub-committee recommendation:

a. the state should examine its own practices in collecting bids for state employee health insurance as cost savings may be realized by self-insurance or other recognized employer/employee benefit negotiations:

b. should cost savings be realized, we prefer the amount be designated toward subsidizing health insurance programs for the medically uninsurable.

Respectfully submitted:

Rep. Ruth Eskesen  
Sen. Jim Buster  
Rep. Peter Goudinoff

Ms. Barbara Honkins  
Ms. Phyllis Ethridge  
Ms. Raena Honan

Appendix I

Prospective Reinsurance Model Subcommittee findings.

JOINT HEALTH INSURANCE PLANNING COMMITTEE ON THE MEDICALLY UNINSURABLE

REPORT OF THE

SUB-COMMITTEE ON THE PROSPECTIVE REINSURANCE MODEL

DATE: January 21, 1992

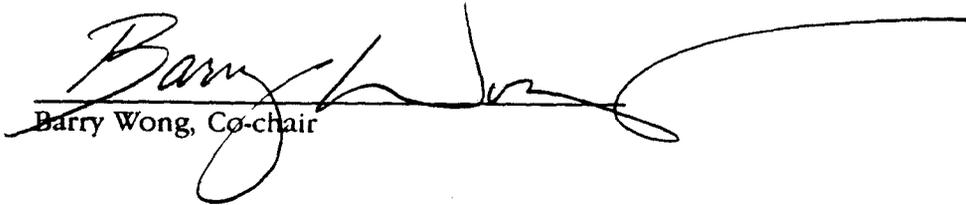
TO: THE JOINT HEALTH INSURANCE PLANNING COMMITTEE ON THE MEDICALLY  
UNINSURABLE  
Senator Cindy Resnick, Co-chair  
Representative Karen Mills, Co-chair

At the request of the Co-chairs of The Joint Health Insurance Planning Committee on the Medically Uninsurable, the Sub-committee on the Prospective Reinsurance Model, after conducting a public hearing, recommends the following:

In light of the complexities of both the Prospective Reinsurance and Allocation Models for increasing the availability of health insurance coverage to small employer groups and in light of the comprehensive changes which will result to the current system of providing health insurance to small employer groups, both models should be studied and analyzed further.

SUB-COMMITTEE ON THE PROSPECTIVE REINSURANCE MODEL

\_\_\_\_\_  
Senator Jim Buster, Co-chair

  
\_\_\_\_\_  
Barry Wong, Co-chair

REPORT OF THE  
SUB-COMMITTEE ON THE PROSPECTIVE REINSURANCE MODEL

I. BACKGROUND

The Joint Health Insurance Planning Committee on the Medically Uninsurable was established to study the issue of the medically uninsurable population in the state and to propose recommendations which would increase the availability of health insurance to this population. The Joint Committee convened a public hearing to address the medically uninsurable population from the perspective of individual as well as small employer uninsurables. The Joint Committee created several sub-committees to address various issues. One of those sub-committees is the Sub-committee on the Prospective Reinsurance Model for small employer group reform.

II. SUB-COMMITTEE HEARING

The Sub-committee on the Prospective Reinsurance Model held one public hearing on January 20, 1992, to receive public testimony regarding the Prospective Reinsurance Model for small employer group reform. The Sub-committee received testimony from Barry Wong, Regional Vice President, Government Affairs, CIGNA Companies; Andrea Lazar, Blue Cross and Blue Shield of Arizona; Jan Doughty, insurance broker; Rena Honan, Association for Retarded Citizens. Mr. Wong provided a presentation on the Prospective Reinsurance Model for Small Employer Group Reform. He provided details of the provision within that model and reasons that the prospective reinsurance model is the best approach for making health insurance coverage more available to employers with between 3 and 25 employees. Further, he provided reasons why the alternative approach, the allocation model, would not be to the best interest of the small employer groups.

Ms. Lazar responded to Mr. Wong's remarks regarding the prospective reinsurance model and addressed the allocation model.

It was agreed among the Sub-committee members that both the prospective reinsurance model and the allocation model are similar in many ways, in that it would increase the availability of health insurance coverage to small employer groups. Further, both models would place limits on pre-existing condition limitations, guarantee renewability of coverage and place restrictions on premium rates. The main difference between the models, as was addressed by the Sub-committee, is the method in which risk is shared among insurance carriers.

III. SUB-COMMITTEE RECOMMENDATION

The Sub-committee on the Prospective Reinsurance Model recommends that both the Prospective Reinsurance and Allocation Models be studied and analyzed further before a final determination is made on which model to adopt for this state.

IV. ATTACHMENTS

Attachment A: Summary of provisions on the Prospective Reinsurance Model  
Attachment B: NAIC Prospective Reinsurance Model

**Appendix J**

Summary of the NAIC Prospective Reinsurance Model.

**Major Provisions  
of the  
NAIC Prospective Reinsurance Model**

1. Guaranteed Issuance. Guarantees issuance of at least a basic health plan to employers of 3 to 25 employees who apply to any carrier selling small employer insurance.
2. Restricts Pre-existing Conditions Limitation (PCL). PCL can only be imposed once, i.e., portable PCL: an individual, once eligible for a plan, must only satisfy a PCL once in continuous employment lifetime.
3. Guarantees Renewability. Guarantees renewability of health plans unless the employer does not meet the contractual requirements, i.e., failing to pay premiums or meet plan requirements or is guilty of fraud.
4. Rate Restrictions. Imposes rate restrictions at initial issuance and at renewal.

**Risk Sharing Mechanism: Reinsurance**

Carriers may elect to opt-out of this risk sharing mechanism, known as reinsurance, by agreeing to assume the risk.

Carriers electing to not opt-out of reinsurance would be subject to the following provisions:

- A. Carriers can reinsure individuals or groups.
- B. Carriers pay a premium to the reinsurance pool for groups or individuals ceded:
  - (i) 500% of the average rate, for individuals ceded.
  - (ii) 150% of the average rate, for groups ceded.
  - (iii) Other variations.
- C. Carriers retain first \$5,000 of claims per individual per year.
- D. Excess losses to the reinsurance pool is offset by a two-tier assessment system:
  - (i) Losses up to 5% of total small group premium are spread to carriers in the small case marketing participating in the reinsurance pool, according to market share.
  - (ii) Additional losses covered by a broad-based funding source.

Appendix K

Small employer Health Insurance Availability Model Act -  
Prospective Reinsurance With or Without an Opt-Out.

12/11/91  
1:30 a.m.

**SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY MODEL ACT  
(PROSPECTIVE REINSURANCE WITH OR WITHOUT AN OPT-OUT)**

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Section 1.	Short Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Applicability and Scope
Section 5.	Establishment of Classes of Business
Section 6.	Restrictions Relating to Premium Rates
Section 7.	Renewability of Coverage
Section 8.	Availability of Coverage
Section 9.	Notice of Intent to Operate as a Risk-Assuming Carrier or a Reinsuring Carrier
Section 10.	Application to Become a Risk-Assuming Carrier
Section 11.	Small Employer Carrier Reinsurance Program
Section 12.	Health Benefit Plan Committee
Section 13.	Periodic Market Evaluation
Section 14.	Waiver of Certain State Laws
Section 15.	Administrative Procedures
Section 16.	Standards to Assure Fair Marketing
Section 17.	Separability
Section 18.	Effective Date

**Section 1. Short Title**

This Act shall be known and may be cited as the Small Employer Health Insurance Availability Act.

**Section 2. Purpose**

The purpose and intent of this Act are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of "basic" and "standard" health benefit plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

This Act is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

**Section 3. Definitions**

As used in this Act:

- A. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a small employer carrier is in compliance with the provisions of Section 6 of this Act, based

upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

- B. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.
- C. "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to Section 12.
- D. "Board" means the board of directors of the program established pursuant to Section 11.
- E. "Carrier" means any entity that provides health insurance in this state. For the purposes of this Act, carrier includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

**Drafting Note:** The term "multiple employer welfare arrangement" should be added to the list of carriers in those states that have separate certificates of authority for such arrangements.

In states that do not have separate licenses for self-funded multiple employer welfare arrangements, such arrangements should be treated as unauthorized insurers. States should enforce their laws against transaction of unauthorized insurance against such unauthorized self-funded multiple employer welfare arrangements.

- F. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this Act.
- G. "Class of business" means all or a separate grouping of small employers established pursuant to Section 5.
- H. "Commissioner" means the Insurance Commissioner of this state.

**Drafting Note:** Where the word "Commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

- I. "Committee" means the Health Benefit Plan Committee created pursuant to Section 12.
- J. "Dependent" shall be defined in the same manner as [insert reference to state insurance law defining dependent]

**Drafting Note:** States without a statutory definition of dependent may wish to use the following definition:

"Dependent" means a spouse or an unmarried child under the age of nineteen [19] years; an

unmarried child who is a full-time student under the age of (insert maximum age) and who is financially dependent upon the parent; and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

**Drafting Note:** States should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law.

- K. "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis.
- L. "Established geographic service area" means a geographical area, as approved by the Commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
- M. "Health benefit plan" means any hospital or medical policy or certificate, (insert reference to subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan), or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.
- N. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.
- O. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, provided that such initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:
  - (1) The individual meets each of the following:
    - (a) The individual was covered under qualifying previous coverage at the time of the initial enrollment;
    - (b) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse or divorce;
    - (c) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage;
  - (2) The individual is employed by an employer that offers multiple health benefit

plans and the individual elects a different plan during an open enrollment period; or

(3) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

P. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

Q. "Plan of operation" means the plan of operation of the program established pursuant to Section 11.

R. "Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

S. "Producer" means [incorporate reference to definition in state's law for licensing producers].

**Drafting Note:** States that have not adopted the NAIC Single License Procedure Model Act should substitute the terms "agent" and/or "broker" for the term "producer" as appropriate.

T. "Program" means the (State) Small Employer Reinsurance Program created pursuant to Section 11.

U. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

V. "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to Section 11.

W. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate reference to state laws regulating health maintenance organizations and preferred provider organizations or arrangements] to provide health care services to covered individuals.

**Drafting Note:** States should modify this subsection to make reference to the types of restricted network arrangements authorized in the state.

X. "Risk-assuming carrier" means a small employer carrier whose application is approved by the Commissioner pursuant to Section 10.

**Drafting Note:** Delete Subsections V and X if participation in the reinsurance program is mandatory.

Y. "Small employer" means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than twenty-five (25) eligible employees, the majority of whom were employed within this state. In determining the

number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

**Drafting Note:** States may wish to consider a different threshold number of employees for the purposes of defining "small employer," depending on the underwriting and marketing practices in the state and other relevant factors.

- Z. "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.
- AA. "Standard health benefit plan" means a health benefit plan developed pursuant to Section 12.
- BB. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
- CC. "Control" shall be defined in the same manner as (insert reference to state law corresponding to NAIC Model Holding Company Act).
- DD. "Qualifying previous coverage" and "Qualifying existing coverage" mean benefits or coverage provided under --
  - (1) Medicare or Medicaid;
  - (2) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or
  - (3) An individual health insurance policy (including coverage issued by a health maintenance organization, (insert appropriate reference for a prepaid hospital or medical care plan) and (insert appropriate reference for a fraternal benefit society)) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one year.

#### **Section 4. Applicability and Scope**

This Act shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

- A. Any portion of the premium or benefits is paid by or on behalf of the small employer;
- B. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or
- C. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code.

**Drafting Note:** In some cases, individual health benefit plans sold to small employers could be subject both to the provisions of this Act and to the provisions of the state's laws for individual health insurance. A state should consider whether inconsistencies in regulatory standards would result, especially in the provisions relating to premium rates. A state may wish to consider exempting individual health benefit plans from the rating provisions of this Act.

- D. (1) Except as provided in Paragraph (2), for the purposes of this act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this act shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.
- (2) An affiliated carrier that is a health maintenance organization having a certificate of authority under (insert reference to state health maintenance organization licensing act) may be considered to be a separate carrier for the purposes of this act.
- (3) Unless otherwise authorized by the Commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. (The provisions of (insert applicable reference to state law on assumption reinsurance) shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.)

**Drafting Note:** The language in brackets should be included in states that have enacted laws regulating assumption reinsurance.

#### **Section 5. Establishment of Classes of Business**

- A. A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:
  - (1) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;
  - (2) The small employer carrier has acquired a class of business from another small employer carrier; or
  - (3) The small employer carrier provides coverage to one or more association groups that meet the requirements of (insert appropriate statutory reference to Section 2E of the NAIC Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act).
- B. A small employer carrier may establish up to nine (9) separate classes of business under Subsection A.
- C. The Commissioner may establish regulations to provide for a period of transition in

order for a small employer carrier to come into compliance with Subsection B in the instance of acquisition of an additional class of business from another small employer carrier.

D. The Commissioner may approve the establishment of additional classes of business upon application to the Commissioner and a finding by the Commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

Section 6. Restrictions Relating to Premium Rates

Drafting Note: States that already have adopted the NAIC Model Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Employers Model Act will have provisions that substantially duplicate the provisions of this section. Some of the provisions in this model, however, are more favorable to policyholders and states may wish to modify their laws to conform to the provisions in this section.

A. Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:

- (1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).
- (2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

- (a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(b) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(4) Adjustments in rates for claim experience, health status and duration of

(10) A small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size without

(9) For the purpose of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(b) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(a) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business.

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(7) In the case of health benefit plans delivered or issued for delivery prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges set forth in Subsections A(1) and (2) for a period of three (3) years following the effective date of this Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(6) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent (15%).

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to Section 11.

coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

prior approval of the Commissioner.

- (11) The Commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this act, including:
- (a) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and.
  - (b) Prescribing the manner in which case characteristics may be used by small employer carriers.
- B. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.
- C. The Commissioner may suspend for a specified period the application of Subsection A(1) as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the Commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.
- D. In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:
- (1) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;
  - (2) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;
  - (3) The provisions relating to renewability of policies and contracts; and
  - (4) The provisions relating to any preexisting condition provision.
- E. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

- (2) Each small employer carrier shall file with the Commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.
- (3) A small employer carrier shall make the information and documentation described in Subsection E(1) available to the Commissioner upon request. Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

### **Section 7. Renewability of Coverage**

**Drafting Note:** States that already have adopted the NAIC Model Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Employers Model Act will have provisions that substantially duplicate the provisions of this section. Some of the provisions in this model, however, are more favorable to policyholders and states may wish to modify their laws to conform to the provisions in this section.

- A. A health benefit plan subject to this Act shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:
  - (1) Nonpayment of the required premiums;
  - (2) Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;
  - (3) Noncompliance with the carrier's minimum participation requirements;
  - (4) Noncompliance with the carrier's employer contribution requirements;
  - (5) Repeated misuse of a provider network provision; or
  - (6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:
    - (a) Provide advance notice of its decision under this paragraph to the Commissioner in each state in which it is licensed; and
    - (b) Provide notice of the decision not to renew coverage to all affected small employers and to the Commissioner in each state in which an affected covered individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the Commissioner under this subparagraph shall be provided at least three (3) working days prior to the notice to the affected small

(ii) The criteria are applied consistently to all small employers applying for coverage in the class of business; and

(iii) The criteria are not related to the health status or claim experience of the small employer;

(iv) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(v) The criteria are not intended to discriminate against a class of business, provided that reasonable criteria in determining whether to accept a small employer of business so established. A small employer carrier may apply benefit plan and at least one standard health benefit plan in each class maintain and issue to eligible small employers at least one basic health class of business pursuant to Section 5, the small employer carrier shall in the case of a small employer carrier that establishes more than one

(2) (a) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act.

(1) A. Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers at least two (2) health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan.

Section 8. Availability of Coverage

C. In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier's operations in such service area.

B. A small employer carrier that elects not to renew a health benefit plan under Subsection A(6) shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the Commissioner.

In such instance the Commissioner shall assist affected small employers in finding replacement coverage.

(b) Impair the carrier's ability to meet its contractual obligations.

(a) Not be in the best interests of the policyholders or certificate holders; or

(7) The Commissioner finds that the continuation of the coverage would:

employers.

- (iv) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of this subparagraph shall not apply to a class of business into which the small employer carrier is no longer enrolling new small employers.

- (3) A small employer is eligible under Paragraph (2) if it employed at least three (3) or more eligible employees within this state on at least fifty percent (50%) of its working days during the preceding calendar quarter.

**Drafting Note:** The minimum group size of three (3) is included to protect small employer carriers from excessive adverse selection.

- (4) The provisions of this subsection shall be effective 180 days after the Commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to Section 12, provided that if the Small Employer Health Reinsurance Program created pursuant to Section 11 is not yet in operation on such date, the provisions of this paragraph shall be effective on the date that such program begins operation.

- B. (1) A small employer carrier shall file with the Commissioner, in a form and manner prescribed by the Commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the Commissioner disapproves its use.

- (2) The Commissioner at any time may, after providing notice and an opportunity for a hearing to a small employer carrier, disapprove the continued use by the small employer carrier of a basic or standard health benefit plan on the grounds that such plan does not meet the requirements of this Act.

- C. Health benefit plans covering small employers shall comply with the following provisions:

- (1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

- (a) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;

- (b) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or

- (c) A pregnancy existing on the effective date of coverage.

- (2) A health benefit plan shall waive any time period applicable to a preexisting

condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not less than thirty (30) days prior to the effective date of the new coverage. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

- (3) A health benefit plan may exclude coverage for late enrollees for the greater of eighteen (18) months or for an eighteen-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months from the date the individual enrolls for coverage under the health benefit plan.
- (4)
  - (a) Except as provided in Subparagraph (d), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.
  - (b) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.
  - (c)
    - (i) Except as provided in Clause (iii), in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.
    - (ii) With respect to a small employer (with ten (10) or fewer eligible employees), a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

**Drafting Note:** In determining whether to include the bracketed language, states should consider the impact of dual choice on small employer carriers in relationship to both the number of health maintenance organizations in the state and the effect on small employers and their employees.

- (d) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.
- (5)
  - (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer

carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in Paragraph (3).

(b) A small employer carrier shall not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

D. (1) A small employer carrier shall not be required to offer coverage or accept applications pursuant to Subsection A in the case of the following:

(a) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;

(b) To an employee, when the employee does not work or reside within the carrier's established geographic service area; or

(c) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(2) A small employer carrier that cannot offer coverage pursuant to Paragraph (1)(c) may not offer coverage in the applicable area to new cases of employer groups with more than twenty-five (25) eligible employees or to any small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employer groups.

E. A small employer carrier shall not be required to provide coverage to small employers pursuant to Subsection A for any period of time for which the Commissioner determines that requiring the acceptance of small employers in accordance with the provisions of Subsection A would place the small employer carrier in a financially impaired condition.

#### Section 9. Notice of Intent to Operate as a Risk-Assuming Carrier or a Reinsuring Carrier

A. (1) Each small employer carrier shall notify the Commissioner within thirty (30) days of the effective date of this Act of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to Section 10.

(2) The decision shall be binding for a five-year period except that the initial decision shall be made within thirty (30) days of the effective date of this Act and shall be made for two (2) years. The Commissioner may permit a carrier to modify its decision at any time for good cause shown.

(3) The Commissioner shall establish an application process for small employer

carriers seeking to change their status under this subsection.

- B. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

Drafting Note: Delete this section if participation in the reinsurance program is mandatory.

#### Section 10. Application to Become a Risk-Assuming Carrier

- A. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the Commissioner in a form and manner prescribed by the Commissioner.
- B. The Commissioner shall consider the following factors in evaluating an application filed under Subsection A:
- (1) The carrier's financial condition;
  - (2) The carrier's history of rating and underwriting small employer groups;
  - (3) The carrier's commitment to market fairly to all small employers in the state or its established geographic service area, as applicable; and
  - (4) The carrier's experience with managing the risk of small employer groups.
- C. The Commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the Commissioner, the carrier may request a hearing.
- D. The Commissioner may rescind the approval granted to a risk-assuming carrier under this section if the Commissioner finds that:
- (1) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with Section 8 without the protection afforded by the program;
  - (2) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or
  - (3) The carrier has failed to provide coverage to eligible small employers as required in Section 8.
- E. A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of Section 11.

Drafting Note: States should consider establishing special rules for carriers whose charter and bylaws place limits on the types or kinds of individuals that can be insured by the carrier. Such carriers should be permitted to operate as risk-assuming carriers, provided that they accept all eligible small employers.

regardless of health status or claims experience, that would be eligible for coverage pursuant to the charter and bylaws of the carrier.

Drafting Note: Delete this section if participation in the reinsurance program is mandatory.

**Section 11. Small Employer Carrier Reinsurance Program**

- A. A reinsuring carrier shall be subject to the provisions of this section.

Drafting Note: Delete Subsection A if participation in the reinsurance program is mandatory.

- B. There is hereby created a nonprofit entity to be known as the (insert name of state) Small Employer Health Reinsurance Program.
- C. (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of Paragraph (2), the board shall consist of (eight) members appointed by the Commissioner plus the Commissioner or his or her designated representative, who shall serve as an ex officio member of the board.
- (2) (a) In selecting the members of the board, the Commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the Commissioner. At least five of the members of the board shall be representatives of reinsuring carriers and shall be selected from individuals nominated by small employer carriers in this state pursuant to procedures and guidelines developed by the Commissioner.
- (b) In the event that the program becomes eligible for additional financing pursuant to Subsection L(4), the board shall be expanded to include two additional members who shall be appointed by the Commissioner. In selecting the additional members of the board, the Commissioner shall choose individuals who represent (include reference to representatives of sources for additional financing identified in Subsection L(4)(d)(iii)). The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing under Subsection L(4).
- (3) The initial board members shall be appointed as follows: one-third of the members to serve a term of two years; one-third of the members to serve a term of four years; and one-third of the members to serve a term of six years. Subsequent board members shall serve for a term of three years. A board member's term shall continue until his or her successor is appointed.
- (4) A vacancy in the board shall be filled by the Commissioner. A board member may be removed by the Commissioner for cause.
- D. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a filing with the Commissioner containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

- E. Within 180 days after the appointment of the initial board, the board shall submit to the Commissioner a plan of operation and thereafter any amendments thereto necessary or suitable, to assure the fair, reasonable and equitable administration of the program. The Commissioner may, after notice and hearing, approve the plan of operation if the Commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon approval in writing by the Commissioner.
- F. If the board fails to submit a suitable plan of operation within 180 days after its appointment, the Commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The Commissioner shall amend or rescind any plan so adopted under this subsection at the time a plan of operation is submitted by the board and approved by the Commissioner.
- G. The plan of operation shall:
- (1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the Commissioner;
  - (2) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;
  - (3) Establish procedures for reinsuring risks in accordance with the provisions of this section;
  - (4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and
  - (5) Provide for any additional matters necessary for the implementation and administration of the program.
- H. The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:
- (1) Enter into contracts as necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the Commissioner, to enter into contracts with similar programs in other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;
  - (2) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;
  - (3) Take any legal action necessary to avoid the payment of improper claims against the program;

- (4) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Act;
- (5) Establish rules, conditions and procedures for reinsuring risks under the program;
- (6) Establish actuarial functions as appropriate for the operation of the program;
- (7) Assess reinsuring carriers in accordance with the provisions of Subsection L, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year;
- (8) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and
- (9) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

**I. A reinsuring carrier may reinsure with the program as provided for in this subsection:**

- (1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.
- (2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan.
- (3) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the coverage with the small employer. A newly eligible employee or dependent of a reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage.
- (4)
  - (a) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10% of the next \$50,000 of incurred claims during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subparagraph shall not exceed a maximum limit of \$10,000 in any one calendar year with respect to any reinsured individual.
  - (b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs

and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the Commissioner approves a lower adjustment factor.

- (5) A small employer carrier may terminate reinsurance for one or more of the reinsured employees or dependents of a small employer on any plan anniversary.
- (6) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that are more restrictive than those specified in Paragraph (4), shall be reduced to reflect that portion of the risk above the amount set forth in Paragraph (4) that may not be ceded to the program, if any.]

**Drafting Note:** Federal law prohibits federally-qualified health maintenance organizations from reinsuring the first \$5000 of covered benefits. States that adopt an initial retention level of less than \$5000 under Paragraph (4) should include the above language.

- J. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, which shall be multiplied by the factors set forth in Paragraph (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the Commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan.
- (2) Premiums for the program shall be as follows:
  - (a) An entire small employer group may be reinsured for a rate that is one and one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this paragraph.
  - (b) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant this paragraph.
- (3) The board periodically shall review the methodology established under Paragraph (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the Commissioner.

- K. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 6.
- L.
- (1) Prior to March 1 of each year, the board shall determine and report to the Commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.
  - (2) Any net loss for the year shall be recouped by assessments of reinsuring carriers.
    - (a) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:
      - (i) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and
      - (ii) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during such calendar year to small employers in this state by reinsuring carriers.
    - (b) The formula established pursuant to Subparagraph (a) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than 150% of an amount which is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.
    - (c) The board may, with approval of the Commissioner, change the assessment formula established pursuant to Subparagraph (a) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to premiums from all health benefit plans and to premiums from newly issued health benefit plans to vary during a transition period.
    - (d) Subject to the approval of the Commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.
    - (e) Premiums and benefits paid by a reinsuring carrier that are less than an

amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

- (3) (a) Prior to March 1 of each year, the board shall determine and file with the Commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.
- (b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in Subparagraph (c), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the Commissioner within 90 days following the end of the calendar year in which the losses were incurred. The evaluation shall include: an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file report with the Commissioner within 90 days following the end of the applicable calendar year, the Commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the Commissioner deems necessary to reduce future losses and assessments.
- (c) For any calendar year, the amount specified in this subparagraph is five percent (5%) of total premiums earned in the previous year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.
- (d) (i) If assessments in each of two consecutive calendar years exceed the amount specified in Subparagraph (c), the program shall be eligible to receive additional financing as provided in Clause (ii).
- (ii) The additional financing provided for in Clause (i) shall be obtained from (the state should specify one or more sources of additional revenue to fund the program. States may wish to consider the alternative revenue sources provided in the NAIC Model Health Plan for Uninsurable Individuals Model Act). The amount of additional financing to be provided to the program shall equal to the amount by which total assessments in the preceding two calendar years exceeds five (5%) of total premiums earned during that period from small employers from health benefit plans delivered or issued for delivery in this state by reinsuring carriers. If the program has received additional financing in either of the two previous calendar years pursuant to this subparagraph, the amount of such additional financing shall be subtracted from the amount of total assessments for the purposes of the calculation in the previous sentence.
- (iii) Additional financing received by the program pursuant to this subparagraph shall be distributed to reinsuring carriers in

proportion to the assessments paid by such carriers over the previous two calendar years.

**Drafting Note:** The purpose of the five percent (5%) limitation is to prevent the program from placing too heavy of a burden on the small employer marketplace. States could also consider suspending the guarantee issue provision in Section 8 if assessments exceed the five percent (5%) threshold.

- (4) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.
  - (5) Each reinsuring carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.
  - (6) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.
  - (7) A reinsuring carrier may seek from the Commissioner a deferment from all or part of an assessment imposed by the board. The Commissioner may defer all or part of the assessment of a reinsuring carrier if the Commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving such deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups in the program until such time as it pays such assessments.
- M. Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.
- N. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration: the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.
- O. The program shall be exempt from any and all taxes.

#### **Section 12. Health Benefit Plan Committee**

- A. The (Commissioner/governor) shall appoint a Health Benefit Plan Committee. The committee shall be composed of representatives of carriers, small employers and employees, health care providers and producers.

**Drafting Note:** A state may wish to add a representative of third-party administrators to the committee membership.

- B. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to Section 8.
- C. The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.
  - (1) The plans recommended by the committee may include cost containment features such as:
    - (a) Utilization review of health care services, including review of medical necessity of hospital and physician services;
    - (b) Case management;
    - (c) Selective contracting with hospitals, physicians and other health care providers;
    - (d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and
    - (e) Other managed care provisions.
  - (2) The committee shall submit the health benefit plans described in Paragraph (1) to the Commissioner for approval within 180 days after the appointment of the committee.

### **Section 13. Periodic Market Evaluation**

The board, in consultation with members of the committee, shall study and report at least every three (3) years to the Commissioner on the effectiveness of this Act. The report shall analyze the effectiveness of the Act in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group health insurance marketplace. The report shall address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the Act. The report may contain recommendations for market conduct or other regulatory standards or action.

### **Section 14. Waiver of Certain State Laws**

No law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, shall apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to this Act.

**Drafting Note:** States should carefully examine how broadly or narrowly they allow the mandate

preemption to apply. Specifically, several mandates (e.g., newborn coverage, adoptive children coverage, and conversion requirements) may reinforce the goals of access and continuity of coverage and hence should be maintained. States which have overly burdensome benefit mandates may want to consider their exclusion from other health benefit plans.

#### **Section 15. Administrative Procedures**

The Commissioner may issue regulations (in accordance with cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable) for the implementation and administration of the Small Employer Health Coverage Reform Act.

#### **Section 16. Standards to Assure Fair Marketing**

- A. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.
- B. (1) Except as provided in Paragraph (2), no small employer carrier or producer shall, directly or indirectly, engage in the following activities:
  - (a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;
  - (b) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.
- (2) The provisions of Paragraph (1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.
- C. (1) Except as provided in Paragraph (2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.
- (2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.
- D. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

- E. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.
- F. No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.
- G. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.
- H. The Commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.
- I.
  - (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under (insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Model Act).
  - (2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

#### **Section 17. Separability**

If any provision of this Act or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the Act and the application of its provisions to other persons or circumstances shall not be affected thereby.

#### **Section 18. Effective Date**

The Act shall be effective on (insert date).

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